



**National Association of State Mental Health Program Directors  
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## **Assessment #2**

# **Applying Medicaid Flexibility to Improve State Design of Benefits to Meet Significant Behavioral Health Needs of Young People**

**September 15, 2014**

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# **Applying Medicaid Flexibility to Improve State Design of Benefits to Meet Significant Behavioral Health Needs of Young People**

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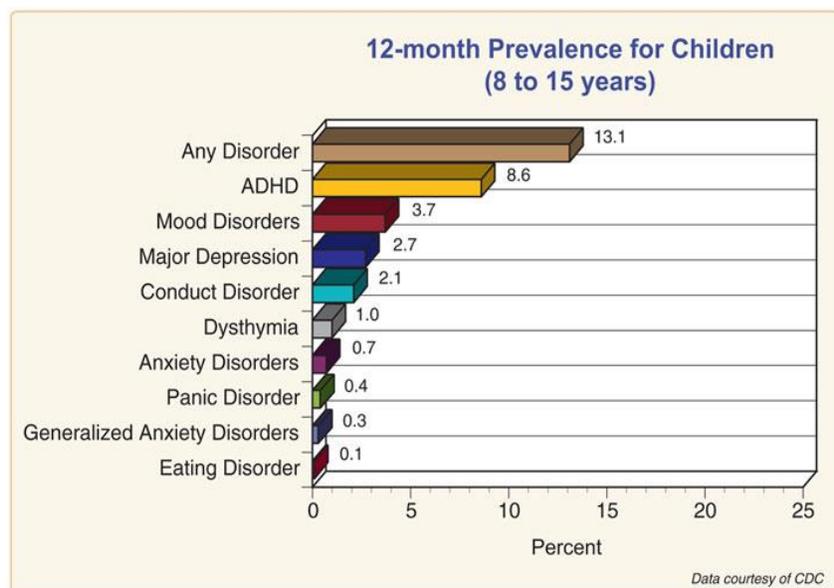
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**Applying Medicaid Flexibility to Improve State Design of Benefits  
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*Frank Rider, MS*

## Imperative to Improve Behavioral Health Services for America’s Young

In the wake of highly visible tragedies in recent years, Americans now demonstrate increased awareness of the importance of effectively addressing behavioral health needs of young Americans.<sup>1</sup> National statistics quantify the extent of those needs. The Centers for Disease Control and Prevention indicate that 13–20% of children living in the United States experience a mental disorder in a given year; and surveillance between 1994 and 2011 has shown the prevalence of those conditions is on the rise.<sup>2</sup> The National Institute of Mental Health (NIMH) has charted the incidence of relatively common mental health needs of school-aged children using CDC data<sup>3</sup> (see Table), while Kessler et al. (2005)<sup>4</sup> reported that major mental health problems may occur in children as young as 7 to 11 years old, and even younger.



The leading federal agency responsible to advance the behavioral health of the nation, the Substance Abuse and Mental Health Services Administration (SAMHSA), issued a recent *Behavioral Health Barometer (2013)*<sup>5</sup> showing that 9.1% (2.2-million) of 12- to 17-year-olds in

<sup>1</sup>Giliberti, M. (August 26, 2014). *National Alliance on Mental Illness Press Release*: “It has now been two years since the tragedy at Sandy Hook elementary school and we continue to see reminders everywhere of the critical need to address mental health reform in this country. While there has been dialogue and some progress since the White House’s Conference on Mental Health last year, the country and those living with mental illness are still waiting on Congress to act.” [http://www.nami.org/Template.cfm?Section=Press\\_Release\\_Archive&template=/contentmanagement/contentdisplay.cfm&ContentID=170805&title=Former%20U%2E%20Rep%2E%20Patrick%20Kennedy%2C%20VA%20Senator%20Creigh%20Deeds%2C%20other%20Mental%20Health%20Advocates%20to%20Urge%20Congress%20to%20Pass%20Comprehensive%20Mental%20Health%20Legislation%20as%20Part%20of%20NAMI%27s%20%22National%20Day%20of%20Action%22%20for%20Mental%20Health](http://www.nami.org/Template.cfm?Section=Press_Release_Archive&template=/contentmanagement/contentdisplay.cfm&ContentID=170805&title=Former%20U%2E%20Rep%2E%20Patrick%20Kennedy%2C%20VA%20Senator%20Creigh%20Deeds%2C%20other%20Mental%20Health%20Advocates%20to%20Urge%20Congress%20to%20Pass%20Comprehensive%20Mental%20Health%20Legislation%20as%20Part%20of%20NAMI%27s%20%22National%20Day%20of%20Action%22%20for%20Mental%20Health)

<sup>2</sup>Perou, R., Bitsko, R., et al. (May 17, 2013). *Mental Health Surveillance Among Children - United States, 2005–2011*, Centers for Disease Control, Morbidity and Mortality Weekly Review (MMWR), Supplements 62(02);1–35. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm>

<sup>3</sup>National Institute of Mental Health, *Mental Health Information*. Retrieved August 21, 2014 from [http://www.nimh.nih.gov/statistics/1anydis\\_child.shtml](http://www.nimh.nih.gov/statistics/1anydis_child.shtml)

<sup>4</sup>Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., Walters, E.E. (2005). Lifetime prevalence and the age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.

<sup>5</sup>Substance Abuse and Mental Health Services Administration [SAMHSA], (2013). *Behavioral Health Barometer: United States, 2013*. HHS Publication No. SMA-13-4796. Rockville, MD. Retrieved from <http://store.samhsa.gov/shin/content/SMA13-4796/SMA13-4796National.pdf>

2012 had at least one major depressive episode (MDE) within the year prior to being surveyed; and that 2012 rate reflected almost a 10% increase over the same measure for 2008.

SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) finds acceleration of mental health disorders in adolescence and early adulthood, reporting that older adolescents have higher rates of mental issues than younger adolescents, with nearly a two-fold increase in mood disorders from 13–14 years old, to 17–18 years old.<sup>6</sup>

Substance use disorders among youth constitute a similarly significant national behavioral health problem. SAMHSA's *Barometer* reported that 6.8% (17.7-million) of persons aged 12 or older in 2012 were dependent on or abused alcohol within the prior year; and 2.8% (7.3-million) of persons aged 12 or older were dependent on or abused illicit drugs.<sup>7</sup>

Against these incidence figures, we note significant gaps in commensurate treatment. The U.S. Surgeon General reported in 1999 that, "In any given year, only 20% of children and adolescents with mental disorders are identified and receive mental health services."<sup>8</sup> SAMHSA's *Barometer* reported that only 37.0% of 12- to 17-year-olds with MDE in 2012 received treatment for depression within the prior year, "a rate that has not changed significantly since 2008."<sup>9</sup> Likewise, only 14.8% of persons aged 12 or older with illicit drug dependence or abuse in 2012 received treatment for their illicit drug use within the prior year.

