Substance Abuse and Mental Health Services Administration
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Medicaid Handbook: Interface with Behavioral Health Services

Module 3

The Medicaid Behavioral Health Services Benefit Package

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Module 3: The Medicaid Behavioral Health Services Benefit Package

Although Medicaid funding for behavioral health services is necessary in some cases, it is not sufficient for a *system of care* for those with mental or substance use disorders (M/SUD). To provide a system-level framework, consider the principles articulated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the *Description of a Good and Modern Addictions and Mental Health Services System:*

> A good and modern mental health and substance use system should be designed and implemented using a set of principles that emphasizes behavioral health as an essential part of overall health in which prevention works, treatment is effective and people recover (p.2).[1]

This framework and its accompanying vision, principles, desired service elements, core structures, and competencies are necessary to inform any current policy discussion concerning behavioral health services, reimbursement, and infrastructure. As we begin to examine the various Medicaid services that comprise components of behavioral health programs, we must ask: What is our goal? It is not simply to pursue reimbursement. Rather, consider this Medicaid service discussion using the Good and Modern System as the scaffolding:

> A vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity (p.1)."[1]

The Policy and Regulatory Context

The Affordable Care Act and the Mental Health Parity and Addiction Equity Act (MHPAEA) provide a number of options and opportunities that can have a dramatic and positive impact on the lives of those requiring behavioral health services. A few of the changes underway include an emphasis on behavioral health parity, requirements for behavioral health services as a component of qualified health plans offered through the Health Insurance Marketplace (also known as the Health Insurance Exchange), new home and community-based behavioral health service options, and payment reform initiatives that facilitate integrated systems of care.

The requirements related to essential health benefits included in the Affordable Care Act also provide an opportunity for greater coverage of behavioral health services. The regulations do not apply to existing Medicaid services; however, should a state choose to expand its Medicaid program, it has the option to utilize a benchmark or benchmark-equivalent plan which *will be* subject to the essential health benefits requirements beginning in January 2014.

Essential health benefits must include items and services within the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) M/SUD services including behavioral health treatment, (6)

prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services including oral and vision care. With the possible exception of maternity and newborn care, all other categories could provide components of behavioral health care through the Good and Modern System.

With this background in mind, we describe the behavioral health services offered under the Medicaid program and the various types of Medicaid authorities that provide the basis for components of state behavioral health programs. As described below, behavioral health services and treatments may be authorized by a state's Medicaid State Plan and/or by waivers that the state chooses to implement.

Whether a service or treatment is authorized by a State Plan or a waiver, it is not a *program of care*. Rather, states implement various services or treatments under their Medicaid programs and, taken together, those services and treatments represent the state's Medicaid-covered behavioral health services package. Inasmuch as Medicaid is a federal-state partnership, each state can determine how it will use Medicaid services to operationalize the Good and Modern System for behavioral health to serve its citizens.

Various components of Medicaid State Plans and waivers can provide the authority by which a state offers a particular behavioral health service or treatment. For example, some states offer individual, group, and family therapy under their State Plan *rehab option*, whereas others offer it as part of their State Plan Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. Still others may offer individual, group, and family therapy as a benefit under their §1915(b) waiver. The rehab option, EPSDT, and §1915(b) waivers as vehicles for behavioral health services are discussed more thoroughly below.

One final point to help frame the context for this discussion is that most of these Medicaid components are expected to be in place for many years. They will be revised, new options that have been added will be perfected, different combinations will be explored, and the accompanying Medicaid managed care tools will continue to mature and be refined. This module describes the foundational and more recent components.

Behavioral Health Services Provided Under a Medicaid State Plan

Federal law contemplates the provision of *services* rather than programs, which are typically the framework or definition used within the behavioral health field. In other words, Medicaid tends to be based on more discrete services rather than a comprehensive package of procedures or services. Section 1905(a) of the Social Security Act outlines the services that state Medicaid programs *must* cover (i.e., mandatory services) and those it *may* cover (i.e., optional services) in its Medicaid State Plan. Inherent in many of these State Plan services are the Medicaid components or building blocks for *programs* that states offer to individuals with mental or substance use disorders. These components, and the associated federal statutory language, authorize most of the specialty services through Medicaid for persons with mental illness, substance use disorders, and developmental disabilities.

Based on a review of many state Medicaid programs, behavioral health services are provided through a diverse set of mechanisms—even for the same service—under the State Plan. For example, one state might provide medication management as a rehabilitative (rehab) service under the *rehab option* (discussed below), whereas another might provide it as an *outpatient* service.

The following list indicates mandatory and optional State Plan services. This list comprises *all* State Plan services enumerated in federal law—not just behavioral health services—that a state is required to provide and may choose to provide under its State Plan. Based on a review of various state Medicaid plans, those followed by an asterisk (*) most commonly provide components of the behavioral health benefit package to eligible consumers. Even when behavioral health services are included as part of a managed care plan's responsibility, its rates may be built to include these service components.

Mandatory Services

- Inpatient hospital*
- Outpatient hospital*
- EPSDT*
- Nursing facility
- Home health
- Physician*
- Rural health clinic
- Federally qualified health center (FQHC)*
- Laboratory and X-ray
- Family planning
- Nurse midwife
- Certified pediatric and family nurse practitioner
- Freestanding birth center (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation and tobacco cessation counseling for pregnant women and youths younger than 21 years as part of EPSDT

Optional Services

- Prescription drugs*
- Clinic*
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder therapy
- Respiratory care
- Other diagnostic, screening, preventive, and rehabilitative care* (also known as the *rehab option*)
- Podiatry
- Optometry
- Dental
- Dentures
- Prosthetics
- Eyeglasses

- Chiropractic
- Other licensed practitioners*
- Private duty nursing*
- Personal care*
- Hospice
- Case management*
- Services for individuals aged 65 years or older in an institution for mental diseases (IMD)*
- Intermediate care facility for the developmentally disabled
- State Plan home and community-based care (under §1915(i))*
- Self-directed personal assistance (under §1915(j))
- Community First Choice Option (under §1915(k))
- Tuberculosis-related care
- Inpatient psychiatric services for individuals younger than age 21*
- Other Secretary-approved care[2]*

Behavioral Health Services Included in the State Plan

The types of services under which Medicaid-eligible beneficiaries most commonly receive diagnosis and treatment for M/SUDs under a state's Medicaid State Plan are defined below.

The Rehab Option

The State Plan *rehab option*[A] is one of the most important and commonly used service components of Medicaid by which states provide noninpatient services to individuals with mental and substance use disorders. In the Medicaid State Plan, the rehab option is defined as *other diagnostic, screening, preventive, and rehabilitative care services.*[3]

Under the State Plan rehab option, states may offer a wide range of recovery-oriented mental health and addiction services to individuals in the community. Treatments may include therapy, counseling, training in communication and independent living skills, recovery support and relapse prevention training, employability skills, and relationship skills. More intensive nonhospital services, such as partial hospitalization or Assertive Community Treatment (ACT), are often covered under the rehab option rather than under outpatient services. Nearly all states offer some rehabilitative mental health services, and some states offer rehabilitative addiction services.

Coverage for rehabilitative services is authorized by §1905(a)(13) of the Social Security Act, which defines *rehabilitative services*[B] as:

[A] SAMHSA uses the term *rehab option*; CMS uses the term *rehabilitative services*. References in this document to the rehab option and rehabilitation services option are interchangeable.

[B] Medicaid law makes an important distinction between rehabilitative services and habilitative services. As noted above, services provided through the rehabilitative option must "involve the treatment or remediation of a condition that results in an individual's loss of functioning." Habilitative services are services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitative services can only be provided through a home and community-based waiver.

> Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[4]

In order for a service to be provided under this option, the service must "involve the treatment or remediation of a condition that results in an individual's loss of functioning."[5]

States can choose to apply the rehab option to behavioral health services (including M/SUD services) or provide other, more expansive access to rehabilitative services, such as physical or orthopedic rehabilitation. In 2004, 73 percent of Medicaid beneficiaries receiving rehabilitation services were individuals with mental health needs, and these beneficiaries were responsible for 79 percent of rehabilitation spending under the option (although not all of this spending paid for mental health services).[6]

As of 2013, all 50 states and the District of Columbia covered behavioral health services to some extent under the rehab option.[7] By comparison, in 1988 only nine states used the rehab option to provide rehabilitative services for individuals with mental health service needs.[7] Increased use of the rehab option for provision of psychosocial rehabilitative services is due, in large part, to the movement toward deinstitutionalization of individuals with serious mental illness (SMI) as states seek a flexible option for providing these services in the community or home.[7]

States have more freedom to design and provide behavioral health services when using the rehab option than when using other State Plan options. Unlike clinic or outpatient hospital services—where treatment location is proscribed—benefits provided under the rehab option can be delivered in a variety of settings, including the consumer's own home or another living arrangement. Another benefit of providing services under the rehab option is that the services can be performed by individuals who are not licensed under professional scope of practice laws, including paraprofessionals and peers.[8]

Perhaps the most valuable benefit of providing services under the rehab option is that rehabilitative services are not limited to *clinical treatment* of a person's mental and/or substance use disorder. Rather, rehabilitative services can be used to attain achievement of skills that are necessary to function in the world.[9] Such services might include individual and group therapy, crisis intervention, family psychosocial education, peer support and counseling, basic life and social skills training, medication management, community residential services, and supported employment.[9] Federal law prohibits Medicaid from funding room and board, education, or vocational services, even under the rehab option.

Between the mid-1980s and mid-2000s, states began to expand use of the rehab option—largely because of the flexibility it offers. Federal entities such as the Government Accountability Office (GAO), the Office of the Inspector General, and Centers for Medicare & Medicaid Services (CMS) auditors started to question whether states were using it appropriately. In 2007, federal regulations attempted to narrow the scope of the rehab option by proposing a rule that would: (1) clarify the service definition, and (2) ensure that Medicaid rehabilitative services must not

include services provided by other programs that are focused on social or educational development goals and/or are available as part of other services or programs (e.g., foster care, child welfare, education, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship).[9] After receiving overwhelming feedback Congress enacted a moratorium on the proposed rule, effectively ending its application.

At the same time that federal policymakers sought to narrow the scope of the rehab option, they also pursued rule changes to eliminate coverage for day habilitation services for individuals with developmental disabilities, prohibit Medicaid payments for school-based administrative activities (including outreach, enrollment, and support in gaining access to EPSDT), prohibit Medicaid payments for transporting school-age children to and from school, restrict the scope of outpatient hospital services, and restrict the scope of targeted case management. These regulatory efforts highlight the delicate balance between maintaining the fiscal integrity of the Medicaid program and providing a range of service components so that states can offer comprehensive behavioral health benefits to their Medicaid consumers.[10]

Early and Periodic Screening, Diagnosis, and Treatment

Under EPSDT, children and youth who are eligible for Medicaid are entitled to evaluation and treatment of developmental and behavioral health problems, along with the full scope of physical health needs. *All Medicaid-eligible children are entitled to the protections afforded by EPSDT.*

EPSDT facilitates access to behavioral health care, including comprehensive health screenings and behavioral health assessments. Virtually any service that is deemed *medically necessary* through an assessment or screening and is recommended by a physician, psychologist, social worker, nurse, or other licensed health care practitioner is covered by Medicaid under EPSDT. A screening does not need to be a formal process; it can include any visit or encounter by a child with a qualified professional.[11] For example, the Bright Futures/American Academy of Pediatrics' periodicity schedule indicates that the following procedures should be performed at the recommended ages—

- Autism screening at ages 18 and 24 months
- Psychosocial/behavioral assessment at ages newborn through 21 years
- Alcohol and drug use risk assessment at ages 11 through 21 years[12]

Once a behavioral health need is identified and diagnosed through a screening or assessment, the child or youth also is entitled to treatment with any allowable Medicaid service—even one not included in the child or youth's home state Medicaid State Plan.

Although the federal requirement to provide services under EPSDT is clear, state implementation has been deemed insufficient in all areas and in need of improvement.[13,14] In December 2010, CMS convened a national improvement network to "discuss steps that the federal government might undertake in partnership with states and others to both increase the number of children accessing services, and improve the quality of the data reporting that enables a better understanding of how effective HHS [the United States Department of Health and Human Services] is putting EPSDT to work for children."[15] It is also helpful for providers to have a practical understanding about the services to which children are entitled. Additional information about benefits provided through EPSDT is discussed in Module 2.

Inpatient Psychiatric Care for Individuals Younger Than 21 Years

Under federal law, federal reimbursement is prohibited for Medicaid services provided to "individuals under age 65 who are patients in an institution for mental diseases [IMDs] unless they are under age 22 and are receiving inpatient psychiatric services."[16] This prohibition is known as the *IMD exclusion* and is discussed more thoroughly in Module 4.

The language of the federal regulation clearly makes exceptions for services provided to individuals younger than 22 years who are receiving inpatient psychiatric services. This *psych under 21 benefit* has been interpreted to allow individuals aged 21 years and younger to receive inpatient psychiatric hospital services in three settings: psychiatric hospitals, psychiatric units in general hospitals, and psychiatric residential treatment facilities (PRTFs). This exception is also discussed more thoroughly in Module 4.

Inpatient psychiatric services are provided to children and young adults who need intensive treatment for a longer period than acute hospitalization. Although inpatient psychiatric care is a coverage *option* for states, it is *mandatory* when: (1) a child's condition is diagnosed through an EPSDT screen, and (2) it is determined that the child requires an institutional level of care.

Services For Individuals Aged 65 Years or Older in an Institution for Mental Diseases

As indicated above, the federal government is prohibited from reimbursing states under the Medicaid program for services rendered to an adult who is a patient in an institution for mental diseases (IMD). However, the IMD exclusion does not apply to individuals aged 65 years or older. Federal reimbursement is permitted for individuals in this age range who require inpatient behavioral health services and receive them in a facility that meets the definition of an IMD.

