



Medicaid Managed Care Mental Health Services **AND** Pharmacy Benefits

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INTRODUCTION

Access to high-quality mental health care and treatment is currently a serious concern for much of the US population. In 2013, more than 43 million adults in the United States—roughly 1 in every 5—were estimated to have experienced some form of mental illness.^a Roughly 10 million (~4%) experienced serious mental illness^b or had thoughts of suicide, and over 1 million (0.6%) actually attempted suicide.¹

Studies have shown that low-income households are particularly likely to feel the impact of mental illness.² As the primary healthcare safety net for low-income individuals, Medicaid is a key resource for accessing mental health treatment in the United States. Access to Medicaid has historically been limited to certain narrow categories of individuals, though, leaving many others uninsured and cut off from crucial services.

By signing the Patient Protection and “Affordable Care Act” (ACA) into law on March 23, 2010, the United States took an important step towards closing this gap in Medicaid access. Effective January 1, 2014, the ACA was set to extend Medicaid coverage to reach nearly all adults^{c3} under the age of 65 with incomes at or below 133% of the federal poverty level (FPL)^d, regardless of disability or family makeup. However, a June 2012 Supreme Court ruling effectively rendered this provision optional, leaving the states to decide whether or not to expand coverage.⁴

Expansion Updates: For a list of states that have chosen to expand Medicaid coverage under the ACA, visit The Kaiser Family Foundation’s website on the Status of State Action on the Medicaid Expansion Decision at: <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

As of the date of this publication, 28 states and the District of Columbia have chosen to move forward with Medicaid expansion.⁵ Others, though, continue to maintain their prior, more restrictive limits. This toolkit is intended to help advocates navigate the current complex Medicaid landscape and understand how recent reforms are impacting access to Medicaid mental health benefits.^e

^a In this survey, “any mental illness,” was defined as “an individual having any mental, behavioral, or emotional disorder in the past year that met DSM-IV criteria [excluding developmental and substance use disorders].”¹

^b In this survey, serious mental illness was defined as having “any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities.”¹

^c Medicaid enrollment will remain limited to United States citizens and certain lawfully present immigrants. Undocumented immigrants are not eligible for Medicaid.³

^d While the ACA Medicaid expansion limit is 133% FPL, a 5% “income disregard” brings the effective income level to 138% FPL.³

^e This report focuses upon the provision of mental health care and treatment to adult beneficiaries of Medicaid. The application of the relevant laws and regulations may vary when considering the care and treatment of children.

What Is Medicaid?

The Medicaid program was established in 1965 under Title XIX of the Social Security Act. It was passed to help address the inadequacy of medical care for poor people under the public welfare system. Medicaid is an “entitlement system,” meaning that all individuals who meet the Medicaid eligibility criteria can obtain benefits without being subject to enrollment caps or waiting lists.³ The program therefore acts as a safety net, providing healthcare coverage to all eligible low-income citizens.

Unlike *Medicare*, which is operated solely by the federal government, *Medicaid* is a federal/state partnership that is administered separately by each state. The federal agency responsible for regulating Medicaid is the Centers for Medicare and Medicaid Services (CMS). At the state level, each state has a single agency designated as the administrator of the state’s Medicaid program.

Who Pays for Medicaid?

As with Medicaid administration, Medicaid funding is handled jointly between the state and federal government. The federal government contributes a matching percentage of state Medicaid outlays, based on the state’s per capita income. This contribution—called the Federal Medical Assistance Percentage (FMAP)—covers between 50% and 83%^{6,7} of enrollees’ healthcare costs, depending on the state.^{6,8,9}

The federal government is also currently responsible for fully funding the healthcare costs for individuals who have become newly eligible for Medicaid coverage based upon ACA Medicaid expansion (ie, the expansion population). After 2016, the federal government’s responsibility for this spending will decline, ultimately falling to 90% by 2020.⁹

Overall, Medicaid financed healthcare and related services for more than 66 million people at last count.¹⁰ As of Fiscal Year (FY) 2012, federal and state Medicaid spending totaled over \$421 billion, 15% of the nation’s total health expenditure.¹¹

Since FY 2012, Medicaid spending has continued to expand, particularly in the wake of ACA implementation. In FY 2014 total Medicaid spending (federal and state) grew by an average of 10.2% and is expected to grow by 14.3% in FY 2015. By comparison, state Medicaid spending has seen more modest growth—6.4% in FY 2014 and a projected 5.2% in FY 2015—reflecting the federal government’s relatively high coverage of expansion population costs.⁹

Medicaid’s Role in Financing Mental Health Services

Medicaid ranks as the single largest payer for mental health services in the United States¹². In 2005, a total of \$113 billion was spent on mental health in the United States. Medicaid provided 28% of this funding. In contrast, Medicare and private insurers provided 8% and 27% of this funding, respectively.¹³ In expansion states, Medicaid may ultimately take on an even greater share of this spending as individuals who previously depended upon state-funded programs (eg, mental health programs, programs for the uninsured, etc.) become newly eligible for Medicaid coverage.⁹

Health Among Medicaid Beneficiaries Living with Mental Illness

Roughly 35% of low-income non-elderly recipients of Medicaid are coping with mental illness. Medicaid coverage is particularly important for these individuals because of the often complex and serious nature of their healthcare needs. Compared with other non-elderly adult Medicaid beneficiaries, those living with mental illness are almost twice as likely to also have a chronic physical condition (61% versus 33%) or report their health status as fair or poor (56% versus 26%).¹⁴

In 2009, the annual per capita health expenditure for non-elderly adult Medicaid beneficiaries with mental illness was also more than twice that for beneficiaries without mental illness (\$9,727 versus \$3,848). Individuals with mental illness also engaged in twice as many provider visits (10.9 versus 4.5), filled three times as many prescriptions per month (3.3 versus 0.9), and were more likely to visit the emergency department over the course of the year (33% versus 23%).¹⁴

Mental Health and Medicaid Eligibility

While Medicaid is the largest funder of medical and health-related services for the nation’s poorest residents, until recently, simply being poor did not qualify an individual for Medicaid health coverage in most states. Instead, beneficiaries also needed to belong to a particular category designated as eligible for Medicaid.

Historically, Medicaid beneficiaries fell into a few main categories: children from low-income families who generally receive cash-assistance benefits, certain parents of children receiving these cash-assistance benefits, pregnant women with income at or below 133% of FPL, low-income elderly individuals who require long-term care, and blind and disabled individuals. Some states also extended coverage to additional patient populations who did not fit into these statutory categories through a section 1115 waiver, a process that requires special application to the secretary of the US Department of Health and Human Services (HHS).

Under this system, low-income individuals who required Medicaid mental health services needed to meet the criteria of one or more of these categories.^{9,13} However, since January 1, 2014, almost all adults living in the Medicaid expansion states can now also qualify for Medicaid if their income is at or below 133% of FPL.

What Eligibility Means

HOW SERVICES ARE PROVIDED

Medicaid has historically provided care through a fee-for-service (FFS) model, in which Medicaid pays providers predetermined amounts for each individual service they provide. Over time, though, many states have become increasingly reliant on managed care models.

Managed care is a form of healthcare that uses tools such as capitated payments, case management, and gatekeepers to attempt to control costs while maintaining quality of care. CMS generally uses three classifications of managed care: managed care organizations (MCOs), primary care case management (PCCM) plans, and limited benefit plans.¹⁵ These models of managed care, as well as how states are using them to provide mental health benefits, are discussed in more detail in **Section 1: Trends in Mental Health Care and Treatment in Traditional Medicaid**.

What Eligibility Means

TRADITIONAL VERSUS ACA MEDICAID PLANS

Although implementation of the ACA has done little to change Medicaid service models, it has had a considerable impact on the benefits included in certain Medicaid plans. Individuals who qualify for Medicaid based upon pre-ACA eligibility standards will continue to receive their state’s traditional Medicaid benefits package, made up of a combination of federally mandated and optional benefits. However, individuals who become newly eligible for benefits based upon Medicaid expansion will typically receive “Alternative Benefit Plans” (ABPs).³

ABPs differ from traditional Medicaid plans in several ways. Most notably, ABPs are based upon state-chosen benchmark plans and cover the same ten “Essential Health Benefits” (EHBs) that form the basis of private plans offered on the healthcare exchanges.³ ABPs are also subject to mental health and substance use disorder (SUD) parity requirements, and therefore must offer mental health and SUD benefits on equal footing with medical/surgical benefits.¹⁶

Due to these differing requirements, mental health coverage under the ABPs can be both broader and narrower than that provided under traditional Medicaid plans. To explore these differences, this toolkit will provide an overview of traditional Medicaid benefits in **Section 1: Trends in Mental Health Care and Treatment in Traditional Medicaid**; ABPs in **Section 2: The Changing Landscape: The Impact of the Affordable Care Act**; and the impact of mental health parity in **Section 3: The Changing Landscape: Mental Health Parity**.

¹ The highest percentage that the federal government will pay in FY 2015 is 73.58%, for Mississippi.⁸ During times of economic downturn, the federal government has also provided additional funding to prevent states from implementing cuts to Medicaid in order to cope with increased demand. In 2009, the American Recovery and Reinvestment Act (Pub. L. 111-5 [ARRA]) temporarily increased the federal government’s share of Medicaid spending, providing over \$100 billion in additional funds.⁹

⁹ Roughly 5% of Medicaid beneficiaries qualify for coverage because they receive disability benefits for a mental illness. However, roughly two-thirds of Medicaid beneficiaries who utilize mental health services qualify for coverage in other ways.¹³

Ongoing Challenges

Changes to the Medicaid landscape under the ACA and other recent reforms have the potential to improve mental health care for millions of Americans. To fully meet that potential, though, beneficiaries and other stakeholders must continue to identify and address the challenges remaining within the Medicaid system.

For example, many Medicaid beneficiaries may experience shifts in coverage as their incomes fluctuate above and below income limits. In Medicaid expansion states, such “churning” will no longer leave individuals uninsured. However, it may still create gaps or discontinuities in coverage as beneficiaries switch from Medicaid to private plans available through the health insurance marketplaces, also known as exchanges. Additionally, as Medicaid spending continues to rise, states may limit access to mental health services in order to control costs.

The impact of and potential solutions to these issues, as well as other ongoing challenges, will be discussed in **Section 4: Ongoing Issues to Monitor**. Tools that advocates can use to address these issues will be discussed in **Section 5: State and Federal Advocacy Tools**.

Roadmap of the Medicaid and Mental Health Toolkit

The remainder of this toolkit takes a closer look at the issues outlined briefly above. The analysis is set out in the following sections:

- ▶ **Section 1:** Trends in Mental Health Care and Treatment in Traditional Medicaid
- ▶ **Section 2:** The Changing Landscape: The Impact of the Affordable Care Act
- ▶ **Section 3:** The Changing Landscape: Mental Health Parity
- ▶ **Section 4:** Ongoing Issues to Monitor
- ▶ **Section 5:** State and Federal Advocacy Tools

SECTION 1

Trends in Mental Health Care and Treatment in Traditional Medicaid

Historically, states have enjoyed considerable flexibility around the structure and content of their Medicaid programs. While this flexibility has led to considerable variation between states, some distinct trends have emerged with respect to both benefit packages and service provision models. The most notable of these trends has been the gradual shift towards managed care models.

Well-coordinated managed care has the potential to benefit Medicaid beneficiaries coping with complex mental and physical issues by reducing gaps and redundancies in care and preventing inappropriate care and unnecessary costs. However, many states have traditionally imposed boundaries on managed care models—either by carving out services or populations—that prevent the full coordination of physical and mental health services.¹⁷ As part of recent reforms, though, some states are exploring the possibility of removing these barriers and increasing the integration of medical, mental health, and social services.

This section of the toolkit explores these trends in the provision of mental health services under traditional Medicaid. As background, the section begins with descriptions of (1) mental health benefits under traditional Medicaid, (2) typical service delivery models, and (3) the traditional delivery of mental health services. The section then examines the ways that recent reforms—especially the emphasis on coordination of care—are impacting the traditional Medicaid landscape.

Introduction to Benefits – Care, Treatment, and Supportive Services

Due to the needs and limited resources of Medicaid beneficiaries, Medicaid covers a wide array of benefits. These benefits include both services typically covered by private insurance as well as additional benefits which reflect the specialized needs of the Medicaid population.³

Traditional Medicaid covers a range of mandatory services that all states must provide to most Medicaid recipients. These services cannot be cut without a federal waiver.

