Senate Finance Committee
Summary and Overview of Mental Health Recommendations

A Joint Initiative by Chairman Baucus and Ranking Member Hatch

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February 2014

On August 1, 2013, Chairman Baucus and Ranking Member Hatch issued an open letter to the mental health care community requesting that they share input on how to improve the mental health system in the U.S. In response to the Senate Finance Committee's call to identify problems and potential improvements to the mental and behavioral health care system, 242 stakeholders submitted 175 letters (see Appendix I for a complete list of stakeholders that submitted responses).

Stakeholder Overview

A variety of individuals, corporate stakeholders, and associations made submissions:

- Providers, trade organizations, and health systems—such as Children's National Health System, Harris Health Systems, the National Association of Social Workers, the Association for Behavioral Healthcare and the National Association of Medicaid Directors;
- Government organizations—such as California's Department of Health Care Services and New York City's Bureau of Mental Health;
- Beneficiary advocacy groups—such as Voice for Adoption, Healthy Teen Network and the National Alliance on Mental Illness;
- Joint government and private organizations—such as the Consortium for Mental Health, the Center for Social Innovation and Partnership for Medicaid;
- Joint provider and consumer advocacy groups—such as the Consortium for Citizens with Disabilities; and
- Others—such as Medicaid recipients and their families.

Scope and Methodology

In order to extract the most salient proposals, we used two frameworks to categorize the recommendations: topic areas and cross-cutting themes.

Topics. The five broad topic areas were: care integration; care expansion; workforce expansion; regulatory alignment and parity; and current legislation.[1] Due to the broad nature of these topics we categorized recommendations by specific subtopics within each area. Table 1 describes each of the five topic areas.

Table 1: Topic Areas

Topic area	Description
Care Integration	Expand integration of primary care and mental and behavioral health care. Enact regulatory changes that mandate and facilitate care integration. Increase funding to allow for expanded access to integrated care.
Care Expansion	Increase funding and decrease regulations to current proven programs.
Workforce Expansion	Allow for an expansion of roles currently undertaken by mental health care providers and encourage more individuals to enter the profession by providing increased scholarships and educational opportunities for students focusing on mental health care, especially in regions where access to quality care is low.
Regulatory Alignment and Parity	Simplify regulations, reimbursements and billable treatments by increasing alignment between Medicare and Medicaid.
Current Legislation	Utilize the legislative process to achieve progress in the mental health care system.

Cross-cutting themes. Several themes—funding, education, and access—cut across multiple topics. Table 2 describes the three cross-cutting themes.

Table 2: Cross-Cutting Themes

Cross-cutting theme	Description
Funding	Increase funding to improve the quality of, and access to, mental and behavioral health care.
Education	Expand training and educational opportunities so that there is a sufficient number of providers to deliver care to patients.
Access	Not every enrollee is receiving the help they need. Expand the level of care to ensure that patients' needs are met.

[1]Because of the nature of the submissions, there is overlap, to some extent, among the different categories.

Recommendation Overview

The following summarizes the recommendations by key topics based on the prevalence of the recommendation. Within each key topic, subtopics and cross-cutting themes are discussed according to the frequency that stakeholders raised them. Inclusion or exclusion of any particular recommendation within this overview does not indicate the Finance Committee's endorsement of, or opposition to, that particular recommendation.

Recommendations by Program Type

Most of the submissions addressed both Medicare and Medicaid, therefore many of the policy recommendations applied to both programs. However, some recommendations focused entirely on one particular program (see table 3).

Table 3: Recommendations by Program Type

Program Type	Number of Papers with Applicable Recommendations	Percentage of Papers with Applicable Recommendations
Medicare and Medicaid	121	69%
Medicare	5	3%
Medicaid	49	28%

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Recommendations by Topic and Cross-Cutting Theme

Care Integration

Care integration is the combination of primary care and mental and behavioral health care in such a way that both are treated holistically. As mental and physical health are highly intertwined, combining care allows for increased coordination between providers and ensures that patients receive the proper level of care required to achieve successful outcomes.