Inpatient Hospital Services

Individuals who experience a psychiatric crisis or require detoxification and stabilization may receive treatment in an inpatient hospital setting. Under the IMD exclusion, Medicaid will pay for inpatient psychiatric services for individuals younger than age 22 and older than age 64 without exception. However, Medicaid will only pay for inpatient psychiatric services rendered to individuals between the ages of 21 and 64 years under certain circumstances. The IMD exclusion does not apply to Medicaid reimbursement for inpatient treatment for mental illnesses in facilities that are part of larger medical entities that are not primarily engaged in the treatment of mental illnesses. Therefore, adults aged 22 through 64 years can access inpatient psychiatric services in psychiatric units of general hospitals. Likewise, the IMD exclusion does not apply when an organization has 16 or fewer beds, so Medicaid reimbursement is permitted for psychiatric services for adults aged 22 through 64 years in these smaller settings. Aside from these two instances, Medicaid reimbursement for inpatient psychiatric services for adults aged 22 through 64 years is not permitted.

Outpatient Hospital, Clinic, or Federally Qualified Health Center Services

Behavioral health treatment may be provided as an *outpatient hospital* or *FQHC service* or as a *clinic service* and may include diagnosis, assessment, treatment, opioid treatment (e.g., methadone maintenance), and other medication management. Although the terms *outpatient hospital*, *FQHC*, and *clinic* refer to provider types, the terms also refer to specific services provided for in state Medicaid State Plans.

Outpatient hospital services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients by or under the direction of a physician or dentist *by a hospital*.[17] Alternatively, clinic services are "preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished *by a facility that is not part of a hospital* but is organized and operated to provide medical care to outpatients." Services must be furnished by or under the direction of a physician.[18] FQHC services are described in greater detail in Module 4.

Behavioral health services delivered under State Plan outpatient hospital, clinic, or FQHC services often include individual and group therapy as well as family counseling and medication management. In some states, more intensive outpatient care—such as day treatment—is provided under outpatient hospital services to individuals who require treatment on an extended basis.

Physician and Other Licensed Practitioner Services

Services provided by a psychiatrist, a physician specializing in addiction treatment, or other type of physician are covered under Medicaid as a *physician service*; services provided by psychologists and/or clinical social workers may be covered as an optional state plan service under the *other licensed practitioner services* category. The types of treatment that may be delivered under these services vary, but may include individual, group, or family therapy. Other types of services—such as medical somatic services—might be provided under the physician service benefit. Under these services, states frequently limit the number of units or visits that may be provided to a Medicaid beneficiary in a given time period.

Section 1915(i) Services

The Deficit Reduction Act (DRA) of 2005 added section §1915(i) to the Social Security Act. This section authorizes states to include in their State Plans home and community-based services (HCBS) *before* an individual needs institutional care. It also provides a mechanism to provide State Plan HCBS to individuals with mental and/or substance use disorders. Although this State Plan service package includes many similarities to options and services available through §1915(c) HCBS waivers, a significant difference is that §1915(i) *does not* require individuals to meet an institutional level of care in order to qualify.

Although the DRA addition of §1915(i) to the Social Security Act was an important step, the provision originally posed some restrictions on states wishing to implement it. In order to promote state utilization of §1915(i), the Affordable Care Act included changes that enable states to target HCBS to particular groups of people, make HCBS accessible to more individuals, and ensure the quality of the HCBS.

Section 1915(i) provides states with the ability to offer a variety of HCBS to individuals with disabilities and mental and/or substance use disorders, including—

- Case management
- Homemaker/home health aide
- Personal care
- Adult day health
- Habilitation
- Respite care
- For individuals with chronic mental illness:

  - Day treatment or other partial hospitalization services
  - Psychosocial rehabilitation services
  - Clinic services[19]
- Other services

This tool allows states flexibility in designing their HCBS benefit package, and it is particularly attractive in addressing the needs of those with behavioral health needs. As of January 2013, nine states had received approval for §1915(i) proposals including Colorado, Connecticut, Idaho, Iowa, Louisiana, Montana, Nevada, Oregon and Wisconsin. Oregon's §1915(i) benefit includes HCBS, including home and community-based psychosocial rehabilitation for those with SMI. Louisiana's §1915(i) benefit includes psychosocial services and is targeted to adults with SMI. The state projected that it will serve 55,000 individuals in the first year of the program.[20]

In order to use a §1915(c) waiver to provide home and community-based mental health services to a Medicaid consumer, a state must select a hospital, nursing facility, or intermediate care facility for the developmentally disabled level of care. Because the §1915(i) option does not require a level of care, it is a more tenable option for providing HCBS to individuals with mental and/or substance use disorders.[19] Section 1915(c) waivers are discussed more thoroughly in Module 9.

Supported employment is not a specifically identifiable Medicaid State Plan service like those services mentioned above. Supported employment helps people with mental illnesses find and keep meaningful jobs in the community. Under supported employment principles, the jobs which exist are in the open labor market, pay at least minimum wage, and are in work settings that include people who are not disabled.[21] Historically, under a state's Medicaid State Plan, a state could not provide reimbursement for supported employment services. This situation is beginning to change, however, as more states provide supported employment services by adding §1915(i) services to a state's Medicaid State Plan or by using §1915(c) waivers. Section 1915(c) waivers are discussed in greater detail in Module 9.

Behavioral Health Services Provided as Part of a Waiver or Voluntary Managed Care Program

States also may provide behavioral health services as part of a waiver or through a voluntary managed care program under the authority of §1915(a) of the Social Security Act. The major difference between services described in this section and those described in the preceding sections is the Medicaid authority under which the state provides them. When deciding how to structure its behavioral health services benefit package, a state needs to consider its goals and the capabilities of the various tools at its disposal.

In general, states may use these waiver authorities to structure their Medicaid programs:

- **Section 1915(b) waivers** are used to implement mandatory managed care or PCCM programs.
- **Section 1915(c) waivers** are used to provide HCBS to individuals meeting an institutional level of care (*hospital*, including psychiatric facilities for individuals

younger than age 21; *nursing facility*; and/or *intermediate care facility* for individuals with developmental disabilities).
- **Combined §1915(b)/(c) waivers** are used to provide HCBS using a managed care framework.
- **Section 1115 research and demonstration programs** are used to improve state Medicaid programs by letting them test innovative ways to deliver and pay for coverage.

A state may also use the authority afforded by §1915(a) of the Social Security Act to implement a voluntary managed care program simply by executing a contract with plans that the state has procured using a competitive bidding process and by obtaining CMS approval. This arrangement does not require a waiver or inclusion in the State Plan. Section 1915(a) voluntary managed care is described more thoroughly in Module 5.

Specialized packages of behavioral health services may be provided under all four types of waivers and under voluntary managed care. Basic waiver information is discussed more thoroughly in Module 9.

One benefit of offering behavioral health services under a waiver or voluntary managed care is that states are afforded more flexibility in defining the benefit package and are not limited to the types of services described in their State Plans. The following examples are illustrative of the creativity with which states are using waivers and voluntary managed care programs to craft their behavioral health benefit packages.

Wisconsin—Children Come First and Wraparound Milwaukee
- Section 1915(a) voluntary managed care
- Services: SUD treatment and case management; a variety of other services—including tutoring and afterschool programs, group care, and recreational, arts, and camp programs—are funded by state and county agencies[22]
- Objective: to keep children with serious emotional disturbances (SEDs) out of institutions and to reallocate resources previously used for institutionalization to community-based services
- Eligibility: a child or adolescent must be a Medicaid recipient, have SEDs, and be at imminent risk of institutional admission to a psychiatric hospital, child caring institution, or juvenile correction facility[23]

Florida—Statewide Inpatient Psychiatry Program
- Section 1915(b) waiver
- Services: provided in an intensive residential setting; they include crisis intervention, biosocial and or psychiatric evaluation, close monitoring by staff, medication management, connection to community based services, and individual, family, and group therapy[24]
- Objective: longer length of stay, when medically indicated, to meet the treatment needs of children and adolescents who are not ready for a safe return to the community [25]

- Eligibility: children younger than age 18 who have a Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) diagnosis other than substance abuse, developmental disability, or autism[25]

Georgia—Community Based Alternatives for Youth

- Section 1915(c) waiver
- Services: care management, respite care, supported employment, community guidance, community transition, consultative clinical and therapeutic care, customized goods and services, family training or supports, financial support, transportation, and wraparound services
- Objective: provide alternatives to treatment in a PRTF
- Eligibility: children, youth, or young adults aged 21 years or younger with serious emotional and behavioral disturbances who have a primary diagnosis of mental illness as identified in the DSM-IV and who are placed, or at risk of placement, in a PRTF[26]

Iowa—Children's Mental Health

- Section 1915(c) waiver
- Services: environmental modifications and adaptive devices, family and community supports, in-home family therapy, and respite care
- Objective: provide alternatives to institutional services; support children with SEDs in the family home
- Eligibility: children with SEDs aged 0–17 years who have needs that, except for the waiver, would be provided in a psychiatric hospital serving children younger than age 21[27]

Montana—Home and Community Based Waiver for Adults With Severe Disabling Mental Illness

- Section 1915(c) waiver
- Services: case management, adult residential care, supported living, adult day health, personal assistance and specially trained attendant care, habilitation, homemaking, respite care, outpatient occupational therapy, psychosocial consultation including extended mental health services, chemical dependency counseling, dietetic and nutrition services, nursing services, personal emergency response systems, specialized medical equipment and supplies, nonmedical transportation, illness management and recovery, and wellness recovery action plan
- Objective: allow an individual with a severe, disabling mental illness a choice of receiving long-term care services in a community setting as an alternative to a nursing home setting.
- Eligibility: individuals with mental illness aged 18 years and older; the consumer must meet nursing home level of care requirements and reside in an area of the state where the waiver is available[28]

North Carolina—Innovations Waiver and Mental Health, Developmental Disabilities, and Substance Abuse Services Health Plan

- Section 1915(b)/(c) waiver

- Services: HCBS for individuals with mental illness, substance use disorders, and developmental disabilities within a managed care framework. Under its §1915(b)(3) waiver authority, the state uses savings it realizes by providing cost-effective care through a managed care program to offer behavioral health services including supported employment, personal care or individual support, one-time transitional costs, and psychosocial rehabilitation or peer supports. Section 1915(b)(3) services offered by a state under the authority of a §1915(b) waiver are discussed more fully in Module 5.
- Objective: to better tailor services to local consumers by adopting a consumer-directed care model. The focus is on community-based rather than facility-based care and on enhancing consumer involvement in planning and providing services through the proliferation of mental health recovery model concepts.
- Eligibility: most Medicaid-eligible consumers living in select geographic areas[29]

Arizona—Arizona Health Care Cost Containment System

- Section 1115 demonstration
- Services: full continuum of behavioral health, acute care, and long-term care; the demonstration also integrates physical and behavioral services provided to adults residing in Maricopa County who are diagnosed with a SMI
- Objective: deliver services to Medicaid beneficiaries on a managed-care basis
- Eligibility: any Medicaid-eligible consumer seeking behavioral health services.[30]
- Note: Arizona's §1115 waiver is the basis for the state's entire Medicaid program, which is built on a managed care model for all physical health and behavioral health services. As such, it requires that all behavioral health services for Medicaid-eligible individuals be provided through Regional Behavioral Health Authorities (RBHAs).[31]

Case Management

Case management works in tandem with behavioral health services provided under a Medicaid State Plan or waiver. Together, they help individuals access medical, social, educational, and community support.[32] Case management is integral in helping individuals understand: (1) their health situation, (2) how to access physical and behavioral health treatment options available to them, and (3) ways in which they can access other community supports. Case management should provide cohesion to an individual's *team* of providers, regardless of whether those providers actually work together. It also helps to avoid duplication of treatments. Without case management, an individual who is seeking services might lack knowledge about the range of treatment options and the variety of providers that are available. Case management can be thought of as the "glue" that keeps an individual's care coordinated.

Case management includes:

- Comprehensive assessment and periodic reassessment of individuals to determine the need for any medical, educational, social, or other services
- Development and periodic revision of a specific care plan for an individual, based on the information collected through the assessment

- Referral and related activities (such as scheduling appointments) to help the individual obtain needed services, including activities that help link him or her with medical, social, and educational providers
- Monitoring and follow-up, including activities that are necessary to ensure that the individual's care plan is effectively implemented and adequately addresses his or her needs. This monitoring may include the individual, family members, service providers, or others. It is conducted as frequently as necessary, including at least once annually.[33]

Separate Medicaid reimbursement is *not* available for case management when case management activities are an integral component of another covered Medicaid service or when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred.

Additionally, Medicaid reimbursement is *not* available for case management when the activities are integral to the administration of: (1) foster care programs, or (2) another nonmedical program, such as guardianship, child welfare or child protective services, parole or probation, or special education program. There is an exception for case management that is included in an individualized education program or individualized family service plan that is consistent with §1903(c) of the Social Security Act.[34]

How Case Management Services May Be Delivered

In §1915(g)(2) of the Social Security Act, case management services are defined as including those that will assist individuals "in gaining access to needed medical, social, educational, and other services."[35] From a practical perspective, these services may be provided in a variety of ways. States use an array of mechanisms to provide case management or similar coordination of services, not solely under the authority of §1915(g)(2). The range of case management approaches includes the following:

1. **"Embedded" in a rehabilitative service available under the Medicaid State Plan.** The rehab option is used to define a variety of treatment services available to Medicaid consumers, including treatment for M/SUDs. Care coordination is inherent in some of the services offered under the rehab option.

2. **As an administrative function of Medicaid**. Some of the administrative responsibilities associated with the Medicaid program include case management functions, such as assessment, referral, and follow-up. Depending on how the state organizes administrative functions, Medicaid administrative funding may finance the cost of some of these related case management functions, although at the lower federal financial participation (FFP) rate associated with administrative claiming. Module 2 provides more detailed information on Medicaid financing.

