Optimizing Medicaid to Improve Child and Youth Mental Health in PA

Introduction

Children are enduring unprecedented rates of anxiety and depression. In Pennsylvania, 50% of children who died by suicide in 2021 never had a prior mental health diagnosis.

The social, emotional, and developmental health needs of our children are not being met. The Commonwealth must adopt reforms to ensure there is a sustainable system of services delivered in school and community-based settings where youth have year-round access to quality mental health supports.

Through extensive research from other states and input from experts in Pennsylvania, areas impacting the access and delivery of mental health supports have been identified and evaluated, including funding streams, types of service providers, places of service delivery and administrative barriers.

These five specific reforms optimize Medicaid as a sustainable funding source to improve the child and youth mental health system and incorporate innovative policies and practices occurring in Pennsylvania and in other states.

We believe the time is now for Pennsylvania to respond more comprehensively to the mental health needs of our children and must act on collaborative and quality mental health reform that ensures every child in the Commonwealth has equitable access to a continuum of services.

Five Essential Mental Health Reforms

1. **Increase resources for prevention, early intervention,** and less intensive services known as Tier One and Tier Two supports.
2. **Broaden the types of providers certified** and eligible to deliver services at each tier of intervention to increase access to diverse and culturally competent professionals.
3. **Ensure that the definition of medical necessity is fully applied** to authorize mental health services and payments for all eligible children.
4. **Integrate mental health services** for parents and young children **in pediatric primary care settings.**
5. **Center schools as critical partners** in mental health care systems and payor networks.

children FIRST
THE ADVOCATE FOR KIDS

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Pennsylvania needs a comprehensive mental health system for children.

Children currently face unprecedented challenges coping with the aftermath of social isolation, grief, and loss from the COVID pandemic, as well as other present-day traumas and adversities associated with opioid abuse, violence, and the pervasive impact of social media. The situation is so dire that the Surgeon General's 2021 Protecting Youth Mental Health Report found that the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%. In Pennsylvania, the data is equally troubling. Across the Commonwealth, youth from wealthy and low-wealth communities alike suffer from nearly the same rates of general anxiety and depression, as well as more intensive issues of suicidal thoughts. Specifically, the data in Pennsylvania shows:

- 41% of students report feeling sad or depressed most of the time.
- Almost 19% of students report intentionally harming themselves.
- 16% of students planned their suicide and 12% attempted suicide.

It's evident that children need access to high-quality mental health services and supports that can wrap around them where they live, learn, and play to prevent senseless tragedy and boost mental wellness.

With the introduction of the 988 suicide and crisis hotline in July 2022, Pennsylvania has begun to address the need for a robust crisis response system that is tailored to meet the needs of children. This work must continue to the fullest extent to support counties in developing children's crisis response teams, stabilization units, and respite programs. And, while the crisis response system is an essential piece in building a continuum of care, Medicaid can be leveraged to ensure that children and adolescents have the necessary supports in place to prevent reaching crisis.

By embracing the full spectrum of settings and adopting policies that support all levels of need, the Commonwealth can shift its child and adolescent mental health system upstream with the goal of reducing youth who need intensive supports for life threatening and/or debilitating mental illness.

To build on these investments, a robust set of reforms are needed to create the conditions for quality mental health services and access in schools, pediatric practices, extracurricular settings, and home-based models. By embracing the full spectrum of settings and adopting policies that support all levels of need, the Commonwealth can shift its child and adolescent mental health system upstream with the goal of reducing youth who need intensive supports for life threatening and/or debilitating mental illness. This will also lead to more productive adults who are able to contribute to society through work, parenting, and their own more positive health outcomes.

Tier One: Universal Mental Health Supports

Universal access to proactive mental wellness resources delivered via safe school climate practices, social emotional learning curricula, and light touch support from staff trained in Mental Health First Aid and Healing Centered Engagement practices.

Tier Two: Targeted Mental Health Supports

Targeted services that offer brief intervention from trained school counselors and/or mental health professionals.

Tier Three: Intensive Mental Health Supports

Intensive mental health services that are associated with a diagnosis treated by fully certified professionals

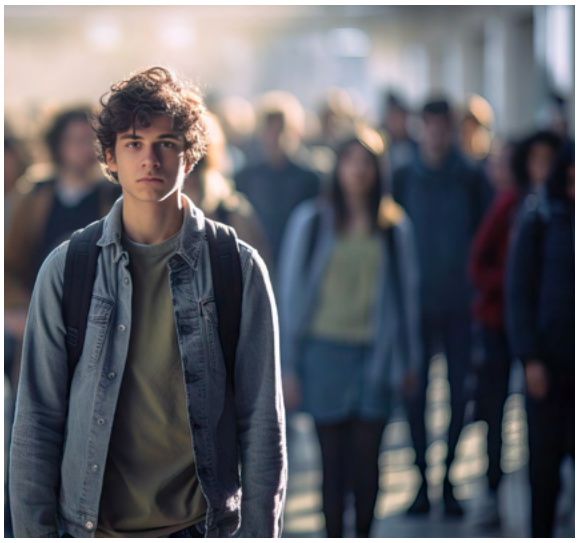
The reforms proposed dramatically expand access to children who have mental health needs and reduce the dependency on high-acuity services. The Commonwealth must also recognize that reform to the private insurance market is essential because students are eligible "on and off" for Medicaid. Some students are not eligible for Medicaid due to immigration status and will not be impacted by these reforms.

