Medicaid Financing for Behavioral Health Services: The Use of Flexibilities and Authorities

November 2020

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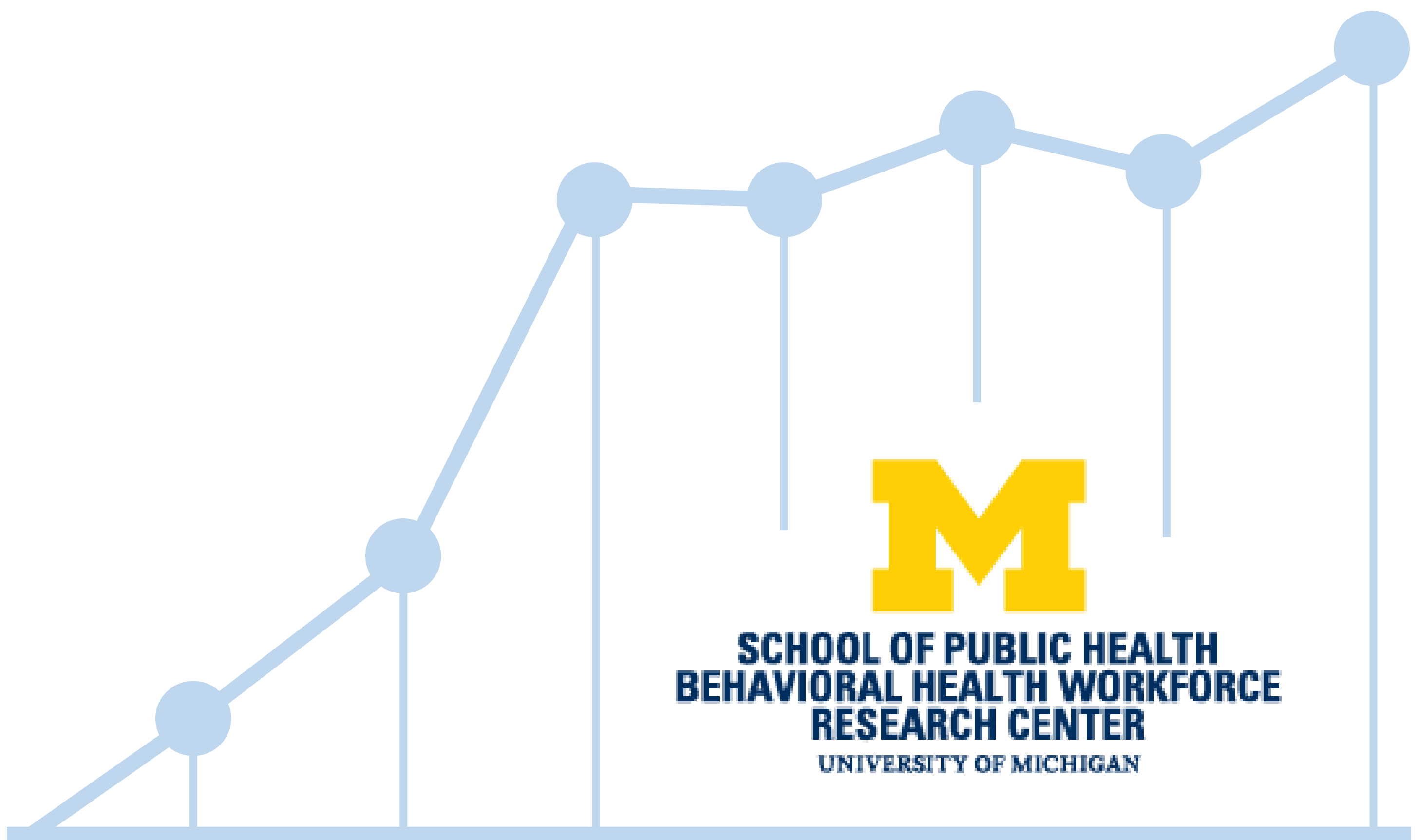

ACKNOWLEDGEMENTS
This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $900,000. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

SUGGESTED CITATION
University of Michigan Behavioral Health Workforce Research Center. Medicaid Financing for Behavioral Health Services: The Use of Flexibilities and Authorities. Ann Arbor, MI: UMSPH; 2020.

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Introduction

Adequate financing is crucial to address the need and demand for behavioral health (BH) services among Medicaid populations. With Medicaid as the dominant payer for BH services, states optimize statutory authorities and other mechanisms to deliver necessary and appropriate care.

Federal restrictions on use of Medicaid funds for BH services, specifically when provided in "institutions for mental disease" (IMDs), have been in place for decades, restricting access to inpatient BH services for Medicaid enrollees and limiting states' ability to provide optimal services and facilities for adults aged 18–64 years. States currently have 4 options that allow federal financial participation through Medicaid matching funds, the Federal Medical Assistance Percentage (FMAP), to finance IMD BH services for nonelderly adults through Medicaid: Section 1115 demonstration waivers, disproportionate share hospital (DSH) payments, managed care "in lieu of" authority, and the state plan option in the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act). This study addresses the Section 1115 demonstration waivers and, to a lesser extent, DSH payments to IMDs; managed care "in lieu of" mechanisms and the SUPPORT Act state plan option are described.

The policy implications of new access to IMD services for adult Medicaid enrollees follow from a detailed review of states' Section 1115 demonstration waiver applications and Centers for Medicare and Medicaid (CMS) approvals, the creation of a detailed typology of these flexibilities, examination of temporal relationships among waiver approvals by state, and states' use of Medicaid DSH payments for Medicaid services in IMDs.

The state-specific nature of the Medicaid program, Medicaid's history of innovation, state budget constraints, and the importance of BH waivers to inpatient care for BH compel research on how states use available statutory and regulatory flexibilities to meet service, budget, and quality of care goals. Changes in Medicaid financing being proposed at the federal and state levels speak to the importance of analyzing the current and proposed mechanisms for federal financial participation in Medicaid financing for BH.

Background

Medicaid as Payer

States operate their Medicaid programs within federal standards in exchange for matching funds based on a federal formula that generates the Federal Medical Assistance Percentage.[1]

As the largest single payer for BH services, Medicaid program financing facilitates access to BH resources, such as psychiatric care, counseling, prescription medications, inpatient treatment, case management, and supportive housing. Innovative federal and state programs and the Patient Protection and Affordable Care Act have increased access to BH care in many states.[2]

Institutional or facility-based BH treatment has undergone major changes in treatment approaches as a result of clinical advances, socio-political changes, and an expanding research evidence base. Deinstitutionalization in the last century shifted financing for inpatient and residential care for individuals with mental conditions from federal sources to states, commercial insurance, or private payers. More recently, the overwhelming demand and unmet need for BH care in the midst of growing resource constraints require careful analysis of Medicaid funding mechanisms and flexibilities to promote access to quality care.

Institutions for Mental Disease

Inpatient BH care is delivered in IMDs, defined in the 1965 Medicaid legislation as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[a]

[a]SSA §1905(i). www.ssa.gov/OP_Home/ssact/Title 19/1905.

IMDs are excluded from federal financial participation in Medicaid for segments of the Medicaid population and for certain services delivered in and out of the facility.[b] The IMD exclusion is found in section 1905(a)(B) of the Social Security Act and prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" except for "inpatient psychiatric hospital services for individuals under age 21." [3,c]

In 1965, the original definition of the Medicaid IMD exclusion included a state option to provide care for individuals aged ≥65 years in inpatient psychiatric institutions. In 1972, a state option was added to cover IMD services with federal financial participation for Medicaid individuals aged <21 years in IMDs. In 1990, the Secretary allowed facilities other than hospitals to qualify as providers of inpatient psychiatric services for individuals aged <21 years. Services to this age group were extended to psychiatric residential treatment facilities in 2001. In 1988, the Medicaid definition of IMD excluded facilities with ≤16 beds. The result was lack of Medicaid federal financial participation in reimbursement to IMDs for Medicaid enrolled adults aged 16–64 years in IMD facilities with >16 beds.[d]

There is extensive research on the beneficial outcomes of reducing institutional lengths of stay by integrating BH with primary care, social systems, and other community services; coordinating and managing care across providers and community-based settings; and aligning payment systems with clinical and management decision systems. Facility-based care and its integration with primary care and other services are included in the American Psychiatric Association's clinical guidelines. However, inpatient hospital care for adults without commercial insurance or financial resources has been limited to psychiatric hospitals owing to policies that exclude IMDs from coverage.