3. **As a Medicaid State Plan service called *targeted case management.*** Targeted case management (TCM) is case management that is restricted to specific beneficiary groups, which can be defined by disease or medical condition (e.g., HIV/AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities) or by

geographic regions (e.g., a few counties within a state).[36] TCM also may target children receiving foster care or other groups identified by a state and approved by CMS. TCM is an optional service that states may elect to cover under their State Plans, but it must be approved by CMS through state plan amendments (SPAs).

Congressional amendments initially made TCM services a payable class of medical assistance service when it was provided as part of state waiver programs under §1915. Congress subsequently amended Medicaid to permit states to furnish TCM services as a coverage option, regardless of whether coverage was offered in connection with a waiver program.[37]

4. **As a component of managed care.** An individual enrolled in a managed care plan receives services to coordinate his or her health care. This coordination typically is provided as a component of administering the managed care benefit. Depending on the state's program, a beneficiary may also receive TCM outside of the plan. Receipt of TCM outside of the managed care plan may require adjustment of the managed care rate if it affects the actuarial value of services provided by the managed care plan. Managed Care is discussed more thoroughly in Module 5.

5. **In accordance with the administration of a waiver.** As a state determines how it wishes to administer a §1915 or §1115 waiver, it may choose to provide case management as either an administrative service or as a discretely identified waiver service.

6. **Under §2703 of the Affordable Care Act, which defines Health Homes.** Comprehensive care management is one of six services specifically required by the legislation to be included in service delivery under the §2703 health home model of care delivery.

7. **"Embedded" in EPSDT.** Like other services coverable under EPSDT, children younger than age 21 are entitled to case management services if deemed medically necessary.[38] Although they are not discretely identified, there may be services provided under EPSDT that include this coordination function.

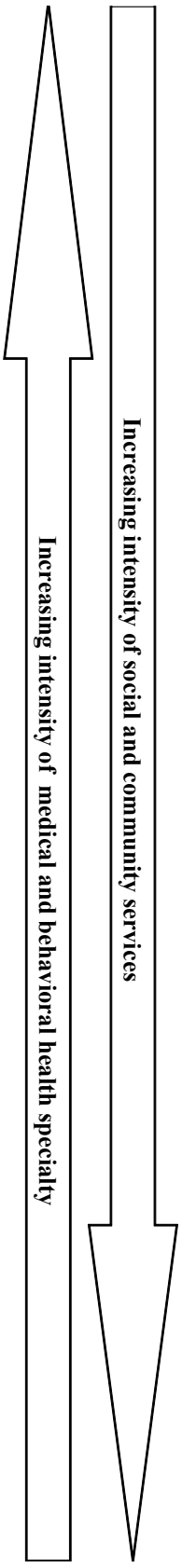
8. **Under §1915(i) of the Social Security Act.** Under §1915(i)(1)(E)(ii) of the Act, the state uses an independent assessment to identify the needs of an individual who is determined eligible for home- and community-based services. The purpose is to: determine a level of services and supports to be provided that is consistent with an individual's physical and mental capacity; prevent the provision of unnecessary or inappropriate care; and establish an individualized care plan.[39]

Analysis of the Good and Modern Addictions and Mental Health Service System Services

A review of the Good and Modern Addictions and Mental Health Service System services chart (see Figure 3-1) provides examples of how the authorities described above are being used to provide behavioral health services.

Figure 3-1 Good and Modern Addictions and Mental Health Service System

Acute Intensive Services	Mobile crisis Medically monitored intensive inpatient Peer based crisis Urgent care 23 hour crisis stabilization 24/7 crisis hotline
Out-of-Home Residential Services	Crisis residential/stabilization Clinically managed 24-hour care Clinically managed medium intensity care Adult mental health residential Children's mental health residential services Youth substance abuse residential Therapeutic foster care
Intensive Support Services	Substance abuse intensive outpatient, Substance abuse ambulatory detoxification Partial hospital Assertive community treatment Intensive home based treatment Multi-systemic therapy Intensive case management
Outpatient Services	Individual evidence based therapies Group therapy, family therapy Multi-family therapy Consultation to caregivers
Healthcare Home/Physical Health	General and specialized outpatient medical services Acute primary care General health screens, tests, and immunizations Comprehensive care management Care coordination and health promotion Compressive transitional care Individual and family support Referral to community services
Medication Services	Medication management Pharmacotherapy (including MAT) Laboratory services
Engagement Services	Assessment Specialized evaluations (psychological, neurological) Service planning (including crisis planning) Consumer/family education Outreach
Prevention (including Promotion	Screening, brief intervention, and referral to treatment Brief motivational interviews Screening and brief intervention for tobacco cessation Parent training Facilitated referrals Relapse prevention Wellness recovery support Warm line
Community Support (Rehabilitative)	Parent/caregiver support Skill building (social, daily living, cognitive) Case management Behavioral management Comprehensive community support Supported employment Permanent supported housing Recovery housing Therapeutic mentoring Day habilitation
Other Supports (Habilitative)	Personal care Homemaker Respite Supported education Transportation Assisted living Recreational services Interactive communication technology devices
Recovery Supports	Peer support Recovery support coaching Recovery support center services Supports for self-directed care Continuing care for substance use disorders



Based on a review of existing Medicaid State Plans and waivers, and as an example of the variability with which states use the authorities discussed above to offer services listed in the Good and Modern services chart above:

- Every first service in each row—including mobile crisis, crisis stabilization, substance abuse intensive outpatient services, individual outpatient evidence based therapies, and medication management—is currently provided as a State Plan service. Peer support is currently provided as a State Plan service, but it also may be provided under a §1915(b) or §1915(c) waiver.
- ACT may be provided as a State Plan service, but may also be provided under a §1915(c) waiver.
- Although the prevention services are not extensively reimbursed by Medicaid today, they may be important to reexamine in light of the Affordable Care Act requirements associated with preventive services.
- With the exception of the housing service component, the more "medical" types of services at the top of the chart above are very commonly available as State Plan services.
- Conversely, the services toward the bottom of the chart above are more commonly provided as §1915(c) waiver services or occasionally as a component of a §1915(b) waiver. It is uncommon to find many of those services in a state's Medicaid State Plan.

Summary

Creation of a state's Medicaid behavioral health benefit package is a multidimensional process. In determining how it wants to put together its behavior health benefit package, a state must consider the types of services it wants to provide and the populations to which it wants to provide them. Then, the state considers the authorities it can use to provide those selected services. Inherent in the State Plan and waiver structures are opportunities and limitations that are unique to each, so a thorough understanding of those authorities is necessary to determine the scope and breadth of its benefit package. This also serves to highlight the fact that Medicaid, although *necessary*, is not *sufficient*, as housing and other key services cannot be provided with Medicaid financing.

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Medicaid Handbook: Interface with Behavioral Health Services

Module 4

Providers of Behavioral Health Services

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Module 4: Providers of Behavioral Health Services

Medicaid Providers

Before addressing issues unique to providers of behavioral health services, it is useful to understand some principles relative to Medicaid providers, in general.

States have latitude within the bounds of federal statute and legislation in defining the types and qualifications of providers that may participate in their Medicaid programs. However, as described in Module 2, having an understanding of several important foundational Medicaid principles will help inform how and why states approach the design of their provider networks and establish their provider requirements.

Reasonable Promptness and Statewideness. The ability to ensure that Medicaid consumers can access needed services in a reasonably timely manner depends on having a sufficient number and type of providers in a given area. Although there may be sufficient numbers and types of providers available in the community, network requirements imposed by the state and the level of reimbursement for services (among other considerations) will impact providers' willingness to participate in the Medicaid program.

Freedom of Choice Among Qualified Providers. As described in Module 2, an individual who is eligible for Medicaid may obtain Medicaid services from any provider that is qualified and willing to furnish the services. The ability to waive this requirement is one of the principal reasons that states employ waivers. Module 5 includes a discussion of the checks and balances that states and the Centers for Medicare & Medicaid Services (CMS) use when states limit freedom of choice in a managed care system.

Many Americans want to be able to choose their provider. Affording a Medicaid consumer the ability to choose among all providers determined by the state to be qualified is considered an important component of quality and safety—the ability to, proverbially, "vote with one's feet." Thus, although the state is given flexibility within the confines of federal statute and regulation to determine provider qualifications and reimbursement rates, and although the state can be restrictive in setting these parameters, once the state establishes the qualifications the consumer is empowered with the ability to choose from among all providers that meet the state's qualifications.

Single State Agency. The role of the single state agency in directing the state's Medicaid policy includes the responsibility to establish and apply consistent requirements for becoming an eligible Medicaid provider. These requirements typically are codified in state law or rule.

> Although many states have dedicated departments of behavioral health that are separate from the Medicaid agency, the Medicaid agency is ultimately responsible for the policy structures of the Medicaid program and interactions with CMS. The behavioral health and Medicaid departments may jointly file rules—or the behavioral health department may maintain administrative rules with greater policy detail—while the Medicaid department maintains a rule that "authorizes" the other department's requirements. When

the Medicaid and behavioral health authorities are in the same department, any concerns about the ultimate authority for Medicaid purposes is lessened significantly.

Efficiency, Economy, and Quality of Care While Assuring Access. Although access to needed services is a primary consideration, it is not the only factor related to provider networks. States must maintain a balance between assuring access and providing quality services in an economical and efficient manner. For example, Medicaid agencies are not required to pay significantly more than the market rate for services simply to assure access. In fact, they are prohibited from doing so. The provider requirements and reimbursement rates the states set must consider efficiency and economy *as well as* quality. Often, states will utilize managed care authorities and waive freedom of choice of providers in order to have a smaller, more manageable, and more cost-effective network.

Is It a *Service* or a *Provider*?

When states consider the design of their provider networks, it is helpful to understand at the outset whether the network is comprised of services or providers. The list of mandatory and optional *services* described in Module 2 is actually a combination of services and *types of providers.* Prescription drugs, dentures, family planning, and respiratory care, for example, are services. A federally qualified health center (FQHC), inpatient hospital, nurse midwife, rural health clinic, and nursing facility are specific types of providers of certain services. The difference between the two categories is illustrated by an example: although several types of providers may be qualified to provide family planning services, only a nursing facility can provide nursing facility services.

For those services that are not provided by a unique type of provider, the state has additional latitude to define the types of providers and requirements needed to provide the service. For example, a state may specify that physical therapy may only be provided through a clinic and not allow independently practicing physical therapists to become eligible providers of physical therapy services.

State-Specific Professional Practice Acts

Professional practice acts are state laws and regulations that define the scope of practice for a particular provider type. They identify what constitutes the independent practice of a certain professional and what activities the professional can or cannot undertake. These requirements apply to providers regardless of the payer source. In other words, state professional practice acts establish practice requirements for providers regardless of whether they receive reimbursement from Medicaid or private insurance.

In addition, the specific licensing requirements, professional standards, and prohibited acts, etc. of professional practice acts often specify the type of oversight or supervision required in order to practice in that state. State laws vary considerably; for example, although all states define who may practice as a nurse or physician, not all will define or allow lay or non-nurse midwives to practice.

Supervision and delegation are important components of professional practice acts. For example, some states define how many physician assistants may be supervised by a single physician. The

requirements for supervision often address various levels within a professional group; a Master's or Ph.D. degree may be required to supervise an entry-level professional holding a bachelor's degree. Also, certain types of tasks may be delegated to another type of professional, with the primary responsibility for the patient's care remaining with the licensed professional. For example, in many state mental health or developmental disability systems, a registered nurse may delegate certain tasks to a trained aide while retaining patient responsibility and liability.

Medicaid regulations give considerable deference to state professional practice acts. In many areas of health care, it is clear what type of provider can perform certain services (e.g., surgery, prescribing medications). However, where a licensing category does not exist or does not fit for the purposes of providing a particular service *within the Medicaid program*, the state can define the requirements for background, training, level of education, etc. Through this process, the state can create its own type of paraprofessional provider solely for delivery of services within the Medicaid program. In reviewing state Medicaid State Plans, CMS pays particular attention to these unique types of providers and their associated requirements. This is particularly important in the behavioral health arena, as we consider rehabilitative services, peer support services, and other essential components of the behavioral health benefit package.

There is an additional distinction that is helpful in understanding how Medicaid approaches provider issues, especially related to non-institutional services. There are at least two layers of provider policy issues that should be considered, and there may be separate requirements addressing each.

The Medicaid provider is the provider agency or independent practitioner who has a direct relationship with the state. It has a signed Medicaid agreement with and is reimbursed directly by the state. The state specifies the requirements to be a Medicaid-eligible provider. The principles discussed above relate to defining who is an eligible provider for Medicaid purposes, and the associated principles of freedom of choice of providers apply to these Medicaid providers. The Medicaid provider may, in turn, employ or subcontract with clinicians or staff members who provide *hands on care* to the Medicaid consumer. These may be known as *rendering providers*.

The rendering provider is a clinician, therapist, program staff, or paraprofessional who provides hands-on care to the Medicaid consumer. The rendering provider may also be the Medicaid provider, as in the case of an independent therapist who is self-employed. Depending on the type of Medicaid service and whether a professional practice act applies, a state may have very specific Medicaid requirements associated with who is eligible to provide hands-on care. If this is the case, such requirements must be followed in order for the service to be properly provided and reimbursed.

Providers of Behavioral Health Services

Many types of providers serve individuals with behavioral health needs. As discussed, behavioral health services are often delivered by a counselor, social worker, physician, psychologist, or community support paraprofessional in an office, outpatient clinic, or community setting. State Medicaid programs frequently cover other provider types that give behavioral health care, such as primary care physicians, clinics, FQHCs, psychiatric residential treatment facilities (PRTFs), and special institutions of mental diseases, as described below. States' administrative rules

and/or statutes typically specify the provider types—including required licensure or certification—that are permitted to provide behavioral health services. A provider can determine if he or she can participate in its state Medicaid program as a provider of behavioral health services by assessing the services for which the state's Medicaid program provides reimbursement, to which populations, and by what types of providers.