Further, gaps between behavioral health needs and commensurate treatment remain disproportionately wider for children, youth, and families of racial and ethnic minority populations than for other Americans. A special supplement to the Surgeon General's landmark 1999 report on mental health, for example, found that members of racial and ethnic minorities:

- are less likely to have access to available mental health services,
- are less likely to receive needed mental health care,
- often receive poorer care, and
- are significantly under-represented in mental health research.<sup>10</sup>

Many factors and barriers discourage minority populations from accessing and receiving proper treatment, including some barriers that are shared by all populations, and others more specific to both their circumstances and their histories. Recent changes in federal policies and national programs offer new opportunities to narrow those gaps and alleviate disparities.<sup>11</sup>

Medicaid is the single largest payer for mental health services in the United States, and has an expanding role in the reimbursement of substance use disorder services,<sup>12</sup> as the combined impacts of the Children's Health Insurance Program Reauthorization Act (2009) and the

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<sup>6</sup> SAMHSA Center for Behavioral Health Statistics and Quality (May 6, 2014). *The CBHSQ Report: Serious mental health challenges among older adolescents and young adults*. Rockville, MD.

<sup>7</sup> SAMHSA, 2013. op. cit.

<sup>8</sup> Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Washington: DHHS. Retrieved July 21, 2014 from <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

<sup>9</sup> SAMHSA (2013), op. cit.

<sup>10</sup> Department of Health and Human Services (August, 2001). *Mental health: culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General*. Rockville, MD. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK44243/>

<sup>11</sup> See Department of Health and Human Services (2011). *HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities*. Washington, DC. Retrieved from [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>12</sup> Centers for Medicare and Medicaid Services (n.d.). *Behavioral health services*. Retrieved August 21, 2014 from <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Benefits/Mental-Health-Services-html>

Affordable Care Act (2010) continue to reduce the percentage of young Americans lacking coverage. Beginning with Dr. Donald Berwick’s announcement of it upon his appointment by President Obama in 2010, three consecutive administrators for the Centers for Medicare and Medicaid Services (CMS) have directed Medicaid’s growing influence in the health care arena toward a **“triple aim”<sup>13</sup> of better health care, yielding better health outcomes, at lower per capita costs.** Indeed, CMS during the Obama administration has established a \$1-billion Innovations Center, has promulgated numerous rules, and has offered guidance to state Medicaid agencies, all in active pursuit of that triple aim.

The Children, Youth & Families Division of the National Association of State Mental Health Program Directors (NASMHPD/CYFD) commissioned the present analysis to examine both the promise, and challenges, of one significant CMS/SAMHSA guidance effort to advance the triple aim on behalf of children and youth with complex behavioral health needs.

### **Background**

The Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program was authorized by Section 6063 of the Deficit Reduction Act of 2005. It provided funding to nine states that then developed and implemented 5-year demonstration programs that provided home- and community-based services to children as alternatives to PRTF’s (October 2007 through September 2012). The nine state projects were designed to test both the cost-effectiveness of serving children in their homes and communities; and whether those services improved or maintained the child’s functioning. The nine states cumulatively served over 5,300 children and youth through their demonstrations. In authorizing the PRTF Demonstration Program, Congress had required a national evaluation whose major findings are presented at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Alternatives-to-Psychiatric-Residential-Treatment-Facilities-Demonstration-PRTF.html> and summarized here:

#### **FINDINGS OF NATIONAL EVALUATION OF CMS’ NINE STATES PRTF DEMONSTRATION, 2007–2012<sup>14</sup>**

- The Demonstration successfully enabled children and youth to either maintain or improve their functional status. The common theme across all states is that children and youth with the highest level of need at baseline benefited the most from participating in the Demonstration. These participants showed the most improvement over time in the following areas: decreased juvenile justice involvement, increased school functioning, decreased alcohol and other drug use, and increased social support.
- There was an average savings of 68 percent. In other words, the waiver services cost only 32 percent of comparable services provided in PRTFs.

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<sup>13</sup> Berwick, D., Nolan, T. & Whittington, J. (2008, May). The triple aim: Care, health, and cost. *Health Affairs*, Vol. 27, #3, pp. 759-769. Retrieved from <http://content.healthaffairs.org/content/27/3/759.abstract>.

<sup>14</sup> Sebelius, K. (2013, July). *Report to the President and Congress: Medicaid home and community-based alternatives to psychiatric residential treatment facilities demonstration as required by the Deficit Reduction Act of 2005 (P.L. 109-171)*. Washington, DC: Department of Health and Human Services. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Downloads/PRTF-Demo-Report.pdf>

- Through satisfaction surveys, enrollees and their families indicated they liked the outcomes of the Demonstration, and their involvement in the treatment.

CMS specifically sought to describe the typical array of services offered by states' PRTF Demonstrations that had generated the success in meeting the multiple and changing needs of children and youth with consequential behavioral health challenges and their families.

Early in 2012, the agency directed an examination of "Lessons Learned from the Community Alternatives to Psychiatric Residential Treatment Facility (PRTF) Waiver Demonstration Project," intending to share how its positive lessons might be applied by states through various Medicaid authorities available to them. John O'Brien, Senior Policy Advisor for CMS' Disabled and Elderly Health Programs Group, expressed the agency's intentions by conceptualizing the examination of four components:

1. Cost effectiveness of using intensive home and community-based services (HCBS) for children under 21 with serious behavioral health issues,
2. Core services and other services used successfully by states across the demonstration,
3. Medicaid Authorities that may be used outside of the specific demonstration grant context, and
4. Technical assistance that can be accessed to extend benefits of home and community-based alternatives to similarly situated children and youth outside of the demonstration grant's program.

CMS, having contracted with the National Technical Assistance Center for Children's Mental Health at Georgetown University's Center for Child and Human Development (NTAC) to provide ongoing technical assistance for the nine states participating in the PRTF Demonstration, asked NTAC to produce the "lessons learned" report. Mr. O'Brien cited CMS' "triple aim" in conceptualizing the examination of lessons learned.<sup>15</sup>

SAMHSA had been contemporaneously managing a national Children's Mental Health Initiative (CMHI) that, since 1993, had been demonstrating the application of a **systems of care** approach<sup>16</sup> to child and adolescent mental health. The longitudinal national evaluation of the CMHI had recognized a strong association between improved child and family outcomes and the provision of a typical service array similar to that provided in the PRTF Demonstration. Furthermore, by 2011-12 the CMHI had penetrated all 50 states, two U.S. territories and 21 American Indian tribes in 173 community-level and occasionally even statewide

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<sup>15</sup> Interview with Sherry Peters, MSW, ACSW, Director of PRTF Waiver Initiative, National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development (August 25, 2014).

