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Financing Mental Health for Children, Youth and their Families

APA Congressional Briefing on Children's Mental Health

October 10, 2007

The Big Picture: Challenges to Financing Effective Care

1) *We invest a lot.* We already spend at least $14 billion to support children's mental health (out of a national behavioral health expenditure report of $104 billion), but a large proportion of the children and youth who need services and supports do not get what they need, as Dr. Knitzer has explained. If they get services at all, it may not be the most appropriate and there is concern that the quality of mental health services needs improvement. Prevention and early intervention services are not widespread.

2) Our financing streams are wrought with restrictions and contradictions that often put fiscal policies out of sync with research-informed policies and practices designed for improved outcomes to children and youth.

3) Our fiscal policies often fail to reflect emerging knowledge in the field or provide the flexibility to support quality improvement.

4) The proprietary nature of many evidence-based practices and the required infrastructural support (including building and sustaining a robust workforce) place these strategies beyond the means of many public systems. Treatment as usual may not be desirable but it may be the only treatment that is affordable. This needs to change.

5) There is a huge funding imbalance between community-based and residential care. States continue to spend the vast proportion of money for treatment on residential treatment. In 2002 alone, states and the federal government spent more than $4.2 billion on residential treatment for children and youth with less than stellar outcomes.[1] Most local area evaluations of out-of-home placements show that residential treatment result in poor outcomes for children and youth.[2]

Challenges Specific to Medicaid

Medicaid represents the single most important funding stream for children's mental health. We must ensure that we spend Medicaid dollars smarter. Current Medicaid policy does not do that. It is narrowly constructed using a medical model that does not fully recognize or endorse the psychosocial nature of mental health problems, the imperative for prevention and early intervention, and, does not fully support evidence-based practice.

1) *With respect to early childhood funding,* two-fifths of state Medicaid programs do not reimburse for the use of standardized screening and assessment tools for young children. Of the states that do, low reimbursement rates and restrictions on eligible providers further impede access. Over half of all states do not allow Medicaid reimbursement for non-physician providers with specialty in early childhood.[3]

2) *The challenge for Medicaid to be developmentally appropriate* also exists at the other end of the age continuum. Youth transitioning to adulthood with mental health problems are often cut-off the rolls before their 18th birthday and are not provided with the supports they need to make a successful transition. Despite Congress' passage of the Chafee Foster Care Independence Act that expands Medicaid coverage for transition-age youth at the state option, only 17 states have taken advantage of the opportunity to cover transition-age youth through Medicaid.[4]

3) Medicaid policy ignores the intergenerational nature of mental illness.
   - Less than 15% of state Medicaid programs permit Medicaid reimbursement for pediatric providers who screen for maternal depression.[5]
   - Mentally ill parents of children and youth with behavioral health problems who are not themselves Medicaid eligible can not access Medicaid funded treatment.

   Medicaid's focus on the "indicated client" pushes up against our knowledge of what works for children and youth and the importance for a family focus for improved outcomes.

4) Medicaid policy is not supportive of school-based mental health services.
   - Medicaid unevenly covers community-based services including those provided in the schools. In some states community-based mental health providers can receive reimbursements for services delivered in office-based practices or health centers but not the schools. As I discuss later, plans are in afoot to curtail other school-based support from Medicaid.

5) Youth who are incarcerated lose access to Medicaid and sometimes do not regain it on release. Federal statutes prohibit coverage for children and youth who are incarcerated.
   - This ban has led to extreme caution in coverage for all children and youth with juvenile justice involvement. States tend to be very slow in restoring coverage for youth when they leave detention or incarceration.[6] Therefore, greater inefficiencies are created as care is interrupted and children and youth seek care in the most costly settings like the emergency room or receive care when the conditions are more costly to treat.

Current Challenges

I. New Medicaid rules threaten current services:

- New rules proposed by the Centers for Medicare and Medicaid Services (CMS) related to the rehab option and administrative and transportation costs raise concerns. Some of the proposed rules would do some good things like mandate person-centered planning and require yearly evaluations and assessment of progress. Others are potentially harmful.

Anticipated Consequences:

These proposed rules:

a) Undermine years of effort to create an integrated care model. A number of communities have mature cross-agency mental health systems that collaboratively support children, youth and their families with multiple system involvement. These initiatives rely on the flexible dollars that CMS wants to recapture.

b) Create a more uneven playing field for states.

Specifically:

1) They pose a challenge to collaborative service delivery process in particular by forcing the separation of services deemed intrinsic to a specific child serving entity. For example education, child care, child welfare or juvenile justice all deliver services which are simultaneously intrinsic to behavioral health and education, child development, stability and justice goals.

2) They narrow flexibility for states on provider qualifications compromising efforts to match the population of focus and to base provider choice on local provider capacity.

3) They undermine efforts to implement evidence-based practices by requiring documentation and billing methods for each component of an evidence-based model that will compromise the built-in service efficiencies and practice advantages associated a whole model.

4) They reduce access to cultural and linguistically competent services available in schools by eliminating federal participating in coordinating and providing translation services through this option. A school district employee with language skills can no longer translate at a direct service meeting through this funding.

5) They hinder schools ability to participate in service coordination and referral and in interagency service planning including addressing gaps in service delivery.

6) They cut-off funding for training and other infrastructural supports critical to the implementation of effective practices.

II. Beyond the problems with current and proposed Medicaid rules, states also face uphill battles to create, support and sustain the widespread adoption of evidence-based practices.

1) They must finance start up costs and ongoing training, technical assistance and clinical consultation to maintain fidelity and adherence to the model.

2) Workforce shortages and poor competency levels in many of these practices strain efforts to use evidence-based practices.

What Can We Learn From What Some States Are Doing?

- New York, California, Oregon, Arizona and Washington are among the states that have invested or are investing state resources heavily in promoting evidence-based practices.
- States are recognizing that access to services and supports that improve quality require **cultural and linguistic competence and application of evidence-based practices relevant for diverse populations**.
- State and federal funding is increasingly being used to support family and youth involvement. In our study states report that they use Medicaid and state funds to support family members and youth in service provision roles. Nearly one third support family members as staff using state funding (over 25% use Medicaid funding). Nearly 20% permit state or Medicaid funding to support family members or youth in case management roles.

Endnotes

1. Atay, J., & Survey and Analysis Branch. (2005). 2002 State Tables. Table 15. Expenditures (in Thousands of Dollars) By Owner According to Organization Type: 2002 IMHO. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

2. Budde, S., Mayer, S., Zinn, A., Lippold, M., Avrushin, A., Bromberg, A., et al. (2004). *Residential Care in Illinois: Trends and Alternatives*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.

3. Rosenthal, J., & Kaye, N. (2005). *State Approaches to Promoting Young Children's Healthy Development: A Survey of Medicaid, and Maternal and Child Health, and Mental Health Agencies*. Portland, ME: National Academy for State Health Policy.

4. Patel, S., & Roherty, M. A. (2007). *Medicaid Access for Youth Aging out of Foster Care*. Washington, DC: American Public Human Services Association.

5. See Endnote 3.

6. Evans Cuellar, A., Kelleher, K. J., Rolls, J. A., & Pajer, K. (2005). Medicaid Insurance Policy for Youths Involved in the Criminal Justice System. *Am J Public Health, 95*(10), 1707-1711.

NCCP study data based on: Cooper, J. L. (Forthcoming). *Making Dollars Follow $ense and Science: Financing Children's Mental Health Services*. New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.