

## BRIEF

NOVEMBER 2016

# Coverage of Behavioral Health Services for Youth with Substance Use Disorders

Substance use disorders affect millions of adolescents each year. The National Survey on Drug Use and Health (NSDUH) found that 8.8% of adolescents aged 12-17 used illicit drugs, with marijuana the most commonly used illicit drug followed by “nonmedical users of pain relievers.”<sup>1</sup>

In January 2015, the Center for Medicaid and CHIP Services (CMCS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a [joint informational bulletin](#) providing guidance to states on designing a benefit “that will meet the needs of youth with substance use disorders (SUD) and their families and help states comply with their obligations under Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements.”<sup>2</sup> The recommendations were developed by a panel of nationally-recognized researchers.

This TA Network brief is intended for use by multiple stakeholders engaged in the design, implementation and/or expansion of Medicaid-covered SUD services, including state and local family- and youth-run organizations, state Medicaid and other public child-serving agencies, Medicaid managed care organizations, providers and other stakeholders. In addition to highlighting the January 2015 CMCS and SAMHSA informational bulletin, this resource provides examples of how SUD services are operationalized in states within Medicaid, to help guide planning, design and implementation efforts in other states and jurisdictions across the country.

## Screening and Assessment

The joint informational bulletin recommends that every youth be screened for substance use and mental health disorders. Youth who screen positive “must be assessed with an evidence-based, comprehensive psychosocial assessment instrument that assists in identifying the level of severity of substance use disorder and/or substance use and mental health disorder and suggests the appropriate level of care.”

Numerous validated screens are available, and the expert panel that informed the bulletin refrained from recommending a particular tool. Recommended screening tools for adolescents and young adults can be found in [Appendix B of the SAMHSA’s Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations](#).<sup>3</sup>

## Screening, Brief Intervention, and Referral to Treatment (SBIRT)

One of the recommended approaches referenced in the bulletin is SBIRT, which is an evidence-based practice used to identify and intervene with youth whose patterns of substance use put them at risk for, or who already have, substance-related health problems. The **screening** component of SBIRT quickly assesses severity (i.e., no or low risk, risky use, or SUD) and identifies the needed level

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of treatment. The **brief intervention** element focuses on enhancing the youth’s motivation to change and can include offering advice and education about substance use and/or eliciting the youth’s own reason to change. Many of the tools used in brief intervention are grounded in Motivational Interviewing techniques and concepts.<sup>4</sup> The **referral to treatment** component provides those identified as needing more extensive intervention. The referral should include assisting the youth and family with accessing treatment services and helping them to navigate barriers to treatment, including locating a culturally and linguistically competent treatment provider and transportation.<sup>5</sup>

SBIRT can be used in many settings that serve adolescents, including physician’s offices, school-based health centers, federally qualified health centers, and community settings such as recreation centers. States may receive Medicaid reimbursement for SBIRT services delivered as part of the EPSDT annual wellness visit but can expand the availability of screening and other services by submitting a state plan amendment or waiver to the Centers for Medicare and Medicaid Services (CMS) to add commonly used codes to their respective reimbursement schedules. Key questions related to adding SBIRT and other SUD services are discussed in the Financing section of this brief, below.