Inpatient Behavioral Health Services Funding for Medicaid Enrollees

The IMD exclusion limited the use of these facilities for much needed BH care for adults. Federal financial participation in providing care to nonelderly adults in IMDs include Section 1115 demonstration waivers, DSH payments, managed care "in lieu of" authority, and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act state plan option.

Social Security Administration Section 1115 Demonstration Waivers

Waiver authority granted by the CMS allows states to test and implement innovative delivery models and payment systems using federal matching funds.[e] Section 1115 of the Social Security Act allows the Department of Health and Human Services Secretary to waive certain provisions of federal Medicaid law to allow states to receive federal funding for an "experiment, pilot, or demonstration" project likely to "promote the objectives" of the Medicaid program. A subsection of Section 1115 authorizes the Secretary to provide Medicaid federal funds to IMDs under certain circumstances. Specific waivers promote integrated care models, managed care, benefit expansion, community-based service models, payment reform, and eligibility and services to populations with "special needs." Many of these provisions impact BH care, including care integration, eligibility expansions, and benefit redesign. In 2018, Section

[b] The Legal Action Center. 2020. The Medicaid IMD Exclusion: An Overview and Opportunities for Reform 2020. "In the State Medicaid Manual, the federal Department of Health and Human Services (HHS) interprets the IMD exclusion to include any institution that, by its overall character is a facility established and maintained primarily for the care and treatment of individuals with mental diseases. The guidelines used to evaluate if the overall character of a facility is that of an IMD are based on whether the facility: is licensed or accredited as a psychiatric facility; Is under the jurisdiction of the state's mental health authority; specializes in providing psychiatric/psychological care and treatment, which may be ascertained if indicated by a review of patients' records, if an unusually large proportion of the staff has specialized psychiatric/psychological training, or if a facility is established and/or maintained primarily for the care and treatment of individuals with mental diseases; or has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases. If any of these criteria is met, a thorough IMD assessment will be made. Therefore, a facility is determined to be an IMD based on the character of the institution, including its governance, staffing, and patient population." p. 2.

[c] 42 U.S.C. § 1396d(a)(29)(B).

[d] 42 U.S.C. § 1396d(a)(29)(B). "The "IMD exclusion" is set forth in the Medicaid statute, which excludes "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental illness." Since its inception in 1965, the IMD exclusion was modified to exempt children under age 21 and to permit coverage for small (16 beds or fewer) mental health institutions." "Thus, over time, the IMD exclusion has been narrowed by both Congress and CMS. However, since the exclusion is statutory, the White House cannot unilaterally "end" it without an amendment by Congress."

[e] Section 1115 of the Social Security Act allows the Health and Human Services Secretary to waive certain provisions of federal Medicaid law for an "experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives of" the program. 42 U.S.C. § 1315 (a). Section 1115 waiver authority is limited to provisions contained in 42 U.S.C. § 1396a, while the IMD payment exclusion is contained in 42 U.S.C. § 1396d. However, the Secretary has approved IMD payment waivers under Section 1115 expenditure authority, which has been interpreted to independently permit the "costs of such [demonstration] project[s] which would not otherwise be included as [federal Medicaid] expenditures. . . [to] be regarded as expenditures under the State [Medicaid] plan. . .." 42 U.S.C. § 1315 (a)(2)." Footnote 11 from KFF 2019.

1115 demonstration BH waivers also allowed for modification of the “IMD exception,” thus eliminating a major barrier to services for Medicaid enrollees in IMDs.

In November 2018, using Section 1115 demonstration waivers for serious mental illness (SMI) and serious emotional disturbance, CMS allowed states to pay for short-term psychiatric care for adults (aged 18–64 years) in IMD settings. Guidance issued by CMS required states to meet several criteria, including access to a continuum of mental health services, use of utilization review, and specific provider requirements. CMS also limited length of stay and frequency of stays in an IMD, as well as the length of the waiver authority itself.

Disproportionate Share Hospital Payments

Medicaid DSH payments are statutorily required payments to states to distribute to hospitals serving Medicaid enrollees. DSH payments are limited to the cost of inpatient and outpatient services to Medicaid and uninsured patients minus payments received from Medicaid (including supplemental payments) and from uninsured individuals. Some criteria exist for hospitals to receive DSH payments, but states have wide discretion in the distribution of the “allocation” to hospitals. States also can provide Medicaid DSH payments to IMDs; these are lump-sum payments provided to the facilities rather than payments for services rendered.[4] Federal statute limits the percentage and level of DSH payments that each state can make to IMDs or other mental health facilities by establishing a formula that caps the allotment to states for IMD payments.

Medicaid Managed Care “in Lieu of” Authority

In 2016, CMS issued final regulations that revised and strengthened Medicaid managed care rules. For the first time, states could receive federal matching funds for capitation payments on behalf of adults who receive psychiatric or substance use disorder (SUD) inpatient or crisis residential services in an IMD for no more than 15 days during a given month.[5] Under this authority, managed care plans could use short-term treatment in an IMD “in lieu of” those available under the state Medicaid plan for services delivered to Medicaid enrollees aged 18–64 years in IMDs. Recently, the Kaiser Family Foundation reported that 31 states used the “in lieu of” authority in fiscal year (FY)2019 and FY2020.[6]

Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act): State Plan Option

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act, P.L. 115-271) created a new state plan option to allow states to pay for care for Medicaid beneficiaries aged 21–64 years with ≥1 SUD in certain IMDs up to 30 days a year. In order for a state to receive state plan approval, several requirements must be met, including coverage of all levels of SUD care, outpatient, residential, and inpatient services. The option is available from October 1, 2019, to September 30, 2023. The Act also created a limited exception to the IMD exclusion for women who are eligible for Medicaid on the basis of pregnancy. Specifically, it prohibits states from denying federal financial participation for non-IMD services delivered to pregnant women (and up to 60 days postpartum) who are patients of an IMD for the treatment of SUD. The Kaiser Family Foundation (KFF) survey of states indicated ≤5 states were considering using this new state option for IMD funding in FY2020. States not considering this option reported that Section 1115 waivers provide more flexible limits on length of state than the state plan option.[7]

Given these available mechanisms for federal financial participation in state Medicaid program costs, how do states achieve goals for delivery of BH care to adult Medicaid enrollees, comply with federal and state mandates and guidelines, and satisfy state budget objectives?

Methods

Investigators analyzed state use of 2 of the 4 financial mechanisms discussed above available to states for financing care delivered in IMDs.

Social Security Administration Section 1115 Demonstration Waivers

In the Spring of 2020, the authors created a typology of the BH components embedded within Section 1115 demonstration waivers. To identify relevant waivers, the research team relied on the KFF Medicaid Waiver Tracker (2020), which tracks information on pending and approved Section 1115 Waivers, including all waivers with BH provisions.[8] The KFF database organizes approved and pending Section 1115 waivers by pre-specified provisions, including BH components, but not why these provisions were selected or if other BH components exist within the waiver documents. After identifying all currently approved Section 1115 demonstration waivers with a BH component, researchers collected the most recently approved waiver applications from the Medicaid.gov State Waivers List on March 6, 2020.[9]

To locate the BH provisions within Section 1115 Waivers, keyword searches used the following terms: “behavioral health,” “mental health,” and “substance use.” Detailed outlines were created for each waiver with descriptions of all provisions. Once all outlines were completed, documents were reviewed to identify the common provisions, which would become the typology components. The team then organized the waivers using the typological classification system.

As the project’s primary aim focused on state financing mechanisms to cover services delivered in an IMD for nonelderly adults, additional data were collected on the Section 1115 Waiver provisions that expanded access to IMD services. Specifically, these data included the approval date, implementation date, and expiration date for the provision permitting the use of federal Medicaid matching funds to reimburse for mental health and SUD services delivered in an IMD. To gather this information all approved versions of the waiver application with the IMD-relevant provision were reviewed. The research team then noted the approval date for the first version containing the IMD payment exemption. Dates were validated using the KFF and Milbank Memorial Fund (2019) report.[10]

Disproportionate Share Hospital Payments

The research team collected data on FY2015 and FY2018 DSH payments to IMDs using publicly available data presented in reports issued by the Congressional Research Services in 2016 and 2020.[11] Collected data included total DSH payments to IMDs and DSH payment as a percentage of Medical Assistance Expenditures.

