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Pieces of the Puzzle: Examining the Problem of Mental Health Coverage for Homeless Children

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PIECES OF THE PUZZLE: EXAMINING THE PROBLEM OF MENTAL HEALTH COVERAGE FOR HOMELESS CHILDREN

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INTRODUCTION

The president and general counsel of a federally-qualified health center in Queens, New York sits in his cramped office covered with documents. Suddenly a small child screams from the waiting room nearby. Though many would be startled, he instantly recognizes the scream. Everyone in the clinic knows this child because the boy screams from the time he comes into the clinic until the time he leaves, and no one is touching him. The President knows that there is little that the clinic can do for this child. For nine years the Office of

Mental Health[1] has delayed the approval of adding a psychiatric license (Article 31) to the center's New York State Article 28 license, preventing the center from providing psychiatric services to the housed poor and homeless communities that it serves.[2] Without this additional licensure, the clinic cannot be reimbursed for any psychiatric services, including treatment by prescription medication. Thus, the clinic's hands are tied in helping this boy with his apparent psychiatric problems.[3]

Meanwhile, in San Diego, California, a young homeless mother is trying to find help for her nine-year-old son.[4] He has exhibited hostile behavior, attacking both his mother and others. Furthermore, he seems to have a conversion disorder, imagining his leg is injured when it is not. He hops or crawls around, and after eight months of not using this leg, his muscles are beginning to atrophy. He has missed months of school at a time. While this young boy has been institutionalized at least three times, he cannot remain long enough for treatment to make any substantial progress. Medi-Cal (California's version of Medicaid) informs the boy's mother that they are discontinuing coverage because she failed to complete an address form. She is living in a homeless shelter with her two younger children. These are just two examples of the ongoing struggle to provide homeless youth the mental health services they need using the Medicaid system.

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1. A sub-unit of the New York Department of Health.

2. Letter from Mark H. Van Guysling, Assistant Dir., N.Y. State Dep't of Health, Div. of Health Care Fin., to Sean T. Granahan, President/CEO and General Counsel, The Floating Hosp. (June 29, 2007) (on file with author) [hereinafter DOH Letter]. The Department of Health in New York State has acknowledged the Office of Mental Health's policy to "freeze" the approval of psychiatric services to such clinics. *Id.*

3. The author was present for this experience firsthand. Occurrences like this are likely a small representation of the struggles many in the community health field feel when attempting to do their jobs. It is estimated that one in three homeless children suffer from serious mental illness, in comparison to one in five for those school-aged children who are not homeless, and their access to resources is limited compared to non-homeless children. *See* NAT'L MENTAL HEALTH ASS'N, CHILDREN WITHOUT HOMES, http://www1.nmha.org/homeless/childrenandHomelessness.pdf (last visited June 27, 2008).

4. Interview with a homeless mother, identity confidential, in San Diego, Cal. (Mar. 25, 2008).

There are approximately one to two million homeless youth in America, although an exact number is difficult to determine.[5] Homeless youth are arguably the most vulnerable group of individuals in our country, specifically with regard to mental health issues, and they are being systematically denied help. Without it, they have little chance of integrating into society. By denying homeless children mental health benefits, states are helping to transform them into homeless adults.[6] Medicaid, the main conduit of health care services to the poor and homeless communities in this country, requires an integrated, multiple-solution change if it is to provide adequate mental health services to homeless children. These changes may also have a broader impact on the functioning of Medicaid as a whole.

This comment describes the current state of mental health care among homeless children and examines the inadequacies of Medicaid in providing such care. Part 1 provides a background of Medicaid and the numerous systems that are designed to provide children with the greatest health benefit packages.[7] Part 2 discusses the risks of mental health among homeless youth and how Medicaid serves such risks. Part 3 discusses potential solutions to various problems with Medicaid as discussed in recent scholarly literature and outlines the strengths and weaknesses of those arguments. Finally, Part 4 suggests an integrated approach to improving Medicaid, taking into account the needs of different Medicaid populations.

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5. *See* Abigail English, *Youth Leaving Foster Care and Homeless Youth: Ensuring Access to Health Care*, 79 TEMP. L. REV. 439, 442-43 (2006) ("Achieving reliable counts of homeless youth is complicated by two challenges: (1) variations in the definitions of 'youth' and 'homeless,' and (2) difficulties in counting a population that, by its very nature, is mobile, transitory, and not usually conspicuous.").

6. *See generally id.* at 440 ("The serious health problems that affect . . . homeless youth . . . place [these] young people at long-term risk for poor health, chronic homelessness, and inability to fully integrate into mainstream society through education, employment, and other means."). Untreated mental health problems in children have a negative impact on their ability to develop skills needed to integrate into society, leaving them with a greater risk of remaining homeless. *Id.*

7. These programs include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and State Children's Health Insurance Programs (SCHIP).

I. BACKGROUND OF MEDICAID

Medicaid was enacted in 1965, at the same time as the more politically charged Medicare.[8] It was codified as Title XIX of the Social Security Act.[9] "Medicaid was a cornerstone in [President Lyndon B.] Johnson's 'War on Poverty,' and its creation has been cited by some as a factor associated with the economic rise of the middle-class, the decline in infant mortality rates, and increased life expectancies for men and women."[10] Medicaid is modeled as a safety net for those individuals who are excluded from the unique, market-oriented healthcare system of the United States.[11] The basic design of the system is that the federal government matches state funds to act as a joint third-party payment system for the poor, not unlike a public form of health insurance.[12]

Even at its inception, some analysts acknowledged Medicaid as a "sleeper program"—due to the potential breadth of its comprehensive coverage for the poor.[13] Indeed, one goal of Medicaid was to provide access for the poor to "mainstream" medical care through "vendor payments."[14] By 1975 some twenty-three million people were reliant upon Medicaid, with a cost of approximately nine billion dollars.[15] Today, Medicaid is the single largest grant given to states by the federal

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8. *See* Delia D. Johnson, *Inadequacies of the Consumer-Driven Health Plan Model as a Template for Medicaid Reform*, 52 WAYNE L. REV. 1279, 1279 (2006); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 9 (2006) (explaining that Medicaid was overshadowed by Medicare when it was enacted in 1965).

9. Rosenbaum, *supra* note 8, at 8.

10. Johnson, *supra* note 8, at 1279 (quoting Joseph A. Califano, Jr., *What Was Really Great About the Great Society: The Truth Behind the Conservative Myths*, THE WASH. MONTHLY, Oct. 1999, at 13, *available at* http://www.washingtonmonthly.com/features/1999/9910.califano.html).

11. *See* Rosenbaum, *supra* note 8, at 7.

12. *See id.* at 9.

13. *Id.* at 10.

14. *Id.* at 5. "Mainstream" healthcare refers to care provided by sources originally only available to the rich; under Medicaid, the poor would have access to care from these same sources. *See id.* (citing ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID, at xvi (Free Pr. 1974) (1974)).

