

Medicaid Handbook: Interface with Behavioral Health Services

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Medicaid Handbook: Interface with Behavioral Health Services

Table of Contents, Introduction
and Glossary

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Acknowledgments

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Introduction

Target Audience

The target audience for this Medicaid handbook is composed of—

- State directors and administrators of mental or substance use disorder (M/SUD) services agencies
- Staff of state directors and administrators of M/SUD services agencies
- State network organizations for behavioral health services
- State Medicaid Authority staff involved with M/SUD services.

Generally, this handbook should prove useful to anyone wishing to learn the fundamental principles of Medicaid and apply them to their existing knowledge of behavioral health services.

Purpose

This handbook is intended to provide the reader with a basic understanding of the Medicaid program. There is a specific emphasis on the interplay between Medicaid principles and behavioral health services. The goal is for the reader to navigate his or her state Medicaid program so that he or she can contribute meaningfully to policy conversations related to provision of behavioral health services to individuals who are eligible for Medicaid.

Throughout this document, the term *behavioral health* encompasses both mental and substance use disorders. When a mental or substance use disorder is addressed singularly, the reference will be only to that disorder.

Because each state's Medicaid program is different from all others and because Medicaid laws and policies are ever changing, this handbook cannot contemplate every permutation of program construction. Rather, it is intended to provide enough structural framework and references to primary source documentation that someone wishing to gain a deeper understanding of his or her state's program will have the necessary tools.

Layout of Handbook

This handbook is arranged in a modular format so that portions that become irrelevant and/or outdated can be removed and updated material can be added.

At some point in the future, the handbook will also become available on the SAMHSA website for the Center for Financing Reform and Innovations (CFRI).

The hard copy handbook and website materials also may be used with webinars and learning collaboratives focused on Medicaid in general or specific Medicaid topics.

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Glossary

Term	Acronym	Definition
Accountable Care Organizations	ACO	Group of providers (e.g., hospitals, physicians, others involved in patient care) that works together to coordinate care for the patients it serves.
Affordable Care Act		Also known as the Patient Protection and Affordable Care Act of 2010. Federal health care reform legislation signed into law by President Obama on March 23, 2010.
Aged, Blind, and Disabled	ABD	A category of Medicaid-eligible individuals who are elderly, blind, and/or disabled.
Agency for Healthcare Research and Quality	AHRQ	
Aid to Families with Dependent Children	AFDC	
Arizona Acute Care Program	AACP	
Arizona Long-Term Care System	ALTCS	
Assertive Community Treatment	ACT	
Assistant Secretary for Planning and Evaluation	ASPE	
Behavioral Health Organization	BHO	
Best Practices in Schizophrenia Treatment	BeST	
Body Mass Index	BMI	

Term	Acronym	Definition
Capitation		Reimbursement methodology whereby a managed care plan receives a set per-member, per-month (PMPM) fee for services it provides or arranges, regardless of each consumer's service utilization and related cost to the managed care organization (MCO).
Case Management		Care coordination of all services for which a Medicaid consumer is eligible, including physical and behavioral health and community supports. It includes development and maintenance of an individualized care plan.
Center for Medicare & Medicaid Innovation	CMMI	
Centers for Medicare & Medicaid Services	CMS	One of several operating divisions of the United States Department of Health and Human Services (HHS). Among other activities, it is responsible for administering Medicaid, the Children's Health Insurance Program (CHIP), and Medicare.
Central Office	CO	
Certified Public Expenditure	CPE	Funds certified by a contributing public agency or provider owned by a state, county, or city as representing expenditures for which federal matching payment is allowable.
Children's Health Insurance Program	CHIP	Health insurance block grant program for children that is administered and financed jointly by the federal and state governments. A state may administer its CHIP as a Medicaid expansion, a separate program, or a combination of the two.

Term	Acronym	Definition
Children's Health Insurance Program Reauthorization Act of 2009	CHIPRA	
Code of Federal Regulations	CFRs	
Community Mental Health Center	CMHC	
Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation	CEDARR	
Condition-Specific Case Rate	CCR	
Coordinated Care Organization	CCO	Community-based organization using patient-centered primary care homes, fixed global budgets, and efficiency and quality improvements to reduce costs.
Covered Families and Children	CFC	Medicaid-eligible children and parents.
Deficit Reduction Act	DRA	
Diagnosis-Related Group	DRG	
Diagnostic and Statistical Manual of Mental Disorders	DSM-IV-TR	
Disproportionate Share Hospital	DSH	Hospital that serves a disproportionately large number of uninsured and Medicaid consumers and is eligible for supplemental payments to defray the costs associated with providing care to this population.
Dually Eligible Person		Individual who is eligible for both the Medicaid and Medicare programs.

Term	Acronym	Definition
Early and Periodic Screening, Diagnosis, and Treatment	EPSDT	Federal requirement for states to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.
End-Stage Renal Disease	ESRD	
Enhanced Benefits Account	EBA	
Evidence-Informed Case Rate	ECR	
Federal Financial Participation	FFP	Medicaid share paid by the federal government.
Federal Medical Assistance Percentage	FMAP	Percentage of Medicaid reimbursement paid by the federal government.
Federally Qualified Health Center	FQHC	Safety-net providers of required primary and other optional services to Medicaid and uninsured individuals. Many FQHCs receive federal grant funding to help defray the cost of serving uninsured individuals.
Fee for Service	FFS	Reimbursement methodology whereby a provider renders a service to a Medicaid consumer, submits a bill to the state Medicaid agency, and is paid a fee by the Medicaid agency for the provision of that service.
Government Accountability Office	GAO	
Health Homes		Team of providers providing patient-centered, integrated physical and behavioral health care. Section 2703 of the Affordable Care Act includes specific provisions related to health homes for individuals with chronic conditions.

Term	Acronym	Definition
Health Maintenance Organization	HMO	
Health Resources and Services Administration	HRSA	The primary federal agency within HHS that is responsible for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
Home and Community-Based Services	HCBS	Services and other supports to help people with disabilities of all ages live in the community.
Institute of Medicine	IOM	
Institution for Mental Diseases	IMD	Hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment, or care of persons with mental illness, including medical attention, nursing care, and related services.
Intergovernmental Transfer	IGT	Funds transferred from other state or local agencies to the administrative control of the state Medicaid agency in order to draw down federal matching dollars.
Intermediate Care Facility for the Developmentally Disabled	ICF-DD	
Joint Commission on Accreditation of Healthcare Organizations	JCAHO	
Local Management Entity	LME	
Managed Care		Medicaid program structure whereby a state contracts with an organization to provide services to Medicaid consumers through its own network of providers.
Managed Care Organization	MCO	

Term	Acronym	Definition
Medicaid		Health insurance program for individuals who are poor, elderly, or disabled, jointly administered by the federal government and each state government that operates a Medicaid program.
Medicaid and Children’s Health Insurance Program	MACPro	
Medicaid State Plan		Also called the State Plan. A state's contract with the federal government that delineates the Medicaid services it provides, the populations eligible for Medicaid, its reimbursement methodologies, and its program structure.
Medicare		Health insurance program for elderly and nonelderly disabled individuals financed and administered by the federal government.
Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000	BIPA	
Medicare-Medicaid Enrollee		Individual who is simultaneously enrolled in both the Medicare and Medicaid programs
Medication Assisted Treatment	MAT	
Mental or Substance Use Disorder	M/SUD	
Mental Health Parity Act of 1996	MHPA	
Mental Health Parity and Addiction Equity Act of 2008	MHPAEA	Federal legislation passed in 2008 intended to align insured health care benefits for M/SUDs with those for medical/surgical procedures.
Mental Health Plan	MHP	
Money Follows the Person	MFP	

Term	Acronym	Definition
National Institutional Reimbursement Team	NIRT	
National Non-Institutional Provider Team	NIPT	
Omnibus Budget Reconciliation Act of 1990	OBRA '90	
Preferred Provider Organization	PPO	
Prepaid Ambulatory Health Plan	PAHP	
Prepaid Health Plan	PHP	
Prepaid Inpatient Health Plan	PIHP	
Primary Care Case Management	PCCM	
Primary Care Provider	PCP	
Program of All-Inclusive Care for the Elderly	PACE	
Provider Tax		Any mandatory payment, including licensing fees or assessments, for which at least 85 percent of the burden falls on health care providers. The tax can apply to health care items or services, or to the provision of or payment for such services.
Psychiatric Residential Treatment Facility	PRTF	Nonhospital setting where an individual younger than 21 years can receive inpatient psychiatric care.
Public Health Service	PHS	
Regional Behavioral Health Authority	RBHA	
Regional Office	RO	

Term	Acronym	Definition
Rehab Option		Service specified in a state's Medicaid State Plan that includes 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.
Request for Additional Information	RAI	
Screening, Brief Intervention, and Referral to Treatment	SBIRT	
Serious and Persistent Mental Illness	SPMI	A mental illness with complex symptoms that significantly impairs functioning, has a lengthy duration, and requires ongoing treatment and management, most often with varying types and dosages of medication and therapy.
Serious Emotional Disturbance	SED	
Serious Mental Illness	SMI	
Social Security Act		Federal legislation signed into law by President Franklin Delano Roosevelt in 1935 that initially provided financial support for retired workers aged 65 years and older (Social Security). The Act has been amended many times, including the addition of Medicare and Medicaid in 1965 and the CHIP in 1997.
Special Terms and Conditions	STCs	

Term	Acronym	Definition
State Plan		Also called the Medicaid State Plan. A state's contract with the federal government that delineates the Medicaid services it provides, the populations eligible for Medicaid, its reimbursement methodologies, and its program structure.
State Plan Amendment	SPA	An amendment to the State Plan. It must be submitted by the state to the federal government for CMS approval in order to change certain portions of the Medicaid program.
Substance Abuse and Mental Health Services Administration	SAMHSA	Federal agency that represents state M/SUD agencies.
Substance Use Disorder	SUD	Dependence on or abuse of a drug or alcohol.
Targeted Case Management	TCM	Case management that is restricted to specific beneficiary groups. Targeted beneficiary groups may be defined by disease or medical condition or by geographic regions.
Upper Payment Limit	UPL	Federal prohibition against states paying certain classifications of facilities more than Medicare would pay for the same services.
U.S. Department of Health and Human Services	HHS	
U.S. Preventive Services Task Force	USPSTF	

Term	Acronym	Definition
Waiver		<p>Contractual agreement between the federal and state government that allows a state to not comply with certain federal Medicaid requirements codified in the Social Security Act. The following are types of waivers a state may seek (all refer to sections of the Social Security Act being waived): §1115 waiver, §1915(a) waiver, §1915(b) waiver, §1915(c) waiver, and §1915(b)/(c) waiver.</p>

Medicaid Handbook: Interface with Behavioral Health Services

Module 1

Medicaid's Importance to Mental Health & Substance Use Services

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Module 1: Medicaid's Importance to Mental Health and Substance Use Services

What is Medicaid's Role in Behavioral Health Services?

Medicaid plays a significant role in the financing of treatment for mental or substance use disorders (M/SUDs). Together, services to treat mental and substance use conditions are referred to as *behavioral health services*. Although spending on behavioral health services is a small portion of all-health care spending (7.3 percent in 2005), it has a large impact on Medicaid spending. This is expected to increase under the Affordable Care Act's^A expansion of Medicaid coverage that is discussed more thoroughly in [Module 7](#).

The Federal-State Medicaid program is currently the single largest funder of behavioral health services.^B Nationally, Medicaid paid for 26 percent of behavioral health services, but only 17 percent of total all-health spending in 2005 (see Figure 1-1). "All-health spending" is the total spending on all behavioral health and physical health acute and long-term care services.^C

In addition to Medicaid paying for a large share of behavioral health services, behavioral health services account for a larger share of Medicaid benefits than it does of all health care services. Spending on behavioral health services accounted for 11 percent of Medicaid spending in 2005, but only 7 percent of spending by all-health care payers, as illustrated in Figure 1-2.

How Has Medicaid Spending on Behavioral Health Changed Over Time?

Medicaid spending on behavioral health treatment has increased from \$6.6 billion in 1986 and to \$35.7 billion in 2005. Along with the increase in spending, Medicaid's share of funding for behavioral health services has risen—from 16 percent to 26 percent of behavioral health spending (see Figure 1-3). Although other non-Medicaid state and local spending on behavioral health treatment has also increased (from \$11.5 billion in 1986 to \$28.2 billion in 2005), it has

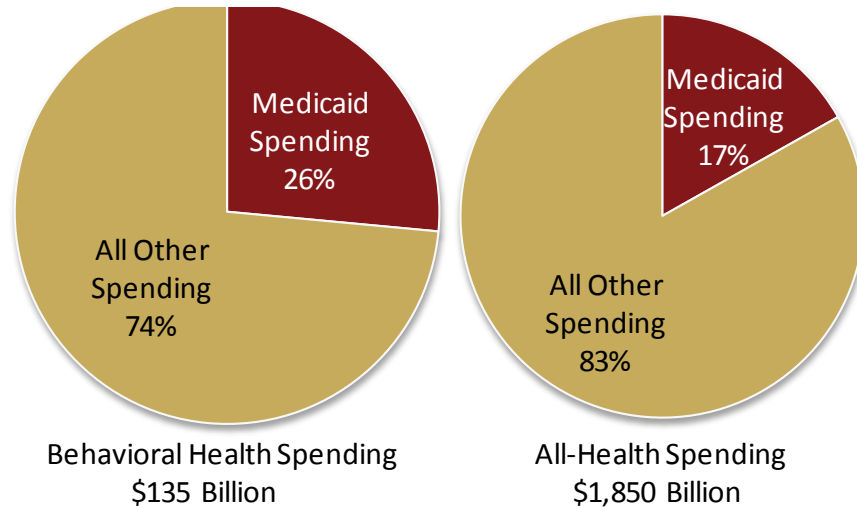
^A Throughout this handbook we refer to the federal health care legislation as the Affordable Care Act. In so doing, we mean both pieces of federal legislation (Public Law No: 111-148 and Public Law No: 111-152) that, together, are generally referred to as the Affordable Care Act or Patient Protection and Affordable Care Act.

^B International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes for mental disorders were used to identify provider services reported in this module when they were listed as the principle diagnosis. The ICD-9 codes used to define behavioral health were 291, 292, 295-304, 3050, 3052-3059, 306-314, 6483, 6484. Certain mental disorders were excluded: intellectual disabilities, developmental delays, dementias (e.g., Alzheimer's disease), and tobacco abuse. Psychotropic prescription medications purchased in retail pharmacies were captured by therapeutic class, including antianxiety agents, sedatives and hypnotics, antipsychotics, and antidepressants. Certain central nervous system stimulants and anticonvulsants were included if they had an accompanying behavioral health diagnosis. For treatment of SUDs, spending was included for buprenorphine to treat opioid addiction and for acamprosate, disulfiram, and naltrexone to treat alcohol addiction. Spending on methadone was captured as part of spending for specialty substance abuse centers where methadone is dispensed.

^C All health spending includes spending on hospital, physician, dental, other professional, home health, nursing home and public health services in addition to spending on prescription drugs, durable medical equipment, administrative costs for operating public programs and the net cost of private health insurance.

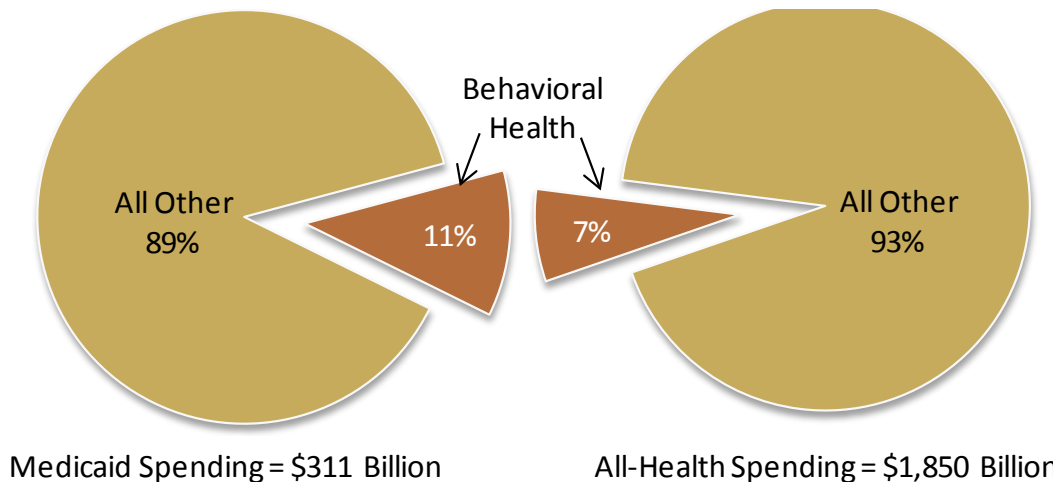
not risen as rapidly as overall behavioral health spending. This has resulted in non-Medicaid state and local spending falling as a share of behavioral health spending from 28 percent in 1986 to 21 percent in 2005, as illustrated in Figure 1-3.

Figure 1-1 Medicaid Paid for a Larger Share of Behavioral Health Spending Than All-Health Spending, 2005



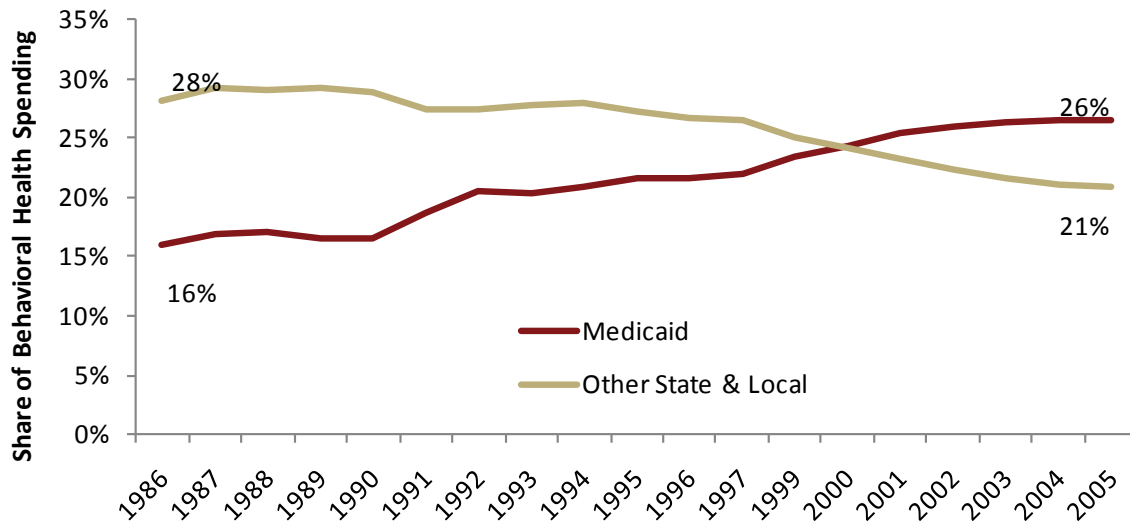
Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

Figure 1-2 Compared to All-Health, Medicaid Spends a Larger Share on Behavioral Health Services, 2005



Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

Figure 1-3 Behavioral Health Spending Share from Medicaid Increased While the Share From Other State and Local Funds Fell



Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

Because states vary greatly in services required by their populations, availability of behavioral health facilities and providers, and economic factors, the mechanisms states employ to leverage funding for behavioral health services also vary. For example, there is variation in the types of treatment services for M/SUDs covered under the *rehab option* and other Medicaid State Plan services across states, as well as waiver services. These options are discussed as part of the behavioral health benefit package section in [Module 3](#).

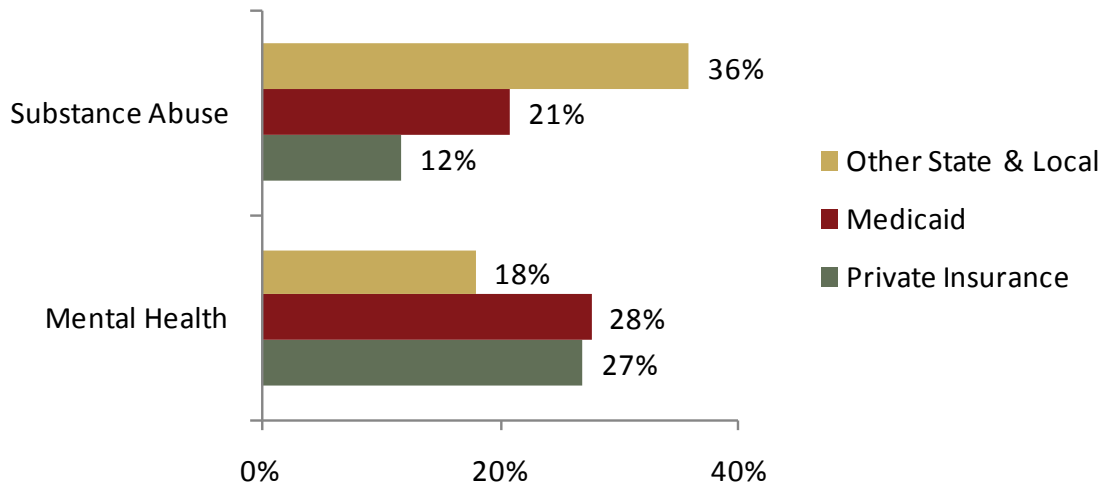
Historically, inpatient hospitalization in state hospitals was the main treatment option for many behavioral health conditions. Over time, state behavioral health agencies have moved aggressively to develop a robust array of community services and relationships to serve those with mental or substance use disorders. Medicaid financing has been a key to this shift. In many cases, the increasing reliance on Medicaid has facilitated the expansion of many needed and evidenced-based behavioral health services. For example, the number of Assertive Community Treatment (ACT) programs generally did not grow until states took steps to fund ACT through the Medicaid State Plan *rehab option*. Other behavioral health services that expanded under Medicaid include crisis intervention, case management, and partial hospitalization, as well as paying for medications. Despite dramatic expansion of community-based services and supports aided by Medicaid funding, Medicaid still has limits. For example, although Medicaid can pay for treatment, medications, and some recovery support services, it cannot pay for housing and some residential treatment.

How Does Medicaid Spending on Behavioral Health Compare to Spending by Other Payers?

Services designed to treat SUDs are more likely to be financed by state and local governments, along with federal block grants, than by other payers, such as private insurance and Medicaid.

The total demand and aggregate costs are much higher for mental health services than for treating SUDs; however, state and local governments pay for a larger share of all substance use treatment services than mental health services, as shown in Figure 1-4.

Figure 1-4 Financing Treatment of Substance Use Disorders is Concentrated in State and Local Governments, 2005



Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

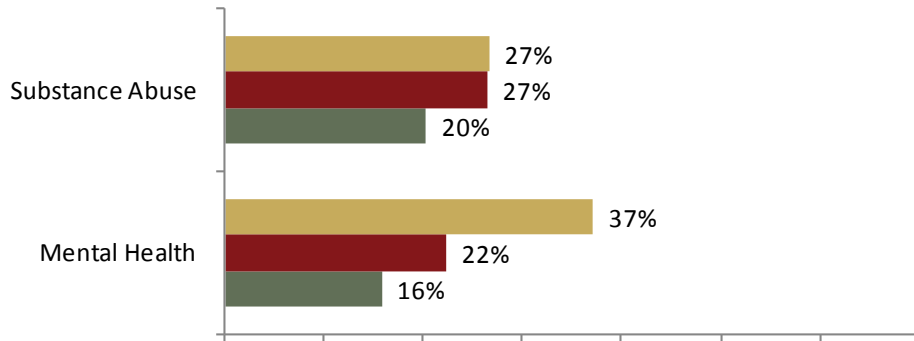
The primary source of payments for similar behavioral health services may be quite different when comparing mental health services to treatment for SUDs. For instance, because of federal restrictions, residential treatment services for SUDs rely primarily on state and local government funding. On the other hand, Medicaid is the largest single financier of mental health residential support services. This sometimes reflects inclusion of different types of treatment professionals or variations in programmatic approaches that may be more or less “medical” in nature.

The disparity between private insurance coverage and Medicaid and other state and local funding is smaller for inpatient services, but much more substantial for residential treatment, as shown in Figure 1-5.

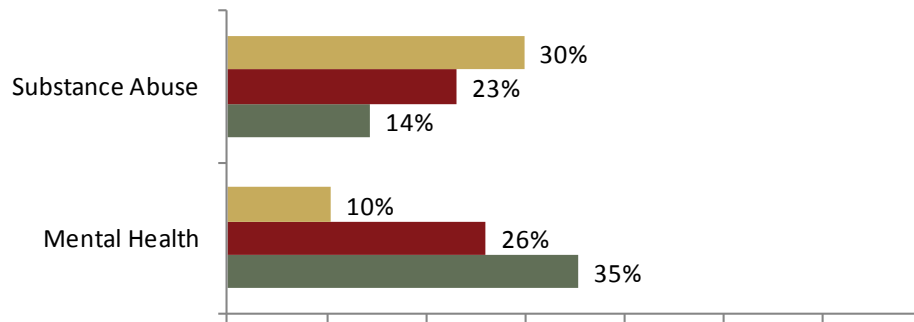
Historically, private health insurance has not covered inpatient hospitalization in state psychiatric hospitals, as well as some other services provided through the publicly funded behavioral health system. Thus, these publicly funded behavioral health services were primarily viewed as safety-net services. This has led to a disparity in funding from private health insurance for outpatient treatment of SUDs and of all residential services. In addition to changes resulting from the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 plays an important role in addressing this disparity, as discussed in [Module 7](#).

