The Honorable Max Baucus, Chairman  
The Honorable Orrin G. Hatch, Ranking Member  
United States Senate  
Committee on Finance  
Washington, DC 20510-6200  

September 30, 2013  

Dear Senators Baucus and Hatch:  

Thank you for the opportunity to provide input into how we might improve the mental health system for children and youth in the United States. I am the Director of The Institute for Innovation & Implementation (The Institute) at the University of Maryland School of Social Work. The Institute (formerly Innovations Institute) was established by the Maryland Children’s Cabinet in 2005 to provide training and technical assistance to state agencies and local jurisdictions on systems of care (SOC) and Wraparound implementation, and has since evolved into a national Center of Excellence for SOC, providing Wraparound training and coaching in over 12 states, as well as serving as an intermediate purveyor of evidence-based practices (EBPs) and supporting states and localities to implement and sustain EBPs.  

We are a founding member of the National Wraparound Initiative and have over $10 million in annual contracts from an array of sources, including the Centers for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), Administration for Children & Families (ACF), Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the Department of Education (DOE), as well as the Annie E. Casey Foundation, and state and local governments. Additionally, effective September 30, 2013, we have been contracted by SAMHSA’s Center for Mental Health Services, Child, Adolescent & Family Branch to develop and implement a technical assistance center to support states and communities funded by the Children’s Mental Health Initiative (CMHI) program.  

The Institute submits these comments from our vantage point as a national technical assistance center that has worked in and directly with state and local agencies, families, youth, and providers in multiple states. We also speak from our perspective of providing project management, policy and financing analysis, training, and evaluation for Maryland’s three current SAMHSA CMHI grants, the CMS-funded 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Demonstration Waiver, and the CMS-funded Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant.  

We offer the following recommendations:  

1) Re-introduce and enact The Children’s Mental Health Accessibility Act (S. 3289 in the 112th Congress) to amend the definition of “institution” to include PRTFs under §1915(c) of the Social Security Act;  

2) Amend §1915(i) of the Social Security Act to unequivocally articulate that states
may serve individuals up to 300% Social Security Income (SSI) Federal Benefit Rate (FBR), 300% Federal Poverty Level (FPL) and individuals who meet institutional eligibility rules;

3) Collaborate with CMS and, as necessary, enact legislation, clarifying that states may establish clinical criteria for enrollment in health homes that are age-specific, so long as there is clinical justification for the exclusions.

4) Require comprehensive, mobile, and universal crisis response systems in all states;

5) Support The Mental Health First Aid Act of 2013 (S.153/H.R. 274) to authorize $20 million grants to fund Mental Health First Aid training programs around the country to train participants in recognizing the symptoms of common mental illnesses and addictions disorders, de-escalating crisis situations safely, and initiating timely referrals to behavioral health care resources in the community;

6) Support the Behavioral Health Information Technology Act (S. 1517/H.R. 2957) to extend financial incentives for the meaningful use of electronic health records to specified mental health and addiction treatment providers and facilities; and,

7) Amend the Deficit Reduction Act of 2005 (42 U.S.C. 1396a) to reduce the institutional length of stay for the Money Follows the Person (MFP) Demonstration Program.

Below please find additional information on each of the recommendations listed above.

Amend the definition of “institution” under §1915(c) of the Social Security Act
As this Committee is likely aware, §1915(c) of the Social Security Act gives CMS the authority to authorize states to implement home- and community-based services, waiving the requirement that the individuals receive the services in an institutional setting. The eligible individuals are thus able to receive the needed services in his or her home or community instead of receiving care in a Medicaid-reimbursed institution, defined as a hospital, institution for mental, disease, intermediate care facility for the mentally retarded, or nursing home. The definition of “institution” has never included Psychiatric Residential Treatment Facilities (PRTF), so states cannot use the 1915(c) Waiver Authority to serve youth in their communities while receiving federal financial participation (reimbursement under Title XIX).