(1) Co-location of Services

Primary care physician offices do not generally provide a range of mental and behavioral health services in the same location. The reverse is also true, as many mental health clinics do not provide primary care services. Both primary care providers and mental health care providers recommended that funding be expanded to make it financially feasible for services to be located together. Co-locating services for Medicare and Medicaid patients is particularly important because of the difficulties faced by the underprivileged and elderly when they are required to travel to different locations in order to receive treatment. These obstacles often lead to patients not receiving needed treatment. Recommendations included the following:

- Require Federally Qualified Health Centers (FQHC) to employ mental and behavioral health staff. Besides providing both types of care under the same roof, this allows for expanded screenings of mental health problems and substance use disorders (SUDs). This increased screening would help patients with mental health problems and SUDs to obtain the help they need and reduce unnecessary emergency room visits.
- Incorporate primary care services in mental health centers, including screenings for certain primary care issues, such as diabetes.
- Revise privacy laws to allow mental health and primary care providers to collaborate on care and communicate patient information more effectively. Integrated communication could increase the quality of care, reduce adverse prescription drug interactions, and lead to other beneficial outcomes.

(2) Billing Reforms

Current Medicare and Medicaid billing regulations can inhibit the provision high quality care. The following changes were recommended to improve billing for mental and behavioral health care:

- Allow flexible funding streams for treatments covered by Medicare and Medicaid. Flexible funding streams remove funding limits for the treatment of individuals in order to provide a full range of medical and nonmedical services. Flexible funding streams are designed to eliminate the cycle of patients receiving limited, incomplete treatment, which leads to the need for additional care for the same issue. This cycle of care is not only more costly in the long-run than flexible funding streams, but it can contribute to adverse patient outcomes.
- Allow for multiple services to be billed for the same patient on the same day in order to prevent a disruption in the continuity of care.
- Simplify the billing process by reducing bureaucratic red tape, decreasing regulations, and improving the uniformity between Medicare and Medicaid.
- Increase reimbursements to providers. A common observation was that current rates were too low and thus increases in reimbursements would attract and retain quality providers.

(3) Information Technology Changes

It was noted that there is a significant discrepancy between the funds allocated to assist mental and behavioral health care providers in accessing health information technology (HIT), as compared to other health providers. This lack of equality leads to fragmented and incomplete care. The Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L. 111-5) was passed in 2009 and is intended to increase the adoption of HIT and support electronic sharing of clinical data among health care stakeholders primarily through electronic health records (EHRs). The HITECH Act provides financial incentives for health care providers to use HIT. It was asserted that mental and behavioral health providers were less able to benefit from these incentives than their “traditional medicine” counterparts. Equality in the incentives process is vital because high-quality health information technologies can lead to better communication between mental health care and primary care providers and thus more successful outcomes.

(4) Center for Integrated Health Solutions (CIHS) and Center for Medicare and Medicaid Innovation (CMMI)

A number of submissions made reference to the CIHS and CMMI's role in developing new and innovative ways to provide higher-quality care at lower costs. Specifically, CIHS fosters the integration of primary and behavioral health services by providing training and assistance in the use of integrated health care delivery methods to community behavioral health organizations, community health centers, as well as primary care providers, with a focus on addressing the needs of those with mental health and SUDs. Moreover, CMMI, which was established in section 1115A of the Social Security Act (as added by section 3021 of the Patient Protection and Affordable Care Act (P.L. 111-148) (ACA)), is tasked with testing new payment and service delivery methods, evaluating the results, and seeking to preserve and enhance the quality of care while reducing program expenditures. Several letters recommended that both of these organizations have an expanded role in creating and implementing new policies to improve both mental health care and integration efforts through Medicare and Medicaid. Many organizations recommended providing these organizations with increased funding to allow for more grants to provider groups and for additional research.

(5) Dual Eligible Beneficiaries

Dual Eligible beneficiaries—individuals who qualify for both Medicare and Medicaid—are more likely to suffer from a mental illness than those who are eligible for only one program. Although 18.6 percent of Americans above the age of 18 have been diagnosed with a mental or behavioral disorder[2], a June 2013 report by the Congressional Budget Office (CBO) found that 30 percent of full dual eligible beneficiaries (those individuals who qualify for full Medicare and Medicaid benefits); 25 percent of partial dual eligible beneficiaries (those individuals who qualify for full Medicare benefits, but only partial Medicaid benefits); and over 50 percent of dual eligible

[2] See Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805 (September 2013).

beneficiaries with chronic health problems, have a mental health disorder.[4] The prevalence of mental health issues within this population increases the need for access to fully integrated mental health care, SUD care, and primary care. However, only a few states have programs to ensure such integration.