Figure 1-5 Residential Treatment for Substance Use Disorders are Largely the Responsibility of State and Local Governments, 2005

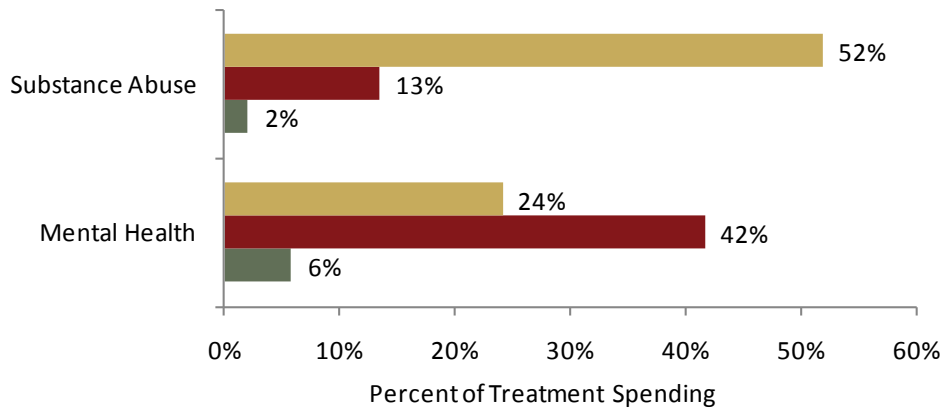
Inpatient Behavioral Health Services



Outpatient Behavioral Health Services



Residential Behavioral Health Services



■ Other State & Local ■ Medicaid ■ Private Insurance

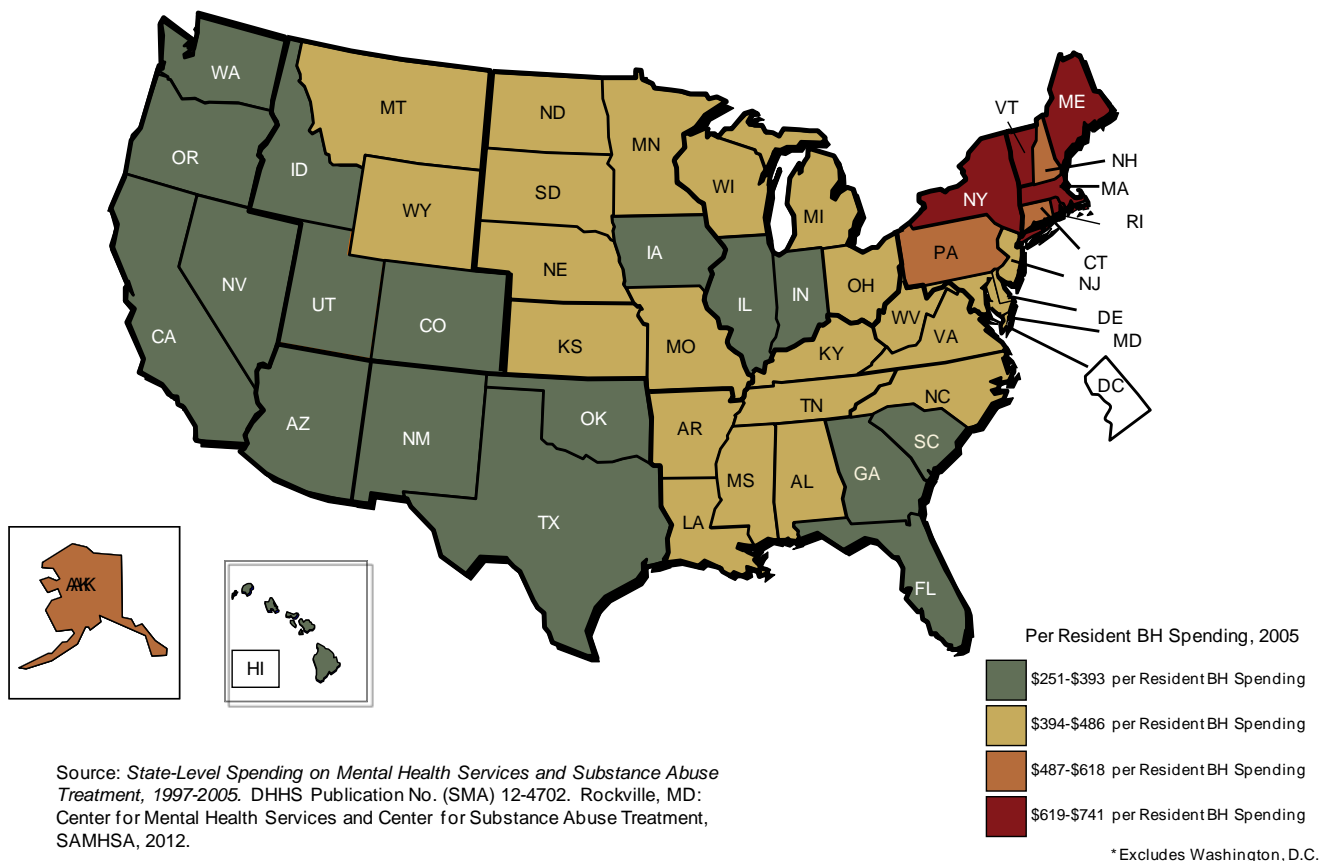
Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

What Is the Impact of Behavioral Health Spending by State?

Spending per person on behavioral health services varies considerably by state. This reflects a number of factors, including the behavioral health services needs of the population, accessibility of behavioral health care facilities and providers, size of the behavioral health workforce, availability of funding, regional variations in health care payments, and other economic and noneconomic factors.

In 2005, behavioral health spending on services averaged \$423 per person across all U.S. residents. As shown in Figure 1-6, regional spending per resident ranged from \$309 in the Southwest to \$646 in New England. In the Southeast, Great Lakes, and Plains, behavioral health spending per resident was closer to the U.S. average (\$394, \$401, and \$435 per person, respectively). By state, spending ranged from \$251 per resident in Nevada to almost three times as much in Vermont (\$741 per person).

Figure 1-6 Behavioral Health Spending per Resident was Highest in New England and Lowest in the Southwest and West in 2005

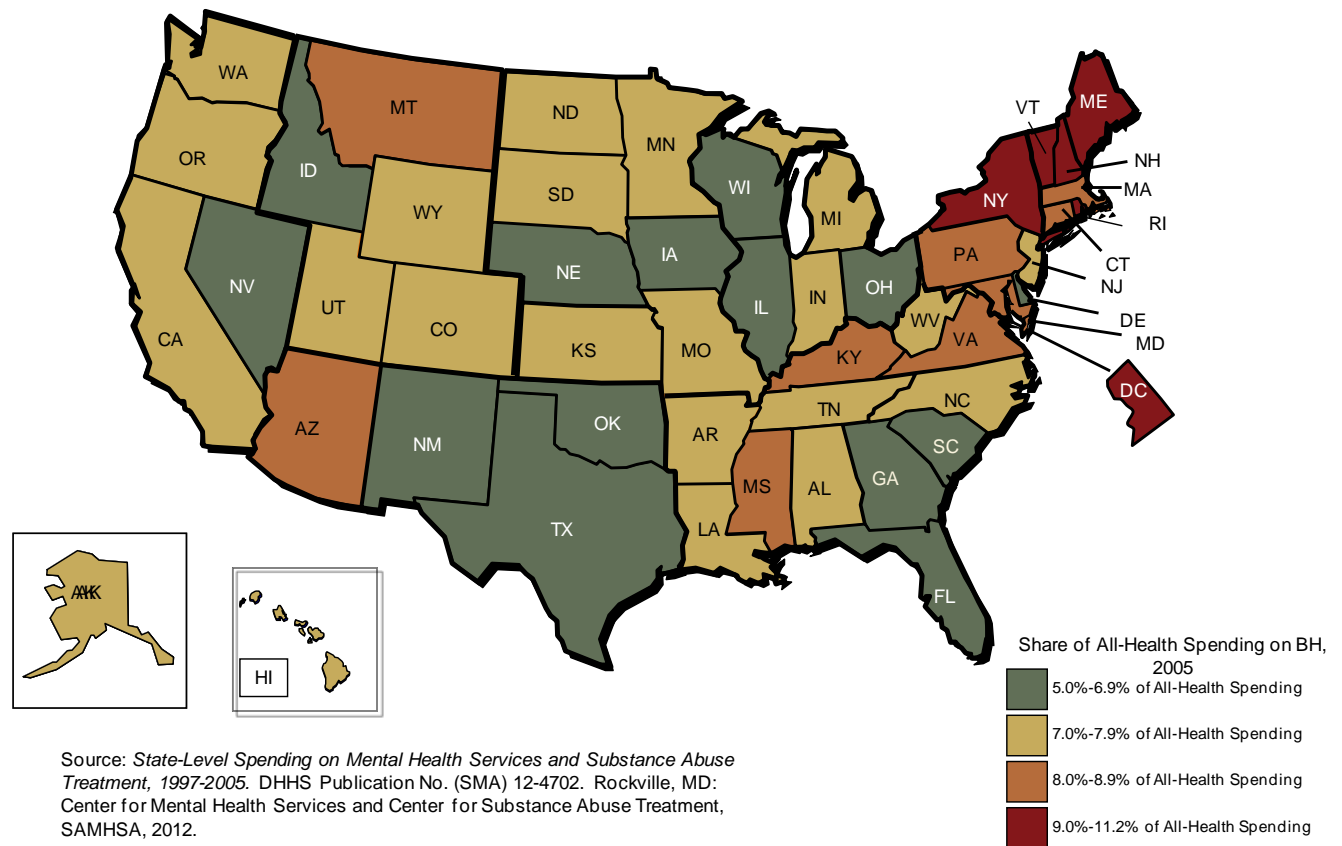


Nationwide, 7.4 percent of all-health spending was allocated to behavioral health services in 2005. Regionally, the behavioral health share of all-health spending ranged from 6.2 percent in the Southwest to 9.1 percent in New England. The regions with the highest share of all-health

spending allocated to behavioral health services (New England and the Mid-Atlantic states) also had the highest levels of behavioral health spending per resident.

By state, the behavioral health share of all-health spending ranged from 5.0 percent in Nevada to 11.7 percent in Vermont. In general, states that tend to spend more per resident on health care overall tend to allocate a larger share of those dollars to behavioral health services, as shown in Figure 1-7.

Figure 1-7 States with High Behavioral Health Spending per Resident Generally Spend a Higher Share on Behavioral Health Services



How Will Medicaid and Non-Medicaid Spending on Behavioral Health Change Under the Affordable Care Act?

The Affordable Care Act provides states with the option of extending Medicaid eligibility to individuals with incomes below 133 percent of the federal poverty guideline.^D Many of these uninsured individuals have mental illnesses and substance use disorders. In addition, behavioral health services are required as essential health benefits under the Affordable Care Act. These services must be covered at parity for health plans offered in the individual and small group markets and for Medicaid benchmark plans for the expansion population. This is especially

^D The option to extend Medicaid eligibility includes a five percent income disregard. Therefore, states may extend Medicaid eligibility to individuals with incomes below 139 percent of the federal poverty guideline.

important for treatment services for SUDs that have historically been covered in a very limited manner. In addition to eligibility and benefit changes, new options for care coordination, health homes with enhanced federal funding, new options for Medicare-Medicaid enrollees, and other initiatives hold promise for improving the quality and cost effectiveness of these services.

Thus, Medicaid is expected to increase its share of spending for behavioral health services under health care reform due to increased Medicaid enrollment in states that expand Medicaid coverage, as well as to provide better coverage and care options for those in need of behavioral health services. Until the Medicaid expansion is implemented in 2014, and indefinitely for states that choose not to expand Medicaid, uninsured individuals needing or receiving services are likely to be supported by state and local funds and federal block grants.

In 2010, there were approximately 18.3 million uninsured people in the United States. Data from the 2008–2010 National Survey on Drug Use and Health suggest that if every state were to expand Medicaid, an additional 1.3 million currently uninsured adults below 133 percent of the federal poverty level would have a serious mental illness (SMI) and would become eligible for Medicaid. This population is characterized by:

- Female sex (64 percent)
- Non-Hispanic, White (67 percent) race
- Metropolitan residence (42 percent)
- High school education (39 percent) or less (31 percent)
- Fair or poor health status (37 percent).

In addition, 2.7 million uninsured adults below 133 percent of the federal poverty level who had serious psychological distress would become eligible for Medicaid.

If every state were to expand Medicaid coverage, an additional 2.5 million currently uninsured adults below 133 percent of the federal poverty level would have a substance use disorder and would become eligible for Medicaid. This population is characterized by:

- Male sex (73 percent)
- Age 18 to 34 years (63 percent)
- Non-Hispanic, White (51 percent) or Hispanic (28 percent) race/ethnicity
- High school education (32 percent) or less (43 percent)
- Metropolitan residence (47 percent)
- Good (36 percent) or very good (28 percent) self-rated health.

Why Should State Behavioral Health Authorities Understand Medicaid?

In summary, Medicaid funding has been essential to the financing of behavioral health services in the United States. In recent years, Medicaid has become the largest financing source of behavioral health services as state governments rely increasingly on Medicaid to expand services by leveraging limited state revenue. However, within behavioral health services financing overall, state and local funding along with federal government block grant funds continue to be important payers of treatment for SUDs, particularly in residential treatment services.

As the Affordable Care Act extends Medicaid coverage to potentially millions of formerly uninsured adults—many of whom have mental illness and substance use disorders—it is important to understand Medicaid financing, in its own right, and to consider it in combination with other state and federal funds and programs. Collaboration and shared understanding between state Medicaid and behavioral health authorities is fundamental to designing effective, efficient, and coordinated behavioral health services for those who need them. Without this holistic view, it will be difficult for state policymakers to accomplish their goals of improved health and behavioral health outcomes for those they serve.

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Medicaid Handbook: Interface with Behavioral Health Services

Module 2

Medicaid Overview

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Module 2: Medicaid Overview

What is Medicaid?

President Franklin Delano Roosevelt signed into law the Social Security Act of 1935 on the heels of the Great Depression. The early part of the decade was characterized by economic hardship that instigated the movement toward development of safety-net services for Americans. Initially, the Act provided financial support for retired workers aged 65 years or older (Social Security).¹ The Act has been amended many times in the intervening 77 years—for purposes of this handbook, most notably in 1965 when the Medicare and Medicaid programs were signed into law by President Lyndon Baines Johnson. In 1996, welfare reform embodied in the Personal Responsibility and Work Opportunity Act effected another monumental change. The federal government created the state-administered Temporary Assistance to Needy Families program, thereby severing the link between welfare or cash assistance and the health coverage provided by Medicaid. Thus Medicaid stands alone as a health care program, having been separated from welfare or cash assistance. Title XIX of the Social Security Act governs the Medicaid program.

Medicaid is a health insurance program jointly administered by the federal government and each state government. Medicaid is a program that entitles eligible individuals to access certain health care services. Contrast this with a federal block grant (such as the State Mental Health or Substance Abuse Block Grant), whereby eligible recipients may receive services funded by the grant only to the extent that funding is available.

Although the federal government created the authority for the Medicaid program in 1965, not all states immediately implemented one. Arizona was the last state to establish a Medicaid program in 1982. At the time of printing, all states and the District of Columbia participate in Medicaid.

Although a state's participation in Medicaid is optional, the federal government has set forth certain requirements with which states must comply if they choose to participate in the program. For example, the federal government has established certain mandatory requirements and state options concerning reimbursement, eligibility standards, and quality and scope of medical services.² A state's Medicaid State Plan is an agreement with the federal government that the state will conform to the requirements of the Social Security Act and the official issuances of the U.S. Department of Health and Human Services (HHS). The *State Plan* is the officially recognized document describing the nature and scope of the state's Medicaid program. In particular instances, a state may request—and the federal government may grant—a waiver of certain specified mandates included in the Social Security Act.

In 1997, Congress added Title XXI to the Social Security Act. Title XXI created the Children's Health Insurance Program (CHIP), which is explained more fully later in this module.

Who Administers Medicaid?

The Centers for Medicare & Medicaid Services (CMS) administer Medicaid, CHIP, and Medicare. CMS is one of several operational agencies of HHS.

Within CMS, the Center for Medicaid and CHIP Services is the entity charged with formulating, implementing, and evaluating all program policies and operations relating to Medicaid and CHIP. The Center also works in partnership with states to evaluate the success of state Medicaid agencies in carrying out their responsibilities for effective program administration and beneficiary protection. If necessary, the Center assists states in ameliorating problems and improving the quality of their operations. The Center is responsible for reviewing and approving state-proposed Medicaid policy changes in the form of waivers and State Plan Amendments (SPAs).³

What are the Roles of Central and Regional Offices?

The CMS Baltimore office is the Central Office (CO). It is responsible for developing Medicaid policies and for the final approval of state requests to change their Medicaid programs.

CMS maintains Regional Offices (ROs) in 10 different cities. The ROs were reorganized in 2007 in a structure based on the Agency's key lines of business: Medicare Health Plans Operations; Financial Management and Fee-for-Service Operations; Medicaid and Children's Health Operations; and Quality Improvement and Survey and Certification Operations. The consortia are meant to standardize issue management and communication, improve performance, and focus leadership on achieving the Agency's strategic plan.⁴

Each consortium is led by a Consortium Administrator (CA), who serves as the Agency's leader in his or her area of business expertise. The CA is responsible for standardized implementation of CMS programs, policy, and guidance across all 10 regions for issues pertaining to the business line he or she oversees. In addition to responsibility for a business line, each CA also serves as the Agency's senior management official for two or three ROs, representing the CMS Administrator in external affairs and overseeing administrative operations. The four CAs are each located in a RO (New York, Kansas City, Chicago, and Dallas). The six ROs without a CA (Boston, Philadelphia, Atlanta, Denver, San Francisco, and Seattle) each report to one of the four CAs. The Regional Administrators (RAs) that are located in the ROs without a CA are responsible for planning and implementing all external affairs initiatives within the geographic area with which they are affiliated. Each RA reports to one of the four CAs.⁴

What is the CMS Relationship With the States?

CMS has a two-way relationship with the states. It is charged with developing Medicaid policy at the CO level and with disseminating guidance for implementing these policies to the states via the ROs. The ROs are responsible for assisting with the interpretation of CMS policy and developing relationships with state and local governments, consumers, providers, and professional associations. The ROs also gather insight and information through their communications with stakeholders; this information is funneled back to the CO. In these ways, the ROs "not only represent the Agency on a grassroots level, they also represent the grassroots to the Agency."⁴ Information and data gathered in the regions impacts policy made at the CO level.

Additionally, ROs engage in ongoing monitoring of state Medicaid agency financial claims, state agencies that inspect health care facilities on behalf of CMS, managed care plans, Medicare

claims processing, and organizations that provide quality assurance services living in the states. Specifically, the agency is responsible for ensuring that beneficiaries' health care is safe, effective, efficient, patient-centered, timely, and equitable.

One of the most important functions of CMS is approving proposed changes to state Medicaid programs. Thus, CMS must review and approve policy changes envisioned at the state level and communicate to states the changes made to the Medicaid program at the federal level. When a state seeks to change any portion of its Medicaid program—such as by adding, deleting, or changing eligibility categories, altering the benefit package it covers, implementing or changing copays it charges consumers, or changing the way providers are reimbursed—it must submit either an SPA or a waiver amendment (depending on the policy to be changed). These processes are discussed further in [Module 9](#).

What is the Role of the Sub-State Entity or Local Behavioral Health Authorities?

In this module and throughout this document, the term *behavioral health* encompasses both mental and substance use disorders. When a mental or substance use disorder is addressed singularly, the reference will be only to that disorder.

Some states use public or quasi-public sub-state entities that have statutory authority to administer services to individuals with mental and substance use disorders. This is often the case for individuals with serious and persistent mental illness (SPMI) or for seriously emotionally disturbed children and youth. In most cases, the Medicaid behavioral health services are administered through this structure while, in other states, Medicaid and behavioral health programs are administered separately.

For example, where Medicaid and other publicly funded behavioral health services are administered in an integrated fashion, the state may operate a county-administered Medicaid program in which a county is responsible for serving as the front door to the Medicaid program. In this case, the county makes determinations about priority needs for services and oversees service delivery and a variety of other administrative responsibilities. The strength of this integrated approach is the ability to manage both Medicaid and non-Medicaid services. This is important for individuals who are eligible for Medicaid and also may need behavioral health services that are not funded by Medicaid—such as housing and supported employment—and for individuals who cycle on and off of Medicaid.

Although federal law mandates that states designate a single state Medicaid agency to supervise the administration of the Medicaid program, states are allowed to delegate certain non-policymaking functions to other state agencies, localities, or private entities.⁵ The state Medicaid agency is responsible for establishing Medicaid policy, rules, and regulations. It is also responsible for providing training and technical assistance on policy implementation to county workers.⁶

Additionally, in some states, the sub-state or local public entity may share the responsibility for funding the non-federal portion of Medicaid expenditures, within certain parameters. Roughly a dozen states provide local funding for services. For example, in Ohio the local entity—the

Alcohol, Drug Addiction and Mental Health Board—has the authority to place a property tax levy on the ballot to collect tax funds for local behavioral health services. [Module 5](#) provides background on intergovernmental transfers (IGTs) and certified public expenditures (CPEs), which are often the vehicles used to finance Medicaid’s non-federal portion.

The challenge with local public entities funding and administering certain activities often rests with some of the key principles of §1902 of the Social Security Act, which are discussed below. Of particular note are non-delegation of the single state agency responsibilities and maintaining a consistent statewide program.

What Federal Laws and Regulations Define Medicaid?

Title XIX of the Social Security Act, titled *Grants to States for Medical Assistance Programs*, provides the foundational authority for the Medicaid program. States are not required to participate in the Medicaid program; however, if they do participate, they must comply with laws that provide the framework and underpinnings of the program. Some of the most important sections of Title XIX are listed below. This list is by no means exhaustive, but is instructive in understanding the framework of Medicaid policy.

Social Security Act Title XIX: Grants to States for Medical Assistance

Social Security Act §1902—Fundamental Medicaid Principles

Section 1902 of the Social Security Act provides the basic tenets of the Medicaid program—those principles that are at the program’s core and apply to all services unless waived through a waiver approved by CMS. The following fundamental Medicaid principles share the common theme of instructing states on how to operate their Medicaid programs and maintain the Medicaid consumer’s best interests. Some of the provisions described below—such as statewideness, freedom of choice of provider, and comparability of services—can be waived under a waiver approved by CMS. Waivers are discussed in greater detail in [Module 9](#). Although the terms used below may seem awkward, they are commonly accepted as part of the Medicaid nomenclature.

Single State Medicaid Agency

- A State Plan must specify a single state agency established or designated to administer or supervise the administration of the Medicaid program.
- Other state agencies and local entities such as counties may perform services for the state Medicaid agency; however, they cannot have the authority to change or disapprove any administrative decision of the Medicaid agency or substitute their judgment for that of the Medicaid agency with respect to the applications of Medicaid policies, rules, and regulations.⁷
- The responsibility for making policy for the state’s Medicaid program must remain with the single state agency.
- Therefore, although state governments are all organized differently and administer their Medicaid programs differently, there must be a single state entity that is ultimately responsible and maintains the relationship with CMS.

Statenideness

- A State Plan for medical assistance must “be in effect in all subdivisions of the state and, if administered by [political subdivisions, such as counties], be mandatory upon them.”⁸
- The purpose of this requirement is to ensure that services—whether mandatory or optional—do not vary from locality to locality, depending on (for example) the amount a locality is willing to contribute toward the state’s share of program costs or on the partisan political orientation of the locality or its elected officials.⁹
- Although Medicaid programs will vary considerably from state to state, *within* a state its Medicaid program must be consistent and uniform.

Reasonable Promptness

- The state Medicaid agency must determine eligibility for individuals who apply for Medicaid within specified time periods.¹⁰
- In *Doe v. Chiles*, the Eleventh Circuit Court of Appeals furthered the reach of the reasonable promptness mandate by holding that Medicaid consumers have a right to reasonably prompt *provision of medical assistance* under §1902(a)(8) of the Social Security Act.¹¹
- When thinking about what constitutes reasonable promptness in terms of the right to *receive services* promptly, it is helpful to consider the experience of an individual with commercial insurance coverage for the same type of service provided by the same type of health care professional in a similar location. For example, within a given geographic area, it may be “normal” to drive 90 minutes to a pediatrician or the nearest hospital. If a significant disparity were to exist for those covered by Medicaid compared to those covered by commercial insurance, there could be a concern about reasonable promptness—that the only pediatrician available to a Medicaid consumer is three or four times the drive time of a pediatrician available to commercially insured consumers.

Freedom of Choice of Provider

- Any individual who is eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified and willing to furnish the services.¹²
- States have significant latitude in defining requirements for providers to become *qualified* Medicaid providers, assuming that the requirements are reasonably related to the demands or responsibilities associated with the service. However, once the requirements have been defined, a Medicaid consumer may select any eligible provider who is willing to provide the service according to the prescribed payment rates or methodology.
- This requirement can be waived under certain waiver authorities or precluded by certain managed care authorities. Medicaid managed care plans are not prohibited from limiting their networks of providers under various managed care authorities, as long as consumers have reasonable access to services. This is discussed more fully below and in [Module 5](#).