15. *See id.* (citing STEVENS & STEVENS, *supra* note 14, at xv).

government (at forty-three percent of total grants),[16] totaling over 300 billion dollars in expenditures in 2005.[17] It is now the third largest mandatory spending budget of the federal government.[18] Medicaid has been the subject of much debate in the last two decades due to the sheer size of resources allocated to it, and yet it remains a complicated system understood by few.

Part of this confusion stems from the organization of Medicaid, which varies among states. Each state is responsible for creating its own Medicaid plan.[19] Some states blend Medicaid with other programs.[20] The Medicaid Act[21] is the federal statute that specifies criteria for a state plan to qualify for federal funding.[22] The extensive list of requirements includes, for example, that participating states define who is qualified for Medicaid,[23] that services be open to all qualified individuals,[24] and that services be delivered with reasonable promptness.[25]

Eligibility for Medicaid is determined in part by the Act and in part by volition of the participating state. In general, individuals are categorized based largely on income and resources into one of three groups: mandatory categorically needy, optional categorically needy, and optional medically needy.[26] The mandatory categorically needy group largely encompasses those already receiving some form of federal

16. VERNON SMITH ET AL., KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE CONTINUING MEDICAID BUDGET CHALLENGE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2004 AND 2005, 8 (2005), *available at* http://www.kff.org/medicaid/upload/The-Continuing-Medicaid-Budget-Challenge-State-Medicaid-Spending-Growth-and-Cost-Containment-in-Fiscal-Years-2004-and-2005-Results-from-a-50-State-Survey.pdf.

17. *Id.* at 7.

18. Johnson, *supra* note 8, at 1279-80.

19. In fact, participation in the Medicaid program is voluntary, yet every state participates in some form. APA Help Center—Managed Care & Health Insurance, http://www.apahelpcenter.org/articles/article.php?id=65 (last visited Nov. 21, 2008).

20. *See, e.g.*, SCHIP *supra* note 8; Dajour v. City of New York, 2001 WL 830674, *4 (S.D.N.Y. July 23, 2001) (explaining that EPSDT services in New York are administered through a program called the Child/Teen Health Program).

21. The Medicaid Act, 42 U.S.C. § 1396 (2008).

22. *See* 42 U.S.C. § 1396a(a) (2008).

23. *Id.* § 1396a(a)(10)(A)(ii) (2008).

24. *Id.* § 1396a(a)(8) (2008).

25. *Id.*

26. Lewis v. Thompson, 252 F.3d 567, 570 (2d. Cir. 2001).

aid (for example, Aid to Families with Dependent Children, or Supplemental Security Income); states must, at a minimum, provide coverage to this group.[27] States have the option, however, of extending coverage to the other groups.[28] The optional categorically needy group includes individuals who are medically vulnerable or needy (as defined by the Act)[29] and meet income and resource requirements for some form of aid.[30] Finally, states can also elect to extend coverage to the optional medically needy, a group comprised of people similar to the optional categorically needy except that they have higher levels of income and resources.[31]

Qualified individuals under Medicaid are entitled to coverage for a broad range of services. They include inpatient hospital services, outpatient hospital services (including rural and federally-qualified health centers), laboratory and x-ray services, nursing facility services, physician services (including office and home care), dental care, physical therapy, prescribed drugs (including dentures and eyeglasses – with some limitations), intermediate care services for the mentally retarded, and extensive services for children under the age of twenty-one.[32] In addition, children under eighteen are guaranteed ambulatory services and pregnant women are guaranteed prenatal care and delivery services.[33] Although the services provided by Medicaid appear exhaustive on its face, the manner Medicaid is implemented in a particular state can affect individual access to such services.[34]

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27. *Id.*; *see also* 42 C.F.R. §§ 435.110-435.170 (outlining the extensive list of individuals who are eligible for mandatory coverage).

28. *Lewis*, 252 F.3d at 570.

29. The optional categorically needy refers to those who are not currently receiving some form of aid but whose income either meets those requirements, or would without some mitigating factor; the categorically needy is also limited to certain groups including children under the age of twenty-one, nineteen, or eighteen (as chosen by the state), the blind, the "totally disabled," and pregnant women. *See* 42 C.F.R. §§ 435.210-435.236.

30. *Lewis*, 252 F.3d at 570.

31. *Id.*

32. 42 U.S.C. § 1396d(a) (2000) (defining what is encompassed within the term "medical assistance" for purposes of the Medicaid Act).

33. 42 U.S.C. § 1396a(A)(10)(C)(iii) (2000).

34. *See infra* Part 1.B.

Furthermore, states can elect to set limits on certain services, such as length of hospital visit or number of annual visits.[35]

A. The Fee-Based System and Managed Care

Medicaid started as a fee-for-service (or fee-based) system, essentially designed for the autonomy of the health professional. The doctor treated episodes of illness and charged separate fees for each treatment.[36] The patient was indemnified for these fees through Medicaid.[37] This older system was transaction-based; doctors determined on their own what services were required and what they would cost.[38] "The institutional centerpiece of this old system was the hospital which provided for both acute and much sub-acute care."[39]

The fee-for-service system led to massive costs for Medicaid, as it gave doctors incentive to over-diagnose.[40] Managed care developed as a more integrated system that was meant to curb the rampant spending under the fee-based system.[41] "The goals of managed care organizations (MCOs) were to (1) provide high quality care while avoiding or minimizing the fee-for-service incentive to 'over-utilize'; and (2) optimize marketplace forces, such as volume and discounting

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35. THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, DEFICIT REDUCTION ACT OF 2005: IMPLICATIONS FOR MEDICAID 3 (2006), *available at* http://www.kff.org/medicaid/upload/7465.pdf [hereinafter DEFICIT ACT].

36. John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions the Building Blocks of Tomorrow's Health Care Delivery and Financing System*, 3 CONN. INS. L.J. 1, 6 (1997).

37. *Id.* at 6-7.

38. *Id.* at 6.

39. *Id.* Acute care refers to immediate treatment for illness or injury, and sub-acute care refers to more long-term treatment or physical therapy after an illness or injury.

40. *See id.* at 16 ("The infusion of money, fee-for-service reimbursement and the highly judgmental nature of what was medically necessary or appropriate incentivized providers to increase the use of medical procedures."). In fact, since the 1970s, health care costs "have risen 5 times faster than the gross domestic product." *Id.* at 3. There are also many issues with Medicaid fraud that are beyond the scope of this comment.

41. *Id.* at 16-17 (discussing the role of legislature in encouraging the growth of HMOs and PPOs to contain the growing costs of healthcare).

arrangements, with providers and hospitals."[42] In short, MCOs use a combination of "medical quality and cost-management tools, i.e. selective contracting, pre and concurrent treatment review, case management, the use of primary care physicians as 'gatekeepers,' outcomes review and financial incentives [(i.e. capitation)]" to contain costs.[43] This shift from fee-for-service to managed care was enhanced by the Balanced Budget Act of 1997, which facilitated mandatory enrollment in MCOs and allowed states to contract with entities that serve Medicaid beneficiaries.[44] Thus, the legislature attempted to extend the utilization management and economic incentives of managed care to the Medicaid population.[45]

However, the implementation of managed care to the homeless population has proven difficult. The practicalities of homeless life often conflict with the basic foundations of managed care, such as keeping a primary care physician (homeless families and youth are often transient, even among shelters within the shelter system), scheduling appointments, and maintaining communication with the MCO.[46] Therefore, fee-for-service still exists in some states for

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42. *Id.* at 8.