Results

Section 1115 Waivers for Behavioral Health Services Typology

Thirty currently approved Section 1115 demonstration waivers contained BH provisions. The waiver review revealed 3 BH-related characteristics of Section 1115 Waivers: (1) BH integration, (2) benefit expansion, and (3) eligibility expansion (Table 1). The Appendix to the report summarizes selected state waiver programs.

Behavioral Health Integration

Behavioral health integration includes provisions that impact the coordination of behavioral and physical health services. Under this category, 2 subcategories were identified: (1) new delivery model, and (2) payment reform. The former refers to waiver components that authorize a new demonstration program that furthers the integration of behavioral and physical health services for some or all Medicaid recipients. For instance, Arizona’s Section 1115 Demonstration Waiver modifies how Medicaid enrollees with SMI receive integrated BH services. The Arizona Acute Care Program (AACP) is a statewide, managed care

Table 1: Typology of Behavioral Health Provisions Embedded Within Section 1115 Demonstration Waivers							
State	**Waiver Title**	**Behavioral Health Integration**		**Benefit Expansion**			**Behavioral Health Eligibility Expansion**
		New Delivery Method	Payment Reform	IMD—Mental Health	IMD—Substance Use Disorder	Other	
AK	Alaska Substance Use Disorder and Behavioral Health Program	Yes	No	No	Yes	No	No
AZ	Arizona Medicaid Section 1115 Demonstration	Yes	No	No	No	No	No
CA	California Medi-Cal 2020 Demonstration	No	Yes	No	Yes	No	No
DE	Delaware Diamond State Health Plan	No	No	No	Yes	No	No
FL	Florida Managed Medical Assistance	No	No	No	No	No	No
HI	Quest Integration Medicaid Section 1115 Demonstration	No	No	No	No	No	No
IL	Illinois Behavioral Health Transformation Section 1115(a) Demonstration	No	No	No	Yes	Yes	No
IN	Healthy Indiana Plan	No	No	Yes	Yes	No	No
KS	KanCare	No	No	No	Yes	Yes	No
KY	KY Health Section 1115 Demonstration	No	No	No	Yes	No	No
LA	Healthy Louisiana Substance Use Disorder 1115 Demonstration	No	No	No	Yes	No	No
MD	HealthChoice Medicaid Section 1115 Demonstration	No	No	No	Yes	No	No
MA	MassHealth Medicaid Section 1115 Demonstration	No	Yes	No	Yes	No	No
MI	Michigan 1115 Behavioral Health Demonstration	No	No	No	Yes	No	No
MN	Minnesota Substance Use Disorder System Reform	No	Yes	No	Yes	No	No
MT	Montana Section 1115 Waiver for Additional Services and Populations	No	No	No	No	No	Yes
NE	Nebraska Substance Use Disorder Program	No	No	No	Yes	No	No
NH	New Hampshire Building Capacity for Transformation	No	Yes	No	Yes	No	No
NJ	Substance Use Disorder Treatment and Recovery Access	No	No	No	Yes	No	No
NM	Centennial Care 2.0 Medicaid 1115 Demonstration	No	No	No	Yes	No	No
NY	Medicaid Redesign Team	Yes	No	No	No	No	No
NC	North Carolina Medicaid Reform Demonstration	Yes	No	No	Yes	No	No
OH	Section 1115 Substance Use Disorder Demonstration	No	No	No	Yes	No	No
PA	Medicaid Coverage for Former Foster Care Youth from a Different State and SUD Demonstration	No	No	No	Yes	No	No
RI	Rhode Island Comprehensive Demonstration	No	No	No	Yes	Yes	Yes
UT	Primary Care Network	No	No	No	Yes	Yes	No
VT	Global Commitment to Health Section 1115 Demonstration	No	No	Yes	Yes	Yes	Yes
WA	Washington State Medicaid Transformation Project	No	Yes	No	Yes	No	No
WV	West Virginia Continuum of Care for Medicaid Enrol-lees with Substance Use Disorders	No	No	No	Yes	Yes	No
WI	Wisconsin Badger Care Reform	No	No	No	Yes	No	No
Total	***30***	***4***	***5***	***2***	***25***	***6***	***3***

system that delivers acute care services to Medicaid beneficiaries that meet specific qualifications, including children and pregnant women. Most AACP enrollees receive BH services as a carved-out benefit, which is managed separately from other services by Regional Behavioral Health Authorities. For AACP members with a SMI, this healthcare delivery structure may create challenges for care access, disease management,

and medication adherence. To address this concern, Arizona's Medicaid agency collaborated with BH partners to develop an integrated care approach for AACP members with an SMI. The demonstration program requires geographically designated Regional Behavioral Health Authorities to manage both the delivery of physical health and BH services.[12]

Integration of BH through payment reform includes waiver provisions that authorize an innovative payment approach to facilitate physical and BH coordination. Five states contain provisions that fall within this category. Examples include California's allocation of $7.6 billion in combined federal and state shares over 5 years to support the Public Hospital Redesign and Incentives in Medi-Cal demonstration program, which directs incentive payments to participating entities to support the integration of physical health and BH in inpatient and outpatient settings. Minnesota's 1115 Waiver authorized the state to continue providing an enhanced set of BH and mental health services through Certified Community Behavioral Health Clinics, which are funded through innovative payment models. New Hampshire's Integrated Delivery Network demonstration encourages regional coalitions of providers to apply collectively for funding for projects in four objective areas, including the promotion of physical health and BH integration. Funds may support the co-location of providers in sites that currently have little or no integration, the adoption of evidence-based standards for care integration, and the use of team-based approaches to care delivery.

Benefit Expansion

Benefit expansion provisions add additional services to the Medicaid benefit package that are otherwise ineligible for federal financial participation. The 3 subcategories within this category include: IMD-Mental Health, IMD-SUD, and Other. Section 1115 demonstration waivers that contain provisions that fall under the category IMD-Mental Health provisions authorize the state to use federal Medicaid matching funds to reimburse for inpatient and residential mental health treatment services delivered in an IMD for nonelderly adults under certain conditions. IMD-SUD provisions similarly allow federal Medicaid matching funds to be used to pay for IMD-delivered services to nonelderly adults but for SUD care instead of mental health care. At the time of this review, Indiana and Vermont were the only states to use the Section 1115 Demonstration authority to permit federal Medicaid matching dollars to be used for mental health care delivered in an IMD. By contrast, 25 states authorized payment for IMD-delivered SUD care through a Section 1115 Demonstration Waiver. Table 2 provides key dates of approved Section 1115 Waivers for the IMD payment exclusion.

The Other category includes provisions that expand Medicaid benefits to BH services beyond those delivered in an IMD. For example, under this expenditure authority, Illinois authorized coverage of peer recovery support services for beneficiaries with an opioid use disorder/SUD who are receiving SUD treatment and have been assessed by a physician or other licensed recovery practitioner. Kansas' approved Section 1115 Waiver contains a voluntary pilot program to provide eligible KanCare (Kansas Medicaid) with supportive employment services. Members eligible for the Disability and Behavioral Health Employment Support Pilot program include individuals with specific BH primary diagnoses and receive benefits through the Supplementary Security Income or Social Security Disability Insurance. West Virginia and Rhode Island also authorize reimbursement for peer recovery services through the expenditure authority.

Eligibility Expansions

Behavioral health eligibility expansions refer to provisions that expand Medicaid eligibility to a population with a BH condition otherwise ineligible for Medicaid under federal or state law. Approved Section 1115 demonstration waivers in 3 states had provisions that fall within this category. Montana authorizes Medicaid coverage for no more than 3,000 adults who have been diagnosed with schizophrenia, bipolar disorder, major disorder, or another SMI who are not otherwise eligible for Medicaid.[f] The

[f] Eligible individuals must also be currently receiving a limited mental health services benefit package through enrollment in the state-financed Mental Health Services and Policy Program, and either have an income >133% up to and including 150% of the federal poverty level, or are eligible for or enrolled in Medicare and have income ≤133% of the federal poverty level.

