September 30, 2013

The Honorable Max Baucus
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 201510

The Honorable Orrin G. Hatch
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

We, the undersigned organizations, are pleased to respond to your request on ways to improve the mental health system for Medicaid-insured children and adolescents in the United States. We appreciate your leadership in drawing attention to the gaps in access to quality mental health services for children and adolescents and the urgent need to expand integrated care approaches to promote early intervention and effective treatment for this underserved population.

Question 1. What administrative and legislative barriers prevent Medicaid child and adolescent recipients from obtaining the mental health and behavioral health care they need?

Numerous administrative barriers limit Medicaid-insured children and adolescents from obtaining needed mental health and behavioral health care. These have been well documented and include problems with inadequate payment, restrictive authorization policies, shortages of child and adolescent mental health clinicians, and managed care arrangements inadequately designed to meet the needs of children.

- **Payment rates are low and certain mental and behavioral health services important to children and adolescents are not reimbursed.** State Medicaid agencies pay insufficient rates for mental health services and for integrated care that are significantly below the rates paid by Medicare and private payers. For example, in 2011, the average Medicaid fee for a psychiatric diagnostic evaluation was $112; a 45-50 minute psychotherapy session was $72; and pharmacological management was $45.[1] Insufficient payment is also the result of existing psychotherapy and diagnostic interview codes that do not account for patient and family complexity or for the communication needed with family members and caregivers, other health providers, school officials, and others involved in the care of children. Equally important, not enough state Medicaid agencies provide coverage for family psychotherapy and multiple family group psychotherapy. Nor do they provide sufficient coverage for services provided by social workers, psychologists, and advanced practice nurses in primary care settings and mental health services provided by primary care clinicians. Additionally, payment is frequently denied for physical and mental health services that take place on the same day, non-face-to-face services, consultation services (including electronic consults and telehealth), care coordination, multidisciplinary team meetings, maternal depression screening, and transportation. Further, opportunities for the early identification and treatment of emerging mental health problems among children and adolescents is made difficult by states' denial of coverage for those with

signs and symptoms associated with an emerging mental health condition not yet at the level of a diagnosed mental disorder.

- **Restrictive authorization policies impede access to needed care**. Prior authorization policies are often used by Medicaid managed care plans to restrict access to coverage of inpatient stays, often resulting in treatment discontinuation and fewer services than mental health and behavioral health specialists recommend. Admission to an inpatient setting when other modes of treatment have proved ineffective is routinely denied unless the child is a threat to himself/herself or to others or has a serious medical complication. Similarly, admission for inpatient substance abuse treatment is typically unavailable except for detoxification purposes. [2] An additional problem is the fact that access to state Medicaid coverage for intensive mental health services is generally restricted to children or adolescents who are designated to have serious emotional disturbance on the basis of their involvement with multiple systems, in or at risk of out-of-home placement, or meeting criteria for a home and community-based waiver program. Moreover, authorization for evidence-based care is frequently not approved by states for the frequency and length of time recommended.

- **Shortages of child and adolescent mental health specialists are pervasive.** According to the American Academy of Child and Adolescent Psychiatry, there are some 7,400 practicing child and adolescent psychiatrists in the US, and over 15 million children and adolescents in need of their special expertise. [3] Moreover, largely because of inadequate reimbursement, Medicaid children are disproportionately affected. [4] Shortages of substance abuse counselors, inpatient psychiatric and substance abuse treatment, intensive outpatient care, and residential treatment for Medicaid-insured children and adolescents are widespread and severely impede access to a continuum of care. In addition, managed behavioral health panels are often too small. Yet, access to out-of-network providers when in-network services are unavailable or wait times too long is routinely denied.

- **Managed care systems have not been effectively designed to meet the needs of all children and adolescents with mental health and behavioral health conditions**. Neither states using general managed care organizations with separate behavioral health care plans nor states using an integrated approach to providing both physical and behavioral health services are adequately meeting the needs of all children and adolescents. In the carve-out model, children and adolescents with serious emotional disturbances are more likely to gain access to the range and intensity of services they need, but the children and adolescents with less serious or emerging mental and behavioral disorders are often not well served. That is because they fail to meet stringent criteria for services established by the carve-out plan and the therapists best able to meet their needs may not be participating in the behavioral health plan. By contrast, in the single, comprehensive managed care model, children and adolescents with emerging mental health conditions are more likely to be identified early and receive coordinated physical and mental health services than in the carve-out model. However, the literature shows that in integrated care arrangements, behavioral health dollars tend to be diverted to physical health care for adult populations; risk adjustment strategies are seldom put in place; and experts in children's mental health care are often not involved in planning and design.[5]

