State Examples of Medicaid Optimization for Child and Youth Mental Health in Alignment with Recommendations for PA

Introduction

In March 2024, Children First published a policy brief entitled "Optimizing Medicaid to Improve Child and Youth Mental Health in Pennsylvania." In that brief, five specific reforms to optimize Medicaid as a sustainable funding source to improve child and adolescent health in Pennsylvania were outlined. To inform the reforms made in the previous brief, several state Medicaid leaders were interviewed. These leaders shared methodologies around the innovative leveraging of Medicaid programming to advance their child-serving behavioral health systems.

To accompany the original brief, the following is a compilation of examples of innovations other states are making that bolster the support of these recommendations. Several states have made great advancements to improve child and adolescent mental health by using creative solutions within the confines of the federal Medicaid program. These state examples demonstrate the potential for Pennsylvania's system and support the five essential mental health reforms outlined in the next column.

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

April 2024

State Examples and Essential Mental Health Reforms

	California	Maryland	New Jersey	Vermont	Washington, DC
Reform One: Increase resources for prevention, early intervention, and less intensive services known as Tier One and Tier Two supports.	●	●		●	
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.	●			●	●
Reform Three: Ensure that the definition of medical necessity is fully applied to authorize mental health services and payments for all eligible children.	●				
Reform Four: Integrate mental health services for parents and young children in pediatric primary care settings.	●				●
Reform Five: Center schools as critical partners in mental healthcare systems and payor networks.	●		●	●	

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

Based on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) guidelines, **Vermont** is increasing screening at the school level to boost early identification of potential challenges and to access real time data to improve the system to meet needs. The state is using the data to build well-defined referral pathways either through embedded school-based clinicians with referrals through the school-based mental health clinicians or directly to the community mental health center. This approach is seen as prevention with the goal of reducing the need for more intensive services later on.

Another state example of using EPSDT to a fuller extent, **Maryland**'s Medicaid program covers the EPSDT treatment services necessary to identify, correct, or ameliorate mental illness, and provides reimbursement for behavioral health services when the diagnosis of a recipient is not included under the specialty mental health system. In addition, the only limitations for these services are those provided while the recipient is in an institution for mental disease, a hospital, or a residential treatment center, as bundled payment for institutional stays includes EPSDT services.

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.

Through several state plan amendments, **California** added four different providers to the continuum of children's metal health service options: certified peer specialists, doulas, community health workers, and wellness coaches. While Pennsylvania is a national leader in peer support, more work can be done to expand the provider class to combat behavioral health workforce shortages, provide culturally relevant care to kids, and to develop career pathways for individuals with lived expertise.

California's wellness coach credential is for individuals with an Associate Degree in Social Work who are building their careers. The wellness coaches work primarily in school-based settings to deliver Tier One and Tier Two supports to students, creating an opportunity for the coaches to further their careers in mental health counseling and addresses workforce shortages.

In **Washington D.C.**, the Primary Project is a Tier Two prevention and early intervention program designed to reduce mild adjustment difficulties of identified children from pre-kindergarten through third grade. The program utilizes "child associates" who are paraprofessionals that provide one-to-one, non-directive play sessions to improve school-related competencies in task orientation, behavior control, assertiveness, and peer social skills.

Vermont provides another example of provider class expansion. The rehabilitative services option for children in Vermont includes paraprofessionals who receive clinical oversight to provide services to individuals or groups of children at risk of mental health issues. This approach was enacted in order to address mental health issues early before they require more intensive and expensive services later in life.

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

In 2022, the **California** Department of Health Care Services received approval for a Section 1915b waiver that expands access to mental health services for beneficiaries under 21 years old. This waiver carves out covered mental health services from the broader Medi-Cal program as specialty mental health services (SMHS). SMHS include a continuum of services such as targeted case management, crisis stabilization, medication support services, or intensive care coordination. These services can be accessed **without a specific mental health diagnosis**, allowing children at high risk for a mental health disorder to access timely services, preventing more acute mental health needs from arising. Children involved with the child welfare or juvenile justice systems are automatically able to access SMHS under this waiver.