MANDATORY SERVICES¹⁸

- ▶ Physician services (includes psychiatrist services)¹⁹
- ▶ Inpatient hospital services
- ▶ Outpatient hospital services
- ▶ Laboratory and X-ray services
- ▶ Early and periodic screening, diagnostic, and treatment (EPSDT) services (individuals under age 21)
- ▶ Federally-qualified Health Center (FQHC) services
- ▶ Rural health clinic services
- ▶ Family planning services and supplies
- ▶ Certified pediatric and family nurse practitioner services
- ▶ Nurse midwife services
- ▶ Nursing facility services (individuals age 21 and older)
- ▶ Home health services (individuals eligible for nursing facility services)
- ▶ Transportation to medical care
- ▶ Freestanding birth center services (added by ACA)¹⁰
- ▶ Tobacco cessation counseling and pharmacotherapy for pregnant women (added by ACA)¹⁰

States may also elect to provide an array of optional services. Most states currently cover a number of optional benefits that are important to enrollees living with mental illness. Perhaps most importantly, all states currently cover prescription drug benefits for most enrollees.²⁰ As of 2012, all states also covered rehabilitation services, such as community support services,^{h21} 48 states covered targeted case management services,ⁱ²² and 35 states covered psychologist services.^{j23}

In FYs 2014 and 2015, almost half of the states. (21 and 22, respectively) reported expansions to their Medicaid benefit plans. Behavioral health services were a common focus of these expansions.²⁴ However, certain noteworthy gaps in mental health coverage remain. In particular, traditional Medicaid currently does not cover inpatient services at psychiatric institutions (ie, “institutions for mental disease,” or IMDs), rather than general medical hospitals, for enrollees 22 to 64 years of age.^{13,25} CMS has initiated a demonstration project to reconsider this exclusion, though.²⁶

Spotlight on Benefit Trends: IMD Coverage: Historically, Medicaid has not covered payments to IMDs for inpatient services for enrollees 22 to 64 years of age.²⁵ However, in July 2012, CMS initiated the Medicaid Emergency Psychiatric Demonstration—a demonstration project under section 2707 of the ACA—to evaluate the possibility of changing this policy. Under this project, CMS will provide \$75 million over the course of three years to 11 states and the District of Columbia, to enable them to reimburse private psychiatric hospitals for the treatment of psychiatric emergencies. The project will attempt to assess “whether providing Medicaid reimbursement for IMDs results in faster, more appropriate care for Medicaid beneficiaries with psychiatric needs and provides relief to general hospitals.”²⁶

Medicaid Service Delivery Models

FEE-FOR-SERVICE

Medicaid has traditionally been a fee-for-service (FFS) system. In such a system, Medicaid pays a set fee for each individual service a beneficiary uses. Within this system, a beneficiary can seek care from the provider of his or her choice.

Although FFS systems have the benefit of providing beneficiaries with significant freedom of choice, such systems may often lack incentives to provide efficient, coordinated care. In FFS systems, providers are not necessarily assigned to help beneficiaries coordinate their care. This lack of care management creates a greater possibility of treatment gaps or redundancies. Additionally, because physicians bear neither the risks nor the costs of unnecessary or expensive services, they may overuse them, thereby driving up costs without necessarily improving outcomes.

Physicians also sometimes refuse to serve Medicaid patients because Medicaid FFS payment rates are notoriously low. This pattern of refusal can limit the availability of physicians, creating a barrier to care.¹⁰

MANAGED CARE

Given the shortcomings of FFS systems, states have become increasingly reliant on managed care models to provide Medicaid benefits. Thus, as of 2011, more than 70% of Medicaid enrollees received at least some portion of their benefits through a managed care model,²⁷ and as of July 2014, all states except Alaska, Connecticut,^k and Wyoming, had implemented some form of managed care in their Medicaid systems.²⁴

Although there are a number of different models of managed care, most share a few key features that are meant to keep costs down, while still maintaining or improving quality of care. These features include:

- ▶ Limits on patient choice of providers
- ▶ The use of primary care providers (PCPs) as gatekeepers for specialist services
- ▶ The use of a physician or organization to manage patient care

Managed Care Regulations: Federal regulations governing Medicaid managed care can be found at 42 Code of Federal Regulations Part 438.

CMS generally uses three classifications of managed care:

1. Managed care organizations (MCOs)
2. Primary care case management (PCCM) plans
3. Limited benefit plans¹⁵

COMPREHENSIVE RISK-BASED MANAGED CARE PLANS/MANAGED CARE ORGANIZATIONS (MCOs)

MCOs contract to provide specified services to their members. They are paid a fixed monthly amount for each member regardless of the services actually used. This payment, referred to as capitation, can cover all—or only some—of the services a member might need.

In standard all-inclusive plans, the MCO bears the entire risk that a member will cost more (or less) than the capitation rate. However, in other arrangements, the MCO will instead split this risk with Medicaid. For example, the MCO may receive a monthly fee to provide a subset of services and a per-service fee for everything else, thereby shifting the risk related to the FFS portion from the MCO to Medicaid. Alternatively, the MCO may place limits on the amount that it can lose or gain, either receiving or providing money to Medicaid when these limits are surpassed.

As of July 2014, 39 states, including the District of Columbia, used MCOs as part of their Medicaid systems. Sixteen of these 39 states reported having enrolled more than 75% of their Medicaid beneficiaries in MCOs.²⁴

^h These data represent the number of states providing rehabilitation services in their FFS Medicaid program.²¹

ⁱ These data represent the number of states providing targeted case management services in their FFS Medicaid program.²²

^j These data represent the number of states providing psychologist services in their FFS Medicaid program.²³

^k Connecticut previously used MCOs in its Medicaid system, but, in 2012, transitioned to a FFS model, using four ASOs to manage medical health, behavioral health, dental services, and non-emergency transportation services.²⁴

PRIMARY CARE CASE MANAGEMENT (PCCM) PLANS

In PCCM plans, PCPs provide basic care as well as referrals to specialty services. Members must see a designated PCP prior to going to a specialist. Thus, the PCP acts as a “gatekeeper” for all healthcare services and manages the member’s care. In return, Medicaid pays the physician a small monthly fee—typically \$2.00-3.00—for each member-patient. Other services from the managing physician or specialists are paid on a FFS basis. PCCM plans are considered no-risk plans because the managing physician does not gain or lose according to overall costs of the member. There are two common variations on the PCCM model:

1. Enhanced primary care case management plans
2. Patient-centered medical homes (PCMH)

Enhanced PCCMs: The goal of enhanced PCCMs is to reduce spending on high-cost members through better management of chronic conditions, including severe/serious mental illness. To achieve this goal, enhanced PCCMs use a wider range of services (eg, social as well as medical services) and case managers, rather than just physicians, to manage member care.

PCMHs: The goal of the PCMH model is to emphasize expanded access and culturally effective care in order to meet the needs of the specific populations served. In the PCMH approach, a PCP coordinates services, which are provided by a team that includes specialists. Specifically, this team can include nurses, social workers, behavioral health specialists, and others to provide care that meets the members’ specific needs.

As of 2014, 22 states used PCCMs either alone or in addition to MCOs in their Medicaid system. However, six states have indicated that they are terminating their PCCM programs in FY 2014 or 2015, and will instead provide benefits to individuals in these programs via risk-based managed care (eg, MCOs).¹²⁴

LIMITED BENEFIT PLANS

Limited benefit plans include a diverse assortment of plans that typically cover only a single type of benefit, such as mental health services. These plans are used to complement FFS models and other forms of managed care, and are usually paid on a capitated basis. As of 2014, 20 states used limited benefit risk-based plans to provide certain Medicaid benefits.²⁴

ADMINISTRATIVE SERVICES ORGANIZATIONS

Companies that only provide administrative services are known as administrative service organizations (ASOs). Although ASOs primarily manage claims and benefits, they may also provide other services, such as data reporting, care coordination, or customer service.

ASOs are paid a fixed fee, which is not tied to the cost of care, to provide these services. Although ASOs do not have financial incentives directly related to the amount or cost of services used by Medicaid enrollees, they are still monitored and held accountable for efficient performance.

How Are Mental Health Services Provided in These Systems?

Although there has been a strong trend towards the use of managed care models to deliver Medicaid services, this trend has not necessarily resulted in Medicaid beneficiaries receiving coordinated mental and physical health services. Instead, many states have traditionally provided mental health care at varying degrees of separation from the other benefits in their Medicaid programs.

In fully integrated systems, the states’ managed care plans manage both mental and physical health benefits. However, many states have traditionally applied more segregated models. In such states, managed care plans may ultimately maintain responsibility for both mental and physical health benefits, but subcontract the management of mental health benefits to other entities. Alternatively, these states may completely carve out some or all mental health benefits from the rest of their managed care system, providing them on a FFS basis or through a distinct managed care plan.²⁸

Additionally, some states have traditionally used distinct service models for particular populations, which may include beneficiaries living with mental illness. For example, some states have chosen to treat groups such as disabled beneficiaries via a FFS model, rather than including them in managed care.²⁸

MANAGED BEHAVIORAL HEALTH ORGANIZATIONS

Companies that specialize in providing mental health services on behalf of managed care entities are called managed behavioral health organizations (MBHOs). They may or may not collaborate or network with other healthcare providers.

MBHOs come in a range of forms, just like managed care in general, and may opt to provide administrative services only. In such cases, MBHOs do not bear any risk and are paid only for the administrative services they control. Although MBHOs, like other ASOs, do not have financial incentives directly tied to the amount or cost of services used by plan members, they are still monitored and held accountable to the state program or MCO that subcontracts with them.

Other MBHOs have partial or full-risk arrangements. These MBHOs make more money by keeping costs for each member low. To do so, they provide guidelines and review provider decisions. They may also limit care to what is “medically necessary.” However, providers and MBHOs sometimes disagree on what treatments are medically necessary. In fact, some MBHOs do not allow providers to dispense any care that the MBHO does not find necessary—even if it is charged to the patient instead of the MBHO.

How Are Mental Health Pharmacy Benefits Provided?

Although prescription drug benefits are considered an optional benefit, all states currently choose to include it in their traditional Medicaid plans.²⁰ However, many states have preferred drug lists (PDLs) for Medicaid participants and require enrollees to use drugs from the preapproved list.

In these states, members—or, more accurately, their healthcare providers—must get prior approval (also called prior authorization) to have Medicaid pay for a drug that is not on the PDL. Prices to members depend on whether the prescribed medication is classified by the PDL as generic, preferred, or non-preferred. Psychiatric medications may, however, be treated differently than other drugs, and in some states, rules on drug choice are less restrictive for mental health medications.

In FY 2014, all states except Arizona, Hawaii, New Jersey, North Dakota, and South Dakota reported using PDLs.²⁴ As of 2012, the majority of states controlled prescriptions for both antidepressant and antipsychotic medications through their PDLs. However, a number of these states did not include other categories of psychiatric drugs—such as those used to treat bipolar disorder—in their PDL programs.²⁹

Reimbursement for pharmacy benefits varies by plan. While some managed care plans include pharmaceutical benefits in the capitated payment scheme, many others have opted to instead pay for these services on a fee-for-service basis.

PHARMACY BENEFITS MANAGERS

As with other mental health benefits, states frequently contract out pharmacy services to specialty organizations. Some states directly contract pharmacy benefits to a pharmacy benefits manager (PBM). In other states, MCOs with Medicaid contracts subcontract these services to PBMs. In either case, PBMs may provide a range of services and interact with public and private MCOs, healthcare providers, patients, and retail pharmacies. PBMs are usually paid through a management fee rather than capitation for these services.

Among the services PBMs can provide are claims processing and discounted drug prices, based on negotiating with drug manufacturers for rebates. PBMs often get lower prices from a manufacturer by agreeing to place that manufacturer’s drugs on their preferred lists and based on the quantities sold. PBMs also contract with pharmacies to get lower dispensing rates. The state Medicaid plan that contracts with the PBM also gets a portion of the discount, so it saves money as well.

In addition, some PBMs provide pharmacy services themselves in the form of mail-order prescription services. Members are frequently eligible to receive discounts for buying prescriptions through these mail-order services and can often make bulk purchases (90-day supply versus the traditional 30-day supply), which lowers their out-of-pocket costs as well.

¹ These states include: Florida, Indiana, Louisiana, Oregon, South Carolina, and Utah.²⁴

PBMs also analyze usage patterns and set limitations. They are often able to profile provider prescribing patterns and offer provider education materials that outline more effective prescribing practices. PBMs create PDLs and dispensing rules by looking at drug costs and effectiveness. Dispensing rules can include which drugs can be used and how often a member may get a prescription refilled. PBMs also ensure that members are staying within these predefined prescription benefit limits.

PBMs may also provide disease-management tools to patients to help prevent complications or adverse drug interactions in members with chronic conditions. PBMs seek to ensure that members are taking the appropriate drugs and getting refills at the recommended intervals.

Recent Trends in Financing/Service Delivery: Coordination of Care

INCREASED EMPHASIS ON MANAGED CARE

States have recently placed an increased emphasis on reforms aimed at enhancing the scope and quality of managed care systems. Such reforms will likely impact the way that individuals living with mental illness receive their Medicaid benefits. In some cases these changes have the potential to reduce existing barriers between mental and physical care, increasing the availability of fully coordinated care options.

MCO Expansion: In FYs 2014 and 2015, 34 of the 39 states (including the District of Columbia) which used MCOs in their Medicaid systems reported implementing or planning to implement policy changes to expand the scope of managed care. These 34 states indicated that they were taking steps to increase MCO enrollment through geographical expansion, mandating participation, and including new eligibility groups. In particular, many states added the following eligibility groups to their MCO programs: the Medicaid expansion population, children, dual eligibles (ie, beneficiaries eligible for both Medicaid and Medicare), and other elderly or disabled populations.²⁴

PCMH Expansion: Additionally, many states are currently engaged in expanding the availability of PCMHs—a delivery model which emphasizes the coordination and integration of care. According to a recent survey by The Kaiser Family Foundation, 24 states reported that they had PCMHs “in place” in FY 2013. In this same survey, 17 states reported that they had adopted or expanded their PCMH programs in FY 2014, and 20 states reported planning to expand or adopt PCMH programs in FY 2015.²⁴

Carve-Out Reduction: States are also increasingly attempting to integrate behavioral health benefits into their managed care plans, rather than relying on carve-outs and fee-for-service models.^{28,30} According to a recent 50-state survey by Open Minds, 16 states currently carve out all behavioral health benefits from their MCO contracts or FFS system. Many more carve out some portion of their program, such as inpatient psychiatric services. However, this survey showed a downward trend in the carving out of certain mental health benefits. In particular, the number of states carving out mental health outpatient benefits from their Medicaid managed care plans fell from 21 in 2011 to 18 in 2014.³¹

ELECTRONIC HEALTH RECORDS

States are also looking for ways to leverage technological advances to improve coordination of care. In particular, states are looking to increase care coordination through the use of electronic health records (EHR). By recording and sharing a patient’s records electronically, providers can better avoid redundancies or gaps in services.