The competitive Demonstration grant program for Community-Based Alternatives to Psychiatric Residential Treatment Facilities was created by §6063 of the Deficit Reduction Act of 2005 (PL 109-171). The PRTF Demonstration Waiver was a five-year demonstration authorized in up to ten states; Alaska, Florida, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina, and Virginia were all awarded Demonstration Grant Awards. The service delivery model for the Demonstration Waiver included an emphasis on systems of care values and the provision of Wraparound services, which has been identified by the Washington State Institute for Public Policy (WSIPP) and the California Evidence-Based Clearinghouse for Child Welfare as a research-informed practice and having promising research evidence. Each state identified its own array of services and supports to be provided under the Waiver, in complement to those services already available under Medicaid State Plans and other community-based service arrays.

1 Florida’s application was placed in abeyance due to a failure to appropriate State matching funds, while the other nine states implemented the 1915(c) PRTF Waivers.
The PRTF Waiver Demonstration ended on September 30, 2012, with no new enrollment into the program permitted as of that date, and the national evaluation concluded that the Demonstration met Congress' statutory requirements in that it was effective at improving or maintaining a child or youth's functional level and that it was cost neutral to serve youth in the community under the Waiver as compared to serving them in a PRTF. In fact, the recently-issued joint bulletin from CMS and SAMHSA stated that youth in the PRTF demonstration cost 25% of what it would have cost to serve the children and youth in a PRTF, an average savings of $40,000 per year per child, and that the State Medicaid Agencies experienced significant cost savings per child within the first six months of the program.²

However, states are unable to continue to use the 1915(c) Waiver Authority to serve youth who are at the PRTF-level of care in their homes and communities using a Wraparound service delivery model because there is no statutory authority for CMS to approve such a Waiver. A select number of states have been utilizing the 1915(c) waiver authority for those youth with serious behavioral health needs who meet the inpatient hospitalization level of care, but that places states in the position of waiting until a youth's functioning deteriorates so as to warrant the most restrictive placement in a hospital. Additionally, the average length of treatment under the model of intensive care coordination using Wraparound is approximately 16-18 months; the burden of ensuring cost neutrality under the 1915(c) Waiver as compared to an inpatient hospitalization means that most states are unable to provide the desired home- and community-based service delivery model and remain cost neutral due to the short lengths of stay in hospitals (typically 3-10 days).

The Children's Mental Health Accessibility Act was introduced by former Senator Kerry (D-MA) as S.3289 in the 112th Congress and received bi-partisan co-sponsorship from Senators Grassley (R-IA), Begich (D-AK), Cochran (R-MS), Brown (R-MA); and Wicker (R-MS). The bill would have amended the Social Security Act to include PRTFs in the definition of an institution under §1915(c) (text of the relevant section of the bill is included). The bill was referred to the Senate Finance Committee but died in committee. There was no companion bill in the House.

RECOMMENDATION: Re-introduce and enact The Children's Mental Health Accessibility Act (S. 3289 in the 112th Congress) to amend the definition of “institution” to include PRTFs under §1915(c) of the Social Security Act.

Amend 1915(i) of the Social Security Act
The Patient Protection and Affordable Care Act (ACA) amended §1915(i) of the Social Security Act to allow states to apply for more than one Medicaid State Plan Amendment (SPA) under §1915(i) of the Social Security Act. Without the concern that states would use their only chance to implement a 1915(i) SPA, states quickly seized on the opportunity to utilize the 1915(i) as a tool to serve individuals with intensive needs in their homes and communities

and receive Medicaid reimbursement. The 1915(i) is a more flexible tool than the 1915(c) because it does not impose cost neutrality and does not require that youth meet the highest levels of care—in fact, it requires that states serve youth just below the level of care that is targeted. However, the statute is unclear as to whether States can serve youth from families with incomes greater than 150% of the federal poverty level (FPL) or youth who qualify for Medicaid under Family of One.3

The statute states the following:

(3) NONAPPLICATION.—A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1902(a)(10)(B) (relating to comparability)[351] and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment.