### 1: Examples of SBIRT Medicaid Billing Codes

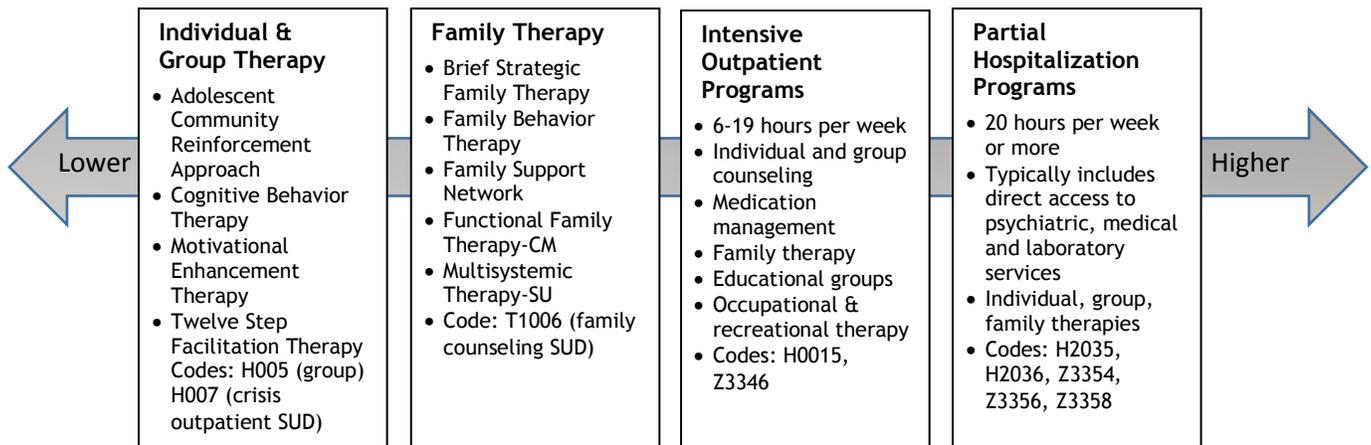
STATE	BILLING CODES
Colorado <sup>6</sup>	<ul style="list-style-type: none"> <li>■ 12 years of age and older</li> <li>■ CPT 99408 and 99409</li> <li>■ Requires providers use AUDIT, DAST, ASSIST, CRAFFT, or POSIT tool</li> <li>■ Licensed provider or unlicensed providers with 60 hours training</li> </ul>
New York <sup>7, 8</sup>	<ul style="list-style-type: none"> <li>■ 12 years of age and older</li> <li>■ HCPCS H0049 or H0050 for Medicaid fee-for-service</li> <li>■ 4283 outpatient assessment visit<sup>9</sup></li> <li>■ Requires providers to use AUDIT, ASSIST, CRAFFT, DAST-10, NIAA for Youth, S2BI, T-ACE, or TWEAK tool</li> <li>■ Licensed provider with four hours training or unlicensed provider with 12 hours training and diploma or GED</li> </ul>
Maryland <sup>10</sup>	<ul style="list-style-type: none"> <li>■ 12 years of age and older</li> <li>■ W7000, W7010, W7020, W7021, W7022</li> <li>■ Requires a SAMHSA validated tool</li> <li>■ Licensed provider</li> </ul>
Missouri <sup>11</sup>	<ul style="list-style-type: none"> <li>■ 13 years of age and older</li> <li>■ Primary Care Health Home Provider Organizations, Section 2703 Health Homes</li> <li>■ H0049, H0050 (licensed substance abuse and/or mental health professionals only), 99408, 99409</li> <li>■ Requires providers use the CRAFFT tool for adolescents</li> <li>■ Licensed provider or behavioral health consultants who has completed training<sup>12</sup></li> </ul>
Texas <sup>13, 14, 15</sup>	<ul style="list-style-type: none"> <li>■ 10 years of age and older</li> <li>■ HCPCS H0049, 99408, and H0050 only at Chemical Dependency Treatment Facilities</li> <li>■ Requires a SAMHSA validated tool</li> <li>■ Licensed provider with four hours of training</li> </ul>

### Outpatient Treatment Services

The expert panel recognized that “evidence-based psychosocial treatment for youth with SUDs is effective (e.g., reduces substance use for youth with SUDs).” The bulletin notes that treatment approaches along the continuum of care should be individualized to the youth’s developmental stage.

Services should be based on the principle that all individuals have the capacity to recover from SUD. The bulletin suggests that states should consider bolstering lower intensity services to support cost-effective early intervention and ameliorate the need for higher intensity, restrictive or residential settings. Services should be goal-oriented and person-centered to support a path to recovery for youth and their families/caregivers.

**Figure 1: Examples from a SUD Continuum of Care**



### Medication-Assisted Treatment

The expert panel agreed there is evidence that medication-assisted treatment (MAT) works if delivered in conjunction with psychosocial treatments and case management. Only a licensed physician or other professional working within their appropriate scope of practice may prescribe MAT, and only to “prevent, stabilize or ameliorate symptoms arising from a behavioral health condition or its treatment. The nature of the services provided (such as dose, level of care, and length of service or frequency of visits) is determined by the patient’s clinical needs. MAT should be considered for adolescents with SUD when clinically indicated, for example, in the situation of relapsive addictive disorders.” SAMHSA permits methadone treatment for adolescents with opioid use disorder with parental consent and in specially licensed programs. Buprenorphine treatment is FDA-approved for opioid dependent adolescents age 16 and older.

STATE	BILLING CODES
Colorado <sup>16</sup>	<ul style="list-style-type: none"> <li>H0020, MAT: administration, acquisition, and dispensing of methadone</li> <li>J0571-5, Buprenorphine/naloxone, oral</li> <li>J2315, Naltrexone, office injection</li> </ul>
New York <sup>17, 18</sup>	<ul style="list-style-type: none"> <li>1671 (clinic) and 2973 (hospital) methadone treatment program</li> <li>H0020, physician services for methadone treatment</li> <li>2531-2534, Buprenorphine treatment in a methadone program</li> </ul>
Maryland <sup>19</sup>	<ul style="list-style-type: none"> <li>H0020, methadone maintenance</li> <li>H0016, induction (Buprenorphine/naloxone)</li> <li>H0047, ongoing (Buprenorphine/naloxone)</li> </ul>
Missouri <sup>20</sup>	<ul style="list-style-type: none"> <li>H0020, opioid (methadone dosing) treatment</li> </ul>
Texas <sup>21, 22, 23</sup>	<ul style="list-style-type: none"> <li>H0020, methadone</li> <li>H2010, non-methadone (e.g., buprenorphine) administration</li> </ul>

