NACBH

National Association *for* Children's Behavioral Health

May 31, 2019

Anne L. Schwartz, Ph.D.
Executive Director
Medicaid and CHIP Payment and Access Commission
1800 M Street, NW, Suite 650 South
Washington, DC 20036

Dear Dr. Schwartz:

The National Association for Children's Behavioral Health (NACBH) is pleased to provide input related to the Commission's upcoming report on Medicaid Institutions for Mental Diseases (IMDs) as required by the SUPPORT for Patient and Communities Act, and for future study and recommendations about federal Medicaid IMD policy.

NACBH represents multi-service treatment agencies providing a wide array of behavioral health and related services, such as crisis intervention, residential treatment, psychiatric hospitalization, therapeutic group homes, in-home services, therapeutic foster care, independent living, alternative educational services, respite, day treatment, outpatient counseling and a range of community outreach programs. Medicaid pays for the majority of treatment services delivered by our members, who are also connected with child welfare, juvenile justice, and educational systems in their communities. Additional payers include TRICARE and private insurance plans.

The Medicaid IMD Exclusion *Does* Apply to Enrollees Under Age 21

There is a widespread misperception that the 1972 addition of "inpatient psychiatric hospital services for individuals under age 21" allows children to receive necessary services in a wide variety of settings. It does not. For the majority of 24-hour settings that meet the Medicaid definition of IMDs, states may not legally claim federal financial participation (FFP) for any of the health care services provided to children residing in them, whether mental or physical, and whether provided on- or off-site.

Commonly referred to as the Psych Under-21 benefit, this narrow exception to the IMD exclusion allows only three types of IMDs to receive Medicaid reimbursement for enrollees under age 21: psychiatric hospitals, psychiatric units of general hospitals, and Psychiatric Residential Treatment Facilities (PRTFs) as defined in federal Medicaid regulations. PRTFs are the only non-hospital setting that the Secretary has exercised statutory authority to define under the Psych Under-21 benefit. Not all residential treatment centers are PRTFs, and not all states have PRTFs within their borders – to our knowledge, only about half do.

EPSDT *Does Not* Trump the IMD Exclusion

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit allows payment only for otherwise covered Medicaid services, i.e., those listed in §1905(a) of the Social Security Act. The addition of 1905(a)(16), inpatient psychiatric services for individuals under age 21, was a first step towards increasing access to necessary services for children and adolescents. However, it authorized FFP only for inpatient psychiatric services, not the full range of health care services available under EPSDT. In fact, there was a series of recoupment actions against states in the early 2000s, upheld by the HHS Departmental Appeals Board, requiring certain states to return federal matching funds for non-psychiatric health care services provided to children in the three allowable types of IMDs. So, even after allowing Medicaid reimbursement for a limited range of inpatient psychiatric settings for children, the payment policy was discriminatory.

In November 2012, new federal guidance gave states the option of including non-psychiatric health care services in active plans of care for children receiving Psych Under-21 services, permitting states to legally claim FFP for all Medicaid-covered services for children in the three allowable types of IMDs. The 21st Century Cures Act went a step further by requiring EPSDT coverage for these children, effective in January of this year. While welcome, it provides only incremental relief from the larger discriminatory barrier imposed by the IMD exclusion.

The IMD Exclusion *Does* Trump EPSDT

Immediately following the list of Medicaid covered services in §1905(a) is the IMD exclusion, with bold added here for emphasis:

except as otherwise provided in paragraph (16), such term does not include –

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

"Such term" refers to medical assistance (Medicaid). Paragraph (16) is the Psych Under-21 benefit, which now includes EPSDT coverage under the Cures Act. Otherwise, no services in paragraphs (1) through (28), including EPSDT at paragraph (4)(B), are covered for children who are in institutions for mental diseases.

CMS Is Not Able to Consistently Enforce the IMD Exclusion

The Centers for Medicare and Medicaid Services (CMS) cannot identify which IMDs are PRTFs and therefore covered by the Psych Under-21 benefit. Over the last decade or so, we have seen several versions of a list of facilities that CMS identifies as PRTFs, none of them accurate. As just one example, all three versions identify no PRTFs in Iowa. Iowa has had PRTFs, licensed as Psychiatric Medical Institutions for Children (PMICs), since 1987; today, Iowa has 29 PMICs with 467 licensed beds. This is a significant

knowledge gap – for policy and financing discussions, but also for quality and other oversight functions – and is one area where CMS should improve its data collection.