43. *Id.* at 40-41.

44. Kristina W. Hanson & Haiden A. Huskamp, *State Health Care Reform: Behavioral Health Services Under Medicaid Managed Care: The Uncertain Implications of State Variation*, 52 PSYCHIATRIC SERVICES 447, 447 (2001).

45. *Id.* In some states, such as New York, the homeless are exempt from mandatory Medicaid managed care, giving them the "option" of selecting an MCO or staying with purely fee-for-service. *See* NEW YORK CITY MEDICAID MANAGED CARE UPDATE: A PROVIDER'S GUIDE TO THE NEW YORK MEDICAID CHOICE PROGRAM, Winter 2007, at 6, *available at* http://www.nyc.gov/html/doh/downloads/pdf/hca/choice-w2007.pdf [hereinafter CHOICE PROGRAM].

46. *See* Howard M. Leichter, *The Poor and Managed Care in the Oregon Experience*, 24 J. HEALTH POL. POL'Y & L. 1173, 1176 (1999). In 1997, the Oregon Health Council stated:

> The paperwork requirements to enroll in the OHP and then to show up for scheduled appointments at distant clinics, between eight and five, Monday through Friday, is extraordinarily difficult, if not impossible, for people without a permanent address, no phone, no predictable schedules and no means of transportation. Some OHP eligibles are simply unable to make their way through the enrollment process, while others have a paranoid fear of "the state" or for other reasons will not seek publicly provided medical attention.

Id.

purposes of serving populations like the homeless.[47] Specifically, homeless families and homeless youth often rely on obtaining their health care from "a variety of 'free clinics' and safety net programs that serve low-income populations regardless of their insurance status."[48] As these clinics are not a part of an MCO, in states that mandate MCOs, clinics are often not licensed to provide the full range of services guaranteed to eligible individuals through the Medicaid Act.[49] Furthermore, state Medicaid agencies can place limits on reimbursement rates for mental health services in fee-for-service systems, further constraining such clinics that provide care to the homeless.[50] Not only do these policies negate the purpose of Medicaid, but they act to systematically deny homeless youth access to the full range of services provided by the Act.[51]

B. Early Periodic Screening, Diagnosis, and Treatment

Early Periodic Screening, Diagnosis, and Treatment, or EPSDT, is one of the required benefits of Medicaid as defined by the statute.[52] EPSDT covers all Medicaid-qualified individuals under the age of twenty-one.[53] EPSDT services include screening services (which involve a comprehensive health and developmental history, including assessment of both physical and *mental health development*), comprehensive unclothed physical exams, age-appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines),

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47. CHOICE PROGRAM, *supra* note 45, at 6.

48. English, *supra* note 5, at 445-46.

49. Such as the federally-qualified health center mentioned in the Introduction, *see supra* text accompanying notes 1-2.

50. In New York, for example, the Department of Health has imposed fifteen percent utilization caps on mental health services provided by Article 28 clinics, such as FQHCs, with the intent that oversight of mental health services be conducted by other agencies. *See* DOH Letter, *supra* note 2.

51. This includes EPSDT services, which are the pinnacle service for children under Medicaid. Unlike adults, children under age twenty-one are guaranteed a broad range of services both for their physical and mental health.

52. 42 U.S.C. § 1396a(a)(43) (2008).

53. *Id.* § 1396a(a)(43)(A).

and laboratory tests.[54] Most importantly, EPSDT services guarantee homeless children mental health services, including: family therapy, crisis intervention, medication monitoring, and behavioral management modeling.[55] That is, assuming that homeless youths are able to get access to a facility providing these services.

Like Medicaid in general, states differ in how they implement EPSDT. In New York, EPSDT is referred to as the Child/Teen Health Program (C/THP).[56] Health care providers must be incorporated into a Medicaid MCO to administer C/THP services. This has resulted in a disconnect because many homeless youth in New York access services through the fee-for-service system. The MCOs refuse to contract with the homeless care providers, as they are strictly fee-for-service, and therefore, homeless youth have no access to C/THP (EPSDT) benefits. Because EPSDT benefits include mental health services, homeless children are systematically denied this help if they are not part of an MCO. While this is a complicated problem, the end result is that many homeless children, who are normally eligible for Medicaid, and thus EPSDT, are systematically denied these benefits if they use the fee-for-service system. This is a violation of the Medicaid Act, which guarantees EPSDT benefits, including mental health services, to homeless youth.[57] This effect is most likely seen in other states as well.

Case law suggests that homeless youth can challenge state Medicaid agencies regarding the administration and notification of EPSDT services. In *Dajour v. City of New York*, an unpublished opinion, the United States District Court for the Southern District of

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54. U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services, EPSDT Benefits, http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/02_Benefits.asp (last visited Apr. 29, 2008).

55. California Adolescent Health Initiative, *EPSDT in the Budget and the Medi-Cal Redesign* (2004), http://www.californiateenhealth.org/AMHPN_EPSDT_june.asp.

56. N.Y. STATE DEPT. OF HEALTH, NEW YORK STATE MATERNAL AND CHILD HEALTH SERVICES TITLE V BLOCK GRANT 2007 APPLICATION/2005 ANNUAL REPORT 120 (2007), *available at* http://www.health.state.ny.us/nysdoh/mchbg/docs/2007_mchbg_application.pdf.

57. *See* Dajour v. City of New York, 2001 WL 830674, at *8 (S.D.N.Y. July 23, 2001) ("The plaintiffs are among the intended beneficiaries of the EPSDT provisions, not because the[y] are homeless or because the[y] have [illness], but because they are Medicaid-eligible children under the age of twenty-one.").

New York held that a group of homeless children and their families presented material issues of fact to whether the availability of EPSDT benefits were a federal right (in that case the specific 'right' was asthma medication).[58] This case and others establish that homeless children can enforce Medicaid benefits guaranteed to them by statute using section 1983 actions.[59] Therefore, homeless children should similarly be able to enforce mental health benefits granted to them through Medicaid. No such cases exist, but a trend where groups of homeless children bring action against Medicaid agencies for enforcement of EPSDT mental health services may help to shed light on this problem.

C. State Children's Health Insurance Program

Congress passed the State Children's Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997.[60] SCHIP is a block grant program, with federal funds matching state funds (often at higher rates than for Medicaid)[61] in order to "'initiate and expand child health assistance to uninsured, low-income children.'"[62] SCHIP is targeted at providing health insurance to those children who are uninsured, by expanding eligibility for those children whose families'

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58. *Id.* at *12 ("In sum, plaintiffs have a private right of action under Section 1983 to enforce the EPSDT provisions of the Medicaid Act and the defendants' motions to dismiss the Section 1983 claims based on these provisions is denied.").