This implies that states can use the same comparability and income/resource rules that are permitted under a 1915(c) or other home- and community-based waiver authority. Further, the interim regulations for the 1915(i) state the following:

“Section 1915(i)(3) of the Act permits States to not apply the requirements of section 1902(a)(10)(C)(i)(III) of the Act relating to income and resource rules in the community for the medically needy. Under this authority States are permitted to use institutional eligibility rules in determining eligibility for the medically needy.”

This seems to imply that states can use institutional eligibility rules, which would enable youth to be served under the “Family of One” criteria for Medicaid eligibility that is often used for youth admitted to a PRTF. However, the 2010 State Medicaid Directors’ Letter from CMS further stated the following:

“The ACA adds a new section to 1915(i) that allows States the option of providing services to individuals with income up to 300 percent of the Supplemental Security Income (SSI) Federal benefit rate (FBR). While individuals served in this new eligibility group must be eligible for HCBS under a 1915(c), (d), or (e) waiver or 1115 demonstration program, they do not have to be enrolled and receiving services in either waiver program. For this eligibility group, States are also permitted to use institutional eligibility and post-eligibility rules in the community, in the same manner they would under a 1915(c) waiver. Post eligibility rules determine the amount (if any) for which an individual is liable to pay for the cost of their 1915(i) HCBS.”

This has been interpreted by individuals within CMS and states to mean that states can only serve individuals up to 300% of the SSI FBR if they would be eligible for a home- and community-based services waiver under a 1915(c), (d), or (e) waiver or 1115 demonstration demonstration

3 Family of One eligibility is when a youth’s financial eligibility is determined as if he or she were not a member of the family unit but as if he or she were living independently, enabling youth with private insurance or whose families do not qualify for Medicaid to receive services through the public mental health system.
program. As such states are pursuing 1915(i) SPAs only for those youth who are up to 150% FPL. To put this into perspective, the following table has been compiled to show the maximum income levels for both the FPL and the SSI FBR with different size families and percentages.4

<table>
<thead>
<tr>
<th>Standard</th>
<th>1 family member (1 Wage-Earner) or Family of 2 (for FPL)</th>
<th>Couple (2 wage-earners)</th>
<th>Family of 3 (2 wage-earners)</th>
<th>Family of 4 (2 wage-earners)</th>
<th>Family of 5 (2 wage-earners)</th>
</tr>
</thead>
<tbody>
<tr>
<td>150% FPL</td>
<td>$17,235</td>
<td>$23,265</td>
<td>$29,295</td>
<td>$35,325</td>
<td>$41,355</td>
</tr>
<tr>
<td>150% SSI</td>
<td>$12,974</td>
<td>$19,188</td>
<td>$19,188</td>
<td>$19,188</td>
<td>$19,188</td>
</tr>
<tr>
<td>200% FPL</td>
<td>$22,980</td>
<td>$31,020</td>
<td>$39,060</td>
<td>$47,100</td>
<td>$55,140</td>
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<tr>
<td>250% FPL</td>
<td>$28,725</td>
<td>$38,775</td>
<td>$48,825</td>
<td>$58,875</td>
<td>$68,925</td>
</tr>
<tr>
<td>300% SSI</td>
<td>$25,588</td>
<td>$38,376</td>
<td>$38,376</td>
<td>$38,376</td>
<td>$38,376</td>
</tr>
<tr>
<td>300% FPL</td>
<td>$34,470</td>
<td>$46,530</td>
<td>$58,590</td>
<td>$70,650</td>
<td>$82,710</td>
</tr>
</tbody>
</table>

The consequence of the interpretation found in the State Medicaid Director letter is that, for those states that serve youth up to 300% SSI FBR and youth who meet institutional eligibility (Family of One) rules in their State Medicaid Plan, they are unable to serve them under a 1915(i) SPA. Under the Children's Health Insurance Program (CHIP), six states and the District of Columbia cover children up to or above 200% FPL and 24 states offer coverage to children with incomes 250% of the FPL or higher.5 The CHIP enhanced match is provided for coverage up to 300% FPL but the youth enrolled in CHIP may not be eligible for the 1915(i) services. This creates a bifurcated system where one cohort of youth (under 150% FPL) can receive services under the 1915(i) SPA but all other youth, regardless of medical necessity, can only be served under a 1915(c) or other HCBS waiver or in an institution.