States will need to consider the unique needs of youth in designing MAT treatment benefits for youth, including system design barriers. The American Academy of Pediatrics recommends that pediatricians facilitate MAT access at a primary care level to young adults and called for further research on “developmentally appropriate treatment of teenage substance use disorders.”<sup>24</sup>

### Case Management

The expert panel found that “low case load, higher fidelity to case management models and more time spent on key case management functions are associated with better outcomes for youth with SUDs.” Case management can take several forms but typically includes linkage or warm hand-offs to facilitate access to medical, social, clinical, therapeutic, educational and other services for the youth and their caregiver(s), including addressing access-related barriers such as transportation, language, or cost.

There is no single definition of case management; it can take many forms with varying intensity.<sup>25</sup> In all cases, for youth with SUD, “a family-centered, youth-guided, strengths-based case management approach” should be employed to promote active participation by the youth and their caregiver(s). States should consider incorporating more than one model of case management in their benefit design to support youth who are at risk of out-of-home placement or juvenile justice involvement, have co-occurring mental health disorders, are entering long term recovery, and are transitioning between levels of care, including those returning to their home community.

High Fidelity Wraparound (HFWA) is a model suited to meet the unique needs of youth with co-occurring disorders. Consistent with the expert panel’s recommendations, HFWA is a strengths-based, individualized approach to care coordination that facilitates the integrated delivery of clinical, therapeutic, and recovery services. Information on case management models is available in SAMHSA’s [Treatment Improvement Series, Comprehensive Case Management for Substance Abuse Treatment](#).<sup>26</sup>

In designing a case management benefit, states must be careful not to duplicate services provided under EPSDT or in other Medicaid programs. In addition, for states that pursue service expansion using a 1915(c) Home and Community-Based (HCBS) Waiver, 1915(i) State Plan Amendment, or through Managed Long Term Supports and Services, managed care programs must ensure that they establish conflict of interest standards, including the separation of needs assessments from service delivery.

STATE	BILLING CODES
Colorado <sup>27, 28, 29</sup>	<ul style="list-style-type: none"> <li>■ H2021 &amp; H2022, community-based wraparound (per 15 minutes and per diem, respectively)</li> <li>■ T1016, targeted case management</li> </ul>
New York	<ul style="list-style-type: none"> <li>■ Existing 1915(c) care coordination services will move to Health Home in 2017<sup>30</sup></li> <li>■ Children’s behavioral health services, including all (HCBS) waivers currently operated by the state will be included in the Medicaid Managed Care benefit package in 2017<sup>31</sup></li> </ul>
Maryland <sup>32</sup>	<ul style="list-style-type: none"> <li>■ T1017, targeted case management (children and youth)</li> </ul>
Missouri <sup>33</sup>	<ul style="list-style-type: none"> <li>■ T1017, youth targeted case management</li> </ul>
Texas <sup>34</sup>	<ul style="list-style-type: none"> <li>■ T1017, targeted case management</li> </ul>

## Recovery Supports and Services

Recovery supports and services are intended to reinforce treatment gains and improve ongoing quality of life for youth and their caregivers. The expert panel stated that “engagement in pro-social activities should be promoted as an essential component of youth treatment and recovery” from the beginning of treatment and continuing after discharge. Recovery services should be offered in various settings, including schools, colleges and universities, and youth recovery centers.

STATE	BILLING CODES
Colorado <sup>35</sup>	<ul style="list-style-type: none"> <li>■ H0038, peer support/recovery services</li> <li>■ H2015 &amp; 2016, community support services (per 15 minutes and per diem, respectively)</li> </ul>
New York <sup>36</sup>	<ul style="list-style-type: none"> <li>■ Only available to children and youth eligible for 1915(c) Children and Adolescents with Serious Emotional Disturbances waiver services <ul style="list-style-type: none"> <li>○ 4655, Family support</li> <li>○ 4374-79, Family support, group</li> </ul> </li> <li>■ Family and youth peer support services are being moved to the Medicaid state plan as part of the state’s Medicaid redesign<sup>37</sup></li> </ul>
Maryland <sup>38</sup>	<ul style="list-style-type: none"> <li>■ Only available to children and youth eligible for 1915(i) Intensive Behavioral Health Services for Children, Youth, and Families state plan amendment services <ul style="list-style-type: none"> <li>○ W5022, face-to-face caregiver peer support</li> <li>○ W5023, telephonic peer support</li> </ul> </li> </ul>
Missouri <sup>39</sup>	<ul style="list-style-type: none"> <li>■ H0038, peer support services</li> </ul>
Texas <sup>40, 41</sup>	<ul style="list-style-type: none"> <li>■ Only available to children and youth eligible for 1915(c) Youth Empowerment Services (YES) waiver services <ul style="list-style-type: none"> <li>○ H0038, family supports</li> <li>○ Children and youth receiving services via 1915(c) YES will be enrolled in STARKids managed care beginning November 2016<sup>42</sup></li> </ul> </li> </ul>

Recovery services take various forms and can include youth peer recovery coaching/support, youth group peer supports, and parent/caregiver peer support. In all cases, the service should provide a structured or semi-structured framework for the youth or parent/caregiver to interact with someone with “lived experience” with SUD.