A demonstration program is underway in some states and several other states are adopting managed care models to help promote integrated care.

Care Expansion

Care expansion focused on two key areas (1) expanding access and scope of care and (2) expanding the benefits under Medicare and Medicaid.

Almost all of the submitted letters asserted the fact that current care levels are not sufficient. Many papers also argued that current regulations limit access to quality care and prevent innovations in providing low-cost, high-quality mental health care.

(1) Tele-Health Services

Tele-Health is the use of technology to facilitate long-distance health care. Such technology includes video-conferencing and streaming services. Currently there are few national standards for allowable services, eligible providers, and reimbursement rates for tele-health. The creation of a national program to permit interstate tele-health services would expand access to care by allowing providers to reach additional patients, particularly those who have difficult traveling or are geographically removed from such providers. Tele-health could also increase access to specialists who may otherwise be inaccessible to a patient in need. Benefits of Tele-health include: appropriate and correct treatment, reduced wait times and reduced costs.[3]

[4] See Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies,* (June 6, 2013).
[3] See The Commonwealth Fund, *Scaling Telehealth Programs: Lessons from Early Adopters,* (January 30, 2013).

(2) Community Health Homes

Community Health Homes are community-based organizations that coordinate care for individuals, often providing more appropriate mental health care than would be received at more institutionalized levels of care. Some letters observed that the lack of a federal definition for what qualifies as a "Community Health Home," in addition to the discrepancies in form and quality of services provided at individual Community Health Homes, is a concern. Also, one result stemming from a lack of federal reporting requirements is a difficulty in quantifying and evaluating the effectiveness of the care provided. Conversely, overly burdensome and complex regulations can also lead to adverse outcomes.

(3) Case Management Services

It was recommended that case management services be provided for patients who frequently utilize emergency room services for mental health services. Case managers can help patients obtain and use their medication, arrange for transportation and child care, locate housing, and assist with other activities. Small demonstration projects have seen successful outcomes for high-use patients through the use of case managers.[4]

(4) Medicaid IMD Exclusion

Institutions for Mental Disease (IMDs) are inpatient facilities with more than 16 beds and 51 percent of patients being treated for mental illness or SUD. Medicaid does not permit federal matching payments for IMDs with patients between the ages of 22 and 64 (known as "IMD exclusion"). States have the option to receive federal funds for IMDs treating persons under the age of 22 or over the age of 64.

The IMD exclusion originates from federal efforts to de-institutionalize large psychiatric hospitals because of a high prevalence of abusive care. However, many letters argued that the IMD exclusion has the overly broad effect of preventing Medicaid patients from receiving otherwise quality residential or psychiatric hospital care. In fact, it was asserted that the exclusion

[4] See Aetna, *Focused Behavioral Health Approach Results in Quicker Return to Work,* (April 9, 2013).

prevents a category of care (specifically psychiatric residential or hospital care) that could be critical for some patients in need. A common recommendation was to eliminate this exclusion.

(5) Lifetime Limits

Medicare currently prevents its enrollees from receiving more than 190 days of inpatient psychiatric hospital care during their lifetime. Similar types of limits are not in place for general hospitals' psychiatric wards, nor are they in place for other Medicare specialty inpatient hospital care. The letters encouraged the elimination of lifetime limits in order to provide better care for those patients who need additional time for treatment and to prevent these patients from requiring additional care that would otherwise be unnecessary.

(6) Encourage States to Utilize Options for Expanded Community-Based Programs

Section 1915(i) of the Social Security Act allows states to provide community-based mental and behavioral health services to beneficiaries who do not require an institutional level of care. Changes from the ACA prohibit states from capping the number of eligible people, keep waiting lists, or limit services to certain geographic areas.

The 1915(i) option can be used to provide community-based services that have proven effective in treating mental and behavioral health issues. It was argued that community-based health services have been shown to reduce emergency room use, health care costs, and empower individuals with serious mental illnesses to obtain and maintain housing and employment. Only a handful of states have utilized the 1915(i) option to cover services for individuals with mental illness.

