NACBH

National Association *for* Children's Behavioral Health

November 15, 2021

The Honorable Ron Wyden
Chairman, Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member, Senate Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The National Association for Children's Behavioral Health (NACBH) appreciates the opportunity to respond to your September 21, 2021 request for legislative proposals to improve access to care for Americans with mental health and substance use disorders.

NACBH represents multi-service treatment and social service agencies providing a wide array of behavioral health and related to services to children, youth and families. Services provided by NACBH members include assessment, crisis intervention, psychiatric hospitalization and partial hospitalization, residential treatment, group homes, therapeutic foster care, independent living, in-home treatment, respite, outpatient counseling, special education services, and a wide range of community programs and outreach.

Medicaid pays for the majority of behavioral health services delivered by our members, who are also connected with child welfare, juvenile justice, and educational systems in their communities. Unfortunately, Medicaid has not kept pace with changes in mental health care, thwarting cost-efficiencies and workforce development that multi-service providers could achieve and making it difficult for 24-hour treatment providers to develop community-based services as part of their array.

NACBH has signed on to multiple coalition letters with data and detailed suggestions related to the five areas outlined in your September 21 letter:

- strengthening the workforce
- increasing integration, coordination, and access to care
- ensuring parity between behavioral and physical health care
- furthering the use of telehealth
- improving access to behavioral health care for children and young people

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Instead of repeating the coalitions' proposals which we support, we offer an additional proposal which would address multiple areas of concern: Pass H.R. 2611, the Increasing Behavioral Health Treatment Act, which would remove the IMD exclusion for states that have submitted a plan to:

- increase access to outpatient and community-based behavioral health care, especially for individuals transitioning from institutional care,
- increase availability of crisis call centers and mobile crisis units, coordinate crisis response involving law enforcement and other first responders, and provide ongoing community-based stabilization services for individuals experiencing SMI, SED, or SUD crisis, and
- improve data sharing and coordination between physical health, mental health, and substance use disorders treatment providers, and first-responders.

Under H.R. 2611, states that wished to implement a full continuum of services without the uniquely discriminatory IMD exclusion would be required to specify their:

- strategies to identify and engage individuals, particularly adolescents and young adults, experiencing an SMI, SED, or SUD crisis,
- utilization review policies to ensure that Medicaid enrollees receive treatment in the least restrictive environment appropriate to their clinical needs, and
- policies to identify and serve the co-occurring physical health needs of enrollees in psychiatric hospitals and residential treatment centers.

They would then have to report annually certain demographic and utilization data demonstrating that a robust continuum of community-based engagement and care are restricting the use of institutional settings to a clinically appropriate population.

When Medicaid was established in 1965, it included an IMD exclusion stating that federal financial participation (FFP) 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 to the federal government costs which historically the states had borne. In 1972, the law was changed to establish a very narrow exception to the IMD exclusion for children and adolescents through Inpatient Psychiatric Services for Individuals Under Age 21, commonly referred to as the "Psych Under 21" benefit. It allows FFP for 24-hour 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 limited exception to the IMD exclusion was established half a century ago, Medicaid covered children's mental health services based on a traditional medical model of care: outpatient and inpatient. Many treatment models, protocols, and tools have been developed in the 50 years since then to better serve individual children's needs and respond to changing community

standards on where and how services should be delivered, but Medicaid IMD policy has not been updated to cover 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. A broad range of 24-hour programs that are designed to serve intermediate levels of acuity are not covered, forcing children into higher or lower levels of care than may be clinically indicated, denying appropriate treatment and, in some cases, inflicting unnecessary trauma on children and families that are routed through a series of wrong services in order to satisfy an antiquated federal policy.

NACBH appreciates the need to ensure that out-of-home placements of children and adolescents are necessary and safe, and provide high-quality, individualized services. Passing H.R. 2611 would ensure that in states that opt-in, a full continuum of community-based behavioral health services would be developed, utilization review would provide guardrails against inappropriate placements, and any new ambulatory or 24-hour services would be defined in state Medicaid plans and subject to federal oversight. States would have the funding certainty needed to develop truly responsive systems of care, the federal government could extend full parity to Medicaid beneficiaries as it has to most privately-insured Americans, and our most vulnerable children would have a better chance of accessing medically necessary services at the right time, in the right setting, for the right duration.

Outside of Medicaid, a complementary action within your jurisdiction would be to federally define all congregate settings eligible for IV-E foster care payments under the Family First Prevention Services Act. Among them, only Qualified Residential Treatment Facilities are currently federally defined. Defining these additional settings would allow federal oversight of the necessity, safety, and quality of non-medical out-of-home placements of children and adolescents, essentially all of whom are also Medicaid beneficiaries:

- settings specializing in providing prenatal, post-partum, or parenting supports for youth
- supervised independent living settings
- settings providing high-quality residential care and support services to children who have been or are at risk of becoming sex trafficking victims
- family-based residential substance abuse treatment facilities

Thank you again for the opportunity to comment. We would be pleased to provide any additional information that would be helpful.

Sincerely,

Patricia Johnston
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