
SMD # 18--011

**RE: Opportunities to Design
Innovative Service Delivery
Systems for Adults with a
Serious Mental Illness or
Children with a Serious
Emotional Disturbance**

November 13, 2018

Dear State Medicaid Director:

The purpose of this letter is to announce opportunities to design innovative service delivery systems, including systems for providing community-based services, for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED) who are receiving medical assistance, as mandated by section 12003 of the 21st Century Cures Act (Cures Act).ⁱ Section 12003 of the Cures Act also mandated that this State Medicaid Director (SMD) letter include opportunities for demonstration projects under section 1115(a) of the Social Security Act (the Act) to improve care for adults with SMI or children with SED (referred to throughout this SMD letter as this “SMI/SED demonstration opportunity”). Improving care for beneficiaries with SMI or SED is a top priority for the Centers for Medicare & Medicaid Services (CMS). With this SMD letter, CMS hopes to enhance our work with states to improve care for Medicaid beneficiaries with serious mental health conditions. This SMD letter is comprised of the following two parts:

- I. Strategies under Existing Authorities to Support Innovative Service Delivery Systems for Adults with SMI and Children with SED; and
- II. SMI/SED Demonstration Opportunity.

Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) has defined “adults with a serious mental illness” as persons, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.ⁱⁱ Major life activities include activities of daily living (e.g., eating, bathing, dressing), instrumental activities of daily living (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication), and functioning in social, family, and vocational/educational contexts.ⁱⁱⁱ An estimated 10.4 million adults in the United States had an SMI during the past year in 2016, but only 65 percent received mental health services in that year (and this rate of treatment remained about the same between 2008 and 2015).^{iv}

SAMHSA has defined “children with a serious emotional disturbance” as persons from birth up to age 18, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.^v “Functional impairment” is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills.^{vi}

Mental health disorders usually first arise in childhood, adolescence, or early adulthood with 50% of people with mental health conditions having experienced those conditions by age 14 and 75% by age 24.^{vii} Approximately 13%–20% of children and adolescents living in the United States experience a mental disorder in a given year^{viii} and nearly half of children under age 21 who qualify for Medicaid based on a disability have a behavioral health condition.^{ix} Rates of unmet need for treatment are high among children and adolescents; only about half of all children with emotional or behavioral difficulties receive mental health services,^x and only 41 percent of the 3.1 million adolescents who experienced depression over the past year in 2016 received treatment.^{xi}

Serious mental health conditions can have detrimental impacts on the lives of individuals with SMI or SED and their families and caregivers. Since these conditions often arise in adolescence or early adulthood, individuals with SMI or SED are less likely to finish high school and attain higher education, disrupting education and employment goals.^{xii} Prior research has found a gap of ten years or more between the first onset of symptoms and initiation of treatment.^{xiii} Adults with SMI comprise about half of the individuals under 65 who are dually eligible for both Medicare and Medicaid, and those with SMI are the costliest subgroup among these younger dual eligibles.^{xiv} Furthermore, adults who are incarcerated and homeless have high rates of SMI.^{xv} Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs),^{xvi} and they die on average 8 years younger than the general population.^{xvii} Suicide, which can be associated with mental health disorders,^{xviii} has been increasing in nearly every state, with increases of over 30% in over half of the states since 1999.^{xix}

I. Strategies under Existing Authorities to Support Innovative Service Delivery Systems for Adults with SMI and Children with SED

Earlier Identification and Engagement in Treatment

Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner, as highlighted in another recent CMS SMD letter.^{xx} Some approaches discussed below for encouraging earlier identification of and engagement in treatment for serious mental health conditions include support for development of referral networks to mental health providers including through improved connections and data-sharing capabilities linking non-specialized health care settings and community organizations with mental health providers. Another approach to support earlier identification and engagement in treatment is support for increased screening for mental health conditions and improved access to mental health services through schools.

One reason that earlier identification and engagement in treatment is critically important is that recent research studies have found that adolescents and young adults with psychosis can have significantly elevated risks of mortality in the first year after diagnosis.^{xxi} One study pointed to a significantly elevated risk of suicide in particular during the first year after a diagnosis of psychosis as well as following a first recorded diagnosis of major depression.^{xxii} Both studies concluded that these findings point to the importance of assertive outreach and engagement as soon as possible after an adolescent or young adult is first diagnosed with a serious mental health condition.

As highlighted in an informational bulletin jointly issued by CMS, SAMHSA, and the National Institute of Mental Health, the Coordinated Specialty Care Model is an evidence-based model of care designed to help identify and engage adolescents and adults with SMI, specifically psychosis, as soon as possible in treatment with specialized mental health providers, e.g., community mental health clinics.^{xxiii} This model takes a multidisciplinary, team-based approach to providing comprehensive services as soon as possible after a person first experiences psychosis. The package of services in this model includes outreach by providers to cultivate referral networks and engage with patients, families, and caregivers as early as possible, coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education. The Joint Informational Bulletin referenced above describes the component services that make up this model and how these components can be reimbursed.^{xxiv} There are also similar care models for children at clinically high risk for SED and adolescents and young adults at high risk of SMI that incorporate comprehensive mental health care, family education, medical care, and strong supports to keep children, adolescents, and adults engaged in school and/or employment.^{xxv}

Lack of coverage of the costs of outreach to engage beneficiaries in treatment and develop referral networks has been identified by providers and advocates as an impediment to broader implementation of these care models. However, states may be able to factor costs of some outreach activities, including patient engagement related to delivering a Medicaid covered service, into provider payment rates even though those activities are generally not separately reimbursable unless specified under a service definition. Activities by providers to engage beneficiaries in treatment including by developing relationships with hospitals to improve coordination and transitions out of inpatient care may be more specifically coverable under the optional Health Home state plan benefit under section 1945 of the Act. This optional state plan benefit includes care coordination, transition care, or individual and family support services and is discussed in more detail in Appendix A.

Individuals with SMI or SED are often first identified as needing treatment for SMI or SED in settings other than specialized mental health care settings including schools, hospitals, primary care, and criminal justice systems. Connecting these other settings with local mental health providers can help improve access to treatment and rehabilitative services as soon as possible after a serious mental health condition has been identified. Medicaid agency costs associated with developing or maintaining a referral network between other systems and settings like those listed above with mental health providers may be reimbursable as administrative costs. State Medicaid agencies should contact CMS for additional information.

Improving data-sharing capabilities between schools, hospitals, primary care, criminal justice, and specialized mental health providers is an effective way to improve communications between these types of entities and the healthcare system. States may be able to access enhanced federal Medicaid matching funds for costs to state Medicaid agencies of implementing and operating technology to improve data-sharing capabilities as part of the Medicaid Information Technology Architecture (MITA).^{xxvi} Many of the business processes described in MITA 3.0 regarding Care Management focus specifically on systems supporting the collection of information about an individual's health status and needs. States could use this authority and enhanced match to develop connections between mental health care providers and schools, hospitals, primary care, criminal justice, and faith communities, consistent with the discussion of "Interoperability" contained in the final rule on this topic.^{xxvii} For example, enhanced federal financial participation (FFP) could be available to states for the development by the state of data-sharing capabilities between hospitals and community-based mental health providers such that when a beneficiary with SMI or SED is being discharged from a hospital, that beneficiary's records regarding treatment could more easily be transferred to a community-based treatment provider or, if the beneficiary was being admitted to a hospital for acute care, the community-based mental health provider could be notified more easily.

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) has published comprehensive guidance for professionals^{xxviii} and health care consumers^{xxix} explaining the circumstances in which health care providers covered by the Health Insurance Portability and Accountability Act (HIPAA) can share information related to mental health. The HHS OCR guidance, required by section 11003 of the 21st Century Cures Act, clarifies how the HIPAA Privacy Rule permits covered health care providers and other mental health treatment professionals to disclose information to a patient's family members, caregivers, and others to facilitate treatment and protect the health and safety of patients with SMI and SED and others.

Furthermore, improving the availability of behavioral health screenings and mental health and SUD services in schools is a key strategy for identifying and engaging children with SED in care sooner. Providing behavioral health services in school settings has been shown to improve access to care,^{xxx} increase early problem identification,^{xxxi} and overcome reticence to access care by providing services in a more mainstream and accessible setting.^{xxxii} States interested in making school-based mental health screening and behavioral health counseling more widely available could do so under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for Medicaid-enrolled children under age 21 as specified in section 1905(r) of the Act. The EPSDT benefit requires states to have a schedule for screening services both at established times and on an as-needed basis. Covered screenings for children include medical, mental health, vision, hearing, and dental. Incorporating an age appropriate, evidence-based screening tool designed to identify behavioral health conditions into well-child examinations is an important step to identify mental health and SUD conditions early. In addition, the EPSDT benefit requires that states provide all medically necessary services covered under the benefits in section 1905(a) of the Act to correct or ameliorate physical and mental illnesses or conditions. Behavioral health counseling could be covered under the rehabilitative services benefit at section 1905(a)(13) of the Act, but states would not need to amend their state plans to add EPSDT coverage for screening and behavioral health

services. However, some states choose to do so in order to clarify the services covered in the school setting.

All providers of Medicaid services in schools must be qualified and enrolled as Medicaid providers. The Department of Health and Human Services and the Department of Education jointly issued a toolkit outlining action steps and practices that states and local communities can take to improve availability of school-based health services and supports that are critical for children with or at risk of SED.^{xxxiii} Other approaches to improving access to mental health services in schools include developing partnerships with Federally Qualified Health Centers (FQHCs) and rural health clinics.^{xxxiv} In addition, states could also ensure that their managed care plans allow for reimbursement of school-based providers.

Integration of Mental Health Care and Primary Care

Integration of mental health care into primary care settings can also help ensure that individuals with SMI or SED are identified earlier and connected with appropriate treatment sooner. In addition, integration is critical for improving access to treatment for comorbid physical health conditions and SUDs that are common among individuals with SMI or SED. Some strategies for increasing integration of mental health care into primary care that are discussed below include encouraging screening for mental health disorders and supporting primary care providers (PCPs) and pediatricians to provide treatment and/or referrals for mental health services with the support of consultations with specialists and care coordinators.