Expanded Criteria to Access Mental Health Services in Medi-Cal:

Criteria 1: The recipient has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

Criteria 2: The recipient meets both of the following requirements in (a) and (b) below:

(a) The beneficiary has at least one of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate.

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

(b) The recipient's condition as described in subparagraph (2) above is due to one of the following:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

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

Operating within the requirements of federal EPSDT, **California** approved new dyadic services and family therapy benefits. Effective January 2023, the dyadic care services benefit reimbursees screening for both children and their caregivers for behavioral health conditions and social determinants of health. The benefit also reimburses for referrals made to appropriate follow-up levels of care.

In alignment with Recommendation Three, additional benefits under Medi-Cal allow for members under 21 years old to receive up to five family therapy sessions without a clinical diagnosis. Additionally, members under 21 can continue to receive the family therapy beyond the five session limit if the parents/caregivers demonstrate risk factors of a mental health or substance use disorder. These risk factors include separation from the parent/caregiver who has been detained either through immigration or criminal legal systems, or who has passed away.

Consultation models can further the expertise for "non-mental health" professionals such as pediatricians and teachers by providing behavioral health professionals as consultants to train and educate non-mental health professionals. Consultation could include how to screen, what to do with results, making sure consideration of differential diagnosis and assuring the right treatment options or supports are provided.

Currently the Health Resources and Services Administration (HRSA) is providing funding in **43 states**, **the District of Columbia and several territories.** The District of Columbia's consultation program is DC MAP (Mental Health Access in Pediatrics) and Maryland's is Behavioral Health Integration in Pediatric Primary Care (BHIPP) offer examples. The District permits consultation services for early childhood providers through its Healthy Futures program, while Maryland delivers the Infant and Early Childhood Mental Health Support Services (IECMHSS) via Medicaid.

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

Vermont's School-Based Mental Health Clinicians (SBMHC) are primarily funded through a local match to maximize Medicaid. Similar to how state funds draw down federal Medicaid dollars, Vermont uses local school budget dollars to draw state funds. Through a transfer mechanism, the local school district provides funds to the Department of Mental Health (DMH) which is then used by the Community Mental Health Centers (CMHC) to provide Medicaid services. Some of the local funding may also be used to support non-Medicaid students if the school agrees to that use. Additionally, any service that can be billed to commercial insurance is billed. This process creates the mechanism to hire and pay for most of a SBMHC direct service time and allows for some flexibility to participate in 'non-direct service' activities. It has been in use for over 25 years as the mechanism to provide these services and is a partnership between the school district, DMH, and CMHCs. In some states, a similar process takes place where the county government uses its funds for state match to increase access to Medicaid billable services.

Indiana does this for their specialized rehab option, which constitutes a large majority of the services a CMHCs provides in the community and schools.

The **District of Columbia** braids multiple funding sources, including an annual appropriation from the City budget to fund behavioral health services in schools for students who are uninsured and underinsured. Other funding sources include Medicaid, commercial health coverage, and federal grant dollars. Through this model, the District began a phased expansion during the 2018-2019 school year of multi-tiered school-based behavioral services in all of its public and public-charter schools. This model includes mental health practitioners in all schools to have clinicians available and on hand in the aftermath of traumatic events affecting a school community and supports a community of practice. This model also includes community leaders, to support the wellbeing of students and their families. The District of Columbia model shows that when states effectively allocate braided funds along with Medicaid reimbursement, programs can be sustained while also providing reimbursable and non-reimbursable services and supports (which can be considered prevention type services).