Unfortunately, though, behavioral health providers currently face certain challenges in engaging in EHR initiatives, impeding the full coordination of patient care. While the American Recovery and Reinvestment Act of 2009 (ARRA) provided more than \$20 billion in funding incentives to encourage providers to engage in or improve “meaningful use” of EHR,³ it did not include most behavioral health providers in these incentive programs.³⁰

To close this gap, some states—such as Pennsylvania and Rhode Island, are moving towards inclusion of mental health providers in EHR incentive programs, while others—such as Maine, Minnesota, and Vermont—are looking to address this issue through their State Innovation Model ACO initiatives.³⁰

IMPLEMENTATION OF ACCOUNTABLE CARE ORGANIZATIONS

Finally, states are also looking to new models of coordinated care—such as Accountable Care Organizations—to improve healthcare quality and cut costs. Accountable Care Organizations (ACOs) are organizations in which providers, such as doctors and hospitals, voluntarily form a network to provide high-quality coordinated care.³² If the organization can show that it is providing both high-quality and cost-effective care, it becomes eligible to share in any resulting cost savings.^{32,33} Thus, while actual ACO models vary, they typically all involve: “use of quality metrics focused on patient-centered care, increased coordination of care, and incentives designed to reward performance (ie, improved outcomes).”³³

Since 2005, various groups have engaged in projects to evaluate the efficacy of the ACO model. With the enactment of the ACA, ACOs officially became an option for Medicare provider payments through the Medicare Shared Savings Program (MSSP). The ACA further encouraged the development of ACOs in the Medicare program through the creation of the “Pioneer” ACO pilot program, in which participating ACOs were required to take on some degree of financial risk if they failed to improve quality and lower costs. The private sector has seen similar growth of accountable care, with many major private payers establishing ACOs.³⁴

Building upon the success of ACOs in the Medicare and private sectors, states have begun to consider incorporating ACOs, or ACO-like models, into their Medicaid programs to improve care and cut costs. However, the nature of Medicaid has presented some unique hurdles in this process. For example, the state Medicaid systems place significantly greater reliance on risk-based managed care models than either the Medicare or commercial coverage systems. Thus, in order to implement ACOs, states have needed to consider how to integrate ACO and managed care systems. As a result, a number of states have implemented models that require ACOs—like MCOs—to assume financial risk. Additionally, some states have set up systems in which existing MCOs coordinate with or essentially become ACOs.³³

Despite these complications, Medicaid ACO initiatives are slowly becoming more widespread. According to the National Academy for State Health Policy, 19 states are currently involved in efforts to lead or participate in accountable care models that include Medicaid and Children’s Health Insurance Program (CHIP).³⁵ According to a recent survey by The Kaiser Family Foundation, 5 states reported that they had ACOs “in place” in FY 2013, while 6 states reported adopting or expanding ACOs in FY 2014, and 10 states reported plans to do so in FY 2015.²⁴

Spotlight on Enrollment Trends: Streamlining the Medicaid enrollment process has been another major theme in recent Medicaid developments. While states are required to make some changes to enrollment under the ACA—as discussed in **Section 2: The Changing Landscape: The Impact of the Affordable Care Act**—many states are going beyond these requirements to make the enrollment process simpler and more efficient. These changes are particularly important as Medicaid enrollment increases—by a national average of 8.3% in FY 2014 and an expected average of 13.2% in FY 2015^{m9}—in the wake of ACA implementation.

In 2013, 38 states reported plans to make changes to their enrollment and renewal processes beyond those required under the ACA. Most of these changes were based upon strategies that CMS outlined in a May 2013 guidance document.³⁷ As of August 2014, CMS had approved seven of these states to adopt a change that allows individuals to enroll in Medicaid based upon their receipt of Supplemental Nutrition Assistance Program (SNAP) benefits. Similarly, CMS had approved four states to adopt a change to allow them to enroll parents based upon income data submitted in Medicaid applications for their children.²⁴ Several states also sought approval to extend the eligibility period for adults, reducing the burden of renewals on enrollees.²⁴ CMS has not approved new waivers on this issue, though New York has reported adopting a 12-month eligibility period based on an existing section 1115 waiver.²⁴

^m Average growth is higher among states implementing Medicaid expansion (12.2% and a projected 18.0%) than among those that have chosen to forego expansion (2.8% and a projected 5.2%). However, Medicaid enrollment generally increased in both expansion and non-expansion states as individuals eligible under previously existing Medicaid criteria were directed to Medicaid when applying for coverage on the private exchanges, or newly applied based on the increased outreach around Medicaid expansion.⁷

The growing movement toward ACO models could prove valuable for individuals coping with both physical and mental health issues. Although, some states have not yet incorporated coverage of mental health services into their Medicaid ACO plans,³⁴ many others, such as Colorado, Oregon, Minnesota, Maine, and Vermont, are using the shift towards ACOs to either merge or create greater coordination between mental and medical health programs.^{30,33} Additionally, some states, such as New York, are looking to use the ACO model to improve upon or expand their current care coordination efforts, such as Health Home programs.³⁰

Additionally, many states have specifically included mental health issues in their ACO quality measures, thereby creating an incentive for providers to improve the quality and efficiency of their mental health services.^{30,36} Massachusetts, for example, bases eligibility for annual incentive payments on 23 quality measures, including three measures related to mental health: (1) rate of depression screening, (2) rate of follow-up after hospitalization for mental illness, and (3) ADHD medication management for children.³⁰

Cost Containment Approaches

Despite promising developments in the area of coordinated care, advocates should be aware that states may still look to other, more restrictive reforms to cut costs in their traditional Medicaid programs. These cost-containment methods frequently involve limiting enrollee access to important Medicaid services.

SERVICES

Although mandatory services cannot be cut without a waiver, states do have the discretion to limit the amount, duration, and scope of both mandatory and optional services within the parameters established by federal law and guidelines. Some states may therefore decide to limit the number of covered physician visits, the duration of hospital stays, or other services in an effort to contain costs. Medicaid plans vary widely from state to state, depending on which optional services the state has decided to provide and what limitations the state has imposed.³

When setting limits, states must, however, provide a sufficient level of services to reasonably achieve the purpose of the benefits. States also cannot impose limits that discriminate against enrollees based upon medical diagnosis or condition.

Additionally, it is important to note that states are only required to provide services (mandatory or optional) when they have been certified to be “medically necessary” by a physician.³ States can use their discretion in defining medical necessity to limit the provision of covered services to particular circumstances (eg, for particular diagnoses), or require prior authorization before certain services are provided.¹⁹ Therefore, depending on the specifics of the case, a patient may not have access to a particular service, regardless of whether it is included in the state’s plan.

PHARMACY BENEFITS

As an optional service which has historically been a major source of Medicaid spending, pharmaceutical benefits are particularly susceptible to access restrictions. Some of the cost-containment approaches used by state Medicaid programs to limit pharmaceutical costs include:

- ▶ PDLs and restrictive drug formularies
- ▶ PA requirements
- ▶ Beneficiary cost-sharing arrangements
- ▶ Limits on the number of prescriptions allowed per month
- ▶ Requiring or incentivizing the use of generic drugs
- ▶ Fail first, step therapy, or therapeutic substitution policies
- ▶ Supplemental rebates
- ▶ Multistate purchasing coalitions

For more detail regarding these cost-containment strategies, and potential advocacy responses, see **Section 4: Ongoing Issues to Monitor.**

State Examples

OREGON: COORDINATED CARE ORGANIZATIONS (CCOs)

On July 5, 2012, CMS approved a section 1115 waiver in which Oregon set out an ambitious plan to apply the ACO model to its state Medicaid program—Oregon Health Plan (OHP).³⁸ Under this plan, Oregon established 16 Coordinated Care Organizations (CCOs), which now provide coverage to most OHP beneficiaries.³⁹

Like ACOs, these CCOs consist of voluntary networks of providers working in the fields of physical health, behavioral health (ie, mental health and SUD), and, in some cases, dental health. Each CCO is provided with a single budget, which grows at a fixed rate, to provide services in these fields.³⁹ As with other ACOs, receipt of this funding is partially contingent on the CCO achieving a series of quality standards.

The federal government agreed to provide Oregon with roughly \$1.9 billion over five years to support the implementation of these CCOs. However, the state is subject to severe penalties—ranging from \$145 million to \$183 million—if it does not meet predetermined goals to slow Medicaid spending. Specifically, OHP must reduce the rate of growth in per capita Medicaid spending by 2% (from a starting point of 5.4%) by the end of the second year of the program.³⁸

The most recent available progress report regarding the Oregon project indicates that, as of the end of 2013, the CCOs were on target to meet the goal of reducing spending by 2%. Additionally, at the end of 2013, 11 out of the 15 existing CCOs had achieved a sufficient number of quality goals to receive 100% of their quality incentive payments.⁴⁰

The CCO quality standards include several measures potentially relevant to individuals coping with mental illness, including: follow-up after hospitalization for mental illness, depression screening and follow-up plan, and screening and intervention for alcohol or other substance misuse. Ten, fourteen, and three CCOs respectively met their improvement goals in these areas in 2013.⁴⁰

The Changing Landscape: The Impact of the Affordable Care Act

By signing the ACA into law on March 23, 2010, the United States government initiated a period of sweeping reform for Medicaid programs across the nation. The most dramatic of these reforms have taken place in the Medicaid expansion states, where almost any adult with income up to 133% of FPL is now eligible for Medicaid coverage, either via an Alternative Benefit Plan (ABP) or a traditional Medicaid plan.

The ACA's impact on Medicaid programs is not confined solely to states that have chosen to implement Medicaid expansion. The ACA also initiated a number of significant changes to Medicaid that apply to all states regardless of their stance on expansion. Some of these changes focus upon streamlining the Medicaid enrollment process and increasing access to preventive care. Others build upon the coordinated care movement by expanding state options for providing integrated whole-person care.

This section of the toolkit explores the impact of ACA on the Medicaid mental health landscape. To do so, the section provides an overview of both categories of ACA reform— [1] the Medicaid expansion option and [2] additional Medicaid reforms—and how they are shaping the provision of Medicaid benefits to individuals living with mental illness in the United States.

ACA Medicaid Expansion

ABPs – WHO ENROLLS?

The ACA generally requires states to enroll all adults who become newly eligible for coverage as a result of Medicaid income-based expansion in “Alternative Benefit Plan[s]” (ABPs).^{41,42} Beneficiaries are considered to be newly eligible for Medicaid if they qualify for coverage based solely upon the ACA’s expansion of Medicaid to adults earning up to 133% of FPL (that is, they would not have been eligible before).⁴¹

In contrast, new beneficiaries who qualify for Medicaid based upon traditional eligibility criteria—as well as beneficiaries enrolled prior to Medicaid expansion—will continue to receive benefits via a traditional benefits package, as described in the previous section of this toolkit. If a new beneficiary qualifies for Medicaid based upon both expansion and traditional criteria, he or she will have the option to choose whether to receive benefits via an ABP or a traditional plan.

Exception for “Medically Frail” Beneficiaries

While most adults in the expansion group must be enrolled in ABPs, there are certain categories of individuals who are exempt from this requirement.⁴³ One of the most important exemptions—from a mental health perspective—relates to individuals who are considered “medically frail.”

Newly eligible beneficiaries who are considered “medically frail” are exempt from the requirement to enroll in an ABP.⁴⁴ While states must typically enroll all newly eligible adults in ABPs, they must provide “medically frail” beneficiaries with the option to enroll in an ABP which is equivalent to the state’s traditional plan.⁴³

Newly eligible adults are considered “medically frail” if they have a serious and complex medical condition, disability, or a physical, intellectual, or developmental disability that significantly impairs daily life. Serious mental illness and chronic SUD are considered to be serious and complex medical conditions.⁴³ Therefore, newly eligible beneficiaries living with mental illness should be aware that they may have the right to choose whether to enroll in their state’s typical ABP or an ABP that replicates the state’s traditional plan.

Additionally, advocates should continue to monitor states’ implementation of this “medically frail” exception to ensure appropriate compliance. Specifically, advocates should monitor whether states are including individuals with serious mental illness in this category, and advocate for states to apply a definition of “medically frail” that is broad enough to cover all individuals with significant healthcare needs.

ABPs – What’s Covered?

Each ABP must be based upon one of the following potential “benchmark” packages:^{41,44,45}

- ▶ The Federal Employees Health Benefit Plan (FEHBP) Equivalent Coverage
- ▶ State employee coverage
- ▶ Coverage offered via the health maintenance organization (HMO) plan with the largest commercial, non-Medicaid enrollment in the state
- ▶ Secretary-approved coverage
- ▶ An actuarially equivalent plan to one of the above^{41,44,46}

Notably, each state’s traditional Medicaid package is considered Secretary-approved coverage.^{45,47}

Therefore, states may choose to base ABP coverage on their traditional plans. States also have the option to create multiple ABPs, and thereby tailor plans to meet the needs of specific groups of beneficiaries.^{48,49}

Essential Health Benefits

While states have considerable flexibility in designing their ABPs, all ABPs must meet certain basic requirements. First, all ABPs must include services falling within ten broad categories of care described in 42 U.S.C. §18022(b)(1).^{44,48} These categories consist of the same ten “Essential Health Benefits” (EHBs) that the ACA requires in all private plans available on the new health insurance marketplaces.^{48,50} Typically, ABPs must provide coverage within each of these ten categories that is similar to the coverage provided in the “benchmark” package that forms the basis of the ABP. If the “benchmark” package does not include services in any EHB category, the state must add appropriate benefits as necessary to meet the EHB requirement.