For youth, services are focused on positive behavioral change, self-management, pro-social activities, and wellness planning. For parents/caregivers, recovery services are designed to strengthen parenting and coping skills, offer emotional support, reduce caregiver strain, and reduce out-of-home placement.

<b>Eligibility Criteria - Kentucky Peer Support Specialists</b> <a href="https://dbhdid.ky.gov/dbh/pss.aspx">https://dbhdid.ky.gov/dbh/pss.aspx</a>	
<p><b>Family Peer Support Specialists</b></p> <ul style="list-style-type: none"> <li>• Be eighteen (18) years of age or older;</li> <li>• Be a self-identified parent or other family member who has lived experience with a client who has received services related to a mental health, substance use, or co-occurring disorder from at least one child-serving agency;</li> <li>• Have a high school diploma or GED;</li> <li>• Have successfully completed a Kentucky Family Leadership Academy (KFLA) training approved by the department;</li> <li>• Successfully complete a Kentucky Family Peer Support Specialist (KFPSS) core competency training approved by the department or receive a training waiver for this; and</li> <li>• Successfully complete, maintain, and submit to the department documentation of a minimum of six hours of related training or education in each subsequent year.</li> </ul>	<p><b>Youth Peer Support Specialists</b></p> <ul style="list-style-type: none"> <li>• Be between 18 and 35 years of age;</li> <li>• Have lived experience;</li> <li>• Be receiving or have received from at least one child-serving agency a state-funded service that is related to the youth's emotional, social, behavioral, or substance abuse disability;</li> <li>• Have a high school diploma or GED;</li> <li>• Have successfully completed the KFLA training approved by the department;</li> <li>• Discuss the experience of receiving state-funded services from at least one (1) child-serving agency on the applicant's responses on the short-essay form;</li> <li>• Demonstrate experience with leadership and advocacy in the field of behavioral health; and</li> <li>• Demonstrate the applicant's own efforts at self-directed leadership development.</li> </ul>

### Residential Treatment Services

Residential treatment can be effective in “interrupting the trajectory of increasing substance use in youth” and is effective for management of withdrawal symptoms (detox). As with any inpatient service, states must pay careful attention to transition and discharge planning to ensure warm hand-offs to community outpatient providers as the youth’s need for intensive treatment lessens.

In May 2016, CMS issued a [final rule governing Medicaid managed care delivery systems](#).<sup>43</sup> States may now cover inpatient treatment services in an Institution for Mental Disease (IMD) for adult Medicaid managed care beneficiaries under certain conditions so long as the stay does not exceed 15 days in a calendar month. While states have been able to opt to cover inpatient services in an IMD for persons under 21 through EPSDT, this change allows states greater flexibility in offering effective, evidenced-based alternatives to emerging adults.

### Medicaid Authorities for SUD

States have several options to maximize federal Medicaid funding to expand SUD services. California used an 1115 Demonstration Waiver to expand access to SUD services<sup>44</sup>; several other states are pursuing delivery system changes under an 1115, including Maryland and Virginia. States could explore using a 1915(i) HCBS State Plan Amendment to include SUD services. Unlike 1915(c) waivers, there is no cost-neutrality requirement nor do individuals have to meet institutional level of care criteria to receive services. However, 1915(i) has more proscriptive financial eligibility limits: under Section 1915(i), states can cover people up to 150% of the federal poverty line with no asset limit and/or people with incomes up to 300% of Social Security Income (SSI) who would be eligible for Medicaid under an existing HCBS waiver. In other words, states must have an existing HCBS waiver to cover persons up to 300% SSI.

Coverage for SUD services is available under EPSDT regardless of whether services are provided under the Medicaid state plan and regardless of any restrictions states may impose on coverage for adult services, as long as those services could be covered under the Medicaid state plan. States have a responsibility to ensure that all eligible children and their caregivers are informed of EPSDT screening

services. Services need not cure a condition in order to be covered under EPSDT. Services that maintain or improve a child or youth's health status may be covered because they "ameliorate" conditions.<sup>45</sup>

1915(b) waivers are one of several options available to states that allow the use of managed care in the Medicaid Program. Utah has used the 1915(b) authority to use selected managed care providers for services for youth with SUDs or co-occurring substance use and mental health disorders. North Carolina uses combined 1915 (b) and (c) waivers for youth with SUD or co-occurring substance use and mental health disorders. Some of these services include respite and supported employment for older adolescents and young adults.