Individual/Consumer Right to a Fair Hearing

- A State Plan must provide an opportunity for a fair hearing before the state agency “to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.”¹³
- The state agency must grant an opportunity for a hearing if any of the following events occur:
 - Denial of eligibility
 - The claim is not acted upon with reasonable promptness
 - Termination of eligibility or covered services
 - Suspension of eligibility or covered services
 - Reduction of eligibility or covered services.¹⁴

Comparability of Services

- A State Plan must specify the amount, duration, and scope of each service that it provides for eligible consumers.
- Each service must be sufficient in amount, duration, and scope to “reasonably achieve its purpose.” For example, if limiting the physical therapy benefit to *one* visit is not reasonable to achieve the purpose of improving or rehabilitating a consumer’s condition, then the service may not be so limited.
- The Medicaid agency or any agency administering a component of the Medicaid program may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
- The Medicaid agency may place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures. Utilization control procedures may not fundamentally impact access to services.
- Regardless of an individual’s category of Medicaid eligibility, the benefit package must be equal in amount, duration, and scope.¹⁵

Efficiency, Economy, and Quality of Care While Assuring Access

- State policies related to the utilization of and payment for services must protect against unnecessary utilization of services and ensure that payments are “consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in a geographic area.”¹⁶
- This requirement allows states to seek the best value through their rate-setting policies and tailor their access strategies to take into account local conditions including geographic disparities in the availability of providers and demand for particular services.
- Regardless of whether payment rate changes are made, this section ensures that consideration is given to the potential impact on access to care for Medicaid consumers and decisions are made with effective processes for ensuring that the impact on access will be monitored and do not lead to access problems.
- Payment rate changes are not in compliance with the Medicaid access requirements if they result in a denial of sufficient access to covered care and services.¹⁷

Additionally, several other parts of the Social Security Act address payment standards.

Social Security Act §1903—Payment to States

Section 1903 of the Social Security Act specifies the amounts states are to be paid by the federal government. It also contains provisions defining and discussing *Medicaid managed care organizations*.

Social Security Act §1905—Mandatory and Optional Services Provided Under Medicaid

Section 1905 of the Social Security Act is titled *Definitions*, and some of its most important content—found in §1905(a)—includes a list of all services that states are *required* to provide (*mandatory services*) or may *choose* to provide (*optional services*) under their Medicaid programs. Medicaid funds *services* and several services may be organized together to create a clinical program. Taken together, the package of Medicaid services comprises a state’s Medicaid program. The mandatory and optional Medicaid services are discussed in greater detail later in this module and in other modules.

The list of services included in §1905(a) serves as the structural framework for the benefits section of each state’s Medicaid State Plan. The Medicaid State Plan is discussed in greater detail in [Module 9](#).

Social Security Act §1915—How a State Can Structure Its Medicaid Program, Including Waivers

Section 1915 of the Social Security Act provides various authorities by which states can structure their Medicaid programs and/or waive certain federal requirements of the Medicaid program.

Section 1915(a)—Voluntary Managed Care

- Section 1915(a) of the Social Security Act is the authority by which a state may implement a voluntary Medicaid managed care program. If the state chooses to implement such a voluntary program, the program does not require a waiver or inclusion in the State Plan.¹⁸
- This section permits states to enter into a voluntary contract with an entity to provide State Plan services (i.e., those services defined in the Medicaid State Plan).
- In a voluntary managed care program, the consumer has the choice to participate in the managed care program or to receive services through the state’s fee-for-service (FFS) program. Managed care and FFS systems are discussed in greater detail in [Module 5](#).

Section 1915(b)—Mandatory Managed Care Waiver

- Several authorities can be used to implement mandatory managed care. Section 1915(b) is the *waiver* authority by which states may implement mandatory managed care.¹⁹ In a mandatory managed care program, all Medicaid consumers who meet the state’s eligibility criteria for enrollment in managed care are enrolled in the program and do not have the choice to opt out.
- Within federal parameters, and with certain exceptions, states have the ability to choose which eligibility groups it requires to participate in managed care and which may participate at their option.

- States can waive statewideness, freedom of choice of provider, and/or comparability of services.
- States wishing to waive additional requirements or include certain eligibility groups beyond those allowed with a §1915(b) waiver must use a different managed care authority to do so.

Section 1915(c)—Home and Community-Based Services Waiver

- This section is the waiver authority by which states can provide community support services in home and community settings rather than institutional settings.²⁰
- This section requires an individual to meet an institutional level of care: hospital, nursing facility, or intermediate care facility for the developmentally disabled. The reason for requiring an institutional level of care is that the home or community setting in which a waiver-eligible individual receives services effectively replaces the institution where services would otherwise be delivered. The institution provides a basis for comparing the cost of the alternative home and community-based services (HCBS).
- States can waive statewideness and/or comparability of services.
- Section 1915(c) requires budget neutrality—the state must show that proposed changes will not increase overall Medicaid costs.

Section 1915(b) and (c) waivers may be combined to allow states to provide HCBS in a managed care structure. Additional information on waivers is located in [Module 9](#).

Section 1915(g)—Targeted Case Management

- This section authorizes states to provide targeted case management services.²¹
- Targeted case management is only one form of case management or care coordination. Case management is discussed more fully in [Module 3](#).

Section 1915(i)—State Plan Home and Community-Based Services

- This section authorizes states to include in their State Plans HCBS before an individual needs institutional care. It also provides a mechanism to provide State Plan HCBS to individuals with mental and 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 for HCBS.
- 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.²² These changes are discussed more fully in [Module 7](#).

Section 1915(j)—State Plan Self-Directed Personal Assistance Services

- This section allows states to elect to provide self-directed personal assistance services in their Medicaid State Plans so that waivers are not necessary.²³

Section 1915(k)—State Plan Community First Choice Option

- This section gives states enhanced federal Medicaid matching funds for providing community-based attendant services and supports to consumers who meet an institutional level of care.²⁴

Social Security Act §1932—Voluntary or Mandatory Managed Care

Section 1932 of the Social Security Act provides states the option—within federal parameters—of including in their Medicaid State Plans a framework for voluntary or mandatory Medicaid managed care or primary care case management (PCCM) programs. States can implement managed care under §1932 of the Act and can choose to disregard any or all of three requirements: statewideness, freedom of choice of providers, and comparability of services.

Social Security Act Title XI:

General Provisions, Peer Review, and Administrative Simplification

§1115—Research and Demonstration Waiver

Section 1115 of the Social Security Act gives states the flexibility to design and improve their Medicaid programs by letting them test innovative ways to deliver and pay for coverage. Under this authority, and subject to the discretion of the Secretary of the U.S. Department of Health and Human Services, states have broad waiver authority to implement projects that test policy innovations that are likely to further the objectives of the Medicaid program. Section 1115 waivers are also known as research and demonstration waivers. The authority provided by this section can be used to waive statewideness, freedom of choice of provider, and/or comparability of services.

Certain policy changes prior to implementation of the Affordable Care Act, such as expanding eligibility to childless adults, cannot be accomplished without the use of an 1115 waiver. In those instances, 1115 waivers are helpful instruments. However, it should be noted that 1115 waivers have more burdensome requirements than other types of waivers. Specifically, 1115 waivers—

- Cannot reduce access or quality of care
- Must be budget neutral—they cannot cost the federal government more than the state Medicaid plans would cost without the waiver
- Must include a research component and test an innovative idea
- Must maintain quality assurance processes

Social Security Act Title XXI: Children’s Health Insurance Program

Title XXI of the Social Security Act describes the CHIP. Like Medicaid, CHIP is administered by the states and jointly funded by the federal and state governments. Unlike Medicaid, however, CHIP is not an entitlement program—it is a block grant; Congress must periodically reauthorize the program and reappropriate funding for it.

States are able to administer their CHIPs in one of three ways:

1. **As an expansion of their Medicaid programs.** As of March 2012, seven states and the District of Columbia operate their CHIPs this way.²⁵ *Example:* Ohio uses the CHIP allocated funding to expand Medicaid eligibility above the minimum level

established in federal law. A child enrolled in Medicaid/CHIP does not necessarily know in which program he or she is enrolled, and delivery of health care services is the same regardless of whether he or she is enrolled in Medicaid or CHIP. To the state, however, there is a significant difference—the portion of the bill paid by the federal government. This is explained in greater detail later in this module.

2. **As a separate CHIP program.** As of March 2012, 17 states operate their CHIPs in this way.²⁵ *Example:* Oregon operates a Medicaid look-alike program that is technically a separate freestanding CHIP. This allows the state to limit the number of enrollees, but the program is identical to Medicaid expansion programs in almost all other respects.²⁶ The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children and youth—which is discussed more fully below and in subsequent modules—is an *optional* service for children covered under separately administered CHIP plans.
3. **As a combination of the first two approaches.** As of March 2012, 26 states operate their CHIPs in this way. Florida and New York have combination CHIP and Medicaid programs—allowing these states to establish an entitlement for certain age or income groups, while maintaining flexibility to implement caseload limits for other groups.²⁵

United States Code

The Social Security Act, along with all other general and permanent laws of the United States, is codified in the United States Code. It is helpful to understand this relationship, because references to Medicaid provisions are sometimes given as sections of the Social Security Act and sometimes as sections of the United States Code. They may be cross referenced as follows—

- §1902 of the Social Security Act = 42 U.S. Code 1396a
- §1905 of the Social Security Act = 42 U.S. Code 1396d
- §1915 of the Social Security Act = 42 U.S. Code 1396n
- §1932 of the Social Security Act = 42 U.S. Code 1396u-2
- §1115 of the Social Security Act = 42 U.S. Code 1301
- Title XXI of the Social Security Act = 42 U.S.C. 1397

Code of Federal Regulations

Rules and regulations are codified in the Code of Federal Regulations (CFR). Federal regulations governing the Medicaid program are located in Title 42 (Public Health), Chapter IV (CMS, HHS) of the CFR, specifically in Parts 430–505.

Who is Eligible for Medicaid?

Medicaid and CHIP provide health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. To participate in Medicaid, federal law *requires* states to cover certain population groups and *allows* them to cover others.²⁷

Because the Affordable Care Act made such significant changes in Medicaid eligibility and insurance coverage policy, and because each state's Medicaid program is built—within federal parameters—on a different foundation of eligibility decisions, it is important to understand the explanation of Medicaid eligibility that follows. For example, Ohio has more than 150 eligibility categories, whereas North Carolina has 25. These states—and all the others—will be impacted differently by full implementation of the Affordable Care Act. Understanding a state's Medicaid eligibility structure is also important when designing and managing the interface with the Health Insurance Marketplace, also known as the Health Insurance Exchange. These considerations are especially true in light of the U.S. Supreme Court's decision to make optional a state's expansion of Medicaid to 133 percent of the federal poverty guideline.

All mandatory and optional populations, except for medically needy beneficiaries, are considered *categorically needy*. States may provide Medicaid to certain groups of individuals who are not otherwise eligible for Medicaid; these are *medically needy* populations.²⁸ The medically needy have too much money and/or resources (e.g., savings) to be eligible as categorically needy, but they are deemed to have excessive medical bills.²⁹ The medically needy program is used by states to expand coverage primarily to two groups: (1) persons who spend down their income by incurring medical expenses so that, after medical expenses, their income falls below a state-established medically needy income limit; and (2) low-income young adults aged 19–20 and parents in states where it is the only eligibility category for these individuals or where the medically needy program has the highest maximum allowable income for Medicaid eligibility.

The Social Security Act mandates that states cover certain population groups and gives them the flexibility to cover others. In general, Medicaid covers low-income mothers and children, elderly people, and people with disabilities, although specific income and other requirements vary by state. Mothers and children are commonly known as the *Covered Families and Children* (CFC) population; elderly and disabled individuals are known as the *Aged, Blind, and Disabled* (ABD) population. Disability status is often linked to disability as determined by the Social Security Administration for Supplemental Security Income (SSI). The CFC group comprises about 75 percent of the total Medicaid population; the ABD group comprises the remainder.³⁰ The inverse is generally true of cost—care for the ABD population is significantly more costly than for the CFC population.

States set individual eligibility criteria within federal minimum standards; they are also able to request from CMS a waiver of federal law to expand health coverage beyond these groups. Many states have expanded coverage above the federal minimums, particularly for children.²⁷

Currently, adults who are childless, nonelderly, or do not have a disability cannot qualify for Medicaid, regardless of their income level. An exception exists if the state in which they live has a waiver that allows coverage, such as the one in Arizona. However, this will change in 2014 with the addition of a new eligibility option for states. In 2014, states will have the option to expand Medicaid eligibility to uninsured earning up to 133 percent of the federal poverty guideline.³¹

For many eligibility groups, income is calculated as a percentage of the federal poverty guideline.^A As a reference, in 2013, 100 percent of the federal poverty guideline for a family of four is \$23,550. For other groups, income standards are based on income or other nonfinancial criteria standards for other programs, such as the SSI program. Beginning in 2014, eligibility for Medicaid and CHIP for most individuals will be determined using methodologies that are based on modified adjusted gross income (MAGI), as defined in the Internal Revenue Code of 1986. For these individuals, eligibility determinations will be based strictly on the individual's MAGI and will no longer take into consideration resource limits, spend-down, and other eligibility determination factors that complicate the process.³²

Mandatory Eligibility Groups

Children

Children are in a mandatory Medicaid eligibility group if they are:

- **Infants born to women who are eligible for Medicaid**—eligibility for these infants must continue through the first year of life.³³
- **Children younger than 6 years old whose families earn up to 133 percent of the federal poverty guideline**
- **Children aged 6–18 years whose families earn up to 100 percent of the federal poverty guideline**
- **Certain children who receive adoption assistance or are in foster care.**³⁴

In an effort to protect this vulnerable population, every state has chosen to expand coverage to children beyond the minimum thresholds established in federal law. Most states have elected to provide Medicaid coverage to children with family incomes above the minimum, and all states have expanded coverage to children with higher incomes through CHIP. In general, children in families earning up to 200 percent of the federal poverty guideline (\$46,100/year for a family of four in 2012 or \$22,340 for an individual) are likely to be eligible for Medicaid or CHIP coverage. In fact, the average CHIP income eligibility level for children is 241 percent of the federal poverty guideline.³⁴

As of 2010, 46 states and the District of Columbia covered children with incomes up to 200 percent of the federal poverty guideline under Medicaid and CHIP.³⁵ In many States, families with higher incomes can still qualify for coverage for their children. Indeed, 18 states and the District of Columbia have CHIP upper income limits of 300 percent of the federal poverty guideline or more.³⁵ This includes children in mandatory Medicaid eligibility groups and children in optional eligibility groups that a state may choose to cover. *Together, as of May 2012, Medicaid and CHIP provide health care to more than 43 million children, including half of all low-income children in the United States.*³⁴

Section 1931 Adults

Section 1931 defines *adults* as parents/caretaker relatives of dependent children with incomes at about 41 percent of the federal poverty guideline. Welfare reform, which took place in 1996,

^A The U. S. Department of Health and Human Services uses the term *poverty guideline*, although this is commonly called the *federal poverty level* (FPL). The poverty guidelines are issued each year in the *Federal Register* by the Department.

delinked Medicaid from welfare/cash assistance—then called *Aid to Families with Dependent Children* (AFDC) and now called *Temporary Assistance to Needy Families*. Previously, this linkage guaranteed Medicaid eligibility for those receiving AFDC benefits. Under welfare reform, §1931 of the Social Security Act froze Medicaid eligibility based on AFDC criteria in effect on July 16, 1996. At the time, AFDC varied significantly among states, but the national average income was about 41 percent of the federal poverty guideline.³⁶ States have the option to cover parents with incomes above the 1996 minimum levels, and many states choose this option.³⁷

Pregnant Women

Pregnant women whose family income is up to 133 percent of the federal poverty guideline are eligible for Medicaid through 60 days following delivery.³⁸ States have the flexibility to offer Medicaid coverage to pregnant women whose family income is greater than 133 percent of the federal poverty guideline, and most have chosen to do so. *Currently, Medicaid finances about 40 percent of all births in the United States.* Pregnant women receive care related to their pregnancy, labor, and delivery and for any complications that may occur during pregnancy, as well as perinatal care for 60 days post partum. States have the option to provide pregnant women with full Medicaid coverage, or they may elect to limit coverage to certain services related to their pregnancy.³⁹ States have placed significant emphasis on getting coverage for pregnant women as early in their pregnancies as possible, striving for the best potential outcomes for the baby and mother.

Individuals Receiving Supplemental Security Income

Individuals who receive SSI are eligible for Medicaid, because SSI establishes both low-income status (adults and elderly) and disability status for adults. Most individuals who qualify for Medicaid based on disability also receive federal cash assistance under SSI.

- In 32 states and the District of Columbia, SSI eligibility automatically qualifies an individual for Medicaid coverage. These are called *1634(a) states*. Linking SSI to the disability status has limited eligibility for those with substance use disorders, as in 1996 when Congress eliminated addictions as a qualifying diagnosis under Social Security programs.
- Seven states use the same Medicaid eligibility criteria for their disabled populations as are used for the SSI program, but the state requires that these individuals apply for Medicaid separately from their application for SSI. These are known as *SSI-criteria states*. In SSI-criteria states, individuals are eligible for Medicaid if they are receiving or deemed to be receiving SSI.⁴⁰ This includes individuals receiving SSI pending a final determination of blindness or disability. This means that in SSI-criteria states, as long as the individual is receiving SSI—even if a final determination is pending—he or she is eligible for Medicaid.
- Eleven states use more restrictive eligibility criteria than those used by the SSI program. In those states—commonly referred to as *209(b) states*—receipt of SSI does not guarantee eligibility for Medicaid. Similarly, an individual may become eligible for Medicaid while still awaiting an SSI-eligibility determination. The 209(b) states use at least one eligibility criterion more restrictive than the SSI program. States that have elected this option may not use more restrictive standards than those in effect in January 1, 1972, and they must provide for deducting incurred medical expenses from

income through Medicaid spenddown so that individuals may reduce their income to the income eligibility level.⁴¹ Individuals not receiving SSI but seeking coverage based on disability must demonstrate that they have an impairment that prevents them from performing “substantial gainful activity” for at least 1 year. Once a disability determination is made, the individual must then undergo an asset test and meet specific income requirements in order to be considered for Medicaid eligibility.⁴² All states are required to establish an “annual review system” to identify individuals “who lose categorically needy eligibility for Medicaid because of a loss of SSI.”⁴³ Generally, states are required to redetermine Medicaid eligibility at least every 12 months to report circumstances that may change. However, states may consider blindness and disability as continuing until the reviewing physician determines that the recipient no longer meets the definition of blind or disabled included in the State Plan.⁴⁴

Medicare Recipients

State Medicaid programs are required to pay for Medicare coverage for elderly and disabled individuals who have limited incomes and resources. For some, Medicaid also covers additional services beyond those provided under Medicare, including nursing facility care outside of Medicare’s 100-day limit, prescription drugs, eyeglasses, and hearing aids. Services covered by both programs are first paid by Medicare, and Medicaid covers the difference up to the state’s payment limit. In total, 8.3 million people are eligible for both Medicaid and Medicare enrollment; these individuals—called *Medicare-Medicaid enrollees* or *dually eligible individuals*—comprise more than 17 percent of all Medicaid enrollees.⁴⁵

Individuals receiving both Medicaid and Medicare benefits may be described as follows:

- **Qualified Medicare Beneficiaries** are eligible for Medicaid if they earn up to 100 percent of the federal poverty guideline and have resources less than \$6,680/individual or \$10,020/couple. For these individuals, Medicaid pays for Part A premiums, Part B premiums, and deductibles/coinsurance/copayments.
- **Specified Low-Income Medicare Beneficiaries** are eligible for Medicaid if they earn up to 120 percent of the federal poverty guideline and have resources less than \$6,680/individual or \$10,020/couple. For these individuals, Medicaid pays for Part B premiums only.
- **Qualified Individuals** are eligible for Medicaid if they earn up to 135 percent of the federal poverty guideline and have resources less than \$6,680/individual or \$10,020/couple. For these individuals, Medicaid pays for Part B premiums only.
- **Qualified Disabled Working Individuals** are eligible for Medicaid if they earn up to 200 percent of the federal poverty guideline and have resources less than \$4,000/individual or \$6,000/couple. For these individuals, Medicaid pays for Part A premiums only.⁴⁵

Certain Individuals Earning Up to 133 Percent of the Federal Poverty Guideline and Former Foster Children Up to Age 26

The Affordable Care Act added two mandatory Medicaid eligibility groups. One mandatory Medicaid eligibility group that the Affordable Care Act added to the Social Security Act is

former foster care children through age 25 who were enrolled in foster care and Medicaid when they turned 18 or aged out of foster care.⁴⁶

Another mandatory Medicaid eligibility group that the Affordable Care Act added to the Social Security Act is nonelderly, non-pregnant adults with income at or below 133 percent of the federal poverty guideline (an annual income of approximately \$15,282 for an individual and \$31,322 for a family of four in 2013) who are not otherwise eligible for a mandatory Medicaid eligibility category or enrolled in or eligible for Medicare. This group is commonly known as the *Medicaid extension* or *Medicaid expansion* group.

The Medicaid expansion provision in the Affordable Care Act required states to implement the expansion or face losing all federal financing for the state's Medicaid program. On June 29, 2012, the U.S. Supreme Court ruled that the Medicaid expansion is constitutional, but the proposed penalty that would result in a state losing all federal financing for its Medicaid program was too harsh and, therefore, unconstitutional. Therefore, although Congress added this Medicaid eligibility group to the section of the Social Security Act that described mandatory Medicaid eligibility group, the Supreme Court's ruling, in effect, made implementation optional.⁴⁷ As of May 2013, 22 states and the District of Columbia had decided to implement the Medicaid expansion, 17 had decided not to implement the expansion, and 11 were undecided.⁴⁸ This eligibility group is discussed at length in [Module 7](#).

Optional Eligibility Groups

In addition to populations that states are required to cover under Medicaid, they can choose to cover additional populations. Optional eligibility groups include:

- Children younger than 6 years who are above 133 percent of the federal poverty guideline
- Children aged 6–18 years who are above 100 percent of the federal poverty guideline
- Parents with low income that is above the 1996 AFDC level
- Women who are pregnant with income above 133 percent of the federal poverty guideline
- Individuals who are disabled, elderly, and have income below 100 percent of the federal poverty guideline
- Residents of nursing homes with income below 300 percent of SSI
- Individuals who are disabled and receiving HCBS under a waiver
- Certain individuals who are working disabled
- Individuals who are medically needy.⁴⁹

According to a 2005 report prepared by the Henry J. Kaiser Family Foundation, 29 percent of national Medicaid beneficiaries qualify for the program on the basis of optional eligibility group criteria. Moreover, although most children (80 percent) qualify on the basis of mandatory coverage, more than half (56 percent) of the elderly qualify through optional eligibility groups.

Presumptive Eligibility

States have the option to authorize “qualified entities” such as health care providers, community-based organizations, and schools to screen for Medicaid and CHIP eligibility and immediately

enroll children and pregnant women who appear to be eligible and those individuals who are *presumed eligible*. The only entities that can determine presumptive eligibility for pregnant women are Medicaid providers that deliver prenatal services. In presumptive eligibility for children, any kind of Medicaid provider can be a qualified entity, as can the organizations that determine eligibility for Head Start; the Special Nutrition Program for Women, Infants, and Children; and the Child Care and Development Block Grant.⁵⁰

Presumptive eligibility allows children to access Medicaid or CHIP services without having to wait for their application to be fully processed. Qualified entities can also help families gather the documents needed to complete the full application process, thereby reducing the administrative burden on states to obtain missing information.⁵¹ Neither families nor providers have to repay the costs of services obtained during the presumptive eligibility period even if the family never completes a Medicaid application or completes the application and is denied coverage. Likewise, states are reimbursed at the regular federal Medicaid matching rate for covering children during the presumptive eligibility period, even if the children are not ultimately found eligible. However, if a child does not establish eligibility after the presumptive Medicaid eligibility period expires, expenditures will be deducted from the state's CHIP allotment.⁵⁰

Medicaid Eligibility for Individuals With Behavioral Health Needs

Like consumers without behavioral health needs, individuals with mental and substance use disorders can qualify for the program through a variety of eligibility categories. Individuals with behavioral health needs are not a specific eligibility category. However, some data exist indicating that although about 5 percent of Medicaid beneficiaries qualify because they receive SSI because of a mental illness, about two-thirds of Medicaid enrollees who use mental health services qualify for the program in ways other than those based on a disability.⁵²

In a research study conducted by the Best Practices in Schizophrenia Treatment (BEST) Center, BEST used Ohio Medicaid claims data to identify adults with serious mental illness (SMI). These individuals were fairly evenly distributed across Medicaid eligibility categories, but most (36 percent) fell into the nonelderly, nondisabled adult category, while 31 percent fell into the category representing elderly or disabled adults, and 32 percent fell into the category of adults who are eligible for Medicaid and Medicare. However, among the group of adults with SMI, the majority of adults with schizophrenia and psychosis are dually eligible for both Medicare and Medicaid. Among adults with substance use disorders, the majority fall into the nonelderly, nondisabled adult category.⁵³

What Services Does Medicaid Cover?

Medicaid is generally considered to be a robust benefit package, especially for children who qualify for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit described below. Additionally, Medicaid is prohibited from excluding beneficiaries for pre-existing conditions, as many commercial plans historically have done.