<sup>16</sup> Stroul, B., Blau, G. & Sondheimer, D. (2008). Systems of care: A strategy to transform children's mental health care. In Stroul, B. & Blau, G., (Eds.). *The System of Care Handbook* (pp. 3–24). Baltimore, MD: Paul H. Brookes Publishing Co.

demonstrations, serving more than 113,000 children and youth.<sup>17</sup> SAMHSA shared CMS' strong interest in describing a "good and modern addictions and mental health service system."<sup>18</sup>

The two Department of Health and Human Services (DHHS) agencies joined forces to guide NTAC's report extracting "lessons learned" from the respective national evaluations of the PRTF Demonstration and the CMHI. Ultimately they decided to issue the content in the form of a joint "informational bulletin" instead. According to CMS' federal policy guidance, such bulletins "are used to communicate with states and other stakeholders interested in Medicaid and CHIP. These communications do not establish new policy; they are designed to highlight recently released policy guidance and regulations and also to share important operational and technical information related to Medicaid and CHIP."<sup>19</sup>

On May 7, 2013, SAMHSA administrator Pamela S. Hyde, JD, and CMS Center for Medicaid and CHIP Services Director Cindy Mann, jointly issued the informational bulletin, entitled ***Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions***.<sup>20</sup> The bulletin "is intended to assist states to design a benefit that will meet the needs" of young people struggling with such conditions. It also aims to help states:

1. Reduce reliance on out-of-home care services,
2. Fulfill their obligations to furnish the Early Periodic Screening, Diagnosis and Treatment [EPSDT] benefit with respect to mental health and substance use disorder needs, and
3. Generate improved child and family outcomes and cost-effectiveness of publicly funded services.

The informational bulletin cites findings from the national evaluations of both the PRTF Demonstration and CMHI, linking the provision of the service array it describes to positive child and family outcomes including:

- Reduced costs of behavioral health care
- Improved school attendance and performance
- Increases in behavioral and emotional strengths
- Improved clinical and functional outcomes
- Promotion of more stable living arrangements
- Improved caregiver employment/productivity
- Reduced suicide attempts, and
- Decreased contacts with law enforcement.

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<sup>17</sup> Stroul, B., Goldman, S., Pires, S., & Manteuffel, B. (2012). *Expanding systems of care: Improving the lives of children, youth, and families*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Retrieved from <http://gucchdtacenter.georgetown.edu/publications/SOC%20Results%205-7-12.pdf>

<sup>18</sup> SAMHSA (April 21, 2011) draft, *Description of a good and modern addictions and mental health service system*. Retrieved from [http://beta.samhsa.gov/sites/default/files/good\\_and\\_modern\\_4\\_18\\_2011\\_508.pdf](http://beta.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf)

<sup>19</sup> CMS (n.d.) Federal Policy Guidance. Retrieved August 21, 2014 from <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>.

<sup>20</sup> Mann, C. & Hyde, P. (May 7, 2013). *Coverage of behavioral health services for children, youth and young adults with significant mental health conditions*. Joint CMCS and SAMHSA Informational Bulletin. (Baltimore, MD.) Retrieved from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf> [Hereinafter "Joint Informational Bulletin."]

The joint informational bulletin offers guidance about improved benefit design, noting that, “While the core benefit package for children and youth with significant mental health conditions offered by these states included traditional services, such as individual therapy, family therapy, and medication management, the experience of the PRTF Demonstration showed that including a number of other home and community-based services significantly enhanced the positive outcomes for children and youth. These services include but are not limited to intensive care coordination (often called wraparound service planning/facilitation), family and youth peer support services, intensive in-home services, respite care, mobile crisis response and stabilization, and flex funds.”<sup>21</sup>

The joint informational bulletin also describes “significant flexibilities” in state Medicaid programs – waivers, demonstrations and other authorities – to cover those, and other promising, mental health and substance use services for young people.

### **CYFD Project**

NASMHPD/CYFD recognizes the importance of the joint informational bulletin. Its members manage public mental health and behavioral health systems in every state. CYFD has made it a priority to illuminate both why, and how, states can apply the bulletin’s content to expand and sustain overall systems of care, including expanded use of family and peer support services, as well as clinical services reflecting the practices associated with the positive results of the CMHI and PRTF Demonstrations.

CYFD membership dedicated the largest portion of its 2014 annual meeting to consider those aims. After supportive dialogue, which involved SAMHSA representatives, the 33 state leaders participated in facilitated small group discussion sessions. (The author subsequently reached out to additional state leaders who did not participate in the annual meeting discussions.)

The following section does not attempt to quantify or compare states’ activities, accomplishments, aspirations, and challenges, but simply to identify:

1. How states are currently using the bulletin;
2. How states can creatively use the bulletin;
3. How states can specifically use the bulletin to address disparities in behavioral health care; and
4. What specific technical assistance needs should be met to positively apply the bulletin at the state and local levels.

*(Examples of states are included in parentheses to help interested readers discover more detailed information.)*

#### **1. How are states currently using the joint informational bulletin?**

State children’s mental health directors report a variety of experiences related to the May 7, 2013 joint CMS and SAMHSA informational bulletin:

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<sup>21</sup> CMS, *Alternatives to psychiatric residential treatment facilities demonstration (PRTF), Service array and lessons learned*. Retrieved July 15, 2014 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Alternatives-to-Psychiatric-Residential-Treatment-Facilities-Demonstration-PRTF.html>

- Several state Medicaid programs are already designed to cover virtually all of the services described in the bulletin for any enrolled member who might have need for that service (e.g., Vermont, since 1982; Arizona, since 2001; New Jersey, Oregon, and Rhode Island, since 2009).
- Several state Medicaid programs already cover at least some of the services described in the bulletin (e.g., intensive care management/wraparound in Delaware, Minnesota, Nevada, and Pennsylvania; family peer support in Arizona, Illinois, Maryland, Missouri, Oklahoma, and Rhode Island; youth peer support in Arizona, New York, and Pennsylvania; trauma-focused clinical practices in Louisiana, Mississippi, New Jersey, and South Carolina).
- Some state Medicaid programs offer virtually all of the services described in the bulletin, but only to defined subsets of the overall population of enrollees (e.g., District of Columbia, Indiana, Maryland, Texas).
- A majority of state children’s mental health directors cite at least some level of progress toward improving their Medicaid mental health program as directly related to the informational bulletin. Representative comments included:
  - ☑ Just completed an analysis of our Medicaid marketplace, and now know which desired services are not covered, and which are not currently available at the scope or scale needed. (Delaware)
  - ☑ Use of bulletin is helping to establish a common service language across state (mental health and Medicaid) agencies, managed care organizations, and service providers. (Tennessee)
  - ☑ Using the bulletin to build our statewide system of care. (Colorado)
  - ☑ Using the bulletin to raise performance standards of Medicaid providers. (Virginia)
  - ☑ Have been able to expand evidence-based family programs and providers. (Oregon)
  - ☑ Informational bulletin has helped push urgency for offering family and youth peer supports, and has helped us expand trauma-focused, evidence-based practices, including more viable reimbursement rates for those services. (Mississippi)
  - ☑ Bulletin has persuaded State Medicaid Agency to sustain family and peer support services through state plan since PRTF Demonstration. (Georgia)
  - ☑ Informational bulletin has convinced State Medicaid Agency to offer expanded services through the state plan, rather than to only a limited waiver population. (Georgia, Kentucky, South Carolina)
  - ☑ Now making care management a Medicaid state plan service. (Maryland)
  - ☑ Administrative support exists to finance mobile crisis team services via Medicaid. (Utah)