States may include SUD services in a [Section 2703 Health Home](#).<sup>46</sup> Health homes are a Medicaid state plan option available for states to design programs to better support and coordinate care for individuals with chronic physical health conditions, mental illness, serious emotional disturbance, and/or substance use disorders. Health homes provide care coordination across multiple health providers, systems, and organizations. While states are permitted to develop standards for health home providers that are relevant to particular age groups, recognizing that the needs of children and youth are different from those of adults, states are not permitted to specifically target by age in the health home state plan amendment.<sup>47</sup> New Jersey<sup>48</sup> and Oklahoma<sup>49</sup> have health homes for children and youth with serious emotional disturbance with co-occurring substance abuse disorder.

States receive a 90% enhanced match rate for the specific health home activities in Section 2703: comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referral to community and social services. The enhanced match applies for the first eight quarters the program is effective. A state may have more than one health home but may only receive the enhanced match a total of eight quarters for any individual enrollee.

No matter which avenue a state chooses to expand access to SUD services for youth, it must consider and answer several questions, including:

- What services will be offered? States need to specify amount, duration, and scope of services.
- At what ages will youth receive each service?
- Who will deliver services and in what setting(s)?
- Which billing codes are most appropriate and at what rates?
- Who will perform utilization management and monitor service delivery for ongoing quality improvement?
- Are the services appropriately balanced? Are they sufficient in type to maintain the youth in the least restrictive setting possible?
- Are the services person-centered and culturally and linguistically competent?
- Will training be needed to effectively implement adolescent SUD services?

## Quality Reporting

The National Committee for Quality Assurance (NCQA) has two measures for SUD treatment that apply to individuals age 13 and older. One measure is related to initiation of treatment within 14 days of diagnosis; the second is related to the percentage of individuals who had at least two treatment contacts within 30 days of treatment initiation. A 2017 proposed HEDIS measure for 2017 is follow-up within seven and 30 days following an emergency department visit for substance use.<sup>50</sup> In addition to NCQA, SAMHSA has developed the Treatment Episode Data Set (TEDS) which includes National Outcome Measures for substance abuse treatment and prevention. Both TEDS and NOMS provide important data regarding client level episodes of care, and outcomes across ten domains including education, use of evidenced-based practices, access, perceptions of care and social connectedness.

CMS launched the Medicaid Innovation Accelerator Program in July 2014 with the goal of improving health care for Medicaid beneficiaries by supporting state efforts on delivery system reform, including for behavioral health. Vermont and Massachusetts shared their experiences in developing SUD quality

metrics, including child and youth measures, in a July 2016 webinar. States may want to consult [the extensive slide deck](#) for guidance on data mapping, quality measures, and data dashboards.<sup>51</sup>

## Conclusion

The CMCS bulletin provided critical guidance to states on an effective benefit for adolescents with SUD. There are a growing number of states using a variety of Medicaid vehicles, e.g., 1115 waivers, health homes, 1915(i), 1915(c), to improve access to an appropriate array of adolescent SUD services. Continued innovation can be expected in this emerging area of Medicaid reform.