Section 1905(a) of the Social Security Act outlines the services that state Medicaid programs *must* cover and those it *may* cover. These services are provided under the state's Medicaid State

Plan. The lists below name services and, in fact, also list some types of providers who are permitted by state professional practice acts to supply a variety of services under these categories. Other services may be covered under an approved waiver. Waivers are discussed in greater detail in [Module 9](#).

The Medicaid behavioral health services benefit package is examined specifically in [Module 3](#). This section discusses all services—not just behavioral health services—that a state may or must provide.

The following services *must* be covered under a state’s Medicaid State Plan—

- 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 youth under 21 as part of EPSDT⁵⁴

A state can *choose* to cover the following optional services under its Medicaid State Plan—

- Prescription drugs
- Clinic
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder therapy
- Respiratory care
- Other diagnostic, screening, preventive, and rehabilitative care
- Podiatry
- Optometry
- Dental
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic
- Other practitioner
- 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^B
- 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 care for individuals younger than 21 years
- Other Secretary-approved care⁵⁴

A state has the ability to reasonably limit services in amount, scope, and/or duration, so long as it does not violate the *comparability of services* standard discussed earlier in this module. For example, many states set annual limits on the number of dental visits or physical therapy sessions to which a Medicaid beneficiary is entitled.

Early Periodic Screening, Diagnosis, and Treatment

The EPSDT benefit for children and youth was established as a mandatory component of Medicaid in 1967—just 2 years after the Medicaid program’s inception—to “ascertain their physical or mental defects and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions.”⁵⁵ It provides an overarching mandate specific to children and youth, including a comprehensive package of services for individuals younger than 21 years. Under EPSDT, “States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.”⁵⁶ Expanded in 1981 and 1989, *Section 1905(r) of the Social Security Act specifically requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available to adults under the state’s Medicaid plan.*⁵⁷ The principles of EPSDT can be summarized as follows:

- **Early**—assess and identify problems early in the child’s life;
- **Periodic**—check the child’s health at periodic, age-appropriate intervals;
- **Screening**—provide physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems;
- **Diagnosis**—perform diagnostic tests to follow up when a risk is identified; and
- **Treatment**—control, correct, or reduce health problems found.⁵⁶

EPSDT is comprised of the following screening, diagnosis, and treatment services—

Screening Services

- Comprehensive health and developmental history, including assessment of both physical and mental health

^B Social Security Act §1905(a) refers to these facilities as “intermediate care facilities for the mentally retarded,” but we choose to refer to them throughout this document as intermediate care facilities for the developmentally disabled.”

- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Centers for Disease Control’s Advisory Committee on Immunization Practices, a group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States)
- Laboratory tests, including lead toxicity screening
- Health education; anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention

Vision Services

- At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary.

Dental Services

- At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services.

Hearing Services

- At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids.

Other Necessary Health Care Services

- States are required to provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses, as well as conditions that are discovered. Any needed Medicaid service must be provided, regardless of whether the service is covered in a state’s Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

Diagnostic Services

- When a screening examination indicates the need for further evaluation of an individual’s health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure that the enrollee receives a complete diagnostic evaluation. States should develop quality assurance procedures to ensure that comprehensive care is provided.

Treatment

- Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.⁵⁶

Periodicity schedules for periodic screening, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice, and states must consult with recognized medical organizations involved in child health care when developing the schedules. Alternatively, states may elect to use a nationally recognized pediatric periodicity schedule (e.g.,

Bright Futures/American Academy of Pediatrics). Each state is also required to develop a dental periodicity schedule.⁵⁶

For example, the Bright Futures/American Academy of Pediatrics' periodicity schedule indicates that the following measurements, screenings, assessments, or procedures should be performed at each visit at the following recommended ages—

- Body Mass Index (BMI) Measurement: Ages 24 months through 21 years
- Alcohol and Drug Use Risk Assessment: Ages 11 years through 21 years
- Immunizations: Ages newborn through 21 years

This list describes just three of many recommendations for preventive pediatric health care.⁵⁸

Medical necessity for EPSDT services is an area where the involvement of the courts has had a significant impact on Medicaid policy. Federal Medicaid law does not define medical necessity directly; instead, it gives states the ability and flexibility to do so. However, federal law reflects the delicate balance between providing clinically appropriate services that are cost effective. Federal law also requires that states do “not arbitrarily deny or reduce the amount, duration, or scope of a required service...solely because of the diagnosis, type of illness, or condition.”⁵⁹ Yet, the state “may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.”⁶⁰

State treatment of medical necessity falls along a continuum. Some states use a definition of medical necessity that is very deferential to the discretion of the medical professional. These states base their policy decision in large part on the outcome of the *Rosie D. v. Romney* court case. Practically speaking, if a state Medicaid program in these states sets a limit on a service specifying that a maximum number of visits to a certain type of professional are adequate to achieve the purpose of the care, a physician's decision that provision of more services is medically necessary can override the state Medicaid program's limitation. Other states employ greater controls in their definition of medical necessity including, for example, language that requires services to be performed in the least costly setting.

EPSDT Toolkit of State Resources

The Bright Futures website (<http://www.brightfutures.org/wellchildcare/toolkit/states.html#>) provides information about each state's EPSDT program, including manuals, forms, rules and regulations, and other detailed policy and operational guidance. It also includes contact information for state Medicaid and health department officials.

Who Provides Medicaid Services?

Medicaid services are provided by a range of public and private health care professionals and organizations, the list of which varies from state to state. By and large, states have latitude in defining the types and qualifications of providers that may receive Medicaid reimbursement for delivering services. The federal government is deferential to state professional practice acts, which are state statutes and regulations that contain specific licensing requirements, professional standards, scope of practice and prohibited acts, etc. for health care providers. These practice acts

often specify the types of providers to whom responsibility for providing services and/or oversight of service delivery may be delegated.

A more extensive discussion of providers of behavioral health services is located in [Module 4](#).

How is Medicaid Financed?

How the Cost is Shared

Fundamentally, Medicaid is a partnership between the federal and state governments, which includes sharing the cost of the program. The percentage of the cost attributable to the parties varies by state and, in certain instances, varies with the activity for which payment is sought.

The Medicaid share paid by the federal government is called *federal financial participation* (FFP) or the *federal medical assistance percentage* (FMAP). Section 1905(b) of the Social Security Act sets forth the formula for calculating FMAPs. The FMAP varies by state based on criteria such as per capita income. The regular average state FMAP is 57 percent, but FMAPs range from 50 percent to 75 percent.⁶¹ The FMAP for family planning services is 90 percent in all states.

FMAPs for Medicaid and CHIP are different, even for states that operate their children's health insurance programs as Medicaid expansions. As an incentive for states to expand Medicaid coverage to children, when Congress created CHIP it allocated federal matching rates that are generally about 15 percentage points higher than the Medicaid rate.⁶²

Further, the federal government assumes a different FMAP for program administration costs than it does for costs associated with the provision of medical services. Medicaid administrative claiming is the payment of FFP at different matching rates—generally about 50 percent—for amounts “found necessary by the Secretary for the proper and efficient administration of the state plan.” Administrative claims must be directly related to Medicaid program administration, and payment may only be made for the percentage of time actually spent on Medicaid-eligible individuals.⁶³

CMS has indicated its approval for the following types of costs that are necessary for proper administration of the Medicaid State Plan:

- Medicaid eligibility determinations
- Medicaid outreach
- Prior authorization for Medicaid services
- Medicaid Management Information System (MMIS) development and operation
- EPSDT administration
- Third Party Liability activities
- Utilization review.⁶³

When an entity other than the single state agency charged with overseeing the state's Medicaid program is involved in the administration of the program, the state can claim—to some degree—administrative costs for the purpose of drawing down federal funding. For example, another state agency or local entity such as a county or parish may be charged with conducting eligibility

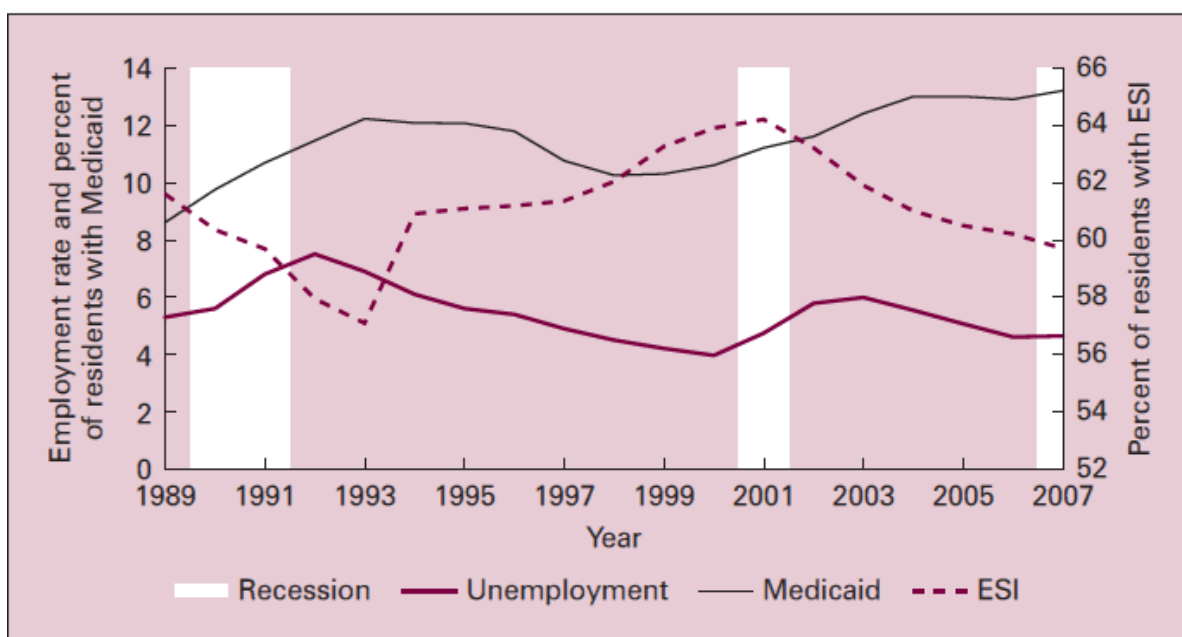
determinations or some aspects of care planning or service coordination. Through Medicaid administrative claiming, the state can develop—subject to CMS approval—a mechanism for identifying allowable time and recouping these costs.

The MMIS is the claims processing and information retrieval system that states are required to have. Although development and operation of the MMIS is a Medicaid administrative function, FFP for this activity is 90 percent for design, development, and installation of the system and 75 percent for operation of state claims processing and information retrieval systems approved by the Secretary.⁶⁴ States request enhanced FMAP for systems design changes by submitting to CMS an advanced planning document.

FMAPs are adjusted regularly to account for fluctuations in the economy. Medicaid is *countercyclical*, meaning that enrollment in the program increases when the economy worsens. Figure 2-1 from the Urban Institute illustrates several important features of Medicaid’s relationship with the economy:

- A change in unemployment is mirrored by a change in Medicaid rates, in the same direction, and at the same time.
- The unemployment rate and Medicaid enrollment peak during times of recession.
- The leveling off or reduction in Medicaid enrollment lags economic recovery following a recession; it takes longer for these individuals to experience the recovery.
- The rate of employer-sponsored insurance enrollment moves opposite the rate of Medicaid enrollment and unemployment.
- Throughout the 18 years illustrated here, at least 4 percent of all Americans have relied on Medicaid.

Figure 2-1 *Unemployment Rate, Share of U.S. Residents with Medicaid, and Share of U.S. Residents with Employer-Sponsored Insurance (ESI), 1988–2007*



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The recent nationwide economic downturn resulted in booming Medicaid enrollment across the country. To soften the significant impact of increased Medicaid rolls on state budgets, the federal government included in the American Recovery and Reinvestment Act a provision increasing FMAPs by 6.2 percent. This was called *enhanced* FMAP (EFMAP). The EFMAP was reduced from 6.2 percent to 3.2 percent in January of 2011, and further reduced to 1.2 percent in the second calendar quarter of 2011.⁶⁶ This is not the first time that Congress has used a change in the FMAP as a vehicle to provide states with additional time-limited funds.

How States Finance The State Portion

States must ensure that they can properly fund the services that they cover in their Medicaid State Plans for all beneficiaries determined eligible. Over the last few years, because of the nationwide economic crisis, states have routinely been tasked with resolving ever-widening budget deficits. For state fiscal years 2012 through 2013, states faced budget shortfalls of at least \$149 billion, on top of the \$430 billion in shortfalls they already closed in state fiscal years 2009, 2010, and 2011.⁶⁷ Because Medicaid is often the largest single expense (except for education) in state budgets, it is often a significant target for state legislators—despite the fact that reducing state spending on Medicaid results in a greater loss of federal reimbursement.

Because Medicaid is an entitlement, a shortage of state matching funds cannot be used by a state to stop providing Medicaid services. State Medicaid directors have essentially three key tools at their disposal to control Medicaid spending (although each comes with limitations): reduce provider payments, eliminate or manage utilization of services, or restrict eligibility. They may reduce reimbursement to providers, although payment cuts may not have a deleterious effect on ensuring adequate access to providers. They also may stop providing optional services or reduce amounts of services provided to adults, although they may not violate the requirement that a service be sufficient in amount, duration, and scope to reasonably achieve its purpose. States also may seek cost savings by restricting eligibility criteria, implementing Medicaid managed care programs, or redesigning service delivery throughout the Medicaid program. The ability to predict costs and control growth is one important reason that state Medicaid programs utilize managed care. Managed care is discussed more thoroughly in [Module 5](#).

Most states use general revenue fund appropriations that are approved by their legislatures to fund the state match, but some also use local government resources to fund a portion. Other financing mechanisms include inter-governmental transfers, CPEs, and permissible taxes and provider donations. However, a provision in §1902(a)(2) of the Act mandates that state governments pay for at least 40 percent of the *non-federal share* of Medicaid.⁶⁸

In fiscal year 2012, states experienced large increases in their spending for Medicaid because the enhanced FMAP ended on June 30, 2011. This forced them to replace lost federal funding with increased state spending. On average, in fiscal year 2012, state funding appropriated for Medicaid increased by about 29 percent compared to the prior year. This is much larger than the two percent growth in total Medicaid spending.⁶⁷

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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 years¹²

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 services¹⁹
- 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 agencies²²
- 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 facility²³

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 therapy²⁴
- 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 community²⁵

- 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 autism²⁵

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 PRTF²⁶

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 21²⁷

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 available²⁸

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 areas²⁹

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	<ul style="list-style-type: none"> Mobile crisis Medically monitored intensive inpatient Peer based crisis Urgent care 23 hour crisis stabilization 24/7 crisis hotline
Out-of-Home Residential Services	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Individual evidence based therapies Group therapy, family therapy Multi-family therapy Consultation to caregivers
Healthcare Home/Physical Health	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Medication management Pharmacotherapy (including MAT) Laboratory services
Engagement Services	<ul style="list-style-type: none"> Assessment Specialized evaluations (psychological, neurological) Service planning (including crisis planning) Consumer/family education Outreach
Prevention (including Promotion)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Personal care Homemaker Respite Supported education Transportation Assisted living Recreational services Interactive communication technology devices
Recovery Supports	<ul style="list-style-type: none"> Peer support Recovery support coaching Recovery support center services Supports for self-directed care Continuing care for substance use disorders

Increasing intensity of social and community services

Increasing intensity of medical and behavioral health specialty

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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² Medicaid.gov. *Benefits*. Retrieved July 9, 2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>.

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⁴ Social Security Act §1905(a)(13). Retrieved July 9, 2013 from http://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

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⁹ Federal Register. Vol. 72, No. 155. (Monday, August 13, 2007.) Proposed Rules. 42 CFR Parts 440 and 441. [CMS 2261-P] RIN 0938-A081 Medicaid Program; Coverage for Rehabilitative Services. Retrieved July 9, 2013 from <http://federal.eregulations.us/fr/noticehome/08/13/2007/07-3925.html>.

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¹¹ Family Networks. *Accessing Mental Health Services for Children in Maryland Through the Medical Assistance/Medicaid EPSDT Benefit*. Retrieved July 9, 2013 from <http://www.pathfindersforautism.org/docs/EPSDT.pdf>.

¹² *Bright Futures Periodicity Schedule*. Retrieved July 9, 2013 from http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html.

¹³ Department of Health and Human Services Office of Inspector General. Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services. May 2010 OEI-05-08-00520 Retrieved July 9, 2013 from <https://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf>.

¹⁴ State Efforts to Limit EPSDT Services Pursuant to Medicaid's Reasonable Standards Provision. Center for Public Representation. April 1, 2005. Retrieved July 9, 2013 from www.acmhai.org/pdf/factsheet_state_limits_on_EPSDT.pdf.

¹⁵ Medicaid.gov. Early and Periodic Screening, Diagnostic, and Treatment. National EPSDT Improvement Workgroup. Retrieved July 9, 2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>.

¹⁶ 42 CFR 435.1009. Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+42%2FChapter+IV%2FSubchapter+C&oldPath=Title+42%2FChapter+IV&isCollapsed=true&selectedYearFrom=2011&ycord=1459>.

¹⁷ 42 CFR 440.20. Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+42%2FChapter+IV%2FSubchapter+C&oldPath=Title+42%2FChapter+IV&isCollapsed=true&selectedYearFrom=2011&ycord=1459>.

¹⁸ 42 CFR 440.90. Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+42%2FChapter+IV%2FSubchapter+C&oldPath=Title+42%2FChapter+IV&isCollapsed=true&selectedYearFrom=2011&ycord=1459>.

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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 buprenorphine²².

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³ U.S. Department of Health and Human Services. *Health Services and Resources Administration. Primary Care: The Health Center Program. What is a health center?* Retrieved July 9, 2013 from <http://www.bphc.hrsa.gov/about/>.

⁴ National Association of Community Health Centers. (July 11, 2011.) *Letter to the Centers for Medicare & Medicaid Services RE: Request for Information Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare*. [PDF version.] Retrieved July 9, 2013 from <http://www.nachc.com/client/documents/7%202011%20NACHC%20Comment%20on%20MC%20MCD%20aligning%20duals.pdf>.

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⁶ 42 USC 254b(b)(1). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

⁷ 42 USC 254b(b)(1)(A)(ii). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

⁸ 42 USC 254b(b)(2). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

⁹ 42 USC 254b(b)(2)(A). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

¹⁰ 42 USC 254b(h)(2) and (h)(5)(C). Retrieved July 9, 2013 from <http://www.law.cornell.edu/uscode/text/42/254b>.

¹¹ National Association of Community Health Centers. (January 2011.) *NACHC 2010 Assessment of Behavioral Health Services in Federally Qualified Health Centers. Clinical Division*. [PDF version.] Report retrieved July 9, 2013 from http://www.nachc.com/client/NACHC%202010%20Assessment%20of%20Behavioral%20Health%20Services%20n%20FQHCs_1_14_11_FINAL.pdf.

¹² CMS.gov. *Psychiatric Residential Treatment Facility Providers*. Retrieved July 9, 2013 from <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/PRTFs.html>.

¹³ Psychiatric Residential Treatment Facilities. (2008.) *Iowa Policy Research Organization*. Retrieved July 9, 2013 from <http://www.docstoc.com/docs/2986536/Psychiatric-Residential-Treatment-Facilities-This-IPRO-report-compares-Psychiatric-Residential>.

¹⁴ National Association for Children's Behavioral Health. *Rationale for Eliminating the IMD Exclusion for Beneficiaries Under Age 21*. Retrieved July 9, 2013 from http://www.nacbh.org/PubDocs/IMD_Exclusion_for_Under-21_080112.pdf.

¹⁵ Social Security Act §1905. Retrieved July 9, 2013 from http://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

¹⁶ Social Security Act §1905(i). Retrieved July 9, 2013 from http://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

¹⁷ Rosenbaum S, Teitelbaum J, and D. Richard Mauery. (December 19, 2002.) *An Analysis of the Medicaid IMD Exclusion*. [PDF version.] Retrieved July 9, 2013 from http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/behavioral_health/reports/IMD%20Report%201202.pdf.

¹⁸ The President's New Freedom Commission on Mental Health. Delivered to the President on July 22, 2003. Retrieved July 9, 2013 from <http://www.nami.org/Template.cfm?Section=Policy&Template=/ContentManagement/ContentDisplay.cfm&ContentID=16699>.

¹⁹ Medicaid Emergency Psychiatric Demonstration. (Publication date not provided). *Demonstration Design and Solicitation*. [PDF version.] Retrieved July 9, 2013 from http://www.innovations.cms.gov/Files/x/MedicaidEmerPsy_solicitation.pdf.

²⁰ Medicaid Manual. Attachment Three. *Requirements and Limits Applicable to Specific Services. 4390. Institutions for Mental Diseases*. [PDF version.] Retrieved July 9, 2013 from http://www.dmh.ca.gov/DMHDOcs/docs/letters10/10-02_Enclosure3.pdf.

²¹ Medicaid Financing of State and County Psychiatric Hospitals. (2003.) *Special Report. U. S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Mental Health Services*. [PDF version.] Retrieved July 9, 2013 from <http://www.ime.state.ia.us/docs/MedicaidFinancingofGovernmentHospitals-SAMHSA.pdf>.

²² Substance Abuse and Mental Health Services Administration. *Medication-Assisted Treatment for Substance Use Disorders. Pharmacotherapy for Substance Use Disorders*. Retrieved July 9, 2013 from <http://www.dpt.samhsa.gov/medications/medsindex.aspx>.

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Medicaid Handbook: Interface with Behavioral Health Services

Module 5

Structure and Reimbursement Methodologies

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Module 5: Structure and Reimbursement Methodologies

How a State's Medicaid Program Can Be Structured

A state can choose to operate its Medicaid program using a fee-for-service (FFS) framework, a managed care framework, or a combination of the two. FFS and managed care are service delivery structures, but they are also types of reimbursement arrangements. Thus, as described below, program architecture and reimbursement are intimately linked.

Fee for Service

Historically, states structured their Medicaid programs as FFS delivery systems. In this structure, a provider renders a service to a Medicaid consumer, submits a bill to the state Medicaid agency, and is paid a fee by the Medicaid agency for the provision of that service.

The FFS system is often regarded as rewarding quantity of services over quality, because its basic structure pays providers for each unit of service rendered, with a financial incentive to increase the number of units delivered. Before advocates and experts in health care delivery systems began to focus on the importance of care coordination and quality, FFS systems were the norm. Over the last few years, however, health care service delivery and payment system reformers have begun to move away from a system that operates strictly based on the number of tests and services provided.

Additionally, FFS systems are often criticized for an inability to adequately coordinate the care of high-risk consumers because consumers can go to any provider they choose. Conversely, Medicaid managed care and the other care coordination strategies discussed below are widely regarded as working to improve care management for Medicaid consumers. For these reasons, FFS is not currently the dominant delivery system for Medicaid services, although it remains a prevalent reimbursement methodology.

While serving fewer individuals in Medicaid systems, for many states FFS systems remain important for more complex or vulnerable populations—for whom care is often more expensive. This is precisely because of the advantages of a FFS arrangement; FFS reimbursement is the most accurate with regard to the type and amount of service rendered to an individual, and it provides no barrier or disincentive for the provider to render needed care.

Managed Care: Arrangements

Under managed care, a state contracts with an organization to provide services to Medicaid consumers through a defined network of providers.

There are three types of Medicaid managed care arrangements:

1. **Primary care case management (PCCM) programs.** PCCM programs build on the Medicaid FFS system but are considered a form of managed care. Under a PCCM program, the state contracts with primary care providers (PCPs) that agree to provide case management services to Medicaid enrollees assigned to them, including

coordination and monitoring of primary health care.¹ This approach has the benefit of the coordination provided by the PCP without the downside associated with managed care risk.

As in risk-based managed care whereby the state develops standards for managed care organizations (MCOs), states set specific requirements for PCPs participating in a PCCM. The requirements for the PCPs may include provision of specified primary care services, minimum hours of operation, specific credentials or training, and responsibility for referrals to specialists.

PCPs are usually paid a monthly fee to provide case management, and they are also paid on a FFS basis for the other health care services they provide. PCPs are usually physicians, physician group practices, or clinics (such as federally qualified health centers [FQHCs]), but a state may also recognize nurse practitioners, nurse midwives, and physician assistants as PCPs. The state Medicaid agency provides or contracts for the administration of the PCCM, including network development, credentialing, and quality monitoring. The state usually assumes full financial risk for the utilization of health care services.²

2. **Risk-based MCOs or health plans.** Under this structure, the state contracts with MCOs to provide a defined package of benefits to enrolled Medicaid consumers. The state pays the MCO a set per-member, per-month (PMPM) fee. This fee is known as *capitation* or a *capitated rate*. It means that the MCO receives the same amount of money for each of its enrollees, regardless of each consumer's service utilization and related cost to the MCO. In this arrangement, the MCO is said to be financially *at risk*.

The MCO is responsible for coordinating the care of its enrollees and must manage the cost of care and all administrative expenses within the capitated amount reimbursed by the state. The financial incentives put a premium on providing preventive or primary care to reduce the use of more expensive services, although some argue that capitated arrangements provide an incentive to deny needed care. Medicaid MCOs may be commercial health maintenance organizations (HMOs) that also serve people with employer-sponsored insurance, or they may be Medicaid-only plans with no commercially insured members.¹

State Medicaid authorities develop their own standards of participation for MCOs, which usually include specified protocols for enrollment and member support, requirements to ensure adequate access to care, benchmarks for quality and quality improvement, and data collection requirements.¹ Section 1932(c) of the Social Security Act requires states operating Medicaid managed care programs to contract with an external quality review organization to ensure compliance with Medicaid managed care standards and state contracts, thereby monitoring the quality of services provided to managed care enrollees.