- A small minority of states indicate no particular activity related to the informational bulletin:
  - ☑ Didn't see the bulletin before now.
  - ☑ Not using the bulletin at all.
  - ☑ Lots of reform going on. Too many other things going on surrounding Affordable Care Act implementation right now.
  - ☑ Political winds oppose adding anything to our Medicaid program.

**2. How can states creatively use the informational bulletin?**

CYFD members generally expressed optimism and confidence that further improvements in the behavioral health benefit will be spurred by the informational bulletin.

- Many state leaders recognize that the informational bulletin can support and even accelerate ongoing, incremental processes that are gradually expanding the array of covered behavioral health services available to a widening population of Medicaid-enrolled children and youth. Representative comments included:
  - ☑ We are rewriting all our Medicaid services now, so the informational bulletin is very helpful. (Delaware)
  - ☑ Currently considering including family peer support and in-home crisis stabilization services in new Section 1915(i) state plan amendment, and working on targeted case management. (Maryland)
  - ☑ State Medicaid agency is developing a Section 1115 demonstration waiver proposal, in partnership with cross-sector system of care expansion team overseen from Governor's office. The bulletin is informing that process. The waiver proposal will, for example, include intensive care management services. (Illinois)
  - ☑ We are developing a health homes state plan amendment, incorporating content from the bulletin. (New Jersey)
  - ☑ Implementing comprehensive 1915(i) state plan amendment now to address needs of persons with autism and other intellectual and developmental disabilities (IDD). Bulletin has helped us to include respite care, non-medical transportation, and independent living skills training services. (New Jersey)
  - ☑ We are now using trauma-informed screening/assessment tools. (Alaska, Mississippi)
  - ☑ We are able to offer respite care as functional support services. (New Hampshire)
  - ☑ Working on incorporating respite care. (District of Columbia, Minnesota)
  - ☑ Expanding Medicaid coverage for substance abuse-related services. (Mississippi)
- Some states identify non-traditional partnerships that bear promise for expanding access to services promoted in the bulletin:

- ☑ Recent state legislation requiring child-serving systems to work together to prevent “lockout children” demands a defined service array by January 1, 2015. The bulletin is informing those discussions. (Illinois)
  - ☑ A local judge is championing an effort for service systems to collaborate to help students with behavioral health needs to remain successful in school and avoid the “school to prison pipeline.” (Michigan)
  - ☑ Potential to more optimally combine child welfare and Medicaid behavioral health resources to expand intensive in-home family support and preservation services. Our state has been setting new highs in its foster care census almost monthly, of late. (Arizona)
- Of particular significance are state efforts to promote the CMS/SAMHSA guidance with private sector service providers (Illinois, Virginia, Washington) and private insurance carriers (Kentucky, Tennessee). By emphasizing findings of cost-effectiveness in terms of positive client outcomes and demonstrated return on investment,<sup>22</sup> states can influence qualified health plans in the private marketplace to offer the services promoted in the informational bulletin as “essential health benefits.” Alignment between public (Medicaid, CHIP) and private benefit packages can minimize service disruptions for young people and families who might “churn” among such coverage options based on even minor fluctuations in family income or other circumstances. It will also greatly expand the availability of best behavioral health services and practices through private insurance carriers that lack experience providing mental health and substance abuse services at parity with primary health care prior to implementation of Affordable Care Act requirements for qualified health plans effective January 1, 2014.

### **3. How can states use the informational bulletin to address disparities in behavioral health care?**

CYFD members appreciate the importance of addressing existing disparities in access to, quality of, and outcomes from behavioral health care among different ethnic, racial, and other subpopulation groups. They recognize a complexity of factors that have led to and reinforce disparities among various subgroups, and that resist and inhibit efforts to produce greater equity along those three dimensions. Some of those factors are historical, others are situational (e.g., New Hampshire and Vermont recognize significant challenges in engaging immigrant children in families that have endured major trauma),<sup>23</sup> and others are socio-economic. At the same time, many leaders recognize opportunities to better understand, and then effectively address and reduce, behavioral health disparities in the near term.

- Some state leaders identify specific endeavors to apply the joint CMS/SAMHSA informational bulletin to promote increased behavioral health equity. For example:

<sup>22</sup> In addition to the PRTF Demonstration and CMHI findings in the Informational Bulletin, see also: Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2014). *Return on investment in systems of care for children with behavioral health challenges*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health. Retrieved from [http://gucchdtacenter.georgetown.edu/publications/Return\\_onInvestment\\_inSOCsReport6-15-14.pdf](http://gucchdtacenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf)

<sup>23</sup> See Dawes, D., Rider, F. & Lambert, L. (September 2013). *Health reform and immigrant children, youth, and families: Opportunities and challenges for advancing behavioral health*. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health. Retrieved from [http://www.tapartnership.org/docs/Health\\_Reform\\_Immigrant\\_Children.pdf](http://www.tapartnership.org/docs/Health_Reform_Immigrant_Children.pdf)

- ☑ Using the informational bulletin as an impetus to require collection and tracking of specific data related to race, gender, and sexual identity of service participants. (Indiana, Louisiana)
  - ☑ Expanding trauma-focused services, and providing behavioral health services through trauma-informed systems of care. (Mississippi)
  - ☑ Using Spanish language speakers to provide services, and interpreter services where necessary to fulfill National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care [CLAS]. (Delaware)
  - ☑ Using the bulletin as a tool to identify service approaches that can interrupt the “school to prison pipeline” for student members of racial and ethnic minorities. (Michigan)
- Many state leaders promote a set of service approaches that, while expected to yield additional benefits, are primarily expected to mitigate behavioral health disparities within only a year or two. The informational bulletin can support three major behavioral health service strategies to achieve greater behavioral health equity for young people with serious behavioral health needs and their families:
  - A. Family and peer support services
  - B. School-based behavioral health services
  - C. Tele-medicine and other professional service extenders.