State	Mental Health				Substance Use Disorder			
	Authority	Approval Date	Authority Begins	Authority Expires	Authority	Approval	Authority Begins	Authority Expires
AK	No	.	.	.	Yes	11/21/2018	1/1/2019	12/31/2023
CA	No	.	.	.	Yes	8/13/2015	1/1/2016	12/31/2020
DE	No	.	.	.	Yes	7/31/2019	8/1/2019	12/31/2023
IL	No	.	.	.	Yes	5/7/2018	7/1/2018	6/30/2023
IN	Yes	2/1/2018	2/1/2018	12/31/2020	Yes	2/1/2018	2/1/2018	12/31/2020
KS	No	.	.	.	Yes	12/18/2018	1/1/2019	12/31/2023
KY	No	.	.	.	Yes	1/12/2018	1/12/2018	9/30/2023
LA	No	.	.	.	Yes	2/1/2018	2/1/2018	12/31/3022
MD	No	.	.	.	Yes	12/22/2016	1/1/2017	12/31/2021
MA	No	.	.	.	Yes	10/30/2014	10/30/2014	6/30/2022
MI	No	.	.	.	Yes	4/5/2019	4/5/2019	9/30/2024
MN	No	.	.	.	Yes	6/28/2019	7/1/2019	6/30/2024
NE	No	.	.	.	Yes	7/9/2019	7/9/2019	6/30/2024
NH	No	.	.	.	Yes	7/10/2018	7/10/2018	6/30/2023
NJ	No	.	.	.	Yes	10/31/2017	7/1/2017	6/30/2022
NM	No	.	.	.	Yes	12/14/2018	1/1/2019	12/31/2023
NC	No	.	.	.	Yes	10/19/2018	1/1/2019	10/31/2024
OH	No	.	.	.	Yes	9/24/2019	10/1/2019	9/30/2024
PA	No	.	.	.	Yes	6/28/2018	7/1/2018	9/30/2022
RI	No	.	.	.	Yes	12/20/2018	1/1/2019	12/31/2023
UT	No	.	.	.	Yes	10/31/2017	1/1/2019	12/31/2023
VT	Yes	1/1/1996	1/1/1996	Phase-out by 2025	Yes	1/1/1996	1/1/1996	12/31/2021
WA	No	.	.	.	Yes	7/17/2018	7/17/2018	12/31/2021
WV	No	.	.	.	Yes	10/31/2018	10/31/2018	12/31/2023
WI	No	.	.	.	Yes	10/6/2017	1/1/2018	12/31/2022

Table 2: Key Dates of Approved Section 1115 Waivers for the Institution for Mental Disease Payment Exclusion as of January 2020

demonstration offers enrollees who meet these criteria a benefit package that aligns with the Medicaid state plan. Prioritization of the eligibility expansion is based on a current schizophrenia diagnosis, subsequent bipolar disorder, followed by major depressive disorder. Rhode Island expands the Medicaid program to include at-risk children who have incomes up to 300% of Supplementary Security Income, including those with special healthcare needs like serious emotional disturbance and behavioral challenges or medically dependent conditions. Under the expenditure authority, Vermont authorizes reimbursement of mental health community rehabilitation and treatment services through a state-funded program for individuals >133% and up to 185% of the federal poverty level who are not otherwise eligible for Medicaid enrollment.

Disproportionate Share Hospital payments to Institutions for Mental Disease

Table 3 presents DSH payments made to IMDs during FY2015 and FY2018. Significant variation existed in the amount of DSH payments paid to IMDs in 2015 and 2018 by state. State variation ranged from no DSH funds used for IMD services to $610.8 million in 2015 and $537.8 million in 2018 paid for IMD

Table 3: Disproportionate Share Hospital Payments to Institutions for Mental Disease in 2015 and 2018					
State	**Section 1115 IMD Payment Exception Begins**	**DSH Payment to IMDs, 2015**	**DSH Payment to IMDs, 2018**	**DSH Payment as a Percent of Medical Assistance Expenditures, 2015**	**DSH Payment as a Percent of Medical Assistance Expenditures, 2018**
				($, millions)	
AL	.	0	0.8	9.20%	8.70%
AK	1/1/2019	10.9	15.1	1.40%	0.90%
AZ	.	28.5	28.5	1.60%	1.20%
AK	.	0.8	0.8	1.20%	0.70%
CA	1/1/2016	0.0[a]	0.0[c]	2.80%[a]	0.70%[c]
CO	.	0	0	2.70%	1.90%
CT	.	105.6	105.6	1.80%	0.80%
DE	8/1/2019	6	5.7	0.80%	0.60%
FL	.	119.1	117.1	1.70%	1.50%
GA	.	0	0	4.50%	4.10%
HI	.	0.00[b]	0.00[b]	0.00%[b]	0.00%[b]
ID	.	0	0	1.40%	1.30%
IL	7/1/2018	82.7	89.3	2.60%	1.50%
IN	2/1/2018	0	0	2.50%	0.60%
IA	.	0	0	1.10%	1.70%
KS	1/1/2019	26	29.4	2.60%	3.10%
KY	1/12/2018	37.7	37.4	2.40%	2.20%
LA	2/1/2018	125.6	77.6	16.90%	11.50%
ME	.	42.1	43.4	1.70%	1.60%
MD	1/1/2017	56	53.7	1.10%	0.90%
MA	10/30/2014	0.0[b]	0.0[b]	0.00%[b]	0.00%[b]
MI	4/5/2019	0.1	140.2	2.10%	3.70%
MN	7/1/2019	25.1	0	0.50%	0.50%
MS	.	0	0	4.40%	4.30%
MO	.	207.2	207.6	7.20%	7.60%
MT	.	0	0	1.60%	0.10%
NE	7/9/2019	1.4	1.8	2.10%	1.90%
NV	.	0	0	2.50%	2.00%
NH	7/10/2018	40.4	36.5	6.30%	10.60%
NJ	7/1/2017	357.4	357.4	7.80%	5.30%
NM	1/1/2019	0	0	0.50%	1.00%
NY	.	610.8	537.8	5.90%	5.60%
NC	1/1/2019	160.3	161.8	4.00%	4.00%
ND	.	0.5	0.7	0.20%	0.10%
OH	10/1/2019	93.4	93.4	3.20%	0.40%
OK	.	3.3	3.3	0.90%	1.00%
OR	.	19.9	20	0.80%	0.70%
PA	7/1/2018	231.8	294.8	3.20%	3.20%
RI	1/1/2019	0	0	5.40%	5.30%
SC	.	52.3	60.9	8.50%	8.80%
SD	.	0.8	0.8	0.20%	0.20%
TN	.	0	0	0.90%	0.30%
TX	.	303.5	292.5	6.70%	5.00%
UT	1/1/2019	0.9	0	1.20%	1.00%
VT	1/1/1996	0	0	2.30%	1.70%
VA	.	11.6	7.3	0.30%	2.20%
WA	7/17/2018	132.2	137.2	3.50%	2.80%
WV	10/31/2018	18.9	18.9	2.00%	1.90%
WI	1/1/2018	0	0	0.40%	0.80%
WY	.	0	0	0.10%	0.10%
Total	.	***2919.1***	***2977.3***	3.50%	2.80%

[a] California made small DSH payments to IMDs in FY2014. Specifically, California had DSH payments to IMDs in the amount of $26,766 in FY 2015.
[b] Massachusetts does not have DSH expenditures because their Section 1115 waivers allow each state to use its DSH allotment to funds its uncompensated care pools.
[c] California had small negative DSH payments to IMDs. Specifically, California had DSH expenditures to IMDs equal in the amount of -$1,237 in FY2018. States may have negative expenditures due to prior period adjustments.
Sources: Congressional Research Services, Medicaid Disproportionate Share Hospital Payments (2016). Congressional Research Services, Medicaid Disproportionate Share Hospital Payments (2020)

services by New York. Variations in DSH funds for IMD services showed no consistent pattern for IMD services among states with a Section 1115 Demonstration Waiver that contained the IMD payment exemption approved before December 31, 2018.

Conclusions

As the dominant payer for BH services, the Medicaid program plays a crucial role in the lives and health of Medicaid beneficiaries. As state budgets decrease and unmet need for BH services increases, state Medicaid programs attempt to optimize legal and regulatory authorities that provide federal matching Medicaid funding for initiatives that further program goals.