Outpatient provider visits offer critical opportunities to screen for mental health issues and suicidal ideation. Research has found that 64 percent of individuals had visited a health care provider within a month prior to attempting suicide and 95 percent visited one within a year prior to attempting suicide.^{xxxv} The Patient Health Questionnaire (PHQ)-9 is a clinically validated assessment tool focused on screening for depression and measuring depression severity which includes screening for the presence of suicidal ideation. States may wish to encourage providers participating in their Medicaid programs to screen for depression and suicidal ideation using the PHQ-9 during outpatient office visits.^{xxxvi}

One evidence-based approach to incorporating specialty mental health care into primary care settings, the Collaborative Care Model, has been proven effective in over 80 randomized controlled trials.^{xxxvii} Although originally designed to treat depression, there is increasing evidence of its effectiveness for treating other behavioral health conditions including anxiety, post-traumatic stress disorder, and SUDs. This care model uses a team-based approach in which PCPs treat mental health and SUD issues of their patients supported by a behavioral health care manager and a psychiatric consultant. The behavioral health care manager is a social worker or psychologist who works with the PCP and is trained to deliver care coordination and brief behavioral interventions. The psychiatric consultant is a psychiatrist or physician assistant, nurse practitioner, or clinical nurse specialist with psychiatric training who makes treatment recommendations to the PCP, including medication and evidence-based therapy recommendations and medical management of any complications associated with treatment. Key components of the Collaborative Care Model include care coordination and care management by the care manager, regular patient monitoring using

clinical rating scales, the use of evidence-based approaches and stepped care that intensifies and/or modifies the approach for complex or treatment resistant cases, and regular psychiatric caseload reviews in person or through use of telemedicine with a psychiatric consultant.

A less intensive model for children with mental health conditions is the Child Psychiatry Access Model supported by the National Network of Child Psychiatry Access Programs.^{xxxviii} These programs generally offer telephonic consultation with a psychiatrist or other licensed behavioral health clinician, face-to-face psychiatric or behavioral health consultations for patients when needed, with a written summary provided to the PCP, and assistance with referral to community-based behavioral health services. For example, the Massachusetts Child Psychiatry Access Project Model, established in 2004, offers statewide access to over 95 percent of pediatric primary care providers in the state through six regional behavioral health consultation hubs. Each hub includes a full-time child psychiatrist, licensed therapist, and a care coordinator. Each hub operates a dedicated hotline and offers immediate clinical consultation over the telephone, expedited face-to-face psychiatric consultation, care coordination for assistance with referrals to community behavioral health services, and continuing professional education for primary care providers. Participating pediatricians have reported a significant improvement in their ability to meet the mental health care needs of their patients (although a considerable gap remains): the percent of participating pediatricians who responded to an annual survey and said they could meet the needs of children with behavioral health problems increased from eight percent in 2008 to 64 percent in 2012.^{xxxix}

One issue that has been identified by a number of stakeholders as impeding broader implementation of these models is a lack of reimbursement for consultation and care coordination outside the presence of the patient. Although the presence of the patient is required for the service to be covered, Medicaid may be able to reimburse for consultations between professionals regarding treatment for a patient and for care coordination if these costs are incorporated into the rate a state pays a provider for a covered service for a beneficiary. Under such circumstances, the resources that go into that encounter (such as a consultation with a specialist regarding treatment options for that beneficiary) can be accounted for in the rate for that service. The provider receiving the reimbursement would then have to reimburse the specialty provider. Furthermore, Medicare covers payments to practitioners for behavioral health integration services, including the Collaborative Care Model, and has identified Current Procedural Technology (CPT) codes for these payments, which may be useful for states interested in supporting this model of care.^{xl} States are also encouraged to eliminate restrictions on same-day billing for primary care and mental health services in order to facilitate implementation of these types of models.

Use of telehealth technologies to support provision of the Collaborative Care model is another important strategy for facilitating broader availability of integrated mental health care and primary care.^{xli} States may be able to access enhanced match under MITA 3.0^{xlii} for state development of telehealth-enabling technology to be used by Medicaid providers to coordinate care for beneficiaries. Some examples include development of virtual treatment centers or remote counseling options integrated into care coordination technology consistent with the “Managing Care Information” business process under MITA 3.0 which includes activities connecting providers to patients and facilitating access to services.^{xliii} For supporting state costs associated with implementing the Collaborative Care model or other team-based approaches, states could also consider using the

existing authority for Care Plan Exchange under MITA 3.0.^{xliv} The treatment services themselves that are provided via tele-health technology could be covered using state plan or other Medicaid authorities.

Similarly, the Health Home benefit under section 1945 of the Act could also be used to support this model of care. The Health Home benefit offers 90 percent FFP for eight quarters for specific services including comprehensive care management, care coordination, comprehensive transition care, individual and family support, and the use of health information technology to link services.

Improved Access to Services Across the Continuum of Care Including Crisis Stabilization Services

Adults with SMI and children with SED need access to a continuum of care since these conditions are often episodic and the severity of symptoms can vary over time.^{xlvi} However, the only treatment options in many regions are inpatient care for acute treatment needs and outpatient care for less serious conditions and on-going maintenance therapy, with little availability of intermediate levels of care.^{xlvi} As a result, individuals with serious mental health conditions often go into inpatient facilities or emergency departments when they could be better served in community-based settings. Furthermore, without the supports needed to help transition from acute care back into their communities, adults with SMI are at heightened risk for relapse and readmission.^{xlvi} Mental health disorders are often the primary cause of hospital readmissions among adult Medicaid beneficiaries,^{xlvi} indicating a need for more evidence-based community-based supports and services.

Strategies for ensuring individuals with SMI or SED are provided appropriate levels of care to meet their needs include encouraging use of evidence-based assessment tools, e.g. the LOCUS and CASII (or CALOCUS), that link clinical assessments with standardized "levels of care" using methods for matching the two.^{xlvi} It is also important that the care provided to individuals with SMI or SED is trauma-informed.¹

Another strategy is to increase availability of intensive outpatient and crisis stabilization programs designed to divert Medicaid beneficiaries from unnecessary stays in emergency departments (EDs) and inpatient facilities as well as criminal justice involvement.^{li} Core elements of crisis stabilization programs include regional or statewide crisis call centers coordinating access to care in real time, centrally deployed mobile crisis units available 24 hours a day and seven days a week, and short-term, sub-acute residential crisis stabilization programs.^{lii}

Depending on the circumstances, services provided to beneficiaries in residential settings may be subject to the payment exclusion for institutions for mental diseases (IMDs).^{liii} Section 1905(i) of the Act defines an IMD as any "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."^{liv} There is some authority for states to receive FFP for monthly capitation payments paid to Medicaid managed care plans for coverage of Medicaid beneficiaries residing in IMDs; Medicaid managed care rules permit FFP for monthly capitation payments to managed care plans for enrollees that are inpatients in a hospital providing psychiatric or SUD inpatient care or in a sub-acute psychiatric or SUD crisis residential setting that

may qualify as IMDs when the stay is for no more than 15 days during the period of the monthly capitation payment and certain other conditions are met.^{lv}

Furthermore, states may be able to access administrative match for crisis call centers as some states have done for tobacco quit lines.^{lvi} However, in order to access administrative match for crisis call centers, a state would have to justify in a reasonable manner how many callers are Medicaid beneficiaries in order to properly allocate costs to Medicaid. States can refer to guidance on tobacco quit lines.^{lvii} Enhanced administrative match may be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment as well as to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions.

States may also coordinate access to outreach, referral, and assessment services for behavioral health care through an established No Wrong Door System.^{lviii} The No Wrong Door System is a collaboration between CMS, the U.S. Administration for Community Living, and the Veterans Health Administration to support states' efforts to develop coordinated systems of access to make it easier for consumers to learn about and access Long-Term Service and Supports.

The Certified Community Behavioral Health Clinic (CCBHC) demonstration^{lix} offers a model for providing comprehensive community-based behavioral health care. Certification criteria for CCBHCs under the demonstration include the availability of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration of mental health, SUD, and physical health care.^{lx} To promote improved quality of care, CCBHCs are required to report on a range of quality measures. States may be able to adapt the CCBHC model of care using different authorities, depending on the services provided, beneficiaries served, and payment methodologies. For example, some CCBHC services may be authorized under the state plan and covered as clinic services with payment made using an encounter rate that pays for a bundle of behavioral health and primary care services. States may also elect to use incentive payments (as is being done in the CCBHC demonstration) to encourage providers to implement the comprehensive model of care delineated for the CCBHC demonstration.^{lxi}

Another strategy for helping adults with SMI or children with SED access appropriate levels of care is development of the capability to track which mental health providers are accepting Medicaid beneficiaries at different levels of care throughout the state, including outpatient, intensive outpatient, inpatient, and community-based crisis services. Development by the state of this capability to track available mental health providers, such as through a type of registry reflecting qualified providers that is frequently updated, could be reimbursed under MITA 3.0 at 90% of the development costs and 75% of the operational costs.^{lxii} Furthermore, Medicaid managed care plans (managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and, where applicable, primary care case management plans) must identify as part of provider directories whether a network provider is accepting new patients under 42 C.F.R. § 438.10(h)(1)(vi).

Additional opportunities to engage Medicaid beneficiaries in community-based treatment include increasing availability of assertive community treatment (ACT) programs.^{lxiii} ACT programs include a multidisciplinary team of mental health professionals with low client to staff ratios allowing for multiple contacts for clients needing intensive support and the capacity to respond 24 hours a day

seven days a week. ACT programs include frequent team meetings and offer integration of services instead of referring clients to other programs for other services. CMS has previously issued a State Medicaid Director letter that included information about covering ACT programs in Medicaid.^{lxiv} Coverable services in ACT programs could include assessment, medication, medication management, therapy/counseling, and case management.