#### **A. Family and Peer Support Services Can Mitigate Behavioral Health Disparities.**

While there is no simple solution to eliminating behavioral health disparities, the federal government’s Health Care Innovations Exchange understands that leveraging peer networks and the power of peer-to-peer interactions has the potential to improve care and outcomes for vulnerable populations.<sup>24</sup>

On July 22, 2003, New Freedom Commission on Mental Health Chairman Michael F. Hogan, Ph.D. reported to President Bush that America’s mental services and supports are “fragmented, disconnected and often inadequate, frustrating... a patchwork relic, the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.”<sup>25</sup> Despite that verdict, however, the Commission’s report, *Achieving the Promise: Transforming Mental Health Care in America*, outlined how attainment of six goals can offer all Americans with mental illness the promise of a fulfilling life in the community. Two of those goals pronounced that mental health care must be consumer and family-driven, and that disparities in mental health services must be eliminated.

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<sup>24</sup> Agency for Healthcare Research and Quality (July 18, 2012). *Reducing disparities through peer support*. Retrieved from <http://www.innovations.ahrq.gov/issue.aspx?id=133>; National Alliance on Mental Illness [NAMI] (2010) *Cultural competency in mental health peer-run programs and self-help groups: A tool to assess and enhance your services*, developed by the. Retrieved from <http://www.innovations.ahrq.gov/content.aspx?id=3679>

<sup>25</sup> Michael F. Hogan (July 22, 2003). Letter of submittal to President George W. Bush. New Freedom Commission on Mental Health. *Achieving the promise: Transforming mental health care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.*

A national meeting of families and stakeholders convened to better understand those challenges yielded families' description of alienation from a system whose professional practices often left them feeling blamed and ashamed. The families articulated a challenge to the mental health system to offer choices in providers, services, and supports that are congruent with the family's culture, especially in communities of color.<sup>26</sup> The CMS/SAMHSA informational bulletin explains how family and peer support services help to bridge such alienation and respond to the families' challenges. Peer services develop linkages with formal and informal supports; instill confidence; can serve as an advocate, mentor, or facilitator for resolution of issues; and teach skills necessary to improve coping abilities."<sup>27</sup> Family and peer support providers are family members or youth with lived experience who have personally faced the challenges of coping with serious mental health conditions, either as a consumer or a caregiver. The best peer services offer supportive partners who can serve as cultural liaisons and brokers between the child and family in need, and the services, programs, and systems designed to address those needs.

Many CYFD members report that family and youth peer supports are available in their state's Medicaid benefit, but with variable reach. A national scan by the Center for Health Care Strategies (2012) identified 16 such states,<sup>28</sup> and the Center has developed an expanding set of technical assistance tools and resources to support development of peer services capacity, including an in-depth description of exemplars in Arizona, Maryland, and Rhode Island.<sup>29</sup>

Peer support services were initially endorsed by CMS on behalf of adults with mental illness and/or substance use disorders in 2007.<sup>30</sup> By 2013, a NASMHPD survey of state mental health directors determined that 32 states and the District of Columbia had incorporated peer support services within their Medicaid behavioral health benefit for adults.<sup>31</sup> Nearly all states in the PRTF Demonstration saw a need to offer those supports, and adjustments will likely optimize their use as they become as prevalent in the child, adolescent, and family context as they are in the adult context.

In the meantime, parent and youth peer support services in some states are currently offered only – or initially – to facilitate the transition of young people from out-of-home care placements back to their family home, but that limitation clearly bypasses opportunities to strengthen or augment caregiver capacities that might prevent the need for such placements in the first place.

In addition, some state leaders express confusion about applying “medical necessity” criteria to parent and youth peer support services. Given the extraordinary caregiving capacity required not only to parent a young person with serious mental health challenges, but also to

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<sup>26</sup> Dababnah, S. & Cooper, J. (2006). Challenges and opportunities in children's mental health: A view from families and youth. *Unclaimed Children Revisited*, Working Paper No. 1. New York, NY: National Center for Children in Poverty, Columbia University.

<sup>27</sup> *Joint Informational Bulletin*, op.cit., p. 4.

<sup>28</sup> Simons, D. & Mahadevan, R. (May 2012). *Medicaid financing for family and youth peer support: A scan of state programs*. Hamilton NJ: Center for Health Care Strategies. Retrieved from [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1261373](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261373)

<sup>29</sup> Kallal, J., Walker, J., Conlan Lewis, L., Simons, D., Lipper, J. & Pires, S. (2014, February). *Becoming a Medicaid provider of family and youth peer support: Considerations for family run organizations*. Hamilton NJ: Center for Health Care Strategies. Retrieved from [http://www.chcs.org/media/Medicaid-FYPS-Considerations-for-FROs\\_FINAL\\_rev.pdf](http://www.chcs.org/media/Medicaid-FYPS-Considerations-for-FROs_FINAL_rev.pdf)

<sup>30</sup> Smith, D. (August 15, 2007). State Medicaid Directors Letter #SMDL #07-011. Retrieved September 3, 2014 from <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>

<sup>31</sup> Interview with David Miller, M.P.Aff., Project Director, National Association of State Mental Health Program Directors (September 3, 2014).

navigate service systems that might resemble those described by the New Freedom Commission, the gap between the high caregiving needs of the child and the primary caregivers' current capacity ("caregiver strain" is one consistent measure evaluated by the CMHI) is one representation of medical necessity for such support.

CMS has developed affirmative guidance regarding the use of peer services (available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>).

## **B. School-Based Behavioral Health Services Can Mitigate Disparities.**

A noteworthy finding in analysis of the CYFD discussions about the informational bulletin is the breadth of states' interest in expanding school-based behavioral health services. Although no discussion prompt mentioned school-based approaches, at least 10 of 33 state leaders identified Medicaid funding support for school-based services as a desirable focus for future federal guidance and/or technical assistance.