EHBs include:^{48,50}

- ▶ Ambulatory patient services
- ▶ Emergency services
- ▶ Hospitalization
- ▶ Maternity and newborn care
- ▶ Mental health and substance use disorder services, including behavioral health treatment
- ▶ Prescription drugs
- ▶ Rehabilitative and habilitative services and devices
- ▶ Laboratory services
- ▶ Preventive and wellness services and chronic disease management
- ▶ Pediatric services, including oral and vision care

Because they are required to include coverage of these ten EHBs, ABPs must cover certain mental health benefits that are considered optional under traditional plans. Most significantly, ABPs must cover mental health and substance use disorder services and prescription drug benefits.

Additional ABP Requirements

In addition to the ten EHBs, ABPs are required to provide coverage of the following benefits: EPSDT services for beneficiaries under the age of 21, family planning services and supplies, federally qualified health center services, rural health clinic services, and non-emergency medical transportation.⁵³⁻⁵⁵ ABPs must also comply with mental health parity requirements, as described in **Section 3: The Changing Landscape: Mental Health Parity**.^{44,53}

Trends in ABP Design

Most states have tried to align their ABPs with their traditional plans. In some cases, noteworthy differences do exist, though. In a recent survey by the Kaiser Family Foundation, three states reported including substance use disorder or mental health services in their ABPs that are not included in their traditional plans. In the same survey, one state reported excluding certain behavioral intervention services and inpatient substance use disorder and mental health services from its ABP that are included in its traditional plan.²⁴ It therefore remains crucial that beneficiaries fully understand the extent of their coverage, especially if they have the option to choose between the state’s ABP and traditional plan when enrolling in Medicaid.

Spotlight on Prescription Drug Benefits: *ABPs must include prescription drug coverage in order to meet EHB requirements. However, beneficiaries should be aware that ABPs may, in some cases, provide more limited prescription coverage than traditional Medicaid plans. In the final rules regarding the development of ABPs, CMS indicated that states are only required to provide prescription drug coverage that is consistent with EHB-private insurance benchmark standards.^{51,52} This means that ABPs must cover at least (1) the same number of drugs per class as the “benchmark” package that the ABP is based upon or (2) one drug per class, whichever is greater. In contrast, traditional plans which include prescription drugs benefits must cover all drugs approved by the FDA and manufactured by companies that participate in the Medicaid drug rebate program.*

CMS does, however, provide some flexibility around prescription drug coverage. Under the ABP minimum coverage rules, states must establish a process by which beneficiaries may request to receive a drug which is not covered by the ABP.⁵²

ABPs – HOW ARE BENEFITS PROVIDED?

The ACA does not mandate that states provide ABP benefits through a particular service delivery model. Therefore states may choose to provide benefits via the same models described in the previous section (eg, FFS, managed care, ACOs, etc.). As with traditional Medicaid, though, many ABP beneficiaries are likely to receive their benefits through managed care. In fact, the expansion population was the beneficiary category most commonly added to state MCO programs in FYs 2014 and 2015.²⁴

MEDICAID EXPANSION ALTERNATIVES – SECTION 1115 WAIVERS

The vast majority of states that have chosen to implement Medicaid expansion will provide benefits to newly eligible beneficiaries as described in the ACA and related regulations. However, as of the date of this publication, four states—Pennsylvania, Arkansas, Iowa, and Michigan—have received CMS approval for section 1115 waivers to pursue alternative approaches to Medicaid expansion.^{56*}

Premium Assistance Programs

Both Iowa and Arkansas have received approval for section 1115 waivers to implement Medicaid expansion via premium assistance programs.⁵⁷ These programs allow states to use Medicaid funds to enroll beneficiaries in Qualified Health Plans (QHPs) available on the private health insurance marketplaces, rather than in Medicaid plans.⁵⁸

States currently have two options for implementing Medicaid premium assistance: they may either apply for a section 1115 demonstration waiver, as described by HHS in a March 2013 guidance document,⁵⁹ or implement the premium assistance state plan option, as outlined by CMS in 42 C.F.R. §435.1015.⁵⁸

Under both of these options, the federal government requires that premium assistance programs track more typical Medicaid models in a number of ways. First, states must ensure that the overall cost of implementing premium assistance is comparable to the cost of implementing a standard expanded Medicaid program. States must also typically provide wraparound services to ensure that premium assistance enrollees have access to all benefits included in the state Medicaid plan and that their cost-sharing obligations do not exceed Medicaid limits.⁵⁸

However, there are a few key differences between the state plan option and the waiver option adopted by Iowa and Arkansas. While enrollment in premium assistance under the state plan option must be voluntary,⁶⁰ states may make such enrollment mandatory under a section 1115 waiver, if beneficiaries are given the choice between at least two QHPs.^{58,59} Additionally, states implementing a section 1115 waiver must limit their premium assistance programs to adults in the expansion population who would otherwise receive benefits via an ABP. They cannot require other beneficiaries—such as the medically frail—to enroll.⁵⁹ In contrast, the state plan option does not limit premium assistance programs to particular populations, though it does require that enrollment be optional for all populations (including the medically frail).⁵⁸

Other Waiver Programs

Michigan and Pennsylvania are not implementing premium assistance programs. Instead they are both implementing Medicaid expansion by enrolling newly eligible adults in Medicaid managed care plans.^{61,62} They have, however, received CMS approval for section 1115 waivers that allow them to implement Medicaid expansion with certain key changes—some of which are also included in the Iowa waiver. Perhaps most importantly, Michigan, Pennsylvania, and Iowa have all received CMS approval to require premium payments from a portion of the expansion population.

Federal regulations typically prohibit states from charging premiums from Medicaid beneficiaries with incomes below 150% of FPL.^{57,63} However, CMS has granted Pennsylvania and Michigan permission to require beneficiaries with incomes between 101% and 138% of FPL to pay monthly premiums equal to 2% of the beneficiaries' monthly incomes.^{61,62} Similarly, Iowa's waiver allows the state to charge beneficiaries in the premium assistance program a monthly premium of \$10.⁶⁴

All three of these states do, however, have exceptions built into their waivers to reduce or relieve the financial burden imposed by the new premium requirements, including: (1) waiver of the requirement for enrollees who attest to financial hardship (Iowa); (2) delayed implementation of the premium requirement (Iowa, Michigan, and Pennsylvania); (3) healthy behavior incentive programs that allow premiums to be waived or reduced (Iowa, Michigan, and Pennsylvania); (4) grace periods in which to pay past-due premiums (Iowa and Pennsylvania), and (5) prohibition of coverage loss for failure to pay premiums (Michigan).^{57,61}

Considerations Moving Forward

Given the sometimes complex nature of these waiver programs, it is particularly important that beneficiaries in these states fully understand the rights, protections, incentives, and obligations included in their Medicaid plans. Outreach and education to such beneficiaries, and monitoring of these programs is therefore crucial to ensuring that these alternative expansion plans provide effective care, especially to individuals with complex mental and physical healthcare needs.

For a more detailed analysis of Medicaid expansion under these section 1115 waivers, see The Kaiser Family Foundation's fact sheets regarding Medicaid expansion in Arkansas, Iowa, Michigan, and Pennsylvania, available at: <http://kff.org/medicaid/>.

Additional ACA Medicaid Reforms

The ACA also mandates that states implement a number of significant changes to their Medicaid programs, regardless of their stance on Medicaid expansion. Many of these changes focus on streamlining Medicaid enrollment and enhancing the role of preventive services in Medicaid plans. Additionally, the ACA provides all states with new options to provide coordinated and integrated services for individuals with complex or chronic health conditions. In particular, the ACA establishes the Medicaid Health Home option as a way for states to provide whole-person integrated treatment of individuals coping with chronic conditions such as serious mental illness.

ENROLLMENT REFORMS

Application Reforms

Since January 1, 2014, the ACA has required all states to take a number of steps to simplify the Medicaid application process, and thereby streamline access to Medicaid coverage. Most importantly, the ACA requires states to establish a “no wrong door” enrollment system whereby individuals can use a single, straightforward application to apply for not only Medicaid, but also

QHPs, CHIP and marketplace subsidies (eg, Advanced Premium Tax Credits available to individuals with income between 100% and 400% of FPL).⁶⁵⁻⁶⁷ States must allow individuals to submit their applications online, by phone, by mail, in person, or by other “commonly available electronic means.”^{65,66}

To further simplify the application process, states must provide assistance to any individuals seeking help with Medicaid applications or renewals. This assistance must be available in person, online, and by phone, and, at the state's option, may be provided by staff members and volunteers certified as Application Counselors. Applicants do not, however, have to rely solely on assistance provided by the state. Instead, applicants may choose to have an individual of their choice assist them in applying for or renewing their benefits.⁶⁸

Eligibility Determination Reforms

The ACA also requires states to simplify Medicaid enrollment by streamlining and standardizing the process by which they evaluate Medicaid applications. For most non-elderly applicants—children, pregnant women, parents, and low-income adults—the ACA requires that states eliminate asset limits and base eligibility on Modified Adjusted Gross Income (MAGI) rather than any other method of income calculation.^{24, 41, 69} The ACA also requires that, to the extent possible, states confirm eligibility via available electronic data rather than requiring applicants to provide hard-copy documentation.^{65,70}

Presumptive Eligibility

Historically, states have had the option to further streamline Medicaid access through presumptive eligibility (PE) programs. These programs allow qualified entities to find individuals presumptively eligible for benefits, and therefore immediately enroll them in Medicaid, even though the state has not yet officially approved them for coverage. These individuals then continue to receive coverage until the state makes a final decision regarding their eligibility.⁷¹

⁷¹ Individuals who do not apply for Medicaid coverage by the last day of the month after the month the PE is determined will lose coverage on that day.⁷¹

*Since the content in this Toolkit was developed, one additional state (Indiana) has received CMS approval to expand its Medicaid program via a section 1115 waiver. On January 27, 2015, CMS approved Indiana's request to implement the “Healthy Indiana Plan 2.0,” beginning on February 1, 2015. See Centers for Medicare & Medicaid Services [CMS]. Healthy Indiana Plan 2.0 Section 1115 Medicaid Demonstration: Fact Sheet. Available at: <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-fs.pdf>.

In the past, PE programs were optional for states and limited to a few specific categories of applicants (eg, pregnant women and children).⁷¹ However, as of January 1, 2014, the ACA expanded these provisions so that all states must now allow qualified hospitals the option to make presumptive eligibility (PE) determinations for most individuals who are likely eligible for Medicaid benefits in their state.^{64,71-73}

Each state must therefore submit a state plan amendment (SPA) to CMS, regarding its implementation of the expanded PE program. This SPA must describe the steps that the state is taking to ensure that qualified entities are informed of relevant Medicaid eligibility policies. Such measures are important to state programs because, while they may provide training and track outcomes, states may not hold hospitals liable for payments based upon erroneous PE decisions.⁷¹ As of the summer 2014, 32 states had received CMS approval for PE amendments, and another 17 states were waiting on approval of submitted plans.²⁴

PREVENTIVE SERVICES

Prior to the implementation of the ACA, all Medicaid programs were required to cover a broad range of preventive services for beneficiaries under the age of 21 as part of the mandatory EPSDT benefit. However, many such services remained optional for adult beneficiaries.⁷⁴ Breaking with this trend, the ACA placed a strong emphasis on preventive care, and included several reforms aimed at expanding adult access to preventive services.

The impact of these reforms differs between traditional Medicaid plans and ABPs. Adult preventive services remain optional in traditional Medicaid plans. However, section 4106 of the ACA establishes an incentive program that provides additional funding to states that voluntarily include certain preventive services in their Medicaid plans.

Specifically, the federal government will cover an additional 1% of costs (ie, a 1% increase in FMAP) for the following services, if states provide them in their Medicaid plans without cost-sharing⁷⁵:

- ▶ Preventive services rated “A” or “B” by the United States Preventive Services Task Force (USPSTF)
- ▶ Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)

As of October 2014, at least eight states—California, Delaware, Hawaii, Nevada, New Hampshire, New Jersey, New York, and Washington—had filed SPAs to provide these services and receive the enhanced federal funds.⁷⁶

In contrast, as of January 1, 2014, all ABPs must provide coverage of these services as well as services recommended for women by the Health Resources and Services Administration (HRSA).^{77,78} As with the incentive option in traditional Medicaid, ABPs must cover these services without cost-sharing.⁷⁷

The expanded coverage of preventive services under the ACA may aid individuals living with mental illness in coping with their often complex healthcare needs. While some preventive services—such as the depression screenings recommended by USPSTF⁷⁹—may directly impact mental health treatment, others may help these beneficiaries obtain whole-person treatment by identifying and addressing comorbid medical conditions that warrant treatment.