Workforce Expansion

Increase the number of mental health care providers, allow for expanded roles for current providers and expand training and educational opportunities.

A common concern raised in the letters was that the current workforce is insufficient to address the many Medicare and Medicaid beneficiaries that need mental and behavioral health care. The following recommendations were made in an effort to expand the current workforce.

(1) Expand Billing Opportunities for Current Outpatient Providers

Many organizations advocated for allowing providers to bill for more services, which would expand access to care and could reduce costs. Several organizations recommended expanding Medicare and Medicaid billing privileges to social workers, nurse practitioners and physician assistants. Specific recommendations included allowing Medicaid to cover mental health services provided by licensed clinical social workers in all states and eliminating other statutory and regulatory obstacles.

(2) Scholarships

In order to encourage more students to join the workforce, it was also recommended that federal scholarships and loan forgiveness be expanded for current graduate students studying to become mental health care professionals. Targeted scholarships and loan forgiveness could be given to students who work in especially high areas of need or who specialize in fields where access is low. Also, establishing scholarships and grants for additional training of current mental health professionals would allow those practicing in the field to provide better care for their patients.

(3) Provider Enrollment Simplification

Extensive paperwork makes it difficult for medical professionals to become providers for Medicare and Medicaid. The lack of uniformity between Medicare and Medicaid exacerbates this problem. While increasing uniformity was cited by a number of letters, reducing the paperwork burden for providers was also recommended.

Regulatory Alignment and Parity

Issues addressed include uniformity between Medicare and Medicaid regulations, as well as parity for mental health issues alongside other medical problems.

(1) Medicare and Medicaid Regulatory Alignment

Disparate Medicare and Medicaid regulations create difficulties for providers as they try to care for their patients. Reduction and simplification of the regulations for mental health providers by increasing the parity between Medicare and Medicaid reduces the time and money spent by on paperwork and gives them increased resources to help their patients. The letters recommended aligning Medicare and Medicaid rules in the following: allowable treatments; allowable providers; provider enrollment; reporting and quality control; billing; and reimbursement rates.

(2) Mental Health Parity

The lack of parity between mental health and primary health care within the insurance market was also addressed. Congress passed the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[5] and incorporated protections into the "minimum essential coverage" established as part of the ACA. CMS recently finalized regulations to reduce confusion and implement the protections included in the MHPAEA.

Legislation

There are a number of current and former bills that the letters believe address issues pertinent to mental and behavioral health care and substance use disorders.

A number of bills have been introduced into the 113th Congress, as well as previous Congresses, which have focused on mental health issues. Many letters supported at least one of the bills listed here, but no one letter explicitly expressed support for all of the bills. The Excellence in Mental Health Act (S.264/H.R.1263) and the Behavioral Health IT Act (S.1517/H.R.2957) were the frequently mentioned. This exercise is not intended to opine on the

[5] P.L. No. 110-343.

merits of any of these pieces of legislation, but simply to provide the Committee and the public with an overview of the issues that arose as part of this public outreach exercise.

(1) Excellence in Mental Health Act (S.264/H.R.1263)

This bill would expand access to mental health treatment by ensuring that mental health services receive adequate reimbursements from Medicaid, comparable to how FQHCs are reimbursed for primary care services. This legislation would create a certification process for Federally-Qualified Behavioral Health Centers (FQBHCs), which would be required to provide a core set of comprehensive evidence-based mental health services including targeted case management, crisis mental health services, psychiatric rehabilitation, acute detoxification, peer counseling and other community-based interventions.

(2) Behavioral Health IT Act (S.1517/H.R.2957)

This bill extends the incentives provided through the HITECH Act for the meaningful use of electronic medical records to mental health and SUD providers, hospitals and facilities to be equal to other national providers of acute care. This bill would create a more level playing field between mental health institutions and other health institutions. The bill would help coordinate care through the use of electronic health records and health information technology which facilitates communication between primary and mental health care providers.

(3) Mental Health First Aid Act of 2013 (S.153/H.R. 274)

The bill would establish $20 million in grants to fund mental health first aid training courses to help participants identify the signs and symptoms of mental illness and provide tools to help participants to know how to respond.