CMS cannot identify improper claims for services provided to children residing in excluded IMDs. Unlike PRTFs, which should be visible to CMS through claims that include a per diem and a particular CPT code, excluded IMDs are invisible to CMS. For example, if children are placed in congregate care facilities for which IV-E or the state is paying room and board, the health care services billed to Medicaid just look like outpatient claims. CMS doesn't know where the children are living. It is up to the states to identify which of their licensed facilities are IMDs and comply with the exclusion across programmatic lines. IMDs are not limited to certain licensing categories or authorities. Medicaid defines them by their characteristics: more than 16 beds, primarily engaged in care or treatment of persons with mental or substance use disorders.

The child welfare example is particularly timely as the imminent implementation of the Family First Prevention Services Act (FFPSA) will make several kinds of congregate care facilities more visible for potential IMD compliance actions in the states. FFPSA restricts federal IV-E payments for congregate care to a short list of specific types of facilities, several of which would appear to meet the definition of an IMD if they have more than 16 beds: Qualified Residential Treatment Programs, family-based residential substance abuse treatment facilities, and, possibly, residential care for children who have been or are at risk of becoming victims of sex trafficking. Unless there is a change in federal Medicaid policy, we believe that states are going to be at high risk for 100% of health care costs historically, although perhaps not lawfully, matched by federal Medicaid payments.

The current policy has been inconsistently enforced by CMS, which doesn't have the capacity to seek out every violation. Their approach has been to address violations when they come to CMS' attention through submission of state Medicaid plan amendments, and even those submissions and entire state Medicaid plans don't reveal the extent or nature of facilities licensed by non-health authorities where Medicaid enrollees may reside.

We appreciate the line that CMS has to negotiate between absolute enforcement and aggressive overreach that could damage the federal-state partnership, and it certainly wouldn't further the purposes of the Medicaid program to blow up a system that has evolved around conflicting statutory authorities. But the uneven enforcement and underlying misalignment with Title IV-E leaves states continually at risk of compliance and recoupment actions, and their concern is escalating. In just the past week, NACBH responded to inquiries from child welfare authorities in two states, asking for information about how the IMD exclusion may affect their IV-E plans under the Family First Prevention Services Act. That is policy clarity that needs to come from both CMS and the Administration for Children and Families, and soon.

Attached is our 2014 brief describing the disconnection between child welfare and Medicaid, produced when an earlier version of FFPSA was under discussion in Congress.

Another area where CMS could improve its data collection would be requiring states to report annually on the in- and out-of-state facilities with which they have provider agreements to deliver Psych Under-21

services, by name/EIN and type of setting (psychiatric hospital, psychiatric unit of general hospital, or PRTF), and some measure of utilization (again, by type of setting and in/out-of-state location). Medicaid law only requires that the inpatient psychiatric services be delivered, not that they be delivered in all or the most appropriate of the three allowable settings. Collecting the information would serve several purposes: (1) illuminate the extent to which states are providing the least restrictive, covered setting within the child's home state, (2) ensure an accurate inventory of PRTFs, including facilities not recognized as PRTFs by the states where they are located and licensed, and (3) identify facilities whose home state may be violating the IMD exclusion by claiming a federal match for what look like outpatient claims, should there be a desire to consistently enforce the IMD exclusion.

MACPAC's Comment Request

Regarding the specific items outlined in your comment request, information gathered by Watson Health and SAMHSA can likely provide a more comprehensive picture than NACBH can of how the visible segment of the IMD universe operates, is regulated and paid.

We hope that your report will acknowledge the limitations of the identified stakeholders, scope of inquiry, and timeline. The IMD exclusion is a hugely complicated topic and, from NACBH's perspective, not generally recognized as affecting children's services. Silence or misinformation on that aspect is not helpful in addressing the very real policy issues.

NACBH has long advocated for the elimination of the IMD exclusion, its antiquated and discriminatory basis, the waste of resources that are spent inappropriately to accommodate it, and the tremendous confusion and system disruption its haphazard enforcement inflicts on the states. We would be happy to provide additional information and answer any questions.