NEW OPTIONS TO PROVIDE INTEGRATED AND COORDINATED CARE – MEDICAID HEALTH HOMES

As with recent trends in traditional Medicaid, a central theme of ACA reform has been the importance of providing coordinated whole-person care. In an effort to reduce costs and expand the availability of coordinated care, section 2703 of the ACA gives states the option to amend their Medicaid plans to include Health Homes. In this context, a Medicaid Health Home is a team-based service delivery model that is meant to “integrate physical and behavioral healthcare (both mental health and substance abuse) and long-term services and supports for high-need, high-cost Medicaid populations.”⁸⁰

Unlike similar managed care models, such as PCMHs, Medicaid Health Homes are meant to specifically target individuals with chronic illnesses.⁸⁰ Thus, Medicaid beneficiaries are only eligible for Health Home services if diagnosed with:

1. Two chronic conditions
2. One chronic condition and are deemed at risk for a second
3. A serious and persistent mental health condition⁸¹

For the purposes of determining eligibility for Health Home services, chronic conditions can include, but are not limited to, mental health conditions, substance use disorders, asthma, diabetes, heart disease, and being overweight (ie, having a Body Mass Index greater than 25).⁸¹

Health Home programs are required to provide a number of core services related to coordination of care, promotion of behavioral healthcare, and connection of beneficiaries to key social supports and services.

These core services include⁸¹:

- ▶ Comprehensive care management
- ▶ Care coordination
- ▶ Health promotion
- ▶ Comprehensive transitional care, including follow-up, from inpatient to other settings
- ▶ Patient and family support
- ▶ Referral to community and social support services, if relevant
- ▶ Use of health information technology to coordinate services (to the extent feasible/appropriate)

These services can be provided by: (1) a “designated provider,” such as a clinical practice or community mental health center, (2) a “team of healthcare professionals” linked to a designated provider, or (3) a “health team.” If a state chooses the second option in this list (ie, a team linked to a designated provider), the team may consist of an array of healthcare professionals, such as physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and any other professionals “deemed appropriate by the State.”⁸¹

However, if the state chooses the third option (a “health team”), the team must meet the definition of a “community health team” under section 3502 of the ACA. Such teams must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative medicine practitioners, and physicians’ assistants.⁸²

In order to encourage participation, the federal government offers significant financial support to states considering implementing Health Homes. During the initial stages of development, states may

apply for planning grants.⁸¹ These grants provide Title XIX funding to states at their medical assistance service match rate.^{81,82} Additionally, states that do implement Medicaid Health Homes receive enhanced federal funding for the first eight quarters of their programs. This enhanced funding covers 90% of spending on core Medicaid Health Home services.^{80,81}

States are also given considerable flexibility in how to design their Health Home programs. States may not specifically limit Health Home programs to certain age groups⁸³ or dual eligibles.⁸⁰ They may, however, focus their programs on certain conditions or locations and “prioritize enrollment or tier payments [to providers] based on severity/risk of the patient.”^{80,81}

As of June 2014, 15 states⁹ have received CMS approval for SPAs to implement Medicaid Health Homes, and nearly a dozen more are currently developing plans to do so. Of the 15 states which have received approval for Health Homes, five have received approval for Health Homes focused specifically on serious mental illness—Iowa, Maryland, Missouri, Ohio, and Rhode Island. Several other states have implemented broad plans, which may focus on a number of conditions, including serious mental illness. Overall, more than one million Medicaid beneficiaries are currently enrolled in Health Homes.⁸⁰

Many Medicaid Health Home programs are still in the early stages of implementation, but preliminary reports indicate that Health Homes have potential to create a positive impact on patient care and coverage costs. In Missouri, for example, the Community Mental Health Center (CMHC) integrated care Health Home has reported a 12.8% annual reduction in hospital admissions as well as an 8.2% reduction in emergency room use for its members. CMHC therefore estimates that the program is creating Medicaid cost savings of \$76.33 per member per month for the state.⁸⁴

As more Medicaid Health Home programs are created, advocates should continue to monitor their implementation (including outreach and enrollment) to ensure continuity of care, integration of community mental and behavioral health providers as appropriate, and other mental health quality indicators. A more thorough, independent longitudinal analysis of the impact of the Medicaid Health Home initiative will be available in 2017, as part of the Independent Health Home Evaluation and Report to Congress.⁸⁴

⁶⁴ As CMS has explained in a related FAQ, “states must implement hospital PE to ensure that hospitals are able to make PE determinations for . . . all MAGI-eligible groups: pregnant women, infants, and children, parents and caretaker relatives, the adult group, if covered by the state, individuals above 133 percent of the Federal Poverty Level under age 65, if covered by the state, individuals eligible for family planning services, if covered by the state, former foster care children, and certain individuals needing treatment for breast or cervical cancer, if covered by the state.” States may also allow hospitals to extend PE to other groups eligible for Medicaid benefits (eg, disabled or elderly individuals).⁷¹

⁹ CMS has indicated, though, that states may indirectly target certain ages groups for care in health homes through their ability to designate providers of health home care.⁸² These states include: Alabama, Idaho, Iowa, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wisconsin.⁸⁰

For further information and resources regarding the implementation and monitoring of Medicaid Health Homes, see the [Guide to Medicaid Health Home Design and Implementation](http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Guide-to-Health-Homes-Design-and-Implementation.html), available at: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Guide-to-Health-Homes-Design-and-Implementation.html>.

State Examples

MARYLAND MEDICAID HEALTH HOMES

In October 2013, as part of the state's efforts to achieve greater integration of physical and behavioral health services,⁸⁵ Maryland initiated a statewide Health Home program focusing on mental illness and substance use disorders.⁸⁶ Maryland's Health Home program is available to individuals who are Medicaid eligible and coping with (1) serious and persistent mental illness (SPMI), (2) serious emotional disturbance (SED), or (3) opioid substance use disorder and risk of an additional chronic condition.⁸⁷ In the case of this third option, the individual must be shown to be at risk for a chronic condition based upon either current alcohol, tobacco, or other non-opioid substance use, or a history of dependence upon these substances.⁸⁷ Beneficiaries must also be "enrolled to receive the appropriate psychiatric rehabilitation program (PRP), mobile treatment, or opioid treatment program (OTP) services from a Health Home provider in order to qualify for Health Home."⁸⁸

In order to successfully apply to participate in the program as a Health Home, Maryland Medicaid providers must meet a number of specific requirements. Most importantly, the provider must be a Psychiatric Rehabilitation Program (PRP), Mobile Treatment Services (MTS) provider, or Opioid Treatment Program (OTP). Providers must also demonstrate that they have obtained, or are seeking to obtain,

Health Home accreditation from an accrediting body approved by the Maryland Department of Health and Mental Hygiene—such as the Commission on Accreditation of Rehabilitation Facilities' (CARF) Health Home Standards or The Joint Commission's Behavioral Health Homes Certification. Finally, providers must meet certain staffing and, if planning to provide Health Home services to children, experience requirements. Once approved, these providers may enroll eligible Medicaid beneficiaries receiving their PRP, MTS, and OTP services in their Health Home programs.^{87,89}

Maryland Health Homes are then "responsible for coordinating primary and behavioral healthcare and social services to address the whole-person needs of participants at both the individual and population levels."⁸⁷ Specifically, Health Homes must provide the core Health Home services—such as comprehensive care management and referral to community and social supports services—as described in the ACA and associated regulations.

To aid in the provision and coordination of these services, Health Homes can access a number of electronic tools. First, Health Homes are to use Maryland's eMedicaid Health Homes tool to report on each patient's intake, services, outcomes, and basic care management. Health Homes must also enroll in the Chesapeake Regional Information System for Our Patients (CRISP), in order to monitor prescription drug and hospital access of Health Home participants. Additionally, Maryland encourages, but does not require, Health Homes to utilize other EHR and care management tools.⁸⁷

As of September 2014, Maryland has approved 60 applications for Health Homes. These Health Homes are situated in 19 of Maryland's 23 counties and provide care to a total of 4,309 Medicaid beneficiaries—80% of whom are adults who receive care from mental health providers. Many of these beneficiaries are likely coping with a mixture of physical and behavioral health issues, as almost 50% of beneficiaries report a substance use disorder, and the majority of beneficiaries are overweight or obese.⁹⁰

Given their complex needs, these beneficiaries will hopefully benefit from receiving integrated care via the Medicaid Health Home model. However, it is important that advocates continue to monitor the outcomes and costs associated with these new and evolving Health Home programs, in order to determine their efficacy in delivering cost-effective whole-person care.

MINNESOTA: HENNEPIN HEALTH

In addition to establishing Medicaid Health Homes, many state Medicaid programs have also been looking to other innovative service delivery models—such as the ACO model discussed in the previous section—to provide whole-person coordinated care. In some instances, these efforts have been specifically aimed at individuals in the ACA expansion population.

Minnesota is currently engaged in two 3-year accountable-care-focused Medicaid demonstration projects. In the broader of its two projects, the state is implementing Medicaid contracts with ACOs in the Twin Cities metropolitan area, involving shared savings and risks. In its second demonstration project—focused on individuals in the expansion population—Minnesota has taken on a smaller, but in some ways more innovative, task: the Hennepin Health safety net.³⁴

Hennepin Health is an ACO partnering Hennepin County's Human Services and Public Health Departments with a local medical center, clinic and HMO. The ACO receives per-member, per-month capitated payments to provide care to its enrollees. However, a percentage of these payments is withheld, pending the ACO's improvement in specified quality areas. As of May 2014, Hennepin Health provided care to 8,600 members. These members consist of adults 21-64 years of age in the Medicaid expansion population. Of these members, 42% had a mental health condition, and 45% had a chemical dependency issue.⁹¹

Hennepin Health's approach to healthcare is particularly innovative because of the expansive reach of its services. Program members are assigned to primary care clinics which operate as patient-centered medical homes. These clinics coordinate each patient's care across an extended team of medical, mental health, and social service providers in order to improve quality and cost-efficiency of care. Through these teams, the program provides services including housing and social services navigation, employment counseling, targeted case management as well as mental and physical health benefits.⁹¹

Hennepin further coordinates care through the use of EHRs. Each patient is associated with a single EHR, which is shared across their service network. Hennepin Health has noted, though, that it has encountered some difficulties when trying to share patient information, due to the regulations and restrictions governing social services records.⁹¹

In the first year of implementation, Hennepin Health experienced a 2.5% increase in primary care visits, as well as 9.1% and 3.2% *decreases* in emergency department visits and inpatient admissions, respectively. Hennepin Health also experienced increases in the number of enrollees receiving optimal care for their chronic conditions and reported high patient satisfaction.⁹¹

^r Notably, however, individuals receiving services via a 1915(i) State Plan Amendment (ie, home and community based services) or Targeted Mental Health Case Management, are excluded from participating in the home health program.⁸⁷

The Changing Landscape: Mental Health Parity

Despite significant demand, health plans have historically provided more limited coverage for benefits related to mental rather than physical health. Since the early 1990s, advocates have therefore called for legislation mandating that plans provide comparable coverage of physical and mental health services, also known as “mental health parity.”⁹²

These efforts resulted in two key federal laws—the Mental Health Parity Act of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.⁹² Under these laws, most plans must implement parity by providing equal access to mental and physical health benefits. For example, they may not charge higher copays for mental health benefits than they typically charge for physical health benefits.

The MHPA and MHPAEA, in conjunction with the ACA, have dramatically changed the rules governing the provision of mental health benefits in the United States. Like many reforms, though, the impact of the parity movement on state Medicaid programs is complex, and varies by population and service delivery model.

This section of the toolkit explores the impact of the ACA and parity laws on the Medicaid mental health landscape. The section begins with an overview of the history of the parity movement in the United States and the current framework of parity law under the MHPAEA and ACA. It then examines the ongoing challenges and concerns associated with mental health parity.

Historical Overview of Mental Health Parity

In 1996, Senators Domenici and Wellstone introduced a bill which Congress passed as the Mental Health Parity Act of 1996 (MHPA, Pub. L. 104-204).^{16,92} The MHPA applied only to large, employer-sponsored health plans and insurance issuers providing coverage in connection with such plans. The act did not require these plans to provide mental health coverage. Instead, it applied solely to plans that already provided both mental and physical health benefits. If a plan covered both types of benefits, the act prohibited it from applying more restrictive lifetime or annual dollar limits to mental health benefits than to medical/surgical benefits.^{93,94}

The MHPA did not address any other financial requirements or treatment limitations.⁹³ As a result, the act likely had limited impact because plans and issuers could compensate for the changes to annual and lifetime limits by making other provisions more restrictive for mental health benefits (eg, limits on office visits).⁹²

Given the limitations of the MHPA, advocates continued to pursue more comprehensive parity legislation. As a result, on October 3, 2008, President George W. Bush signed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, Pub. L. 110-343) into law.⁹² Like the MHPA, the MHPAEA originally applied only to large group plans—and associated insurance issuers—that provided coverage of both mental and physical health benefits. The MHPAEA broadened the scope of the MHPA with respect to these entities by: (1) extending parity protections to substance use disorder benefits, (2) establishing parity requirements for financial requirements (eg, copayments), treatment limitations (eg, limits on office visits) and out-of-network coverage, and (3) creating new transparency requirements for decisions related to mental health and substance use disorder services.⁹⁵

Although it did not alter the parity requirements established by the MHPAEA,⁹⁶ the enactment of the ACA in 2010 then expanded its impact in two significant ways. First, the ACA extended parity requirements to several new types of health plans, including individual plans, non-grandfathered small group plans, and Medicaid ABPs.^{44,97,98} Second, the ACA triggered parity requirements in these new plans by mandating that they cover both mental health and medical benefits as part of the EHBs.^{44,99,100} Thus, the ACA went beyond the MHPAEA by actually mandating coverage—and therefore parity—in many plans, rather than only applying parity requirements to those plans that already provided mental health benefits.

The Current Parity Framework – MHPAEA

Taken together, the MHPAEA and the ACA require most plans and insurance issuers⁵ (collectively referred to here as “relevant plans”) to provide equal access to both mental health or substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits.