In Maryland, even though approximately 15% of the youth served in the PRTF Demonstration Waiver were enrolled under Family of One criteria, they would not be eligible to be served under a 1915(i) SPA. However, if the youth required the services of a PRTF, the State would likely still be responsible for their care in the PRTF, with the federal government responsible for the federal financial participation on that youth's PRTF stay. Similarly, there are youth who are 150-300% of SSI and are covered under the State Plan but can only receive services in a PRTF and not in their homes and communities under a 1915(i) SPA—costing both the State and federal governments more money.

As noted above, the 1915(c) authority does not extend to PRTFs at this time, so states like Maryland who have achieved relatively low lengths of stay for psychiatric inpatient hospitalizations have no financing mechanism available to serve youth whose families' incomes are greater than 150% FPL who meet the medical necessity criteria for PRTF in their homes and communities and must serve them in an institution. This is not

5 http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Eligibility-Standards-.html
equitable, cost-effective, or likely to produce positive outcomes for the youth and their families. In fact, families have told PRTF Waiver Staff in Maryland that they felt like they were being “penalized for having a good job” because their incomes would prevent their children from enrolling in Maryland’s proposed 1915(i) SPA.

Amending both the 1915(c) Authority and the 1915(j) Authority would provide greater flexibility to States to determine how best to serve youth who meet the PRTF Level of Care. Both the 1915(c) and 1915(j) authorities have particular benefits and challenges for States, and amending both components of the statute would provide states with greater flexibility to tailor their state plan to match the existing benefit structure and service array.

RECOMMENDATION: Amend §1915(i) of the Social Security Act to unequivocally articulate that States may serve individuals up to 300% SSI FBR, 300% FPL and individuals who meet institutional eligibility rules.

Amend submission requirements under §1945 of the Social Security Act Regarding Health Home State Plan Amendments
Currently, States implementing health homes are required by CMS to submit SPAs that address the entire population, regardless of age, who meet the clinical criteria established. CMS has provided States with the option to submit a single SPA that addresses both children and adults or two separate SPAs in quick succession. States are required to serve all categorically needy individuals who meet the State’s criteria for enrollment. The statute and the State Medicaid Director letter (#10-024) are silent regarding the age of the population served. On page 4 of CMS’ Frequently Asked Questions regarding health homes, the following is stated: “All beneficiaries eligible for Medicaid under the State Plan or a waiver of the State Plan who meet the criteria of the chronic conditions and geographic location outlined in the State’s health home SPA are eligible to be enrolled in the health home. Eligibility is not dependent on any other factors such as age, use of a specific delivery system, or category of aid (e.g., duals). The State may, however target chronic conditions that have a higher prevalence in particular age groups.” Despite this, States are being required to submit a health home SPA that either includes both adults and children or two separate SPAs in quick succession to address both populations.

This is problematic, though, because children with serious behavioral health disorders do not have the same high co-morbid chronic medical conditions as the adult population, even those with serious persistent mental illness. Instead, these populations of children have many more needs for coordination with social services, the courts and education. Integrated primary and behavioral health care models designed for adult populations often fail to adequately incorporate the complex multi-system service and fiscal coordination required to effectively and efficiently serve children with complex behavioral health needs and their families (Pires, S., personal communication).