In addition to programmatic, clinical, and other requirements developed by state Medicaid programs, most state insurance regulations also govern Medicaid MCOs.

This requires the state Medicaid authority and insurance regulators to communicate to prevent duplicative regulations and to react in the event that quality or financial problems with a health plan arise.

3. **Noncomprehensive prepaid health plans (PHPs).** States contract with PHPs on a risk basis to provide either comprehensive or noncomprehensive benefits to enrollees.¹ Federal regulations that govern Medicaid managed care refer to MCOs as a comprehensive type of PHP and identify two types of noncomprehensive PHPs: prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs).³

A PIHP provides, arranges for, or otherwise has responsibility for a defined set of services that include some type of inpatient hospital or institutional service, such as inpatient behavioral health care.²

A PAHP provides, arranges for, or otherwise has responsibility for some type of outpatient care only.²

Common types of noncomprehensive PHPs provide only behavioral health services or only dental services. In many instances, these are *carved out* of the benefit package provided by MCOs.

Today, 23 million people—about 40 percent of the Medicaid population—are enrolled in MCOs and another 13 million, or 22 percent are enrolled in PCCMs.⁴ As of October 2010, only three states (Alaska, New Hampshire, and Wyoming) reported that they did not have *any* Medicaid managed care.⁵

Choosing to Carve Behavioral Health In or Out

A state may choose to “carve out,” meaning that it contracts with a specialty MCO for management of its Medicaid behavioral health benefit. A state might choose this option for the expert knowledge the organization has in providing specialized services.

The creation of separate benefits for physical and behavioral health care reflects a desire to manage the behavioral health benefit within different limits and in different ways from medical/surgical benefits. Some would suggest that the *separateness* has become an impediment to the desired goals of greater access, incentivizing cost effective alternatives, and innovation. As states continue to review their decisions related to the use of managed care for those with specialty needs and the goal of improving integration they will, by necessity, be compelled to reconsider the structural use of carve outs.

Ohio is an example of a state with behavioral health services carved out of its managed care program. Ohio’s Medicaid program uses mandatory risk-based managed care structure as the foundation for physical health care. Publicly funded mental or substance use disorder (M/SUD) treatment services are provided through a *carve out* administered through the Ohio Department of Mental Health and Addiction Services. Although services are coordinated with the managed care plans, the plans are not *at risk* for behavioral health services.

In a research study conducted by the BEST Center, BEST used Ohio Medicaid claims data to identify adults with serious mental illness (SMI). Several findings shed light on the dynamic of a carved out behavioral health system, specifically with regard to adults with SMI—

- Approximately 29 percent of adults with SMI do not receive services in the carved out, specialty behavioral health system
- Adults with adjustment disorder or substance use disorders were mostly—approximately 56 percent—served in the carved out system
- The majority of adults with schizophrenia and bipolar disorder receive services from both systems—65 percent and 56 percent, respectively⁶

In any consideration of how to integrate physical and behavioral health services, the issue of carving in or carving out will arise. There is no one right way to address this issue, but there is a growing body of information about financial, structural, and clinical practice to improve integration. The goal is for individuals to experience care and communication with their providers in a seamless fashion. Although there are a number of ways to approach it, there should be alignment in the financing, structural relationships, and infrastructure.

Some carved out models have been customized to support clinical integration efforts, whereas some carved in models have had the effect of reducing overall levels of behavioral health spending and services. In all aspects related to integration and the associated structural considerations, details are critical.

Managed Care: Authorities

States can implement managed care under several types of federal authorities, all of which give them the flexibility to waive Medicaid principles outlined in §1902 of the Social Security Act—

- **Statewideness.** Waiving statewideness lets states implement a managed care delivery system in specific areas of the state (generally counties or parishes) rather than the whole state.
- **Comparability of Services.** Waiving comparability of services lets states provide different benefits to people enrolled in a managed care delivery system.
- **Freedom of Choice.** Waiving freedom of choice lets states require individuals to receive their Medicaid services from a managed care plan or primary care provider. Using this authority allows the managed care plan to specify requirements to be included in their panel of providers.⁷

When deciding the authority under which it should design its managed care program, a state should formulate goals and consider the policy options afforded by each authority that may best accomplish the identified objectives. For example, states should contemplate the following:

- **Geography.** Some of the authorities described below permit a state to limit statewideness. Choosing an authority that allows for this option is necessary for a state that wants to target its managed care program to a certain region(s).
- **Population.** Some of the authorities below permit a state to offer its managed care program to all consumers or to select populations. Choosing an authority that allows

for this option is necessary for a state that wants to target its managed care program to a population based on age, eligibility category, disability, etc.

- **Voluntary or Mandatory Implementation.** Some of the authorities below permit a state to establish its managed care program as mandatory for populations that are not specifically precluded from mandatory enrollment; others allow a state to offer its managed care program as voluntary for those eligible individuals who choose to enroll.
- **Network of Service Providers.** Some of the authorities below permit a state to limit freedom of choice of provider. Choosing an authority that allows for this is necessary for a state that wants to let managed care plans restrict or tailor the network of providers with which it contracts. A state wishing to limit the provider network has significant flexibility in deciding the degree of limitation that it includes in its contract. For example, a state may very specifically describe network criteria—including provider types and minimum provider requirements—or it may give little specificity regarding the types and number of providers that a network must include.
- **Choice of Managed Care Plans.** Some of the authorities below permit a state to selectively contract with managed care plans, thereby limiting the consumer's choice of plans.

Section 1932(a) State Plan Option

States can establish a managed care delivery system by getting Centers for Medicare & Medicaid Services (CMS) approval to include it in the Medicaid State Plan. The state indicates on the preprinted State Plan pages the types of entities it will use and what groups of people will be enrolled. Section 1932(a) State Plan managed care and §1915(b) waiver managed care—described below—are the two most common types of managed care arrangements that states employ.

Section 1932(a) State Plan Medicaid managed care authority does the following—

- Allows the state to implement a voluntary or mandatory managed care program
- Allows the state to offer managed care statewide or limit the program by geography
- Allows the state to offer the program to all consumers or select populations
- Requires that managed care enrollment be voluntary for certain children with special needs, those dually eligible for Medicaid and Medicare, and Native Americans
- Allows the state to selectively contract with plans as long as there is a choice of two plans in rural areas⁸
- Allows the state to selectively contract with providers

CMS currently reports that 21 states are operating 28 managed care programs using §1932(a) State Plan authority.⁷

Example: Ohio

- Mandatory statewide managed care for certain populations
- State divided into regions
- Choice of at least two plans in all regions

Section 1915(a) Voluntary Contracting

States can implement a voluntary managed care program under §1915(a) of the Social Security Act simply by executing a contract with plans that the state has procured using a competitive bidding process and by getting CMS approval. This arrangement does not require a waiver or inclusion in the State Plan. This authority cannot be used to implement a mandatory managed care arrangement.

Section 1915(a) managed care authority does the following—

- Allows the state to offer managed care statewide or limit the program by geography
- Allows the state to offer a unique benefit package to specific populations
- Prohibits the state from selectively contracting with plans

CMS currently reports that 13 states (and Puerto Rico) use §1915(a) contracts to administer 24 voluntary managed care programs.⁷

Example: Minnesota (Special Needs Basic Care)

- Special Needs Basic Care is a voluntary managed care program for individuals aged 18 through 64 years, who are certified as disabled through the Social Security Administration or the state Medical review team or who have a developmental disability.
- Enrollees may have a care coordinator or navigator to help them obtain health care and support services.
- Plans coordinate with other payers, including Medicare.
- Beginning in 2012, people with disabilities who are younger than age 65 and who have FFS coverage will be asked to enroll in a special needs basic care health plan for their health care.
- Some populations may be excluded.
- Anyone can choose not to enroll and to stay in the FFS plan.⁹

Example: New York (Managed Long-Term Care Plans)

- Managed long-term care plans provide long-term care services (e.g., home health, adult day care, and nursing home care) and ancillary and ambulatory services (e.g., dentistry, optometry, eyeglasses, and medical equipment) and receive Medicaid payment only.
- Members continue to receive Medicaid and Medicare to obtain services from their PCPs and inpatient hospital services—the managed long-term care plan does not control or provide any Medicare services, and it does not control or provide most primary Medicaid care.
- Members must be eligible for nursing home admission.
- Although several plans in New York state enroll younger members, most managed long-term care plan enrollees must be at least 65 years old.¹⁰

Example: Wisconsin (Children Come First and Wraparound Milwaukee)

- Wisconsin has two multiagency, community-based programs for M/SUD services for children with serious emotional disturbance (SED).

- The goals of these programs are to keep children with SEDs out of institutions and to reallocate resources previously used for institutionalization to community-based services.
- To be eligible, 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.¹¹

Section 1915(b) Waiver

States can use waiver authority under §1915(b) of the Social Security Act to create a mandatory managed care program. Section 1915(b) waiver managed care authority does the following:

- Allows the state to require enrollment of Medicare-Medicaid enrollees and other aged, blind, or disabled (ABD) populations through §1915(b)(1) authority
- Allows the state to offer managed care statewide or limit the program by geography
- Allows a state to selectively contract with providers under §1915(b)(4) authority
- Prohibits a state from impairing access to medically necessary services.⁷

The state can choose to use the §1915(b) managed care authority under one or more subsections of §1915(b).

- **§1915(b)(1).** The state requires enrollees to obtain medical care through a PCCM system or specialty physician services arrangements. This includes mandatory capitated programs.
- **§1915(b)(2).** A locality will act as a central broker (i.e., agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs, PIHPs, or PAHPs in order to provide enrollees with more information about the range of health care options that are available to them.
- **§1915(b)(3).** The state will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver.

Section 1915(b)(3) offers states the opportunity to provide additional services to waiver enrollees that are paid through savings achieved under the waiver. In order to offer additional services under §1915(b)(3), the §1915(b)(3) authority must be concurrent with the §1915(b)(1) or §1915(b)(4) authority. 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.

- **§1915(b)(4).** The state requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provision of covered care and services.

If it chooses to use §1915(b)(4) authority, the state must choose one of the following managed care programs: PIHP, PAHP, MCO, PCCM.¹²

CMS currently reports that there are 48 approved §1915(b) waivers operating in 28 different states.⁷

Example: California (Medi-Cal Specialty Mental Health Services)

- Coverage for specialty mental health services is provided through Mental Health Plans (MHPs) in California’s 58 counties. In most cases, the MHP is the county mental health department. MHPs render or authorize and pay for specialty mental health services.
- Medi-Cal recipients are enrolled automatically in the MHP serving their county. The MHP in the recipient’s assigned county is responsible for providing MHP-covered services for eligible recipients in that county.
- Medi-Cal beneficiaries who have a mental disorder or a treatment need that requires the services of a mental health specialist are entitled to services from the MHP.¹³

Section 1915(b)/(c) Waiver

Section 1915(b)/(c) waiver authority is used to implement a mandatory managed care program that includes home and community-based waiver services in a managed care arrangement. The §1915(b) authority is used to mandate enrollment in managed care and to limit freedom of choice and/or create selective contracts. The §1915(c) authority is used to target eligibility and provide home and community-based services (HCBS).

Section 1915(b)/(c) managed care authority does the following—

- Allows the state to selectively contract with providers
- Requires the state to apply for each waiver authority separately and concurrently
- Requires cost effectiveness for §1915(b) and cost neutrality for §1915(c)
- Allows the state to add non-State Plan HCBS in the capitation rate under the §1915(c) waiver authority or in the §1915(b) waiver as §1915(b)(3) services
- Allows the state to use §1915(b) authority to use a limited pool of providers

Example: North Carolina (Innovations waiver and Mental Health, Developmental Disabilities, and Substance Abuse Services Health Plan waiver)

- Local management entities (LMEs) operate as PIHPs to coordinate the provision of specialty services, including mental health, developmental disability, and substance use services to certain mandated populations.
- LMEs contract for services with provider agencies.
- The LMEs assume financial risk for a set of services and act as managed care entities; however, the state bears some of the financial risk because the state law limits the financial risk on counties.
- Historically, this capitated model operated as a pilot in five counties, but the state is expanding this model statewide.
- Consumers meeting eligibility requirements are mandatorily enrolled.¹⁴

Section 1115 Waiver

Under §1115 of the Social Security Act, states have broad waiver authority at the discretion of the Secretary of HHS to implement projects that test policy innovations that are likely to further the objectives of the Medicaid program. They can use this authority to structure managed care programs to suit the needs of their beneficiaries.

Example: Arizona (Arizona Health Care Cost Containment System)

- The Arizona Health Care Cost Containment System is inclusive of the Arizona Acute Care Program (AAP) and the Arizona Long-Term Care System (ALTCS).
- Both of these programs contract with providers and MCOs to deliver services to Medicaid beneficiaries on a managed care basis.
- Behavioral health services are delivered separately through AAP and ALTCS, and are provided by regional behavioral health authorities (RBHAs).
- The state also received federal Medicare-Medicaid enrollee program-planning grant dollars to implement a health home initiative. The initiative will make the RBHA in Maricopa County fully responsible for coordinated and integrated behavioral health care and physical health care for Medicaid-eligible adults with SMI.¹⁵

Example: Florida (Florida Medicaid Reform)

- Florida requires most Medicaid-eligible individuals in several counties to enroll in a managed care plan—either a capitated health plan or the FFS Provider Service Network plan.
- The state allows consumers to choose the plan that best suits their needs.
- It allows plans to offer customized benefit packages, but each plan must cover all mandatory services as outlined in federal law.
- The Florida Demonstration program also allows the establishment of an Enhanced Benefits Account (EBA). This program provides direct incentives to Florida Demonstration enrollees who participate in state-defined activities that promote healthy behaviors. Beneficiaries accumulate funds in their EBA and use them for approved, noncovered health-related needs such as over-the-counter medications. Individuals who leave the Medicaid program can retain use of any funds remaining in their EBA (for approved health-related uses) for up to 3 years, as long as their incomes remain at or below 200 percent of the federal poverty guidelines.
- Participation is mandatory for §1931 eligible persons and related groups and the ABD group, with some exceptions.¹⁶

In short, a state should evaluate the following policy interests in addition to considerations related to the authority under which it chooses to implement its managed care program—

- Degree of risk each party will tolerate
- Type and degree of care coordination desired
- Core benefits and additional or optional services to be included
- State and federal procurement requirements
- State insurance requirements
- Contractual issues

Reimbursement Methodologies

How Do States Set Reimbursement Rates for Services?

Before 1990, federal law required states to pay hospital, nursing home, and several other provider categories their *reasonable costs* or rates that were *reasonably cost-related*. Reimbursement for all other providers was to have been in compliance with the *Equal Access*

Provision described below. During this period, at least with respect to hospitals and nursing homes, CMS actively reviewed and approved changes to state Medicaid payment methodologies.¹⁷

In 1990, Congress enacted the *Boren Amendment*, which required rates for hospitals and nursing homes to be “reasonable and adequate.” It also required states to assure the federal government that their rates conformed with federal law. While the Boren Amendment was in effect, HHS construed its role to be extraordinarily minimal and, in essence, to simply ensure that states made certain advance findings before changing their Medicaid reimbursement rates. As a result, reimbursement rates for these classes of providers were predominantly the product of negotiation between the states and providers. When states attempted to change their rates to levels that provider groups considered inadequate, providers would challenge the methodology by bringing actions in federal and state courts or by using the Boren amendment standard to negotiate an acceptable alternative.¹⁷

As part of the Balanced Budget Act of 1997, Congress repealed the Boren Amendment, leaving the Equal Access Provision to govern the adequacy of reimbursement for all providers.

Today, states have significant latitude in deciding how to structure reimbursement methodologies for the Medicaid services they provide, as long as they are in compliance with the *Equal Access Provision* of §1902(a)(30)(A) of the Social Security Act. CMS regional offices (ROs), overseen by the central office (CO), are charged with reviewing and approving proposed payment methodologies in light of this federal statute and its associated regulations.

The Equal Access Provision of §1902(a)(30)(A) of the Act requires that payment standards:

- Guard against unnecessary utilization;
- Are consistent with efficiency, economy, and quality of care; and
- Are sufficient to enlist enough providers so that care and services are available to the same extent that care and services are available to others in the community.¹⁸

The Equal Access Provision ensures that state reimbursement methodologies provide Medicaid consumers with adequate access to health care services.

Because there is limited guidance in federal law or regulation pertaining to payment standards, federal case law largely fills in the gaps. The courts are split as to what §1902(a)(30)(A) actually requires—a process by which states ensure access to care (i.e., focus on process or procedure) or that services are accessible (i.e., focus on result). Examples are provided below.

- In *Methodist Hospitals v. Sullivan*, the Seventh Circuit Court of Appeals held that §1902(a)(30)(A) does not require states to conduct access studies before modifying their rates. Rather, the question for states to consider is whether the rate “elicited enough medical care.” This ruling squarely focused on access over procedural requirements.
- The Third Circuit reached a similar conclusion in *Rite Aid v. Houstoun*, holding that the Equal Access Provision dictates a result (adequate access), not a process. It further noted that §1902(a)(30)(A) does not specify a particular process for a state Medicaid agency to follow in establishing rates.

- The Ninth Circuit reached a different result in *Orthopaedic Hospital v. Belshe*, holding that §1902(a)(30)(A) requires that state payment rates “bear a reasonable relationship” to the cost of providing services, and that states cannot set rates without doing a cost study.¹⁹

The variability in interpretation, coupled with review standards applied differently by each CMS RO, often leads to unpredictability and does little to standardize the understanding of reimbursement methodologies.

Fee-for-Service Rates

As described above, in an FFS structure, a provider renders a service to a Medicaid consumer, submits a bill to the state Medicaid agency, and is paid a fee by the Medicaid agency for the provision of that service. States may develop FFS rates based on—

- The costs of providing the service
- A review of what commercial payers pay in the private market
- A percentage of what Medicare pays for equivalent services

Payment rates are often tied to inflationary factors like the Medicare Economic Index. States must describe reimbursement methodologies in their Medicaid State Plans.²⁰

Currently, FFS is not the predominant structure by which Medicaid programs are operated, although it is still a dominant reimbursement methodology. For example, managed care plans may negotiate their own reimbursement methods with network providers for services, but many utilize similar or, in some cases, identical FFS rates as the state’s Medicaid rates.

Medicaid Managed Care Rates and Capitation

Just as states have significant flexibility in determining FFS rate structures, the process by which they develop managed care rates may vary in a number of ways, including the type and time frames of data they use as the basis for setting rates and the approach they use to negotiate rates with health plans. States make capitation payments prospectively to Medicaid managed care plans to provide or arrange for services for their Medicaid enrollees.²¹ Managed care plan capitation rates are *risk-based*. This means that the managed care plan receives the same payment from the state for each of its enrollees every month, regardless of whether (and the extent to which) each enrollee actually receives services.

Because Congress was concerned that this system might create an incentive to deny access to care, they implemented several safeguards. One is the requirement that state capitation rates be *actuarially sound*.²² According to the Balanced Budget Act of 1997, actuarially sound rates are payments that are adequate to cover medical costs, administration, taxes, and fees.²³ In 2002, CMS issued regulations defining actuarially sound rates as those that are:

- Developed in accordance with generally accepted actuarial principles and practices;
- Appropriate for the populations to be covered and the services to be furnished; and
- Certified as meeting applicable regulatory requirements by qualified actuaries.²⁴

The regulations also require states to submit their rate-setting methodologies to CMS. Finally, they specify the documentation that states must submit to CMS ROs to demonstrate compliance with the requirements, including a description of their rate-setting methodology and the data used to set rates.²³ In 2003, CMS finalized a detailed checklist that its RO staff could use in their reviews of state rate settings. States and their actuaries also use the checklist when setting their rates. The items included in the CMS checklist illustrate the detailed type of information that the state must consider in setting managed care rates. For example—

- **Overview of Rate-Setting Methodology.** The state is required to provide documentation regarding the general rate-setting methodology, contract procurement, and the actuarial certification, including all of the following—
 - The rates and the time period for the rates
 - Description of risk-sharing mechanisms
 - A projection of expenditures
 - An explanation of rate setting
- **Base-Year Utilization and Cost Data.** The state is required to provide documentation and an assurance that all payment rates are:
 - Based only upon services covered under the state Medicaid Plan or costs related to providing these services, such as health plan administration; and
 - Provided under the contract to individuals eligible for Medicaid.
- **Adjustments to Base-Year Data.** The state is required to provide documentation of any adjustments to the base-year data, including the policy assumptions, size, and effect of the adjustments. Adjustments may include changes to the following—
 - Services covered
 - Administration
 - Medical service cost and trend inflation
 - Utilization
- **Rate Category Groupings.** The state is required to create rate cells that are specific to the enrolled population. Categories the state should normally consider in the establishment of rates include age, sex, locality or region, and eligibility. States may omit or combine categories.
- **Other.** The state is required to document their methodology in a number of other areas. For example:
 - Document that they have examined base year data for distortions—such as special populations with catastrophic costs—and adjusted rates in a cost-neutral manner
 - Document the use of reinsurance and other risk-sharing mechanisms
 - Explain any incentive arrangements in the contract.²⁵

The CHIP Reauthorization Act of 2009 (CHIPRA) required the General Accounting Office (GAO) to examine the extent to which state rates are actuarially sound. GAO's assessment concluded that CMS had been inconsistent in reviewing state rate settings for compliance with the actuarial soundness requirements. GAO specifically cited variation in CMS RO practices as a factor contributing to this inconsistency in oversight. For example, ROs varied in the extent to which they tracked state compliance with the actuarial soundness requirements, their interpretations of how extensive a review of a state's rate setting was needed, and their determinations regarding sufficient evidence for meeting the actuarial soundness requirements.

As a result of the study, CMS implemented practices to address some of the variation that contributed to inconsistent oversight.²⁵

Encounter Data

When states initially began to implement managed care programs, the reimbursement relied almost entirely on historical FFS data. As managed care expanded, there became less FFS data on which to rely. Most states use encounter claims data, which includes information related to the services provided by the Medicaid managed care program. Encounter claims data are the primary records of services for Medicaid managed care-enrolled consumers. Collecting data from encounter claims provides a basis for accurate managed care rate development and requires that fewer assumptions be made in the development of actuarially certified rates.²⁶ However, although encounter claims provide information about the types and volume of services, they do not necessarily provide any information about the cost of the services. To address this, some states utilize *pseudo billing* or *shadow billing* algorithms to provide a reflection of the estimated cost of providing services. As the managed care plan expands and matures, there is less FFS data and an increasing reliance on encounter data or other comparable commercial experience upon which to draw. CMS does not require that Medicaid managed care plans submit encounter information. The differences in information collected and reported for managed care services compared to FFS data present some challenges to getting a complete picture of cost and utilization at both the state and federal level.

Prospective Payment Rates

In most states, Medicaid reimbursement for inpatient and outpatient hospital services is not a retrospective, cost-based system; instead, it is a prospective payment system. These systems generally involve calculating per-case reimbursements, which are determined prospectively based on the patient's condition. Adjustments are made for certain categories of facilities or certain types of patients.²⁷ Under a prospective payment system, a provider receives a fixed payment to cover an episode of care during a period of time. The payment formulas are complex and have many adjustments to address everything from outliers or teaching-related costs to uncompensated care. The goal is to set the prospective payment based on what it costs an efficient provider to serve the patient.²⁸

Inpatient Hospital Prospective Payment System: Diagnosis-Related Groups

For inpatient hospital services, rates are often based on diagnosis-related groups (DRGs). DRGs classify patients according to diagnosis, complications, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for the hospital or facility cost of treating patients in a single DRG, regardless of the actual cost of care for the individual.²⁹

Hospitals also may be paid an additional payment for covered inpatient hospital services that exceed certain thresholds established per DRG by the state. These *outlier payments* are intended to provide additional reimbursement for the provision of care that exceeds the anticipated regular cost or length of stay.

Outpatient Hospital Prospective Payment System

The outpatient prospective payment system is based on a fee schedule or cost-to-charge ratio. It sets payments for individual services using a set of relative weights, a conversion factor, and adjustments for geographic differences in input prices.³⁰

Bundled Payments

In the last few years—and embodied in the Affordable Care Act—the federal and state governments have been focused on increasing quality of care in conjunction with pursuing payment reform. The general idea is that the historical FFS system does not reward quality of care; instead, it focuses on more payment for more services.

One payment reform strategy is implementation of bundled payments. Bundled payments link payments for multiple services during an episode of care. For example, instead of a surgical procedure generating multiple claims from multiple providers, the whole team is reimbursed with a *bundled* payment. This method provides incentives to coordinate and deliver health care services more efficiently while improving quality of care.³¹ There is a continuum of payment bundling approaches; some even consider DRGs to be a limited form of bundling.

