



# Medicaid Managed Care Mental Health Services **AND** Pharmacy Benefits Toolkit **Executive Summary**

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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. Studies have shown that low-income households are particularly likely to feel the impact of mental illness.<sup>1</sup> Thus, as the primary healthcare safety net for low-income individuals, Medicaid is a key resource for accessing mental health treatment in the United States. Medicaid coverage is particularly important for these individuals because of the often complex and serious nature of their healthcare needs. Roughly 35% of non-elderly recipients of Medicaid are coping with mental illness, and as 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%).<sup>2</sup>

Prior to the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, Medicaid coverage had historically been limited to certain narrow categories of individuals, leaving many others uninsured and without access to crucial mental and physical care. The ACA sought to extend Medicaid coverage to reach nearly all adults<sup>a3</sup> under the age of 65 with incomes at or below 133% of the federal poverty level (FPL)<sup>b</sup> (approximately \$31,720.50/year for a household of four<sup>4</sup>), regardless of disability or family makeup. However, a US Supreme Court decision effectively rendered ACA Medicaid expansion optional for states, and as of the date of this publication, only 28 states and the District of Columbia have chosen to expand.<sup>5</sup> The remaining 22 states continue to maintain their prior, more restrictive limits.

**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/>

The ACA's impact on Medicaid programs, is not, however, confined solely to states that have chosen to implement Medicaid expansion. It also initiated a number of significant changes to Medicaid that apply to all states. This Executive Summary—as well as the full Medicaid Managed Care Mental Health Services and Pharmacy Benefits Toolkit—is therefore intended to help advocates navigate the current complex Medicaid landscape and understand how recent reforms and trends are impacting access to Medicaid mental health benefits.<sup>c</sup>

<sup>a</sup> Medicaid enrollment will remain limited to United States citizens and certain lawfully present immigrants. Undocumented immigrants are not eligible for Medicaid.<sup>3</sup>

<sup>b</sup> While the ACA Medicaid expansion limit is 133% FPL, a 5% "income disregard" brings the effective income level to 138% FPL.<sup>3</sup>

<sup>c</sup> 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.

## Trends in Mental Health Care and Treatment in Traditional Medicaid

Medicaid provides healthcare coverage to all eligible low-income citizens.<sup>3</sup> Unlike the federally-run Medicare system, state and federal governments jointly manage Medicaid administration and funding. Overall, Medicaid finances healthcare and related services for more than 66 million people<sup>6</sup> and ranks as the single largest payer for mental health services in the United States.<sup>7</sup>

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 mental health benefit packages and service provision models under traditional Medicaid.

### Recent Trends in Mental Health Benefits

Unlike the individuals who become newly eligible for Medicaid based upon Medicaid expansion, individuals who qualify for Medicaid based upon pre-ACA eligibility standards will continue to receive their state's traditional Medicaid benefits package. These traditional Medicaid packages cover a range of federally mandated services that all states must provide to most Medicaid recipients, such as physician services (including psychiatrist services),<sup>8</sup> inpatient and outpatient hospital services, federally qualified health center (FQHC) services and others,<sup>9</sup> which cannot be cut without a federal waiver.

States may also elect to provide an array of optional services in their traditional Medicaid package. 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.<sup>10</sup> As of 2012, all states also covered rehabilitation services, such as community support services,<sup>d11</sup> 48 states covered targeted case management services,<sup>e12</sup> and 35 states covered psychologist services.<sup>f13</sup>

<sup>d</sup> These data represent the number of states providing rehabilitation services in their FFS Medicaid program.

<sup>e</sup> These data represent the number of states providing targeted case management services in their FFS Medicaid program.

<sup>f</sup> These data represent the number of states providing psychologist services in their FFS Medicaid program.

In fiscal years (FYs) 2014 and 2015, almost one-half of the states reported expansions to their Medicaid benefit plans.<sup>14</sup> Behavioral health<sup>9</sup> services were a common focus of these expansions.<sup>14</sup> However, certain noteworthy gaps in mental health coverage remain. For example, traditional Medicaid packages still do 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.<sup>15,16</sup> The Centers for Medicare and Medicaid Services (CMS) has initiated a demonstration project to reconsider this exclusion, though.<sup>17</sup>

### Recent Trends in Service Delivery: Coordination of Care

In addition to expanding Medicaid benefit packages, many states are also shifting their approach to service delivery by implementing reforms that emphasize coordination of care. Such reforms have the potential to benefit Medicaid recipients coping with complex mental and physical issues by reducing gaps and redundancies in care and preventing inappropriate care and unnecessary costs.