Fully utilizing all Commonwealth resources can improve children's mental health.

The Commonwealth has many tools at its disposal to ensure sustained funding for these services including Medicaid, County Mental Health Block Grants, Opioid Settlements Funds, Managed Care Organization (MCO) payments to municipalities, and line-item appropriations such as the school-based mental health services funds. To make this impact, a bold vision needs to be put forward and the resources and tools currently available need to be maximized.

Medicaid funds are and should comprise the largest portion of funds spent to meet these needs. Delivering these services will require:

- Submission of a State Plan Amendment (SPA)
- Adoption of allowable Alternative Payment Models (APM) and Value Based Payments (VBP)
- New contract requirements for MCOs
- New policies and guidelines for county funding received from the state and via the MCO payments, county mental health block grants, and opioid settlement funds



Existing funding streams can support these reforms and sustain a comprehensive, multi -tiered child and adolescent mental health system but additional state and federal funds will also be necessary to increase the number of children served. Medicaid is a sustainable funding source with a federal match, meaning that the federal government will match every state Medicaid dollar.

Medicaid

Activities funded through Medicaid must adhere to federal guidelines as defined by the Centers for Medicare and Medicaid Services (CMS) and are restricted to direct service programming for Medicaid-eligible participants.

Reinvestment Funds

Reinvestment dollars are monies remaining after covered services are paid for through Medicaid per member per month. Counties have the ability to submit reinvestment plans to the state to use the unspent funding on innovative approaches to mental health and substance use that are not typically covered by Medicaid. Reinvestment programs are often established with the goal of demonstrating effectiveness or value and can ultimately be transitioned to more sustainable Medicaid programming once proven effective.

County Mental Health Block Grant

The County Mental Health Services Block Grant funding comes from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), passed through the Office of Mental Health and Substance Abuse Services (OMHSAS) to counties, to implement community mental health services. These grants are also known as the “mental health safety net” and are often viewed as less restricted than Medicaid dollars. While they still have parameters, the funding is not always tied to a specific service being provided.

Opioid Settlement Funds

Pennsylvania is set to receive over $1 billion from opioid-related lawsuits. The settlement dollars are a one-time funding source and have limited restrictions on its utilization. In Pennsylvania, a trust has been created to distribute the funds to counties to use to meet each locality’s unique needs in responding to the opioid epidemic. These funds can be used to address the trauma and adverse childhood experiences of children growing up with parents who use drugs.

Line-Item Appropriations

Finally, in Governor Shapiro’s inaugural budget, $100 million was included to be spent on student mental health. This is a carryover from the Behavioral Health Commission established under his predecessor, Governor Tom Wolf. The funding will be one-time and fiscal code bills were passed in December 2023 to enable the state to administer the funds. Each school district will have the opportunity to apply for the funding, which will be awarded through formula-based solicitation.

Chart 1: Uses and Sources of Funds by Tier

			Source of Funds				
			Medicaid	Reinvestment	County Block Grants	Opioid Settlement	Shapiro Proposed Allocation
Type of Care/Activities				Setting a designated portion	Setting a designated portion	$1.07b *one-time	$100m
MTSS Tier 1	a. Universal Supports	**School-wide prevention models such as social emotional learning, positive behavioral interventions and supports (PBIS), or healing-centered engagement that reach every child in the school.**	🔵	🟡	🟡		
	b. Screening	**Universal screening for behavioral health challenges supports early identification and prevention.**	🟡	🟡	🟡		
	c. Implementation	**Planning, training/development costs of the service**	🔵	🟡	🟡	🔴	🟡
	d. Operations	**Maintenance/sustainability of the service**	🔵	🟡	🟡		🟡
MTSS Tier 2	a. School-Based Mental Health Counselors	**School district have the resources to contract for trained metnal health professionals to provide therapy within the school.**	🟡	🟡			🟢
	b. Student Assistance Program (SAP)	**SAP is a team process in all PA high schools (9-12) used to mobilize school resources to remove barriers to learning, including alcohol, drugs, tobacco, and mental health issues.**	🔵		🟢		
	c. Supportive Therapeutic and Educational Partnerships (STEP)	**A four-person support team employed by the school district that provides behavioral health interventions and increases access to more intensive services when needed.**	🟡	🟡			
	d. Implementation	**Planning, training/development costs of the service**		🟡		🔴	
	e. Operations	**Maintenance/sustainability of the service**		🟡			
MTSS Tier 3	a. Intensive Behavioral Health Services (IBHS)	**IBHS is an array of services in schools, community, and homes, including individual and group serivces as well as Applied Behavior Analysis.**	🟢				
	b. Outpatient Clinics in Schools	**Traditional outpatient therapy offered in school buildings.**	🟡				
	c. Implementation	**Planning, training/development costs of the service**				🔴	
	d. Operations	**Maintenance/sustainability of the service**	🟢				

LEGEND:

🟢 In place	🟡 Underutilized Authority	🔴 Improve Counties utilization of funding	🔵 Federal Authority Needed	Funding stream not permitted to pay for the SBBH-services and/or not appropriate to fund the service.

It is reasonable to anticipate that with maximizing federal match and Medicaid spending, more children and youth will be identified and a short-term increase in funding may be needed. However, over time with the provision of more prevention and early intervention services, higher cost services such as crisis care and inpatient hospitalizations will decrease and savings will be achieved.