59. *See* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 509-10 (1990). In *Wilder*, the Supreme Court held that the Boren Amendment granted a non-profit association of hospitals a substantive right to reasonable reimbursement rates under the Medicaid Act by a section 1983 action, the vehicle for enforcing federal rights. *Id.* Subsequent decisions have relied upon the *Wilder* framework to determine that individuals covered by the Medicaid Act have standing to enforce individual federal rights under the statute. *See, e.g., Dajour*, 2001 WL 830674.

60. Lynn A. Blewett & Michael Davern, *Distributing State Children's Health Insurance Program Funds: A Critical Review of the Design and Implementation of the Funding Formula*, 32 J. HEALTH POL. POL'Y & L. 415, 418 (2007); *see also* ELICIA HERZ & EVELYNE PARIZEK BAUMRUCKER, CONG. RESEARCH SERV., REACHING LOW-INCOME, UNINSURED CHILDREN: ARE MEDICAID AND SCHIP DOING THE JOB? 4 (2001), http://digital.library.unt.edu/govdocs/crs/permalink/meta-crs-1426:1.

61. HERZ & BAUMRUCKER, *supra* note 60, at 4.

62. Blewett & Davern, *supra* note 60, at 418 (quoting 42 U.S.C. § 1397aa).

income put them basically at the cusp of receiving Medicaid.[63] As a result, SCHIP largely expands Medicaid services in the opposite direction from the homeless—towards the lower middle class. Some fear that SCHIP expands coverage too far. Indeed, when the program was up for renewal in 2007, President George W. Bush vetoed two versions of a bill expanding coverage under SCHIP.[64]

Medicaid, while a system that varies from state to state, was designed to provide health care to the poor community.[65] Today, most homeless youth are eligible for Medicaid (or SCHIP), yet many are not receiving the full range of services guaranteed to them as beneficiaries (for example, EPSDT services).[66] The next section of this comment discusses more specifically mental health problems faced by homeless youth and Medicaid's role in providing mental health services.

II. MENTAL HEALTH

Mental health is a severe problem among homeless populations. The California Psychiatric Association estimates that one third of all homeless individuals suffer from mental illness.[67] One study found that among the homeless population in New York City, mental health and substance abuse accounted for sixty-nine percent of hospitalizations, compared with ten percent among the rest of New York City.[68] These gross differences in prevalence of mental illness

63. HERZ & BAUMRUCKER, *supra* note 60, at 4 ("The law requires that states cover children in families with incomes that are either: (1) above the state's Medicaid financial eligibility standard but less than 200% of the FPL, or (2) in states with Medicaid income levels for children already at or above 200% FPL, within 50 percentage points over the state's current Medicaid income eligibility limit for children.").

64. Sheryl Gay Stolberg, *President Vetoes Second Measure to Expand Children's Health Program*, N.Y. TIMES, Dec. 13, 2007, at A36.

65. Rosenbaum, *supra* note 8, at 9 (quoting TIMOTHY STOLTZFUS JOST, DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 63 (2003)).

66. *See* HERZ & BAUMRUCKER, *supra* note 60, at 5-6.

67. California Psychiatric Association, Homelessness and Mental Health (Mar. 28, 2003), http://www.calpsych.org/publications/access/homelessness.html.

68. CITY OF N.Y., THE HEALTH OF HOMELESS ADULTS IN NEW YORK CITY: A REPORT FROM THE NEW YORK CITY DEPARTMENTS OF HEALTH AND MENTAL

between the homeless and the rest of society are undoubtedly transferred to homeless children. This section provides a brief background into the mental health problems faced by homeless youth and how Medicaid is both able and unable to remedy these problems.

A. Mental Health and Homeless Youth

Homeless youth includes young people who have spent time in juvenile justice placements and foster care, and children who are thrown out of homes by their families or effectively forced out by extreme abuse.[69] Homeless families also contribute to the growing number of homeless youth—it is estimated that on any given night, families make up thirty-four percent of the homeless, consisting of more children than adults.[70] Homeless youth experience high rates of serious health problems, including substance abuse and mental health issues.[71] Studies suggest that overall health declines after becoming homeless for both behavioral and situational reasons.[72] Similarly, a study found that homeless youth in Hollywood, California were found to have higher mental health indicators than non-homeless youth—examples of serious problems include major depression, conduct disorders, and post-traumatic stress disorder.[73] It is important to point out that several studies have shown a negligible difference between

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HYGIENE AND HOMELESS SERVICES 1 (2005).

69. English, *supra* note 5, at 443; *see also* Scott Hollander et al., *Helping Clients Transition to Independent Living*, 45 FAM. CT. REV. 444, 445 (2007) (discussing a study that suggested that thirty percent of the homeless in America spent some time in foster care placement).

70. Debra J. Rog & John C. Buckner, *Homeless Families and Children, in* U.S. DEP'T OF HOUS. AND URBAN DEV., TOWARD UNDERSTANDING HOMELESSNESS: THE 2007 NATIONAL SYMPOSIUM ON HOMELESSNESS RESEARCH, HOMELESS FAMILIES AND CHILDREN 5-1 (2007).

71. English, *supra* note 5, at 443.

72. *Id.* at 444. *See also* Edna M. Menke & Janet D. Wagner, *A Comparative Study of Homeless, Previously Homeless, and Never Homeless School-Aged Children's Health*, 20 ISSUES COMPREHENSIVE PEDIATRIC NURSING 153, 153 (1997) (discussing homeless children's increased risk of depression and anxiety compared to children who have never been homeless).

73. James A. Farrow et al., *Health and Health Needs of Homeless and Runaway Youth*, 13 J. ADOLESCENT HEALTH 717, 721 (1992).

homeless youth and low-income youth, suggesting that both groups suffer as a result of poverty—and not homelessness per se.[74]

Substance abuse severely compounds mental health among older homeless youth, many of them runaways. Homeless youth often turn to drugs and alcohol as coping mechanisms for the difficulties of homeless life.[75] However, these substances further destabilize the child and can exacerbate mental health issues.[76] One study of 432 homeless Los Angeles youth found that seventy-one percent had abused either drugs, alcohol, or both.[77] Youth who lived in households have a lower rate of using marijuana, alcohol, and crack cocaine when compared to street youths.[78] Drug use is also linked to living on the streets as opposed to a shelter; youth living on the streets use more heroin, methamphetamines, and crack cocaine.[79]

The conclusion to be drawn from these studies is that homelessness creates a substantial risk for mental illness and substance abuse[80] in children. These are just two of many hurdles homeless youth face that complicate their ability to integrate into society. Furthermore, those youth who could have been identified during preventive stages of treatment, and later develop severe mental problems and/or substance abuse issues, will likely consume more resources in back-end care—either through institutionalization or emergency room care.[81] Federal and state governments should take a

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74. ROG & BUCKNER, *supra* note 70, at 5-11.

75. Farrow, *supra* note 73, at 720.

76. *Id.* at 721.