To implement this principle, the MHPAEA requires relevant plans to provide comparable treatment of MH/SUD and M/S benefits in four areas: (1) annual and aggregate lifetime limits, (2) financial requirements, (3) treatment limitations, and (4) out-of-network benefits.⁹⁸ As described below, the MHPAEA provides specific parity requirements in each of these areas. However, each of these requirements generally boils down to the idea that plans may not place more restrictive limits on access to MH/SUD benefits than they impose on M/S benefits.

- ▶ **Annual and Aggregate Lifetime Limits¹:** A relevant plan may not impose an annual or aggregate lifetime limit on MH/SUD benefits unless it imposes such a limit on “substantially all” M/S benefits. If the plan does impose an annual or lifetime limit on “substantially all” M/S benefits, then it may impose such a limit on MH/SUD benefits. To do so, the plan may either: (1) impose one limit, covering both MH/SUD and M/S benefits, or (2) impose a separate limit on MH/SUD benefits that is no more restrictive than the limit placed on M/S benefits.⁹⁸
- ▶ **Financial Requirements:** The MHPAEA defines financial requirements as including: “deductibles, copayments, coinsurance, and out-of-pocket expenses.” Under the MHPAEA, relevant plans may not apply financial requirements to MH/SUD benefits that are more restrictive than the “predominant” financial requirements applied to “substantially all” M/S benefits covered by the plan. As part of this rule, plans may not include separate cost-sharing requirements that apply only to MH/SUD benefits.⁹⁸
- ▶ **Treatment Limitations:** The MHPAEA defines treatment limitations as including: “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.” Under the MHPAEA, relevant plans may not apply treatment limitations to MH/SUD benefits that are more restrictive than the “predominant” treatment limitations applied to “substantially all” M/S benefits covered by the plan. As part of this rule, plans may not include separate treatment limitations that apply only to MH/SUD benefits.⁹⁸

- ▶ **Out-of-Network Benefits:** If a relevant plan provides out-of-network coverage for M/S benefits, then it must also provide out-of-network coverage for MH/SUD benefits. Such coverage must be provided in a manner consistent with the parity requirements described above.⁹⁸

In addition to its parity requirements, the MHPAEA also includes several important provisions regarding plan transparency and exemptions to the parity rules. These provisions are briefly described below.

- ▶ **Plan Transparency:** The MHPAEA establishes two important provisions regarding plan transparency. Under the act, relevant plans must disclose both: (1) criteria for making medical necessity determinations related to MH/SUD benefits, and (2) reason(s) for denying any request for reimbursement or payment for services related to MH/SUD benefits.⁹⁸
- ▶ **Exemptions:** The MHPAEA provides two exemptions to federal parity requirements: (1) a small employer exemption, and (2) a cost exemption.⁹⁸ The small employer exemption currently applies to grandfathered small-group market coverage.^{97,101} The cost exemption provides a one year exemption for relevant plans which experience a cost increase of at least 2% in the initial year in which the MHPAEA provisions apply to a plan, or a 1% increase in any subsequent year. The exemption is only available to plans which experience increased costs as a result of MHPAEA implementation, and applies to the plan year following the period of increased costs. During that year, the plan is not subject to any federal parity requirements.⁹⁸

Example: Financial Requirements and Quantitative Treatment Limitations under the Final Rules: A plan imposes copay requirements for 80% of M/S benefits in the emergency classification, and 60% of those benefits have a \$10 copay. Thus, the plan applies a copay to at least two-thirds (ie, “substantially all”) of M/S benefits within the emergency benefit classification. In the second step of the assessment, \$10 is the “predominant” level at which the copay is applied because more than half of M/S emergency benefits that have a copay set that copay at \$10. The plan may therefore require copays of up to \$10 for MH/SUD benefits in the emergency classification.

⁵ The ACA and MHPAEA still only apply parity requirements to plans that cover both mental health or substance use disorder benefits and medical/surgical benefits. However, the ACA requires that non-grandfathered plans offered in the individual and small group markets and ABPs cover the 10 EHBs, including mental health and substance use disorder services. Therefore, the ACA and MHPAEA require parity in (1) all non-grandfathered individual and small group plans and ABPs, and (2) in certain other plans that choose to cover both mental health or substance use disorder benefits and medical/surgical benefits (eg, large employment-based group plans).

¹ Notably, the ACA significantly limits the impact of parity requirements regarding annual and lifetime limits. The ACA prohibits annual or lifetime limits from being applied to EHBs. Therefore annual and lifetime limits may only be applied to MH/SUD benefits that are not provided as part of the EHBs requirements.¹⁰⁴
⁹⁷ The ACA effectively narrowed the small employer exemption to apply only to grandfathered small group market coverage, by requiring that non-grandfathered small group plans cover EHBs in a manner consistent with parity laws.^{97,101}

The Current Parity Framework – Final Rules for Private Health Plans

The Departments of Treasury, Labor, and Health and Human Services published interim rules on February 2, 2010 (75 Fed. Reg. 5410), and then published final rules on November 13, 2013 (78 Fed. Reg. 68240) explaining how to implement the provisions of the MHPAEA in relevant private plans. The final rules generally became effective on January 13, 2014, and apply to plan years beginning on or after July 1, 2014.¹⁰² As explained below, these rules generally do not apply to public health plans, such as those provided by Medicaid.

These final rules provide instructions and examples explaining how relevant private plans should implement the provisions of the MHPAEA. First, the rules define key terms in the act, such as: “substantially all” (defined as at least two-thirds), and “predominant level” (defined as more than half).¹⁰³

Additionally, the final rules establish detailed frameworks for implementing parity requirements regarding financial requirements and treatment limitations. Specifically, the rules provide a two-step mathematical process for assessing parity for all financial requirements and treatment limitations that can be described as numbers (“quantitative treatment limitations”),^v and a broader, process-focused framework for assessing parity for “nonquantitative treatment limitations” (NQTLs), that is, treatment limitations that cannot be described as numbers (eg, prior authorization rules).^{w103}

Parity Regulations: The final regulations governing the application of parity laws to private plans can be found at: 26 Code of Federal Regulations Part 54, 29 Code of Federal Regulations Part 2590, and 45 Code of Federal Regulations Part 146

^v The framework first considers whether the type of financial requirement or quantitative treatment limitation applies to two-thirds (“substantially all”) M/S benefits within a classification. The framework then considers whether the level at which the requirement or limitation is applied to MH/SUD benefits is equal to or less restrictive than the predominant level that applies to M/S benefits in the same classification. The predominant level is the level applied to more than half of M/S benefits subject to the type of requirement or limitation in a given classification.¹⁰³

^w Under this framework, issuers and plans that provide both MH/SUD and M/S benefits may not apply a NQTL to MH/SUD benefits unless the “processes, strategies, evidentiary standards, or other factors” used in applying the NQTL to MH/SUD benefits are “comparable to, and are applied no more stringently than,” those used in applying the NQTL to M/S benefits in the same classification.¹⁰³

^x The final rules establish six “classifications” of benefits: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care, and (6) prescription drugs. The rules require relevant private plans to divide all benefits into these classifications, and then assess whether the plan meets parity requirements within each classification.¹⁰³

^y However, if a plan merely provides preventive services, based upon the requirements of the ACA, it does not trigger parity requirements.¹⁰⁴

Finally, the rules establish several important requirements that go beyond the statutory protections, including: (1) a prohibition on applying cumulative financial requirements (eg, deductibles) or quantitative treatment limitations (eg, annual visit limits) which accumulate separately for MH/SUD benefits,¹⁰³ (2) a requirement that relevant plans provide MH/SUD benefits in all categories of benefits (eg, inpatient in-network)^x in which they provide M/S benefits,^{y103} and (3) a requirement that relevant plans include benefits and restrictions provided via carve-out plans when applying parity requirements.^{103,105}

Example – NQTLs: A plan requires prior authorization for all MH/SUD and M/S benefits in the outpatient, in-network classification. The plan will not pay for MH/SUD benefits that do not receive prior authorization. However, the plan will pay for M/S benefits that do not receive prior authorization in some cases. Although it applies the same NQTL to all benefits (ie, prior authorization), this plan violates parity requirements because the NQTL is applied more stringently to MH/SUD benefits.

The Current Parity Framework – Medicaid Programs

As the preamble to the final rules explains, the statutory provisions of the MHPAEA apply to two types of Medicaid programs—ABPs and Medicaid MCOs.^{16,44,53,106,107} However, the final rules do not.¹⁰⁶ Therefore, CMS is expected to issue a separate set of proposed rules regarding the application of the MHPAEA to these two Medicaid programs in the near future, possibly as early as December 2014.¹⁰⁸

Until such rules are in effect, ABPs and Medicaid MCOs must implement the statutory requirements of the MHPAEA based upon CMS guidance provided in a January 16, 2013 State Health Official and Medicaid Director Letter.¹⁰⁶ In contrast, traditional FFS Medicaid programs are generally not subject to federal parity requirements, and therefore must only implement parity requirements established by state law.^{z109}

PARITY IN MEDICAID MCOs

In its January 16, 2013 State Health Official and Medicaid Director Letter, CMS confirms that Medicaid MCOs (defined in Section 1903 of the Social Security Act) are subject to the provisions of the MHPAEA. However, for the purposes of determining compliance with the MHPAEA, CMS divides Medicaid MCO benefits and restrictions into two categories: (1) those required by the state plan/contract, and (2) those that the MCO provides in addition to or as an alternative to the state plan/contract.¹⁶

With respect to the first category, CMS indicates that MCOs will not be found out of compliance with the MHPAEA if they are in compliance with state plan/contract requirements, but that CMS encourages states to amend their plans to promote parity. Specifically, CMS explains:

In light of Medicaid regulations that direct states to reimburse MCOs based only on state plan services, CMS will not find MCOs out of compliance with MHPAEA to the extent that the benefits offered by the MCO reflect the financial limitations, quantitative treatment limitations, nonquantitative treatment limitations, and disclosure requirements set forth in the Medicaid state plan and as specified in CMS approved contracts. However, this does not preclude state use of current Medicaid flexibilities to amend their Medicaid state plans or demonstrations/waiver projects... in ways that promote parity.¹⁶

With respect to the second category, CMS states that benefits or restrictions outside the scope of the state plan/contract must comply with mental health parity requirements. In listing these requirements, CMS largely echoes the statutory requirements under the MHPAEA. However, CMS does go beyond the statutory language in at least two ways. First CMS indicates that, like plans subject to the final rules, Medicaid MCOs must provide parity for NQTLs (eg, prior authorization requirements). Additionally, the guidance urges—but does not require—states

to apply parity principles across the entirety of their managed care delivery systems if certain services are offered through carve-out arrangements.¹⁶

Parity in ABPs

In its January 16, 2013 State Health Official Letter, CMS also acknowledges that MHPAEA requirements apply to all ABPs. CMS states that ABPs must therefore meet MHPAEA requirements regarding financial requirements, treatment limitations, out-of-network coverage, and transparency.¹⁶

As with Medicaid MCOs, CMS does not provide detailed guidance regarding how ABPs must meet these requirements, but does clarify that, like plans subject to the final rules, ABPs must provide parity with respect to both quantitative limitations and NQTLs.¹⁶

Challenges and Concerns With Mental Health Parity

LIMITS TO PARITY REQUIREMENTS IN MEDICAID PROGRAMS

The MHPAEA and the regulations governing its implementation create several new parity protections, which have the potential to significantly improve access to MH/SUD benefits. However, these protections currently have limited applicability to Medicaid programs. Most significantly, no federal parity requirements currently apply to traditional Medicaid plans provided via FFS models. Therefore, beneficiaries of such plans may be unfairly disadvantaged in accessing MH/SUD benefits, unless their state programs apply their own parity protections.

Additionally, while Medicaid MCOs and ABPs are subject to the provisions of the MHPAEA, as of November 2014, CMS has yet to issue rules regarding the implementation of the MHPAEA in these programs. As a result, beneficiaries of these programs may not have access to important protections provided under the final rules.

Medicaid programs may not, for example, be subject to the provision of the final rules requiring plans and issuers to include carve-out plans in their parity assessments.^{103,105} This provision is important to the efficacy of the MHPAEA because federal parity requirements only apply to issuers and plans that provide both MH/SUD benefits and M/S benefits. Therefore, without this protection, plans and issuers may attempt to avoid parity requirements by carving out MH/SUD benefits into a separate plan.

^z However, it is worth noting that states do have the option to create ABPs (ie, benchmark and benchmark equivalent plans) to provide coverage for portions of the Medicaid population under traditional Medicaid. These ABPs, like those for the expansion population, are subject to MHPAEA requirements.⁴⁴

While CMS guidance “urges” states with carve-out arrangements “to apply the principles of parity across the whole Medicaid managed care delivery system,” it does not strictly require them to do so.¹⁶ As a result, Medicaid beneficiaries in states that carve out mental health benefits into a separate plan may have more limited access to parity protections.

LACK OF SPECIFIC MANDATED SERVICES

Although the MHPAEA and its implementing regulations require parity, neither the law nor the rules mandate that plans or issuers must provide any particular MH/SUD benefit or cover all mental health conditions.⁷⁴ The ACA’s EHB requirements, as well as requirements regarding mandatory benefits in traditional Medicaid programs, ensure that all Medicaid beneficiaries receive at least some mental health benefits. However, without more specific mandates, even Medicaid programs that comply with all parity and coverage requirements may still not provide beneficiaries with access to the specific mental health benefits that they require.

DETERMINING PARITY OF NQTLs

One of the most difficult challenges in implementing the MHPAEA is determining whether plans or issuers are meeting parity requirements when applying NQTLs. Unlike limitations that are expressed as numbers—such as financial requirements and quantitative treatment limits—NQTLs cannot typically be directly compared. Therefore, the final rules direct private plans and issuers to ensure parity in the processes and standards used to apply NQTLs, rather than requiring that each NQTL actually have an equivalent impact on the provision of MH/SUD and M/S benefits.