School-based health centers and school-based mental health services offer some obvious advantages as instruments to reduce barriers to care that otherwise yield disparities for some groups of children and youth. Schools are physically ubiquitous, located in virtually every community, usually served by transportation – and we know that almost all students are almost always there on school days. School-based health services (partnerships between schools and community health and behavioral health organizations) can help students access preventive care (e.g., immunizations, well-child exams, and mental health counseling) right where they already are. Further, diverse families have affirmed their relative comfort with and trust in their children's schools as venues for health and social services support.<sup>32</sup>

The Robert Wood Johnson Foundation (RWJF) recently counted more than 2,000 school-based health centers across the country. "Besides removing barriers to health care that many families face, school-based health centers help reduce inappropriate visits to emergency departments by up to 57 percent, research has found. They also help lower Medicaid expenditures, decrease student absences from school, and do a better job of getting students with mental health issues the services they need."<sup>33</sup> RWJF cites recent research by the University of Washington that found that high school students who used school-based health centers experienced greater academic improvements over the course of five semesters than students who didn't use these centers; and the effect was especially pronounced among those who took advantage of mental health services."<sup>34</sup>

Pertinent comments and suggestions of the CYFD membership include:

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<sup>32</sup> Kaiser Commission on Medicaid and the Uninsured (2000). *Medicaid and children: Overcoming barriers to enrollment - Findings from a national survey*. Washington, DC. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-and-children-overcoming-barriers-to-enrollment-report.pdf>

<sup>33</sup> RWJF Public Health Blog (August 29, 2014). *School-based health centers help remove barriers to care*. Retrieved from [http://www.rwjf.org/en/blogs/new-public-health/2014/08/school-based\\_health.html](http://www.rwjf.org/en/blogs/new-public-health/2014/08/school-based_health.html)

<sup>34</sup> Walker, S., Kerns, S., Lyon, A., Bruns, E. & Cosgrove, T. (March 2010). Impact of school-based health center use on academic outcomes. *Journal of Adolescent Health*, 46(3):251-7

- ☑ Would like to see more information about Medicaid support for school-based prevention services. (Delaware, Pennsylvania, Vermont)
- ☑ Would welcome a special CMS/SAMHSA informational bulletin addressing school-based mental health services. (District of Columbia, New Mexico)
- ☑ Want to understand how Medicaid could support tele-psychiatry services and/or consultative support in school settings – or already developing this. (District of Columbia, Maryland, North Carolina)
- ☑ Want to provide mental health and substance abuse screening services in schools (New Jersey, Pennsylvania)
- ☑ Our schools are now able to be licensed as mental health clinics. (District of Columbia.)

### **C. Tele-Medicine and other Professional Extender Strategies Can Mitigate Disparities.**

Many state leaders comment about the tension between the behavioral health services that are possible, and have proven merit – and the challenges of then developing a sufficient workforce to make the promise real. They note that the informational bulletin fails to address concomitant workforce challenges. Several CYFD members indicate their states already lack sufficient professional capacity, beginning with significant deficiency in psychiatry and child psychiatry resources. Others note an uneven distribution of professional expertise, with plentiful expertise serving highly desirable communities, and inadequate workforces common in other communities.

Contemporary research and literature about persistent behavioral health disparities substantiates the importance of a diversified workforce to significant improvements in equity in service access, utilization and results among subpopulations,<sup>35</sup> so standards for workforce sufficiency should give substantial weight to that criterion, too.

As their discussions evolve to problem-solving options, the same leaders gravitated toward a combination of technological mechanisms and redistribution of responsibilities to preserve limited, and highly valuable, expertise where it can have the biggest impact. Among the relevant comments:

- ☑ Lacking psychiatrists, we hope to teach pediatricians to manage relatively simple conditions like ADHD. (District of Columbia)
- ☑ Interested in using tele-psychiatry services in our schools. (North Carolina, District of Columbia)
- ☑ Could build on an existing, successful model of psychiatric consultation to primary care physicians at the University of Chicago. (Illinois)

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<sup>35</sup> American Psychological Association (n.d.). *Health disparities and mental/behavioral health workforce*. Retrieved August 26, 2014 from <http://www.apa.org/about/gr/issues/workforce/disparity.aspx>; and Department of Health and Human Services (2011). *HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities*. Washington, DC. Retrieved from [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

- ☑ Have huge geographic barriers, as 80% of our population lives in only 20% of our state. (Utah, Arizona)
- ☑ Need to provide professional consultation services via Medicaid – including consultation to group settings, such as schools and day care, without requiring billing tied to each specified client. (Vermont)

The Annapolis Coalition on the Behavioral Health Workforce (Annapolis Coalition) was originally commissioned by SAMHSA to undertake extensive study of national workforce challenges. Long before the unforeseen expansion of health care coverage and mental health parity laws increased the demand for behavioral health services, the Annapolis Coalition (2007) had already concluded, “It is difficult to overstate the magnitude of the workforce crisis in behavioral health. There is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services. There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population in this country.” (p.2)<sup>36</sup>

The Affordable Care Act includes a plethora of healthcare workforce development programs and strategies, but there is little doubt that health care and behavioral health care will remain a “growth industry” in the United States for the foreseeable future. The state leaders correctly recognize that workforce development looms as a major technical assistance need.

At the same time, the primary goal (of seven) in the Annapolis Coalition’s 2007 action plan called for significantly expanded roles for individuals in recovery, and for families, within the behavioral health workforce.<sup>37</sup> The action plan included objectives to develop formal roles for them through expanded peer- and family-support services, and through their increased employment as paid staff in prevention and treatment systems. The CMS/SAMHSA joint informational bulletin has provided significant impetus to apply the “lived expertise” of family and youth peers in uniquely advantageous roles as essential pieces of the overall workforce development puzzle.

#### **4. What technical assistance needs should be met to positively apply the informational bulletin in states?**

CYFD members have identified a large number of technical assistance needs, ranging from considerations of format to both broad and very specific problems in search of solutions. At the same time, many states (e.g., Alaska, Illinois, New York, Tennessee, Washington) have established internal technical assistance mechanisms and processes that have actively spread the content and the promise of the joint CMS/SAMHSA informational bulletin among behavioral health and Medicaid agency managers, across numerous collaborating child- and family-service systems (primary and public health, education, child welfare, juvenile justice, housing and other safety net agencies), private service providers and insurance carriers, parents, youth advocates, and other community members of their systems of care.

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<sup>36</sup> Annapolis Coalition on the Behavioral Health Workforce (2007). *An action plan for behavioral health workforce development: A framework for discussion*. Cincinnati, OH. Retrieved from <http://annapoliscoalition.org/wp-content/uploads/2013/11/action-plan-full-report.pdf>

<sup>37</sup> Ibid., pg. 15.

Representative suggestions by state leaders to simplify and focus technical support include:

- ☑ Need CMS/SAMHSA to provide ‘Medicaid 101’ basics, to teach Medicaid’s technical language and nuances to state officials.
- ☑ Simplify technical guidance by developing state-specific, two-page Medicaid program/options TA tool. Given each state’s existing Medicaid plan and waivers, what options can support our aims to add or expand service coverage, and what are the advantages and disadvantages of each option?
- ☑ Some states have found participation in focused “policy academies” to be productive in moving multiple systems toward common system improvement aims.