77. June R. Wyman, *Drug Abuse Among Runaway and Homeless Youths Calls for Focused Outreach Solutions*, NIDA NOTES , May-June 1997 1 (U.S. Dep't of Health and Human Services, Nat'l Inst. Of Health, Nat'l Inst. on Drug Abuse, 1997), *available at* http://www.nida.nih.gov/NIDA_Notes/NNVol12N3/Runaway.html. These findings of drug and substance abuse had occurred by the time of being surveyed. The report continued by also stating that in a nationwide study of 600 homeless youth, fifty percent of those who had attempted suicide had done so because of the influence of drugs or alcohol. *Id.*

78. *Id.*

79. *Id.*

80. Substance abuse, although just as substantial a problem among homeless youth as mental illness, is outside the scope of this comment.

81. *See, e.g.*, Marcela Berdion, *The Right to Healthcare in the United States: Local Answers to Global Responsibilities*, 60 SMU L. REV. 1633, 1661-62 (2007) ("These hospitals, . . . are providing preventive care because they have realized that

much greater interest in preventive methods of providing mental health and substance abuse care for homeless youth, as it is a much more financially feasible option compared to emergency care.[82]

B. Mental Health and Medicaid

The funding of mental health services was traditionally a state-only system, but as this shifted to a more concerted effort between federal and state systems, Medicaid's role grew.[83] Ten percent of Medicaid expenditures are now spent on mental health care, excluding prescription drugs.[84] Under the Medicaid statute, states can provide inpatient psychiatric care to individuals under age twenty-one.[85] EPSDT services under Medicaid also include mental health screening for this age group.[86] Given these facts, it should be of little doubt that Medicaid *should be* providing mental health services to homeless children when such children are covered by Medicaid. However, as discussed above, the trend towards mandating Medicaid managed care in many states has had the effect of greatly stalling or completely preventing homeless children from access to psychiatric services.[87]

In general, states use one or a combination of three different models for providing mental health services through Medicaid: integrated programs, carve-out programs, and strict fee-for-service programs.[88] In an integrated program, the state Medicaid agency contracts with MCOs to provide some measure of mental and physical health services under a single capitation rate, which is determined by

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non-emergency medical care not only saves the health of the patient, but also saves the hospital significant amounts of money."); Erik Eckholm, *To Lower Costs, Hospitals Try Free Basic Care for Uninsured*, N.Y. TIMES, Oct. 25, 2006, at A1.

82. *See* Eckholm, *supra* note 81 ("'For most preventive efforts there is an upfront expense,' said Alan D. Aviles, president of the corporation. 'But over the long term it saves money.'").

83. Diane Rowland et al., *Accomplishments and Challenges in Medicaid Mental Health*, 22 HEALTH AFF. 73, 74 (2003).

84. *Id.*

85. *Id.* at 76.

86. *See supra* text accompanying notes 54-55.

87. *See id.*

88. Hanson & Huskamp, *supra* note 44, at 447-48.

the federal government.[89] In a carve-out program, the state agency contracts directly with mental health entities that provide treatment and services.[90] These entities assume the financial risk for the provision of services, either through capitation or on a risk-sharing basis.[91] Finally, in a strict fee-for-service program, mental health services are reimbursed without any management of resources.[92]

These three mental health service models potentially effect homeless youth in substantially different ways. In an integrated program, homeless youth are largely excluded, as managed care systems are often ineffective for those without stable homes.[93] Even in integrated programs, like New York, services are still largely administered to the homeless on a fee-for-service basis.[94] This leads to the following problems: 1) homeless care providers (fee-for-service) are not licensed to provide the full range of mental health services;[95] and 2) the fee-for-service rates are capped at a low rate,

89. *Id.* at 448. Capitation rates are determined by the federal government and act as a sort of "lump sum" method of covering a particular population. *See* California Health Care Foundation, Medi-Cal: Reports & Initiatives, Capitation Rates in the Medi-Cal Managed Care Program, *available at* http://www.chcf.org/topics/medi-cal/index.cfm?itemID=20381 (last visited July 4, 2008). In 2001, fifteen states and the District of Columbia used integrated programs to administer mental health services through Medicaid, including New York and Ohio. Hanson & Huskamp, *supra* note 44, at 448.

90. Hanson & Huskamp, *supra* note 44, at 448. In 2001, sixteen states used carve-out programs to administer mental health services through Medicaid, including California, Massachusetts, and Texas. *Id.* at 449.

91. *Id.* at 448.

92. *Id.* In 2001, nineteen states used fee-for-service programs to administer mental health services through Medicaid, including Alaska, New Jersey, and Georgia. *Id.* Of these, three states, Louisiana, South Dakota, and Wyoming, did not use any form of managed care in their administration of Medicaid. *Id.*

93. Leichter, *supra* note 46, at 1176.

94. While New York generally mandates managed care, there are twenty categories of individuals who are exempt from this requirement, including the homeless. *See* CHOICE PROGRAM, *supra* note 45, at 6. While hypothetically this gives homeless the "choice" to select a managed care provider or remain on fee-for-service, the needs of the homeless are not realistically met by managed care without inclusion of community health clinics, where many homeless receive the bulk of their care. Email from Sean T. Granahan, President/CEO and General Counsel, The Floating Hospital to author (Nov. 28, 2007 8:01 EST) (on file with author).

95. *See supra* text accompanying note 49.

keeping facilities from being able to afford the provision of needed services.[96] While carve-out programs are possibly more effective in allowing facilities to provide mental health services, they also effectively separate mental health services from physical health services. As we have learned from managed care, an integrated system that takes into account preventative, front-end care would be a more effective and efficient use of Medicaid, specifically with regard to homeless youth. Homeless children are vulnerable and at greater risk to develop more expensive physical and mental health issues later in life if neglected while they are young. Finally, strict fee-for-service systems are expensive and tend to create the most potential for abuse and over-utilization.[97]

In regard to substance abuse, Medicaid currently accounts for approximately one third of all public funding of substance abuse (as well as mental health) treatment.[98] An older study done in Michigan and California found that spending on alcohol abuse, drug abuse, and mental health accounted for eleven to twelve percent of all Medicaid expenditures.[99] The issues that stem from Medicaid mental health services likely mirror those issues in Medicaid substance abuse treatment.[100]

Steps have been taken to create parity between physical and mental health coverage in private insurance.[101] Under the mental health parity bill, physical health and mental health are given equal weight of coverage by insurers.[102] Efforts have been passed that

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96. *See supra* text accompanying note 50. The cap imposed in New York for fee-for-service mental health services to the homeless is fifteen percent, not high enough to support the need.

97. *See supra* text accompanying note 40.

98. JEFFREY A. BUCK & KAY MILLER, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES IN MEDICAID 1995 (1995), *available at* http://mentalhealth.samhsa.gov/publications/allpubs/SMA02-3713/default.asp.

99. *Id.*

100. Substance abuse treatment is outside the scope of this comment. The author's primary concern is mental health treatment and prevention, specifically among younger homeless youth.