Given the more subjective nature of these comparisons, plans and issuers have historically had considerable difficulty in appropriately applying parity principles to NQTLs. For example, a study released by HHS in November 2013 “uncovered numerous areas of concern” regarding how employer-sponsored group health plans, and insurance coverage offered in connection with such plans, applied NQTLs under the MHPAEA.^{110,111} In particular, the report noted that a considerable number of plans applied more stringent precertification and utilization management controls for MH/SUD benefits than for M/S benefits.¹¹⁰

Beneficiaries should therefore be particularly attentive to the application of NQTLs when assessing whether the coverage provided by their Medicaid MCOs or ABPs is in compliance with the requirements of the MHPAEA.

ACCESS TO PLAN INFORMATION

In order to determine whether plans or issuers are providing coverage in accordance with the provisions of the MHPAEA, beneficiaries and advocates must have access to underlying plan information. Although the MHPAEA requires plans and issuers to disclose both medical necessity criteria and reasons for payment and reimbursement denials, advocates continue to express concerns regarding access to plan information.⁹⁴ Therefore, in order to ensure effective enforcement of the MHPAEA, advocates must continue to monitor the availability of plan information.

Conclusion – Parity Moving Forward

Over the last 20 years, the parity movement has made great strides towards ensuring that most individuals have equal access to both mental and physical health benefits. The MHPA, MHPAEA, and ACA have established that most plans may not implement (1) annual or aggregate lifetime limits, (2) financial requirements, (3) treatment limitations, or (4) out-of-network benefits more restrictively for MH/SUD benefits than for M/S benefits. Furthermore, the ACA has established that many plans—including Medicaid ABPs—must provide at least some mental health benefits.

However, many challenges still remain. While Medicaid MCOs and ABPs are subject to federal parity requirements, CMS has yet to issue detailed rules describing how states should implement parity requirements with respect to these programs. Additionally, most traditional FFS Medicaid programs are not yet subject to federal parity requirements.

Therefore advocates must use the current momentum around mental health parity to build upon these initial advances. In particular, advocates must urge state and federal policymakers to establish a clear and complete parity framework, which applies to all public as well as private plans.

Ongoing Issues to Monitor

Despite recent promising reforms, the work of ensuring meaningful access to appropriate mental health care is far from over. This section of the toolkit provides an overview of some of the ongoing barriers to care—and potential advocacy responses—in the Medicaid mental health landscape.

Ongoing Issues Related to Health Reform Implementation

ISSUES FACING MEDICAID EXPANSION

Medicaid expansion under the ACA has the potential to extend Medicaid coverage to nearly all adults under the age of 65 with incomes at or below 133% of federal poverty level (FPL). Such expansion would extend mental health services to millions of previously uninsured Americans as a required element of the new Medicaid ABPs. To date, 22 states have not implemented Medicaid expansion.⁵ As a result, millions of low-income adults still lack access to key mental and physical health services.

Advocacy Response to Issues Facing Medicaid Expansion

Moving forward, advocates must continue to encourage the remaining 22 states to approve Medicaid expansion. In particular, advocates should be sure to emphasize the enhanced funding that the federal government will provide to support coverage of the expansion population (ie, 100% of FMAP until 2016, declining to 90% as of 2020). If standard expansion options lack popular support, advocates may also want to consider whether states could use alternative models—like those in Arkansas, Iowa, Michigan, and Pennsylvania—to achieve coverage.

Advocates must also continue to defend healthcare reforms from legal attacks. Since its enactment, the ACA has been subject to a number of legal challenges, including the 2012 Supreme Court case which rendered Medicaid expansion optional and the upcoming Supreme Court review of *King v. Burwell*,¹¹² a case which threatens the provision of tax credits to low-income individuals in many states. By attempting to damage important elements of the ACA, these challenges pose a serious threat to the success of healthcare reform as a whole.^{9a}

CHURNING

Over the course of each year, many Medicaid beneficiaries experience shifts in coverage as their incomes fluctuate above and below income limits. In Medicaid expansion states, such “churning” will no longer leave individuals uninsured. However, it may still create gaps or discontinuities in coverage as beneficiaries switch from Medicaid to private plans available through the private exchanges.

“Churning” has been predicted to impact as many as 9 million people^{bb113} over the course of a year, and may be particularly problematic for individuals with chronic conditions such as mental health and substance use issues.^{113,115} As these individuals experience fluctuations in income, they may be

^{9a} While the full impact of the recent mid-term elections remains to be seen, advocates should be prepared for a potential increase in these types of challenges to the ACA, given the recent shift towards Republican control of the federal legislature.

^{bb} Others have predicted that more than 28 million individuals may experience churning between exchange plans and public coverage or between exchange plans and being uninsured within six months of enrollment in a plan on the health exchanges.¹¹⁴

separated from the providers with whom they have a stable relationship, forgo or delay treatment based on increases in cost-sharing, or lose access to certain psychiatric medications due to differences between prescription drug formularies.^{113,115}

Advocacy Response to Churning

Several states are taking steps to address the issues associated with “churning.” For example, Delaware has created a requirement that companies offering plans in the exchange continue to cover existing prescriptions and treatment for a set period of time for individuals transitioning from Medicaid coverage.^{113,114} Other states have created programs to encourage companies to offer similar plans via both Medicaid and the exchanges.¹¹³

States may also wish to consider implementing a Basic Health Program, as described in the final rules published by the CMS on March 12, 2014 (79 Fed. Reg. 14112). The Basic Health Program option allows states to create a plan to provide affordable coverage—including EHBs—to individuals whose incomes are between 133% and 200% of FPL.¹¹⁶ This coverage is to be coordinated with coverage under other programs, including Medicaid, in order to ensure continuity of care.^{116,117} Studies have indicated that Basic Health Programs could significantly reduce the number of individuals churning between healthcare coverage programs.¹¹⁸

To help address the ongoing issue of “churning,” advocates should continue to monitor the progress of all of these options and encourage additional states to adopt promising changes.

INTEGRATION OF PHYSICAL AND MENTAL HEALTH CARE AND SERVICES

Stakeholders have also identified several challenges that still stand in the way of recent efforts to integrate the provision of physical and behavioral health (ie, mental health and substance use disorder) services.

In a July 2013 report, Massachusetts’ Behavioral Health Integration Task Force identified six significant barriers to integration:

1. Reimbursement issues (eg, restrictive billing policies that prevent integration of services)
2. Outdated regulations based on separate systems for behavioral and physical health
3. Inaccessibility of behavioral health services

4. The need to provide training/education to primary care and behavioral health providers
5. Lack of connection between behavioral health systems and EHR
6. Privacy concerns¹¹⁹

Advocacy Response to Integration Issues

Advocates can address these challenges by encouraging policymakers to follow the example of states, like Massachusetts, that are actively working to identify and address barriers to integration. In its final report, Massachusetts’ Task Force made 29 recommendations that might prove useful to other states, including¹¹⁹:

- ▶ Waiving prior authorization requirements for first visits to behavioral health services so that issues identified during a primary care visit can be referred and addressed by a behavioral health specialist that same day
- ▶ Allowing the reimbursement of behavioral and physical health services on the same day
- ▶ Requiring Massachusetts-based schools that prepare students for careers in medicine, nursing, and behavioral health to educate students regarding behavioral health and related medical care issues

Cost Containment Issues and Concerns

PHARMACY BENEFITS

For people living with serious mental illness, prescription drugs are a critical and integral part of medical treatment. In this patient population, access to medication can mean the difference between being a productive, fully engaged participant in a community and being institutionalized, incarcerated, or homeless. Like most preventive care, effective medications tend to improve health outcomes and prevent more expensive medical interventions from becoming necessary in the future. Access to prescription drugs is therefore crucial to the health and well-being of people living with serious mental illness—and to reducing overall Medicaid expenditures for this population.

Nevertheless, states often attempt to limit the access of Medicaid beneficiaries to prescription drugs. Medication costs have historically been a major expense for Medicaid, and so most states have put in place some sort of cost-containment measures for prescription drug expenses.

As an EHB, prescription drugs are a required element of the new ABPs. However, in traditional Medicaid plans, prescription drugs remain an optional benefit. Although all states have currently chosen to cover medications—at least to some extent—states can still opt to limit or even eliminate access to prescription drugs in their traditional plans without a federal waiver. It is for this reason that pharmacy benefits are particularly vulnerable to budget cuts and other attempts to restrict access.

States have employed a number of strategies to contain pharmacy benefit costs. Several of these strategies, and potential advocacy responses, are described below.

PREFERRED DRUG LISTS (PDLs), RESTRICTIVE DRUG FORMULARIES, AND PA REQUIREMENTS

One way states try to control the cost of Medicaid pharmacy benefits is to restrict the number and range of medications (the formulary) for which Medicaid will pay. As described earlier, states create PDLs of medications that providers can prescribe, within certain limits, without needing to get permission first.

As of early 2014, 46 states reported using PDLs²⁴ but some states have historically carved out whole drug classes for specific (generally costly) medical conditions, such as HIV/AIDS, cancer, and certain categories of mental illness. For example, while most PDLs covered antidepressants and antipsychotics as of 2012, most did not cover bipolar specific medications.²⁹ If a provider wants to prescribe a medication that is not on the PDL, he or she must obtain prior authorization (PA) so that Medicaid will cover the cost of the prescription.

Advocacy Response to PDLs, Restrictive Formularies, and PA Requirements

Research has shown that restricting access to mental health medications does not, in fact, save money. Restrictive formularies and PDLs increase the chance that patients will have a lapse in treatment—or stop treatment altogether—resulting in the need for more costly interventions.¹²⁰ Specifically, such restrictions shift costs to more expensive forms of care within Medicaid budgets (eg, emergency department visits and hospitalizations)¹²¹ and result in higher costs for other government programs—such as the criminal justice system and homeless services—which are not eligible for federal Medicaid matching payments.¹²²

Ideally, all mental health medications would be exempt from PDL and PA requirements. When this level of access is not possible, advocates can argue for other measures to help maintain quality of care for patients with mental and/or emotional disorders, such as:

- ▶ “Grandfathering” Medicaid prescription benefits for patients who are already stabilized on non-preferred drugs
- ▶ Not using “fail first” policies
- ▶ Allowing prescribers a “dispense as written” option
- ▶ Ensuring a PA process that is easy to use and requires a quick response
- ▶ Making sure that Medicaid rules about PA response time (within 24 hours) and provision of emergency supplies of medications (72-hour supply) are followed
- ▶ Ensuring that PDL is based on the most recent clinical evidence and current standards of care
- ▶ Including practicing mental health clinicians on the Pharmacy and Therapeutics Committee that determines the program’s PDL
- ▶ Holding the state accountable for tracking administrative costs, healthcare costs, and the impact on beneficiaries of restricted access to medication^{123,124}

BENEFICIARY COST-SHARING ARRANGEMENTS

States have also imposed premiums and cost-sharing obligations on Medicaid beneficiaries to shift some of the cost of medications and services back on patients. For Medicaid beneficiaries, the most common form of cost-sharing is copayments, or copays, for prescriptions, which most states have implemented.

The federal government has, however, placed some limitations on the extent of such cost-sharing arrangements. In the summer of 2013, CMS issued regulations which, among other things, capped copayments at \$4 for outpatient services, \$75 for inpatient admission, \$4 for preferred drugs, and \$8 for non-preferred drugs and non-emergency use of the emergency department for beneficiaries with incomes at or below 100% of federal poverty level.¹²⁵ Additionally, the total burden—including both premiums and cost-sharing—cannot exceed 5% of quarterly or monthly family income for any beneficiary.³

Advocacy Responses to Beneficiary Cost-Sharing Arrangements

Even modest copays of \$2.00-\$5.00 can be a hardship for Medicaid enrollees, who, by definition, have very low incomes. In addition, people living with mental illness often have other medical conditions that require multiple prescriptions, further compounding the financial hardship to these individuals.

Copays do not generate significant revenue—nor do they offset a significant percentage of the cost of medications. In fact, any cost-sharing amount paid by a Medicaid beneficiary is not eligible for matching federal funds. Instead, copays may save states money primarily because they discourage low-income beneficiaries from filling prescriptions at all.

The use of copays just shifts costs; it does not necessarily save money. Discouraging individuals living with mental illness from filling prescriptions can lead to lapses in treatment, and expensive interventions. A 2004 study found that Medicaid mental health patients with irregular medication use were hospitalized twice as often as patients with consistent medication use.¹²⁰

Studies have shown that cost-sharing arrangements can have major adverse consequences for Medicaid beneficiaries. One study found that, after cost-sharing arrangements were implemented, patient emergency department use increased by 78% while hospitalization, institutionalization, and death increased by 88%.¹²⁶

LIMITS ON THE NUMBER OF PRESCRIPTIONS ALLOWED PER MONTH

In an attempt to keep costs down, some states also set limits on the number of prescriptions that a Medicaid beneficiary can fill in any given month, on the number of pills allowed to be dispensed at one time, or on the number of refills permitted before a new prescription is required. States may also limit the number of brand-name prescriptions a beneficiary may have.

In what is hopefully a downward trend, the number of states imposing monthly limits on the number of prescriptions that a beneficiary may fill dropped from 18 in FY 2013 to 16 in FY 2014.²⁴

Advocacy Responses to Limits on Number of Prescriptions

People living with serious mental illness are more likely to have multiple chronic medical conditions that require additional medications. Numerical prescription limits pose significant challenges to people trying to manage multiple health issues.