Sincerely,

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national association for children's behavioral health

Addressing the Mental Health of Youth in Foster Care

Principles

- Individualized needs must drive case planning and treatment planning, with the involvement of the child and family.
- Placement and treatment decisions must be based on comprehensive physical, mental, developmental, functional and environmental assessments.
- Services must support children and families in their homes and communities, whenever indicated by comprehensive assessment.
- A full array of treatment and support services must be available to meet the complex needs of children and families experiencing mental or emotional disturbance or other traumatic events.
- Services must be coordinated across child-serving systems.
- The scope and duration of treatment and support services must be determined by ongoing assessment and measurement against outcome goals.

Background

Most children and youth served by child welfare agencies are also eligible for Medicaid. Child welfare is responsible for their safety, wellbeing and permanency, and Medicaid is responsible for their health care. Both programs are federal-state partnerships, and each has evolved over time in terms of both federal requirements and state options to best meet their population's needs. However, what should be a collaborative, comprehensive approach to improving the functioning and future prospects of these children is not. The federal child welfare and Medicaid laws disconnect where they should most logically meet, if not overlap: mental health. And the gap widens with every discussion of reforming either program without considering how both should work together for children and families.

Mental Health Gaps Between Child Welfare and Medicaid

States receive federal financial participation under Title XIX Medicaid (for health care and treatment services) for virtually all children in foster care, and Title IV-E foster care assistance (for room, board and maintenance) for about 40 percent of them. States rely on these federal funding streams to substantially underwrite the costs of caring for children and youth in their custody. However, differing requirements and practices of the two programs create a significant gap in a critical area: mental health.

It is well documented that foster children and youth have much higher mental health needs than their non-foster care peers. Studies have demonstrated that rates of mental illness are high among children who have experienced maltreatment and have been in foster care. Many children meet diagnostic criteria for major disorders before entering foster care, indicating that it is frequently the experience of maltreatment, not foster care, that predicates mental health problems (McMillan, et al, 2005). By the time they are teenagers, 63 percent of children in foster care have at least one mental health diagnosis; 23 percent have

three or more (White, Havalchack, Jackson, O'Brien & Pecora, 2007). According to a 2010 study of Medicaid-enrolled children in thirteen states, children in foster care were prescribed antipsychotic medications at nearly nine times the rate of children enrolled in Medicaid who were not in foster care. The alarming over-prescription of powerful psychotropic drugs, which have not been tested for safety and effectiveness in children, points to a clear lack of assessment, monitoring and referral to appropriate services.

A common misconception about Medicaid is that under the Early and Periodic Screening, Diagnosis and Treatment mandate (EPSDT), states provide all medically necessary Medicaid services to enrolled children and youth, including a comprehensive array of mental health services. While it is true that Medicaid covers an increasingly robust variety of outpatient, in-home, peer support and other community-based mental health services, there are too few options for beneficiaries who need a 24-hour treatment environment that falls below an acute care setting.

When Medicaid was established in 1965, it included an IMD exclusion stating that federal financial participation is not available for any services provided to an individual who is under age 65 and is a patient in an institution for mental diseases (IMD). The intent was to prevent states from shifting costs which historically they had borne to the federal government. In 1972, the law was changed to establish an exception to the IMD exclusion for individuals under age 21 through a benefit called Inpatient Psychiatric Services for Individuals Under Age 21, commonly referred to as the "Psych Under-21" benefit. It allows inpatient psychiatric services in three settings: psychiatric hospitals, psychiatric units in general hospitals, and other settings as defined by the Secretary. Thus far the Secretary has defined only Psychiatric Residential Treatment Facilities (PRTFs) as an "other setting," and only about half the states license and regulate them.

When the under-21 exception to the IMD exclusion was established, Medicaid covered children's mental health services based on a traditional medical model of care: outpatient and inpatient. Many treatment models and settings have been developed in the four decades since then to better serve individual needs and respond to changing community standards on where and how services should be delivered, but the Medicaid program has not been updated to include them. A strict interpretation of the IMD definition – institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases – inhibits provider agencies from developing a robust array of services if their cumulative bed count would exceed 16. This, in turn, prevents administrative economies of scale, seamless service delivery for children who move between levels of care and, ultimately, the availability of necessary and effective services that should be provided under EPSDT.