101. *Senate Passes Mental Health Parity Bill*, N.Y. TIMES, Sept. 19, 2007, http://www.nytimes.com/2007/09/19/us/19mental.html?ex=1347854400&en=5ebdb52bf4d450cf&ei=5088&partner=rssnyt&emc=rss [hereinafter *Senate Parity Bill*].

102. *Id.* ("The Senate unanimously approved legislation on Tuesday night that would require equal health insurance coverage for mental and physical illnesses

would include Medicaid managed care in such legislation,[103] and the legislative branch is currently contending with the issue.[104] While no such parity currently exists for Medicaid, it would certainly help to improve the situation facing homeless children with mental health risks. States would be forced to acknowledge that the organization of their Medicaid plans often neglect mental health among the poor and homeless communities.

The need for legitimate mental health services is greater for homeless and poor children in comparison to other youth.[105] While Medicaid has improved the landscape of mental health in America, the benefits of the program could be better utilized by improving the efficiency of state implementation and passing legislation that applies commercial sector mental health parity to Medicaid.

III. SOLUTIONS FROM THE LITERATURE

This section will discuss the strengths and the weaknesses of two models that have been used in the recent literature as examples of how to reform Medicaid in general. It is unclear from these models whether they would 1) be practical solutions across the board, and 2) even if they would be practical, how the reforms would affect Medicaid mental health services specifically. The first, a move towards a consumer-driven health plan model, is a dramatic shift in the way Medicaid would be administered and would have as much impact on the current system as the trend from fee-based to managed-care organizations. The second is an account of the success of community-based healthcare centers (also called Federally Qualified

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when policies cover both.").

103. CONG. BUDGET OFFICE COST ESTIMATE, S. 558 MENTAL HEALTH PARITY ACT OF 2007 (2007) http://www.cbo.gov/ftpdocs/78xx/doc7894/s558.pdf ("The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. CBO estimates that enacting S. 558 would increase federal direct spending for Medicaid by $280 million over the 2009-2012 period and by $790 million over the 2009-2017 period.").

104. *See Senate Parity Bill*, *supra* note 101; *see also* Robert Pear, *House Approves Bill on Mental Health Parity*, N.Y. TIMES, Mar. 6, 2008, http://www.nytimes.com/2008/03/06/washington/06health.html ("Insurers and employers supported the Senate bill. Many opposed the House version, saying it would drive up costs.").

105. *See supra* Part II.A.

Health Centers), which specifically have come far in providing some services to the homeless population.

A. Consumer-Driven Health Plan Model

Consumer-driven health plan models, introduced recently into private health insurance plans, offer a radical departure from previous forms of health coverage. Health Savings Accounts (HSAs), enacted by Congress in 2003, are set up to encourage saving for future health-care expenses through tax incentives.[106] A patient pays for services with their own money using an HSA account, which theoretically introduces consumer-based forces to help regulate the market.[107] This system is relatively new and few employers even offer HSAs to their employees.[108]

The consumer-driven model is predicated on individuals' access to information about the cost and quality of available care; this allows individuals to make educated decisions about how they spend their HSA funds.[109] Such access to information is one of the primary disadvantages of Medicaid populations—specifically the homeless. The homeless and housed-poor communities live based on need, not market forces. Furthermore, consumer-driven health plan models cannot provide the Medicaid community with the same tax incentives that it offers those with private insurance because many in the Medicaid community already have little to no tax liabilities.[110]

What a consumer-driven model could provide is assistance to higher-income populations who, despite their resources, still qualify for Medicaid or who are on the cusp of qualifying for Medicaid. This includes those families whose incomes make them ineligible for Medicaid, but who are eligible for SCHIP and other programs.[111] However, to implement such an option into the Medicaid sphere would completely redefine the basic design of Medicaid. Medicaid is,

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106. Johnson, *supra* note 8, at 1288.

107. *Id.* The consumer-driven health plans were seen as a way for employers to reduce their contributions to employee health plans. *Id.* at 1287-88.

108. *Id.* at 1288.

109. *Id.* at 1288-89.

110. *Id.* at 1302.

111. *See supra* Part I.B.

after all, not designed as a grant program, but as a third-party payment system[112]—the federal-state funds go directly to the health-care facility or doctor, and not to the covered individual.[113] It could be possible (although not desirable) to set up HSAs for uninsured individuals using Medicaid funds, but considering that HSAs have struggled to be adopted in private insurance, it is currently hard to picture this as a viable option.

B. Federally-Qualified Health Centers

A Federally-Qualified Health Center (FQHC) provides "primary and preventive health care services for people living in rural and urban medically underserved communities regardless of their ability to pay. These health centers overcome economic, geographic, and cultural barriers to primary health care, and they tailor services to the needs of the community."[114] FQHCs operate as a primary source of care for the homeless and are a key to establishing a viable solution to the lack of mental health care for the homeless.

In 2003, there were an estimated 890 FQHCs operating in 4990 sites throughout the United States.[115] FQHCs are the medical home for over fourteen million people, nine million of whom are minorities.[116] In 2004, President Bush called for a doubling of these health centers across the nation.[117] FQHCs play an important role in providing better access to those who slip through the cracks of the private health insurance system—an important goal of Medicaid. In recent years there has been a surge of patients in these clinics, emphasizing the growing need for their inclusion in national health initiatives.[118]

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112. Rosenbaum, *supra* note 8, at 9.

113. *Id.*

114. Juniper Lesnik, *Community Health Centers: Health Care as it Could Be*, 19 J.L. & HEALTH 1, 5 (2005) (quoting U.S. DEPT. OF HEALTH AND HUM. SERVS. (HHS), HEALTH RES. AND SERVS. ADMIN. (HRSA), & BUREAU OF PRIMARY HEALTH CARE (BPHC), COMTY. HEALTH CTR. PROGRAM INFO., MISSION STATEMENT, http://bphc.hrsa.gov/programs/CHCPrograminfo.asp).

115. *Id.* at 7.

116. *Id.*

117. *Id.* at 12.

118. *Id.* at 10 ("In fact, in 2003 there was an 11 percent increase overall in the

FQHCs are competent in administering the goals of the American healthcare system to the homeless community. A report by the Department of Health and Human Services (DHHS) entitled *Healthy People 2010*[119] established two goals of the American healthcare system: 1) "[i]ncrease the quality and years of healthy life," and 2) "[e]liminate health disparities."[120] FQHCs are meeting these two goals more effectively than other healthcare providers.[121] This suggests that FQHCs are more than adequate to provide mental health services to homeless youth—if properly funded.

A solution leaning on FQHCs alone will not provide an adequate remedy to the current problems with Medicaid overall. FQHCs depend heavily upon Medicaid reimbursements, so increasing reliance on FQHCs suffers from the same inadequacy as increasing Medicaid itself: cost. President Bush pledged to increase the number of FQHCs, but shortly thereafter enacted the Deficit Reduction Act which aimed to decrease the Medicaid budget over the course of five years.[122] These are inconsistent goals. Federal grants outside of Medicaid reimbursements are not substantial enough to singularly support an FQHC, nor are donations or patient fees. A more pragmatic solution would be to increase current funding to those FQHCs already in operation around the country.