Many Medicaid beneficiaries with SMI or SED need skilled, person-centered planning, services, and supports that address their cultural needs and values and help them access services across a continuum of care as needed. This type of planning identifies and addresses the person's preferences and interests and those paid and unpaid supports needed to achieve them. The planning and services can be directed with the support of others whom the beneficiary selects. Those responsible for person-centered practices should be engaged in a continuous learning and improvement process.

HHS policy on person-centered thinking, planning, and practice is articulated in statute, regulations, guidance documents, prior grant and contract actions, and numerous HHS-sponsored presentations (see e.g., CMS' January 2014 HCBS final rule^{lxv} and HHS Guidance for Implementing Standards for Person Centered Planning and Self-Direction issued in June 2014^{lxvi}). These expectations apply to 1915(c) waivers, and the 1915(i) and 1915(k) state plan options. In addition, the 2014 Guidance applies to all HHS programs serving people with disabilities and older adults including several programs that serve people with SMI and SED, e.g., the Administration for Community Living No Wrong Door program, the SAMHSA CCBHC program, and the SAMHSA Mental Health Block Grant Program. The Medicaid Health Home state plan option also requires person-centered planning and the Office of the National Coordinator (ONC) eLTSS data elements provide an electronic mechanism to track key components of the person-centered service plan as part of a comprehensive health IT strategy. Furthermore, psychiatric advance directives and individual participation in treatment and recovery services planning are important components of person-centered planning for people with SMI and SED.

There is a strong role for peers as natural allies in the facilitation of person-centered planning processes, and self-direction for mental health is an emerging practice that is being developed in several states and shows promising outcomes.^{lxvii} Innovative models of community recovery support, such as "clubhouse" programs and wrap-around recovery support services provided by community health workers, emphasize the use of peer support specialists and others to provide skills training, and assistance with educational and vocational needs. CMS has previously issued a State Medicaid Director letter on covering peer support services in Medicaid,^{lxviii} as well as additional clarification that peer supports in some circumstances can include peer supports for the parents/legal guardians of Medicaid eligible children.^{lxix}

Better Care Coordination and Transitions to Community-based Care

Improving coordination of care between levels of care and particularly as individuals with SMI or SED leave inpatient or residential treatment is a critical issue that states should address in order to improve outcomes for beneficiaries with these conditions. The risk of suicide following discharge from psychiatric hospitals or wards is greatest immediately following an inpatient stay, with the rate of suicide during the first three months after discharge approximately 100 times higher than the

global suicide rate according to a 2017 systematic review and meta-analysis.^{lxx} This study highlights how important it is for individuals with SMI or SED to receive timely follow-up care after leaving residential or inpatient treatment.

Unfortunately, many Medicaid beneficiaries do not receive timely follow-up care within the timeframes of 7 or 30 days that are used to measure timely follow-up care in the widely used measure “Follow-up After Hospitalization for Mental Illness” (NQF #0576). This measure is included in both the core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set) and the core set of children’s health care quality measures for Medicaid and the Children’s Health Insurance Program (CHIP) (Child Core Set). According to Medicaid data submitted by the thirty-six states that reported the follow-up after hospitalization measure in fiscal year (FY) 2016 (the latest data available), a median of only 38 percent of adult beneficiaries (ages 21 and older) who were hospitalized for mental illness had a follow-up visit within 7 days of discharge and only 60 percent had a follow-up visit within 30 days of discharge.^{lxxi} A median of 45 percent of children (ages 6 to 20) who were hospitalized for mental illness had a follow-up visit within 7 days of discharge and only 68 percent had a follow-up visit within 30 days of discharge for FY 2016 for the forty-one states who reported.^{lxxii}

One approach to improve care coordination following hospitalization is to implement accountability measures and payment incentives for plans and providers. A model for this approach is the Medicare Hospital Readmission Reduction Program, which financially penalizes hospitals with relatively high rates of Medicare readmissions for specific conditions.^{lxxiii} Medicaid managed care plans can also be held accountable for performance on the widely used measures assessing follow-up after hospitalization (discussed above) and follow-up after emergency room care for mental illness (both of which are included in both the Adult^{lxxiv} and Child Core Sets^{lxxv}). States can add these requirements to their contracts with managed care plans either through inclusion in a plan’s quality assessment and performance improvement (QAPI) program or through a plan or provider incentive arrangement.

Ensuring that hospitals and residential treatment settings contact discharged individuals with SMI or SED within a few days of leaving inpatient or residential care can help improve outcomes as can connecting those individuals with community-based care. One recent study found that follow-up via mailed postcards, follow-up via telephone outreach, and suicide-focused cognitive behavioral therapy could each be highly effective, relative to usual care alone, at reducing suicides and attempted suicides for which there is a heightened risk following inpatient care.^{lxxvi} These interventions were also expected to be relatively cost-effective as compared to the usual cost of care.^{lxxvii} There is not a Medicaid benefit category that specifically authorizes coverage of contacts by hospital/residential treatment program staff via mail or phone calls following inpatient care or emergency room visits; however, the cost of providing these kinds of follow-up contacts to Medicaid beneficiaries could be included in the rates that states set for inpatient and emergency room services. Cognitive behavioral therapy can be covered using the rehabilitative services benefit.

Peer support providers can help make connections between inpatient facilities and emergency departments and outpatient treatment providers.^{lxxviii} In addition, peer navigators, one-to-one support in group homes, and providing staff to accompany an adult with SMI when they attend medical and social services can also help prevent hospitalization of adults with SMI.

The optional Health Home benefit can also support improved care coordination following an inpatient stay. As discussed above, Health Home services include comprehensive transitional care from inpatient to other settings including appropriate follow-up care. Currently, 18 out of 22 states with approved Health Home programs have identified beneficiaries with a mental health condition as a target population for the Health Home benefits

Increased Access to Evidence-based Services that Address Social Risk Factors

Supportive services designed to help individuals with SMI or SED maintain a job or stay in school are often identified as crucial for keeping these individuals healthy and on the path to recovery.

These types of services can offer key incentives for individuals with serious mental health conditions, particularly adolescents and young adults, to enter and remain engaged in treatment programs.^{lxxix} In addition, helping adults with SMI maintain stable housing has been identified as a critical foundation for improving health outcomes.^{lxxx} However, only 2 percent of adults and transition-age youth with SMI received supported employment in 2016 (according to data from 43 states) and only three percent received supportive housing in 2016 (according to data from 35 states).^{lxxxi}

Improving access to these supportive services, including supported education, which is a variation on supported employment, is a critical strategy for improving outcomes for Medicaid beneficiaries with SMI or SED. States can use existing Medicaid authorities, including 1915(c) Home and Community-Based Waivers and 1915(i) State Plan Amendments, to provide many of these supports. Where Medicaid does not cover the supportive service itself, it generally covers services to connect beneficiaries to the necessary supports.

States could also adopt, or expand eligibility for, Medicaid “buy in” programs to allow working individuals with disabilities whose income and/or assets exceed limits for other eligibility pathways to “buy-in” to Medicaid coverage.^{lxxxii} Medicaid “buy-in” programs could help eligible individuals with SMI or SED obtain and maintain employment by helping them avoid having to choose between healthcare coverage and work.^{lxxxiii}

A summary of the key components of the models of care and activities highlighted above along with Medicaid authorities that states may be able to use to implement these strategies and additional information on the specific Medicaid authorities are provided in Appendix A. However, which services are coverable by Medicaid would depend on the Medicaid authority the states seek to use, and states should work with CMS on specific proposals to ensure they are feasible within Medicaid authority.

II. SMI/SED Demonstration Opportunity

As required by section 12003 of the Cures Act, CMS is announcing opportunities for demonstration projects under section 1115(a) of the Act to improve care for adults with SMI and children with SED (referred to as this “SMI/SED demonstration opportunity”). Under section 1115(a) of the Act, the Secretary of HHS (“Secretary”) or CMS, operating under the Secretary’s delegated authority, may authorize a state to conduct experimental, pilot, or demonstration projects that, in the judgment of the

Secretary, are likely to assist in promoting the objectives of title XIX of the Act. This SMI/SED demonstration opportunity will allow states, upon CMS approval of their demonstrations, to receive FFP for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services as described below. This SMI/SED demonstration opportunity is comparable to the recent section 1115(a) demonstration opportunity to improve treatment for SUDs, including opioid use disorder (OUD).^{lxxxiv} However, through these demonstrations, states will focus on demonstrating improved care for individuals with serious mental health conditions in inpatient or residential settings that qualify as IMDs as well as through improvements to community-based mental health care.

The payment exclusion for services provided to most Medicaid beneficiaries while residing in IMDs is often cited as a significant impediment to ensuring adequate access to acute care for beneficiaries with SMI or SED. Some stakeholders assert that as a result of this payment exclusion, Medicaid beneficiaries with these conditions often present in emergency rooms where they are unlikely to receive adequate care and where they often must wait for hours and even days before space in an inpatient psychiatric facility becomes available. Alternatively, beneficiaries may be admitted to a general hospital, but usually only for a very short period of time before being discharged, sometimes before being stabilized, and often without being connected to outpatient care. In addition, some stakeholders assert that the lack of intensive community-based services and discharge planning linking people with community-based supports results in individuals not transitioning out of acute care facilities in a timely fashion, which further limits inpatient capacity to address the acute care needs of individuals with SMI or SED. CMS is proposing to test these assertions. Furthermore, CMS believes that increasing access to mental health care, including acute treatment as well as community-based services, could help address increasing suicide rates^{lxxxv} since mental health disorders are often implicated in suicidal behavior.^{lxxxvi}

Through this demonstration opportunity, FFP would be available for services for beneficiaries who are short-term residents in IMDs primarily to receive mental health treatment. While residing in those facilities primarily to receive mental health treatment, Medicaid beneficiaries should also be screened for co-occurring SUDs as well as physical health conditions. States with approved demonstrations could also receive FFP for Medicaid coverable services provided to otherwise eligible beneficiaries to treat any co-occurring SUD and physical health conditions while those beneficiaries are residing short term in IMDs primarily to receive mental health treatment.