The study identified 30 currently approved Section 1115 waivers that explicitly address BH through support for integration of BH services, expansion of benefits, and expansion of eligibility. Waivers for BH integration permit federal matching funds for experimental, innovative, or pilot programs for novel service delivery models and payment reforms. Section 1115 demonstration waivers allow states to expand BH benefits for services and receive reimbursement using federal matching funds for certain inpatient and residential services for mental disorders and SUD. The Section 1115 IMD-Mental Health and IMD-SUD waivers authorize the states to use federal funds for Medicaid beneficiaries in IMDs for services delivered inside and, in some cases, outside the IMD. These provisions in these waivers modify or waive the long-standing IMD exclusion. More IMD-SUD waivers have been filed/approved than the IMD-Mental Health waivers to date.

Section 1115 demonstration waivers also expand BH eligibility for certain populations otherwise ineligible for the Medicaid program. States prioritize the conditions for which eligibility is extended, consistent with the state plan.

States are required to allocate Medicaid DSH funds to selected hospitals that serve Medicaid beneficiaries, uninsured, and vulnerable populations, although states have discretion in the choice of hospitals. The proportion of those funds that can be allocated to IMDs is fixed by formula, but states also have discretion in which IMDs receive the DSH funding. As the study shows, a portion of states use this mechanism to fund IMDs but only 3 states provide all DSH Medicaid funding to IMDs, rather than to hospitals.

Of the 4 avenues available to states to receive federal Medicaid funds for IMD services, the Section 1115 waiver program dominates. The Section 1115 Demonstration Waiver program offers innovation and flexibility to states seeking federal financial participation in Medicaid BH expenditures in IMDs for specific populations, facilities, and services.

As states address growing unmet need for BH services among adults currently eligible for or receiving Medicaid benefits and services, the authorities and flexibilities offered under the waiver program and spending authorizations provide crucial resources for these vulnerable populations.

Policy and Research Considerations

Medicaid helps assure access to health and medical services for adult and child beneficiaries. It is the primary source of coverage for BH services for these beneficiaries. Research shows that the needs are substantial and demand is often constrained by supply of providers, appropriate facilities, innovative programs, and community involvement.

Programmatic and funding authorities and flexibilities available to Medicaid beneficiaries can address these supply and demand limitations through greater coordination and integration of BH and other services, increased available financing, implementation of innovative payment methods, and eligibility and benefit expansion beyond state and federal, condition-specific programs otherwise ineligible for federal

financial participation.

Growing numbers of laws, regulations, administrative guidances, and administrative letters dictate criteria and performance related to all aspects of Medicaid programs, including eligibility, access to providers, the types and duration of stays in specific types of facilities, eligible medical conditions, income, and age of beneficiaries. Federal financial participation through matching funds, the Federal Medical Assistance Percentage, is necessary to mount and sustain programs.

State Medicaid administrators are charged with understanding and implementing policies that meet guidelines and adhere to statute while increasing access and improving outcomes. Real-time data systems on funding mechanisms, legislative changes, and mechanisms for financing, as well as program performance and beneficiary outcomes, could help streamline decision processes and support evidence-based processes and improve outcomes.

Partnerships among federal agencies, state officials, and organizations could address the regulatory and financing complexity within the Medicaid program. For example, state Medicaid authorities would benefit from a compilation and easy access to available flexibilities and authorities that facilitate federal Medicaid financial participation. State Medicaid agencies might partner with agencies, universities, and other organizations to create dashboards of the available financing mechanisms to support BH services, including waiver authorities, DSH funding to IMDs, and managed care contracts that use “in lieu of” clauses or state plan options to remove the IMD exclusion.

Future research can also provide insight into the interactions between financing mechanisms by systematically comparing how states use the variety of authorities available to enhance access to BH care. For instance, this review revealed no study that directly compared how state agencies make decisions about which financing mechanism to pursue to fund BH services delivered in IMDs for nonelderly adults through Medicaid. Do states use multiple financing mechanisms, or do they prefer a specific financing approach over others? Does the interaction between financing mechanism vary by demand for BH services or other aspects of the Medicaid program? Answers to these questions will help federal policymakers design and implement policies that align with state agency preferences and priorities, while also providing state officials with useful guidance on available financing approaches and how they relate to one another.

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Appendix: Section 1115 Waiver Summaries

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Search Strategy

Search Strategy 1

- Go to the Preface Section
- Under Preface Section find the Special Terms and Conditions (STCs) arrangement order
- Identify the Continuing Operation of Demonstration Programs and Additional Demonstration Programs
    - ◊ Note: There may additional relevant sections depending on state (e.g., California Drug Medi-Cal Organized Delivery System
- Note all relevant sections
- Search each major program component for their behavioral health relevance

Search Strategy 2

- Use control F to find all references of “substance” and “behavioral”
- Summarize the behavioral health components identified through the keyword search

Alaska Medicaid Section 1115 Behavioral Health Demonstration

- **Integrated Behavioral Health System (see demonstration programs and benefits pg. 14):** Program to create an integrated behavioral health system of care for individuals enrolled in Medicaid or CHIP with SMI, severe emotional disturbance, mental health disorders, and/or substance use disorders. The state will achieve this in two ways:
    1. **Behavioral Health Benefits:** More robust continuum of behavioral health care services that target three specific groups
        - ◊ Group 1: Children, Adolescents, and their Parents or Caretakers with or at risk of mental health and substance use disorders
        - ◊ Group 2: Transition age youth and adults with acute mental health needs
        - ◊ Group 3: Shared behavioral health program benefit (shared group 1 and group 2)
    2. **Substance Use Disorder/Opioid Use Disorder Program:** Demonstration benefit package for state's Medicaid recipients must include SUD/OUD treatment services, including services provided in residential and inpatient treatment settings that qualify as IMD

Arizona Health Care Cost Containment System (see page 22 for demonstration programs)

- **Arizona Acute Care Program (AACP):** AACP members determined to have a SMI receive integrated physical and behavioral health services through a geographically designated Regional Behavioral Health Authority (RBHA) (same as individuals with SMI).
- **AHCCS Care Program:** Medicaid program for expansion adults. Persons with serious mental illness, among others, are exempt from enrollment.
- **Children in Foster Care:** Creates a program for children in foster care who receive acute care services.
- **Children Rehabilitative Services:** Children enrolled in specific programs who also have a CRS condition receive care for their CRS condition and behavioral health condition through a different mechanism than other children.
- **Individuals with Serious Mental Illness:** AACP members determined to have a SMI receive integrated physical and behavioral health services through a geographically designated Regional Behavioral Health Authority (RBHA) (same as AACP but this section provides more detail).
- **Arizona Long Term Care System:** Program for individuals 65 and over, blind, disabled or who need ongoing services at a nursing facility of ICF/IDD level of care.
- **Medicare Part B Premiums:** State of Arizona pays the Medicare Part B premium on behalf of individuals enrolled in ALTCS with income up to 300 percent of FBR who are eligible for Medicare, but do not qualify for other programs.

California Medi-Cal 2020

- **Community Based Adult Services (CBAS)** (Continuing Operation of Demonstration Program)
    - ◊ Description: Outpatient, facility-based program that delivers skilled nursing care, social services,

therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.

- ◊ BH Component: Additional services required include behavioral health services for treatment or stabilization of a diagnosed mental disorder (pg. 34) .