Reform One: Increase resources for prevention, early intervention, and less intensive services known as Tier One and Tier Two supports.

EPSDT is an important component of Medicaid services for children and supports screening and delivery of services for identified needs and to ameliorate potential concerns. In Pennsylvania, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit states, "children and youth under the age of 21 will receive all medically necessary services coverable under 1905(a) [Social Security Act] regardless of whether the service is otherwise covered under the state plan." This definition can and should be understood to include prevention services which are defined as Tier One and Tier Two supports. By using the full breadth of the current federal statute to modify the state's interpretation of allowable EPSDT services to include prevention, Pennsylvania can expand access to Tier One and Tier Two services.

OMHSAS has recently focused on the implementation of 988 and expansion of crisis services across the lifespan. These new policies are evidence that the Department of Human Services is interested in reducing the need for crisis services. Pennsylvania can go further and expand the use of the EPSDT benefit to reduce the volume of children and adolescents who reach high acuity mental health crises.

By using the full breadth of the current federal statutes to modify the state's interpretation of allowable EPSDT services to include prevention, Pennsylvania can expand access to Tier One and Tier Two services.

Specifically, EPSDT services can be used to ameliorate mental health concerns; this means providing services to "stay as healthy as possible" and can include prevention or early intervention types of services. Pennsylvania's EPSDT screenings, in alignment with the Bright Future Guidelines developed by the American Academy of Pediatrics (AAP), include:

- Maternal depression screenings, universal at well visits from birth to nine months.
- Mental/Social/Emotional screenings, universal at well visits from birth to nine months.
- Tobacco, alcohol, and drug use assessments, selective (only those of higher risk), ages 11 to 20 years old.
- Depression and suicide risk screenings, universal, ages 11 to 20 years old.

The prevalence of screening is only as effective as the ability to address identified needs.

The Commonwealth can augment the guidance of the AAP and ensure that the EPSDT benefit is applied more intentionally to ameliorate a potential mental health condition requiring more intensive and expensive services later in life.

These services could include skill building supports, motivational interviewing, conflict resolution, care coordination, family meetings to address family needs, or parenting skills development. To ensure access to these services, the Commonwealth can certify family services professionals to deliver these services thus decreasing the overwhelming demand for clinical mental health providers.

EPSDT Administrative Claiming can Expand Available Services.

Additionally, Medicaid administrative claiming (EPSDT administrative claiming) can be used to support actions that help children enroll in Medicaid and access needed screenings and needs identification as early as possible. For instance, Vermont uses Medicaid/ EPSDT administrative claiming to ensure enrollment in Medicaid to gain better access to services and provide broad support to all students.

Vermont school nurses and guidance counselors play an important role in ensuring enrollment and reimbursement under the Medicaid/ EPSDT administrative claiming. This can also include ensuring children have a primary care provider and accessing required screenings, including social/emotional screenings, so children at risk of mental health challenges can be identified early.

EPSDT administrative claiming can also be used to ensure that children have a primary care provider and are able to access the required screenings (above) so that the children at risk of developing mental health challenges can be identified early.

The federal Medicaid Payment and Access Commission delineates federal matching payment rates for what is called administrative claiming that supports activities beyond direct service for children. Importantly, administrative claiming can be used to support a prevention-based approach since the funding is not tied to an individual child. Below are two ways this can work:

1. Presumptive Eligibility (50% match): Frontline mental health professionals, school district staff, or other community-based child-serving professionals can determine presumptive eligibility for children and provide services to presumptively eligible children.

This is often used to begin to support children prior to their potential Medicaid enrollment and to ensure children are enrolled in Medicaid to get the required screenings and to provide "support" outside of diagnosis. For instance, in Vermont, school nurses and guidance counselors once a year track their time and activities that would fall under this definition, which is used to justify the Medicaid Department including it in their costs (and then associated federal match) to CMS.

2. Training or Consultation by Medical Personnel (75% match): Activities conducted by skilled professional medical personnel and their direct support staff can be included in administrative claiming. This could be used to provide training and/or consultation for other professionals related to mental health needs and increase recognition of and support for emerging mental health concerns. Pennsylvania's Infant Early Childhood Mental Health Consultation Program is a good example of a program that could be scaled up through Medicaid administrative claiming.

Reform Two: Broaden the types of providers certified and eligible to deliver services at each tier of intervention to increase access to diverse and culturally competent professionals.

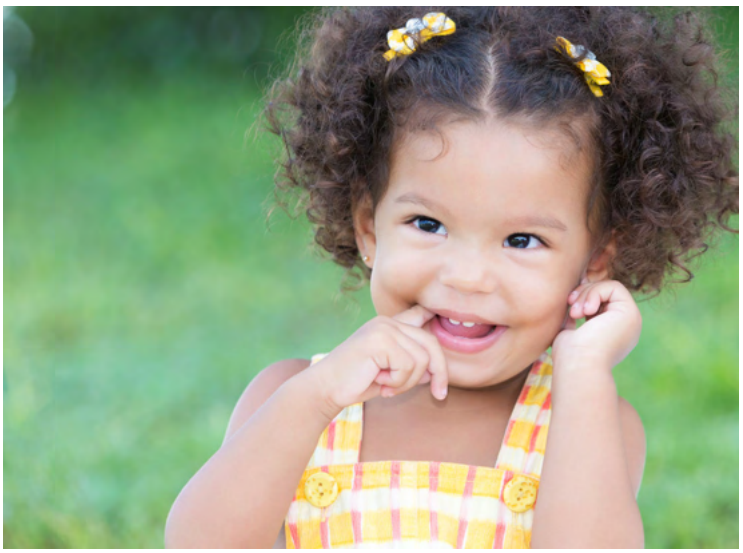
An estimated 47% of the country lives in a designated mental health workforce shortage area. Nationally, there is an estimated deficit of 31,000 psychiatrists. Currently in Pennsylvania, the ratio for school psychologists is 1:997 (recommended ratio is 1:500) and the ratio for school social workers is 1:3,416 (recommended ratio is 1:250). More information on how Pennsylvania compares to other states is available here.