Community Mental Health Centers

The Mental Retardation Facilities and Community Mental Health Centers Construction Act was signed into law in October of 1963 only nine months after President John F. Kennedy proposed in a major public address a national mental health program. The Act provided an alternative to institutionalization for those with serious mental illness (SMI). It "drastically altered the delivery of mental health services and inspired a new era of optimism in mental health care. This law led to the establishment of more than 750 comprehensive community mental health centers (CMHCs) throughout the country."[1]

Along with pharmacologic advances, growing evidence about the efficacy of community-based treatments, and changes in underlying beliefs and attitudes about mental illness, the CMHCs became an important vehicle for change. Rather than a singularly-focused medical approach to caring for those with mental illness, the CMHCs developed an array of medical, social, educational and rehabilitative supports and services designed to address the practical needs of individuals who were being discharged from state psychiatric hospitals.

Although there is no standard definition of what constitutes a CMHC, what made them unique was the comprehensive scope of their services, their provision of services for individuals who were indigent and to individuals with SMIs or children with SEDs, and their distinctive involvement in their community and neighborhood. These agencies have remained the backbone of community mental health services in the United States, providing a comprehensive array of community support services as well as embracing the need for coordinated care and addiction treatment services.

Over time, the CMHCs have adapted to the changing service and reimbursement environment by providing services to those with commercial insurance, Medicare, and, particularly, Medicaid. Unlike FQHCs—discussed more fully below—community mental health centers are subject to the varied requirements of state Medicaid programs and have no consistent federal requirements. Some state regulatory frameworks acknowledge comprehensive providers as a unique subset of providers, and some receive special funding. For example, Minnesota indicates that covered Medicaid services include "community mental health center services" and identifies a minimum set of services that must be available.[2] Other states require service-specific regulations without regard to the type of provider entity.

There have been efforts in Congress to create a statutory definition of *federally qualified behavioral health centers.* Doing so would establish a federal status for community mental health and addiction providers—similar to the status for FQHCs—and would make them subject to federal requirements while also opening up the potential for federal grant funding and alternative payment methodologies under Medicare and Medicaid.

Federally Qualified Health Centers

FQHCs are community-based and consumer-governed organizations that serve populations with limited access to health care. There are three types of FQHCs:

1. Health Center grantees are grant-supported FQHCs that are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Program (respectively, Sections 1861(aa)(4) and 1905(1)(2)(B) of the Social Security Act) and receive funds under the Health Center Program (Section 330 of the Public Health Service Act). Some health center grantees receive specific funding to focus on certain special populations:
    - Migrant and seasonal farmworkers
    - Individuals and families experiencing homelessness
    - Residents of public housing.
2. FQHC Look-Alikes are non-grant supported health centers that have been identified by the Health Resources and Services Administration (HRSA) as meeting the definition of a health center under §330 of the Public Health Service (PHS) Act, but they do not receive grant funding under §330 of the Act.
3. Outpatient health programs or facilities operated by tribal organizations (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

Most FQHCs are specifically described in §330 of the Federal PHS Act. Many health centers receive Section 330 grant funds and have a unique, direct relationship with the HRSA of HHS. But FQHC Look-Alikes, tribal groups, or Urban Indian Health Organizations are FQHCs that do not receive 330 grant funding. These Section 330 FQHCs:

- Are located in or serve a high-need community
- Are governed by a community board, a majority (51 percent or more) of whose members are health center patients who represent the population served
- Provide comprehensive primary, preventive, and enabling health care services as well as supportive services (e.g., education, language translation, transportation) that promote access to health care
- Provide services to all individuals, whether insured or not, with fees adjusted based on the person's ability to pay
- Meet other performance and accountability requirements.[3]

States are *required* by §1905(a) of the Social Security Act to provide FQHC services in the Medicaid program, and FQHCs are eligible for a distinct payment system under both Medicare and Medicaid. In 2009, FQHCs served almost 7.8 million Medicaid patients.[4] The Affordable Care Act included a significant increase in funding for new and expanded health centers in anticipation of an expanded need for services.

Health centers are required to provide primary health services with an identified team of health professionals.[5] *Required primary health services* include those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology provided by physicians and, where appropriate, physician assistants, nurse practitioners, and nurse midwives.[6] In addition to health

services provided by physicians and physician extenders, health centers must provide in their package of required primary health services referrals to providers of "other health-related services, including substance use disorder and mental health services."[7] The referral requirement is a minimum and does not preclude a health center from directly providing behavioral health services. Therefore, although FQHCs may not *target* individuals with serious and persistent mental illness (SPMI) or serious addictions, anyone receiving services at the FQHC is eligible to have his or her behavioral health needs addressed—even if it is not onsite but provided on referral. Those with SPMI or serious addictions are disproportionately represented in the health centers targeting homeless individuals or targeting those in public housing.

Health centers, at their discretion, also may provide *additional health services* "appropriate to meet the health needs of the population served by the health center."[8] These may include behavioral, mental health, and substance use disorder (SUD) services.[9]

A health center that receives grant funding to serve homeless populations is required by statute to provide—either with staff or under contract with outside specialty providers—SUD services (including detoxification, risk reduction, outpatient treatment, and rehabilitation for substance use provided in settings other than hospitals).[10]

FQHCs are important providers of behavioral health services because: (1) they serve as safety net providers to individuals who might not otherwise have access to care, and (2) they are largely committed to integrating behavioral and physical health care. According to a survey conducted by the National Association of Community Health Centers (NACHC)—

> Mental health services are provided by over 70 percent of FQHCs, and SUD services are provided by 55 percent of the health centers that responded to the NACHC survey. Almost 65 percent of FQHCs that responded meet all of the components of integrated care. That is, services are co-located on site; they have good communication and coordination among behavioral health and primary care providers; they share behavioral health treatment plans, problem lists, medication and laboratory results; and behavioral health and medical providers make joint decisions on patient treatment. Only 10 percent of the FQHCs that responded do *not* routinely screen for depression. FQHCs are utilizing evidence-based tools for screening for M/SUD.[11]

The Substance Abuse and Mental Health Services Administration (SAMHSA) has historically worked and continues to work with HRSA to increase and improve delivery of behavioral health services in FQHCs and to more fully integrate behavioral and physical health services.

Psychiatric Residential Treatment Facilities

The Social Security Act was amended in 1972 to allow states the option of covering inpatient psychiatric hospital services for individuals younger than age 21 (the *psych under 21 benefit*). Originally, the statute required that inpatient psychiatric hospital services for individuals younger than age 21 be provided exclusively by psychiatric hospitals that were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). However, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) specified that states can provide inpatient psychiatric services for this population in psychiatric hospitals *or* in another inpatient setting that

the Secretary of HHS has specified in regulations. OBRA '90 authorized CMS to specify inpatient settings *in addition to* the traditional psychiatric hospital setting for the *psych under 21 benefit* without continuing to require that providers obtain JCAHO accreditation. Thus, CMS established the PRTF as a new type of setting where inpatient psychiatric hospital services for individuals younger than age 21 can be provided.[12]

The major benefit of a PRTF is that an individual can receive inpatient psychiatric care in a nonhospital setting and reimbursement rates can include room, board, and expenses. PRTFs are secured facilities that provide a structured, therapeutic environment for children and youth younger than 21 years who need intensive services to effectively treat severe behavioral and/or developmental disturbances. Most individuals are referred following the receipt of outpatient treatment or stabilization in an acute care setting. The goal is to provide a specialized, therapeutic treatment setting so that individuals can improve their functioning and transition to a less-restrictive community placement or, when possible, to a family setting.

PRTFs must comply with many federal regulations, but states are also given significant flexibility in designing policies in areas including daily rate, services provided, licensing, and admissions certification.

Daily Rate and Services: Medicaid funding for the PRTF benefit is called the *daily rate*. The services that states provide as part of the PRTF benefit vary, as do the daily rates at which the services are reimbursed, as shown in Table 4-1. For example, as of 2008:

Table 4-1 PRTF Benefit Services Provided, By State and Daily Rate

State	Daily Rate	Services Provided
Iowa	$165.53	Rate covers all room, board, and services with the exception of medical expenses such as prescriptions, physician fees, and hospitalization.
Indiana	$322.00	Medicaid reimbursement excludes pharmaceutical supplies and physician services.
Kentucky	$230.00	Rate covers total facility costs for PRTF services, excluding the cost of drugs.
Mississippi	from $425 to $564	Mississippi's Division of Medicaid is responsible for determining what services are included.
Nebraska	from $235.98 to $295.28	These rates are all inclusive, although medication is excluded.
Oklahoma	vary between $190.97 and $413.49	Rates vary depending on the type of treatment.
Oregon	vary between $270 and $640	Rates vary depending on the type of treatment.

Licensing: States may establish licensing requirements in addition to those established by federal law. In addition to accreditation by the JCAHO, some states include accreditation from the Commission on Accreditation of Rehabilitation Facilities or the Council on Accreditation.

Admissions Certification: For Medicaid purposes, patients entering a PRTF must be certified by the state as meeting specific criteria for admission and additional criteria for continued stay.[13]

Fewer than half of states have PRTFs; states that have PRTFs may call them something else (e.g., Psychiatric Medical Institutions for Children in Iowa). Absent a definitive list from CMS, the best available information indicates that the following states have PRTFs: Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Mississippi, Montana, Nebraska, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, South Dakota, and Wyoming.[14]

Institutions for Mental Diseases

Mental diseases include all diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, Edition 4, Text Revision (DSM-IV-TR), including those for substance use and addiction. Section 1905(a) of the Social Security Act prohibits the federal government from reimbursing states under the Medicaid program for services rendered to a Medicaid beneficiary who is a patient in an institution for mental disease (IMD).[15] This prohibition, known as the *IMD exclusion*, does not mean that an individual in an IMD cannot receive treatment; it means that federal Medicaid reimbursement is not available for those services or any other Medicaid-funded services rendered to a patient in an IMD.

It is generally understood that this exclusion was developed so that Medicaid would not pay for care in the large state psychiatric hospitals that existed in the 1960s when the Medicaid program was implemented; state hospital care should remain the responsibility of states. These state psychiatric hospitals are largely closed or significantly downsized; however, the IMD payment exclusion remains as a barrier to Medicaid reimbursement for acute behavioral health services.

An IMD is a *hospital*, *nursing facility*, or *other institution* that is primarily engaged in providing diagnosis, treatment, or care for persons with mental or substance use disorders, including medical attention, nursing care, and related services.[16] The *IMD exclusion* does not apply to inpatient treatment for mental illnesses in facilities that are part of larger medical entities not primarily engaged in the treatment of mental illnesses. Identification of IMDs is fact specific but includes tests to determine if 51 percent or more of the patient population was admitted for treatment of a mental illness, whether the primary mission of the facility is to treat mental illnesses, and whether the staff of the facility is primarily in professions that treat mental illnesses. Some facilities are excluded from the definition of an IMD because they are primarily engaged in treating those with physical illnesses with staff trained in treating physical illnesses. Assume that a general hospital has a psychiatric unit; if treatment of psychiatric conditions is not the primary business of the general hospital and 51 percent or more of the patient population was not admitted for treatment of a mental illness, this psychiatric unit can receive Medicaid payments for inpatient behavioral health treatment. The determination of when a portion of an institution is sufficiently distinct in character and operation to be classified as an IMD requires a fact-specific analysis; therefore, disputes over classification may not be uncommon.[17]

There are four limitations to the IMD exclusion:

1. It does not apply to adults aged 65 years and older residing in a Medicare-certified hospital or nursing facility.
2. It does not apply to individuals younger than age 21 or, in certain circumstances, younger than age 22 receiving services under the inpatient psychiatric services for individuals under age 21 benefit (subject to the limitation on Federal financial participation [FFP] for other, non-IMD services discussed below).
3. It does not apply to institutions with 16 or fewer beds.
4. It does not apply to partial hospitalization and day-treatment programs that do not *institutionalize* their patients.[17]

The *psych under 21 benefit* allows individuals younger than age 21 to receive inpatient psychiatric services in three settings: psychiatric hospitals, psychiatric units in general hospitals, and PRTFs. FFP is available only for the inpatient psychiatric services that are provided to children and youths in these facilities who are enrolled in Medicaid; FFP is not available for any other health services that the beneficiary may need until unconditionally discharged from the IMD. For example, temporary discharge to treat medical or dental needs is not considered unconditional discharge; therefore, Medicaid will not pay for this medical treatment.[14]

The IMD exclusion is instructive, as it illustrates the disconnect between policies related to individuals with severe mental illnesses compared to other persons who rely upon Medicaid:

- Adults with severe mental illness are severely limited in their ability to receive inpatient care that is reimbursed for their disease, whereas other individuals can receive inpatient care for their chronic health condition. For youths younger than age 21, states *must* provide inpatient psychiatric care under EPSDT, and states have the *option* of providing inpatient psychiatric care to adults older than age 64.
- Nursing home care is available to seniors and individuals with disabilities, as long as they are not primarily disabled by severe mental illness.
- Medicaid covers residential treatment for adults with developmental disabilities.

The President's New Freedom Commission on Mental Health, appointed by President George W. Bush, addressed the IMD issue along with many others. Specifically, the Commission recommended that CMS explore Medicaid reform efforts to address the IMD exclusion, including using HCBS as an alternative to IMDs; redefine IMDs and the services funded; and use self-directed services and supports for people with mental illnesses.[18]

Additionally, adherence to the law has proved cumbersome for states. The problems that states face are described in a policy brief published by the National Association for Children's Behavioral Health (quote):

> As noted, CMS relies upon states to self-identify which of their licensed facilities are IMDs and to comply with the IMD exclusion and exception. The CMS State Medicaid Manual gives vague, subjective and even inaccurate guidance to identify IMDs, beginning with the statement that inpatient psychiatric hospital services are "currently being provided in a wide variety of psychiatric facilities."