- **California Children Services** (Continuing Operation of Demonstration Program) – no relevant BH component
- **Managed Care Delivery Systems for Coordinated Care Initiative** (Continuing Operation of Demonstration Program)
  - ◊ Description: Cal MediConnect program is a program for dual eligible. Care coordination is a central element of the program, in which managed care plans must provide the capacity to address the needs of the CCI population by providing linkages to services not available within the benefit package, including (behavioral health services) (pg. 46).
  - ◊ BH Component: Care coordination
- **Access Assessment** (Additional Demonstration Program) – no relevant BH component
- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME)** (Additional Demonstration Program)
  - ◊ Description: PRIME encourages state's effort to adopt alternative payment models and to provide direct incentives to participating PRIME entities to support behavioral and physical health integration in inpatient and outpatient settings (pg. 56). DPH systems and DMPHs will receive payments for receiving certain outcomes.
  - ◊ BH Component: Payment reform to incentivize integrated care.
    - ♦ Domain 1 allow PRIME funds to provide incentive payments to participating PRIME entities that ensure that patients experience timely access to high-quality, efficient, and patient-centered care. One project in this domain is "Integration of Physical and Behavioral Health," which is required for DPH systems. Domain 2 also includes projects related to "Integrated Health Home for Foster Children" and "Transition to Integrated Care: Post Incarceration" (pg. 58).
- **Dental Transformation Initiative** (Additional Demonstration Program) – no relevant BH component
- **Whole Person Care Pilot** (Additional Demonstration Program)
  - ◊ Description: Identify high-risk, high-utilizing Medi-Cal beneficiaries in geographic areas that they serve and assess their unmet need. WPC Pilots must provide integrated services to high users of multiple systems, including the integration of health, behavioral health, and social services (pg. 92).
  - ◊ BH Component: Care and service coordination for vulnerable populations
- **Drug Medi-Cal Organized Delivery System** (Other)
  - ◊ Description: Pilot program for the organized delivery of health care services for Medicaid eligible individuals with a substance use disorder (pg. 101). It is a Medi-Cal benefit available in counties that choose to opt into and implement the Pilot program. The program provides additional benefits beyond those available in the state plan to program beneficiaries (pg. 103). Counties participating in the program must describe their care coordination plan (pg. 125).

◊ BH Component: Expands SUD services for enrolled beneficiaries. Includes IMD.

Delaware Diamond State Health Plan

- **DSHP Benefits (pg. 23):** Medicaid state plan benefits provided through managed care organizations or managed care delivery stems. Some benefits still provided via FFS.
- **DSHP Plan Benefits:** Provides HCBS LTSS to eligible individuals.
- **Substance Use Disorder Program:** Benefit package for Delaware Medicaid recipients will include SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as IMD.
- **PROMISE Benefits:** Individuals will receive all of their DSHP and DSHP Plus state plan benefits through the MCOs, just as they would have before enrollment in PROMISE. However, PROMISE enrollees will have a Department of Substance Abuse and Mental Health counselor as their primary case manager. PROMISE beneficiaries receive additional non-state plan benefits.
  - ◊ PROMISE enrollees are individuals with a severe and persistent mental illness and/or a substance use disorder and require HCBS to live and work in integrated setting.

Florida Managed Medical Assistance

- **Behavioral Health and Supportive Housing Assistance Pilot (pg. 32):** Voluntary pilot program to provide Medicaid beneficiaries with SMI, SUD, or SMI with co-occurring SUD and are homeless or at risk of homelessness due to a disability with additional behavioral health services and supportive housing assistance services. Services provided include transitional housing services, tenancy sustaining services, mobile crisis management, and self-help/peer support.
- **Low Income Pool (pg. 39):** LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Community Behavioral Health Providers is one of the groups that meet the participation requirements for receiving LIP funds.

Hawaii QUEST Integration

- **Quest plans (pg. 18):** State MCO plans must provide a full array of standard behavioral health benefits (including substance abuse treatment).
- **Community Integration Services (pg. 20):** State requires all MCOs to determine an enrollee's eligibility for CIS programs. CIS benefits include pre-tenancy supports and tenancy sustaining services (pg. 21-22). Eligible individuals must meet health needs criteria and risk criteria:
  - ◊ Health needs: Behavioral health need defined as mental health or substance use need, or individual assess to have a complex physical health need.
  - ◊ Risk need: Homelessness or at risk of homelessness.

Illinois Behavioral Health Transformation

- **Opioid Use Disorder Substance Use Disorder Program (pg. 8):** OUD/SUD treatment services including those provided in residential and inpatient treatment settings that qualify as an IMD.
- **Clinically managed residential withdrawal management pilot (pg. 15):** State will cover clinically managed withdrawal management services under expenditure authority because the state

may implement this pilot less than statewide and may institute annual enrollment limits.

- **Peer recovery support services pilot (pg. 18):** State will cover peer recovery support services under expenditure authority because the state may implement this pilot less than statewide and may institute annual enrolment limits.
- **Evidence-based home visiting services pilot (pg. 20):** State will cover evidence-based home visiting services under expenditure authority because the state may implement this pilot less than statewide and may institute annual enrolment limits.
- **Supported employment services pilot (pg. 25):** State will cover a set of employment services. Beneficiaries qualify if they meet one or both of the following criteria: (1) serious and persistent mental health needs or (2) substance use needs. They must also meet one of the following risk factors: unable to be gainfully employed for at least 90 days, more than one instance of inpatient substance use treatment, or at risk of deterioration from mental health or SUD.
- **Intensive In-Home Services Pilot (pg. 30):** State will cover intensive in home services for beneficiaries who have (1) high physical and behavioral health need or (2) high behavioral low physical health need.
- **Respite Services Pilot (pg. 32):** Respite services provide safe and supportive environments on a short-term basis to Medicaid clients age 3 up to age 21 with a behavioral health condition. Eligible beneficiaries include those who have (1) high physical and behavioral health need or (2) high behavioral low physical health need.

Healthy Indiana Plan (HIP) 2.0

- **Residential Treatment Services (pg. 30):** Coverage of services delivered in an IMD for Medicaid recipients with a SUD diagnosis.
- **SMI (pg. 38):** Coverage of services delivered in an IMD for Medicaid recipients with an SMI/SED diagnosis.

KanCare

- **Expenditures for Additional Services for Individuals with Behavioral Health or Substance Use Disorder Needs (pg. 18-19):** KanCare MCOs will also provide physician consultation, personal care services for beneficiaries with severe and persistent mental illness or a serious emotional disturbance, and rehabilitation services (e.g., intensive services for individuals with a substance use disorder in their community).
- **Opioid Use Disorder/Substance Use Disorder Program (pg. 19):** Residential Treatment for Individuals with SUD including services delivered in an IMD.
- **Disability and Behavioral Health Employment Support Pilot Program (25):** Voluntary pilot program to help certain KanCare members maintain employment by providing s supportive services. To be eligible, a beneficiary must have a primary behavioral health diagnosis. Benefits are delivered through an MCO and cover pre-vocational services, supported employment, personal assistant services, independent living skill straining, assistive technology, and transportation.

Kentucky Health

- **Substance Use Expenditures (pg. 54) & Opioid Use Disorder/Substance Use Disorder (pg. 60):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.

Healthy Louisiana Substance Use Disorder

- **Opioid Use Disorder/Substance Use Disorder Program (pg. 8):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.

Maryland Health Choice

- **Residential Treatment for Individuals with SUD program (pg. 18):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.

Massachusetts MassHealth

- **CommonHealth Adults** (Demonstration Population Expenditures) – no BH component
- **CommonHealth Children** (Demonstration Population Expenditures) – no BH component
- **Family Assistance** (Demonstration Population Expenditures) – no BH component
- **Breast and Cervical Cancer Demonstration Program** (Demonstration Population Expenditures) – no BH component
- **MassHealth Small Business Employee Premium Assistance** (Demonstration Population Expenditures) – no BH component
- **TANF and EAEDC Recipients** (Demonstration Population Expenditures) – no BH component
- **End of Month Coverage** (Demonstration Population Expenditures) – no BH component
- **Provisional Coverage Beneficiaries** (Demonstration Population Expenditures) – no BH component
- **Presumptively Eligible Beneficiaries** (Demonstration Population Expenditures) – no BH component
- **Out-of-state Former Foster Care Youth** (Demonstration Population Expenditures) – no BH component
- **Recipients of State Veteran Annuities** (Demonstration Population Expenditures) – no BH component
- **Premium Assistance** (Service Related Expenditures) – no BH component
- **Pediatric Asthma Pilot Program** (Service Related Expenditures) – no BH component
- **Diversionary Behavioral Health Services**
  - ◊ Description: Home and community-based mental health and substance use disorder services that are clinically appropriate alternatives to inpatient mental health and substance use disorder care. They also support the care transition from 24-hour inpatient care to inpatient. There are two categories of diversionary services: (1) those provided in a 24-hour facility (e.g., IMD for SUD, but not MD); (2) those provided on an outpatient basis in non-24 hour facility (pg. 24). Any managed care beneficiary is eligible for receiving service.
  - ◊ BH Component: Diversionary BH care