Children in Medicaid who use behavioral health services have higher mean Medicaid expenditures (physical health and behavioral health care) than Medicaid children in general. Expenditures are driven more by behavioral health service use than by physical health service use except for children on SSI/Disabled for whom mean physical health expenditures are
slightly higher. Children with mental health and substance abuse disorders represent less than 10% of the overall Medicaid child population but an estimated 38% of the total Medicaid child expenditures. Children with serious behavioral health problems are often involved with multiple systems: child welfare, juvenile justice, education, and the courts. Integrated primary and behavioral health care models designed for adult populations often fail to adequately incorporate the complex multi-system service and fiscal coordination required to effectively and efficiently serve children with complex behavioral health needs and their families.6

<table>
<thead>
<tr>
<th></th>
<th>All Children Using Behavioral Health Care</th>
<th>TANF</th>
<th>Foster Care</th>
<th>SSI/Disabled**</th>
<th>Top 10% Most Expensive Children Using Behavioral Health Care***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health Services</td>
<td>$3,652</td>
<td>$2,053</td>
<td>$4,036</td>
<td>$7,895</td>
<td>$20,121</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>$4,868</td>
<td>$3,028</td>
<td>$8,094</td>
<td>$7,264</td>
<td>$28,669</td>
</tr>
<tr>
<td>Total Health Services</td>
<td>$8,520</td>
<td>$5,081</td>
<td>$12,130</td>
<td>$15,123</td>
<td>$48,790</td>
</tr>
</tbody>
</table>

* Includes children using behavioral health services who are not enrolled in a comprehensive HMO, n = 1,213,201
** Includes all children determined to be disabled by SSI or state criteria (all disabilities, including mental health disabilities)
*** Represents the top 10% of child behavioral health users with the highest mean expenditures, n = 121,323


A health home SPA that uses a single design to serve both children and adults with serious mental health conditions is unlikely to be effective for both populations. States should be required to separate these populations—and should be permitted to submit them at different time points if the necessary service array does not yet exist within the State (rather than being required to submit both SPAs in rapid succession).

RECOMMENDATION: Collaborate with CMS and, as necessary, enact legislation, clarifying that states may establish clinical criteria for enrollment in health homes that are age-specific, so long as there is clinical justification for the exclusions.

Require comprehensive, mobile, universal crisis response systems
The evidence demonstrates that comprehensive crisis response and stabilization systems help improve behavioral health outcomes, deter emergency department and inpatient admissions, reduce out-of-home placements, reduce lengths of stay and costs of inpatient hospitalizations, and improve access to behavioral health services.7 There also is evidence that effective mobile response and stabilization services can help to reduce placement disruption rates in child welfare (Wraparound Milwaukee). Investment in comprehensive

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crisis response and stabilization systems for children, youth and young adults is a particularly wise public health strategy given that the risk factors for behavioral health needs are well established with clear windows of opportunity to prevent mental and behavioral health disorders and related problems before they occur.

Crisis response and stabilization services provide intervention by trained professionals and support to those experiencing a crisis, allowing for immediate de-escalation of the situation in the least restrictive setting possible, the prevention of the condition from worsening, and the timely stabilization of the crisis. The primary concern is safety of the child, family and community. Diverting children, youth and young adults with serious emotional disturbances from emergency departments and hospitalization requires comprehensive crisis response services to address immediate crises, as well as stabilization services to prevent repeat crises. Many states have a patchwork of crisis providers and response services available throughout the state, which needs to be re-evaluated and strengthened to ensure a well-connected response system exists in every jurisdiction.⁸

The component that often is missing in states is effective mobile response and stabilization capacity. Milwaukee County and the State of New Jersey are implementing similar and “newer generation” models of mobile response and stabilization that allow for teams to work with children, youth, families, schools, etc. to provide crisis intervention and ongoing stabilization services, often using one-to-one crisis stabilizers, over a thirty day period. Milwaukee’s crisis response system is particularly noteworthy, with a requirement that all psychiatric inpatient admissions first be assessed by a crisis response and stabilization team. This practice results in significant inpatient diversion. In the wake of the recent tragedy at Sandy Hook Elementary School in Connecticut, Wraparound Milwaukee’s Mobile Urgent Treatment Team (MUTT) was highlighted as a crisis response system that intervenes effectively in the lives of children, youth, and young adults to avert tragedy.⁹