Among technical assistance needs identified by multiple CYFD members:

- ☑ Many states seek specific guidance about the Money Follows the Person (MFP) rebalancing demonstration program.
- ☑ Many states seek technical assistance to support potentially large-scale investments in school-based delivery options for health care and behavioral health services.
- ☑ Many states have identified technical assistance needs related to development of sufficient, high quality, culturally diverse workforces to deliver behavioral health services such as those promoted in the CMS/SAMHSA informational bulletin.
- ☑ Several states seek technical assistance to exploit the fullest potential of Medicaid to support primary prevention, including environmental and other whole population approaches; and early identification and early intervention opportunities for children and youth.
- ☑ Several states seek technical assistance to support provision or expansion of Medicaid-reimbursable tele-health/tele-medicine clinical service delivery.
- ☑ Several states have identified as a key issue the need to “normalize and de-stigmatize” mental health treatment; and ask for technical assistance support to develop effective messaging and social marketing campaigns.
- ☑ Several states seek technical assistance to improve programming and service delivery for young people with co-occurring intellectual/developmental disabilities, including autism spectrum disorders and mental/behavioral health needs.
- ☑ Some states seek technical support to evaluate which of several standard assessment/tracking tools (e.g., CANS, CAFAS, CASII, CBCL) to use as a basis for service planning and delivery.
- ☑ Some states seek technical assistance from the CMS to its own regional field offices about the informational bulletin, expressing concern that the regional

offices do not seem to share the same “can do” spirit of encouragement the bulletin expresses.

Additional technical assistance needs identified by state leaders include:

- ☑ Billing challenges related to provision of particular evidence-based programs and practices.
- ☑ How to distinguish between criminogenic behaviors and mental health symptoms that are a response to suffered trauma.
- ☑ How to improve accountability for and effectiveness of clinical treatment services.
- ☑ How to recruit and develop a viable workforce to provide youth peer support services.
- ☑ How to justify the higher cost of intensive in-home service provision to pass an audit compared to traditional, clinic-based services that typically yield inferior client/family engagement and inferior outcomes.
- ☑ How to balance time-limited service provision with placement stability for maltreated youth in therapeutic family foster care settings.

Although identified technical assistance needs are numerous, so too are technical assistance opportunities and resources that can support effective use of the CMS/SAMHSA informational bulletin. Federal agencies’ direct technical support, their subcontractors, and non-affiliated consultant resources might all play a role in helping state leaders to address their identified and emerging needs.

A. **Federal agencies offer direct technical support.** The informational bulletin specifically identified John O’Brien as an initial contact person for questions about the bulletin, or to suggest additional resources. It indicated that Mr. O’Brien can be reached at [John.O’Brien3@cms.hhs.gov](mailto:John.O’Brien3@cms.hhs.gov).

In addition, both CMS and SAMHSA offer a variety of focused technical assistance resources.

- CMS Medicaid Managed Care – Individualized Technical Assistance to States: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Request-Managed-Care-Technical-Assistance.html>
- Medicaid Health Home Information Resource Center: [www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html](http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html)
- CMS Health Homes Guiding Document: [http://www.samhsa.gov/healthreform/docs/Guidance\\_Doc\\_Health\\_Homes\\_Consultation\\_Process.pdf](http://www.samhsa.gov/healthreform/docs/Guidance_Doc_Health_Homes_Consultation_Process.pdf)
- CMS Long-Term Care Services and Supports Technical Assistance: <http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LongTermCare.html>

- Medicaid Money Follows the Person Technical Assistance: [www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Money-Follows-the-Person-Tech-Assist/Money-Follows-the-person-TA.html](http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Money-Follows-the-Person-Tech-Assist/Money-Follows-the-person-TA.html)
  - SAMHSA-HRSA Center for Integrated Health Care: <http://www.integration.samhsa.gov/>
  - CMS Medicaid Prevention Learning Network facilitates exchange of promising prevention practices: [MedicaidCHIPPrevention@cms.hhs.gov](mailto:MedicaidCHIPPrevention@cms.hhs.gov)
  - CMS Workforce Development Data Collection Technical Assistance (direct services workforce): <http://ici.umn.edu/index.php?projects/view/127>
- B. Many CYFD members actively participate in formal technical assistance processes hosted by **technical assistance entities contracted for that purpose by CMS and by SAMHSA.**
- The American Institutes for Research and the National Technical Assistance Center for Children’s Mental Health at Georgetown University co-host a Medicaid Learning Community that produces bi-monthly topical calls that feature behavioral health benefit improvements among states, and provides members with a Sharepoint resource library of materials and past presentations. Over 160 individuals from at least 30 states are members of the five-year-old learning community. Interested persons can join the Medicaid Learning Community by contacting Frank Rider ([frider@air.org](mailto:frider@air.org)) or Gary MacBeth ([gfm5@georgetown.edu](mailto:gfm5@georgetown.edu)).
  - The TA Network provides technical assistance to the Child, Adolescent and Family Branch (CAFB) of SAMHSA's Center for Mental Health Services, and to CMHI grantees across the nation to support states and communities to expand and sustain their systems of care for children, youth, and young adults and their families. CMHI grantees may contact the Technical Assistance Network for Children's Behavioral Health (Ph: 410-706-8300/e-mail: [SOCTANetwork@ssw.umaryland.edu](mailto:SOCTANetwork@ssw.umaryland.edu)).
  - Peer-to-peer sharing is viewed by many state leaders as a valuable way to learn from others how they have accomplished Medicaid benefit improvements. While CYFD members are encouraged to reach out to and learn from one another, the CMS/SAMHSA informational bulletin has also provided weblinks to multiple state exemplars for each of the specific services the bulletin promotes.
- C. State leaders have identified several **potential new products** that might help them to apply the CMS/SAMHSA informational bulletin and/or otherwise improve their state’s design of benefits to meet significant behavioral health needs of young people. Among specific products recommended by CYFD members are:
- Translation of the May 7, 2013 informational bulletin into Spanish (New Mexico).
  - Development of an informational bulletin to specifically describe options for Medicaid support of school-based behavioral health services.
  - Development of an informational bulletin to describe how to improve application of Medicaid coverage, including the EPSDT benefit, for primary prevention (e.g., environmental) of, early identification of, and early intervention with emerging

behavioral health needs of children and youth – including options (e.g., global reinvestment) not solely restricted to Medicaid enrollees.

- Simple (e.g., two page), state-specific Medicaid technical assistance tools describing waivers, Medicaid authorities, and related opportunities for benefit improvement, with consideration of advantages and disadvantages/limitations of the options considered.