This leaves the impression that more than three types of facilities may deliver the services for which states may then claim FFP.

The manual's guidelines for determining what constitutes an institution and whether an institution is an IMD list factors to be considered, such as ownership, governance and licensure, with the statement that "if any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered." No description of the assessment or other factors is included. The relative weight of known and unknown factors is determined by CMS regional staff, headquarters staff or auditors on a case-by-case basis.

Part of the regulatory definition of IMDs is that the "overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases." The State Medicaid Manual says that the guidance is met if more than 50 percent of the residents of the facility "require specialized treatment of serious mental illness." One statement focuses on the purpose of the facility. The other focuses on the mental health needs of the residents, *regardless of whether the facility is providing mental health treatment or was established to do so, or even whether that was the reason for admission* [emphasis added]. The need for a person to be in a particular facility, e.g., a rehabilitation facility for traumatic injury, is not necessarily related to their mental health needs. The reliance on individuals' understanding of the intent of inconsistent language results in subjective and variable decision making.[14]

The Medicaid Emergency Psychiatric Demonstration

Section 2707 of the Affordable Care Act created the Medicaid Emergency Psychiatric Demonstration, a 3-year demonstration that allows participating states to provide payment to certain nongovernment psychiatric hospitals for inpatient emergency psychiatric care. The target population is Medicaid recipients aged 21 to 64 years who have expressed suicidal or homicidal thoughts or gestures and are determined to be dangerous to themselves or others. The federal government will contribute its regular FFP for these services. The purpose of the demonstration is to determine whether coverage of certain emergency services provided in nongovernment inpatient psychiatric hospitals improves access to—and quality of—medically necessary care, discharge planning by participating hospitals, and Medicaid costs and utilization.[19]

The demonstration provides $75 million over 3 years to 11 states and the District of Columbia. Each state selects which private psychiatric hospitals with 17 or more beds will participate in the demonstration. States will contact the hospitals they wish to include in the demonstration and make arrangements to provide Medicaid payment for emergency psychiatric admissions under the demonstration. The Center for Medicare & Medicaid Innovation (CMMI) estimates that, based on state applications, 26 IMDs among the 11 states and the District of Columbia will participate. Participating states will submit a quarterly statement to CMS enumerating all inpatients receiving services under the demonstration. CMS will provide federal matching funds for Medicaid payments made by participating IMDs for the services they provided to beneficiaries aged 21 to 64 years.[19]

Institutions for Mental Diseases and Substance Use Disorder Services

In evaluating IMDs with regard to SUD services, CMS guidance indicates that there is a continuum of care for chemical dependency. At one end of the spectrum, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. Services like this are considered medical treatment of a mental disease, and patients admitted for such treatment are considered as mentally ill. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.[20]

At the other end of the spectrum are facilities that provide services based on peer counseling models and meetings to promote group support and encouragement, such as Alcoholics Anonymous. These programs primarily use laypersons and recovering peers as counselors. Lay counseling does not constitute medical or remedial treatment. In these settings, consumers receiving lay counseling or peer recovery services are not considered mentally ill for purposes of determining whether a facility is an IMD. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD.[20]

Institutions for Mental Diseases and Managed Care

In a 2003 Special Report, SAMHSA identified a number of ways in which Medicaid managed care may play a role in allowable Medicaid reimbursement for services provided to residents of IMDs. Specifically, SAMHSA identified three ways in which states can use managed care programs to pay for IMD services.

1. **States can pay for IMD services with savings generated from Medicaid managed care programs.** As explained in Module 5, states can use §1915(b) authority to create a managed care program. Four subsections of §1915(b) allow states to structure their programs in a variety of ways. Section 1915(b)(3) offers states the opportunity to provide additional services to waiver enrollees that are paid through savings achieved under the waiver. If a state uses the §1915(b)(3) authority, the managed care program must be cost effective and must demonstrate that it will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services.

   According to the SAMHSA Special Report, a §1915(b)(3) waiver does not grant "IMD expenditure authority," meaning it does not give states the authority to reimburse IMDs directly for inpatient services provided to adults. However, because states are allowed to use any savings generated from the §1915(b)(3) managed care program to provide additional services to waiver enrollees, states technically can use the savings to pay for inpatient services provided to adults in IMDs.[21]

2. **IMD services may be provided by a managed care plan or behavioral health organization (BHO) that contracts with the state's Medicaid program**. A BHO is an organization that manages the behavioral health of Medicaid consumers; it is a specialty managed care organization. In some states, psychiatric inpatient services may be included in the managed care arrangement, and managed by a BHO or other managed care plan. In some states with these arrangements, the state requires the

inclusion of the state psychiatric hospital in the provider network. Whether mandatory or voluntary, the Medicaid managed care plan may purchase services from an IMD.[21]

3. **The states can obtain IMD expenditure authority through a §1115 Medicaid waiver.** As discussed in Module 5, §1115 waivers offer states significant flexibility in designing their managed care programs. Some states have sought and received CMS approval to incorporate IMD services into their Medicaid managed care programs by obtaining IMD expenditure authority. According to SAMHSA's 2003 Special Report, CMS indicated at the time the report was published that as §1115 waivers with IMD expenditure authority expire, the authority would not be reapproved.[21] CMS continues to receive requests to grant §1115 expenditure authority for services provided to individuals residing in an IMD. These requests are heavily scrutinized to determine the potential for evaluating health reform initiatives.

Medication-Assisted Treatment Providers

Specific to SUDs, providers of Medication-Assisted Treatment (MAT) provide treatment that includes a pharmacologic intervention as part of a comprehensive substance use treatment plan with an ultimate goal of patient recovery with full social function. In the United States, a variety of Food and Drug Administration approved drugs have been proven effective in the treatment of alcohol dependence, including disulfiram, naltrexone, and acamprosate; similarly, opioid dependence has been treated successfully with methadone, naltrexone, and buprenorphine[22].

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Medicaid Handbook: Interface with Behavioral Health Services

Module 7

Recent Federal Legislation and Medicaid and Medicare

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Module 7: Recent Federal Legislation and Medicaid and Medicare

Introduction

This module examines the relationship of two major recent pieces of federal legislation—the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act—to the existing Medicaid and Medicare programs, and the importance of these laws to behavioral health care and the people who have mental and substance use disorders.

The Mental Health Parity and Addiction Equity Act of 2008

Passage of the Paul Wellstone and Pete Domenici MHPAEA was intended to align insured health care benefits for M/SUDs with those for medical and surgical care. The goal of MHPAEA was to stop inequitable practices that had been undertaken by some health insurers.[1]

Requirements of the Act

MHPAEA requires certain group health plans, which are described more thoroughly below, to ensure that financial requirements (e.g., copays and deductibles) and treatment limitations that are applicable to M/SUD benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits.[2] MHPAEA does not mandate that a plan *must* provide M/SUD benefits. Rather, it requires that *if* a plan provides medical, surgical, and M/SUD benefits, it must provide them in an equitable fashion.[3]

MHPAEA supplements the provisions that were included in the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPA did not, however, apply to SUD benefits; MHPAEA continues the MHPA parity rules for mental health benefits and extends them to benefits for SUDs.[3]

Application of the Act

MHPAEA applies to fully insured and self-insured group health plans covering more than 50 employees, Medicaid managed care plans, Taft-Hartley group health plans, Children's Health Insurance Program (CHIP), and federal employee benefits plans.[1] MHPAEA's requirements apply to Medicaid only insofar as a state's Medicaid agency contracts with managed care organizations (MCOs) or prepaid inpatient health plans (PIHPs) to provide medical, surgical, and M/SUD benefits. In these cases, the MCOs or PIHPs must meet the parity requirements. MHPAEA parity requirements *do not apply* to a state's Medicaid program if it does not use MCOs or PIHPs to provide benefits.[4] MCOs and PIHPs are discussed more fully in Module 5.

Application of the MHPAEA to CHIP is broader than its application to Medicaid. CHIP is a health insurance program for children; it is jointly funded by state and federal governments. States may choose to operate their CHIPs as an expansion of their Medicaid programs, as a separate program, or as a combination of both. Module 2 contains a more detailed discussion of CHIPs.

MHPAEA requirements apply to a state's entire children's health insurance plan including, but not limited to, any MCOs that contract with the state. Additionally, §502 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that CHIPs comply with the MHPAEA requirements "in the same manner" as such requirements apply to a group health plan. Therefore, if a state's CHIP provides medical, surgical, and M/SUD benefits, then any treatment limitations, lifetime or annual dollar limits, or out-of-pocket costs for M/SUD benefits must comply with the provisions added to the Public Health Service (PHS) Act by MHPAEA. Section 502 of CHIPRA also specifies that CHIPs must satisfy M/SUD parity requirements if they provide coverage for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). This means that any state that operates its CHIP as an expansion of its Medicaid program or provides coverage of EPSDT benefits in a separate or combination CHIP will be in compliance with M/SUD parity requirements.[4] EPSDT is discussed more fully in Module 2.

Benefits That Require Parity

The MHPAEA defines six classifications of benefits that require parity: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. If a plan has no network of providers, all benefits in the classification are characterized as out of network. If a plan provides any M/SUD benefits, it must provide M/SUD benefits in each classification for which any medical or surgical benefits are provided.[5] If a plan or issuer that offers out-of-network medical and surgical benefits also offers M/SUD benefits, it must offer out-of-network M/SUD benefits.[3]

The MHPAEA requires that plans make available certain information about M/SUD benefits. Specifically, the method by which determinations of medical necessity are made with respect to M/SUD benefits and the reason for a denial of payment for services with respect to M/SUD benefits must be made available to the participant or beneficiary.[3]

The Relationship of the Affordable Care Act's Essential Health Benefits to the Mental Health Parity and Addiction Equity Act

The Affordable Care Act extends application of MHPAEA to qualified health plans sold within states' Health Insurance Marketplace (also known as the Health Insurance Exchange or Affordable Insurance Exchange). A qualified health plan is an insurance plan that is certified by the Marketplace, provides essential health benefits, and meets other requirements.[6]

The Affordable Care Act requires that by 2014, health plans offered in the individual and small group markets—both inside and outside of the Health Insurance Marketplace—offer a comprehensive package of items and services known as essential health benefits. A small group market has the meaning given under the applicable state's rate filing laws, except that where state law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act.[7] These benefits must include items and services within at least the following 10 categories.[8]

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care

- Mental and substance use disorder services, including treatment of behavioral disorders
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace.

Congress directed HHS to construct the details of the essential health benefits package. HHS, in turn, asked the Institute of Medicine (IOM) to recommend a *process* for defining and updating the package, but not a specific list of benefits. After receiving input from the IOM and many other stakeholders interested in the outcome of the design, HHS announced in December 2011 a policy for implementing this section of the Affordable Care Act.

The announcement proposed that essential health benefits should be defined using a benchmark approach. Essential health benefits will be defined by a benchmark plan selected by each state. The selected benchmark plan will serve as a reference plan. Under this approach, states will have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." This gives states the flexibility to select a plan that best meets the needs of their citizens. States will choose one of the following benchmark health insurance plans:

- One of the three largest small-group plans in the state by enrollment
- One of the three largest state employee health plans by enrollment
- One of the three largest federal employee health plan options by enrollment
- The largest HMO plan offered in the state's commercial market by enrollment.[9]

The benefits and services included in the benchmark plan selected by the state will be the essential health benefits package. Plans can modify coverage within a benefit category, as long as they do not reduce the value of coverage. If a state does not select a benchmark plan, HHS intends that the default benchmark will be the small group plan with the largest enrollment in the state.[9]

In addition to these considerations regarding essential health benefits, the Centers for Medicare & Medicaid Services (CMS) has provided guidance for defining essential health benefits for Medicaid benchmark or benchmark-equivalent plans. Note that the term *benchmark* used in this instance does not have the same meaning as the term *benchmark* used above. Since 2006, state Medicaid programs have had the option to provide certain groups of Medicaid enrollees with an alternative benefit package known as *benchmark* or *benchmark-equivalent* coverage, based on one of three commercial insurance products or a fourth, "Secretary-approved" coverage option. Beginning on January 1, 2014, all Medicaid benchmark and benchmark-equivalent plans must include at least the 10 statutory categories of Essential Health Benefits.[10]

Mental and/or Substance Use Disorder Benefits as Part of the Essential Health Benefits Package

As noted above, M/SUD benefits are included in the Affordable Care Act's essential benefits package. Additionally, the Affordable Care Act extends the parity requirements for M/SUD benefits of MHPAEA to plans that provide the essential health benefits package.

In order to craft an essential health benefits package that is focused on the total health and well-being of the individual, there must be comprehensive physical and behavioral health components. This will necessarily mean addressing the historical imbalance between M/SUD benefits and physical health benefits, including significant differences in public and private coverage for M/SUD services and an unacceptably large treatment gap for people with mental and substance use disorder service needs. The inclusion of M/SUD benefits in the essential health benefits package underscores that meeting the needs of an individual's behavioral health is integral to improving and maintaining overall health. [11]

According to the Institute of Medicine (IOM) Committee on Determination of Essential Health Benefits, requirements for a broad and robust M/SUD benefit should include coverage for and access to:

- The full range of quality M/SUD prevention, treatment, rehabilitation, and recovery support
- The clinically appropriate type, level, and amount of care
- All services, interventions, and strategies to help people avoid disease and to help people with these illnesses achieve and maintain long-term wellness
- Ongoing supports to help people manage their disease throughout their lifetimes
- Services for children and families
- Services that are culturally appropriate.[11]

The committee also recommended using the Substance Abuse and Mental Health Service Administration's *Description of a Good and Modern Addictions and Mental Health Service System* to aid in determining which services should comprise the M/SUD benefit.[12]

The Affordable Care Act of 2010

The Affordable Care Act makes important changes to the U.S. health care system. The goals of health care reform include expanded coverage, controlled health care costs, and an improved health care delivery system. Many of these changes have begun and will continue to impact the Medicaid program and behavioral health services as they are implemented over the next few years.