The city of San Francisco has focused on FQHCs in implementing a new program that provides health-care coverage for all uninsured individuals within its city limits.[123] A recent initiative, Healthy San Francisco, provides free medical services to all individuals under the federal poverty line and subsidized services to others (quarterly fees

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number of uninsured patients who received health care through [FQHC]s; some centers saw increases as high as 73 percent in their uninsured patient rolls.").

119. U.S. DEPT. OF HEALTH AND HUMAN SERVS., HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH 7-10 (2d ed. 2000) [hereinafter HEALTHY 2010].

120. *Id.* at 2.

121. *See generally id.* at 14-16 (discussing ways in which FQHCs (referred to in that article as CHCs) are eliminating disparities in care that are not as much of a concern to mainstream healthcare).

122. *Id.* at 11. *But see* DEFICIT ACT, *supra* note 35, at 1.

123. Kevin Sack, *San Francisco to Offer Care for Uninsured Adults*, N.Y. TIMES, Sept. 14, 2007.

ranging from 60 dollars to 675 dollars).[124] The program finances itself with the hope of not increasing taxes but instead utilizing the funds, about 200 million dollars, that the city already spends on health care for uninsured individuals.[125] The program is not a proxy for insurance, but instead a restructuring of the San Francisco healthcare safety net.[126] It is the first program of its kind—a system developed entirely by a city government to compensate for increasingly insufficient federal and state funds. San Francisco is the ideal environment to pilot a program of this kind: it has compact geographical limits, a liberal political climate that largely supports universal health care, and an integrated city-county government.[127] Whether a program like Healthy San Francisco could be replicated in other communities is difficult to determine, but it is a step in the right direction.[128]

While FQHCs do provide an opportunity to overhaul the implementation of Medicaid services to poor communities, this requires the integration of FQHCs into the mainstream healthcare scheme. For example, FQHCs need the participation of MCOs in order to try to stave off the huge financial flux that would occur if the number of FQHCs were actually doubled (or tripled) and became a more significant staple of the American health-care system. Beyond financial reasons, FQHCs need inclusion within managed care, which is now the only way for homeless populations to access certain services (for example, mental health services) in some states.[129] FQHCs have to become a bigger contender not only in policy but in

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124. *Id.*

125. *Id.*

126. Healthy San Francisco: About Us, http://www.healthysanfrancisco.org/about_us/ (last visited Nov. 21, 2008).

127. Sack, *supra* note 123, at A1.

128. The Healthy San Francisco plan was recently challenged in court as a violation of the 1974 Employment Retirement Income Security Act (ERISA), but was upheld by the Ninth Circuit. Amy Lynn Sorrel, Court Upholds San Francisco Employer Insurance Mandate, American Medical News, Oct. 27, 2008, available at http://www.ama-assn.org/amednews/2008/10/27/gvsb1027.htm.

129. As previously stated, FQHCs that service the homeless currently operate on the fee-for-service basis, which is still vulnerable to the spending problems faced by Medicaid prior to the switch to managed care. Therefore, many state Medicaid plans only offer mental health services through managed care, called "integrated programs." *See* Hanson & Huskamp, *supra* note 44, at 448.

practice—and this requires the participation of not only the state agencies that administer Medicaid, but also participation of the MCOs.

Creative solutions are available to make substantial positive changes in Medicaid administration but, they have not been implemented by the legislature. Bringing in unique structures such as the consumer-driven model (as in private insurance), or bolstering support and integration of FQHCs into the mainstream health care system, will help to solve problems with Medicaid. The sum of all these parts, however, could have a much greater impact.

IV. AN INTEGRATED SOLUTION

Unfortunately, a satisfactory overhaul of Medicaid mental health services for homeless youth requires a larger overhaul of Medicaid and related state programs. These problems include general organizational problems within states. Beyond organizational problems are reports that states have manipulated Medicaid expenditure requirements to increase the amount of federal contribution above their entitlement.[130] The Bush Administration has already responded to this latter concern by implementing a half-dozen new rules regulating federal spending on public hospitals, teaching hospitals and services to the disabled, among others.[131]

A single solution to the issues stemming from Medicaid will not be enough. Indeed, the very design of the system allows for flexibility among states and various regions. Yet, like the transition from fee-for-service to managed care, there needs to be integrated changes in the administration of services; these changes could include further reliance upon FQHCs, as well as adoption of cost-reducing strategies like the consumer-driven health care model. Drastic uniform changes

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130. KATHRYN G. ALLEN, U.S. GEN. ACCOUNTING OFFICE, MEDICAID: INTERGOVERNMENTAL TRANSFERS HAVE FACILITATED STATE FINANCING SCHEMES 1-5 (2004), *available at* http://www.gao.gov/new.items/d04574t.pdf.

131. Robert Pear, *Governors of Both Parties Oppose Medicaid Rules*, N.Y. TIMES, Feb. 24, 2008, at A18 [hereinafter Pear II]. The article discusses the opposition Governors have to the new rules, which federal officials estimate will save the federal government fifteen billion dollars over a course of five years. *Id.* States disagree, with California officials reporting that they would lose an estimated twelve billion dollars alone during the five-year period. *Id.*

will not necessarily work across the board, as Medicaid serves such a large and diverse subset of Americans. FQHCs, if supported by MCOs, would be able to help the homeless and housed-poor communities, while the consumer-driven models would only go to benefit low- to mid-income families who access Medicaid services through programs like SCHIP.

A. Changes in Implementation of Medicaid

Medicaid will always be a complex system, as it is different in each state and each state has different populations to cover. In New York, which includes the massive homeless population in New York City, there has been great disparity in the services provided to different groups in need. Low-income housed communities may be covered by Medicaid managed care, which provides them with the full range of Medicaid services. The homeless are dependent largely upon the fee-based system of FQHCs, which have difficulty in providing some of the services technically guaranteed by Medicaid. As the head of one FQHC explained: "Our largest problem currently is a lack of access to related health care services . . . psychiatry, therapy-based services . . . and the State is reluctant to allow . . . more access to the services . . . forcing us to rely on referrals that never occur because our patients are charity care."[132]

Homeless youth could more adequately access mental health services if mental health parity legislation was passed that included the Medicaid population. Currently, mental health parity bills are being considered by Congress, but they apply only to private insurance.[133] Mental health parity would help make access to mental health services equivalent to that of physical health services for all Medicaid enrollees. For homeless youth, this would mean that upon visiting a FQHC, full access to both physical and mental health services would be available, and fewer mental health problems would slip through the cracks.

Second, it is necessary to acknowledge that many diverse groups of individuals qualify for Medicaid and have different needs. The

132. Email from Sean T. Granahan, President/CEO and General Counsel, The Floating Hospital to author (11/28/07 8:01 EST) (on file with author).