As with PDLs, PA requirements, and cost-sharing arrangements, creating barriers to pharmacy access through prescription limits may not save money in the long run. When beneficiaries are unable to take prescribed medications, they are likely to need more expensive medical care in the future as a result of deferred treatment.

REQUIRING OR INCENTIVIZING USE OF GENERIC DRUGS

Because generic drugs cost 80-85% less than brand-name medications (ie, before drug rebates are deducted), states may require providers to prescribe generic equivalents when they are available. Other ways to incentivize the use of generic drugs are to lower copays for generics and to require PA for brand-name medication when a generic is available. As of 2010, 12 states also used tiered copayment policies (charging beneficiaries less to purchase generic drugs).¹²¹ However, some states allow providers to override Medicaid requirements to prescribe generic drugs.

Advocacy Responses to Requiring or Incentivizing the Use of Generic Drugs

Policies that restrict access to brand-name drugs can be particularly harmful to people living with serious mental illness because newer and more effective medications generally do not have generic equivalents.

In addition, mental health medications are not interchangeable—even medications in the same drug class can differ from one another. Mental health drugs have different chemical structures and may work differently and have different efficacy and side effect profiles in different people. Providers and patients should be able to make the choice of the most effective medication based on the individual patient's situation. Mandating the use of generics takes away that choice.

Finally, if a generic drug fails to work for a patient, treatment will ultimately cost more than if the patient had been allowed access to a brand-name drug in the first place.

“FAIL FIRST,” STEP THERAPY, AND THERAPEUTIC SUBSTITUTION POLICIES

Under a “fail first” policy, providers must prescribe the oldest and least expensive drug available to treat a given disease or condition. If that medication fails to help the patient, the provider can then move to the next least expensive model. Step therapy and therapeutic substitution (ie, requested or required substitution of one drug for another when a patient goes to fill a prescription) are similar methods of trying to have Medicaid beneficiaries use less expensive medications.

Advocacy Responses to Fail First, Step Therapy, and Therapeutic Substitution Policies

There have been tremendous advances in mental health medications during recent decades. Newer drugs are often more targeted and more effective and have fewer severe side effects.

As noted previously, mental health medications are unique and cannot be used interchangeably. Substituting one medication for another poses health and safety risks. A study of Medicare patients with mental illness looked at beneficiaries who were stabilized on medications but then switched by their Part D plans to other drugs; more than one in three had an emergency department visit, and 15% were hospitalized.¹²⁷

As with policies that mandate the use of generic drugs, the implementation of fail first, step therapy, and therapeutic substitution policies interferes with the provider-patient relationship and is neither cost-effective nor compassionate.

SUPPLEMENTAL DRUG REBATES

In addition to the federal Medicaid rebate program, most states negotiate additional rebates from pharmaceutical companies. As of June 2014, supplemental rebates were used by 45 states and the District of Columbia.¹²⁸ The basic mechanism of supplemental rebates works like this: (1) a state creates a Medicaid PDL, then (2) manufacturers that agree to pay an increased, or “supplemental,” rebate to the state have their drugs included on the PDL. Alternatively, manufacturers that do not enter such agreements often find that their drugs are given non-preferred status in the Medicaid PDL and require PA when prescribed to Medicaid enrollees.

The ACA has increased the federal Medicaid drug brand-name rebate from 15.1% to 23.1% for most brand-name drugs (applicable only to the federal portion of the drug cost).¹²⁹ The legislation also extended the prescription drug rebate to Medicaid managed care organizations for the first time, retroactive to January 1, 2010.¹²¹

Advocacy Responses to Supplemental Drug Rebates

To the extent that supplemental rebates reduce access to certain medications, the advocacy responses to PDLs and PA requirements discussed previously also apply to these rebates.

MULTISTATE PURCHASING COALITIONS

To contain costs and leverage more bargaining power with pharmaceutical manufacturers, many states have also voluntarily joined multistate buying pools. As of 2012, there were three such multistate Medicaid buying pools, involving 27 state Medicaid programs (including the District of Columbia).¹³⁰

Two of three multistate Medicaid buying pools are administered by Provider Synergies, LLC (Cincinnati, OH): the National Medicaid Pooling Initiative (NMPI), started in 2003 and serving 10 states and the District of Columbia; and the Top Dollar Program, started in 2005 and serving 8 states.¹³⁰ Goold Health Systems (Augusta, ME) currently manages rebate negotiations for the Sovereign States Drug Consortium (SSDC), a state-owned program started in 2006 which currently services 8 states.¹³¹

Advocacy Responses to Multistate Purchasing Coalitions

To the extent that multistate purchasing reduces access to certain medications, the advocacy responses to PDLs and PA requirements discussed previously also apply to this state-initiated cost-saving measure.

ALTERNATIVE, QUALITY-DRIVEN WAYS TO CONTAIN MEDICAID PHARMACY COSTS

All the approaches discussed previously represent cost-driven utilization management of Medicaid pharmacy benefits—all of which can actually prove not to be cost-effective if beneficiaries end up needing more expensive medical interventions because of inadequate access to medications. These are not the only cost-containment options open to states. Below are several examples of alternative cost-containment approaches that focus on improving the quality and effectiveness of pharmacy benefit use.

- ▶ **Provider Education and Feedback Programs:** These programs review pharmacy claims and prescribing patterns with the goal of educating providers about best practices.¹²³ Research indicates that provider education programs can lead to significant savings.¹³²
- ▶ **Prescription Case Management:** Using clinical reviews, these programs help monitor and ensure appropriate use of medications when prescribing activity is unusually high or outside of usual clinical practice. Such management programs have been shown to both contain costs and improve patient health.¹²³
- ▶ **Disease Management Programs:** These programs—commonly developed for chronic diseases such as diabetes—provide patient education on disease management, medication usage, medication side effects, and self-care strategies.¹²³ By better managing medication use, patients may avoid lapses and problems leading to more expensive interventions.

MEDICAL NECESSITY

As noted earlier, states are only required to pay for Medicaid services that have been certified to be “medically necessary” by a physician.³ However, this term is largely undefined by federal law. Therefore, states may use their discretion in defining medical necessity to limit the provision of covered services to particular circumstances (eg, for particular diagnoses), or require prior authorization before certain services are provided.¹⁹

Advocacy Responses to Medical Necessity Issues

Advocates may have the opportunity to influence the content of Medicaid programs in a number of ways, including, but not limited to, public comment on state rule-making; state Medicaid waiver applications; at Medicaid Pharmacy and Therapeutics Committees (which make recommendations for preferred drug lists); during managed care contract renewals; and within managed care plans themselves, such as through formal member grievance procedures.

In their efforts in these areas, advocates can encourage Medicaid programs to more clearly delineate the bounds of medical necessity, such as by including a clear definition of medical necessity in managed care contracts. This definition should be broad enough to cover the comprehensive services needed by people living with mental illness.

Well-defined, current clinical standards should be used to guide decision-making processes regarding whether a service is necessary and therefore covered. Finally, medical necessity determinations for mental health services should be made in a timely way by licensed clinicians with experience in treating people with mental illness.

Tools for Enforcement and Correction

GRIEVANCE AND APPEALS PROCESSES

Medicaid applicants and beneficiaries have the right, through the state agency appeals process, to seek review of program decisions—or inaction—regarding eligibility and receipt of benefits.^{41,133,134} These rights must be explained in a notice provided to the applicant or beneficiary when they apply for benefits or when the state acts in a way that impacts their claims for benefits.^{133,134}

Additionally, under the federal regulations regarding managed care—in Title 42, Part 438 of the Code of Federal Regulations—Medicaid MCOs must establish their own internal grievance and appeals processes. MCO beneficiaries may be required to attempt to address their concerns through MCO appeal processes prior to pursuing a hearing through the state agency.^{133,135}

Advocacy Approach to Grievance and Appeals

Medicaid beneficiaries should familiarize themselves with program policies regarding grievances and appeals so that they are able to contest any incorrect determination on the part of a state Medicaid agency or Medicaid MCO.

Advocates should work to ensure that these policies provide a fair and adequate opportunity to be heard. Medicaid MCO contracts should ensure that a thorough description of formal processes is provided to members in writing in a format that is easy to understand. Grievance appeals and processes should be straightforward. They should specify and clearly define the steps that members need to take to file a grievance or appeal. Similarly, reasonably prompt response times from plan administrators after a grievance or appeal has been filed should be well-defined.

ENFORCEMENT, CORRECTIVE ACTION, AND SANCTIONS

Medicaid managed care contracts must also specify how they will be enforced, including the corrective actions that will be taken if a problem is identified with plan performance, and sanctions that may be imposed for such issues.

Advocacy Approach to Enforcement, Corrective Action, and Sanctions

Advocates should urge states to include effective enforcement, corrective action, and sanction measures in Medicaid managed care contracts. In particular, sanctions for noncompliance should be included—and they should be significant enough to give plans an incentive to comply.

State and Federal Advocacy Tools

There are a number of different ways for mental health advocates to communicate their messages to various audiences—and to encourage others to join them in promoting their priorities and goals. Some of these tools are listed in this section.

Examples of these tools can frequently be found on the websites of mental health organizations such as the National Alliance on Mental Illness (www.nami.org), the National Council for Behavioral Health (www.thenationalcouncil.org), and Mental Health America (<http://www.mentalhealthamerica.net/>).

Social Media

Also referred to as new media. Advocates continue to explore new uses for web-based and mobile technologies with a goal of transforming existing one-way communication models (ie, “traditional media,” such as newspapers, radio, and television) into interactive dialogues that foster online communities. Social media is used to share information and to mobilize advocates, allowing supporters and key stakeholders to connect in “real time.”

Types of social media include social networking sites (eg, Facebook), blogs and microblogs (eg, Twitter), content communities (eg, YouTube), and collaborative projects (eg, Wikipedia).

Fact Sheet

A reference document that provides concise information about a particular topic, including a description of the issue, relevant statistics and a summary of supporting information and research. Ideally, fact sheets should not be longer than one double-sided page. However, they can be longer for more complex issues.

Organization Sign-on Letter

A template letter to lawmakers or policymakers, to which multiple organizations can attach their names, that advocates for a particular action or provision. Organization sign-on letters are intended to demonstrate “strength in numbers,” and can help persuade public officials that the action or position called for has broad support among his or her constituents.

Action Alert

A time-sensitive request from organizations that asks advocates to take a particular action, such as calling elected officials to voice concern about an issue and ask for the official to support their position. Action alerts are often sent via email and usually ask people to take action either immediately or within a day or two.

Constituent Letter

Personal correspondence addressed to elected officials from people within their districts. These letters convey a specific message about an issue and reflect how it relates personally to the constituent.

For constituent letters to have the most impact, the sender should be a registered voter. In fact, the elected official (or a member of his or her staff) will often verify the sender's voting status.

Talking Points

A brief list of key arguments and responses for advocates to use as they speak about an issue. Talking points can be used for telephone calls to elected officials, in one-on-one meetings with legislators and representatives, or in "town hall" meetings. They should present the most persuasive arguments in favor of the advocate's position and anticipate and address objections and opposing views.

Op-Ed

A short article that appears opposite the editorial section of a newspaper or magazine. An op-ed is basically a long letter to the editor. It seeks to convey a particular opinion and is often used to advocate a cause, draw attention to an issue, and educate the public.

Although op-eds are generally published by invitation only, some publishers accept unsolicited manuscripts. Before writing an op-ed, however, it is recommended that writers contact the editor of the editorial page to "pitch" their idea (ie, promote the topic and inquire as to the publisher's level of interest). Op-eds that are signed by a prominent individual (eg, well-known physician, state legislator, or public health official) are more likely to be published. In addition, to ensure the accessibility and timeliness of the content, editors generally have word count guidelines and submission deadlines for writers.

Telling Your Story

Highly structured, strategic testimonials are another tool available to advocates. Personal stories of this kind can be used effectively in one-on-one meetings with legislators and representatives, town hall meetings, and in multimedia promotional materials.

APPENDIX: TABLE OF ACRONYMS	
ABP	Alternative Benefit Plan
ACA	Affordable Care Act
ACIP	Advisory Committee for Immunization Practices
ACO	Accountable Care Organization
ARRA	American Recovery and Reinvestment Act of 2009
ASO	Administrative Service Organization
CARF	Commission on Accreditation of Rehabilitation Facilities
CCO	Coordinated Care Organization
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
EHB	Essential Health Benefit
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FEHBP	Federal Employees Health Benefit Plan
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally-Qualified Health Center
FY	Fiscal Year
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
MAGI	Modified Adjusted Gross Income
MBHO	Managed Behavioral Health Organization
MCO	Managed Care Organization
MHPA	Mental Health Parity Act of 1996
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
MH/SUD	Mental Health or Substance Use Disorder
M/S	Medical/Surgical
MSSP	Medicare Shared Savings Program
MTS	Mobile Treatment Services
NMPI	National Medicaid Pooling Initiative
NQTL	Nonquantitative Treatment Limitation
OHP	Oregon Health Plan
OTP	Opioid Treatment Program

APPENDIX: TABLE OF ACRONYMS (cont.)	
PA	Prior Authorization
PCCM	Primary Care Case Management
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PDL	Preferred Drug List
PE	Presumptive Eligibility
PRP	Psychiatric Rehabilitation Program
QHP	Qualified Health Plan
SED	Serious Emotional Disturbance
SNAP	Supplemental Nutrition Assistance Program
SPA	State Plan Amendment
SSDC	Sovereign States Drug Consortium
USPSTF	United States Preventive Services Task Force

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