The conflict for states is that ensuring the safety of foster children with significant behavioral health needs can mean placement in 24-hour settings which meet the definition of an IMD but are not one of the three allowed within the Psych Under-21 benefit. Legally, Medicaid should not be paying their health care claims. However, the Centers for Medicare and Medicaid Services relies on states to comply with the exclusion, including identifying which facilities are IMDs. This has led to various levels of interpretation and compliance across the country, and confusion about whether compliance is even necessary. The IMD exclusion is antiquated and not uniformly applied. Eliminating it would remove a legislative barrier to necessary services, effective clinical practices and cost efficiencies.[1]

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[1] A more comprehensive review of the IMD exclusion is available online at www.nacbh.org, under "About Us," *Rationale for Eliminating the IMD Exclusion for Medicaid Beneficiaries Under Age 21.*

Assessment

Jane Knitzer's 1982 ground-breaking report, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services,* was the first significant study to identify the service gaps for children most in need. She found that many children were inappropriately receiving services at more restrictive levels of care than were needed, due to lack of alternative resources. The 1999 Supreme Court *Olmstead* decision energized the trend, started in the 1960s with de-institutionalization, to transform the delivery system and transition individuals from institutions to community services and settings in compliance with the Americans with Disabilities Act. In this decision, the Supreme Court ruled that states must have a "comprehensive, working plan for moving qualified individuals in institutional settings to less restrictive settings." The Surgeon General's 1999 *Report on Children's Mental Health* and the United Nations Convention on the Rights of the Child emphasized that treatment should be considered a basic right for families that suffer from a mental health or substance use disorder. In 2001, the President's New Freedom Initiative, designed to encourage the development of community-based services, stated that there should be "no wrong door" for accessing services.

Assuring that the right services are accessed must begin with a comprehensive assessment of a child's physical, mental, developmental, functional and environmental status, continuing with reassessment at specific intervals. The assessment must be at the core of an individualized service plan to meet the unique needs of each child and family. Tools exist, such as the Early Childhood Service Intensity Instrument (ECSII, for ages 0-5 years) and the Child and Adolescent Service Intensity Instrument (CASII, for ages 6-18 years), which link comprehensive assessment to the appropriate level of care and service intensity, taking into account relevant dimensions of safety, function, and family and environmental resources. We must continue to develop multi-dimensional assessment tools to identify problems as early as possible to ensure that children and families receive timely and adequate services, monitor outcomes, and inform development of responsive programs.

Unfortunately, child welfare position papers and legislation currently floating on Capitol Hill reject a common sense approach of using assessment to determine the right services at the right time in the right amount. Under the banner of reinvestment, they would prohibit or strictly limit federal financial participation for some settings, based solely on their congregate or group nature, and unrelated to a child's individual needs or circumstances. If these funding restrictions are adopted, there is tremendous potential that mental health services and supports will become even less accessible and responsive to the children who need them most.

Any reform of the child welfare system must examine Medicaid's role in providing health care, as well as what states will be required to fully finance if federal reimbursement is further restricted under Titles IV-E and XIX.

Common Language

Contributing to the misalignments of child-serving systems is a lack of common language. Terminology can be based in federal law, state licensing, academic theory, front-line practice or philosophical values. Language that is outdated or ambiguous, in particular, invites unintended consequences. For example, "institutions," "congregate care," "group placements" and "residential care" have been used almost interchangeably to refer to an array of 24-hour settings developed to respond to different treatment and safety needs. The antiquated and imprecise usage reveals, at best, a lack of understanding of current evidence-informed practice and, at worst, a desire to invalidate a group of services or providers.

A prerequisite to system reform must be the development of consistent terms to define child welfare and mental health placements and services.

Recommendations

- Do not reduce or eliminate federal financial participation for existing placement and treatment options until capacity is established in other settings or services that are more responsive to assessed need.

- Develop common terminology defining child welfare and mental health placements, settings and services, including the purpose, attributes, eligibility and payer for each.

- Direct relevant agencies within the U.S. Department of Health and Human Services to develop a 5- to 10-year child welfare-mental health workforce development plan, engaging professional schools, clinical guilds, provider agencies, family and foster family organizations in the effort.

- Eliminate the Medicaid IMD exclusion for enrollees under age 21.

- Fully implement EPSDT, ensuring state accountability and federal oversight.