133. *See Senate Parity Bill*, *supra* note 101.

homeless and housed poor, who already utilize FQHCs, rely on such community-based facilities for much of their care. MCOs must incorporate FQHCs into their networks such that FQHCs can provide the broadest range of services possible, as guaranteed by the Medicaid Act, while simultaneously effecting cost reduction. To make this practicable, it may be necessary to consider a new form of Medicaid payment system that is a hybrid of the fee-for-service and managed care systems, i.e., a system that takes into account the transient nature of many homeless youths' lives, but still focuses on preventative treatment and cost management. For the low-income population—who have more resources than the homeless—a program like the consumer-driven model may have a positive impact on current Medicaid spending. At least the introduction of market forces such as public relations would incentivize physicians to focus on caring for these populations.

Another possible partial solution to the problem is to eliminate the current overlap between Medicaid and Medicare. The Medicare program, which is the federal government's primary health care program for the elderly, is estimated to cost roughly 374 billion dollars per year.[134] Many individuals are dually eligible for both Medicaid and Medicare.[135] Much of the care required by these dually eligible individuals is long-term care—bills that are often covered by Medicaid, as opposed to Medicare; thus the elderly who are dually eligible also put pressure on Medicaid.[136] If long-term care were to be covered entirely by Medicare for these individuals, it would reduce pressure on Medicaid by a substantial amount, saving those resources

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134. Eleanor Bath Sorresso, *A Philosophy of Privatization: Rationing Health Care Through the Medicare Modernization Act of 2003*, 21 J.L. & HEALTH 29, 30 (2008).

135. NAT'L GOVERNORS ASS'N, MEDICAID REFORM: A PRELIMINARY REPORT 2 (2005), *available at* http://www.nga.org/Files/pdf/0506medicaid.pdf [hereinafter GOVERNORS ASS'N] ("Approximately six million Americans are dually eligible for full Medicare and Medicaid benefits, and another one million receive financial assistance to cover out-of-pocket costs, such as co-payments and deductibles.").

136. *Id.* ("These individuals represent a small portion of Medicaid's 53 million person caseload, and despite the fact that they are fully insured by Medicare, they still consume *42 percent* of all Medicaid expenditures.") (emphasis added); *see also* Wayne L. Anderson et al., *Adoption of Retrospective Medicare Maximization Billing Practices by State Medicaid Home Care Programs*, 28 J. HEALTH POL. POL'Y & L. 859, 863 (2003).

for other demographics, such as homeless children.[137] Medicaid, which has a smaller budget than Medicare, should not be picking up the tab of long-term health care for the elderly.[138]

B. Regulation on Spending

The federal government has recently responded to the rampant spending under Medicaid by enacting new rules that limit federal payments for certain services, including training of doctors and services for the mentally disabled.[139] The desired results of such rules would only be saving the federal government about fifteen billion dollars over a course of five years—a minimal improvement to a program that costs over 300 billion dollars a year. The rules however, seem to be a response in part to problems with states misappropriating Medicaid funds.[140] As much as managed care was once implemented to avoid the over-utilization of fee-based services, some federally-imposed mechanism is required to curb states from being incentivized to misappropriate Medicaid as a source of state funding.

Beyond the problems faced at the state level, budget restrictions have also targeted the individual Medicaid beneficiaries. The Deficit Reduction Act of 2005 (DRA) set out to reduce spending on Medicaid by increasing co-payments, even for children, shifting some of the financial burden back onto individuals and families.[141] Further limitations on benefits affect adults and other groups, while allegedly maintaining EPSDT benefits for children.[142] The Congressional Budget Office predicted that the changes reflected in the DRA would result in a savings of over eleven billion dollars within five years, and

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137. With a budget larger than Medicaid, it seems unreasonable that services charged to Medicaid are later reimbursed by Medicare (referred to retrospective billing). *See* Anderson, *supra* note 135, at 864. Medicaid should not be used to subsidize long-term costs unless it is the last resort. *Id.* at 865.

138. The restructuring of those who are dually eligible under Medicare and Medicaid is beyond the scope of this paper, the author merely acknowledges that it is another compounding factor to the financial strain on Medicaid. *See generally* GOVERNORS ASS'N, *supra* note 135.

139. Pear II, *supra* note 131.

140. *See* ALLEN, *supra* note 130, at 1.

141. DEFICIT ACT, *supra* note 35, at 1-2.

142. *Id.* at 3.

over forty-three billion dollars over the next ten years.[143] But these changes are not focused on cost-efficiency through consolidating Medicaid bureaucracy; they are only focused on cost-reduction by limiting services and making the poor pay more for the same services.

Scaling back the costs of Medicaid, while attempting to increase access and services, is a poor decision and only a temporary fix. Focusing efforts on increasing preventive care among all populations, especially homeless children, will undoubtedly save costs in hospital stays and long-term care down the road.[144] The best solution to the current problem of providing mental health services to homeless youth through Medicaid lies in fusing together the various resources currently in existence and treating these children in a more efficient and preventative manner.

CONCLUSION

It has been said that "a nation's greatness can be measured by how it treats its weakest members."[145] It is difficult to imagine a more weak or vulnerable group in our society than homeless children. Many of these youth require more adequate mental health treatment, if they are to have any hope of integrating into society. Without this help, they are likely to remain homeless, becoming a greater burden on society as they develop into adults.[146] Most importantly, unlike our frequent justifications for ignoring homeless adults, we cannot believe that children are homeless by choice. Homeless children are homeless through no fault of their own, yet they are virtually ignored by society. Providing them with the same mental health services we provide to insured children is the least our society can do to give them stable footing on which to make a better life for themselves.

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143. *Id.* at 1.

144. *See* A PLAN TO STABILIZE AND STRENGTHEN NEW YORK'S HEALTH CARE SYSTEM: FINAL REPORT OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE 21ST CENTURY 13 (2006), http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf (discussing that back-end care is usually more costly and less beneficial than front-end care).

145. This quotation has been cited to everyone from Mahatma Ghandi, to Winston Churchill, as well as American President Harry Truman.

146. English, *supra* note 5, at 440.

In our current and seemingly unending debate over healthcare, it is crucial to remember that the programs we already have in place need to function properly and effectively. Health care is consistently a hot-button issue in presidential campaigns, yet the discussion is almost entirely focused on private health insurance—dodging the issues of Medicaid.[147] Medicaid, currently a gigantic siphon of federal and state budgets, has the potential to solve many of our current mental health problems, most importantly with regard to homeless children. The pieces of the puzzle must be put together to ensure that deserving and vulnerable groups like homeless children are not overlooked or ignored as is now often the case under private insurance. Medicaid has seen many changes, as has the rest of the healthcare system; it is essential for it to continue to evolve to meet the needs of all its beneficiaries.

Justin Keller[*]

147. *See* Robin Toner, *2008 Candidates Vow to Overhaul U.S. Health Care*, N.Y. TIMES, July 6, 2007; *see also* Healthcare '08—Candidate positions, Issues, Health Insurance, Coverage, Reform, http://www.healthcentral.org/healthcare08/ (last visited Mar. 22, 2008) (presenting a graphical view of the various presidential candidates' views on healthcare reform, emphasizing government action with regard to prescription drugs, the uninsured, and private insurance issues).

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