States may participate in the SUD demonstration opportunity and this SMI/SED demonstration opportunity at the same time. In the event that a state already has an approved SUD demonstration—or is seeking concurrent approval of an SUD *and* SMI/SED demonstration—CMS will provide technical assistance regarding how the two demonstration types may be operationalized. Consistent with the SUD demonstration opportunity, states will be expected to achieve a statewide average length of stay of 30 days for beneficiaries receiving care in IMDs pursuant to this SMI/SED demonstration opportunity.

Through this SMI/SED demonstration opportunity, states may receive federal matching funds for Medicaid-coverable services provided to individuals residing in psychiatric hospitals and residential treatment settings that are not ordinarily matchable because these facilities qualify as IMDs; however, this SMI/SED demonstration opportunity does not allow for room and board payments in residential treatment settings unless they qualify as inpatient facilities under section 1905(a) of the Act. This limitation on covering room and board is a long-standing Medicaid policy based on statute and regulations.^{lxxxvii} Furthermore, FFP will not be available through these demonstrations for services provided in nursing homes that qualify as IMDs as CMS understands that nursing homes do not specialize in providing mental health treatment and may not have staff with appropriate credentials and training to provide good quality treatment to individuals with SMI or SED. FFP also will not be available through these SMI/SED demonstrations for services provided in treatment settings for individuals 21 years of age or younger if those settings do not meet CMS requirements to qualify for the Inpatient Psychiatric Services for Individuals under Age 21 benefit.^{lxxxviii} In addition, FFP will not be available through these demonstrations for services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in the facility by operation of criminal law.^{lxxxix} States should contact CMS with any questions regarding these limitations.

CMS will not approve a demonstration project under section 1115(a) of the Act unless the project is expected to be budget neutral to the federal government.^{xc} A budget neutral demonstration project does not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration. What the federal government's Medicaid costs would likely have been absent the demonstration may include coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act. CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS currently adjusts the budget neutrality test to effectively treat these expenditures as if they were approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable costs. Nonetheless, with the approval of an SMI/SED demonstration, states will agree to report all title XIX expenditures, except spending under certain managed care arrangements, during SMI/SED-related IMD stays consistent with the Special Terms and Conditions (STCs) for the demonstration.

States participating in the SMI/SED demonstration opportunity will also be expected to commit to taking a number of actions to improve community-based mental health care, as section 12003 of the Cures Act also directed CMS to address systems for providing community-based services for beneficiaries with SMI or SED. These commitments to improving community-based care are to be linked to a set of goals for the SMI/SED demonstration opportunity described below and should include actions to ensure good quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI or SED in treatment as soon as possible. These state actions should build on the opportunities for innovative service delivery reforms discussed in Part I of this letter to achieve the goals and milestones described below.

CMS will consider a state's commitment to on-going maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project in order to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Furthermore, CMS strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, particularly crisis stabilization services.^{xc1}

Similar to the SUD demonstration opportunity, this SMI/SED demonstration opportunity offers states the flexibility to design section 1115(a) demonstrations aimed at making significant improvements on a number of goals and milestones that are described below.

Goals:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Milestones:

Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving FFP for services provided to beneficiaries;
- Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

- Use of a utilization review entity (e.g., a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers);

Improving Care Coordination and Transitions to Community-Based Care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services - as well as requirements that community-based providers participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);
- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available;
- Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to;

- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers^{xcii} and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
- Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED;

Increasing Access to Continuum of Care Including Crisis Stabilization Services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability;
- Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers as well as on-going community-based services, e.g., intensive outpatient services, assertive community treatment,^{xciii} and services in integrated care settings such as the Certified Community Behavioral Health Clinic model described in Part I of this letter as well as consideration of a self-direction option for beneficiaries;
- Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
- Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association, e.g., LOCUS or CASII,^{xciv} to help determine appropriate level of care and length of stay;

Earlier Identification and Engagement in Treatment Including Through Increased Integration

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs;^{xcv}
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers; and

- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.^{xcvi}

Demonstration Application

States wishing to participate in this initiative can submit a demonstration application to CMS outlining the state's strategy for achieving the goals of this demonstration opportunity, including a commitment to meeting the milestones described above that are critical steps for achieving these goals over the course of the demonstration. CMS strongly encourages states to articulate in their demonstration applications how their proposals will apply evidence-based programs to meet the needs of people with SMI or SED in their states. States' applications should also describe the state's capacity for regular reporting on progress toward meeting these milestones as well as for collecting and reporting data on performance measures. In addition, states' applications should confirm their commitment to assuring the necessary resources will be available to effectively support implementation of a robust monitoring protocol and evaluation.

Implementation Plan

Participating states will also develop implementation plans describing the various timelines and activities the states will undertake to achieve the milestones listed above. States will have the option of submitting their implementation plans as part of their applications or as post approval protocols. Authorization of FFP for services in inpatient hospitals or residential treatment settings that qualify as IMDs will be contingent upon assurance by the state that all participating IMDs are licensed and accredited, community-based alternatives are or will be available throughout the state under the state's financing plan described above, and CMS has approved the SMI/SED demonstration's implementation plan. The expectation is that states will meet the milestones by the end of the first two years of the demonstration. However, regardless of whether the implementation plan is submitted as part of a state's application or as a post-approval protocol, FFP for services provided during Medicaid beneficiary stays in IMDs will be prospective only and contingent upon CMS approval of the state's implementation plan.

As a state's SMI/SED demonstration progresses, the state will be expected to include, in its section 1115(a) demonstration monitoring reports, information detailing the state's progress toward meeting the milestones and timeframes specified in the state's implementation plan, as well as information and data so that CMS can monitor budget neutrality.

States seeking approval of an SMI/SED demonstration also will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals. The HIT Plan should address electronic care plan sharing, care coordination, and behavioral health-physical health integration. CMS will provide additional guidance on these expectations.

Monitoring Protocol for Performance Measures Aligned with Initiative Goals

As outlined above, states will include in their section 1115(a) demonstration reports, information detailing milestones and performance measures representing key indicators of progress toward meeting the goals for this initiative. Participating states will report on a common set of measures and the states and CMS will agree to additional measures and measure concepts specific to a particular state's demonstration parameters. A list of potential measures is included in Appendix B. Reporting templates are subject to OMB review and approval under the Paperwork Reduction Act.

CMS will provide guidance to participating states on development of monitoring protocols that will identify expectations for quarterly and annual monitoring reports, including agreed upon performance measures, measure concepts, and qualitative narrative summaries. For performance measures, CMS' guidance will include recommendations for baselines and targets. Both quantitative and qualitative information will align with the milestones outlined above. Any deviations from CMS' guidance the state wishes to make will be documented in the monitoring protocol. The monitoring protocol will be developed after CMS approval of the demonstration in consultation with CMS, and a timeframe for finalizing the monitoring protocol will be included in the STCs of each demonstration.

The data reported by the state will inform a mid-point assessment between years two and three of the demonstration during which CMS will identify whether states are making sufficient progress toward meeting the milestones and performance measure targets. The mid-point assessment will also include an assessment of whether a state is on track to meet the budget neutrality requirements. States at risk of not meeting these targets will submit modifications to their implementation plans, which will be subject to CMS approval. CMS may require a state to provide a corrective action plan if it fails to meet the required annual triggers indicating that waiver spending is diverging from the expected trajectory under the budget neutrality requirements. Furthermore, FFP for services to individuals residing in IMDs may be withheld if states are not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones and the required performance measures in the monitoring protocol agreed upon by the state and CMS. Additionally, achievement of the milestones and performance measure targets will be taken into consideration by CMS if a state were to request an extension of its demonstration.

States will also be required to conduct independent and robust interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval. The evaluation design will include detailed analytic plans, data development, collection, and reporting details and will be subject to CMS approval. States that fail to submit an acceptable and timely evaluation design as well as any required monitoring, expenditure or other evaluation reporting, are subject to a \$5 million deferral per deliverable. The interim evaluation will be required one year before expiration of the demonstration or when the state submits a proposal to renew the demonstration. The final evaluations will be due eighteen months after the demonstration period ends.

Public Availability of Data on State Progress toward Meeting Milestones and Performance Measure Targets as well as Evaluation Reports

CMS will regularly post information on the Medicaid.gov website regarding the states' progress in meeting the agreed upon milestones and performance measure targets. In addition, states' regular 1115 reports, as well as their evaluation reports, will be posted, as required by section 1115 transparency rules.

Submission Process for Section 1115(a) Demonstration

States should follow the usual process for submitting section 1115(a) demonstration proposals as outlined in the federal section 1115(a) demonstration project transparency regulations at 42 CFR 431.412 and 42 CFR 431.408. As explained in these regulations, states should submit an application that includes the following information:

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with SMI or SED, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the State's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations. Specifically, CMS requests that states' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;
- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- Written documentation of the state's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the state considered those comments when developing the final demonstration application submitted to CMS;

- The research hypotheses that are related to the demonstration’s proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation Plan (if being submitted at the time of application).

CMS requests that these Section 1115(a) demonstration proposals describe, in as much detail as possible, the state’s strategy for improving access to and quality of mental health care through the proposed demonstration and how the state’s proposed demonstration will further the goals of the initiative described above. The application should include a description of the activities the state plans to undertake to address the milestones listed above and to report on progress toward meeting the milestone and performance measures. If it is not feasible to include in the application a detailed implementation plan specifying how and when the state proposes to meet the milestones, the state should propose a date by which an implementation plan will be submitted by the state (generally within at least 90 days of approval of the application), and this date will be included in the STCs. As a reminder, FFP for services in IMDs will not be available through the demonstration until the implementation plan/protocol is approved by CMS, at which time FFP will be available only prospectively. In addition, the state should indicate what data sources and resources it proposes to use for reporting on performance measures. CMS will work with states to develop a detailed monitoring protocol for these data points and performance measures after the application is received from the state.