In addition to severe professional shortages, the composition of the mental health workforce lacks diversity and, thus, cultural competence. The Bureau of Labor Statistics data demonstrates that, nationally, 70% of social workers and 88% of mental health counselors are white, while the American Psychological Association reports that 86% of psychologists are white.

Adopting innovative solutions can address mental health workforce shortages.

To respond to significant mental health workforce shortages as well as to provide support that is culturally competent, Pennsylvania must broaden the pool of providers eligible to deliver services across each tier. While the traditional provider class is limited to highly credentialed mental health

professionals such as psychiatrists, psychologists, social workers, and licensed professional counselors, not every child needs that level of specialized clinical care.



Many children can benefit from community-level supports offered in Tier One and Tier Two. In order to expand the workforce and meet the needs of more children earlier, Pennsylvania can apply for a waiver that would allow Medicaid to cover services delivered by youth development professionals such as school social workers, certified peer specialists, and community health workers.

Expanding the provider class will broaden access to services provided in schools and in home and community settings. This improves the system of care by organizing and coordinating services across a comprehensive array of providers and supports. To put it simply, the expansion of the provider class moves mental health care beyond just meeting the needs of children with acute clinical needs and can open up the workforce to provide services in Tier One and Tier Two.

Expanding who delivers services increases cultural competency.

Expanding the provider class uplifts the value of lived experience in Pennsylvania's mental health system.

By creating more pathways for individuals who have accessed mental health services to become mental health professionals, the services inherently become recovery-oriented and trauma-informed. Broadening the provider class creates intentional career pathways with a focus on recruiting employees of color. Additionally, broadening the provider class creates career pathways for adults with lived experience who have been systemically excluded from accessing higher education and thus excluded from achieving the credentials necessary to serve children clinically.

The current parameters on reimbursable behavioral health professionals increases barriers for Black and brown people to serve their own communities. Expanding the workforce will expand the professionals available to provide culturally relevant care to children and youth who see themselves in their provider. Service providers with shared lived experience have been demonstrated to improve engagement and satisfaction with mental health services and supports, empower children and youth to set and achieve goals in their recovery journeys, and improve the whole health of the child, including chronic conditions like diabetes and obesity.

Reform Three: Ensure that the definition of medical necessity is fully applied to authorize mental health services and payments for all eligible children.

Pennsylvania must reimagine the mental health system as a support for wellness rather than a response to pathology. Most mental health services included in the Pennsylvania Medicaid plan require that the recipient have a clinical diagnosis to be eligible for services. Fifty percent of children and adolescents who die by suicide never received a clinical diagnosis of a mental health disorder, showing that 50% of children are not getting the support that they need through the mental health system. The need for a clinical diagnosis presents a significant barrier to receiving timely services, and even children with high acuity often find themselves on months-long waitlists to receive a formal evaluation so they can begin treatment.

Pennsylvania can interpret more broadly the existing statute that defines medical necessity to be able to serve children with mental health needs faster and without a clinical diagnosis. This will reduce a key barrier to getting help and boost the share of children who are served in Tiers One and Two before their needs become severe and expensive.

Three increasingly employed strategies to open up access to mental health services for children based on medical necessity criteria include:

- Utilize EPSDT as a vehicle for claims that ameliorate future mental health challenges.
- Include specific life experiences in the definition of eligible conditions.

Pennsylvania Code 1101.21a defines medical necessity as: a service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

1. Will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.

2. Will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability.

3. Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.

Utilize EPSDT as a vehicle for claims that ameliorate future mental health challenges.

Pennsylvania must expand definitions of services allowable under EPSDT to increase access to mental health services for children before receiving a mental health diagnosis.

Pennsylvania must reimagine the mental health system as a support for wellness rather than a response to pathology.

Currently, children are determined in need of EPSDT services if they have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis. However, this manual is written primarily for adults and does not consider a child's developmental stage or how a child/adolescent's presentation may be different than an adult. Instead of relying on the DSM, Pennsylvania's mental health system can move to prevention-based services through the EPSDT benefit. EPSDT allows for the provision of Medicaid services to lessen mental health challenges in children through early intervention.

The most important aspect is that the assessment, treatment plan, and notes reflect that the services provided address the unique needs of the child.

Include specific life experiences in the definition of eligible conditions.

Pennsylvania's medical necessity criteria enables the state to offer services to children independent of a diagnosis. To ensure that services are targeted to children with the greatest needs, the Commonwealth can consider a child's ACEs score as a reasonable measure of need.

ACEs, inventoried by the Center for Disease Control, are an evidence-based set of childhood experiences that are empirically linked to increased risk of poor physical and mental health outcomes. In alignment with research, it is well established that children with juvenile justice involvement, child welfare involvement, or ACEs scores of four or more are at a greater risk of developing serious mental health challenges.

