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Appropriate Access to Behavioral Health Treatment for Children in Medicaid: Draft Policy Options

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MACPAC

Medicaid and CHIP Payment and Access Commission

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Overview

- Background
- Federal requirements and guidance
- Summary of key findings
- Draft policy options for consideration
- Next steps

Background

- Federal law requires services (e.g. behavioral health) be provided to youth with disabilities.
  - In the most integrated setting appropriate (ADA, P.L 101-336); and
  - In community-based settings if the individual does not oppose such services, they are appropriate, and can be reasonably accommodated (Olmstead v. L.C.).
- Some youth with intense treatment needs or who pose a safety risk to themselves or their families and cannot be served in the community require access to residential treatment.
- Residential treatment services for youth may be provided in a psychiatric residential treatment facility (PRTF), qualified residential treatment program (QRTP) for children in foster care, or in other settings that do not meet the requirements of a PRTF or QRTP.

Overview of Federal Rules

- The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement mandates that states provide beneficiaries age 21 and younger access to medically necessary Medicaid services.
- The institution for mental disease (IMD) exclusion prohibits Medicaid payments for services provided to beneficiaries in an IMD unless the state covers PRTF services provided (i.e., psych under 21 benefit).
- Federal rules set expectations for PRTFs and QRTPs (e.g., accreditation, certification or assessment of need, and plan of care).

Review of Key Findings

Information on Facility and Bed Availability

- Difficulty finding real-time information on facility and bed availability and specialized care can hinder access to residential services.
- Some state and federal sources provide information but there are gaps in information.
  - State bed registries,
  - The Centers for Medicare & Medicaid Services (CMS) Quality, Certification, and Oversight Reports system identifies facilities and provides health and safety survey information, and
  - The Substance Abuse and Mental Health Services Administration's (SAMHSA) FindTreatment.gov is a searchable database but does not provide bed availability and the Office of the Inspector General has identified inaccuracies and incomplete information.

Data Collection, Sharing, and Analysis

- There is no single federal data source on the use of residential treatment, including in out-of-state facilities.
- PRTF annual attestation statements to states must include the number of beneficiaries receiving the psych under 21 services in the facility, the number of out-of-state patients, and a list of states from which it has received payment for psych under 21 services.
- Transformed Medicaid Statistical Information System (T-MSIS) behavioral health data book provided information on use of services by state, but does not differentiate between children and adults, in- or out-of-state users.

Out-of-state Placements

- Out-of-state placements occur if in-state facilities are unable to meet a child's needs or denies admission but there is no national data source on these placements.
- Interviewees indicated that facilities prefer to admit out-of-state youth because they garner higher payment rates than in-state youth.
- Out-of-state placements can make it difficult to maintain connections with family and transition back to the community in the sending state.
- Federal rules for discharge planning are brief and do not address out-of-state considerations.

Other Findings

- Assessment and admissions
  - Processes are described as fragmented and variable by agency, facility type, and provider.
  - PRTF rules do not specify a timeframe for certifying need for residential care or the use of assessment tools, but some states have opted to use them.
- Home- and community-based behavioral health services (HCBS)
  - Lack of access HCBS affects access to residential treatment services.
- Prohibition on payment for room and board in non-PRTFs
  - Lack of Medicaid payment for room and board is a disincentive to accepting beneficiaries.
- Workforce
  - Difficulty hiring, training, and retaining clinical and direct care staff is a barrier for states to operate facilities at their licensed residential bed capacity.

Draft Policy Options for Consideration

Finding	Policy objective	Policy option
1. Lack of information on facility and bed availability or areas of expertise.	Ensuring the availability of up-to-date and complete information on facility and bed availability.	Recommend Congress to require HHS to develop and maintain a directory of youth residential treatment facilities.
2. Lack of data on use of residential treatment services, including in out-of-state facilities.	Increasing the availability of data on use of residential treatment services, particularly in out-of-state placements.	Recommend CMS to report on the use of residential treatment services, including non-PRTFs and out-of-state residential treatment providers.
3. Placement in out-of-state facilities can make it difficult for children to maintain connections with family and transition back to their respective states of residence.	To provide clarity on expectations for discharge planning to ensure those being discharged from out-of-state facilities return to the community in their home state and receive needed services.	Recommend CMS to revise federal regulations to establish minimum requirements for discharge planning processes.

Option 1. Recommend Congress to require HHS to develop and maintain a directory of youth residential treatment facilities

- The U.S. Department of Health and Human Services (HHS) through CMS and SAMHSA should develop, maintain, and make publicly available a centralized, up-to-date directory of youth residential treatment facilities serving Medicaid beneficiaries.
- At a minimum, this directory should include regularly updated information on the behavioral health conditions that facilities treat, bed availability for in- and out-of-state Medicaid beneficiaries, and other considerations for beneficiaries seeking care (e.g., accessibility of facilities and services).
- Federal agencies should leverage information they are already collecting, while also integrating other information needed to determine whether the facility can meet beneficiary need. This directory should be created with input from stakeholders, including states, families, and providers.

Option 1. Recommend Congress to require HHS to develop and maintain a directory of youth residential treatment facilities

- There is no single source of information to help states, families, and providers identify Medicaid-serving residential treatment facilities, the conditions they treat, and bed availability, which can lead to delays in services for youth needing such care.
- There is no federal mandate that states or CMS produce such information about residential treatment facilities.
- The limited information collected and shared by federal agencies is incomplete for purposes of easing placement.

Option 2. Recommend CMS to report on the use of residential treatment services, including non-PRTFs and out-of-state providers

- CMS should regularly report on children's use of residential treatment services, including those provided by PRTFs and out-of-state residential treatment providers.
- This report should provide data on the characteristics of youth using the services (e.g., demographics, disability and co-occurring conditions, and urbanicity and rurality); types of services used; average length of stay; and discharge outcomes.
- CMS should leverage existing data collection reporting mechanisms. If data are unavailable, CMS should develop a plan to collect and publicly report on the missing data. CMS should engage states, providers, and other stakeholders to develop the data collection and reporting efforts.

Option 2. Recommend CMS to report on the use of residential treatment services, including non-PRTFs and out-of-state providers

- Data are not readily available to understand use and outcomes of residential treatment facility services, which could be used to develop interventions to address access concerns.
- Federal regulations do not require that CMS or states report information on the use of residential treatment in non-PRTF settings or out-of-state providers.
- Congress has previously acted on the need for data on the use of out-of-state providers serving children with medical complexity in Section 1945A health homes.

Option 3. Recommend CMS to revise federal rules to establish minimum requirements for discharge planning

- CMS should revise federal regulations at 42 CFR 441.155 to establish minimum requirements for discharge planning processes, and coordination and information sharing between out-of-state providers and the post-discharge providers.

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- Research shows that discharge planning can help facilitate transitions from inpatient to other health care settings, including in the community.
- Federal PRTF rules require a plan of care that includes a discharge plan, but does not elaborate on requirements for discharge planning, including for youth in out-of-state facilities.
- CMS has expectations for discharge planning and beneficiaries returning to the community for other CMS programs (e.g., Section 1945A health homes, Medicare hospital discharge planning).
- Existing state discharge policies are more likely to be a function of licensure standards than Medicaid requirements.

Next Steps

- Are there questions staff can answer about the findings or draft policy options?
- Commissioner feedback on the following would be helpful:
  - Do draft policy options address the key challenges identified through our work?
  - Are there considerations for further refining the draft policy options?
- Staff will adjust the policy options based on Commissioner input and return for further discussion in future meetings.

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JANUARY MEETING

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