Currently, Medicaid and Medicare make separate payments to providers for a single illness or course of treatment, which results in little coordination across providers and health care settings. Payment is based on *how much* a provider does, rather than *how well* the provider treats the patient. Research has shown that bundled payments can align incentives for providers to partner closely across all specialties and settings to improve the consumer's experience during a hospital stay and following discharge.³¹

In an effort to test payment innovations, CMS is working with providers to develop models of bundled payments through the Bundled Payments initiative. In these models, CMS and providers will set a target payment amount for a defined episode of care. Applicants will propose the target price, which will be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants will be paid for their services under an FFS system, but at a negotiated discount. At the end of the episode, the total payments will be compared with the target price. Participating providers may share the gains resulting from the more efficient, redesigned payment model.³¹

Case Rates

A case rate is a reimbursement methodology in which a flat fee covers a defined group of procedures and services.³²

- An **evidence-informed case rate (ECR)** is a single, risk-adjusted payment to providers to care for patients who are diagnosed with a specific acute or chronic condition. The case rates are based on the resources required to provide health care in accordance with nationally accepted, evidence-based clinical guidelines.³³
- A **condition-specific case rate (CCR)** is an approach to bundling for outpatient care of chronically ill patients. A group of providers is paid a global fee to care for a patient with a chronic condition. The case rate covers the services needed during a defined period, such as a year. To the extent feasible, the case rate is all-inclusive,

covering all of the primary and preventive care, care management, patient education, and minor acute care services associated with the patient's chronic condition. Major acute care services, such as inpatient admissions, are paid separately.³³

Global Payments

A global payment is a patient-specific, prospective payment that is intended to cover the costs of care for all covered services delivered over a defined period (e.g., one year). Global payments are set based on an actuarial analysis, and they should be risk adjusted to recognize the variation in costs between patients with different health care conditions. Unlike ECRs and CCRs, global payments can be used for patients with no specific chronic or acute condition.³³

Individualized Budgets and Self-Directed Services

As discussed in [Module 9](#), self-direction of Medicaid services is a model of service delivery that is an alternative to managed care or the traditional FFS system. Self-directed services can be provided under several Medicaid authorities, including §1915(c), §1915(i), §1915(j) and §1915(k) of the Social Security Act. Although each authority has slightly different requirements and guidelines, there are consistent principles.

From a reimbursement perspective, a unique feature of self-directed services is the use of individualized budgets. A budget is created based on an individualized plan of care in accordance with the needs and preferences of each individual. The plan is *costed out* using a method for calculating the dollar value that is specified by the state, and the budget is under the control and direction of the individual. Self-direction can include the hiring or employment of support staff. There is much evidence to demonstrate that when individuals direct their own services, their care can be provided more economically and with higher levels of satisfaction.³⁴

Reimbursement Methodology for Federally Qualified Health Centers

As discussed in [Module 4](#), FQHCs serve a disproportionate number of uninsured and Medicaid-covered consumers. In recognition of health centers' status as important safety-net providers for these populations, the federal government provides grant funding to many health centers to support their efforts to treat the uninsured. The *Medicare, Medicaid, and State Children's Health Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA)* established an all-inclusive (regardless of the medical prevention and/or treatment services rendered) Medicaid per-visit payment rate for health centers, using a prospective payment system methodology. The BIPA was created so that FQHCs receive adequate funding for the Medicaid-covered consumers they serve and so they are not forced to subsidize Medicaid losses with the grant funding they receive from the federal government for treatment of the uninsured.

This single all-inclusive rate guarantees health centers a minimum payment for services provided to Medicaid beneficiaries. The all-inclusive payment is specific to each health center and is calculated using an initial-year, per-visit rate based on the health center's reasonable cost per visit. The payment is capped at a maximum upper payment limit. It is adjusted annually for inflation and increases if there is growth in the center's scope of service.³⁵

Although the BIPA established the prospective payment system methodology for FQHCs, it does not require states to use it. States are allowed to select an alternative payment methodology—including reasonable cost reimbursement—as long as the methodology the state employs reimburses health centers at least what they would receive under the prospective payment system methodology, and as long as it is agreed to by the state and each health center.

With Medicaid managed care programs, health centers receive a *wrap-around* payment that is equal to the difference between the prospective payment system rate and the amount they receive under their contract with Medicaid managed care plans.³⁵ The intent of this supplemental payment is to ensure that the health center receives no less payment when it contracts with a managed care plan than it would receive if it was contracting directly with the state and being paid the full prospective payment system rate.

This reimbursement system is in return for the significant federal oversight with which the health centers comply and for their commitment to comprehensively serving uninsured consumers, including enabling services to assure access. This dynamic—described in §330 of the Federal PHS Act—is unique to health centers.

Some state Medicaid programs prohibit billing for a behavioral health visit and a physical health visit at the FQHC on the same day. There is no general Medicaid prohibition against this procedure, although some states follow the Medicare policy. Medicare reimburses a second all-inclusive rate for a FQHC visit with a clinical psychologist or clinical social worker on the same day as a medical visit. Medicare reimbursement is also permitted when a patient suffers another illness unrelated to the first medical visit.³⁶

Other Financing Mechanisms

Although the requirements of §1902(a)(30)(A) of the Social Security Act are one consideration that states contemplate when setting rates, they employ additional policies to ensure sufficiency of payment and access to services. These mechanisms, described more fully below, are frequently the subject of skepticism and congressional studies tasked with evaluating their value and appropriateness.

Disproportionate Share Hospital Payments

In the early 1980s, federal legislation established a requirement that states consider special payment needs of hospitals that serve a large portion of Medicaid and uninsured patients.³⁷ The rationale for the Disproportionate Share Hospital (DSH) program is that hospitals providing high volumes of care to low-income patients often lose money as a result of low Medicaid reimbursement and high levels of uncompensated care. Moreover, unlike other hospitals, they have fewer privately insured individuals onto which the costs of uncompensated care can be shifted. *High-DSH* hospitals tend to be public hospitals, children's hospitals, or certain other private nonprofit hospitals. They share a commitment to providing access to high-quality, cost-effective health care to all individuals in their communities, regardless of ability to pay.

Under the DSH program, the federal government makes supplemental Medicaid payments to eligible hospitals. States generally determine the amount of payments and methodology for

distribution. Aggregate DSH payments are capped by §1902(a)(13)(A)(iv) of the Social Security Act, and any individual hospital's DSH payments are capped at the difference between its costs of serving Medicaid and uninsured patients and its Medicaid compensation.³⁸

Under the Affordable Care Act, DSH payments to hospitals will be reduced over time. This scenario is discussed in greater detail in [Module 7](#).

Upper Payment Limit

Although states have great flexibility in setting Medicaid rates, federal law prohibits them from paying certain types of facilities more than what Medicare would pay for the same services. For example—

- **For inpatient hospital or institutional services**, providers are divided into three primary groups: inpatient hospitals, nursing facilities, and intermediate care facilities for the developmentally disabled (ICFs-DD). Within these three provider groups, a secondary distinction is made for state owned or operated, non-state government owned or operated, and privately owned or operated facilities. Aggregate payments to each primary group of providers cannot exceed a reasonable estimate of what Medicare would have paid for those services.³⁹
- **For outpatient hospital and clinic services**, a single upper payment limit (UPL) is applied to aggregate payments for all providers combined; no distinctions are made between primary groups of providers or groups of facilities based on ownership (operation) status.³⁹

This ceiling is called the UPL. Because the rates that states pay providers are generally *lower* than Medicare rates, states can receive additional federal funding for the amount under the UPL by making supplemental payments to providers that are beyond regular Medicaid payments. Payments made to providers to fill in the gap between actual payments and the UPL are often generated by provider taxes and/or intergovernmental transfer (IGT) of funds from county or municipal governments (often the owners of local public hospitals) to state governments in order to generate the state's match. Provider taxes and IGTs are discussed further below.

The extra federal funding associated with the gap between Medicaid payments and the UPL can be retained by the state as net savings. These funds are used to finance other programs, paid to hospitals and/or other providers, or divided between the state and the provider community in any other fashion based on the state's UPL program design.³⁹

Medicaid managed care constrains states' gap financing. Services provided to Medicaid consumers enrolled in managed care are not included in the calculation of the gap financing payment to be made to the state. This means that states often must weigh the savings resulting from implementing or expanding managed care and the gap financing payments it receives from the federal government.⁴⁰

Provider Taxes

Under federal rules, the Medicaid state share (i.e., the portion of the Medicaid payment made by a state government) must be non-federal *public funds*. These may come from three sources—

- Direct appropriations to the state Medicaid agency (from the state legislature)
- IGTs
- Certified public expenditures (CPEs)⁴¹

Provider taxes fall into the first category because they produce revenue that flows into a state's treasury and are then directly appropriated to the state Medicaid agency. States can use provider taxes as part of the state Medicaid share in order to draw down FFP. As of May 2011, 47 states had at least one provider tax—

- 38 states had nursing home taxes
- 34 states had hospital taxes
- 34 states had taxes on ICFs-DD
- 11 states imposed taxes on MCOs⁴²

Provider taxes are any mandatory payment, including licensing fees or assessments, for which at least 85 percent of the burden falls on health care providers. The tax can apply to health care items or services or to the provision of (or payment for) such services.⁴³ Assessments or fees imposed on health insurance premiums paid by individuals or employers are not provider taxes.⁴⁴ There are 19 classes of health care services on which provider taxes may be imposed.⁴⁵ They are—

1. Inpatient hospital services
2. Outpatient hospital services
3. Nursing facility services
4. ICF-DD services^A
5. Physician services
6. Home health care services
7. Outpatient prescription drugs
8. Services of MCOs (including HMOs and preferred provider organizations [PPOs])
9. Ambulatory surgical center services (includes facility services only and not surgical procedures)
10. Dental services
11. Podiatric services
12. Chiropractic services
13. Optometric/optician services
14. Psychological services
15. Therapist services (includes physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services)
16. Nursing services (includes all nursing services, including those of nurse midwives, nurse practitioners, and private duty nurses)
17. Laboratory and x-ray services (includes services provided in a licensed, free-standing laboratory or x-ray facility)
18. Emergency ambulance services

^A This includes similar services furnished by community-based residences for the developmentally disabled, under a waiver under §1915(c) of the Act, in a state in which (as of December 24, 1992) at least 85 percent of such facilities were classified as ICFs-DD prior to the grant of the waiver.

19. Other health care items or services not listed above on which the state has enacted a licensing or certification fee, subject to certain additional requirements.

States may not use revenue from a provider tax as a state share unless the tax meets three basic requirements. Provider taxes must—

- **Be broad based.** To be broad based, a provider tax must be imposed on all the health care items or services furnished by all the non-federal, non-public providers in the class in the state. This principle also applies to taxes imposed on managed care plans. For example, a tax cannot be levied against just *Medicaid* managed care plans; it must be levied against *all* managed care plans.
- **Be uniformly imposed.** In general, a provider tax is uniformly imposed if it is the same amount or rate for each provider in the class.
- **Not hold providers harmless.** A provider tax is considered to hold a provider harmless if the providers paying the tax receive, directly or indirectly, a non-Medicaid payment from the state or any offset or waiver that guarantees to hold the provider harmless for all or a portion of the tax.⁴⁶

A general business tax that is not limited to health care providers—for example, a tax based on commercial activity—is not a provider tax, so the above analysis does not apply.

Intergovernmental Transfers

IGTs are funds transferred from other state or local public entities to the administrative control of the state Medicaid agency in order to draw down federal matching dollars. The funds used in IGTs must be *public* funds. IGTs are a permissible funding mechanism under §1903(w)(6)(A) of the Social Security Act, although §1902(a)(2) of the Act mandates that state governments pay for at least 40 percent of the non-federal share of Medicaid.

A survey conducted by the Kaiser Commission on Medicaid and the Uninsured in April 2001 indicated that there were 20 states with some form of local financial matching requirement. For example, New York requires counties to contribute 50 percent of the state share for Medicaid acute care services.⁴⁷ Note that just because a state has a county-based Medicaid delivery system does not necessarily mean that it uses IGTs.

IGTs are a legal and helpful financing tool for states, but they may become problematic when used in conjunction with other Medicaid special financing mechanisms such as UPLs or DSH payment arrangements. IGTs are sometimes criticized for:

- Making federal matching funds available for purposes other than purchasing covered health care services for Medicaid-eligible individuals
- Inflating Medicaid spending rates without a commensurate increase in spending for services for Medicaid enrollees
- Creating incentives for states to reduce their own funding for the facilities they operate and replacing their funds with federal dollars.⁴⁷

Certified Public Expenditures

CPEs are funds certified by a contributing public agency, such as a county government, or provider that is owned by a state, county, or city, such as a county hospital. They represent expenditures for which federal matching payment is allowable. A CPE must be an expenditure by another unit of government on behalf of the single state Medicaid agency. A CPE equals 100 percent of a Medicaid expenditure, and the federal share is paid in accordance with the appropriate federal medical assistance percentage (FMAP). In a state with a 60 percent FMAP for services, the CPE would be equal to \$100 in order to draw down \$60 in FFP.⁴⁸

A nonprovider public agency that pays for a covered Medicaid service that is furnished by a provider can certify its actual expenditure, in an amount equal to the State Plan rate (or the approved provisions of a waiver, if applicable) for the service. In this case, the CPE would represent the expenditure by the governmental unit to the service provider.⁴⁸

If the unit of government is the health care provider, then it may generate a CPE from its own costs if the State Plan (or the approved provisions of a waiver, if applicable) contains an actual cost-reimbursement methodology. If this is the case, the provider may certify the costs that it actually incurred that would be paid under the State Plan.⁴⁸

With both IGTs and CPEs it is important to note that, although a sub-state entity may contribute matching funds, Medicaid eligibility cannot be limited to the availability of funds within the local jurisdiction unless operating under a waiver of statewideness. So, although the responsibility for match can be shared with local jurisdictions, the Medicaid eligibility remains statewide.

¹ 42 CFR 438.2. Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+42%2FChapter+IV%2FSubchapter+C&oldPath=Title+42%2FChapter+IV&isCollapsed=true&selectedYearFrom=2011&ycord=1564>.

² Gifford K, Smith V, Snipes D, and J Paradise. (September 2011.) The Henry J. Kaiser Family Foundation. *Kaiser Commission on Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50 State Survey.* [PDF version.] Page 12. Retrieved July 9, 2013 from <http://www.kff.org/medicaid/upload/8220.pdf>.

³ 42 CFR 438.2. Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+42%2FChapter+IV%2FSubchapter+C%2FPart+438&oldPath=Title+42%2FChapter+IV%2FSubchapter+C&isCollapsed=true&selectedYearFrom=2011&ycord=1726>.

⁴ Stateline. State Policy & Politics, Updated Daily. (May 31, 2011.) *Managed care explained: Why a Medicaid innovation is spreading.* Retrieved July 9, 2013 from <http://www.Stateline.org/live/details/story?contentId=577819>.

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- ¹⁴ See <http://www.ncdhhs.gov/dma/waiver/>.
- ¹⁵ Arizona 1115 Waiver. Retrieved July 9, 2013 from <http://www.azahcccs.gov/reporting/Federal/waiver.aspx>.
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Medicaid Handbook: Interface with Behavioral Health Services

Module 6

Care Coordination Initiatives

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Module 6: Care Coordination Initiatives

The health care environment at the federal and state levels is ripe with ideas aimed at better coordination of consumer care. The coordination efforts are intended to improve delivery system performance and lower health care costs. At the federal level, such initiatives are virtually synonymous with the health care reform movement. States are implementing innovative health care delivery systems modeled on programs introduced in the Affordable Care Act or, in some instances, using those models to create something truly “home grown.”

Coordinated and integrated health care models are discussed throughout this handbook. Organizationally, these issues are raised in several other modules. In particular, note the discussion of targeted case management in [Module 3](#). Several dominant options are described below.

Emphasis on quality outcomes is a theme that consistently runs through the care coordination initiatives discussed in this handbook and one that is generally prevalent in Medicaid programs today. For example, as of the time of publication of this handbook, the Centers for Medicare & Medicaid Services (CMS) had been working closely with states for 2 years to support the voluntary collection of the initial core set of health care quality measures for children in Medicaid and the Children’s Health Insurance Program (CHIP). Additionally, all states contracting with a Medicaid managed care plan must have a written and CMS-approved strategy for assessing and improving the quality of managed care services offered by the state. Moreover, as described further below, measurement of quality outcomes is an important platform of the success of the health home initiative included in the Affordable Care Act. The emphasis on quality in the Medicaid program reflects the recognition that delivery of high *quality* services to consumers should have priority over high *volume* of services.

Health Homes

Section 2703 of the Affordable Care Act adds §1945 to the Social Security Act and allows states the option of amending their Medicaid State Plans to provide health home services for enrollees with chronic conditions. The goal of this new initiative is improved integration and coordination of physical health, behavioral health, and long-term services and supports for individuals with chronic illness. CMS is working closely with the Substance Abuse and Mental Health Services Administration (SAMHSA), the HHS Assistant Secretary for Planning and Evaluation (ASPE), the Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ) to ensure that state-proposed health homes are appropriately developed.¹

The integration of physical and behavioral health care is critical to achievement of the enhanced outcomes that are required of health homes. The Affordable Care Act health home provision affords states the opportunity to build a person-centered care system, which results in improved outcomes for consumers and better services and value for state Medicaid programs and behavioral health agencies. Health homes are an important tool in addressing the needs of people with mental or substance use disorders (M/SUD). It is estimated that 70 percent of individuals in

this population have at least one chronic physical health condition; 45 percent have two; and almost 30 percent have three or more.²

States implementing a health home initiative will be required to measure outcomes. Although federal regulations regarding health homes were not finalized as of the publication of this handbook, CMS has shared a recommended core set of health care quality measures for assessing the health home service delivery model that it intends to promulgate in the rulemaking process. CMS chose the recommended core set of health home measures because they reflect key priority areas such as behavioral health and preventive care. The eight recommended measures are—

- Adult body mass index (BMI) assessment
- Ambulatory care sensitive condition admission
- Care transition—transition record transmitted to health care professional
- Follow-up after hospitalization for mental illness
- Plan—all cause readmission
- Screening for clinical depression and follow-up plan
- Initiation and engagement of alcohol and other drug dependence treatment
- Controlling high blood pressure³

A health home is a model of service delivery that coordinates and integrates all types of care needed by an enrollee: physical health care, behavioral health care, and long-term services and supports. Additionally, §2703 of the Affordable Care Act created six health home services that are also delivered through the health home model. *Health home services* are—

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
4. Individual and family support
5. Referral to community and social support services, if relevant
6. The use of health information technology to link services, as feasible and appropriate

States implementing a health home will receive 90 percent federal financial participation (FFP) for eight consecutive quarters from the effective date of the state plan amendment (SPA) for these six services; they will receive their regular FFP for these services after eight quarters. During and after the eight quarters, they will receive their regular FFP for other Medicaid-covered services delivered to the health home enrollee.¹

States wishing to implement a health home can target one or all of the following populations—

- Individuals who have at least two chronic conditions
- Individuals who have one chronic condition and are at risk for another
- Individuals with one serious and persistent mental health condition

Chronic conditions, described in §1945(h)(2) of the Affordable Care Act include a mental and/or substance use disorder, asthma, diabetes, heart disease, being overweight as evidenced by a BMI over 25, or having another condition that is approved by the HHS Secretary.¹

Section 1945(a) of the Affordable Care Act describes three types of *health home provider* arrangements that a state can use to deliver health home services: designated providers; a team of health care professionals, which links to a designated provider; and a health team.

- **Examples of providers that may qualify as a designated provider** include physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers (CMHCs), home health agencies, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the state and approved by the HHS Secretary. States may include additional providers in this category, including other agencies that offer behavioral health services.
- **Examples of the providers comprising a team of health care professionals** include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the state and approved by the HHS Secretary. These *teams of health care professionals* may operate in a variety of ways, such as in a free-standing, virtual, or hospital-based facility; community health center or CMHC; rural clinic; clinical practice or clinical group practice; academic health center; or any entity deemed appropriate by the state and approved by the HHS Secretary.
- **A health team** should be interdisciplinary and interprofessional. The team must include the following providers: medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral health providers (including mental health providers and SUD prevention and treatment providers), doctors of chiropractic medicine, licensed complementary and alternative medicine practitioners, and physician's assistants.¹

These arrangements afford states the flexibility to fashion the team and designated providers in ways that best address the populations it wishes to serve. This allows a unique opportunity to include peer counselors, navigators, recovering individuals, or other nonlicensed individuals who can offer unique experiences and insight.

The Affordable Care Act gives states considerable flexibility in designing their *payment methodology* for health home services. They may: (1) use a tiered payment structure that takes into account the severity of each person's conditions and the capabilities of the health home provider, (2) pay for health home services on a fee-for-service (FFS) or capitated basis, or (3) propose an alternate payment model for CMS approval. Whatever methodology is chosen, the state must include a comprehensive description of its rate-setting policies in its SPA.¹

Because states have considerable leeway in designing their health home initiatives, examples of approved or submitted models provide insight into possible options. The following examples are specific to individuals with mental and/or substance use disorders.

Missouri (approved by CMS October 21, 2011)

- **Health Home Providers** are defined as CMHCs meeting state qualifications.
- **Delivery System** is managed care and FFS.
- **Target Population** includes: (1) individuals with serious and persistent mental illness (SPMI), (2) individuals with a mental or substance use disorder plus a chronic

- condition, or (3) individuals with a mental or substance use disorder plus tobacco use. Chronic conditions include: asthma, cardiovascular disease, diabetes, having a developmental disability, or being overweight as evidenced by a BMI over 25.
- **Payment** is clinical care PMPM in addition to existing FFS or managed care payments for direct services. Administrative payment is included in the rate to support transforming traditional CMHCs into health homes. The state will make health home payments directly to health home providers. The state is interested in a shared savings strategy and performance incentive payments and plans to revisit the idea.⁴

New York (approved by CMS February 3, 2012)

- **Health Home Providers** are any interested providers or groups of providers that meet state-defined health home requirements; ensure access to primary, specialty, and behavioral health care; and support the integration and coordination of all care.
- **Delivery System** is managed care and FFS.
- **Target Population** includes: (1) individuals with SPMI; (2) individuals with two or more chronic conditions; or (3) individuals with HIV/AIDS and at risk for another chronic condition. Chronic conditions include: mental and/or substance use disorder, asthma, diabetes, heart disease, BMI over 25, HIV/AIDS, hypertension, and other conditions associated with 3M™ Clinical Risk Group.
- **Payment** is PMPM care management fee, adjusted based on region, case mix, and patient functional status (once the data become available).⁴

Rhode Island (approved by CMS November 23, 2011)

- **Health Home Providers** are Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation (CEDARR) Family Centers that are certified to meet health home criteria. CEDARR Family Centers provide services to Medicaid-eligible children who are identified as having one or more special health care need.
- **Delivery System** is managed care and FFS.
- **Target Population** includes: (1) individuals with SPMI or serious emotional disturbance (SED), (2) individuals with two chronic conditions, or (3) individuals with one of the following conditions and at risk of developing another: mental disorder, asthma, diabetes, developmental disability, Down syndrome, or seizure disorder.
- **Payment** is an alternate payment method; the rate is developed based on level of effort required and the market-based hourly rate.⁴

Accountable Care Organizations and Coordinated Care Organizations

The Affordable Care Act contains two provisions that recognize the existence of accountable care organizations (ACOs)—one for providers of services to Medicare consumers and one for pediatric providers, including those reimbursed by Medicaid. Medicare ACOs are much more thoroughly defined in federal law and regulations than are pediatric ACOs. The federal law gives states considerable authority to define parameters for pediatric 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 organized around the principles of: (1) patient-centered aims (defined as better overall health through higher quality care and lower costs for patients); (2) provider accountability through transparent performance measures that reflect those aims; and (3) payment reform that uses the measures to align provider support with the aims.⁵

The parameters of Medicare ACOs are specifically identified in the Affordable Care Act and the rules that accompany it.

- Key characteristics include a formal legal structure with a governing board that is responsible for measuring and improving performance and a strong primary care focus.
- The organization is based on a shared savings and shared loss model. The benchmark is based on an estimate of what the total expenditures for the group of beneficiaries would have been without the ACO; the ACO gets shared savings if its actual costs are lower, but it must pay if they are higher.
- Primary care providers may only participate in one ACO, although hospitals and other providers may participate in more than one.
- The ACO must meet established quality and performance measures. Providers are removed if they fail to meet quality standards.
- ACOs are required to have a minimum patient population of 5,000.
- Patients are not required to seek care *in network*. Although providers will likely want to refer patients to hospitals and specialists within the ACO network, patients would be free to see doctors of their choice outside of the network without additional payment.⁶

Pediatric ACOs are discussed in [Module 7](#).