In an effort to bring together school-based and community-based mental health services and increase access through a hub and spoke model, **New Jersey** is currently reviewing RFPs to create 15 regional hubs to drive more prevention services in schools and other community settings. The NJ Statewide Student Support Services (NJ4S) intends to reach beyond the current 2% of students that have access through the School Linked Services network. Part of the intent is to create increased access through services being available outside of the school system and be available in other community settings such as libraries, after school programs, and community settings. While the funding is specifically being used to create the hub and spoke model, the intent is to identify more students with needs who can then access Medicaid services either in the school or community.

While the **New Jersey** model required a specific line-item investment, Pennsylvania could structure their system this way without the same investment in order to achieve more common service availability statewide with an increased school/CMCH partnership expectation. Part of why New Jersey is moving in this direction is because of a survey that indicated not all students wanted services in the school setting. This supports the idea that access for mental health services needs to be available in multiple settings, home, community, school, pediatric office, etc.

Similar to IBHS in Pennsylvania, **Vermont** has a rehab option called Specialized Rehabilitation. This service includes four service types: basic living skills, social skills, counseling, and collateral contact. All of these services are provided by either a paraprofessional or master's level clinician which can be provided in a school setting (and clinic, community, or home) to address mental health needs so that a student can participate in their education. Pennsylvania can edit their definition to include these services AND include a payment model to expand supports beyond intensive levels. This change to the definition could happen by simply making changes to the policies (and definitions) and if not, it can be changed through a SPA.

In **Vermont** an alternative payment model is being used to create more flexibility in what the school-based clinician can provide, especially in relation to the Multi-Tiered Support System (MTSS). In the past this service was paid fee-for-service (FFS). FFS is known to drive units of service rather than outcomes or flexibility so Vermont changed the payment model to a per member per month (PMPM). The model was built on the service deliver history of:

- The average amount of services billed in a given year.
- The average number of students served per year.
- Basic calculation:
  - Amount billed/number served/12 months to develop the PMPM.
  - Then reduced the number served for the purpose of increasing the rate and creating flexibility by a percentage and established a new PMPM.
  - The clinician needs to see at least the number of students identified in the reduced PMPM rate to draw down the funding to support their position and then it creates flexibility for them to be involved in other students' needs and universal activities focused on the whole school culture.

IBHS could be billed through a PMPM or other APM to create more flexibility. How and who provides the IBHS services will matter. Some schools may contract for service by student or for school-based mental health clinician FTEs. A more robust contract that allows for an FTE and certain number of students served creates more stability and flexibility in the program.

In **California**, the state Department of Health Care Services developed a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to students at a school. The state statute requires commercial health plans and the Medi-Cal delivery system to reimburse school-linked providers, regardless of network provider status, for services provided to students within the fee schedule. Further, services provided as part of the fee schedule are not subject to copayment, coinsurance, deductible, or any form of cost sharing. Essentially, all school districts in California are automatically in-network with Medi-Cal and commercial payers to deliver school-based mental health and substance use services. The state also established a third-party administrative entity to handle all billing on behalf of school districts.

Conclusion

Several states have leveraged Medicaid innovatively to advance their child-serving mental health systems. Vermont, California, New Jersey, and Maryland are states that have been able to reach more children and provide more Tier One and Tier Two supports by maximizing Medicaid and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) programming. Pennsylvania can adapt these existing state models to meet the needs of the children across the Commonwealth.

Children First, formerly known as Public Citizens for Children and Youth (PCCY), serves as the leading child advocacy organization that improves the lives and life chances of children in Southeastern Pennsylvania.

Children First undertakes specific and focused projects in areas affecting the healthy growth and development of children, including child care, public education, child health, juvenile justice, and child welfare.

Through thoughtful and informed advocacy, community education, targeted service projects, and budget analysis, Children First watches out and speaks out for children and families.

Children First serves the families of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties as well as children across the commonwealth. We are a committed advocate and an independent watchdog for the well-being of all our children.

childrenfirstpa.org
facebook.com/childrenfirstpa
twitter.com/childrenfirstpa
instagram.com/childrenfirstpa

Children First
990 Spring Garden Street
Suite 600
Philadelphia, PA 19123
215-563-5848