(4) Children's Mental Health Accessibility Act, 112th Congress (S.3289)

This bill proposed expanding a demonstration program that expanded Medicaid's 1915(c) waiver authority to provide home and community-based services for children that would

otherwise be provided through a residential psychiatric facility. The Children's Mental Health Accessibility Act would have provided states with flexibility and options to provide children and youth with the most appropriate care, in home and community-based mental health facilities or in residential psychiatric facilities.

Conclusions

The recommendations that were received by the Senate Finance Committee are an important resource for the Committee to use to improve the quality of mental and behavioral health services provided through Medicare and Medicaid. These programs were designed to serve some of our country's most vulnerable citizens, and should be enhanced to provide better quality of care. The Senate Finance Committee is grateful for the input received from the mental health community.

Appendix I: List of Organizations that Submitted Letters

Academic Pediatric Association
Academy on Violence and Abuse
Access Living
Advantage Behavioral Health
Adventist Behavioral Health
AIDS Alliance for Women, Infants, Children, Youth & Families
Alexian Brothers Center
Alkermes
Alliance for Children and Families
America's Essential Hospitals
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association of Nurse Practitioners
American Association on Health and Disability
American College of Obstetricians and Gynecologists
American Congress of Obstetricians and Gynecologists
American Foundation for Suicide Prevention
American Hospital Association
American Institutes for Research
American Medical Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Professional Society on the Abuse of Children
American Psychiatric Association
American Psychoanalytic Association
American Psychological Association
American Psychological Association Practice Organization
American Public Human Services Association
American Society of Addiction Medicine
Anxiety and Depression Association of America
Asian American Family Services
Association for Behavioral Health and Wellness
Association for Behavioral Healthcare
Association for Community Affiliated Plan
Association of Clinicians for the Underserved
Association of Medical School Pediatric Department Chairs
Attach-China / International
Attachment & Trauma Network
Baylor College of Medicine, Division of Adolescent Medicine and Sports Medicine
Ben Gordon Center
Boston Children's Hospital, Division of Adolescent and Young Adult Medicine
Boys Town
Brian Bronson
Bridging the Gap Recovery
California Council of Community Mental Health Agencies
California Department of Health Care Services
California Health and Human Services Agency
California Hospital Association
California Mental Health Oversight and Accountability Commission
California Mental Health Planning Council
California State Association of Counties
Career and Recovery Resources
Casey Family Programs
Catholic Charities of the Archdiocese of Galveston-Houston
Celina Jungheim
Center for Adoption Support & Education
Center for Health and Health Care in Schools at the George Washington University
Center for Law and Social Policy
Center for School Mental Health at the University of Maryland
Center for School, Health and Education at the American Public Health Association
Center for Social Innovation
Child Welfare League of America
Children Now
Children's Defense Fund
Children's Hospital Colorado, Division of Adolescent Medicine
Children's National Health System
Children's National Medical Center
Christopher Camilleri, MD
Client Congress Advisory Board
Coalition for Whole Health Community Behavioral Healthcare Association of Illinois
College of Psychiatric and Neurologic Pharmacists
Commonwealth Care Alliance
Community Behavioral Health Association of Maryland
Community Catalyst
Consortium for Citizens with Disabilities
Council on Alcohol & Drugs Houston
County Alcohol and Drug Program Administrators' Association of California
Crestwood Behavioral Health
DePelchin Children's Center
Early Assessment and Support Alliance (EASA) Center for Excellence, Portland State University
Eating Disorders Coalition for Research, Policy, and Action
Elderly Workforce Alliance
Exceptional Children's Foundation
Fairfield Mental Health Consumer Group
Family Service of Waukesha
Family Services of Greater Houston
Family Voices
Fight Crime: Invest in Kids
First Focus Campaign for Children
Fort Bend Regional Council on Substance Abuse
Foster Care Alumni of America
Foster Club
Foster Family-Based Treatment Association