- **Expanded Substance Use Treatment Services**
    - ◊ Description: Additional services for SUD treatment (pg. 43-44)
    - ◊ BH Component: IMD authorization for SUD
- **Full Medicaid Benefits for Presumptively Eligible Pregnant Women** (Service Related Expenditures) – no BH component
- **Medicare Cost Sharing Assistance** (Service Related Expenditures) – no BH component
- **Continuous Eligibility Period for Individuals enrolled in Student Health Insurance Plans** (Service Related Expenditures) – no BH component
- **PCCM Entities and Pilot ACOS (Delivery System-Related Expenditures)**
    - ◊ Description: MassHealth benefits are delivered through four mechanisms: (1) FFS; (2) a behavioral health contractor (PIHP); two primary care case management systems – PCCM - PPC Plan and the Primary Care ACOs; and two MCO-based delivery systems – the MassHealth MCO and Accountable Care Partnership Plans (pg. 46).
        - ♦ Members in the PCCM system receive their behavioral health through a single behavioral health program contractor, which is a Prepaid Inpatient Health Plan (PIHP).
        - ♦ MCO provide comprehensive services, including behavioral health.
    - ◊ BH Component: Two mechanisms by which BH care is reimbursed.
- **Incentive-Based Pools** (Delivery System-Related Expenditures)
    - ◊ Cambridge Health Alliance Public Hospital Transformation and Incentive Initiatives (PHTII): Program that emphasizes integration of behavioral health services. Changes funding structure so an increasing proportion of PHTII funding will be at risk based on ACO performance (pg. 66).
    - ◊ Delivery System Reform Incentive Program: Payments to ACOs and community providers to help further, among other goals, integration of PH, BH, long-term services, and supports, and health-related social services (pg. 68, 72).
- **Disproportionate Share Hospital-like (DSH-like) Pool** (Delivery System-Related Expenditures)– no BH component
- **Uncompensated Care Pool** (Delivery System-Related Expenditures) – no BH component
- **Designated State Health Program (DSHP)** (Delivery System-Related Expenditures) – no BH component

Michigan Pathway to Integration

- **Opioid Use Disorder/Substance Use Disorder Program (pg. 9):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis

Minnesota Substance Use Disorder System Reform

- (under Program Description and Objectives pg. 5)
- **Opioid Use Disorder/Substance Use Disorder Program:** Extends coverage to services for all Medicaid recipients to include residential services provided in settings that qualify as IMD (pg. 11-

12). State must also submit a plan detailing the necessary health IT capabilities to support SUD goals of demonstration.

- **Certified Community Behavioral Health Clinics (CCBHCs):** Authorized states to continue providing an enhanced set of behavioral and mental health services using innovative payment models through CCBHCs. The state received a grant from SAMHSA that allowed them to establish a prospective payment system rate through its fee for system and a directed PrePrint payment for payments made to CCBHCS from managed care organizations. The goals of the grant were to (1) improve availability, quality, and outcomes of ambulatory services and (2) to provide coordinated care that addresses both behavioral and physical health conditions. Within a year, the state must submit materials to include CCBHC services in the Medicaid state plan (pg. 16-17).

Montana Additional Services and Populations

- (Pg. 6): Coverage of health care services for no more than 3,000 individuals age 18 or older, not otherwise eligible for Medicaid who have been diagnosed with a SDMI of schizophrenia, bipolar disorder, major depression, or another SDMI, and at the time of their initial enrolment were receiving (or meet the qualifications to receive) a limited mental health services benefit package through enrolment in the state-financed MHSPP and either: (1) have income above 133 up to and including 150 percent of the FPL, or (2) are eligible for or enrolled in Medicare and have income at or below 133 percent of the FPL. The demonstration offers a benefit package that aligns with the Medicaid state plan. Prioritization of the eligibility expansion based upon a current diagnosis of schizophrenia, then bipolar disorder, and remaining slots to individuals with major depressive disorder.

Nebraska Substance Use Disorder Demonstration Program

- **Opioid Use Disorder/Substance Use Disorder Program (pg. 8):** Extends coverage to services for all Medicaid recipients to include residential services provided in settings that qualify as IMD (pg. 11-12).

New Hampshire SUD Treatment and Recovery Access

- (under Demonstration Programs and Benefits pg. 9)
- **Opioid Use Disorder/Substance Use Disorder Program:** Extends coverage to services for all Medicaid recipients to include residential services provided in settings that qualify as IMD (pg. 9). State must also submit a plan detailing the necessary health IT capabilities to support SUD goals of demonstration (13).

New Hampshire Building Capacity for Transformation

- (under Delivery System Reform Program pg. 9)
- **Integrated Delivery Network (IDN):** Provider networks that are funded to participate in projects. Participating providers must form regional coalitions that apply collectively for pool funds as a single IDN. IDNs must complete project milestones and measures as specified in the planning protocol and are the only entities that are eligible to receive IDN incentive payments. Projects must further each of the following four objective areas:
  - ◊ Creating appropriate behavioral health capacity in order to expand effective community based-treatment models; reduce unnecessary use of emergency rooms and hospitals as the site of care for individuals with behavioral health issues; and support prevention through screening, early intervention, and population health management initiatives. Projects will bolster behavioral

health capacity by supporting workforce development programs; medication adherence trainings; cross training of mental health, physical health and substance use providers; development of new treatment and intervention capacity (e.g., behavioral health community crisis stabilization and ambulatory detoxification initiatives); and expansion of community-based health navigation services with community based social service agencies.

  - ◊ Promoting integration of physical and behavioral health providers through physical or virtual integration. Projects may include: co-location of behavioral health providers with primary care providers as a first step at sites that currently have little to no integration, but, more often will be used to foster fuller integration thorough bi-directional embedding of providers; adoption of evidence-base standards of integrated care including medication management for individuals with serious mental illness, medication-assisted treatment for individuals with substance use disorders; and use of team-based approaches to care delivery that address physical, behavioral and social barriers to improved outcomes. Along with directly promoting integration, the projects will promote ancillary changes by supporting the IT capacity and protocols needed for integration, offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models.
  - ◊ Promoting smooth transitions across the continuum of care for beneficiaries and incentivizing coordination of providers. Projects will be used to promote evidence-based practices such as behavioral health specific discharge and care coordination plans, coordinated referrals to socials service agencies, medication adherence and management plans, medication assisted treatment and continuity of care for individuals transitioning between the community and institutions, including hospitals, prisons, and jails.
  - ◊ Ensuring IDNs participate in Alternative Payment Models that are adopted by the State with Medicaid Service delivery and Medicaid managed care plans.
- Series of milestones, performance indicators, and outcome measures that IDNs must have to meet.

New Jersey Comprehensive Waiver

- **Children's Support Services Program (pg. 30, attachment C pg. 17):** Provides behavioral health and home and community based services and supports to individuals under age 21 that have a serious emotional disturbance (SED).
- **Intensive In Community/Intensive In Home Behavioral Services (attachment C pg. 19):** Services provided to developmentally disabled youth in the home and in the community.
- **Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program (pg. 41):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.
- **Behavioral Health Organization (pg. 59):** Coverage of behavioral health services for demonstration beneficiaries will be excluded from the coverage furnished through the primary manage care organization and instead will be covered through a behavioral health organization.
- **Delivery System Reform Incentive Payment Program (pg. 60):** Provides payment incentives to hospitals in a variety of areas including, chemical addiction/ substance abuse.

New Mexico Centennial Care 2.0

- **Program description and objectives (pg. 2):** Centennial Care 2.0 is New Mexico's Medicaid managed care program in which a member's MCO must provide physical health, behavioral health, home and community based, and long-term care needs.

- **Opioid Use Disorder (OUD)/ Substance Use Disorder (SUD) Program) (pg. 33):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.

New York Medicaid Redesign Team (update)

- **Health and Recovery Plans (HARP) (pg. 24):** This component provides integrated Medicaid covered services and services specifically to address the needs of individuals with a serious mental illness (SMI) and substance use disorder (SUD) conditions under the demonstration. Individuals eligible for HARP include Medicaid adult beneficiaries age 21 or over eligible for Medicaid furnished in MMMC under the demonstration with a specified SMI and/or serious SUD diagnosis and who meet categorical criteria or risk factors specified by New York's Office of Mental Health (OMH) or New York's Office of Alcoholism and Substance Abuse Services (OASAS).