After states develop 1115 demonstration proposals that include the information listed above, states must follow the minimum 30-day public notice and comment procedures outlined in 42 CFR 431.408, to allow opportunity for public input on the application prior to submission to CMS. These procedures include consultation with Indian tribes and Indian health providers (to the extent there are Indian tribes and Indian health providers located within geographic boundaries of the state) to solicit advice from the Indian health providers on ensuring access for American Indian and Alaska Native (AI/AN) individuals to the services that are part of the demonstration and that these services meet the unique and cultural needs of AI/AN individuals.

CMS is available to provide technical assistance to states on how to meet federal transparency requirements as well as to preview states’ draft 1115(a) proposals and public notice documentation to help ensure states successfully meet federal requirements.

Section 1115(a) demonstration applications may be submitted electronically to 1115DemoRequests@cms.hhs.gov or by mail to:

Judith Cash
Director, State Demonstrations Group
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-26-12
7500 Security Boulevard
Baltimore, MD 21244-1850

As required by 42 CFR 431.416, when states submit section 1115 proposals, CMS will send written notice within 15 days of receipt to the state on whether its application meets all federal transparency requirements and is determined complete for purposes of initiating CMS' review and the federal 30-day public notice and comment process.

CMS is committed to supporting states that wish to implement innovative service delivery models for beneficiaries with SMI or SED including community-based services as mandated by section 12003 of the Cures Act. Questions regarding this guidance may be directed to Kirsten Beronio, Senior Behavioral Health Policy Advisor, Disabled and Elderly Health Programs Group, at Kirsten.Beronio@cms.hhs.gov. We look forward to continuing our work together on improving the health and wellness of Medicaid beneficiaries with SMI or SED.

Sincerely,

Mary C. Mayhew
Deputy Administrator and Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Academy Health

National Association of State Mental Health Program Directors

Appendix A

In the table below is a summary of some key services included in the models of care and activities highlighted in Part I of the letter above and summarized in the left column below, entitled “Model, Benefit, or Activity”. The middle column below, entitled “Potential Medicaid Authority”, lists examples of Medicaid authorities that states may be able to use to cover the services and activities summarized in the left column next to the corresponding number. In addition, the third column below, entitled “Potential Payment Strategy” lists payment strategies that could be used by states to support implementation of the model or activity summarized in the left column. The services that can be eligible for FFP would depend on the specific authority that states seek to use, and states should submit specific proposals to CMS.

Model, Benefit, or Activity	Potential Medicaid Authority	Potential Payment Strategy
<u>Coordinated Specialty Care Model and Similar Programs for High Risk Adolescents^{xcvii}</u> 1. Provider outreach and early engagement and clinical supervision/coordination of team members; 2. Mental health services including mental health assessment, psychotherapy, medication management, case management, family supports, ACT programs, and peer supports; 3. Care coordination among team members and with primary care; 4. Supported Employment/Education	1. Provider costs for outreach and team supervision are not directly coverable by Medicaid state plan authorities, but provider costs related to delivery of covered services may be incorporated into rates for covered services; 1945 Health Home state plan option; 2. 1905(a) state plan benefits including Rehabilitative Services, Case Management, Other Licensed Practitioner Services, Clinic Services; 3. 1945 Health Home state plan option; 4. 1915(i), 1915 (c), 1915(b)(3)	<ul style="list-style-type: none"> • Administrative match may be available for state referral network development activities that may be allocated to Medicaid; • FFS payments for covered Medicaid service under appropriate benefit category; • Enhanced match under the Health Home benefit for 8 quarters; • Payments through managed care entities^{xcviii}
<u>Improved data sharing between schools, hospitals, primary care, criminal justice, faith communities, and specialized mental health providers</u> <ul style="list-style-type: none"> • Technology for screening & assessment tools, analytics for prevention and treatment, web or application based tools for prevention and treatment. 	<ul style="list-style-type: none"> • MITA Architecture^{xcix} 	<ul style="list-style-type: none"> • Enhanced administrative match approved via an advanced planning document (APD) under MITA^c
<u>School-based behavioral health^{ci}</u>		

<ul style="list-style-type: none"> • Screening and counseling and referral to specialty care 	<ul style="list-style-type: none"> • 1905(a) state plan benefits such as EPSDT, Other Licensed Practitioner Services 	<ul style="list-style-type: none"> • Managed Care - Ensure providers in school settings are included in Medicaid managed care networks or set up appropriate coordination; • FFS payments for covered Medicaid service under appropriate benefit category; • Partnerships with FQHCs
<p><u>Collaborative Care Model</u></p> <ol style="list-style-type: none"> 1. Referral network development and team building; 2. Management of overall care by primary care physician; 3. Screening for mental health disorders and on-going monitoring of treatment adherence, effectiveness, side effects usually by care manager; 4. Care coordination (including with outside specialty care and social services), patient engagement and education, and brief psychotherapeutic interventions by care manager; 5. Psychiatric specialist consultations regarding patient progress including recommendations for treatment strategies and adjustments; 6. Telehealth and other technology support 	<ol style="list-style-type: none"> 1. Provider costs for outreach and team supervision are not directly coverable by Medicaid state plan authorities, but provider costs related to delivery of covered services may be incorporated into rates for covered services, 1945 Health Home state plan option; 2. 1905(a) state plan benefits such as Physicians' Services, Clinic Services; 3. 1905(a) state plan benefits such as Clinic Services, Other Licensed Practitioner Services; 4. 1905(a) state plan benefits such as Case Management Services, Other Licensed Practitioner Services, 1945 Health Home state plan option; 5. Provider costs, including consultation with specialists, may be able to be incorporated into rates for underlying covered services; 6. MITA Architecture^c 	<ul style="list-style-type: none"> • Administrative match may be available for state referral network development activities that may be allocated to Medicaid; • Payments through managed care entities;^{xcix} • FFS payments for covered Medicaid service under appropriate benefit category; • Enhanced match for Health Homes services for 8 quarters; • Enhanced administrative match approved via an APD under MITA^{ci}
<p><u>Child Psychiatry Access Model</u></p> <ol style="list-style-type: none"> 1. Referral network development and infrastructure and technology support; 2. Care coordination of behavioral health treatment; 3. Consultation; 4. Mental health services 	<ol style="list-style-type: none"> 1. Provider costs for outreach and team supervision are not directly coverable by Medicaid state plan authorities, but provider costs related to delivery of covered services may be incorporated into rates 	<ul style="list-style-type: none"> • Administrative match may be available for state referral network development activities that may be allocated to Medicaid;

	<p>for covered services, MITA Architecture;^c</p> <ol style="list-style-type: none"> 2. 1905(a) state plan benefits such as Case Management Services, 1945 Health Home state plan option; 3. Provider costs, including consultation with specialists, may be able to be incorporated into rates for underlying covered services; 4. 1905(a) state plan benefits such as Physicians' Services, Other Licensed Practitioner Services 	<ul style="list-style-type: none"> • Enhanced administrative match approved via an APD under MITA;^{ci} • Enhanced match for Health Home services for 8 quarters; • FFS payments for covered Medicaid service under appropriate benefit category; • Payments through managed care entities^{xcix}
<u>Telehealth infrastructure as a delivery vehicle for services</u>	<ul style="list-style-type: none"> • MITA Architecture^c 	<ul style="list-style-type: none"> • Enhanced administrative match via APD under MITA^{ci}
<u>Services provided via Telehealth</u>	<ul style="list-style-type: none"> • State Plan 	<ul style="list-style-type: none"> • Payments through managed care entities;^{xcix} • FFS payments for covered Medicaid service under appropriate benefit category
<u>Crisis Stabilization and Comprehensive Care Model (e.g., CCHBC^{cii})</u> <ul style="list-style-type: none"> • Crisis behavioral health services, screening, assessment, and diagnosis, mental health and SUD services, targeted case management, psychiatric rehabilitation services, peer supports and family supports 	<ul style="list-style-type: none"> • Provider costs for outreach and team supervision are not directly coverable by Medicaid state plan authorities; but provider costs related to delivery of covered services may be incorporated into rates for covered services; • 1905(a) state plan benefits such as Clinic Services, Diagnostic Services, Rehabilitative Services, Physicians' Services, Other Licensed Practitioner Services; 	<ul style="list-style-type: none"> • FFS payment for covered Medicaid services under appropriate benefit category; • Administrative match for state administrative activities that may be allocated to Medicaid;^{ciii} • Payments through managed care entities^{xcix}

	<ul style="list-style-type: none"> 1945 Health Home state plan option, primary care case management 	
<u>Registry of Available Behavioral Health Providers</u>	<ul style="list-style-type: none"> MITA Architecture^c 	<ul style="list-style-type: none"> Enhanced administrative match via APD under MITA;^{ci} Administrative match for state administrative activities that may be allocated to Medicaid.^{civ}
<u>Supported Employment and Supportive Housing</u> <ul style="list-style-type: none"> Assistance finding a job or home and supportive services to help maintain that job or home 	<ul style="list-style-type: none"> 1915 (i) 1915 (c) 1915(b)(3) 1115(a)(2) 	<ul style="list-style-type: none"> FFS payments for covered Medicaid service under appropriate benefit category; Payments through managed care entities^{xcix}

Additional Information on Medicaid Authorities

Many of the services that are essential to the implementation of services for adults with a SMI and children with a SED may be covered based on section 1905(a) of the Act. A number of Medicaid service categories that are particularly relevant to covering the innovative service delivery strategies and community-based services for adults with a SMI or children with a SED described above are discussed below.

Section 1905(a) – State Plan Benefits:

Section 1905(a)(13) - Rehabilitative Services

Rehabilitative services, as set forth in 42 C.F.R § 440.130(d), are “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.” Services such as individual and group therapy, crisis stabilization, peer support, behavioral interventions, and care coordination of other behavioral health services may be authorized under this benefit.

Section 1905(a)(6) - Other Licensed Practitioner Services

Other licensed practitioner services, as set forth in 42 C.F.R § 440.60(a), are “medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” For example, this benefit could be used to cover counseling services of a licensed clinical social worker.