By revising the medical necessity criteria specified in the state regulations for child-serving levels of care, Pennsylvania can allow Medicaid-eligible children with an ACEs score of four or higher to receive mental health services without a clinical diagnosis.

Additionally, Pennsylvania can revise the criteria to include youth in the juvenile justice or foster care systems, those experiencing housing insecurity, food insecurity, or discrimination to receive services without a clinical diagnosis.

Reform Four: Integrate mental health services for parents and young children in pediatric primary care settings.

Ninety percent of families with young children go to the pediatrician. It is well established that parent/caregiver mental health directly affects a baby's physical and mental health development and lifetime outcomes. That's why investing in the mental health of caregivers while babies are under three leads to improved social-emotional development, parental involvement, educational performance, and reductions in juvenile justice and child welfare involvement.

Pennsylvania does not need federal authority to allow family therapy to be delivered in pediatric primary care offices. This simple change will expand access for children and their families to receive mental health support earlier and in less acute settings.

Pennsylvania can and must integrate mental health services for caregivers in pediatric primary care settings by covering universal access to a dyadic services benefit. A dyadic services benefit is a family/caregiver-focused model of care intended to address developmental and mental health conditions of children as soon as they are identified. The model also fosters access to Tier One services for children, including care coordination, screening, developmentally appropriate parenting education, and support in addressing the social drivers of health (SDOH).

Remove barriers to dyadic services.

The dyadic benefit is designed to support care providers in providing holistic services to both children and caregivers in one setting. Under CMS, there are Current Procedural Terminology (CPT) codes for family therapy that allow for billing of services rendered whether or not the patient (the child) is in the room. This allows for flexibility in service delivery and the ability for mental health providers to support parents and caregivers in the best interest of a child's social emotional development. Under the current state plan in Pennsylvania, providers are not able to bill for family therapy CPT codes in pediatric primary care settings, meaning that pediatric offices cannot be the location where the service is delivered.

Establish dyadic standards of care.

There are several models of evidence-based dyadic care, primarily Parent-Child Interaction Therapy (PCIT), HealthySteps, Parent Child Psychotherapy (PCP), and Attachment Biobehavioral Catch-Up (ABC). A number of these programs have been piloted in pediatric and mental health settings in Pennsylvania, primarily funded through government grants or private philanthropy. Pennsylvania must maximize the federal Medicaid match to broaden access to dyadic care in primary care settings.

Another barrier to providing dyadic care is the credentialing requirements of those able to bill for the service. In Pennsylvania, family therapy must be provided by a masters-prepared, licensed mental health professional such as LPCs, LMFTs, LSW, psychologists, or psychiatrists.

To expand availability of family therapy services, Pennsylvania can broaden the credentialing requirements to include masters-prepared clinicians who did not complete the additional state requirements to achieve licensure. These clinicians, while unlicensed, are professionals trained and prepared to deliver valuable clinical services. Pennsylvania can amend service descriptions to allow for clinicians without a license to deliver mental health care in pediatric primary care under the supervision of the licensed clinician. This will increase opportunities for families to receive the care they need while expanding the workforce and training opportunities for clinicians to achieve licensure.

Many of the barriers to integrated mental health in pediatric primary care involve implementation challenges, such as physical space in a primary care setting, developing workflows and warm hand offs between physical and mental health providers, and ensuring that mental health professionals are embedded into the pediatric practice. Additionally, documentation is critical to the success of dyadic care. Mental health care providers need to be trained to write treatment plan goals that are centered on what the child needs, e.g. “working on the relationship between mother and child to ensure that mom’s depression does not impact child’s social-emotional development.”

These challenges can be overcome through clear regulations, and training and regular reminders by MCOs and the Office of Medicaid Services. Dyadic family therapy services should be reimbursed at higher rates than individual therapy and other services to account for the full participation of the clinical team managing transitions and developing effective workflows and processes.

Reform Five: Center schools as critical partners in mental healthcare systems and payor networks.

School-based mental health services play an important role in the social and emotional health of children and youth. The school setting offers a unique opportunity to engage children in services and provide coverage directly to Medicaid-enrolled children. Historically, schools have focused their attention and funding on Tier Three services, reaching only the fewest students with the highest level of need. Schools can provide a mechanism to enhance early identification of health needs and connect students to a broad range of health care services, including mental health supports across Tiers One to Three.

Several school-based mental health models have emerged across the Commonwealth – wealthier districts hire their own mental health professionals, some districts contract with third-party mental health providers, and others are enrolling with OMHSAS as mental health providers themselves.

Many are left struggling without solutions. School districts desperately need guidance from DHS to streamline and strengthen school-based approaches to mental health services.

Schools must be engaged to connect youth to the appropriate mental health services.

School-based mental health services play an important role in the social and emotional health of children and youth. The school setting offers a unique opportunity to engage children in services and provide coverage directly to Medicaid-enrolled children. Historically, schools have focused their attention and funding on Tier Three services, reaching only the fewest students with the highest level of need. Schools can provide a mechanism to enhance early identification of health needs and connect students to a broad range of health care services, including mental health supports across Tiers One to Three.

Students must be able to access mental health supports in schools without an Individualized Education Plan (IEP).

