February 28, 2025

Appropriate Access to Residential Services for Children and Youth with Behavioral Health Needs

Interview findings

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Overview

- Federal requirements
- Approach
- Key findings
  - Data collection, sharing, and analysis
  - Assessment and admissions
  - Coverage and payment
  - Behavioral health workforce
  - Continuum of care

Federal requirements

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit
  - States must ensure Medicaid-covered children under age 21 have access to medically necessary, Medicaid coverable behavioral health services
- Institution for Mental Diseases (IMD) exclusion
  - Federal law prohibits payment for services provided to beneficiaries in IMDs (i.e., hospitals, nursing facilities, or other institutions of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases
  - Psych under 21 benefit and Section 1115 demonstration exceptions

Federal requirements

- Psychiatric residential treatment facilities (PRTF)
  - Accredited, non-hospital-based facilities that have an agreement with a state Medicaid agency to provide the psych under 21 benefit
  - Federal rules require certification of need, an individualized plan of care and an interdisciplinary treatment team, and limits the use of seclusion or restraint
- Qualified residential treatment programs (QRTPs)
  - Accredited group placement setting that is required to use a trauma-informed treatment model to address the needs of children in child welfare with serious emotional or behavioral disorders
  - Medicaid may cover clinical, therapeutic, and rehabilitation services, if the QRTP is not an IMD, or if the QRTP meets IMD exceptions

Federal requirements

- Other residential treatment facilities
  - Public or private congregate or group care settings that do not meet the requirements of a PRTF or QRTP
  - Examples include group homes, therapeutic boarding schools, and therapeutic wilderness programs
  - May be state licensed, but federal law does not define residential programs
  - May receive federal financial participation (FFP) for clinical, therapeutic, or rehabilitative services

Interviews

- Stakeholder interviews in five states, including officials from state Medicaid, behavioral health, and child welfare agencies
- CMS officials
- National experts, beneficiary advocates, and providers

Data on residential treatment facilities and the youth using them are limited

- No complete source of information on all residential facilities (e.g., QRTPs, other facilities), treatment modalities, or areas of expertise
  - CMS maintains a website of state-reported PRTFs and states collect some information
- States collect some data on use of residential treatment services, but vary in what is collected and the level of detail
- Some states indicate a need for guidance on data sharing between child-serving agencies, developing interagency data use agreements, and designing and developing data exchanges

Varied assessment and admission processes may lead to inappropriate use of residential care and is a concern

- Approaches for assessing need for residential treatment services vary
  - PRTF: the care team must specify that community resources do not meet the child's needs, and that inpatient care is required and expected to improve the condition
  - QRTP: a trained professional must use an age-appropriate, evidence-based, and validated functional assessment tool to document need
- No federal requirement to audit clinical appropriateness of decisions for admissions and denials for residential treatment

Federal and state coverage and payment rules factor into access to appropriate residential treatment services

- Medicaid payment for room and board is limited to PRTFs
  - QRTPs may receive Title IV-E payment
  - Other facilities must seek other funding
- One state increased payment for PRTFs and made supplemental payments to in-state PRTFs to increase wages and benefits
- All states use single case agreements with non-participating and out-of-state providers
  - Out-of-state placements can introduce post-treatment complexity and challenges
- Some facilities admit more out-of-state patients due to higher payment rates

Non-Medicaid specific considerations play a role in beneficiaries' access to residential care

- Workforce shortages can limit state ability to operate facilities at their licensed bed capacity
  - Recruiting, training, and retaining staff to serve youth with co-occurring conditions is especially challenging
  - Lack of awake overnight staff is acute
- Lack of home- and community-based services (HCBS) increases the demand for residential treatment beds and increases length of stay
  - For example, some states use targeted case management to increase provision of respite care and reduce caregiver burnout, and to provide warm hand offs with community-based provider post-crisis response

Next steps

- Discussion and thoughts on
  - Findings
  - Issues in need of clarification
  - Factors to consider in developing policy options
- Consider future phases of analytic work

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