In conjunction with site visits and technical assistance from Wraparound Milwaukee and the State of New Jersey, Maryland’s Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant Crisis Workgroup conducted an analysis of crisis response systems and best practices literature and made a series of recommendations that are not applicable only to Maryland. They identified three broad components and seven core services that should be incorporated within a comprehensive and effective crisis response and stabilization system. The Crisis Workgroup observed that the services are most effective when interwoven as functions within an entire continuum of care and are not likely to be as effective when implemented as stand-alone programs. The seven proposed Core Services are:

- **Core Service #1** - Hotlines and Online Resources
- **Core Service #2** - Mobile Crisis and Stabilization Services Teams
- **Core Service #3** - Urgent Care Services
- **Core Service #4** - Emergency Respite

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• Core Service #5 - Crisis Beds
• Core Service #6 - Emergency Department and Detention Center Diversion Programs
• Core Service #7 - Care Coordination and Stabilization

As a parent of a child with serious behavioral health needs and the leader of the statewide family network told the crisis response workgroup, “Crisis services for mental health should be like a fire department with services available in every neighborhood. Anyone can experience a mental health crisis in their family.”

RECOMMENDATION: Require all states to develop and maintain comprehensive, mobile, universal crisis response systems to serve all residents.

Support The Mental Health First Aid Act of 2013 (S.153/H.R. 274)
The Mental Health First Aid Act of 2013 (S.153/H.R. 274) would authorize $20 million grants to fund Mental Health First Aid training programs around the country to train participants in recognizing the symptoms of common mental illnesses and addictions disorders, de-escalating crisis situations safely, and initiating timely referrals to behavioral health care resources in the community. Mental Health First Aid is a live training course that supports participants to identify the signs and symptoms of specific mental illnesses and provides concrete tools to help participants know what to do and how to assist someone in getting the help they need. As of June 2013, more than 100,000 people in the United States have been trained in Mental Health First Aid, and it is being adopted by cities, counties, government agencies, faith community leaders, universities, and public safety officials as a strategy to create healthier and safer communities. (More information can be found at www.mentalhealthfirstaid.org)

S. 153 was introduced by Senator Mark Begich (D-AK) in January 2013, and was read twice and referred to the Committee on Health, Education, Labor, and Pensions. The legislation currently has bi-partisan support with 16 co-sponsors. It’s companion bill in the House, H.R. 274, was introduced by Congressman Ron Barber in January 2013, has 54 co-sponsors and has been referred to the Energy and Commerce Subcommittee on Health.


Behavioral Health Information Technology Act of 2013
The Behavioral Health Information Technology Act (S.1517/H.R. 2957) was recently introduced in Congress. In August 2013 it was introduced in the House and has bi-partisan support with 18 co-sponsors. In September 2013, Senator Whitehouse (D-RI) introduced it and it has been referred to the Senate Finance Committee. This legislation would extend financial incentives for the meaningful use of electronic health records to specified mental health and addiction treatment providers. The Behavioral Health Information Technology Act will add community mental health centers, psychiatric hospitals, residential and outpatient mental health treatment facilities, and substance abuse treatment facilities to the list of organizations eligible for “facility payments” (up to $1 million per year for 6 years). These monies can be used to support the adoption, implementation, or upgrading of a
certified electronic record. This legislation also adds licensed psychologists as eligible professionals. Health information technology (HIT) is the foundation for high-quality coordinated care. With the money from these incentive payments, behavioral health agencies can get critical help for bringing their IT systems up to speed and into the future.

**RECOMMENDATION:** Support S. 1517, the Behavioral Health Information Technology Act of 2013.

**Amend the Deficit Reduction Act of 2005 (42 U.S.C. 1396a)**
The Deficit Reduction Act of 2005 established the Money Follows the Person (MFP) Demonstration Program, which was further amended under the Affordable Care Act. MFP was created to enable individuals to leave institutions while they still meet the medical criteria for those services in order to receive comparable community-based services. MFP also enables States to receive a portion of the savings from serving the individuals in the community as re-balancing funds to better align services and system supports to serve individuals in their communities rather than institutional settings.