In 1997, The Center for Medicare and Medicaid Services (CMS) established the Free Care Rule, which prohibited schools from billing Medicaid if the same services were provided free of charge to the general student population. Schools were allowed to bill Medicaid only if three conditions were met:

1. The student is enrolled in Medicaid.
2. The student has an individualized education plan (IEP).
3. The health care services provided are related specifically to the IEP.

To spur greater access to health care services in school for all children, CMS reversed the Free Care Rule policy in 2014, permitting states to decide to pay for health care services in schools for students without IEPs. This evolution in Medicaid reimbursement for services provided in schools has particular implications for children and youth who have or are at increased risk of mental health conditions.

Currently, Pennsylvania limits Medicaid reimbursement to Medicaid-eligible students with an IEP, resulting in a missed opportunity to recoup additional federal dollars for Medicaid-eligible mental health services provided by school-employed professionals. Pennsylvania can expand access to school-based mental health services to all students regardless of IEP status by submitting a state plan amendment. To date, 18 states have expanded coverage with four more in the process of implementation.

Schools must be in-network for mental health services to deliver tier one and tier two services.

While Pennsylvania allows Medicaid reimbursement for school-based mental health services, the administrative process required to enroll as a Medicaid provider and obtain reimbursement can significantly deter school districts from enrolling.

To center schools as a resource for community-based mental health support, Pennsylvania can establish a statewide, school-linked fee schedule in which Local Educational Agencies (LEAs) will be automatically enrolled as in-network providers for mental health services. Alleviating the LEAs' administrative burden of enrolling as a Medicaid provider will significantly increase access to school-based mental health services for children and youth.

In Pennsylvania, the infrastructure for schools to be a venue and payee in Medicaid already exists in the School-Based ACCESS Program (SBAP) designation. School districts, charter schools, intermediate units, vocational-technical schools, and preschool early intervention programs are eligible to enroll in Medicaid as Provider Type 35.

Enrollment in Medicaid as a Provider Type 35 allows LEAs to receive reimbursement for health-related services provided to Medicaid-enrolled children under 21 years of age. Covered services include many physical-health related services such as occupational therapy, vision services, physical therapy, and speech and language services.

Remove administrative barriers so schools can be a licensed location and full Medicaid partner in facilitating and getting paid for the provision of a continuum of mental health services.

On the mental health side, SBAP covers psychiatric services, psychological services, and social work and counseling services. Professionals delivering these services must maintain their current Pennsylvania licensure or certification, regardless of where the service is provided.

Another key benefit of the SBAP program is the third-party claims administrator. Pennsylvania DHS contracts with Sivic Solutions Group (SSG) to submit claims on behalf of the LEAs, alleviating the administrative burden of Medicaid claiming for school districts.

Pennsylvania can build on the existing SBAP infrastructure to further support LEAs in Medicaid enrollment and broaden the types of services offered through the SBAP. The Free Care Rule described above presents a limitation to the use of SBAP. Students must have the necessary services documented in an IEP to receive services. Pennsylvania must reverse the Free Care Rule so that more students can access mental health services earlier.

The Commonwealth must support school districts in partnership with community mental health providers to deliver more intensive services.

Currently, Pennsylvania school districts differ with respect to what it means to offer mental health services and who offers it. To address discrepancies and build a robust, quality model of school-based mental health, state agencies can and should develop an internal transformation team that includes key staff from OMHSAS, the Department of Education (DOE), and the Office of Medical Assistance Programs (OMAP). This team will enable approaches that are practical and actionable and transform the system to ensure access to the three tiers of services.

Intensive Behavioral Health Services (IBHS) is an excellent service model that can allow for the provision of school-based mental health services across Tiers One, Two, and Three. The Pennsylvania Medicaid plan provides payment for intensive behavioral health services (IBHS) so that community mental health providers can enroll as an IBHS provider and services can be provided in schools, at home, or in the community.

There are several ways that the IBHS regulations can be interpreted to provide care to more students across the continuum of tiers:

- Under IBHS, there is no limit on which diagnostic codes can be used to be eligible for the service; children can be diagnosed with "adjustment disorder not otherwise specified" or, in alignment with Reform Three, have experienced an adverse childhood event (discrimination, food insecurity, housing insecurity, or are involved in the child welfare or juvenile justice systems). This is important to note for IBHS services because the DSM provides a series of options that, when documented appropriately, can support children and adolescents early on in their mental health trajectory and can include the amelioration of a condition.

- The IBHS service description includes consultation as a covered service. Consultation models can provide non-clinical supports for children by providing services such as skill building, motivational interviewing, conflict resolution, care coordination, family meetings, or parenting skill building. Additionally, consultation models can deepen the expertise for non-mental health professionals such as pediatricians and teachers. Consultation increases their knowledge, understanding, and skills to address mental health concerns within their professional role.

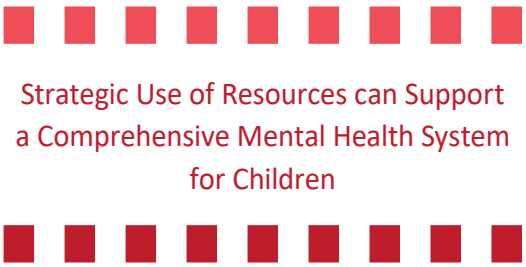
Pennsylvania currently has the Pennsylvania Key Infant and Early Childhood Mental Health (IECMH) Consultation program, which provides free infant and early childhood mental health consultation to early learning programs participating in Keystone Stars. This program includes 29 staff to provide consultation and support to the over 6,800 early child care centers across the state. Under a broader interpretation of IBHS services, this model could be made financially sustainable by maximizing the Medicaid program and its federal match. The funding that the state has provided towards IECMH Consultation can be billed as a consultation service under IBHS and thus draw down a 50% federal match. With this financially sustainability, the model could be expanded to provide more services to more early childhood learning centers across the state and reduce wait times for centers in need of support. Pennsylvania can provide clarification to the already allowable consultation services in the IBHS policies, promote the use of consultation services, and apply for grant funding through the Health Resources and Services Administration (HRSA). HRSA is currently providing funding for increased access to consultation services in 43 states, the District of Columbia, and several territories.