### Conclusion

State directors of child and adolescent mental and behavioral health services express optimism that the joint CMS/SAMHSA informational bulletin, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Behavioral Health Conditions (May 7, 2013)*, can continue to serve as a catalyst and support for improvement in the design of Medicaid benefit packages, advancing the triple aim of better care, better behavioral health, and lower per capita service costs for young people with significant needs. Intensive care coordination (wraparound service planning/facilitation), family and youth peer support services, intensive in-home services, respite care, mobile crisis response and stabilization, and flex funds and other creative benefits including mentoring, therapeutic foster care, and supported employment options can underpin all three aims.

CYFD/NASMHPD and its members acknowledge availability of a range of Medicaid vehicles to incorporate benefit enhancements, and appreciate technical assistance support to aid their continuing efforts to enable young people with complex needs to live, learn, and thrive in family and community settings.

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*Information resources in the Appendices might assist states to pursue benefit enhancements described in this paper.*

## **Appendix A: Key Websites for State-Specific Medicaid Options**

**CMS: Medicaid Waivers, by State:** <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html> and

**CMS: Medicaid Waivers database with detailed information attached:**  
[http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers\\_faceted.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html)

**CMS: Medicaid Home and Community-Based Services**  
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

**CMS: Medicaid Money Follows the Person (MFP)**  
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Money-Follows-the-Person.html>

**Center for Health Care Strategies: Customizing Health Homes for Children with Serious Behavioral Health Challenges**  
<http://www.chcs.org/resource/customizing-health-homes-for-children-with-serious-behavioral-health-challenges/>

**Center for Health Care Strategies: Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles**  
<http://www.chcs.org/resource/intensive-care-coordination-using-high-quality-wraparound-children-serious-behavioral-health-needs-state-community-profiles/>

**Kaiser Family Foundation: Status of State Action on the Medicaid Expansion Decision**  
<http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

**National Association of States United for Aging and Disabilities: State Medicaid Integration Tracker**  
<http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker/>

**National Technical Assistance Center for Children's Mental Health (Georgetown University): Health Reform Tracking Project**  
<http://gucchdtacenter.georgetown.edu/TATopics/HealthReform.html> (Health Reform Tracking Project)

## **Appendix B: Section 1915(i) State Plan Amendments**

*The following information is copied directly from:*

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html>

States can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. People must meet State-defined criteria based on need and typically get a combination of acute care medical services (like dental services, skilled nursing services) and long-term services (like **respite, case management, supported employment and environmental modifications**).

### **1915(i) State plan HCBS: State Options**

- Target the HCBS benefit to one or more specific populations
- Establish separate additional needs-based criteria for individual HCBS
- Establish a new Medicaid eligibility group for people who get State plan HCBS
- Define the HCBS included in the benefit, including State-defined and CMS-approved "other services" applicable to the population
- Option to allow any or all HCBS to be self-directed

### **1915(i) State plan HCBS Guidelines**

States can develop the HCBS benefit(s) to meet the specific needs of a population(s) within Federal guidelines, including:

- Establish a process to ensure that assessments and evaluations are independent and unbiased
- Ensure that the benefit is available to all eligible individuals within the State
- Ensure that measures will be taken to protect the health and welfare of participants
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that services are provided in accordance with a plan of care
- Establish a quality assurance, monitoring, and improvement strategy for the benefit.

## **Appendix C: ACA Section 2703 Health Homes**

*The following information is copied directly from:*

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects States' health home providers to operate under a "whole-person" philosophy. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

Who Is Eligible for a Health Home?

Health Homes are for people with Medicaid who:

- Have two or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.

- States can target health home services geographically
- States cannot exclude people with both Medicaid and Medicare from health home services

Health Home Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient and family support
- Referral to community and social support services

## **Appendix D: Medicaid Coverage for Tele-Medicine Services:**

*The following information is copied directly from:*

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient) that States can choose to cover under Medicaid. This definition is modeled on Medicare's definition of telehealth services (42 CFR 410.78). Note that the Federal Medicaid statute does not recognize telemedicine as a distinct service.

**Medical Codes:** States may select from a variety of HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services.

Telehealth (or telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services (under section 1905(a) of the Social Security Act).

### **Provider and Facility Guidelines**

Medicaid guidelines require all providers to practice within the scope of their State Practice Act. Some states have enacted legislation that requires providers using telemedicine technology across state lines to have a valid state license in the state where the patient is located. Any such requirements or restrictions placed by the state are binding under current Medicaid rules.

### **Reimbursement for Telemedicine**

Reimbursement for Medicaid covered services, including those with telemedicine applications, must satisfy Federal requirements of efficiency, economy, and quality of care. States are encouraged to use the flexibility inherent in Federal law to create innovative payment methodologies for services that incorporate telemedicine technology. For example, states may reimburse the physician or other licensed practitioner at the distant site and reimburse a facility fee to the originating site. States can also reimburse any additional costs such as technical support, transmission charges, and equipment. These add-on costs can be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state. If they are separately billed and reimbursed, the costs must be linked to a covered Medicaid service.

### **State Flexibility in Covering/Reimbursing for Telemedicine Services and the Application of General Medicaid Requirements to Coverage of Telemedicine Services**

Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient). As such, states have the option/flexibility to determine whether (or not) to cover telemedicine; what types of telemedicine to cover; where in the state it can be covered; how it is provided/covered; what

types of telemedicine practitioners/providers may be covered/reimbursed, as long as such practitioners/providers are "recognized" and qualified according to Medicaid statute/regulation; and how much to reimburse for telemedicine services, as long as such payments do not exceed Federal upper limits.

If the state decides to cover telemedicine, but does not cover certain practitioners/providers of telemedicine or its telemedicine coverage is limited to certain parts of the state, then the state is responsible for assuring access and covering face-to-face visits/examinations by these "recognized" practitioners/providers in those parts of the state where telemedicine is not available. Therefore, the general Medicaid requirements of comparability, statewideness, and freedom of choice do **not** apply with regard to telemedicine services.

#### **CMS Approach to Reviewing Telemedicine SPAs**

- States are not required to submit a (separate) SPA for coverage or reimbursement of telemedicine services if they decide to reimburse for telemedicine services the same way/amount that they pay for face-to-face services/visits/consultations.
- States must submit a (separate) reimbursement (attachment 4.19-B) SPA if they want to provide reimbursement for telemedicine services or components of telemedicine differently than is currently being reimbursed for face-to-face services.
- States may submit a coverage SPA to better describe the telemedicine services they choose to cover, such as which providers/practitioners are; where it is provided; how it is provided, etc. In this case, and in order to avoid unnecessary SPA submissions, it is recommended that a brief description of the framework of telemedicine be placed in an introductory section of the State Plan and then a reference made to telemedicine coverage in the applicable benefit sections of the State Plan. For example, in the physician section it might say that dermatology services can be delivered via telemedicine provided all state requirements related to telemedicine as described in the state plan are otherwise met.