Many of the Affordable Care Act's provisions are discussed in other modules of this handbook. Those that are not comprehensively addressed elsewhere are discussed below.

Provisions Included in the Affordable Care Act That Impact Medicaid

Medicaid Expansion

The Affordable Care Act establishes a new Medicaid eligibility category for low-income adults between 19–64 years of age and with income at or below 133 percent of the federal poverty level (FPL), which is an annual income of approximately $15,282 for an individual and $31,322 for a family of four in 2013.[13]

In states that implement this Medicaid expansion, eligibility will be determined using Modified Adjusted Gross Income (MAGI) based methods. If necessary for establishing income eligibility, an income disregard equal to 5 percentage points of the FPL will be applied. Under the law, the "newly eligible" individuals will be enrolled into a Medicaid Alternative Benefit Plan, which must include coverage of the ten statutory essential health benefit categories and comply with state and federal regulations.

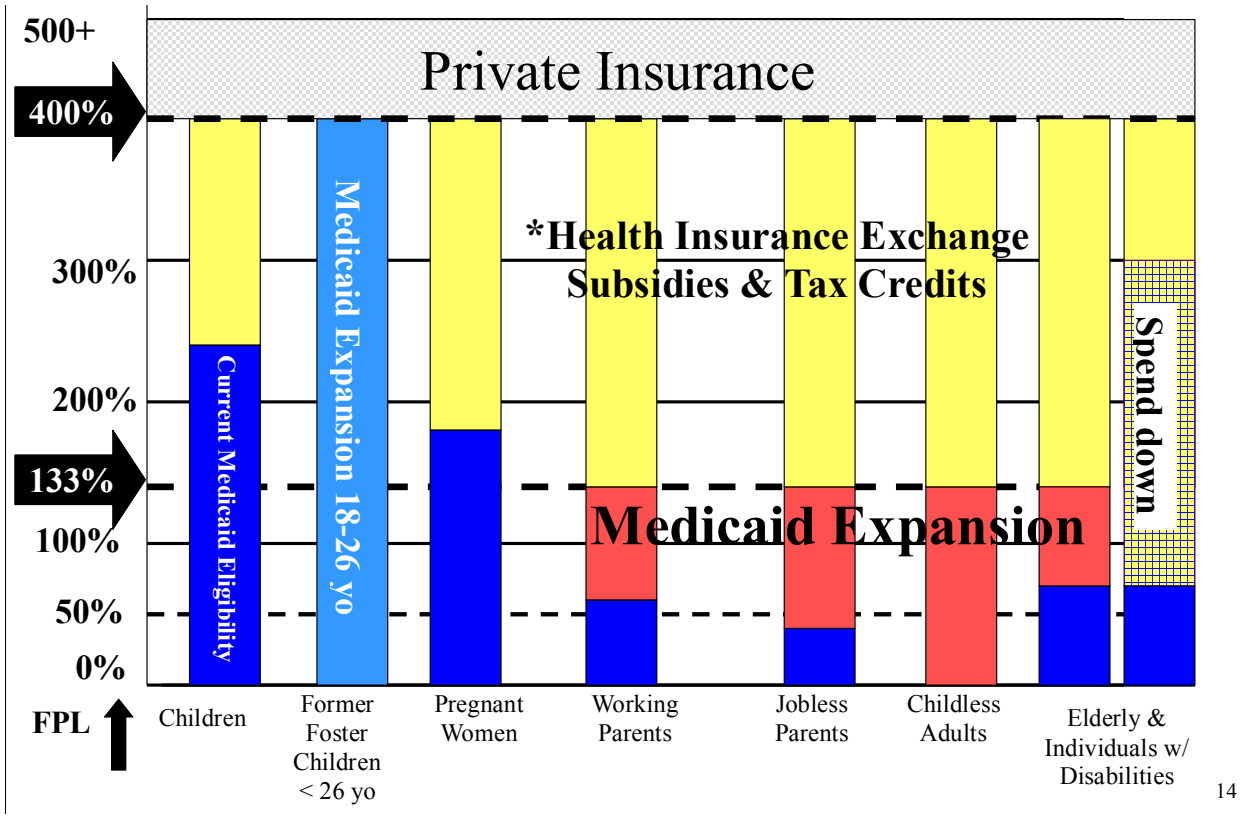
Individuals earning more than their state's Medicaid eligibility threshold but less than 400 percent of the federal poverty guidelines have access to federal premium tax credits and/or cost sharing reductions to help pay for private health insurance—specifically qualified health plans—through the Health Insurance Marketplace. The Health Insurance Marketplace is intended to provide a central location where predictable and transparent insurance products can be purchased.

Individuals earning more than 400 percent of the federal poverty guidelines will not receive tax credits or subsidies to purchase insurance. However, these individuals will have the opportunity to purchase coverage in the Health Insurance Marketplace. The Health Insurance Marketplace is designed to make health insurance coverage in the individual and small group market easier to buy and more affordable. These Marketplaces will provide a "one-stop shop" for individuals to compare qualified health plan options, get answers to health coverage questions, find out if they are eligible for affordability programs like Medicaid and CHIP or premium tax credits to purchase private insurance, and enroll in a qualified health plan that meets their individual needs.

Although there is significant variation among state eligibility categories and associated requirements, the Figure 7-1 provides an overview of eligibility changes related to the Medicaid expansion using median Medicaid eligibility data from the states.

Current Medicaid eligibility is shown in bright blue and reflects the national median eligibility threshold. For example, in a list of eligibility thresholds from lowest to highest, the median eligibility for children is 250 percent of the federal poverty guideline. The yellow bars reflect the income categories that will be eligible for subsidies and tax credits associated with the Health Insurance Marketplace. The eligibility category associated with individuals who are elderly and/or individuals with disabilities is not directly impacted by the Affordable Care Act. The bars with the blue and yellow pattern represent the impact of spending down, which some states use to determine eligibility. For those states without spenddown provisions for the elderly and disabled, these individuals may qualify for the expansion, up to 133 percent of the federal poverty level, if they are not eligible for Medicare. The Medicaid expansion option is shown in red.

Figure 7-1 Current Median Medicaid/CHIP Eligibility Thresholds as a Percentage of the Federal Poverty Guideline and Eligibility Under the Affordable Care Act



Understanding the Opportunities for Expansions in Medicaid Coverage and Associated Affordable Care Act Provisions

According to a 2009 report, because almost half (46 percent) of uninsured Americans, or 21 million people, live in households with incomes under 133 percent of the federal poverty guidelines, the Medicaid expansion was projected to do more to increase the number of people with health insurance than any other provision in the law.[15] As originally intended, between 15 and 17 million Americans were projected to become insured through Medicaid, either because they were newly eligible or because of increased awareness of the Medicaid program as a result of the expansion.

Childless Adults and Others Earning Up to 133 Percent of the Federal Poverty Guidelines

The Medicaid expansion will most significantly impact the childless adult population. Most states do not cover childless adults, regardless of their income. As of January 2010, adults with low income and without dependent children could not qualify for Medicaid in 43 states.[16] Module 2 contains additional information on Medicaid eligibility. In states that choose to implement the Medicaid expansion, childless adults—and all other nonelderly individuals—earning up to 133 percent of the federal poverty guidelines will gain coverage.

Individuals Not Covered by Their State's Medicaid Program and Earning Between 100 Percent and 400 Percent of the Federal Poverty Guideline

As noted above, individuals earning between 100 percent and 400 percent of the federal poverty guidelines will have access to federal premium tax credits and/or cost sharing reductions to help pay for private health insurance—specifically qualified health plans—through the Health Insurance Marketplace. Therefore, even in states that choose not to implement the Medicaid expansion, individuals earning at least 100 percent of the federal poverty guidelines will have access to affordable insurance. In states that choose not to implement the Medicaid expansion, there will likely be a gap for childless adults earning less than 100 percent of the federal poverty guidelines.

There also could be a gap in access to affordable health care for parents with low income. Medicaid eligibility for parents varies by state. For example, as of December 2012—

- In Arizona, parents earning up to 106 percent of the federal poverty guidelines are eligible for Medicaid
- In New York, parents earning up to 150 percent of the federal poverty guidelines are eligible for Medicaid
- In Ohio, parents earning up to 90 percent of the federal poverty guidelines are eligible for Medicaid
- In Arkansas—the state that covers parents at the lowest income threshold—parents earning up to 17 percent of the federal poverty guidelines are eligible for Medicaid[17]

These examples illustrate the various ways in which individuals may be impacted by a state's decision to not implement the Medicaid expansion. Using the information above, if Arizona or New York chooses not to implement the expansion, there will be no gap in access to affordable insurance coverage because Medicaid eligibility for parents begins at greater than 100 percent of the federal poverty guidelines—the threshold for subsidies in the Health Insurance Marketplace. However, if Ohio or Arkansas chooses not to implement the expansion, the portion of the parent population earning more than the income threshold for Medicaid eligibility—90 percent and 17 percent, respectively—and less than 100 percent of the federal poverty guidelines will not have access to affordable insurance.

Implications for States that Implement the Medicaid Expansion

For many of the states that choose to implement the expansion, the implications are significant. For example:

- Under the terms of the expansion, children in families with income between 100 percent and 133 percent of the federal poverty guidelines who are covered by a CHIP at the time that the Medicaid expansion takes effect will be transitioned to Medicaid. This means that all children in families earning between 0 and 133 percent of the federal poverty guidelines will be in Medicaid beginning in 2014.[18]
- Medicaid eligibility for this expansion group will be based on income only, with no asset or resource test. This is a significant departure from the way most states currently determine eligibility.
- Using available tax return information, states will apply the modified adjusted gross income (MAGI) standard for determining financial eligibility for most Medicaid and

CHIP enrollees. This includes a special income adjustment of 5 percentage points, so 133 percent of the federal poverty guideline becomes 138 percent. This is also a departure from the way that states currently determine eligibility. The transition to MAGI will require considerable systems and process changes by states, plus a significant increase in state or local capacity to process millions of applications.

- States will be responsible for up to 10 percent of the cost of the expansion population. The federal government will pay for 100 percent of the cost of the expansion for the first 2 years, decreasing to 90 percent in 2020 and beyond. According to the Congressional Budget Office, over the next 10 years the federal government will pay $434 billion of the cost of the expansion and states will pay about $20 billion.[19]
- States must extend Medicaid coverage to individuals younger than 26 years who were in foster care at age 18. This includes access to the federal EPSDT benefit. EPSDT is discussed more fully in Module 2.
- Starting in 2014, considerable interface will be required between Medicaid, CHIP, and the new state Health Insurance Marketplace. Specifically, states must:
  - Allow individuals to apply for Medicaid, CHIP, and Marketplace plan coverage through a single state-run website
  - Allow Medicaid applications and renewals online, with electronic signatures
  - Conduct outreach to uninsured and underinsured persons
  - Decide if the Marketplace may determine eligibility for premium subsidies.[18]

The Affordable Care Act gave states the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010. For states that chose this option, they will continue to receive their regular FMAP until 2014 even if they implement the expansion before that year. Beginning on January 1, 2014, if these states choose to implement the Medicaid expansion, they will then begin to receive 100 percent FMAP.

States that have already expanded eligibility to adults with incomes up to 100 percent of the federal poverty guideline will receive a phased-in increase in the FMAP for nonpregnant childless adults, so that by 2019 they will receive the same financing as other states. The Affordable Care Act requires that states maintain current Medicaid and CHIP eligibility levels for children until 2019 and current Medicaid eligibility levels for adults until a Marketplace is implemented.[18]

In deciding whether to implement the Medicaid expansion, states will need to evaluate the effects of insuring individuals who currently do not have access to health care and the cost of providing services. Following the Court's ruling on the Medicaid expansion, some states inquired as to whether they could expand Medicaid coverage to an income level less than 133 percent of the federal poverty guidelines and still receive enhanced federal financing. HHS responded that Congress directed that the enhanced matching rate be used to expand coverage to 133 percent and the law does not provide for a phased-in or partial expansion. As such, HHS will not consider partial expansions for populations eligible for the 100 percent federal matching rate in 2014 through 2016.

One additional impact of the expansion should be noted. There is widespread concern that adding this many people to the Medicaid program will result in a shortage of primary care providers—especially those most likely to work with Medicaid patients, such as pediatricians

and family practitioners. The shortage is exacerbated by current Medicaid reimbursement rates that often are criticized as being too low to encourage doctors to treat Medicaid consumers. This problem also needs to be considered in the context of the shortage in behavioral health service providers that already exists, in large part because of state budgetary pressures.