Under the ACA, the minimum length of stay in an institution was lowered from six months to 90 consecutive days. We strongly encourage you to amend the statute to further lower the minimum length of stay in to 30 days. Youth who require an admission to a PRTF in order to be stabilized should not be required to remain in the PRTF for at least 3 months if they are able to be safely served in their homes and communities under MFP. The 90-day requirement creates a scenario where youth may remain in an institution when alternative services exist in the community.

**RECOMMENDATION:** Amend the Deficit Reduction Act of 2005 to reduce the minimum length of stay under MFP to 30 days.

Again, I want to thank you for providing this opportunity to share our expertise and experience from working across the nation in the field of children’s behavioral health. We would be happy to provide further information and respond to any questions that the Committee might have on how to improve financing for children with behavioral health needs and how these efforts can lead to improved quality and effectiveness of care as well as decreased costs of care in Medicaid as well as in other service delivery systems. We have included as appendices to this letter a table that highlights key systems of care activities in the states of the Committee members as well as the relevant excerpt from S. 3289 (112th Congress). Please do not hesitate to contact us if we can be of further assistance.

Sincerely,

Michelle Zabel, MSS

C: Richard P. Barth, Dean & Professor, University of Maryland School of Social Work  
   Kevin P. Kelly, Director, Government Affairs, University of Maryland  
   The Honorable Benjamin L. Cardin
### Appendix 1: Systems of Care Activity in States of Senate Finance Committee Members (as of 9/13)

<table>
<thead>
<tr>
<th>Member</th>
<th>State</th>
<th>Participant in CMS’ 1915(c) PRTF Demonstration Waiver</th>
<th>Current Recipient of SAMHSA Children’s Mental Health Initiative Grant(s)</th>
<th>Participant in 3-State Collaborative on Care Management Entities in the CMS CHIPRA Quality Demonstration Grant</th>
<th>Other Key System of Care Activity including 1915(c) Waiver for youth with SED at the Inpatient Hospitalization Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max Baucus, Chairman</td>
<td>Montana</td>
<td>X</td>
<td></td>
<td></td>
<td>1915(i) State Plan Amendment to serve youth with SED</td>
</tr>
<tr>
<td>Orrin Hatch, Ranking Member</td>
<td>Utah</td>
<td>X</td>
<td></td>
<td></td>
<td>Includes Peer Support in the Medicaid State Plan</td>
</tr>
<tr>
<td>Michael Bennet</td>
<td>Colorado</td>
<td>X</td>
<td></td>
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<td>Colorado Access Care Management Entity</td>
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<tr>
<td>Sherrod Brown</td>
<td>Ohio</td>
<td>X</td>
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<td>Cuyahoga County System of Care</td>
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<tr>
<td>Robert Casey</td>
<td>Pennsylvania</td>
<td>X</td>
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<td></td>
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<td>John Rockefeller IV</td>
<td>West Virginia</td>
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<tr>
<td>Debbie Stabenow</td>
<td>Michigan</td>
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<td>1915(c) SED Waiver</td>
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<td>Ron Wyden</td>
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<td>Richard Burr</td>
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<tr>
<td>Maria Cantwell</td>
<td>Washington</td>
<td>X</td>
<td></td>
<td></td>
<td>Home to the National Wraparound Initiative at the University of Washington</td>
</tr>
<tr>
<td>Benjamin Cardin</td>
<td>Maryland</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Home to The Institute for Innovation &amp; Implementation, University of Maryland</td>
</tr>
</tbody>
</table>

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10 Information compiled from SAMHSA and CMS websites as well as The Institute’s direct experience in working in and with the states.