- In alignment with Reform Four, IBHS services can also be interpreted to cover family therapy as long as the documentation reflects that services delivered were appropriate to ameliorate any potential worsening of the child's mental health.

Funding Opportunities

Maximize the federal Medicaid match on state spending.

The Commonwealth must effectively leverage state budget line items to draw down matching funds from Medicaid for mental health services. The state budget includes line items for school-based mental health and county mental health block grants which can be used to maximize Medicaid and then be used for non-Medicaid billable services or other types of needs such as infrastructure investment or administrative costs. In order to maximize the Medicaid match, Opioid Settlement funds and new funding for school-based mental health allocated in the budget can be used, in addition to the state line items for mental health services.



Medicaid and County Block Grants are sustainable funding that can be drawn down consistently year after year. Opioid Settlement Funds and the Shapiro Budget Allocation are one-time funding opportunities that can be used to address some of the training and implementation challenges described in the above reforms.

Prioritize county mental health block grant and opioid settlement funds for gaps in services and training.

The state can encourage county mental health block grants be used to cover additional students who are not eligible for Medicaid services, whether they are undocumented students, uninsured, or underinsured. DHS should provide a detailed document to counties with guidance, expected impact, and how to operationalize alternative uses of the funding to create more long-term outcomes for future generations.

Counties have the discretion to determine how their portion of the opioid settlement funds are used. DHS can guide local counties to use a portion of these funds to support one-time costs associated with the training and implementation needs of school districts who plan to enroll as Medicaid providers, support IBHS expansion through one-time operational start up costs, or other one-time costs associated with training and credentialing an expanded provider class. These funds can be used as state funds to match federal spending in Pennsylvania's Medicaid program.

To address the disparities in mental health access and programming across the Commonwealth, DHS can provide more guidance and technical assistance to county mental health offices and direct a portion of the expenditure of county block grants more clearly for these purposes.

Utilize reinvestment funds to drive system reform.

The Pennsylvania HealthChoices program allows for counties to utilize unspent revenue and investment income to reinvest in programs and services that will fill gaps in the county's service system. The funds can be utilized to develop new or expand existing services for Medicaid-eligible children and families. Reinvestment plans are an opportunity for counties to develop individualized programs that meet the needs of their communities. Ultimately, successful reinvestment programs can be made sustainable by transitioning to Medicaid-reimbursable services. For example, peer support services began as a pilot through reinvestment funds and were ultimately added to service descriptions across various levels of care to become sustainable through Medicaid claiming.

Reinvestment funds can be used to pilot innovative programming with the ultimate goal of establishing sustainability on Medicaid-matched funding. For example, counties could use reinvestment dollars to pilot the delivery of family therapy services in pediatric primary care, with the ultimate goal to establish family therapy in pediatric settings as a Medicaid compensable service. It is the

responsibility of each county's mental health administrator to develop reinvestment plans that meet the needs of their community; DHS can make recommendations that counties prioritize children's mental health as they are crafting their reinvestment plans.

The proportion of youth eligible for Medicaid varies considerably across the Commonwealth, which affects the impact that Medicaid can have in funding school-based mental health services. However, Medicaid sets the benchmark for enforcing pay parity within the commercial insurance sector for mental health services.

Chart 2: Optimizing All Available Funds and Authority to Build and Support Mental Wellness Systems for Children and Youth

	Medicaid	Reinvestment	County Block Grants	Opioid Settlement	Shapiro Proposed Allocation
	Annual	Some Portion of the 3% Set Aside	Annual Some Portion of the $27.7 Million	One Time Some Portion of the $1.07 B	One Time $100 Million
Recommendation One: Expand access to mental health services by increasing resources for early and less intensive services known as tier one and tier two supports.					
Recommendation Two: Ensure ready access to diverse and culturally competent professionals by broading the qualified entities certified and eligible to deliver services at each tier of intervention.					
Recommendation Three: Remove the stigma of accessing services by fully using Pennsylvania's defintition of medical necessary to authorize services and payment.					
Recommendation Four: Intervene early by integrating behavioral health services for parents as well as young children in pediatric primary care settings.					
Recommendation Five: Increase access to behavioral health services for children, youth, and families by centering schools as critical partners in behavioral healthcare systems and payor networks.					

Current authority in place, state policy changes needed (DHS)

County coordination / guidance / action needed

Current authority not in place, Federal action needed (waiver, SPA)

State Authority to Drive Innovation and Reform

The Commonwealth has the authority and the identification of existing services in place to drive innovation and reform.

The Biden-Harris Administration is encouraging expanded use of school-based services through Medicaid including funding, documentation, and expanding services, in accordance with the CMS Informational Bulletin: Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services.