Section 1905(a)(19) - Case Management Services

Case management services include services that assist eligible individuals to gain access to needed medical, social, educational, and other services. 42 C.F.R § 440.169(a). Case management services include all of the following components: comprehensive assessment and periodic assessment of an eligible individual’s needs; development and periodic revision of a specific care plan; referrals to services and related activities to help the eligible individual obtain needed services; and monitoring and follow-up activities. 42 C.F.R. § 440.169(d). States may target case management services to a specific group of beneficiaries, such as adults with SMI or children with SED, or to individuals who reside in specified areas of the state (or both). 42 C.F.R § 440.169(b).

Section 1905(a)(9) - Clinic Services

Clinic services refer to “preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.” 42 C.F.R § 440.90. Clinic services include “services furnished at the clinic by or under the direction of a physician or dentist” and “services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.” 42 C.F.R. § 440.90(a)-(b).

Section 1905(a)(5) - Physicians’ Services

Physicians’ services refer to services “whether furnished in the office, the beneficiary’s home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician (1) within the scope of practice of medicine or osteopathy as defined by State law; and (2) by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.” 42 C.F.R. § 440.50(a).

Section 1905(r) - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit

Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit set forth in section 1905(r) of the Act, states must make available any service listed in section 1905(a) of the Act that is needed to correct or ameliorate defects and physical and mental conditions discovered by EPSDT screening services, whether or not the service is covered under the state plan.

Section 1905(a)(1) and (2) - Hospital Services

Hospital Services, defined at 1905(a)(1) and 1905(a)(2) and implemented at 42 C.F.R. § 440.10 and 42 C.F.R. § 440.20, includes both inpatient hospital and outpatient hospital services. For inpatient hospital services, the term means services (1) that are ordinarily furnished in a hospital for the care and treatment of inpatients, (2) are furnished under the direction of a physician or dentist; and (3) are furnished in an institution that is maintained primarily for the care and treatment of patients with disorders other than mental diseases and is licensed or approved as a hospital by an officially designated authority for state standard setting. There must be in effect a utilization review plan, applicable to all Medicaid patients that meets the requirements of 42 C.F.R. § 482.30, absent a waiver from the Secretary. For outpatient hospital services, the term means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that (1) are furnished to outpatients and (2) are furnished by or under the direction of a physician or dentist. The criteria listed for inpatient hospital services regarding standard setting mean that meeting the requirements for Medicare participation also apply. Outpatient hospital services may be limited by a Medicaid agency by excluding from the definition those items and services that are not generally furnished by most hospitals in the state.

Section 1905(a)(16) - Inpatient Psychiatric Services for Individuals under Age 21

Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual who is under age 65 and who is residing in an Institution for Mental Diseases (IMD) unless the payment is for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(a)(16) of the Act, as defined in section 1905(h) of the Act. Implementing regulations at 42 C.F.R. § 440.160 and 441 Subpart D define these inpatient psychiatric hospital services as services furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements. Section 12005 of the 21st Century Cures Act amends section 1905(a)(16) of the Act to require Medicaid reimbursement for EPSDT services to individuals under age 21 receiving inpatient psychiatric services pursuant to section 1905(a)(16) of the Act. The effective date of this amendment is January 1, 2019.

Section 1905(a)(14) - Inpatient Hospital Services and Nursing Facility Services for Individuals Age 65 or Older in Institutions for Mental Diseases

Services to individuals age 65 or older in these types of facilities may be reimbursed when the individuals meet the requirements for admission to these facilities and the facilities meet applicable federal requirements as set forth in 42 C.F.R § 440.140.

School-based Services

While there is no state plan benefit entitled “school-based services,” CMS allows reimbursement of Medicaid-covered services to Medicaid-eligible children when delivered by Medicaid providers, including in a school setting. Many states have already developed reimbursement mechanisms where Medicaid pays for medical services, including mental health treatment services in school settings. States can consider developing school-based health centers to enhance their capacity to deliver mental health services, require managed care plans responsible for delivering mental health

services to contract with school providers, or develop other arrangements between health facilities and schools.

Sections 1903(m) and 1932 – Managed Care

Consistent with sections 1903(m) and 1932 of the Act, states may deliver Medicaid-covered services through managed care plans by way of an amendment to the Medicaid state plan. States must continue to assure adequate access to and the availability of the full set of covered state plan services, including EPSDT and generally must provide beneficiaries with a choice of at least two managed care plans. Managed care contracts are subject to CMS review and approval; managed care capitation rates must be projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract and be reviewed and approved by CMS as actuarially sound.

Section 1915(b) Authority – Freedom of Choice

Under section 1915(b) of the Act (1915(b) waiver), CMS may grant a waiver to permit states to restrict beneficiary free choice of provider, to create defined provider networks, which could be part of a managed care service delivery system. When using this authority, states may use the savings accrued through the use of a managed care delivery system to provide additional services. Unless an expenditure authority is provided as part of a section 1115 demonstration, managed care service delivery systems that rely on contracts with managed care plans must also comply with section 1903(m). Under section 1915(a) of the Social Security Act, states can implement a voluntary managed care program by executing a contract with organizations that the state has procured using a competitive procurement process.

Section 1915(c) - Home and Community-based Services Waiver Authority

States may request a waiver to provide beneficiaries who would otherwise need to receive care in an institution, certain long-term care services and supports in community settings. States can use this authority to develop comprehensive benefit designs that include additional supportive services. States may not restrict freedom of choice under this waiver but may request waivers of comparability and state-wideness, enabling them to limit the services to subgroups of Medicaid beneficiaries and to an area within the state. States may also limit participation to a specific number of beneficiaries.

Section 1915(i) – Home and Community-based Services State Plan Amendment

Section 1915(i) provides an opportunity for states to amend their state Medicaid plans to offer home and community-based services (HCBS) including case management, respite, and other HCBS for elderly and disabled individuals who meet needs-based eligibility criteria set by the state. Section 1915(i) State plan HCBS is a benefit that is very similar to Section 1915(c) HCBS waivers except that unlike 1915(c), authority under 1915(i) delinks the provision of HCBS from the requirement that participants must meet an institutional level of care. In order to target the initiative and limit costs,

states may identify a specific population and can also establish additional needs-based criteria by service. States may target the 1915(i) benefit to particular population groups such as adults or adolescents with mental health disorders, but cannot waive the requirement to provide the HCBS statewide, nor limit the number of participants in the state who may receive the HCBS if they meet the population definition.

Section 1945 - Health Home Optional Benefit

Section 1945 of the Act provides an optional Medicaid state plan benefit available to states to design Health Homes to coordinate care for individuals with Medicaid who have chronic conditions, including a mental health condition or SUD. Health Homes must provide comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, beneficiary and family/caregiver support, and referral to community and social support services.

Appendix B

Potential Standard Measures and Measure Concepts

Participating states will commit to reporting on a standard set of measures and data points to demonstrate progress on the goals of the demonstration. Examples of measures and measure concepts that could be included in a standard set measures include --

- Evidence of availability of community-based services and alternatives to inpatient and residential services in each geographic region of the state (e.g., maps of provider availability and provider agreements)
- ED use among Medicaid beneficiaries with SMI or SED and their lengths of stay in the ED;
- Readmissions to inpatient psychiatric or crisis residential settings;
- Average lengths of stay in participating psychiatric hospitals and residential settings;
- Medication reconciliation upon admission (Medicare Inpatient Psychiatric Facility (IPF) Reporting Requirement);
- SUD screening of beneficiaries admitted to psychiatric hospitals or residential treatment settings (Medicare IPF Reporting Requirement);
- Timely transmission of transition records (Medicare IPF Reporting Requirement);
- Medication continuation following discharge (Medicare IPF Reporting Requirement);
- Follow up after hospitalization for mental illness (NQF# 0576, Adult and Child Core Set);
- Follow up after ED visit for mental illness or alcohol and other drug abuse or dependence (NQF# 2605, Adult Core Set);
- Use of first-line psychosocial care for children and adolescents on antipsychotics (NQF#2801, Child Core Set);
- Patient referral into treatment by specified care setting (school, community, criminal justice, faith communities);
- Diabetes care for patients with SMI: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NQF # 2607, Adult Core Set)^{cv};
- Screening for Depression and Follow-Up Plan (NQF #0418/0418e, Adult Core Set);

- Rates of involuntary admissions to treatment settings;
- Access to preventive/ambulatory health services for Medicaid beneficiaries with SMI or SED; and
- Suicide or overdose death within 15 days of discharge from an inpatient facility or residential setting for treatment for an SMI or SED.