Although many providers find the goals of the ACO to be laudable, there is significant criticism that the cost to establish one is prohibitive and that the structural requirements described in the Affordable Care Act are too prescriptive. According to the American Hospital Association, “the costs of the necessary elements to successfully manage the care of a defined population is considerably higher—\$11.6 to \$26.1 million—than the \$1.8 million estimated by the Centers for Medicare & Medicaid Services (CMS).”⁷

Because providers will become aligned together to form ACOs, there are also antitrust concerns. In order to clarify their antitrust enforcement policy regarding collaborations among independent providers that seek to become ACOs in the Shared Savings Program, the Federal Trade Commission and the Antitrust Division of the Department of Justice released the Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. The antitrust analysis of ACO applicants to the Shared Savings Program seeks to protect both Medicare beneficiaries and commercially insured patients from potential anticompetitive harm while allowing ACOs the opportunity to achieve significant efficiencies. CMS will provide the Federal Trade Commission and the Antitrust Division of the Department of Justice with aggregate claims data regarding allowed charges and fee-for-service

payments for all ACOs accepted into the Shared Savings Program as well as copies of all of the applications to the Shared Savings Program of ACOs formed after March 23, 2010. The Federal Trade Commission and the Antitrust Division of the Department of Justice will vigilantly monitor complaints about an ACO's formation or conduct and take whatever enforcement action may be appropriate. The statement describes (1) the ACOs to which the Policy Statement will apply; (2) when the Federal Trade Commission and the Antitrust Division of the Department of Justice will apply rule of reason treatment to those ACOs; (3) an antitrust safety zone; and (4) additional antitrust guidance for ACOs that are outside the safety zone, including a voluntary expedited antitrust review process for newly formed ACOs. Additionally, upon request, the Federal Trade Commission and the Antitrust Division of the Department of Justice will provide an expedited 90 day review for newly formed ACOs that wish to obtain additional antitrust guidance.⁸

Some state Medicaid agencies have begun to develop health care delivery systems that *look like* ACOs, but are slightly different. Oregon, for example, is on the leading edge of this movement and recently won CMS approval to implement coordinated care organizations (CCOs). CCOs are similar to ACOs in some ways. They are community-based organizations using patient-centered primary care homes, fixed global budgets, and efficiency and quality improvements to reduce costs. Unlike ACOs, CCOs may function as a single corporate structure or a network of providers that are organized through contractual relationships.⁶

In Oregon, each city will have its own umbrella group (the CCO) charged with caring for the Medicaid population. Under these umbrellas will be hospitals, doctors, mental health providers, and dentists, as well as providers of community supports. The vision is that all health care businesses will stop competing for patients and will be linked electronically so that health care providers can share information. Patients then can choose whatever provider they need to get the best care. The sickest people will have outreach workers to help them navigate the system and avoid costly hospitalizations. These outreach workers will manage a caseload of about 30 patients.⁹ The CCO will be paid with a lump sum (called a *global budget*) to manage a population of Medicaid patients.

Like an ACO, CCOs have quality standards, and providers may be removed for failure to meet them. Unlike ACOs, providers may participate in more than one CCO. In a CCO, the emphasis is on hiring community health workers, prevention, and traditional medical and nonmedical components of health (e.g., housing, transportation). In short, a CCO is a more *organic* version of an ACO. States are engaged in developing and defining models.

Money Follows the Person

The Money Follows the Person (MFP) Rebalancing Demonstration was enacted as part of the Deficit Reduction Act (DRA) of 2005. It is part of a comprehensive, coordinated strategy to assist states in reducing their reliance on institutional care while developing community-based long-term care opportunities.¹⁰ Federal MFP rules specify five population groups that are eligible to participate in the MFP program: (1) individuals over age 65, (2) individuals with disabilities under age 65, (3) individuals with intellectual disabilities, (4) individuals with serious mental illness (SMI), and (5) others, such as individuals with two or more primary diagnoses and those who do not fit into one of the other four groups.¹¹

As of 2007, the vast majority of MFP-eligible individuals (75 percent) were classified as age 65 or older and living in a nursing home; another 15 percent were individuals younger than age 65 living in a nursing home. Almost 9 percent were living in an intermediate care facility for the developmentally disabled, whereas just .8 percent were individuals younger than age 22 residing in an inpatient psychiatric hospital and .4 percent were individuals age 65 or older living in a mental hospital.¹¹ Because federal law prohibits Medicaid reimbursement for services provided to residents aged 22 to 64 years who reside in institutions for mental disease (IMDs), it is very likely that a portion of these individuals are participating in the MFP program but living in a place other than a facility likely to be classified as an IMD (e.g., a mental hospital). IMDs are discussed more thoroughly in [Module 4](#).

Under the MFP grants, states must maintain: (1) a transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them do so, and (2) a rebalancing initiative that invests the enhanced federal matching funds MFP programs receive into programs and services that increase, relative to institutional care, the proportion of Medicaid long-term care expenditures flowing to community services and supports.¹²

MFP is a valuable opportunity for states because the program offers significant flexibility in determining the populations they want to transition out of institutional settings, the services they want to offer in the community, and how they want to use their grant money to accomplish set goals. For example, a state may use its funds to pay the first month's rent and security deposit for an individual transitioning from a mental hospital to an apartment. Or, a state may use its funds to pay a transitioning individual's unpaid utility bill that would otherwise prevent the individual from receiving a necessary utility service—such as electricity or water—in his or her new apartment.

Because states are developing their MFP programs very differently and at different paces, universal success is difficult to measure. However, a 2011 report published by Mathematica Policy Research—the entity with which CMS contracts for evaluation of state implementation efforts—shares the following statistics on the success of state MFP programs:

- Forty-three states and the District of Columbia have been awarded MFP demonstration grants—31 in 2007 and 13 in 2011. The first three MFP programs began transitioning participants in late 2007, and 30 programs were fully operational by the end of 2009. In calendar year 2010, the MFP demonstration grew to a total of nearly 12,000 transitions from institutions to community living and community-based care. Considering the amount of work it takes to transition just one individual, this is phenomenal progress.
- In 2010, on average, states were spending approximately \$31,000 on home and community-based services (HCBS) per MFP participant. This per-person spending is more than one-third lower than that of average annual Medicaid spending on institutional care for elderly beneficiaries residing in nursing homes for at least 3 months, but nearly twice the per-person HCBS costs among all Medicaid beneficiaries and one-third greater than the HCBS costs of those in §1915(c) waiver programs. The greater per-person expenditures for MFP participants may partly reflect the additional services these beneficiaries receive; approximately one-third of the expenditures for MFP participants are spent on MFP demonstration or

- supplemental services that states provide participants during the first year after they return to community living.
- When compared to beneficiaries who transitioned to the community in 2006 before the program began, MFP participants were far younger and less likely to be reinstitutionalized or die during the year after their transition.¹²

As originally conceived, in order to qualify for the MFP program, individuals were required to reside in an institution for 6 months. By the time an individual has been in an institution for 6 months or longer, the hurdles to his or her successful transition to the community are significant. By 6 months, many will have lost their living arrangement, household belongings (e.g., pots and pans, bedding, other items) may be dispersed, and their social network is weakened or nonexistent. The Affordable Care Act extends the MFP demonstration through September 30, 2016, and adjusts the amount of time an individual must be institutionalized in order to take advantage of the program from 6 months to 90 consecutive days.¹³

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive long-term services and supports to individuals enrolled in both Medicaid and Medicare. PACE serves individuals who are aged 55 years or older, certified by their state to need nursing home care, able to live safely in the community at the time of enrollment, and live in a PACE service area.¹⁴

Under the PACE program, an interdisciplinary team of health care professionals provides coordinated care to enrollees. For most enrollees, the comprehensive service package enables them to receive care at home rather than in a nursing home.¹⁵ Although all PACE participants must be certified to need nursing home care, only about seven percent of participants nationally reside in a nursing home.¹⁵

Financing for the program is capitated, which allows providers to deliver all services that participants need rather than limit them to those reimbursable under Medicare and Medicaid FFS plans. The capitated funding arrangement rewards providers that are flexible and creative in providing the best care possible.¹⁵

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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.

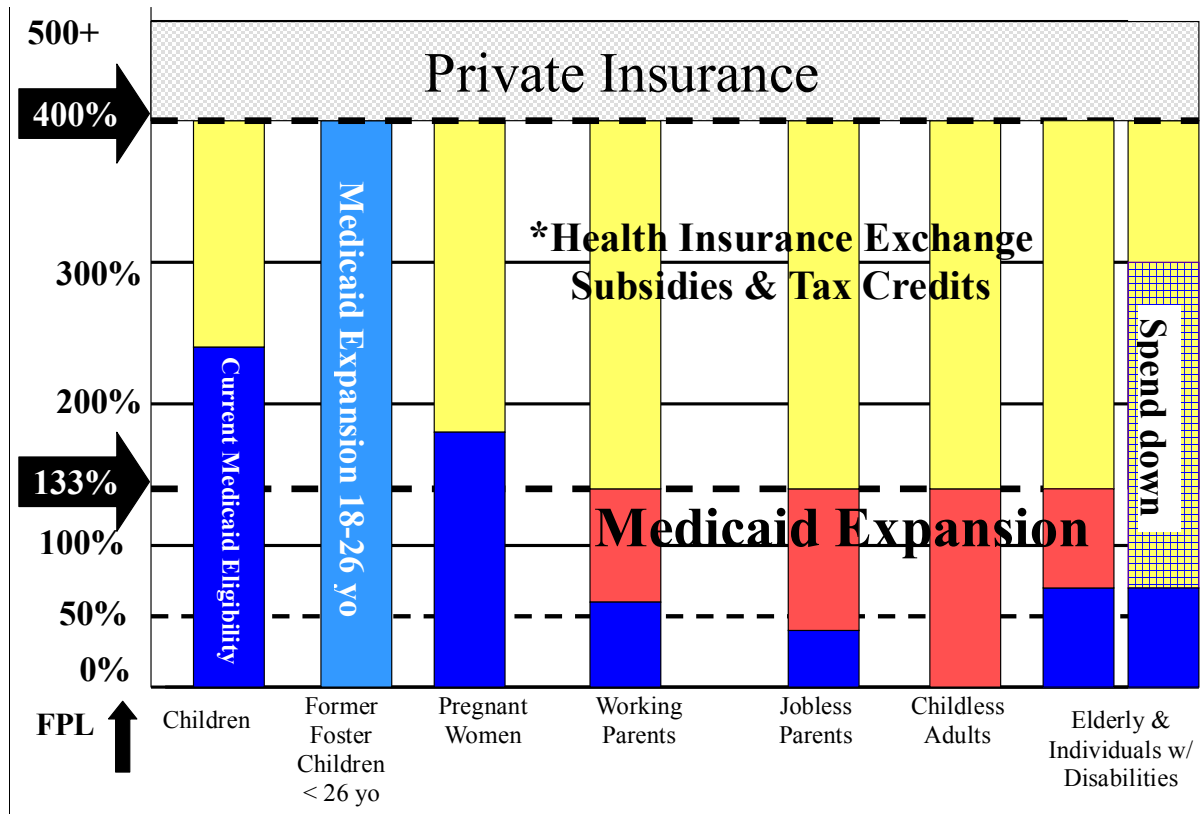
Individuals earning more than their state’s Medicaid eligibility threshold but less than 400 percent of the federal poverty guidelines have access to federal premium tax credits and/or cost sharing reductions to help pay for private health insurance—specifically qualified health plans—through the Health 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*



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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 Medicaid¹⁷

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.

¹ Milliman. Mental Health Parity and Addiction Equity Act. *Basics*. Retrieved July 9, 2013 from <http://www.milliman.com/expertise/healthcare/services/mhpaea/basics/>.

² Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. SEC. 512. MENTAL HEALTH PARITY.(a)(1)(A)(i). [PDF version.] Retrieved July 9, 2013 from <https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/MHPAEA.pdf>.

³ United States Department of Labor. (January 29, 2010.) Employee Benefits Security Administration. Fact Sheet. *The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Retrieved July 9, 2013 from <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

⁴ Centers for Medicare and Medicaid Services. (November 4, 2009.) *Center for Medicaid and State Operations*. [PDF version.] SHO 09-014. CHIPRA #9. Retrieved July 9, 2013 from <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf>.

⁵ *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*. Federal Register / Vol. 75, No. 21 / Tuesday, February 2, 2010 / Rules and Regulations. [PDF version.] Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf>.

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⁷ 45 CFR 154.102. Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+45+percent2FSubtitle+A+percent2FSubchapter+B&oldPath=Title+45+percent2FSubtitle+A&isCollapsed=true&selectedYearFrom=2011&ycord=1558>.

⁸ HealthCare.gov. *Glossary*. Retrieved from <http://www.healthcare.gov/glossary/e/essential.html>. Accessed July 9, 2013.

⁹ HealthCare.gov. *Essential Health Benefits: HHS Informational Bulletin*. Retrieved July 9, 2013 from <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

¹⁰ Centers for Medicare & Medicaid Services. Center for Medicaid and CHIP Services. (May 22, 2012.) *Medicaid/CHIP Affordable Care Act Implementation. Answers to Frequently Asked Questions*. Benefits and

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¹¹ Samuels P. (January 13, 2011.) *Addressing Mental Health and Substance Use Disorder Needs: Priorities for AFFORDABLE CARE ACT Implementation*. Institute of Medicine, Meeting of the Committee on Determination of Essential Health Benefits. [PDF version.] Retrieved July 9, 2013 from [http://www.iom.edu/~media/Files/Activity/percent20Files/HealthServices/EssentialHealthBenefits/2011-JAN-12/350 percent20Samuels.pdf](http://www.iom.edu/~media/Files/Activity/percent20Files/HealthServices/EssentialHealthBenefits/2011-JAN-12/350%20percent20Samuels.pdf).

¹² Substance Abuse and Mental Health Services Administration (SAMHSA) (April 18, 2011). *Description of a Good and Modern Addictions and Mental Health Service System, draft*. [PDF version.] Retrieved July 9, 2013 from http://www.samhsa.gov/healthreform/docs/good_and_modern_4_18_2011_508.pdf.

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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 to \$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 referrals¹⁷
- 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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Medicaid Handbook: Interface with Behavioral Health Services

Module 9

Practical Guides to Medicaid State Plans and Waivers

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Module 9: Practical Guides to Medicaid State Plans and Waivers

What is the Medicaid State Plan?

A state's Medicaid State Plan is a contractual agreement, approved by the Centers for Medicare & Medicaid Services (CMS), that describes the nature and scope of the state's Medicaid program. The agreement is between the state and federal government and pledges the state's commitment to conform to the requirements of the Social Security Act and the official issuances of HHS. Each state develops its own State Plan, as required by §1902 of the Act. The State Plan dictates the policies and procedures that a state will follow in administering its Medicaid program, including those related to the methods of administration, eligibility criteria, covered services, and reimbursement methodologies.

Any time the federal government has a question relating to whether a state is appropriately drawing down federal funds, CMS will look at the State Plan to determine whether it reflects appropriate and accurate reimbursement policy. Therefore, it is in a state's best interest to ensure that its State Plan is complete and correct.

The processes and regulations that are described in this module are from the federal perspective only. States may have additional statutory or administrative processes related to State Plans, State Plan Amendments (SPAs), waivers, and waiver amendments. To understand how each state treats these issues, there must be an understanding of how the federal and state processes and regulations fit together.

Shortly after the federal government established the Medicaid program in 1965, it created and distributed to states a preprinted document outlining the program's major components, as specified in §1902 of the Act. The *preprint* creates the framework for a state's program; attachments to the preprint allow the state to describe its unique design, within the parameters of federal law. The document contains seven sections and a variety of attachments that, when taken together, should completely and accurately describe the state's Medicaid program. State Medicaid State Plans are generally arranged as follows (some states may add sections, but this is the general framework for the State Plan)—

STATE PLAN SUBMITTAL STATEMENT

Section 1. SINGLE STATE AGENCY ORGANIZATION

- 1.1 Designations and Authority
- 1.2 Organization for Administration
- 1.3 Statewide Operation
- 1.4 State Medical Care Advisory Committee
- 1.5 Pediatric Immunization Program

Section 2. COVERAGE AND ELIGIBILITY

- 2.1 Application, Determination of Eligibility, and Furnishing Medicaid
- 2.2 Coverage and Conditions of Eligibility
- 2.3 Residence

- 2.4 Blindness
 - 2.5 Disability
 - 2.6 Financial Eligibility
 - 2.7 Medicaid Furnished Out of State
- Section 3. SERVICES: GENERAL PROVISIONS
- 3.1 Amount, Duration, and Scope of Services
 - 3.2 Coordination of Medicaid with Medicare Part B
 - 3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases
 - 3.4 Special Requirements Applicable to Sterilization Procedures
 - 3.5 Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries
 - 3.6 Ambulatory Prenatal Care for Pregnant Women During Presumptive Eligibility Period
- Section 4. GENERAL PROGRAM ADMINISTRATION
- 4.1 Methods of Administration
 - 4.2 Hearings for Applicants and Recipients
 - 4.3 Safeguarding Information on Applicants and Recipients
 - 4.4 Medicaid Quality Control
 - 4.5 Medicaid Agency Fraud Detection and Investigation Program
 - 4.6 Reports
 - 4.7 Maintenance of Records
 - 4.8 Availability of Agency Program Manuals
 - 4.9 Reporting Provider Payments to the Internal Revenue Service
 - 4.10 Free Choice of Providers
 - 4.11 Relations With Standard-Setting and Survey Agencies
 - 4.12 Consultation to Medical Facilities
 - 4.13 Required Provider Agreement
 - 4.14 Utilization Control
 - 4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases
 - 4.16 Relations With State Health and Vocational Rehabilitation Agencies and Title V Grantees
 - 4.17 Liens and Recovering
 - 4.18 Cost Sharing and Similar Charges
 - 4.19 Payment for Services
 - 4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services
 - 4.21 Prohibition Against Reassignment of Provider Claims
 - 4.22 Third Party Liability
 - 4.23 Use of Contracts
 - 4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facilities
 - 4.25 Program for Licensing Administrators of Nursing Homes
 - 4.26 RESERVED
 - 4.27 Disclosure of Survey Information and Provider Contractor Evaluation
 - 4.28 Appeals Process for Skilled Nursing and Intermediate Care Facilities
 - 4.29 Conflict of Interest Provisions

- 4.30 Exclusion of Providers and Suspension of Practitioners Convicted and Other Individuals
 - 4.31 Disclosure of Information by Providers and Fiscal Agents
 - 4.32 Income and Eligibility Verification System
 - 4.33 Medicaid Eligibility Cards for Homeless Individuals
- Section 5. PERSONNEL ADMINISTRATION
- 5.1 Standards of Personnel Administration
 - 5.2 RESERVED
 - 5.3 Training Programs; Subprofessional and Volunteer Programs
- Section 6. FINANCIAL ADMINISTRATION
- 6.1 Fiscal Policies and Accountability
 - 6.2 Cost Allocation
 - 6.3 State Financial Participation
- Section 7. GENERAL PROVISIONS
- 7.1 Plan Amendments
 - 7.2 Nondiscrimination
 - 7.3 Maintenance of Aid to Families With Dependent Children (AFDC) Effort
 - 7.4 State Governor’s Review

The information included in the preprint is standard language with citations to federal laws and/or regulations. The vast majority of detail about a state’s Medicaid program is found in the attachments to the various sections. In the attachments, the state has an opportunity to include a narrative describing the particular aspect of the Medicaid program being addressed. For example, Section 4.19 describes payment for Medicaid services. The preprint language in Section 4.19(c) says, “Payment is made to reserve a bed during a recipient’s temporary absence from an inpatient facility” and cites 42 CFR 447.40. The state has the option of checking one of two boxes, *yes* or *no*. If a state chooses the *yes* option, it is asked to provide a detailed description of its policy on this matter in an attachment. (Medicaid State Plan Preprint, February 25, 2013)

Because each state’s Medicaid State Plan is the compilation of policies that describe its particular Medicaid program, and because the policies are so complicated and detailed, State Plans are generally voluminous. The hard copy of Ohio’s State Plan, for example, is contained in eight, 4-inch binders. There is no requirement that states make their State Plans available online, although many have done or are doing so.

CMS has established a new Medicaid and Children’s Health Insurance Program (CHIP) system (MACPro) to comply with the Paperwork Reduction Act requirements for public review and comments. MACPro will be a mechanism to ensure timely approval of Medicaid and CHIP SPAs and waivers. The MACPro system will serve as the system of record for all state Medicaid and CHIP actions. It is expected to become operational in 2013.¹ Having an understanding of the current process will be useful, as it will take years to migrate to the new system.

Examples of Medicaid State Plans

The following list provides links to Medicaid State Plans that are currently available on state websites. **Module 10** provides instructions and resources regarding how and where to locate State Plans, waivers, and other important information.

Alaska

<http://www.hss.state.ak.us/commissioner/medicaidstateplan/default.htm>

Arizona

<http://azahcccs.gov/reporting/PoliciesPlans/stateplan.aspx>

California

<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx>

Colorado

<http://www.colorado.gov/cs/Satellite?c=Page&cid=1197969486289&pagename=HCPF%2FHCPFLayout>

Florida

<http://ahca.myflorida.com/Medicaid/stateplan.shtml>

Indiana

http://www.indianamedicaid.com/ihcp/StatePlan/state_plan.asp

Iowa

<http://www.ime.state.ia.us/StatePlan/#search='medicaid%20state%20plan'>

Kansas

http://www.kdheks.gov/hcf/healthwave/state_plan.html

Kentucky

<http://chfs.ky.gov/dms/state.htm>

Louisiana

<http://bhsfweb.dhh.louisiana.gov/onlinemanualspublic/>

Michigan

http://www.michigan.gov/mdch/0,4612,7-132-2943_4860-225474--,00.html

Mississippi

<http://www.medicaid.ms.gov/MississippiStatePlan.aspx>

Nebraska

http://dhhs.ne.gov/medicaid/Pages/med_xixstateplan.aspx

Nevada

<https://dhcfnv.gov/MSPTableofContents.htm>

New York

http://www.health.ny.gov/regulations/state_plans/

North Carolina

<http://www.dhhs.state.nc.us/dma/plan/index.htm>

Oklahoma

<http://www.okhca.org/providers.aspx?id=122>

Oregon

http://www.oregon.gov/DHS/healthplan/tools_policy/stateplan.shtml

South Carolina

<https://www.scdhhs.gov/site-page/state-plan-under-title-xix-social-security-act-medical-assistance-program>

Tennessee

<http://www.tn.gov/tenncare/pol-stateplan.html>

Texas

<http://www.hhsc.state.tx.us/medicaid/StatePlan.html>

Utah

<http://www.health.utah.gov/medicaid/stplan/index.htm>

Vermont

<http://ovha.vermont.gov/administration/state-plan>

Virginia

<http://leg1.state.va.us/000/reg/TOC12030.HTM#C0010>

Washington

<http://hrsa.dshs.wa.gov/medicaidsp/>

West Virginia

<http://www.dhhr.wv.gov/bms/smp/Pages/WVMedicaidStatePlan.aspx>

Wisconsin

<http://dhs.wisconsin.gov/aboutdhs/DHCF/MASStatePlan/>

Wyoming

<http://www.health.wyo.gov/healthcarefin/medicaid/spa.html>

What is a State Plan Amendment?

A Medicaid *State Plan* is not the same thing as a *SPA*. A State Plan is the collection of policies upon which the State's Medicaid program is established. A SPA is an amendment to that collection of policies. Any time a state wishes to change its Medicaid program, it must request

and receive CMS approval. The vehicle by which these changes are made is the SPA process. Federal statutes and regulations require CMS to review and approve SPAs for consistency with the requirements of §1902(a) of the Social Security Act before a state may implement program changes.

Once a SPA is approved, it becomes part of the State Plan. For those states that make their State Plans and SPAs available online, the SPAs are posted separately from the State Plans and incorporated into the State Plan once approved by CMS, as described below.

Process for Amending the State Plan

The process by which a state changes its Medicaid program is as follows—

1. **The state identifies a needed or desired change.** This often happens as part of a state's operating budget approval process, during which the state's administrative or legislative body modifies the Medicaid program in an effort to produce cost savings. Other times, a state administrative agency or legislature may want a policy improvement or change that is unrelated to the budget. Frequently, this results in a state deciding to exercise a Medicaid policy option not currently in use or halting the use of the option, such as covering an optional eligibility group or providing (or not providing) an optional service. Another reason a state may seek a Medicaid policy change is in response to a federal law that requires compliance by the states. This has happened many times during the course of the Medicaid program's existence, most recently with passage of the Affordable Care Act in 2010. Many of the Affordable Care Act's provisions will require states to modify their State Plans to be in compliance with the federal law.

Other common reasons for amending the State Plan include—

- Adding or changing the amount, scope, or duration of a service
 - Adding or changing a requirement for a provider to participate in the state's Medicaid program
 - Adding a new type or class of provider
 - Changing eligibility determination processes
 - Adding or changing an eligibility group
 - Changing a reimbursement methodology
2. **If the state is submitting a SPA to amend a reimbursement methodology, it must provide notice of the proposed policy change to the public.** The purpose of the notice—which may appear in the state's newspapers and online register—is to inform Medicaid consumers, providers, stakeholders, and the general public of substantial proposed changes to the Medicaid State Plan. The notice also offers the opportunity to comment on such changes. The notice must describe the proposed change in reimbursement methods and standards, provide an estimate of any expected increase or decrease in annual expenditures, and explain why the state is making the change. Publication of the notice must occur prior to the proposed effective date of the change.

3. **The state drafts the SPA and submits it to CMS.** This process entails identifying the pages of the State Plan that must be amended, removing them from the State Plan, making the required changes, and submitting the amended pages to CMS. SPAs are generally transmitted to CMS as pages excerpted from the existing approved State Plan containing the provisions that the state wishes to modify. CMS is developing a new, electronic format for states to submit SPAs; until that occurs, states must submit their changes as attachments to e-mail communications or in hard copy form.

States must submit SPAs no later than the end of the quarter in which the state would like the SPA to be effective. For example, if the state wants its policy to become effective on July 1, it must submit its SPA by the end of September. Once approved, the requested effective date becomes the SPA effective date—in this example, July 1.