Pennsylvania already has IBHS in place, which can be applied more broadly to deliver school-based mental health, applied behavior analysis (ABA), and other innovations for which other states have to submit waivers. This change can be made simply by changing the state policy for IBHS services.

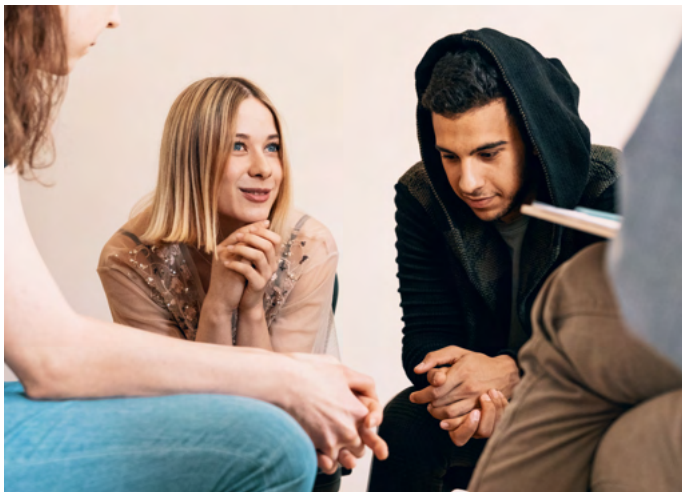
Pennsylvania already has a broad definition of medical necessity written in statute. The categories of medical necessity narrow when defined in service descriptions. The state has the authority to revise service definitions to apply the full definition of medical necessity more broadly across children's mental health services.

Pennsylvania also has the authority to integrate mental health services in pediatric primary care settings. The dyadic benefit is already a billable service in the state plan, and Pennsylvania has the ability to establish a system of supports and guidance for pediatric primary care to be able to deliver family therapy.

Drive reform by using Alternative Payment Models (APMs) within managed care.

The Department can incentivize dyadic models and IBHS service delivery by implementing alternative payment models for these services in collaboration with the Behavioral Health Managed Care Organization (BHMCOs) across the Commonwealth.

APMs drive provider behavior as well as shape what services can be delivered. Pennsylvania can develop and implement various APMs based on different levels of care/services so that Tier One and Tier Two services can be provided to students who may not currently meet diagnostic criteria. The APM could be an incentive to create more partnerships between schools and third-party mental health providers.



In Pennsylvania, IBHS could be billed through an APM to create more flexibility – how and who provides the IBHS services will matter. Some schools may contract for services per student or for school-based mental health clinician FTEs.

A more robust contract that allows for an FTE and certain number of students served helps create more stability and flexibility in the program.

Pennsylvania can edit service definitions to include broader service types such as basic living skills, social skills, or collateral contact. APMs can accompany edits to service definitions to expand supports beyond intensive levels. This change to service definitions can happen simply by making changes to the policies and definitions, or, if necessary, through a State Plan Amendment.

Chart 3: Steps to Medicaid Maximization

	State Plan Amendment	State Authority for Regulation change	Alternative Payment Models	Waiver
Increase resources for prevention, early intervention, and less intensive services known as Tier One and Tier Two supports.		X		
Broaden the types of providers certified and eligible to deliver services at each tier of intervention to increase access to diverse and culturally competent professionals.	X			
Ensure the definition of medical necessity is fully applied to authorize mental health services and payments for all eligible children	-	-	-	-
A: Include specific life experiences in the definition of eligible conditions.		X		
B: Utilize EPSDT as a vehicle for claims that ameliorate mental health challenges		X		
Integrate mental health services for parents and young children in pediatric primary care settings.		X	X	
Center schools as critical partners in mental healthcare systems and payor networks.	-	-	-	-
A: Schools must be engaged to connect youth to the appropriate mental health services		X	X	
B: Students must be able to access mental health supports in schools without an individualized education plan	X			
C: Schools must be in-network for mental health services to deliver tier one and tier two services		X	X	
D: The Commonwealth must support school districts in partnership with community mental health providers		X	X	

Many BHMCOs across the Commonwealth are already embarking on value-based purchasing or APMs with their provider networks. Pennsylvania DHS can streamline this process by offering state-level coordination in value-based purchasing (VBP) and other APMs that will ensure quality service delivery.

Pennsylvania has sufficient existing authority to enact the reforms outlined in this memo.

State plan amendments and waivers can be utilized when establishing a new provider class or when embracing the reversal of the Free Care Rule to strengthen the ability to provide mental health services in schools.

Conclusion

Pennsylvania is leaving available funding unspent by not maximizing the federal funding available to match state spending.

Pennsylvania can maximize existing state-level authority that is underutilized by using intensive behavioral health services (IBHS) services to its fullest extent and apply the policy more broadly.

The Commonwealth can also optimize the use of existing funding sources such as the Opioid Settlement Funds, County Mental Health Block Grants, or new funding allocated in the Shapiro Administration's budget to increase the federal match for Early and Periodic Screening, Diagnostic (EPSDT) and Treatment and Medicaid services.

Finally, by submitting a state plan amendment and applying for a waiver, Pennsylvania can gain federal authority to maximize funding and make a significant change to children's mental health across the Commonwealth.

Editor's Note: Throughout this report, Children First uses "mental health" instead of "behavioral health" to reflect the changing conversation around mental health and wellbeing. The term mental health includes emotional, psychological, and social wellbeing, and is inclusive of both mental health and substance use.

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