In addition to these administrative barriers, the Medicaid statute itself contains several provisions that effectively serve as barriers to improvements for mental health and substance abuse care for children and adolescents. These are provisions that pertain to waiver program demonstration funds, managed

care arrangements, health home services for individuals, and long term care services. They either restrict access to participation by children and adolescents or fail to address their unique mental and behavioral health provider and treatment requirements. Our recommendations to the Committee, presented below in response to question #3, are intended to address these legislative concerns.

Question 2. What are the key policies that have led to improved outcomes for child and adolescent beneficiaries in programs that have tried integrated care models?

State Medicaid agencies have adopted numerous different policies that have led to improved outcomes for children and adolescents served in integrated care models. Experience has shown that careful planning for the design and broad implementation of integrated care, which involves both state policy and practice-based changes, is essential. States have financed this planning and on-going support not only through foundation grants and grants from their Departments of Health and Mental Health but also through the Centers for Medicare and Medicaid Services (CMS) health home planning grants and CMS innovation awards. Training of primary care clinicians by mental health and behavioral health providers is also critical, and states have funded their training activities using Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) administrative funds and CMS innovation grants, in addition to state grants, often partnering with psychiatric and social work training programs. Equally important, of course, is the availability of appropriate payment, and states with successful integrated care models in place have revised their payment policies to support direct patient services, case conferences, and other related services. States have changed their payment policies to allow, for example, for the administration of standardized mental health assessment instruments, medical team conferences, consultation without the patient present, family therapy, and care coordination that takes into account the complexity of the child's needs.

Question 3. How can Medicaid be cost-effectively reformed to improve access to and quality care for people with mental and behavioral needs?

We have identified nine policy reforms that we believe could improve the mental health system for Medicaid-insured children and adolescents.

1. **Congressional Support for Integrated Physical and Behavioral Health Care for Children and Adolescents**

Direct the Secretary to support integrated physical and behavioral health care for children and adolescents, both in primary care and behavioral health care settings, by requiring states to document how their Medicaid systems support provider and payment arrangements to facilitate access to integrated care and to ensure the intensity and range of services needed by children and adolescents. The requirement should address the needs of all children and adolescents with mental or behavioral health treatment needs, ranging from those with emerging mental health problems to those with severe emotional disturbances. It should apply to state managed care arrangements established under Sections 1115, 1915(b), and 1932(a).

2. **Adequate Access to Mental Health and Substance Use Providers For Children and Adolescents**

Require states to ensure that children and adolescents enrolled in either general managed care or behavioral health managed care arrangements have appropriate and timely access to the types of mental health and substance use providers they need. Such providers would include, but not be limited to, providers with expertise in serving children and adolescents with serious mental illness. States should be required to document that its networks have sufficient participation by child and adolescent mental health and substance use providers and, when access problems exist, to allow children and adolescents to seek care out of network without financial penalties. The requirement should apply to managed care arrangements established under Sections 1115, 1915(b), and 1932(a).

3. **Coverage and Authorization for Evidence-Based Mental Health and Substance Use Treatment**

Require states to cover all mental health and substance use treatment services for children and adolescents that have been shown to be evidence-based. The Secretary should rely on the National Institute for Mental Health, the National Institute on Drug Abuse, and the Substance Abuse and Mental Health Services Administration to compile a list of evidence-based interventions.

4. **Waiver Demonstration Program for Early Detection and Intervention of Major Mental Illness among Children, Adolescents, and Young Adults**

Amend Section 1115A(b)(2)(B) to expand CMS' criteria for selecting innovative payment and service delivery models to include: *preventing major mental illness and reducing the impact of long-term mental illness among children, adolescents, and young adults through community education and rapid outreach, clinical assessment, and intensive multi-level treatment that includes evidence-informed mental health services, family psychoeducation services, and supported education and employment.*

5. **Enhanced Administrative Payments for State Children's Mental Health Training and Consultation for Primary Care**

Amend Section 1903(a)(7) to provide federal payments to states at the enhanced rate of 100 percent declining to 60 percent in year four to a designated team of child and adolescent mental health professionals for the purposes of developing:

- a statewide system of child psychiatry consultation to primary care providers and referrals to child and adolescent mental health specialists, and
- training of primary care providers and mental health professionals in the early identification of behavioral health issues in children and adolescents, including risk factors for major mental illness.