## References

- <sup>1</sup> Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (September 4, 2014). *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*. Rockville, MD. Retrieved from <http://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm>
- <sup>2</sup> Wachino, V. & Hyde, P.S. 2015, Jan. 26. Coverage of Behavioral Health Services for Youth with Substance Use Disorders. Joint CMCS and SAMHSA Informational Bulletin. Center for Medicaid and Children's Health Insurance Program Services and Substance Abuse and Mental Health Services. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf>
- <sup>3</sup> Substance Abuse and Mental Health Services Administration. (2011). Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations (HHS Publication No. SMA 12-4670). Rockville, MD. Retrieved from <http://store.samhsa.gov/shin/content/SMA12-4700/SMA12-4700.pdf>
- <sup>4</sup> Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration Center for Integrated Health Solutions. SBIRT: Brief Interventions. Retrieved from <http://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions>
- <sup>5</sup> Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration Center for Integrated Health Solutions. SBIRT: Referral to Treatment. Retrieved from <http://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment>
- <sup>6</sup> Colorado Medical Assistance Program. 2016, Apr. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program Manual. Retrieved from <https://www.colorado.gov/pacific/sites/default/files/SBIRT%20Billing%20Manual%200416.pdf>
- <sup>7</sup> New York Department of Health. 2016, Apr. Medicaid Expands Coverage for Screening, Brief Intervention, and Referral to Treatment. New York State Medicaid Update 32(4). Retrieved from [https://www.health.ny.gov/health\\_care/medicaid/program/update/2016/2016-04.htm](https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-04.htm)
- <sup>8</sup> New York Office of Alcoholism and Substance Abuse Services. Part 823, Outpatient Chemical Dependency Services for Youth, Programs and Services. Retrieved from <https://www.oasas.ny.gov/regs/823.cfm>
- <sup>9</sup> New York Office of Alcoholism and Substance Abuse Services. Outpatient Chemical Dependency for Youth, Medicaid Fee for Service Fees and Rate Codes. Retrieved from <https://www.oasas.ny.gov/admin/hcf/ocdy.cfm>
- <sup>10</sup> Maryland Department of Health and Mental Hygiene. 2016, Jun. 6. Maryland Medicaid Assistance Program Transmittal No. 82, Medicaid Updates for Spring 2016. Retrieved from [https://mmcp.dhmh.maryland.gov/MCOupdates/Documents/pt\\_43\\_16\\_edicaid\\_program\\_updates\\_for\\_spring\\_2016.pdf](https://mmcp.dhmh.maryland.gov/MCOupdates/Documents/pt_43_16_edicaid_program_updates_for_spring_2016.pdf)
- <sup>11</sup> Missouri Department of Social Services. 2015, Dec. MO HealthNet Billing Instructions for Screening, Brief Intervention and Referral to Treatment (SBIRT) Services. Retrieved from <https://dss.mo.gov/mhd/cs/health-homes/pdf/billing-instructions-sbirt.pdf>
- <sup>12</sup> Missouri Department of Social Services. 2014, Sept. 17. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training and Certification. Retrieved from <https://dss.mo.gov/mhd/cs/health-homes/pdf/sbirt-training-certification.pdf>
- <sup>13</sup> Texas Medicaid & Healthcare Partnership. 2016, May 24. Benefits to Change for Screening Brief Intervention and Referral to Treatment (SBIRT) Effective July 1, 2016. Retrieved from [http://www.tmhp.com/News\\_Items/2016/05-May/05-24-16%20Benefits%20to%20Change%20for%20Screening%20Brief%20Intervention%20and%20Referral%20to%20Treatment%20SBIRT%207-2016.pdf](http://www.tmhp.com/News_Items/2016/05-May/05-24-16%20Benefits%20to%20Change%20for%20Screening%20Brief%20Intervention%20and%20Referral%20to%20Treatment%20SBIRT%207-2016.pdf)
- <sup>14</sup> Texas Health and Human Services Commission, Rate Analysis Department. 2016, May 11. Proposed Medicaid Payment Rates for Medical Policy Review of Screening, Brief Intervention and Referral to Treatment (SBIRT). Retrieved from <http://legacy-hhsc.hhsc.state.tx.us/rad/downloads/07-01-sbirt.pdf>
- <sup>15</sup> Texas Children's Health Plan. 2016, Jan. Provider Manual. Retrieved from [http://www.texaschildrenshealthplan.org/sites/default/files/provider%20Manual\\_JAN%202016.pdf](http://www.texaschildrenshealthplan.org/sites/default/files/provider%20Manual_JAN%202016.pdf)
- <sup>16</sup> Colorado Medical Assistance Program. 2015, Oct. Outpatient Behavioral Health Fee-for-Service. Retrieved from [https://www.colorado.gov/pacific/sites/default/files/CMS1500\\_Behavioral\\_Health%20.pdf](https://www.colorado.gov/pacific/sites/default/files/CMS1500_Behavioral_Health%20.pdf)
- <sup>17</sup> New York State Office of Alcoholism and Substance Abuse Services. Methadone Treatment Medicaid Fee for Service Rates and Rate Codes. Retrieved from <https://www.oasas.ny.gov/admin/hcf/mm.cfm>
- <sup>18</sup> New York State Office of Alcoholism and Substance Abuse Services. Medicaid CD [Chemical Dependency] Services and Corresponding Fees, Rates and Billing Codes. Retrieved from <https://www.oasas.ny.gov/admin/hcf/ffschart.cfm>