The State Plan pages that the state is seeking to amend must be accompanied by *CMS Form 179, Transmittal and Notice of Approval of State Plan Material*. This form captures basic but important information about the SPA, including the proposed effective date, the federal statute/regulation that is the authority for the program policy, the federal budgetary impact, and the State Plan page numbers to be impacted.

4. **CMS reviews the SPA.** CMS reviews the proposed specific amendment and all other provisions included on the submitted pages. For example, if a state is proposing to change its policy related to provision of dentures and the page on which this policy is contained also includes the policy related to provision of eyeglasses, CMS will review the policies related to both dentures and eyeglasses.

In addition, CMS also reviews any related or corresponding State Plan provisions contained elsewhere in the State Plan that are integral to understanding the pages being submitted for review and approval, including corresponding coverage and payment methodology pages. This review process may lead to the identification of existing State Plan provisions that the state is *not* proposing to modify and that are *not* integral to the proposed SPA modifications, but that appear to be contrary to federal statute, regulations, or established guidance. States have the option of resolving issues related to State Plan provisions that are *not* integral to the SPA through a separate process.

To improve national consistency in the issuance and application of Medicaid reimbursement policies, CMS developed the National Institutional Reimbursement Team (NIRT) and the National Non-Institutional Provider Team (NIPT). The NIRT is responsible for reviewing all institutional SPAs, providing technical assistance to the states, and developing Medicaid institutional reimbursement regulations and policy. NIPT functions similarly to the NIRT, but for noninstitutional providers.

Once the state submits the SPA to CMS, various groups within CMS review its different components. CMS has 90 days to take action (approve, deny, or issue a formal request for additional information [RAI]) on a SPA. During this time, CMS is *on the clock*. If CMS does not take action on the SPA by the end of this 90-day period, the SPA is deemed approved. CMS may send a denial of the SPA to the state

by the end of this first 90-day period, although that rarely happens. Most commonly, if CMS has significant questions about the SPA, CMS responds to the state within the 90-day period with an *RAI*. The *RAI* is an official action that *stops the clock*, meaning that CMS has met its regulatory requirement to take action within 90 days. This gives the state time to respond to CMS. CMS may also submit to the state an *informal RAI*, which is meant to gather information from the state without stopping the clock.

The RAI often includes a set of standard funding questions, which seek to gather additional information about a SPA's reimbursement component. Because these questions are standard, states generally submit responses with the SPA. These questions ask the state to describe how the state's share of each type of Medicaid payment is funded, whether the state uses intergovernmental transfers (IGTs) or certified public expenditures (CPEs), whether the state is using supplemental payments, and other reimbursement-related questions. CMS also will include questions related to coverage or reimbursement that may be specific to the particular SPA.

When the state responds to the RAI, the SPA is on a second 90-day clock. CMS has 90 days to approve or deny the SPA. As mentioned above, CMS can approve the SPA retroactive to the date for which the state requested approval.

5. **Once CMS has approved the SPA, the state implements the changes contained in the SPA.** Theoretically, the state is at risk if it implements the policy prior to CMS approval. Practically speaking, states frequently implement their changes before they are approved by CMS. If CMS were to deny a requested change or require significant edits to the SPA after the state already implemented the change, the state must repay the federal government the amount of federal reimbursement it collected while the unapproved changes were in effect.

Once CMS approves the SPA, the pages of the State Plan it approved become the new official State Plan pages. The state will remove the old pages and replace them with the newly approved pages.

Examples of State Plan Amendments

The following list provides links to SPAs that are available online. This list is not exhaustive. When a SPA is approved, it is incorporated into the State Plan. The SPA might remain on the state's website for historical or reference purposes even after the changes it proposes have been approved by CMS and incorporated into the State Plan.

Mississippi

<http://www.medicaid.ms.gov/MsStatePlanAmendments.aspx>

North Carolina

<http://www.ncdhhs.gov/dma/plan/index.htm>

Oregon

http://www.oregon.gov/OHA/healthplan/tools_policy/stateplan.shtml

South Carolina

<https://www.scdhhs.gov/site-page/state-plan-amendment-spa-approvals>

What is a Waiver?

A state's Medicaid State Plan contains extensive information about its Medicaid program. However, it is not the only document that describes eligibility, covered services, and reimbursement for services.

As described in [Module 2](#), states have flexibility in designing and administering their Medicaid and CHIP plans, but several federal laws and regulations set minimum standards with which states must comply. Sections 1115 and 1915 of the Social Security Act define specific circumstances in which the federal government may, at a state's request, waive certain provisions of federal Medicaid and CHIP law. The principles of Medicaid law that are commonly waived under various waiver authorities are statewideness, freedom of choice of provider, and comparability of services.

Just as the State Plan is the state's contract with the federal government that describes how the Medicaid program is administered, a *waiver* is an agreement between the state and federal governments that exempts the state from certain provisions of federal law. The waiver—which must be approved by CMS—may include special terms and conditions (STCs) that define the strict circumstances under which and for whom the state is exempt from the provisions of federal Medicaid and CHIP laws.² Once a waiver is approved by CMS, it becomes an official document. It is kept separately from the State Plan or a SPA that outlines a portion of the state's Medicaid program.

Types of Waivers

Section 1915(b) Waiver

States use waiver authority under §1915(b) of the Social Security Act to create a mandatory managed care program. Section 1915(b) waiver managed care authority does the following—

- Allows the state to require enrollment of Medicare-Medicaid enrollees, foster care children, and other populations in managed care programs
- Allows the state to offer managed care statewide or limit the program by geography
- Allows a state to selectively contract with providers for managed care³

When using the §1915(b) waiver authority, the state can choose to do so under one or more subsections of §1915(b).

- **§1915(b)(1).** The state requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- **§1915(b)(2).** A locality will act as a central broker (i.e., agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs). This provides enrollees with more information about the range of health care options open to them.

- **§1915(b)(3).** Section 1915(b)(3) offers states the opportunity to provide additional services to waiver enrollees and to cover the cost of those added services through savings achieved under the waiver. In order to offer additional services under §1915(b)(3), the §1915(b)(3) authority must be used in conjunction with the §1915(b)(1) or §1915(b)(4) authority. 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.
- **§1915(b)(4).** The state requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards. These standards are consistent with access, quality, and efficient and economic provision of covered care and services.⁴

According to CMS, as of April 2012, there are 48 approved §1915(b) waivers operating in 28 different states.

Section 1915(c) Waiver

Section 1915(c) waiver authority is used to offer long-term care home and community-based services (HCBS) that are not offered under a state’s Medicaid State Plan to individuals meeting a certain level of care and other eligibility criteria.

Section 1915(c) waiver authority—

- Allows the state to offer a different package of services (home and community-based services) to Medicaid long-term care consumers who meet the level of care and target group criteria specified in the waiver that the state offers in its Medicaid State Plan. This is a waiver of comparability of series.
- Allows the state to offer HCBS statewide or limited to certain geographical regions.⁵

Under a §1915(c) waiver, states can provide a combination of standard medical and nonmedical services. Standard services include, but are not limited to, case management (e.g., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community, such as home modifications. States can choose the degree to which they allow a consumer to direct provision of his or her services.

To be eligible for §1915(c) waiver services, an individual must require a hospital, nursing facility, or intermediate care facility for the developmentally disabled level of care—the cost of which would otherwise be reimbursed under the approved Medicaid State Plan.⁵ The state chooses the level or levels of care criteria and also additional target group eligibility requirements. The state can choose to offer HCBS under the waiver to aged or disabled consumers, aged *and* disabled consumers, consumers with a developmental disability, and/or consumers with a mental illness.

Section 1915(b)/(c) Waiver

Section 1915(b)/(c) waiver authority is used to implement a mandatory managed care program that includes home and community-based waiver services in a managed care arrangement. The §1915(b) authority is used to mandate enrollment in managed care and limit freedom of choice and/or selectively contract with providers; the §1915(c) authority is used to target eligibility to Medicaid consumers with a certain level of care and provide HCBS.

Section 1915(b)/(c) managed care authority does the following—

- Allows the state to selectively contract with providers
- Requires the state to apply for each waiver authority separately and concurrently
- Requires cost effectiveness for §1915(b) and cost neutrality for §1915(c)
- Allows the state to add non-State Plan HCBS in the capitation rate under the §1915(c) waiver authority or in the §1915(b) waiver as §1915(b)(3) services

Section 1115 Waiver

Section 1115 of the Social Security Act give states the flexibility to design and improve their Medicaid programs by letting them test new and innovative ways to deliver and pay for coverage. Under §1115, states have broad waiver authority—at the discretion of the Secretary of HHS—to implement projects that test policy innovations that are likely to further the objectives of the Medicaid program. For this reason, §1115 waivers are also referred to as research and demonstration waivers.

In [Module 5](#), there is a discussion about using §1115 waivers to implement a managed care program; however, §1115 waivers offer states the ability to do more than institute managed care. One of the most common reasons states use the §1115 waiver is to offer Medicaid coverage to populations that the federal government generally does not permit. For example, some states choose to cover childless adults up to a certain percentage of the federal poverty guideline.

One unique requirement of the §1115 waiver is that it must be *budget neutral* to the federal government. This means that the state must show that over the duration of the entire waiver, federal Medicaid expenditures will not exceed the amount of money the federal government would have spent without the waiver.

Because §1115 waivers are vehicles for creative and flexible policy changes, CMS requires that many detailed parameters of the waiver should be memorialized in a list of STCs. Such STCs may include descriptions of the program, reporting, and financial requirements; the populations affected by the demonstration; the delivery system to be used; how the demonstration will be operated; and how the demonstration's budget neutrality will be monitored. STCs are unique to §1115 waivers and are not included in other types of waivers.

Examples of Waivers

1915(b) Waiver—Managed Care

Texas Star+Plus

<http://www.hhsc.state.tx.us/starplus/>

1915(c) Waiver—Home and Community-Based Services

Alabama Home and Community Based Services Living at Home Waiver for Persons With Intellectual Disabilities

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/AL0391.zip>

Kansas Serious Emotional Disturbance Waiver

<https://www.cms.gov/MedicaidStWaivProgDemoPGI/downloads/KS0320R0300.zip>

1915(b)/(c) Waiver—Combined Managed Care and Home and Community-Based Services

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

<http://www.ncdhhs.gov/mhddsas/providers/1915bcWaiver/index.htm>

1115 Waiver—Demonstration

Colorado Adults Without Dependent Children Waiver

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/co/co-awdc-ca.pdf>

Vermont Global Commitment to Health

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf>

What Are Waiver Applications and Waiver Amendments?

When a state first seeks to implement a waiver, it must submit a waiver application to CMS for approval. In the application, the state must describe the purpose of the waiver, the provisions of federal law it seeks to waive, eligibility parameters for participation in the waiver, the services it seeks to provide under the waiver, and provider requirements. A state wishing to amend, renew, or continue a waiver must seek CMS approval.^A

Process for Applying for or Amending a Waiver

The process for applying for or amending a waiver is the same as that of amending the State Plan, although the teams within CMS that review and approve waiver amendments are different from those that review and approve SPAs.

Examples of Waiver Applications and Amendments

The following list provides links to waiver applications and amendments that are available online. This list is not exhaustive.

^A A §1915(b) waiver generally does not extend beyond 2 years, unless a state requests a continuation; a §1915(c) waiver is initially approved for 3 years and renewed in 5-year increments; an §1115 waiver is approved for an initial 5-year period and renewed for an additional 3 years.

Waiver Application

New York Nursing Home Transition and Diversion Medicaid §1915(c) Waiver

http://www.health.ny.gov/facilities/long_term_care/waiver/docs/application_2005-12-12.pdf

Waiver Amendment

Indiana Traumatic Brain Injury §1915(c) Waiver

<https://www.cms.gov/MedicaidStWaivProgDemoPGI/downloads/IN40197R0200.zip>

Delaware Diamond State Health Plan §1115 Waiver

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf>

Self-Directed State Plan Services and Waiver Options

CMS developed the basic foundation of self-directed services in conjunction with the waiver authority to provide HCBS under §1915(c) of the Social Security Act. The national demonstration and evaluation of the Robert Wood Johnson *Cash and Counseling* project provided the programmatic and financial evidence that helped establish self-directed services in Medicaid policy and practice.

The Deficit Reduction Act (DRA) of 2005 authorized self-direction through two additional State Plan options—§1915(i) and §1915(j) of the Social Security Act. In 2010, the Affordable Care Act authorized another self-directed State Plan option, §1915(k) of the Social Security Act.

As referenced in [Module 5](#), self-direction of Medicaid services is a model of service delivery that is provided as an alternative to managed care or the traditional fee-for-service (FFS) systems. Although each of the waiver and State Plan authorities has slightly different requirements and guidelines, there are consistent principles.

Common characteristics and requirements of self-directed options that have been identified by CMS include:

- A person-centered planning process is directed by the individual (with assistance as needed) to develop a person-centered plan. The individual's strengths, needs, and preferences are identified, including an evaluation of risk and identification of backup plans.
- An individualized budget based on the person-centered plan is “costed out” using a state-specified method for calculating the costs.
- Information and support are tailored to assist with self-direction.
- A “support broker” serves as a counselor or consultant. The support broker must be available to each individual to assist him or her in whatever way necessary to carry out the individual's plan. The support broker does not serve in a traditional case management role on behalf of the system or the provider, but acts as an agent of the individual and takes direction from the individual.
- Financial management services must be available to assist the individual with his or her budget. These services can include functions such as paying the individuals who provide supports, managing payroll or documentation associated with service

- provision, purchasing goods and services, and tracking the individual's overall budget.
- The state Medicaid agency is required to have a system of continuous quality assurance and improvement in place.⁶

¹ Medicaid and CHIP Program (MACPro) Portal. Retrieved July 9, 2013 from <http://www.medicaid.gov/State-Resource-Center/Medicaid-and-CHIP-Program-Portal/Medicaid-and-CHIP-Program-Portal.html>.

² Families USA. Citing Websites. *Frequently Asked Questions About Medicaid Waivers*. Retrieved July 9, 2013 from <http://www.familiesusa.org/issues/medicaid/other/waivers/waiver-faqs.html>.

³ Centers for Medicare and Medicaid Services. (December 2009.) *Providing Long Term Services and Supports in a Managed Care Delivery System. Enrollment Authorities and Rate Setting Techniques: Strategies States May Employ to Offer Managed HCBS, CMS Review Processes, and Quality Requirements*. [PDF version.] [PDF version.] Retrieved July 9, 2013 from <http://www.hcbs.org/openFile.php/fid/9510/did/3262>.

⁴ Section 1915(b) Waiver Application. Retrieved July 9, 2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

⁵ Section 1915(c) Waiver Application. Retrieved July 9, 2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

⁶ Medicaid.gov. Self Directed Services. Retrieved July 9, 2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html>.

Medicaid Handbook: Interface with Behavioral Health Services

Module 10

Basic Information and Tools

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Module 10: Basic Information and Tools

The tone of this module is decidedly different from the tone used throughout the rest of the handbook. By now, you have saturated your brain with all things Medicaid and are ready to use your knowledge. So, at the risk of sounding like the author of *All I Really Need to Know I Learned in Kindergarten*,¹ the following is food for thought.

Behavioral Health Staff Working With Medicaid Staff

Here are some basic principles that govern the relationship between Medicaid staff and behavioral health agency staff—

- You have no choice; you must work together...because people's lives depend on it
- It is always about the relationships
- It is a cross-cultural relationship, by definition
- You may not share the same language and culture, even if you think you do
- Even though both of your agencies/divisions share the individual or consumer as the priority, you need to sort out competing and complementary interests

When behavioral health agency staff is preparing to meet with Medicaid staff, it is helpful for them to keep the following information in mind and to prepare accordingly.

- What is the nature of your working relationship? A good, ongoing relationship that seeks to maximize the interests of both parties is essential to long-term success. Recognizing that governors and cabinet officers change with the state's election cycles, developing relationships of understanding and trust with agency staff is essential. Differences of organizational, political, or policy priorities are a part of the environment. Relationships that function on considerations other than power and control will be most successful.
- Consider that if you have a relationship with someone whose native language differs from your own, you must be aware of both language and cultural issues associated with your different backgrounds. Each agency's language and style of communication may be different from yours.
 - Does your agency/division have a designated contact person with the other? Some state Medicaid programs have designated policy staff whose primary responsibility is to serve as a liaison with the behavioral health agencies that assist with the administration of the Medicaid specialty programs. This person's most important role is to be familiar with the larger context and policy goals operating in the specialty system and to be able to translate between Medicaid and behavioral health issues. These policy staff members often have worked in that system.
 - Is there a staff person who has worked in the other agency or division? Can this person assist you regarding who you should contact or how the other agency will view the issues or provide other perspective that may be helpful?
 - Do not assume that you are speaking the same language. Ever.
- What history and experience do you and your agencies/divisions share?

- Any well-developed Medicaid-related policy requires good clinical judgment, financial consideration, understanding of the system-level implications for consumers and how they will help or hinder the consumer’s experience, and knowledge of associated regulatory and implementation considerations. Who are the best people to bring these various kinds of expertise to your shared work? This is more important than having an equal number or “rank” of individuals from each “side.”
- Highly skilled professionals—plentiful in every Medicaid, mental health, and substance use disorder (SUD) department or division across the country—desire little else than to be able to see their work successfully implemented. Harnessing those varied skills can be a challenge. For any project of significant size or scale, project management and a consistent, dedicated team are essential.

As consultants and administrators who have worked in various states on a variety of Medicaid and behavioral health issues, you would be surprised by how many of these principles are forgotten “in the heat of the moment”!

Behavioral Health Staff Working With Regional and Central Office Staff from the Centers for Medicare & Medicaid Services

All of the principles discussed above also apply to relationships with Centers for Medicare & Medicaid Services (CMS) staff.

In addition to the obvious, do your homework, know your audience, and have a clear agenda. To this end, here are two observations—

- If you are a behavioral health agency staff member, central office (CO) and regional office (RO) staff are very open to and interested in your issues. Our experience, as staff of a behavioral health agency, is that you will probably find them very responsive to your calls or questions. However, keep in mind that their primary relationship is with the designated single state Medicaid entity. Therefore, although they will probably listen, they may not give you a definitive answer and they likely will communicate with and through the Medicaid entity. On significant or ongoing projects, CMS will come to know the behavioral health leadership staff, directly or indirectly.
- If you are the Medicaid staff member, it is in everyone’s best interest to include the staff from the behavioral health agency or division in discussions and negotiations with CMS related to behavioral health issues. Together, you will want to review the “ground rules” ahead of time and debrief afterward; know that you may need to “translate.” Our experience (as Medicaid staff) is that, in the long run, it does not help if Medicaid officials are viewed as an impenetrable wall between behavioral health leadership goals and CMS.

How to Find What You Need to Know About Medicaid in Your State

The websites for the sources discussed below are provided at the end of this module in the *List of Web Resources*.

State Medicaid Agency and Human Service Agency Websites

Although it may seem obvious, frequently the best way to begin a search for information on your state's Medicaid program is to enter "Medicaid" and your state's name into a search engine, such as Google. This process should provide you with some basic information about your state's Medicaid program, such as whether the Medicaid agency in your state is a free-standing, cabinet-level department or part of another department, such as a health or human services department.

A basic internet search will lead you to your state's Medicaid agency website, where you should be able to access information by topic. Possible topics may include consumer resources (enrollment in Medicaid and the services Medicaid covers), provider resources (billing and enrollment practices), important forms and contact information, and other resources.

When seeking to understand your state's Medicaid program and policies, it is important to know the basic structure of the health and human services agencies in your state. As indicated in [Module 2](#), although there is a federal requirement for a state to maintain a single state Medicaid agency that is responsible for administering or overseeing the administration of the Medicaid program, states are allowed to share certain program functions with other state agencies. Many states maintain an agency that is distinct from the Medicaid agency and is responsible for mental health programs and policies and/or substance abuse programs and policies. Note that the terms *mental health* and *substance abuse* are often used to refer to state programs that provide services to *people with mental or substance use disorders* (M/SUDs); the term *behavioral health* is often used in agencies that manage both types of services and conditions under one organization. Therefore, states may have one agency—with a combined focus on M/SUDs—or two separate agencies, each focused on either mental or substance use disorders. Other states include Medicaid, mental health, and SUD programs and policies under one umbrella agency, such as a human services agency. Noticing how these agencies apportion programs and policies will allow for a fuller understanding of how your state organizes its human services and policies.

Medicaid Managed Care Plan Websites

If your state operates a Medicaid managed care program, the managed care plans' websites should also provide information on their covered services, consumer enrollment processes, provider networks (including how a consumer can find a provider), provider enrollment processes, and provider billing practices.

Medicaid State Plan and Waiver Documents

As discussed in [Module 9](#), Medicaid State Plan and waiver documents are a very good source of state-specific Medicaid information. State Plans and waivers are a state's contracts with the federal government for provision of Medicaid services. As approved by CMS, these documents serve as the framework for each state's Medicaid program. A description of how and where to access these documents is included below.

State Laws and Regulations

Another excellent source of Medicaid program information for each state is its laws and administrative rules or regulations. If you are not familiar with where to find your state's laws

and rules, enter into a search engine your state’s name and “laws” or “administrative rules.” Once you are able to access the body of laws and regulations, look in the table of contents or index for titles and sections that logically could hold Medicaid program information. Additionally, most (if not all) state statutes and rules have a search function that allows the reader to search by keyword, such as “Medicaid” or “medical assistance.” You also can search using more specific search terms, such as “Medicaid providers” or “Medicaid eligibility.”

Centers for Medicare & Medicaid Services and Substance Abuse and Mental Health Services Administration Websites

The official websites of CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) contain a wealth of general Medicaid information. The CMS website allows readers to search by state for data and statistics; it also contains waivers that are current, pending, or expired for each state. The SAMHSA website contains many surveys, reports, and data sets that include state-specific information.

Health Policy Expert Websites

Health policy experts—like the Henry J. Kaiser Family Foundation, the Commonwealth Fund, the Center for Health Care Strategies, and Mathematica Policy Research—have extensive resources for data and substantive reviews of Medicaid-related topics. These websites provide the capability to search for well-developed, pertinent, state-specific data, as well as for reports that include overviews of policies and how they are being utilized or implemented in the states.

Technical Assistance Websites

The Integrated Care Resource Center provides technical assistance to states that wish to engage in strategies to improve their Medicaid service delivery system and improve cost efficiencies. The resource center is assisting the CMS Medicare-Medicaid Coordination Office and the Center for Medicaid and Children’s Health Insurance Program (CHIP) Services in working with states to design and implement new programs that better serve beneficiaries, improve quality, and reduce costs. Its website allows you to search policy initiatives by state.

How to Find Relevant Federal Laws and Regulations

Links to the Social Security Act, Affordable Care Act, Mental Health Parity and Addiction Equity Act (MHPAEA), and Code of Federal Regulations (CFR) are provided below. With the information provided in this handbook, you should be able to select the appropriate title and (in many cases) section of the Social Security Act to search. For example, Title XIX houses all fundamental laws pertaining to Medicaid; §1905 specifically addresses services covered by Medicaid. Once you select the appropriate title and section, you can use the search function to enter a search term and narrow your results.

To search the Affordable Care Act and MHPAEA, you should simply use the website’s search function and enter keywords or phrases such as “health home” or “accountable care organization.”

To search the CFRs, you must know the title, chapter, and subchapter in which the information you are seeking is located. Most regulations pertaining to Medicaid are located in Title 42.

How to Find Examples of State Plan Amendments and Waivers

Many states make their State Plans and waivers available online. See [Module 9](#) for a complete list. The CMS website also maintains a list of current, pending, and expired waivers by type and by state. CMS does not yet maintain an online catalog of state Medicaid State Plans, although it may in the future.

Although not all states make their State Plans and waivers accessible online, all states should maintain a hard copy of their State Plans and waivers at the state Medicaid agency's office. These documents are available to the public.

List of Web Resources

Centers for Medicare & Medicaid Services

<http://www.cms.gov/>

Center for Medicare & Medicaid Innovation

<http://innovations.cms.gov/>

Substance Abuse and Mental Health Services Administration

<http://www.samhsa.gov/index.aspx>

The Henry J. Kaiser Family Foundation

<http://www.kff.org/>

The Commonwealth Fund

<http://www.commonwealthfund.org/>

Integrated Care Resource Center

<http://www.integratedcareresourcecenter.net/Default.aspx>

Center for Health Care Strategies

<http://www.chcs.org/>

Mathematica Policy Research

<http://mathematica-mpr.com/>

Social Security Act

http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm

Code of Federal Regulations

<http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>

Affordable Care Act

<http://www.healthcare.gov/law/index.html>

Mental Health Parity and Addiction Equity Act

<http://www.govtrack.us/congress/bills/110/hr6983>

¹ Fulghum R. *All I Really Need To Know I Learned in Kindergarten*. New York: Villard Books; 1988.

Appendix A: Authors and Reviewers

Authors

Vorys Health Care Advisors

Maureen M. Corcoran, M.S.N, M.B.A

Daphne Kackloudis Saneholtz, J.D.

Truven Health Analytics

John Easterday, Ph.D.

Rosanna Coffey, Ph.D.

Linda Lee, Ph.D.

Anika Hines, Ph.D.

Katharine Levit

Susan Raetzman, M.S.P.H.

Reviewers

Substance Abuse and Mental Health Services Administration

Kevin Malone

Juli Harkins

Rita Vandivort-Warren, M.S.W.

Allison Colker

Centers for Medicare & Medicaid Services

John O'Brien, M.A.

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