Futures Without Violence
Gerontological Advanced Practice Nurses Association
Geropsychiatric Nursing Collaborative Work Group
Harbour Area Halfway Houses
Harris County Protective Services for Children & Adults
Harris County Psychiatric Center
Harris Health Systems
Healthy Teen Network
Hogg Foundation for Mental Health
Houston Galveston Institute
Houston Recovery Center
Illinois Association of Rehabilitation Facilities
Illinois Children's Mental Health Partnership
INSPIRA
InterNational Council on Infertility Information Dissemination
IntraCare Behavioral Health
Iroquois Center for Human Development
Janssen Pharmaceuticals
Jewish Family Service
Jewish Federations of North America
Johnson County Mental Health Center
Kathy Ramsay
Ken Jones
Laura Welborn
Legacy Community Health Services
Legal Action Center
Lisa Holder
Liz George
Lois Earley
Los Angeles County Department of Mental Health
Louis A. & Margarita Iparraguirre
Lundbeck
Magellan Health Services
Maine Department for Health and Human Services
Mark S. Gale
Matthew Kunze
Mclean Hospital
MediaHealth Technologies, LLC
Medicaid Coalition
Memorial Hermann Behavioral Health Services
Mental Health America
Mental Health America of Greater Houston
Mental Health Liaison Group
Mental Illness Policy Organization
MHMRA of Harris County
Milestone
Minnesota Hospital Association
Missouri Coalition of Mental Health Center
Montefiore Medical Center
Mount Sinai Medical Center
National Alliance on Mental Illness
NAMI Austin
NAMI California
NAMI Illinois
NAMI Montana
NAMI Ohio
NAMI Oregon
National Alliance to End Homelessness
National Association for Children's Behavioral Health
National Association of Anorexia Nervosa and Associated Disorders
National Association of Community Health Centers
National Association of Counties
National Association of Medicaid Directors
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Association of Psychiatric Health Systems
National Association of Public Child Welfare Administrators
National Association of Rural Health Clinics
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Association of State Mental Health Program Directors
National Children's Alliance
National Committee for Quality Assurance
National Council for Behavioral Health First Aid
National Council for Community Behavioral Healthcare
National Health Care for the Homeless Council
National Hispanic Medical Association
National Indian Child Welfare Association
National Network for Youth
National Organization of Nurse Practitioner Faculties
National Rural Health Association
National Technical Assistance Center for Children's Mental Health at Georgetown University
New Jersey Association of Mental Health and Addiction Agencies
New Roads Treatment Centers
New York City Department of Health and Mental Hygiene
Northwestern Memorial Health Care
OSFMG Community Behavioral Health Services
Pacific Asian Counseling Services
Partners Healthcare
Partnership for Medicaid
Patient-Centered Primary Care Collaborative
Penndel Mental Health Center
Physician Assistant Education Association
Pocono Health System
Ray Helfer Society
Rimal Bera, MD
Robert Wood Johnson Foundation
Rosecrance
Sakinah Abduir-Rasheed
Sandra Cheng
Santa Maria Hostel
School-Based Health Alliance
SEARCH Homeless Services
Society for Adolescent Health and Medicine
Society of Professors of Child and Adolescent Psychiatry
St. Joseph Medical Center
State Associations of Addiction Services

Sunovion Pharmaceuticals
Survival Coalition of Wisconsin Disability Organizations
Susquehanna Health
Takeda Pharmaceuticals
Tennessee Association of Mental Health Organizations
Texas Hospital Association
The Association for Ambulatory Behavioral Healthcare
The Center for Success and Independence
The Children's Hospital of Philadelphia
The General Electric Foundation
The Judge David L. Bazelon Center for Mental Health Law
The Kennedy Forum
The Menninger Clinic
The Montrose Center
The National Alliance to Advance Adolescent Health
The Network of Behavioral Health Providers
The Trevor Project
The Women's Home
Thresholds
Transitions of Western IL
Treatment Communities of America
Tribal Leaders Council
Tulare County Mental Health
Turning Point Behavioral Health Care Center
University of Colorado School of Medicine
University of Maryland School of Social Work
University of Massachusetts Medical School
University of Washington Department of Pediatrics, Division of Adolescent Medicine
University of Washington's AIMS Center
University of Colorado at Colorado Springs
Value Options
Vecino Health Centers
Virginia Organization of Consumers Asserting Leadership
Voice for Adoption
Volunteers of America Texas
Warren Alpert Medical School of Brown University,
Wellpoint
Youth Villages
Zero to Three