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Medicaid Handbook: Interface with Behavioral Health Services

Module 3

The Medicaid Behavioral Health Services Benefit Package

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Module 3: The Medicaid Behavioral Health Services Benefit Package

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

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

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

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

The Policy and Regulatory Context

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

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

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

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

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

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

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

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

Behavioral Health Services Provided Under a Medicaid State Plan

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

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

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

Mandatory Services

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

Optional Services

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

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

Behavioral Health Services Included in the State Plan

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

The Rehab Option

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Early and Periodic Screening, Diagnosis, and Treatment

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

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

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

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

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

Inpatient Psychiatric Care for Individuals Younger Than 21 Years

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

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

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

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

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

Inpatient Hospital Services

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

Outpatient Hospital, Clinic, or Federally Qualified Health Center Services

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

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

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

Physician and Other Licensed Practitioner Services

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

Section 1915(i) Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Georgia—Community Based Alternatives for Youth

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

Iowa—Children's Mental Health

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

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

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

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

- Section 1915(b)/(c) waiver

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

Arizona—Arizona Health Care Cost Containment System

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

Case Management

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

Case management includes:

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

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

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

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

How Case Management Services May Be Delivered

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

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

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

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

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

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

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

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

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

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

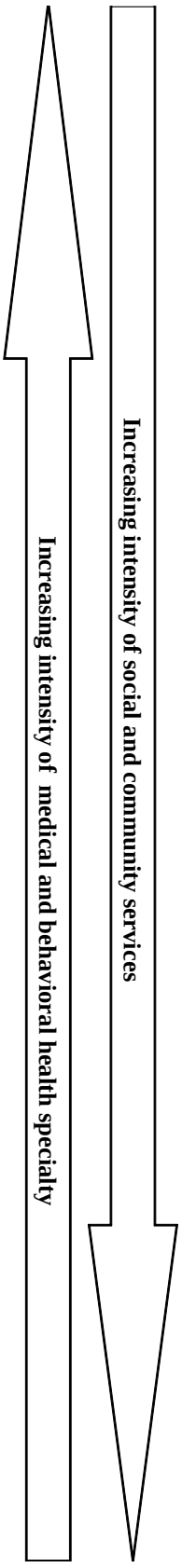
8. **Under §1915(i) of the Social Security Act.** Under §1915(i)(1)(E)(ii) of the Act, the state uses an independent assessment to identify the needs of an individual who is determined eligible for home- and community-based services. The purpose is to: determine a level of services and supports to be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

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

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

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

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



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

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

Summary

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

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