- <sup>19</sup> Maryland Department of Health and Mental Hygiene. 2016, July 1. Substance Use Disorder Fee Schedule. Retrieved from [http://maryland.beaconhealthoptions.com/provider/claims\\_finance/SUD-Fee-Schedule2.pdf](http://maryland.beaconhealthoptions.com/provider/claims_finance/SUD-Fee-Schedule2.pdf)
- <sup>20</sup> State of Missouri, MO HealthNet. 2015, Dec. 8. CSTAR [Comprehensive Substance Treatment and Rehabilitation] Manual. Retrieved from [http://manuals.momed.com/collections/collection\\_cst/print.pdf](http://manuals.momed.com/collections/collection_cst/print.pdf)
- <sup>21</sup> Texas Medicaid and Healthcare Partnership. 2011, May/June. Update to Substance Use Disorder Services (Abuse and Dependence) Are a Benefit of Texas Medicaid. Retrieved from [http://www.tmhp.com/Texas\\_Medicaid\\_Bulletin/235\\_M.pdf](http://www.tmhp.com/Texas_Medicaid_Bulletin/235_M.pdf)
- <sup>22</sup> Texas Medicaid and Healthcare Partnership. 2011, July/Aug. Substance Use Disorder Services (Abuse and Dependence) Benefit Criteria Has Changed. Retrieved from [http://www.tmhp.com/Texas\\_Medicaid\\_Bulletin/236\\_M.pdf](http://www.tmhp.com/Texas_Medicaid_Bulletin/236_M.pdf)
- <sup>23</sup> Texas Medicaid and Healthcare Partnership. 2016, Sept. Texas Medicaid Provider Procedures Manual, Behavioral Health, Rehabilitation, and Case Management Services Handbook. Retrieved from [http://www.tmhp.com/tmppm/tmppm\\_living\\_manual\\_current/Vol2\\_Behavioral\\_Health\\_Handbook.pdf](http://www.tmhp.com/tmppm/tmppm_living_manual_current/Vol2_Behavioral_Health_Handbook.pdf)
- <sup>24</sup> American Academy of Pediatrics, Committee on Substance Use and Prevention. 2016, Aug. Medication-Assisted Treatment of Adolescents with Opioid Use Disorders. Retrieved from <http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1893>
- <sup>25</sup> **Note:** The child and youth behavioral health system of care field is moving away from using “care management” in response to feedback from youth and families who find the term off-putting; care coordination is the preferred term.
- <sup>26</sup> Substance Abuse and Mental Health Services Administration. Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 12-4215. Rockville, MD: 2012. Retrieved from [https://www.ncbi.nlm.nih.gov/books/NBK64863/pdf/Bookshelf\\_NBK64863.pdf](https://www.ncbi.nlm.nih.gov/books/NBK64863/pdf/Bookshelf_NBK64863.pdf)
- <sup>27</sup> Colorado Department of Human Services. 2016, June. Uniform Coding Service Standards Manual. Retrieved from <https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%202016.PDF>
- <sup>28</sup> Colorado Access. Colorado Access Behavioral Health Codes. Retrieved from [http://www.coaccess.com/documents/BehavioralCodes\\_all\\_LOB\\_grid.pdf](http://www.coaccess.com/documents/BehavioralCodes_all_LOB_grid.pdf)
- <sup>29</sup> Colorado Department of Human Services. State Plan Under Title XIX of the Social Security Act, Medical Assistance Program, Targeted Case Management Services for Substance Abuse Treatment. Retrieved from [https://www.colorado.gov/pacific/sites/default/files/Supplement\\_1c%20-%20Limitations%20to%20Care%20and%20Services%20Targeted%20Case%20Management%20Services%20for%20Substance%20Abuse%20Treatment.pdf](https://www.colorado.gov/pacific/sites/default/files/Supplement_1c%20-%20Limitations%20to%20Care%20and%20Services%20Targeted%20Case%20Management%20Services%20for%20Substance%20Abuse%20Treatment.pdf)
- <sup>30</sup> New York Department of Health, Offices of Mental Health, Alcoholism and Substance Abuse Services, and Children and Family Services. 2016, Aug. 11. Children’s Health & Behavioral Health MRT Subcommittee Quarterly Meeting Presentation. Retrieved from [https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/2016-08-11\\_quarterly\\_meeting.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2016-08-11_quarterly_meeting.pdf)
- <sup>31</sup> New York Department of Health. 2015, Dec. Behavioral Health Transition to Managed Care. Retrieved from [http://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/index.htm](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/index.htm)
- <sup>32</sup> Maryland Department of Health and Mental Hygiene. 2016, July 1. Public Mental Health System Rates. Retrieved from [http://maryland.beaconhealthoptions.com/provider/claims\\_finance/PMHS-Reimbursement-Schedule.pdf](http://maryland.beaconhealthoptions.com/provider/claims_finance/PMHS-Reimbursement-Schedule.pdf)
- <sup>33</sup> State of Missouri, MO HealthNet. 2015, Dec. 7. Youth Targeted Case Management Manual. Retrieved from [http://manuals.momed.com/collections/collection\\_you/print.pdf](http://manuals.momed.com/collections/collection_you/print.pdf)
- <sup>34</sup> Texas Medicaid and Healthcare Partnership. 2016, Sept. Texas Medicaid Provider Procedures Manual, 5.2.2 Mental Health Targeted Case Management. Retrieved from [http://www.tmhp.com/HTMLmanuals/TMPMP/Current/Vol2\\_Behavioral\\_Health\\_Handbook.14.037.html](http://www.tmhp.com/HTMLmanuals/TMPMP/Current/Vol2_Behavioral_Health_Handbook.14.037.html)
- <sup>35</sup> Colorado Department of Human Services. 2016, June. Uniform Coding Service Standards Manual. Retrieved from <https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%202016.PDF>
- <sup>36</sup> New York Department of Health, Office of Mental Health. 2014, Jan. (updated). Division of Children and Families Home and Community-Based Services Guidance Documents. Retrieved from <http://www.omh.ny.gov/omhweb/guidance/hcbs/>
- <sup>37</sup> New York Department of Health, Offices of Mental Health, Alcoholism and Substance Abuse Services, and Children and Family Services. 2016, Aug. 11. Children’s Health & Behavioral Health MRT Subcommittee Quarterly Meeting Presentation. Retrieved from [https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/2016-08-11\\_quarterly\\_meeting.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2016-08-11_quarterly_meeting.pdf)
- <sup>38</sup> Maryland Department of Health and Mental Hygiene. 2016, July 1. 1915(i) Fee Schedule. Retrieved from [http://maryland.beaconhealthoptions.com/provider/claims\\_finance/1915i-MDRN-Grant-Fee-Schedule.pdf](http://maryland.beaconhealthoptions.com/provider/claims_finance/1915i-MDRN-Grant-Fee-Schedule.pdf)
- <sup>39</sup> State of Missouri, MO HealthNet. 2015, Dec. 8. Community Psych Rehab Program Manual. Retrieved from [http://manuals.momed.com/collections/collection\\_cpr/print.pdf](http://manuals.momed.com/collections/collection_cpr/print.pdf)
- <sup>40</sup> Texas Department of State Health Services. 2016, Sept. 6. Youth Empowerment Services Waiver Program. Retrieved from <http://www.dshs.texas.gov/mhsa/yes/>
- <sup>41</sup> Texas Medicaid and Healthcare Partnership. 2014, Aug. 8. New Items: Effective September 1, 2014, TMHP Will Process Youth Empowerment Services (YES) Waiver Claims. Retrieved from [http://www.tmhp.com/News\\_Items/2014/08-August/8-8-](http://www.tmhp.com/News_Items/2014/08-August/8-8-)

