Pathways for Covering Mental Health and Substance Use Disorder Services

The following federal authorities offer states the flexibility to transform their systems and improve coverage for individuals with mental health or substance use disorder (MH/SUD) conditions:

1. Coordinating physical and behavioral health

A primary goal of MH/SUD system reform is to encourage care models that thoughtfully integrate primary care. As part of an interdisciplinary approach to improving the delivery of behavioral, mental and physical health services to individuals with MH/SUD, states are encouraged develop a clear approach for integrating primary care. Entry into treatment for mental health conditions and/or substance use disorder should serve as a touch point for access to primary care or specialist services and vice versa. An uptick in ambulatory care utilization is generally seen as a favorable outcome for individuals engaging in treatment. CMS encourages states to submit proposals that integrate MH/SUD services and medical care, in concert with acute treatment and continuously throughout long-term treatment and recovery.

a. Health Home for Enrollees with Chronic Conditions

Section 2703 of the Affordable Care Act (Health Home for Enrollees with Chronic Conditions) offers a new Medicaid State Plan option offering states enhanced FMAP for specific health home services to provide coordinated care to individuals with chronic conditions, which includes individuals with MH/SUD. Section 1945(h)(2) of the Social Security Act identifies both substance use disorder and a mental health condition as chronic conditions for which health home services are eligible. This provision offers important coordinated care opportunities for supporting physical and behavioral health, as well as linkages to long-term supports, which are fundamental elements of a successful health home. The Section 1945 authority and Section 2703 enhancements allow states the option to provide comprehensive coverage to specific populations through innovative care models. Additional information regarding this program can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html

b. Integrated Care Models (ICM)

ICMs are characterized by organized and accountable care delivery and payment methodologies aligned across payers and providers to ensure effective, seamless, and coordinated care. By orienting the system around the needs and preferences of beneficiaries, successful ICMs can demonstrate improved health care outcomes and result in improved beneficiary experience, while reducing overall health care expenditures. ICMs include integration of various types of health care services such as primary, acute, specialty, dental, behavioral, and long-term support services. To implement ICMs within Medicaid programs, states may seek to explore new initiatives or enhance existing efforts under a Medicaid state plan, or use demonstration or waiver authority. There are several Medicaid authorities that allow states the opportunity to

implement ICMs on a statewide basis or through a more limited approach based on geographic area, individual needs, or through selective provider contracts. More information regarding ICMs can be found at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf and http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf.

c. Managed Care Organization

States can contract with Managed Care Organizations (MCOs) who offer care coordination to individuals, including individuals that have primary care, behavioral health and long term services and supports. States can use a managed care delivery system by getting a state plan amendment under 1932 of the Social Security Act (SSA) or 1915(b) approved by CMS. The state plan includes information such as the types of entities that will be used and what groups of people will be enrolled.

Many states are interested in testing shared savings methodologies in the Medicaid program as a means to promote better coordination efforts. CMS has issues guidance that focuses specifically on reimbursement methodologies that can be adopted in the context of integrated care models to incentivize improved quality and outcomes and reduce costs by sharing program savings with high performing providers. Information regarding the Medicaid Shared Savings Program can be found at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf

2. Expanding the availability of recovery services

a. Section 1915(i) State Plan Home and Community-Based Services (HCBS)

Section 1915(i) of the Social Security Act (HCBS as a State Plan option) offers the opportunity to effectively serve individuals with MH/SUD. Section 1915(i) was modified through Section 2402 of the Affordable Care Act with changes that became effective October 1, 2010. CMS released a State Medicaid Director letter (http://www.cms.gov/smdl/downloads/SMD10015.pdf) in 2010 discussing the changes, including expanded eligibility criteria, the ability for states to target the benefit to certain populations, and an expanded array of services. HCBS can be an essential component of an individual's health care continuum, and can work to support and bolster clinical interventions. This option provides more flexibility than the Section 1915(c) HCBS waivers because it includes less restrictive cost neutrality and institutional level of care requirements, allowing states to provide HCBS to prevent or delay the need for institutional care. In addition to population and service specification, Section (i) allows states the flexibility to change provider qualifications, benefit management criteria, and reimbursement methodologies.

To the extent that states choose to embrace a home and community based service (HCBS) model to make recovery supports and services available to beneficiaries, it is CMS' expectation that states offer HCBS services consistent with our regulations regarding the 1915(i) program. These regulations can be found at: https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider.

b. Section 1915(b) Managed Care Options

CMS recognizes the logistical complexity of transforming a service delivery system through comprehensive reforms. To that end, we encourage states to be strategic about how and where they want to begin their efforts. For example, it may be more productive to focus on one or several distinct geographic areas, or pilot different models for different populations.

Section 1915(b) waivers are one of several opportunities available to states that allow the use of targeted managed care in the Medicaid program. The 1915(b) managed care delivery system authorities provide states the option to deliver cost-effective and efficient care in accordance with the principles of the Medicaid program, while allowing states to waive certain federal requirements outlined in Section 1902, such as statewideness, comparability of service and freedom of choice. States may define a broad target group for a 1915(b) waiver into which individuals with SUD would be included, or states may use additional targeting criteria to specifically design a waiver to serve individuals with MH/SUD. Section 1915(b) also affords states the ability to target certain parts of the state.

In addition to these flexibilities, Section 1915(b)(3) of the Act allows states to use the savings realized from its managed care delivery system to provide additional services to its beneficiaries in managed care. For individuals with MH/SUD, health plans can provide important evidence-based and promising recovery support services otherwise not coverable under 1905(a) authority.

c. Section 1115(a) Demonstration Projects

Section 1115 of the Act allows the Secretary of Health and Human Services (the Secretary) to waive certain provisions of Title XIX of the Act for experimental, pilot, or demonstration projects (demonstrations). When the Secretary finds that a demonstration is likely to assist in promoting the objectives of Medicaid, Section 1115 provides for federal financial participation (FFP) for demonstration costs which would not otherwise be considered as allowable expenditures under the Medicaid State Plan. Section 1115 demonstrations also offer states the waivers of requirements not offered through other authorities, allowing for states to target select populations or geographic areas and test innovative policy and delivery approaches.

3. Traditional Health and Behavioral Health Benefits

a. Section 1905(a) State Plan Authority

Section 1905(a) authority allows states to cover mandatory and optional health, behavioral health and long-term services and supports through their Medicaid State Plan. States can complement benefits funded and delivered through other federal authorities with 1905(a) services for a comprehensive benefit package offering individuals with MH/SUD a full continuum of evidence-based physical and behavioral health services. Section 4106 of the Affordable Care Act expanded the suite of 1905(a) services available to treat individuals with MH/SUD, clarifying that the preventive services benefit includes services that are recommended, not only provided, by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law.

b. Alternative Benefit Plan

Section 1937 of the Act allows states to establish an Alternative Benefit Plan (ABP) to cover services without regard to statewideness, comparability and other Medicaid requirements. ABPs provide coverage, quality, and mental health parity assurances. ABPs are required to include MH/SUD services, and ABPs must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).