ENDNOTES

- ⁱ See Pub. L. 114-255. Available at <https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf>.
- ⁱⁱ See definition developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) as mandated by the Congress in the ADAMHA Reorganization Act (Public Law 102-321) at 58 Fed. Reg. 96, pp. 29422-29425 (May 20, 1993).
- ⁱⁱⁱ *Ibid.*
- ^{iv} SAMHSA, NSDUH Data Review, “Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health” (Sept. 2017).
- ^v See definition developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) as mandated by the Congress in the ADAMHA Reorganization Act (Public Law 102-321) at 58 Fed. Reg. 96, 29422-29425 (May 20, 1993) (The definition included in the regulation references DSM-III, however the latest edition is DSM-V.).
- ^{vi} *Ibid.*
- ^{vii} Kessler RC, Chiu WT, Demier, O, et al. Prevalence, severity and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry* 2005; 62: 617–627.
- ^{viii} National Research Council and Institute of Medicine, “Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities” (2009).
- ^{ix} Perou R, Bitsko RH, Blumberg SJ. Mental health surveillance among children--United States, 2005-2011. *MMWR Suppl.* May 2013; 62(2):1-35.
- ^x Simon AE, Pastor PN, Reuben CA, et al. Use of mental health services by children ages six to 11 with emotional or behavioral difficulties. *Psych Services* 2015; 66(9): 930–937.
- ^{xi} Substance Abuse and Mental Health Administration, “Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health” (2017).
- ^{xii} Stagman S and Cooper JL, “Children’s Mental Health: What Every Policymaker Should Know”, National Center for Children in Poverty, April 2010: http://www.nccp.org/publications/pdf/text_929.pdf; Wagner M and Newman L. Longitudinal Transition Outcomes of Youth with Emotional Disturbances. *Psych Rehab* 2012; 35(3): 199-208.
- ^{xiii} Wang PS, Berglund PA, Olfson M, et al. Delays in initial treatment contact after first onset of a mental disorder. *Health Serv Res* 2004; 39(2):393-415.
- ^{xiv} Frank RG and Epstein AM. Factors Associated with High Levels of Spending for Younger Dually Eligible Beneficiaries with Mental Disorders. *Health Affairs.* 2014; 33(6): 1006-1013..
- ^{xv} Steadman HJ, Osher FC, Robbins PC, et al., Prevalence of Serious Mental Illness among Jail Inmates, *Psych Services*, 60 (6): 761-765 (2009); Point in time estimate based on applications to U.S. Department of Housing and Urban Development for 2016 Continuum of Care Homeless Assistance Programs, Retrieved from https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2016.pdf.
- ^{xvi} Interdepartmental Serious Mental Illness Coordinating Committee, Report to Congress, “The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers” (Dec 2017): <https://store.samhsa.gov/product/PEP17-ISMICC-RTC> (citing Uniform Reporting System which can be found at <https://www.dasis.samhsa.gov/dasis2/urs.htm>).
- ^{xvii} Druss GB, Zhao L, Von Esenwein S, et al. Understanding Excess Mortality in Persons with Mental Illness. *Medical Care* 2011; 49(6).
- ^{xviii} Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, “Surveillance for Violent Deaths – National Violent Death Reporting System, 17 States, 2013” 2016; 65 (No. SS-10): 1-42; Brown NM, Green JC, Desai MM, et al. Need and Unmet Need for Care Coordination Among Children With Mental Health Conditions, *Pediatrics.* March 2014; 113(3): e530-537.
- ^{xix} Centers for Disease Control and Prevention, Vital Signs Report, “Suicide Rising Across the US” (June 2018): <https://www.cdc.gov/vitalsigns/pdf/vs-0618-suicide-H.pdf>.
- ^{xx} CMCS Informational Bulletin, “Prevention and Early Identification of Mental Health and Substance Use Conditions” (March 2013): <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf>.
- ^{xxi} Schoenbaum M, Sutherland JM, Chappel A, et al. Twelve-Month Health Care Use and Mortality in Commercially Insured Young People with Incident Psychosis in the United States. *Schizophr Bull.* Oct 2017; 43(6): 1262-1272; Simon GE, Stewart C, Yarborough BJ, et al. Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults. *JAMA Psych.* 2018; 75(3):254-260.

- ^{xxii} Simon GE, Stewart C, Yarborough BJ, et al. Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults. *JAMA Psych*. 2018; 75(3):254-260.
- ^{xxiii} Dixon LB, Goldman HH, Bennett ME, et al. Implementing Coordinated Specialty Care for Early Psychosis: the RAISE Connection Program. *Psych Services*. July 2017; 66 (7): 691-698.
- ^{xxiv} CMCS Informational Bulletin, “Coverage of Early Intervention Services for First Episode Psychosis” (Oct 2015): <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf>
- ^{xxv} For example the Robert Wood Johnson Foundation initiative, The Early Detection and Intervention for Prevention of Psychosis Program, with six sites nationwide resulted in some positive outcomes, for additional information see reports at the following links: <http://dev.nasmhpd.seiservices.com/content/about-edipp> and <https://www.nasmhpd.org/sites/default/files/RWJF%20Findings%20Report%202014.pdf>.
- ^{xxvi} See webpage on the Medicaid Information Technology architecture (MITA) 3.0: <https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html> ; Under MITA 3.0, implementation of new technologies may qualify for enhanced match of 90 percent federal match for establishing the technology and 75 percent match for operational support. CMS State Medicaid Director Letter # 18-006, “Leveraging Medicaid Technology to Address the Opioid Crisis” (June 2018): <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>.
- ^{xxvii} See CMS Final Rule: Mechanized Claims Processing and Information Retrieval Systems (90/10), 80 FR 75817.
- ^{xxviii} See <https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html>, *Information Related to Mental and Behavioral Health, including Opioid Overdose* (fact sheets and materials written for professionals).
- ^{xxix} See <https://www.hhs.gov/hipaa/for-individuals/mental-health/index.html>, *Information Related to Mental and Behavioral Health, including Opioid Overdose* (consumer facing materials and fact sheets)
- ^{xxx} Rones M, Hoagwood K, School-based mental health services: a research review. *Clin Child Fam Psychol Rev*. Dec. 2000; 3(4): 223-241.
- ^{xxxi} Weist MD, Myers CP, Hastings E, et al. Psychological functioning of youth receiving mental health services in the schools versus community mental health centers. *Community Ment Health J*. Feb 1999; 35(1): 69-81.
- ^{xxxii} Nabors LA, Reynolds MW. Program evaluation activities: Outcomes related to treatment for adolescents receiving school-based mental health services. *Children’s Services: Social Policy, Research, and Practice*. 2000; 3(3):175-189.
- ^{xxxiii} Department of Health and Human Services and Department of Education, “Healthy Students, Promising Futures: State and Local Action Steps and Practices to Improve School-Based Health” (January 2016): <https://www2.ed.gov/admins/lead/safety/healthy-students/toolkit.pdf>.
- ^{xxxiv} Price OA. School-centered approaches to improve community health: lessons from school-based health centers. *Economic Studies at Brookings* July 2016; No. 5: <https://www.brookings.edu/wp-content/uploads/2016/07/Price-Layout2-1.pdf>.
- ^{xxxv} Ahmedani BK, Stewart C, Simon GE, et al. Racial/ethnic differences in healthcare visits made prior to suicide attempt across the United States. *Medical Care*. May 2015; 53(5): 430-435.
- ^{xxxvi} For more information about the PHQ-9 and how to score, refer to http://www.cqaimh.org/pdf/tool_phq9.pdf
- ^{xxxvii} AIMS Center (Advancing Integrated Mental Health Solutions). Collaborative Care Evidence Base: <https://aims.uw.edu/collaborative-care/evidence-base> ; Archer J, Bower P, Gilbody S, et al. Collaborative Care for People with Depression and Anxiety. *Cochrane Review*. Oct. 2012: http://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety; Community Preventive Services Task Force, “Improving Mental Health and Addressing Mental Illness: Collaborative Care for the Management of Depressive Disorders” (June 2010): <https://www.thecommunityguide.org/sites/default/files/assets/Mental-Health-Collaborative-Care.pdf>.
- ^{xxxviii} A list of programs by state is on the network website: http://web.jhu.edu/pedmentalhealth/nncpap_members.html.
- ^{xxxix} Straus JH, Sarvet B. Behavioral Health Care for Children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*. 2014; 33 (12): 2153-2161.
- ^{xl} See Medicare fact sheet on Collaborative Care Model including CPT codes that can be used: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>.
- ^{xli} Raney L, Bergman D, Torous J, et al. Digitally driven integrated primary care and behavioral health: how technology can expand access to effective treatment. *Curr Psychiatry Rep*. 2017; 19(11): 1-8.
- ^{xlii} Under MITA 3.0, implementation of new technologies may qualify for enhanced match of 90 percent federal match for establishing the technology and 75 percent match for operational support. See CMS State Medicaid Director Letter # 18-006, “Leveraging Medicaid Technology to Address the Opioid Crisis” (June 2018): <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>.

- ^{xliii} CMS State Medicaid Director Letter # 18-006, “Leveraging Medicaid Technology to Address the Opioid Crisis” (June 2018): <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf> .
- ^{xliv} CMS State Medicaid Director Letter #16-003, “Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers”, (Feb 2016): <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf> .
- ^{xliv} See CMCS Informational Bulletin, “Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions” (May 2013): <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>.
- ^{xlv} National Association of State Mental Health Program Directors, “Issue Brief: Crisis Services’ Role in Reducing Avoidable Hospitalization” (Aug 2017).
- ^{xlvii} National Association of State Mental Health Program Directors, “Issue Brief: Care Transition Interventions to Reduce Psychiatric Re-hospitalizations” (Sept 2015).
- ^{xlviii} Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) on hospital readmissions involving psychiatric disorders, “AHRQ/HCUP Statistical Brief #189: Hospital Readmissions Involving Psychiatric Disorders, 2012”,(May 2015): (<http://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf>).
- ^{xliv} Additional information regarding the LOCUS tool is available at <https://sites.google.com/view/aacp123/resources/locus> and for the CASII tool at http://www.aacap.org/aacap/Member_Resources/Practice_Information/CASII.aspx .
- ⁱ See State Health Official Letter issued jointly by CMS, SAMHSA, and the Administration on Children and Families regarding Trauma-informed Care (July 2013): <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf> .
- ⁱⁱ National Association of State Mental Health Program Directors, “Issue Brief: Crisis Services’ Role in Reducing Avoidable Hospitalization” (Aug 2017).
- ⁱⁱⁱ National Action Alliance for Suicide Prevention, Crisis Services Task Force, “Crisis Now: Transforming Services Is Within Our Reach” (2016): <https://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/CrisisNow.pdf> .
- ^{liii} Clause (B) following section 1905(a)(29) of the Act.
- ^{liv} Section 1905(i) of the Act.
- ^{lv} See Medicaid managed care rules at 42 CFR 438.6(e).
- ^{lvi} See Medicaid webpage on tobacco quitlines: <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/tobacco/quitlines/index.html> .
- ^{lvii} *Ibid*.
- ^{lviii} Guidance for Administrative Claiming through the No Wrong Door System is available on the Medicaid website at <https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html>.
- ^{lix} Authorized by Section 223 of the Protecting Access to Medicare Act (Pub.L. 113-93).
- ^{lx} For additional information on the CCBHC Criteria see https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf
- ^{lxi} See CMS webpage on CCBHCs at <https://www.medicaid.gov/medicaid/financing-and-reimbursement/223-demonstration/index.html> and Prospective Payment System Guidance at <https://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf#page=94> .
- ^{lxii} See CMS webpage on Medicaid Information Technology (MITA) 3.0: <https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html>; Under MITA 3.0, implementation of new technologies may qualify for enhanced match of 90 percent federal match for establishing the technology and 75 percent match for operational support. CMS State Medicaid Director Letter # 18-006, “Leveraging Medicaid Technology to Address the Opioid Crisis” (June 2018): <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>; See also CMS Guidance “Questions and Answers: Administrative Claiming Related to Training and Registry Costs” (July 2015): <https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/qa-training-registry-costs-071015.pdf> (regarding Medicaid support for development of registries of qualified providers of long term services and supports with costs of its establishment and maintenance allocated between Medicaid and non-Medicaid funding streams).
- ^{lxiii} Bond GR, Drake RE. The critical ingredients of assertive community treatment. *World Psychiatry*. June 2015;14(2): 240-242.
- ^{lxiv} CMS State Medicaid Director Letter on Assertive Community Treatment (June 1999): <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD060799b.pdf> .