11
<table>
<thead>
<tr>
<th>Member</th>
<th>State</th>
<th>Participant in CMS' 1915(c) PRTF Demonstration Waiver</th>
<th>Current Recipient of SAMHSA Children's Mental Health Initiative Grant(s)</th>
<th>Participant in 3-State Collaborative on Care Management Entities in the CMS CHIPRA Quality Demonstration Grant</th>
<th>Other Key System of Care Activity including 1915(c) Waiver for youth with SED at the Inpatient Hospitalization Level of Care</th>
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<td>Thomas Carper</td>
<td>Delaware</td>
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<td>School of Social Work</td>
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<td>Michael Enzi</td>
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<td>John Isakson</td>
<td>Georgia</td>
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<td>1st Statewide System of Care in the Nation</td>
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<td>Robert Menéndez</td>
<td>New Jersey</td>
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<td>1915(i) State Plan Amendment for Youth with psychiatric disorders to be redirected from juvenile services</td>
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<td>Bill Nelson</td>
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<td>Cuyahoga County System of Care</td>
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<td>Robert Portman</td>
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<td>1915(c) SED Waiver</td>
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<td>Pat Roberts</td>
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<td>1915(c) Waivers—Bridges to Health</td>
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<td>Charles Schumer</td>
<td>New York</td>
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<td>John Thune</td>
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Section 2 of S.3289 Children's Mental Health Accessibility Act of 2012

SEC. 2. EXPANDING THE MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER TO INCLUDE YOUTH IN NEED OF SERVICES PROVIDED IN A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY.

(a) In General-Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) is amended--
(1) in paragraph (1)—
(A) by striking 'a hospital or a nursing facility or intermediate care facility for the mentally retarded' and inserting 'a hospital, a nursing facility, an intermediate care facility for the intellectually disabled, or a psychiatric residential treatment facility'; and
(B) by striking 'a hospital, nursing facility, or intermediate care facility for the mentally retarded' and inserting 'a hospital, nursing facility, intermediate care facility for the intellectually disabled, or psychiatric residential treatment facility';
(2) in paragraph (2)(B), by striking 'or services in an intermediate care facility for the mentally retarded' each place it appears and inserting 'services in an intermediate care facility for the intellectually disabled, or services in a psychiatric residential treatment facility';
(3) in paragraph (2)(C)—
(A) by striking 'or intermediate care facility for the mentally retarded' and inserting 'intermediate care facility for the intellectually disabled, or psychiatric residential treatment facility'; and
(B) by striking 'or services in an intermediate care facility for the mentally retarded' and inserting 'services in an intermediate care facility for the intellectually disabled, or services in a psychiatric residential treatment facility';
(4) in paragraph (7)(A), by striking 'or intermediate care facilities for the mentally retarded,' and inserting 'intermediate care facilities for the intellectually disabled, or psychiatric residential treatment facilities'; and
(5) by adding at the end the following new paragraph:
'(11) For purposes of this subsection, the term 'psychiatric residential treatment facility' means a facility other than a hospital that is certified as meeting the requirements specified in regulations promulgated for such facilities under section 1905(h)(1) and that provides psychiatric services in an inpatient setting to individuals under age 21 for which medical assistance is available under a State plan under this title.'.

(b) Waiver Limitation-Section 1915(c) of such Act, as amended by subsection (a), is further amended--
(1) in paragraph (2)—
(A) in subparagraph (D), by striking '; and' and inserting a semicolon;
(B) in subparagraph (E), by striking the period at the end and inserting a semicolon; and
(C) by adding at the end the following new subparagraphs:
'(P) under the waiver, the total number of Medicaid inpatient bed days at psychiatric residential treatment facilities during each fiscal year within the waiver period will not exceed the total number of Medicaid inpatient bed days at such facilities for the previous

11 http://www.govtrack.us/congress/bills/112/s3289/text
fiscal year as increased by the estimated percentage increase (if any) in the population of individuals under age 21 residing in the State over the preceding 12-month period; and ‘(G) the State will provide to the Secretary annually, subject to such requirements as the Secretary determines appropriate, relevant information and evidence as to the manner in which the State will satisfy the requirements described in subparagraph (F).’; and (2) by adding at the end the following new paragraph: ‘(12) For purposes of paragraph (2)(F), an individual who is under age 21 and is an inpatient in a bed in a psychiatric residential treatment facility for a single day shall be counted as one inpatient bed day.’.