6. **Medicaid Health Home Options for Children and Adolescents**

Amend Section 1945(a) to permit states the option to offer health home services only to eligible children up to age 21 with chronic conditions.

Amend Section 1945(a) to require that states submitting a health home amendment for all individuals include in their plans a description of how they will address the unique service requirements and providers for children and adolescents.

Amend Section 1945(h) to expand the definition of eligible individuals with a serious and emotional condition to include children and adolescents with a mental health condition with an expected duration

of 12 months or longer. Children should be eligible participants for this model even if their mental health issues do not rise to the level of a DSM V diagnosis.

Amend Section 1945(c)(1) to extend the enhanced Federal Medical Assistance Percentage (FMAP) of 90 percent for health home services to 12 fiscal quarters.

7. **Community-based Mental Health Services for Children in or at Risk of Psychiatric Residential Treatment**

Amend the 1915(c) home and community based waiver program to allow eligibility for home and community-based mental health services in the community for children under 21 who would otherwise require the level of care provided in a psychiatric residential treatment facility. Alternatively, permanently reauthorize the Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program (Section 6063 of the Deficit Reduction Act) to allow home and community-based services to children under 21 as alternatives to psychiatric residential treatment facilities.

8. **Child Eligibility Expansion for Money Follows the Person Rebalancing Demonstration**

Direct the Secretary to expand the eligibility criteria established under Section 6071(b)(2) of the Deficit Reduction Act to allow eligible children up to age 21 to qualify for home and community-based long term care services under the Money Follows the Person (MFP) Rebalancing Demonstration Grant Program if they reside in an inpatient facility for a period of not less than 30 consecutive days. Also, expand the definition of inpatient facilities under Section 6071(b)(3) to include a psychiatric residential treatment facility.

9. **EPSDT Mental Health Screening and Reporting**

Direct the Secretary to modify the CMS 416 Annual EPSDT Participation Report to include the total number of adolescents ages 12-21 receiving mental health screening services, referral for mental health treatment, and treatment for mental health conditions.

We would welcome the opportunity to discuss our policy recommendations with you or your staff. If you require additional information or have any questions, please contact Peggy McManus or Harriette Fox at The National Alliance to Advance Adolescent Health (mmcmanus@thenationalalliance.org; hfox@thenationalalliance.org).

Sincerely,

The National Alliance to Advance Adolescent Health
Academic Pediatric Association
AIDS Alliance for Women, Infants, Children, Youth & Families
American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Association for Marriage and Family Therapy
American Foundation for Suicide Prevention
American Psychological Association

Anxiety and Depression Association of America
Association of Medical School Pediatric Department Chairs
Baylor College of Medicine, Division of Adolescent Medicine and Sports Medicine
Boston Children's Hospital, Division of Adolescent and Young Adult Medicine
Children Now
Children's Defense Fund
Children's Hospital Colorado, Division of Adolescent Medicine
Children's National Health System
Early Assessment and Support Alliance (EASA) Center for Excellence, Portland State University
Eating Disorders Coalition for Research, Policy, and Action
Family Voices
First Focus Campaign for Children
Healthy Teen Network
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Pediatric Nurse Practitioners
National Network for Youth
School-Based Health Alliance
Society for Adolescent Health and Medicine
Society of Professors of Child and Adolescent Psychiatry
The Trevor Project
University of Washington Department of Pediatrics, Division of Adolescent Medicine
Warren Alpert Medical School of Brown University, Division of Child and Adolescent Psychiatry

REFERENCES

[1] American Academy of Pediatrics. *Medicaid Reimbursement Survey, 2010-2011*. Elk Grove Village, Il: AAP, 2012.
[2] McManus MA, Shejavali KI, Fox HB. *Is the Health Care System Working for Adolescents?* Washington, DC: Maternal and Child Health Policy Research Center, October 2003.
[3] American Academy of Child and Adolescent Psychiatry. Workforce Issues. Available at http://www.aacap.org/AACAP/reources_for_primary_care/workforce_issues.aspx
[4] Koppelman J. *The Provider System for Children's Mental Health: Workforce Capacity and Effective Treatment.* Washington, DC: National Health Policy Forum, October 2004.
[5] Information from the Health Care Reform Tracking Project found at: http://www.fmhi.usf.edu/cfs/stateandlocal/hcrtrking/hctrkprod.htm.