Provisions in the Affordable Care Act That Impact Medicaid and/or Medicare

Establishment of the Center for Medicare & Medicaid Innovation

The Affordable Care Act established the Center for Medicare & Medicaid Innovation (CMMI) within CMS. CMMI is charged with designing innovative payment and service delivery models for implementation in the Medicare and Medicaid programs. CMMI has already funded, and will continue to fund, a variety of projects nationwide that are focused on improving health care quality and efficiency while reducing costs.[20]

The Center's mission is:

- Better health care by improving all aspects of patient care, including safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity (the domains of quality in patient care as defined by IOM).
- Better health by encouraging healthier lifestyles in the entire population, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventative care.
- Lower national cost of health care and lower out-of-pocket expenses for all Medicare, Medicaid, and CHIP beneficiaries, through preventive medicine, coordination of health care services, and reduction of waste and inefficiencies.[21]

The Center is committed to discovering existing—and encouraging development of new—care delivery and payment models that result in better health care and better health at reduced costs. These models should:

- Have the ability to improve how care is delivered nationally and the greatest potential impact on Medicare, Medicaid, and CHIP beneficiaries.
- Focus on health conditions that offer the greatest opportunity to improve care and reduce costs.
- Address the priority areas in the National Quality Strategy.
- Meet the needs of the most vulnerable populations and address disparities in care.
- Improve existing Medicare, Medicaid, and CHIP payments to promote patient centeredness and better health outcomes.
- Be relevant across diverse geographic areas and states.
- Involve major provider types.
- Engage broad segments of the delivery system.
- Balance short-term and long-term investments.
- Be structured at a scale and scope consistent with the evidence.
- Be consistent with CMMI and CMS capacities.[22]

Prevention and Wellness

Improved Access to Preventive Services

The Affordable Care Act expands the current Medicaid State Plan rehab option to include: (1) any clinical preventive service recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and (2) with respect to adults, immunizations recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices. Included in USPSTF's grade of A or B is alcohol misuse counseling, depression screening, and tobacco use counseling.[23] States that cover and prohibit cost sharing for these additional services and vaccines will receive a one percentage point increase in the FMAP effective January 1, 2013.[24]

Annual Medicare Wellness Visit

For preventive services provided on or after January 1, 2011, Medicare enrollees will have access to an annual wellness visit, a comprehensive risk assessment, and a personalized prevention plan. Medicare enrollees are eligible for an initial preventive physical exam during their first year of Medicare coverage and for personalized prevention services thereafter.[20]

Improving Reimbursement for Primary Care

Increased Medicare Reimbursement for Primary Care

Primary care physicians and general surgeons will receive a 10 percent reimbursement increase for services rendered on or after January 1, 2011. The rate increase is to be effective for 5 years.[20]

Increased Reimbursement to Medicaid Primary Care Providers

The Affordable Care Act requires states to make Medicaid reimbursement at least equal to Medicare payment rates—which are typically higher than Medicaid reimbursement—for primary care services provided between January 1, 2013 and December 31, 2014. Primary care services eligible for this payment increase include: (1) evaluation and management services—the billing codes that most frequently correspond to new and establish patient office visits, and (2) services related to immunizations that are provided by a physician that primarily specializes in family medicine, general internal medicine, or pediatric medicine. Medicaid managed care plans are also subject to this requirement. The federal government will be responsible for paying 100 percent of the cost of the increase.

Shared Savings and Innovative Care Models

Medicare Shared Savings Program

Beginning in January 2012, providers became eligible to organize as accountable care organizations (ACOs). An ACO is an organization of providers such as hospitals, physicians, and others involved in patient care that shares responsibility for coordinating and providing care to patients and is accountable for the care of consumers assigned to it. ACOs are responsible for the overall health care of a certain group of people for a fixed amount of money. ACOs are more thoroughly defined in Module 6.

The goal of the ACOs under the Shared Savings Program is to coordinate care for beneficiaries under Medicare Parts A and B. Providers organized as ACOs that meet quality-of-care targets and reduce costs are eligible to share in the savings they generate for Medicare.[20]

Pediatric Accountable Care Organizations

As discussed in Module 7, the Affordable Care Act contains two provisions that recognize the existence of ACOs—one for providers of services to Medicare consumers under the Medicare Shared Savings Program and one for pediatric providers, including those reimbursed by Medicaid. The Affordable Care Act establishes a demonstration project that allows states to implement pediatric ACOs. Under the demonstration, pediatric medical providers can organize as ACOs and are eligible to receive incentive payments from Medicaid. States will work with HHS to establish a minimal level of savings that must be reached for an organization to qualify for an incentive payment.

The pediatric ACOs must meet quality standards ensuring that care provided under the ACO is of no less quality than care that would otherwise be delivered by Medicaid and CHIP outside of the ACO. The federal law gives states considerable authority to define parameters for pediatric ACOs, unlike ACOs established under the Medicare Shared Savings Program.[20]

Payment Innovations

National Pilot Program on Medicare Payment Bundling

The Affordable Care Act established a pilot program aimed at encouraging hospitals and physicians to improve patient care and achieve savings for Medicare by implementing bundled payment models. Under the program, CMS will link payments for multiple services that patients receive during an episode of care and will evaluate how services surrounding an episode of acute care can be integrated to improve the coordination, quality, and efficiency of Medicare services.[20] Bundled payments are discussed more thoroughly in Module 5.

Pharmaceuticals

Discounts to Medicare Part D Enrollees

Beginning in January 2011, a new Medicare coverage gap discount program began to provide a 50 percent discount on brand-name drugs to Medicare Part D enrollees who spend enough money on prescription drugs to enter the *doughnut hole*. Medicare enrollees enter the doughnut hole when they reach Medicare Part D's initial coverage limit for prescription drugs and become responsible for 100 percent of their drug costs until they become eligible for catastrophic coverage. Under the Affordable Care Act, additional discounts on brand-name and generic drugs will be phased in to completely close the doughnut hole by 2020.[20]

Hospital and Other Quality Initiatives

Medicaid Payment for Health Care Acquired Conditions

The HHS Secretary was charged with developing, by July 1, 2011, regulations prohibiting Medicaid from paying for costs associated with treating certain health care acquired conditions. To develop a list of health care acquired conditions for use in the Medicaid program, the Secretary identified current state practices that prohibit payment for health care acquired conditions.[20]

Reducing Avoidable Hospital Readmissions in Medicare

For discharges from hospitals occurring on or after October 1, 2012, there will be a reduction in inpatient hospital reimbursement for hospitals with excess hospital readmissions for certain

conditions. The HHS Secretary named the first three conditions—heart attacks, congestive heart failure, and pneumonia—and will incorporate additional conditions by 2015.[20]

Medicare Hospital Value-Based Purchasing Program

For hospital discharges occurring on or after October 1, 2012, a percentage of hospital reimbursement will be tied to hospital performance on quality measures related to common and high-cost conditions. This provision requires the HHS Secretary to select measures, other than measures of readmissions, and requires that quality measures chosen for fiscal year 2013 cover at least the following—

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Surgeries
- Health care-associated infections.[20]

Medicare Payment Adjustment for Conditions Acquired in Hospitals

Beginning October 2014, hospitals in the top 25th percentile for rates of hospital-acquired conditions will be subject to a 1 percent payment penalty under Medicare.[20]

Disproportionate Share Hospital Payments

Reductions in Medicaid Disproportionate Share Hospital Payments to States

Because the original goal of the Affordable Care Act was to expand coverage to millions of currently uninsured Americans, Congress targeted Medicaid disproportionate share hospital (DSH) payments for a reduction. The DSH program is discussed in detail in Module 5. Congress reasoned that the DSH program will not need to be funded at its current level because hospitals now receiving DSH payments to cushion the blow of providing uncompensated care will instead receive reimbursement from Medicaid or other insurance plans once the Affordable Care Act is in effect.

DSH payments will decrease by $14.1 billion between 2014 and 2020, with the reduction per year more heavily weighted toward the end of the decade. DSH cuts will be split among states based on the overall size of DSH participation per state. When making DSH allocation decisions, the HHS Secretary is instructed to look at the percentage of a state's reduction in the uninsured and whether a state targets DSH funds to hospitals with high Medicaid volumes or uncompensated care.[25]

Medicare Disproportionate Share Hospital Payment Reductions

Beginning in October 2013, Medicare DSH payments—payments made to hospitals that provide a large amount of care to patients with low income—will be reduced by 75 percent. The Medicaid DSH program is discussed more fully in Module 5.[20]

Examples

The Medicaid program and the Affordable Care Act provide tools to improve care and services for individuals with behavioral health needs and to undertake system reform. Development, enactment, and implementation of MHPAEA and the Affordable Care Act provide a strong public policy platform to remedy the historic disparity between: (1) the *benefits* provided in the

physical and behavioral health systems (e.g., absence of the provision of needed behavioral health treatments), and (2) the *system requirements* (e.g., limitations on behavioral health services, dissimilarities between behavioral and physical health benefits). However, it is imperative that policymakers, stakeholders, and advocates remain engaged and vocal in keeping the importance of these issues at the forefront of policy discussions. The significance of a state's decision to implement the Medicaid expansion to those served in our nation's behavioral health system cannot be overstated. Extending Medicaid to individuals earning up to 133 percent of the federal poverty guideline will provide access to behavioral health coverage for millions of individuals who previously did not have access to services or had access to services paid only with state funds.

For example, in Missouri, expanding Medicaid would provide coverage to an additional 300,000 Missourians; an estimated 50,000 of these previously uninsured Missourians would seek mental health services, including treatment for SMI.[26] Likewise, Michigan estimates that its mental health program would save approximately $175 million in general fund/general purpose dollars by expanding Medicaid. Over 10 years, that would lead to about $2 billion in savings to the state.[27] These are not small numbers. It is incumbent upon behavioral health stakeholders to ensure that state Medicaid officials understand the benefits of Medicaid expansion to the Medicaid and behavioral health programs and to their state and local economies.

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Medicaid Handbook: Interface with Behavioral Health Services

Module 8

The Relationship between Medicare and Medicaid

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Module 8: The Relationship Between Medicare and Medicaid

Although this handbook is focused on providing *Medicaid* information to state M/SUD staff, any such discussion would be incomplete without a dialogue about *Medicare's* role in providing behavioral health benefits.

Medicare is a health insurance program primarily for older adults and people with disabilities. Unlike Medicaid, Medicare is administered entirely by the federal government. Medicare funding comes from several sources, including Medicare payroll taxes, beneficiary premiums, and federal general revenue. The Medicare law is set forth in Title XVIII of the Social Security Act.

Medicare provides services to individuals who are eligible only for Medicare and to individuals who are eligible for Medicare *and* Medicaid. The latter population is commonly known as *Medicare-Medicaid enrollees*. In the past they were sometimes called *dual eligibles*, although this terminology has been replaced with *individuals who are dually eligible* for both programs. Medicare coverage is primary to Medicaid coverage for individuals enrolled in both programs. This means that Medicaid is the payer of last resort.

Many individuals with mental disorders are Medicare-Medicaid enrollees. For example, in a research study conducted by the BeST Center, BeST used Ohio Medicaid claims data to identify adults with serious mental illness (SMI). The study indicates that the majority of adults diagnosed with schizophrenia or psychosis are eligible for both Medicaid and Medicare.[1] The discussion below of service utilization and costs associated with Medicare-Medicaid enrollees shows that they are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs, and they are heavy users of behavioral health services.

Affordable Care Act Emphasis on Medicare-Medicaid Enrollees

Individuals enrolled in both Medicare and Medicaid must navigate two separate systems in order to access the full range of health services to which they are entitled. This results in care that is often uncoordinated, inefficient, and costly.

Understanding that there are unique opportunities to improve the service delivery and payment systems for care provided to Medicare-Medicaid enrollees, Congress created in the Affordable Care Act the Medicare-Medicaid Coordination Office within CMS. This office is charged with making the two programs work together more effectively in order to improve care and lower costs. This collaboration is enabling states and the Center for Medicare & Medicaid Services (CMS) to work together to design coordinated efforts to improve care, share data, and share savings. These efforts were never possible before. Specifically, the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees, simplifying processes, and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, states, and the federal government.[2]

In conjunction with this effort, in April 2011 CMMI launched a project titled *State Demonstrations to Integrate Care for Dual Eligible Individuals*. Under the project, CMS is

working with 15 states to design person-centered approaches to better coordinate care for Medicare-Medicaid enrollees. The goal is to develop, test and validate integrated delivery system and care coordination models that can be replicated in other states.[3]

The states selected to receive design contracts are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. Each state will be awarded up $1 million to develop a model that describes how it will structure and implement its planned intervention. States that engage with beneficiaries and other stakeholders and successfully complete their design contract may be eligible to receive support to implement their proposals. After federal review of the proposals, CMS will work with states to implement the plans that hold the most promise.[3]

A key component of these initiatives will be testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs between Medicare and Medicaid.[3] Some states whose planning efforts are not funded under the demonstration are pursuing integrated care delivery systems without the aid of federal funding. CMS is providing technical assistance to these states.

Some of the goals that characterize projects proposed by the states selected to receive design contracts are—

- Create an accountable care organization (ACO) with embedded medical education programs that specifically serve high-cost patients that are eligible for both Medicare and Medicaid.
- Explore the feasibility of establishing a benefit plan and network—administered and operated by the state—that combines the funding streams from Medicare and Medicaid and uses these funds to purchase coverage through a plan and network developed and administered by the state.
- Expand the state's Program of All-Inclusive Care for the Elderly (PACE).
- Expand the state's Medicaid program being administered through a managed care program to include Medicare Part A and B services.
- Establish local Integrated Care Organizations to create a single point of accountability for the delivery, coordination, and management of primary, preventive, acute, and behavioral health that is integrated with long-term supports and services and medication management for Medicare-Medicaid enrollees.[4]

Who is Eligible for Medicare?

To be eligible for Medicare, individuals must be: aged 65 years or older, younger than age 65 with a disability, or any age with end-stage renal disease (ESRD). Additional eligibility criteria also apply for these categories of individuals.

Generally, individuals who meet all of the criteria for Social Security disability are automatically enrolled in Medicare Parts A and B. Individuals younger than age 65 with a mental disorder, as defined by the Social Security program, may be eligible for Medicare by virtue of their entitlement to Social Security disability benefits status.

Many individuals younger than age 65 qualify for Medicare because of a mental disorder, as defined by the Social Security Administration. Under the Social Security program, the evaluation of disability *on the basis of mental disorders* requires documentation of a medically determinable impairment, consideration of the degree of limitation such impairment may impose on the individual's ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. *Substance addiction disorders* are included in the list of nine diagnostic categories of mental disorders.[5]

Although some individuals qualify for Medicare specifically *because* of the presence of a Social Security-approved mental disorder, many additional Medicare enrollees experience behavioral health needs. SMIs are especially prevalent among individuals younger than age 65 who are eligible for Medicare because of a disability. Approximately 37 percent of Medicare beneficiaries who are eligible because of a disability have a SMI.[6] Medicare enrollees aged 65 and older also may have behavioral health needs.