North Carolina's Medicaid Reform Demonstration

- **Opioid Use Disorder (OUD)/ Substance Use Disorder (SUD) Program) (pg. 10):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.
- **Managed Care Organizations (pg. 17):** All Medicaid populations are mandatorily enrolled in an MCO called a Prepaid Health Plan (PHP), except for certain populations excluded (see Table 3 pg. 18). Some individuals are enrolled in BH I/DD Tailored Plans, which provided integrated physical health, behavioral health, I/DD, TBI, and pharmacy services to enrollees. Enrollees eligible for these plans include those with the following diagnosis categories: serious mental illness, serious emotional disturbance, severe substance use disorder, and I/DD and/or TBI.

Ohio Substance Use Disorder Demonstration

- **Opioid Use Disorder (OUD)/ Substance Use Disorder (SUD) Program) (pg. 8):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.

Pennsylvania Medicaid Coverage for Former Foster Care Youth from a Different State and Substance Use Disorder Demonstration

- **Opioid Use Disorder (OUD)/ Substance Use Disorder (SUD) Program) (pg. 8):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.

Rhode Island Comprehensive Demonstration

Several provisions related to expanding Medicaid eligibility:

- **Budget Population 8 [Substitute Care]:** Expenditures for parents pursuing behavioral health treatment with children temporarily in state custody with income up to 200 percent of the FPL.
- **Budget Population 16 [Uninsured adults with mental illness]:** E Expenditures for a limited benefit package of supplemental services for uninsured adults with mental illness and/or substance abuse problems with incomes above 133 and below 200 percent of the FPL not eligible for Medicaid. The benefits do not meet Minimum Essential Coverage (MEC) requirements.
- **Budget Population 17 [Youth at risk for Medicaid]:** Expenditures for coverage of detection and intervention services for at-risk young children not eligible for Medicaid who have incomes up to 300 percent of SSI, including those with special health care needs, such as Seriously Emotional Disturbance (SED), behavioral challenges and/or medically dependent conditions, who may be safely maintained at home with appropriate levels of care, including specialized respite services.

- **Budget Population 21 [Beckett aged out]:** Expenditure authority for young adults aged 19-21 aging out of the Katie Beckett eligibility group with incomes below 250 percent of the FPL, who are otherwise ineligible for Medicaid, are in need of services and/or treatment for behavioral health, medical or developmental diagnoses.
- **Demonstration Benefits:** Expenditures for core and preventive services and home and community- based therapeutic services as identified in Attachment B for Medicaid eligible youth who are at risk youth for out-of-home care or hospitalization and adults with a behavioral health diagnosis and/or developmental disability (Budget Services 4).
  - ◊ Home Stabilization Services will be available to individuals who meet at least one of the following health needs-based criteria and is expected to benefit from the provision of Home Stabilization Services (pg. 29):
    - ♦ ii. The individual is assessed to have a mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or
    - ♦ vii. Past or present substance use that interfered with ability to pay rent, maintain apartment according to lease, or created interpersonal issues that jeopardized housing.
- **Expenditures for Recovery Navigation Program (Budget Services 5):** Expenditures to deliver a recovery-oriented environment and care plan dedicated to connecting individuals with a substance use disorder eligible for RNP services as specified in STC 90, with the necessary level of detox, treatment, and recovery services within a less-intensive and less-costly level of care than is furnished in an inpatient hospital setting.
- **Expenditures for Peer Recovery and Family/Youth Support Specialist Program (Budget Services 6):** Expenditures to deliver services using a Peer Recovery or Family/Youth Support Specialist who provides an array of interventions that promote socialization, long- term recovery, wellness, self-advocacy, and connections to the community, as well as offer services, as outlined in STC 99, that will focus on the treatment of mental health and/or substance use disorders for those individuals who have trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community.
- **Expenditures for Behavioral LINK Program (Budget Services 9):** Expenditures to deliver the services within one Behavioral Health Link (BH Link) triage center, to support crisis stabilization and short-term treatment for individuals experiencing a behavioral health (mental health or substance use disorder) crisis, as outlined in STC 104.
- **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (Budget Services 11):** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institute for mental diseases (IMD).
- **Expenditures for Telephonic Psychiatric Consultation Services (Budget Services 13):** Expenditures for telephonic psychiatric consultation services as described in STC 109.

Utah Primary Care Network

- **Opioid Use Disorder (OUD)/ Substance Use Disorder (SUD) Program) (pg. 47):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.

- **Targeted Adults**
    - ◊ Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs, who are not otherwise eligible for Medicaid. Expenditures to provide dental benefits for individuals in this expenditure population who are receiving substance use disorder (SUD) treatment.
    - ◊ Involved in the criminal justice system and in need of substance use or mental health treatment (pg. 16).
- **Clinically Managed Residential Withdrawal Pilot:** Expenditures to provide clinically managed residential withdrawal services to adult Medicaid beneficiaries, age 18 and older, who reside in Salt Lake County, have a Physician or Licensed Practitioner of the Healing Arts determine the beneficiary demonstrates moderate withdrawal signs and symptoms, have a primary diagnosis of opioid use disorder (OUD) or another SUD, and require round-the- clock structure and support to complete withdrawal and increase the likelihood of continuing treatment and recovery (pg. 13).
- **Intensive Stabilization Services Program:** Expenditures to provide an assessment and service package including state plan behavioral services and home and community based respite and non-medical transportation services reimbursed using a daily bundled rate during the first eight weeks of the 16-week intensive stabilization program for Medicaid eligible children/youth in state custody or at risk of being placed in state custody experiencing significant emotional and/or behavioral challenges.
    - ◊ Eligible children must meet one of the following criteria, including: the child has a mental health condition or substance abuse history.

Vermont Global Commitment to Health

- **Expenditures for Mental Health Community Rehabilitation and Treatment (CRT) Services:** Expenditures for mental health community rehabilitation and treatment (CRT) services, as defined by Vermont rule and policy, provided through a state-funded program to individuals with severe and persistent mental illness who have incomes above 133 percent of the FPL and up to and including 185 percent of FPL who are not otherwise Medicaid enrolled (pg. 32).
- **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD):** Effective July 1, 2018, expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
- **Residential and Inpatient Treatment for Individuals with Serious Mental Illness:** Expenditures for Medicaid state plan services—furnished to eligible individuals who are primarily receiving short-term treatment for a serious mental illness (SMI) in facilities that meet the definition of an IMD.

Washington Medicaid Transformation Project

- Accountable Communities for Health:
    - ◊ This demonstration authorizes Accountable Communities of Health (ACHs) to coordinate and oversee regional projects aimed at improving care for Medicaid beneficiaries with a focus on building health systems capacity, care delivery redesign, prevention, and health promotion, and preparing for value-based payments.

- ◊ ACHs are self-governing organizations with multiple community representatives defined in STC 20, that address care in regions with non-overlapping boundaries that also align with Washington's regional service areas for Medicaid purchasing. ACHs, through their governing bodies, are responsible for managing and coordinating the partnering providers.
- ◊ Incentive payments for partnering providers and the ACHs will transition from pay-for- reporting to outcome-based over the course of the demonstration.
- ◊ ACHs will design and integrate projects that further the objectives of the program, including: comprehensive integration of physical and behavioral health services through new care models (pg. 18).

- **Opioid Use Disorder (OUD)/ Substance Use Disorder (SUD) Program) (pg. 41):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.

West Virginia Creating a Continuum of Care for Medicaid Enrollees with a Substance Use Disorder

- **Opioid Use Disorder (OUD)/ Substance Use Disorder (SUD) Program) (pg. 8):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.
- **Methadone Treatment:** Expenditures for services that could be covered under the Medicaid state plan; however, the state has elected to cover the services through expenditure authority instead.
- **Peer Recovery Support Services:** Expenditures for services that could be covered under the Medicaid state plan; however, the state has elected to cover the services through expenditure authority instead.

Wisconsin Badger Care Reform

- **Opioid Use Disorder (OUD)/ Substance Use Disorder (SUD) Program) (pg. 15):** Coverage of services delivered in an IMD for Medicaid recipients with SUD diagnosis.