- [14%20Effective%20September%201%202014%20TMAP%20Will%20Process%20Youth%20Empowerment%20Services%20YES%20Waiver%20Claims.pdf](#)
- <sup>42</sup> Texas Department of Health and Human Services. STAR Kids. Retrieved from <https://hhs.texas.gov/services/health/medicaid-and-chip/programs/star-kids>
- <sup>43</sup> Centers for Medicare and Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. 81 Federal Register 27497-27901. Retrieved from <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicicaid-managed-care-chip-delivered>
- <sup>44</sup> U.S. Department of Health and Human Services. 2015, Jul 31. Letter Approving your request to amend California's section 1115 demonstration project, entitled California Bridge to Reform Demonstration (Project Number 11-W-00193/9). Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/Bridge-to-Health-Reform/ca-bridge-to-health-reform-demo-appvl-07312015.pdf>
- <sup>45</sup> U.S. Department of Health and Human Services. 2014, June. EPSDT A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. Retrieved from [https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt\\_coverage\\_guide.pdf](https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf)
- <sup>46</sup> Centers for Medicare & Medicaid Services. Health Homes. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>
- <sup>47</sup> Centers for Medicare & Medicaid Services. 2012, May. Health Homes (Section 2703) Frequently Asked Questions. Retrieved from [https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12\\_2.pdf](https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12_2.pdf)
- <sup>48</sup> Center for Medicare & Medicaid Services. 2015, March 12. New Jersey State Plan Amendment Section 2703. Retrieved from <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/nj/nj-14-0006.pdf>
- <sup>49</sup> Centers for Medicare & Medicaid Services. 2015, Feb. 10. Oklahoma State Plan Amendment Section 2703. Retrieved from <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/ok/ok-14-11.pdf>
- <sup>50</sup> National Committee for Quality Assurance. 2016. Proposed New Measures for HEDIS®1 2017: Follow-Up After Emergency Department Visit for Mental Illness and Alcohol and Other Drug Dependence. Retrieved from <https://www.ncqa.org/Portals/0/PublicComment/HEDIS2017/4.%20FUA%20Materials.pdf>
- <sup>51</sup> Centers for Medicare & Medicaid Services. 2016, Jul 16. Medicaid Innovation Accelerator Program, Substance Use Disorder (SUD) Targeted Learning Opportunities, State of SUD-Related Quality Metrics Webinar. Retrieved from <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/07112016-iap-sud-tlo15.pdf>

## **ABOUT THE NATIONAL TECHNICAL ASSISTANCE NETWORK FOR CHILDREN'S BEHAVIORAL HEALTH**

The National Technical Assistance Network for Children's Behavioral Health (TA Network) operates the National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC), funded by the Substance Abuse and Mental Health Services Administration, Child, Adolescent and Family Branch. The TA Network partners with states, tribes, territories, and communities to develop the most effective and sustainable systems of care possible with and for the benefit of children and youth with behavioral health needs and their families. The TA Network provides technical assistance and support across the country to state and local agencies, including youth and family leadership organizations.