^{lxv} Final Rule entitled “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers” (issued 01/16/2014): <https://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf> .

^{lxvi} HHS Guidance for Implementing Standards for Person Centered Planning and Self-Direction issued in June 2014: <https://www.acl.gov/sites/default/files/programs/2017-03/2402-a-Guidance.pdf> .

^{lxvii} Croft B, Isvan N, Parish S, et al. Housing and Employment Outcomes for Mental Health Self-Direction Participants. *Psych Services*. July 2018; 69(7):819-825.

^{lxviii} CMS State Medicaid Director Letter on peer supports (Aug 2007): <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf>.

^{lxix} CMS Guidance, “Clarifying Guidance on Peer Support Services Policy” (May 2013): <https://www.medicaid.gov/medicaid/benefits/downloads/clarifying-guidance-support-policy.pdf> .

^{lxx} Chung DT, Ryan CJ, Hadzi-Pavlovic D, et al. Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis. *JAMA Psychiatry*. 2017; 74(7): 694-702.

^{lxxi} CMS, Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program, “Quality of Care for Adults in Medicaid: Findings from the 2016 Adult Core Set: Chart Pack” (Dec. 2017) : <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2017-adult-chart-pack.pdf>.

^{lxxii} CMS, Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program, “Quality of Care for Children in Medicaid and CHIP: Findings from the 2016 Child Core Set: Chart Pack” (Dec. 2017) <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2017-child-chart-pack.pdf> .

^{lxxiii} See the CMS webpage on the Medicare Hospital Readmissions Reduction Program: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html> .

^{lxxiv} CMS webpage, “2018 Core Set of Adult Health Care Quality Measures (Adult Care Set)” : <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-core-set.pdf>

^{lxxv} CMS webpage, “2018 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set)” : <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf>.

^{lxxvi} Denchev P, Pearson JL, Allen MH, et al. Modeling the cost-effectiveness of interventions to reduce suicide risk among hospital emergency department patients. *Psych Services*. Jan 2018; 69 (1): 23-31.

^{lxxvii} Denchev P, Pearson JL, Allen MH, et al. Modeling the cost-effectiveness of interventions to reduce suicide risk among hospital emergency department patients. *Psych Services*. Jan 2018; 69 (1): 23-31 (assuming for the telephone and CBT interventions a societal willingness to pay to reduce mortality of \$50,000 per life-year).

^{lxxviii} National Association of State Mental Health Program Directors, “Issue Brief: Care Transition Interventions to Reduce Psychiatric Re-hospitalizations” (Sept 2015).

^{lxxix} Lucksted A, Essock SM, Stevenson J, et al. Client views of engagement in the RAISE Connection Program for early psychosis recovery. *Psych Services* July 2015; 66(7): 699-704.

^{lxxx} National Association of State Mental Health Program Directors, “Issue Brief: The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity” (August 2017).

^{lxxxi} Interdepartmental Serious Mental Illness Coordinating Committee, Report to Congress, “The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers” (Dec 2017): <https://store.samhsa.gov/product/PEP17-ISMICC-RTC> (citing Uniform Reporting System which can be found at <https://www.dasis.samhsa.gov/dasis2/urs.htm>).

^{lxxxii} The optional eligibility groups that serve people who have disabilities and are earning income are described at sections 1902(a)(10)(A)(ii)(XIII), (XV), and (XVI) of the Act. These eligibility groups generally have higher income and resource standards than other mandatory and optional eligibility groups that serve people who have disabilities, and states have the flexibility to increase these standards beyond the statutory minimums. Nearly all states cover at least one of these groups, and most have exercised their flexibility relating to financial eligibility.

^{lxxxiii} The Medicaid Buy-in program is authorized at section 1902(a)(10)(A)(ii)(XV) of the Act. It establishes an optional state Medicaid benefit group for workers with disabilities who have earnings in excess of traditional Medicaid rules. Individuals with disabilities who would be ineligible for Medicaid because of earnings can work and access the services and supports they need. For more information go to the CMS webpage at <https://www.medicaid.gov/medicaid/tss/employment/ticket-to-work/index.html> .

^{lxxxiv} CMS State Medicaid Director Letter #17-003, “Strategies to Address the Opioid Epidemic” (Nov 2017): <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf> .

^{lxxxv} Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief No. 293 “Mortality in the United States, 2016” (Dec. 2017): <https://www.cdc.gov/nchs/data/databriefs/db293.pdf> .

^{lxxxvi} Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, “Surveillance for Violent Deaths – National Violent Death Reporting System, 17 States, 2013” 2016; 65 (No. SS-10): 1-42; Cho SE, Na KS, Cho SJ, et al. Geographical and temporal variations in the prevalence of mental disorders in suicide: systematic review and meta-analysis. *J Affect Disord* 2016; 190:704-713.

^{lxxxvii} See sec. 1905(a) of the Act (does not include room and board as a separate, coverable benefit); 42 CFR § 440.2 (room and board costs are included in the definition of inpatient); 42 CFR § 440.140 (regarding services for individuals age 65 and older in an IMD).

^{lxxxviii} See sec. 1905(a)(16) of the Act authorizing the Inpatient Psychiatric Services for Individuals under Age 21 benefit and CMS implementing regulations defining the types of settings that can provide this benefit at 42 C.F.R. § 440.160 and 441 Subpart D.

^{lxxxix} CMS State Health Official Letter #16-007, “To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities” see Question 8: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>.

^{xc} CMS recently issued a State Medicaid Director Letter on “Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects (August 2018): <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD18009.pdf>

^{xci} For guidance on comprehensive crisis stabilization systems and an assessment template, see the National Action Alliance for Suicide Prevention: Crisis Services Task Force, “Crisis now: Transforming services is within our reach (2016): <http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/CrisisNow.pdf> ; an example of a crisis stabilization system assessment tool is at <https://www.slideshare.net/davidwcovington/crisis-now-assessment-framework>

^{xcii} CMS has also previously issued a State Medicaid Director Letter on covering peer support services in Medicaid, <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf> , as well as additional clarification that peer supports in some circumstances can include peer supports for the parents/legal guardians of Medicaid eligible children, <https://www.medicaid.gov/medicaid/benefits/downloads/clarifying-guidance-support-policy.pdf> .

^{xciii} Bond GR, Drake RE. The critical ingredients of assertive community treatment. *World Psychiatry*. June 2015; 14(2): 240-242.

^{xciv} Additional information regarding the LOCUS tool is available at <https://sites.google.com/view/aacp123/resources/locus> and for the CASII tool at http://www.aacap.org/aacap/Member_Resources/Practice_Information/CASII.aspx .

^{xcv} For example, the Robert Wood Johnson Foundation’s initiative on the Early Detection and Intervention for the Prevention of Psychosis Program with six sites nationwide resulted in some positive outcomes: <http://dev.nasmhpd.seiservices.com/content/about-edippp> ; and <https://www.nasmhpd.org/sites/default/files/RWJF%20Findings%20Report%202014.pdf>.

^{xcvi} See CMCS Informational Bulletin, “Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions” (May 2013): <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf> .

^{xcvii} See CMCS Informational Bulletin (CIB) on “Coverage of Early Intervention Services for First Episode Psychosis” (10/16/2015): <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf>

^{xcviii} Please note that if the state is directing the expenditures a managed care plan is making to its providers, it must comply with the requirements in 42 CFR 438.6(c); this includes obtaining prior approval for such directed payments. For more information, please see the following CIB published on November 2, 2017: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf>. Also published as part of this CIB are --

- an appendix that provides some examples of approvable directed payments: <https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/appendix-a.pdf>; and
- the preprint that states would need to submit to obtain prior approval of such directed payments: <https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/438-preprint.pdf>.

^{xcix} See CMS guidance on MITA 3.0 at <https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html>.

^c See SMDL # 18-006, “Leveraging Medicaid Technology to Address the Opioid Crisis” June 11, 2018.

^{ci} See Department of Health and Human Services and Education toolkit on improving availability of school-based services: <https://www2.ed.gov/admins/lead/safety/healthy-students/toolkit.pdf> .

^{cii} See CMS information on CCBHCs: <https://www.medicaid.gov/medicaid/financing-and-reimbursement/223-demonstration/index.html> and Prospective Payment System Guidance: <https://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf#page=94>

^{ciii} See CMS guidance on tobacco quitlines: <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/tobacco/quitlines/index.html>

^{civ} See CMS guidance on Administrative Claiming Related to Training and Registry Costs: <https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/qa-training-registry-costs-071015.pdf>.

^{cv} Additional information on endorsed measures is available by using the National Quality Forum's QPS tool: http://www.qualityforum.org/Measures_Reports_Tools.aspx.