Who Are Medicare-Medicaid Enrollees?

Medicare-Medicaid enrollees may be: (1) receiving Medicare and full Medicaid benefits, (2) receiving assistance from a state's Medicaid program to pay their Medicare premiums and, in some cases, cost sharing, or (3) receiving assistance in paying Medicare out-of-pocket costs *and* receiving full Medicaid benefits.[7]

As of 2007, more than 9 million Americans were enrolled in both Medicare and Medicaid. At that time, two-thirds of the Medicare-Medicaid enrollee population was low-income elderly, whereas one-third were individuals younger than age 65 with a disability.[8] As of 2009, about 12 percent of Medicare-Medicaid enrollees were enrolled in a *Medicaid* managed care plan; 15 percent were enrolled in a private *Medicare* Advantage plan.[9] Medicaid managed care is discussed more fully in Module 5.

Utilization and Cost

There is significant variation in the needs of Medicare-Medicaid enrollees. For example, a June 2011 MedPAC report to Congress indicates that although more than 25 percent have three or more limitations in the ability to perform activities of daily living, almost half have no such limitations. [10] In terms of clinical conditions, 19 percent of full benefit Medicare-Medicaid enrollees have five or more chronic conditions, whereas 34 percent have one or two and 24 percent have none.[7] These disparities indicate that the amount of care coordination needed by Medicare-Medicaid enrollees varies drastically—as does the related cost of the care.

Individuals enrolled in both Medicare and Medicaid generally have the most complex conditions and generate the highest costs for both programs. For example:

- In 2007, the total annual spending for the care of Medicare-Medicaid enrollees was $229 billion across both programs.[7]
- In the Medicaid program, these individuals represent 15 percent of enrollees but 35 percent of all Medicaid expenditures.[7]
- In Medicare, they represent 20 percent of enrollees and 32 percent of program expenditures.[7]

- Medicare-Medicaid enrollees' health costs are nearly five times greater than those of all other people with Medicare.
- Compared with all other Medicaid enrollees, Medicare-Medicaid enrollees' health costs are nearly six times greater.
- Medicare-Medicaid enrollees are three times more likely to have a disability, and overall these individuals have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.[8]

Some social characteristics are known about Medicare-Medicaid enrollees, as demonstrated in Table 8-1. For example:

- Overall, Medicare-Medicaid enrollees have less education and much lower income than all other individuals enrolled in Medicare.
- Medicare-Medicaid enrollees are more likely than Medicare enrollees who are not dually eligible to have mental health needs.
- Medicare-Medicaid enrollees have more significant and costly health needs and require more long-term services and supports than Medicare enrollees who are not dually eligible.[11]

Table 8-1 Comparison of Medicare-Medicaid Enrollees and All Other Medicare Enrollees, Based on Data from the Kaiser Commission (2011).

Characteristic	Medicare-Medicaid Enrollees (%)	All Other Medicare Enrollees (%)
Less than high school education	52	19
Income less than $10,000/year	55	6
Cognitive or mental disorder	54	24
Fair to poor overall health	50	22
Nonelderly disabled	41	11
Long-term care residents	15	2

What Services Does Medicare Cover?

Medicare has four different parts that help cover specific services:

- **Part A** is known as hospital insurance. Medicare Part A helps cover medically necessary inpatient care in hospitals, including critical access hospitals and psychiatric hospitals and care in skilled nursing facilities (not custodial or long-term care). Part A also helps cover hospice care and some home health care.[12]

Most individuals do *not* pay a premium for Part A because they or a spouse have already contributed through payroll taxes deducted during their working years. Some individuals can enroll in Part A if they pay a monthly premium, which was $441 in 2013.[13]

An individual can get Medicare Part A at age 65 *without* having to pay a premium if:

- He or she already gets retirement benefits from Social Security or the Railroad Retirement Board.
- He or she is eligible to get Social Security or Railroad benefits but has not yet filed for them.
- The individual or his or her spouse had Medicare-covered government employment.

An individual younger than age 65 can get Medicare Part A without having to pay a premium if he or she:

- Received Social Security or Railroad Retirement Board disability benefits for 24 months; individuals with amyotrophic lateral sclerosis qualify the month disability benefits begin.
- Has ESRD and meets certain requirements.[14]

Regardless of their eligibility for Medicaid benefits, Medicare beneficiaries with limited resources and income can get their Medicare Part A premiums and, in some cases, Medicare Part A coinsurance and deductibles paid by Medicaid.

- **Part B** is known as supplementary medical insurance. Medicare Part B helps cover medically necessary doctors' services, outpatient care, durable medical equipment, and preventive services. It also covers some other medical services that Part A does not cover, such as physical and occupational therapy and some home health care.[12] Most individuals pay a monthly premium for Part B. The standard Part B monthly premium in 2012 is $104.90.[13] Individuals with higher income pay a higher premium. If an individual decides not to enroll in Part B when he or she is first eligible, there may be a penalty to pay if the individual enrolls later.

Regardless of their eligibility for Medicaid benefits, Medicare beneficiaries with limited resources and income can get their Medicare Part B premiums and, in some cases, Medicare Part B coinsurance and deductibles paid by Medicaid.

- **Part D** is prescription drug coverage. This coverage is available from Medicare-approved private insurance companies from which individuals choose their drug plan. Part D plans can vary in deductibles, copayments or coinsurance, specific drugs covered, and premiums. Most individuals pay a monthly premium for this benefit. As with Part B premiums, individuals with higher income pay more. In addition, if an individual decides not to enroll in a drug plan when he or she is first eligible, there may be a penalty to pay if the individual joins later.[12]

Medicare beneficiaries with limited resources and income can get extra help from Medicare in paying out-of-pocket costs under Medicare Part D.[15] This is known as the Low Income Subsidy.

- **Part C**—also known as *Medicare Advantage*—is *not* a defined benefit. Rather, Part C makes Part A and B benefits and services available through private Medicare-approved health plans for most individuals who are eligible for Medicare. Individuals with ESRD are not eligible to enroll in a Part C plan; however, if they develop ESRD

while enrolled in Part C, they can stay. Medicare Advantage Plans must follow rules established by Medicare. They must cover Part A and B services—except hospice care—but they can have different rules for how individuals access services such as specialty care or non-urgent care. Most Medicare Advantage Plans also cover Medicare prescription drug coverage (Part D). Some Advantage Plans include extra benefits such as hearing, vision and dental coverage, although there may be an additional cost.[16] Premiums for Part C vary by plan.

Behavioral Health Services Covered by Medicare

Behavioral health service coverage under traditional Medicare includes medically necessary services to diagnose and treat behavioral health conditions. Medicare helps cover outpatient and inpatient behavioral health care as well as prescription drugs. Individuals who receive Medicare coverage through a Medicare Advantage Plan are covered for the same behavioral health services as those provided by traditional Medicare, although deductibles, coinsurance, or copayments may differ.[17]

Medicare Part A (hospital insurance) helps cover medically necessary inpatient hospital behavioral health care provided in a general hospital or in a psychiatric hospital. Medicare Part A covers an individual's room, meals, nursing care, and other related services and supplies. Medicare Part A does *not* cover the cost of private duty nursing, a telephone or television in an individual's room, personal items (like toothpaste or socks), or a private room unless medically necessary.[17]

Medicare Part A measures use of hospital services, including services an individual receives in a psychiatric hospital, based on benefit periods. A *benefit period* begins the day an individual is admitted to a hospital or skilled nursing facility for physical or mental health care and ends after the individual has not had hospital or skilled nursing care for 60 consecutive days. A new benefit period begins after 60 days without hospitalization have passed. There is no limit to the number of benefit periods an individual can have when he or she receives behavioral health care in a general hospital; however, deductibles and coinsurance apply to certain days of the hospital stay within a benefit period and there is a *lifetime coverage limit* of 60 hospital days beyond the 90th day in each benefit period. An individual can also have multiple benefit periods when he or she receives care in a psychiatric hospital, but Medicare imposes a *lifetime coverage limit* of 190 days of inpatient psychiatric hospital services provided in a psychiatric hospital.[17]

Medicare Part A also covers alcohol detoxification and rehabilitation services furnished as inpatient hospital services. Both diagnostic and therapeutic services for treating alcoholism are covered in an outpatient hospital setting. Treatment for drug abuse or other chemical dependency also is covered.

Medicare Part B (medical insurance) helps cover medically necessary outpatient behavioral health services, including visits with a psychiatrist or other physician, visits with a clinical psychologist or clinical social worker, and laboratory tests ordered by a physician. Outpatient mental health services covered under Part B may be provided in a clinic, doctor's or therapist's office, or hospital outpatient department. Services must be provided by licensed professionals permitted by state professional practice acts.[17]

Medicare helps cover the following outpatient services under Part B—

- Individual and group psychotherapy with physicians or certain other licensed professionals who are allowed by the state to provide these services
- Family counseling, if the main purpose is to help with treatment
- Testing to determine if the individual is getting the services he or she needs and/or if current treatment is helping
- Psychiatric evaluation
- Medication management
- Occupational therapy that is part of the individual's mental health treatment
- Certain prescription drugs that are not usually self-administered, such as some injections
- Individual patient training and education about the individual's condition
- Diagnostic tests
- Annual depression screening in a primary care setting that can provide follow up treatment and referrals[17]
- Annual alcohol misuse screening with brief counseling sessions for those who screen positive
- Counseling for smoking and tobacco use cessation, including intermediate and intensive counseling levels

Medicare Part B may pay for partial hospitalization services associated with treating mental illness. Partial hospitalization is a structured program of outpatient active psychiatric treatment that is more intense than standard outpatient mental health services delivered in a physician's or therapist's office. Partial hospitalization is provided during the day and does not involve an overnight stay. These programs are usually provided through hospital outpatient departments and local CMHCs. For Medicare to cover a partial hospitalization program, a physician must certify that the individual would otherwise need inpatient psychiatric treatment.[17]

Medicare Part B also covers structured assessment and brief intervention provided in a doctor's office or outpatient hospital department for substance use (other than tobacco). This is related to the screening, brief intervention, and referral to treatment (SBIRT) services recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA); CMS uses the SBIRT acronym for the structured assessment and brief intervention covered by Part B, without referring to the original name.

After an individual pays his or her Medicare Part B deductible, the amount of coinsurance for behavioral health services under traditional Medicare depends largely on whether the service is diagnostic or therapeutic.[17] The copayment amount for a diagnostic service, as well as brief visits for managing medications of mentally ill patients, is 20 percent; in 2012, the copayment for most other outpatient behavioral health treatment services was 40 percent, but it will fall to 20 percent by 2014.

Medicare Part B does *not* cover the following services:

- Meals
- Transportation to or from mental health care services

- Support groups that bring people together to talk and socialize (unlike group psychotherapy, which is covered)
- Testing or training for job-related skills that are not part of mental health treatment.[17]

Medicare Part D (prescription drug coverage) helps cover prescription drugs needed to treat a mental disorder as well as prescribed smoking and tobacco use cessation agents. Almost all Medicare drug plans have a list of drugs that the plan covers, called a *formulary*. Medicare drug plans generally are not required to cover all drugs, but they *are* required to cover all or almost all antidepressant, anticonvulsant, and antipsychotic medications that may be necessary to keep an individual "mentally healthy." Medicare reviews each drug plan's formulary to ensure that it includes a wide range of medically necessary drugs and that it does not discriminate against certain groups, such as individuals with disabilities or mental health conditions.[17] Medicare drug plans are *not* required to cover certain kinds of drugs, such as benzodiazepines and barbiturates. Some Medicare drug plans may *choose* to cover these drugs as an added benefit.

Additionally, a state Medicaid program may cover these drugs for individuals enrolled in *Medicaid*, so Medicare-Medicaid enrollees may be able to access coverage through Medicaid if Medicare does not cover a particular drug. If a physician believes that an individual needs a particular drug not covered by his or her Medicare drug plan, the individual can ask the drug plan to make an exception.[17]

Prescription Medications, Medicare Part D, and Medicaid Implications

With the advent of Medicare Part D in 2006, the major financial responsibility for prescription medications for those dually enrolled in Medicare and Medicaid was transferred from Medicaid to Medicare. Medicare Part D plans provide coverage for most antidepressant, anticonvulsant, and antipsychotic medications; however, these plans are not required to include coverage for benzodiazepines, barbiturates, or drugs for weight loss or gain, although many plans choose to provide this coverage. For those dually enrolled, medications not covered by Medicare may be covered by Medicaid, depending on the state.

Nationwide, Medicaid spending on all prescription drugs in 2006 fell by almost 50% of the 2005 level when financial responsibility for medications for dually enrolled individuals was transferred to Medicare Part D.[18]

Behavioral Health Providers Covered by Medicare

Medicare Parts A and B cover services delivered in or by the following providers:

- General hospital
- Psychiatric hospital that cares only for people with mental health conditions
- Psychiatrist or other doctor
- Clinical psychologist
- Clinical social workers
- Clinical nurse specialists
- Nurse practitioner
- Physician's assistant

Certain conditions apply. For example, services of some providers must be performed under the general supervision of a physician. Providers also must be legally authorized to perform the services in the state.

Summary

The CMS focus on coordinating and integrating care for Medicare-Medicaid enrollees, coupled with the state's commitment to implement such programs, highlights a new opportunity to improve care and outcomes for this population—many of which have mental and substance use disorders. As these initiatives continue to grow and mature, it is imperative for behavioral health policymakers to be attuned to developments and involved in shaping policy in ways that help ensure success for consumers and providers.

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