#### *Increased Emphasis on Managed Care*

Medicaid has historically been a fee-for-service (FFS) system in which Medicaid pays a predetermined amount for each individual service provided. However, over time, Medicaid programs have gradually shifted away from the FFS model and have become increasingly reliant on managed care. Although there are a number of different models of managed care, most share a few key features, including: (1) limiting patient choice of providers, (2) using primary care providers (PCPs) as gatekeepers for specialist services, and (3) using physicians or organizations to manage patient care. If carefully implemented, these features have the potential to keep costs down, while enhancing service coordination.

As of 2011, more than 70% of Medicaid enrollees received at least some portion of their benefits through a managed care model,<sup>18</sup> and as of July 2014, all states except Alaska, Connecticut,<sup>h</sup> and Wyoming, had implemented some form of managed care in their Medicaid systems.<sup>14</sup> In recent years, states have continued to expand the role of managed care in their Medicaid systems through reforms involving geographical expansion, mandated participation, and the inclusion of new eligibility groups.<sup>14</sup>

Some states are also taking steps to build upon the opportunities for care coordination in their managed care systems by reducing existing barriers between mental and physical care. Such reforms include expanding the availability of Patient-Centered Medical Homes (PCMHs)<sup>14</sup>—a managed care model which emphasizes coordination and integration of care—and reducing reliance on carve-outs that require beneficiaries to receive their physical and mental health benefits through separate plans.<sup>19-21</sup>

#### *Electronic Health Records*

States are also looking to increase care coordination through the use of technological advances, such as electronic health records (EHRs). By recording and sharing a patient’s records electronically, providers can better avoid redundancies or gaps in services.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), the federal government provided more than \$20 billion in funding incentives to encourage providers to engage in “meaningful use” of EHR.<sup>3</sup> Unfortunately, most behavioral health providers were not included in this initiative. In order to address this issue, some states are therefore moving towards inclusion of mental health providers in their own EHR programs and State Innovation Model Accountable Care Organization (ACO) initiatives.<sup>19</sup>

### 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.

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.

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.<sup>3</sup> 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.<sup>8</sup> 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.

<sup>9</sup> Behavioral health is a broader category which encompasses both mental health and substance use disorder services.

<sup>h</sup> Connecticut previously used managed care organizations (MCOs) in its Medicaid system, but in 2012 transitioned to a FFS model, using four administrative service organizations (ASOs) to manage medical health, behavioral health, dental services, and non-emergency transportation services.<sup>14</sup>

## The Changing Landscape: The Impact of the Affordable Care Act

With the passage of the ACA, almost all adults living in the Medicaid expansion states now qualify for Medicaid if their income is at or below 133% of FPL. As noted previously, 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).<sup>22,23</sup>

### ACA Medicaid Expansion – (ABPs)

While most adults in the ACA Medicaid expansion group must be enrolled in ABPs, there are certain categories of individuals that are exempt from this requirement. Most notably, newly eligible beneficiaries who are considered "medically frail"—those who have a serious and complex medical condition, disability, or a physical, intellectual, or developmental disability that significantly impairs daily life<sup>24</sup>—are not required to enroll in a standard ABP.<sup>25</sup> Individuals coping with serious mental illness or chronic substance use disorder (SUD) are considered medically frail.<sup>24</sup>

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.<sup>24</sup> 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.

ABPs differ from traditional Medicaid plans in several ways. Most notably, ABPs are based upon a state-chosen benchmark plan—which can be the state's traditional Medicaid plan.<sup>26,27</sup> In addition, ABPs must cover the same ten "Essential Health Benefits" (EHBs) that form the basis of private plans offered on the healthcare marketplaces (also known as "exchanges").<sup>25</sup> These EHBs include, among other things, mandated coverage of mental health and substance use disorder services and prescription

<sup>1</sup> Other options for the state-chosen benchmark plan include the following: the federal or state employees benefit plan; the health maintenance organization (HMO) plan with the largest commercial, non-Medicaid enrollment in the state; or Secretary-approved coverage.<sup>25,26</sup>

drugs.<sup>28,29</sup> ABPs are also subject to mental health and SUD parity requirements, and therefore must offer mental health and SUD benefits on equal footing with medical/surgical benefits.<sup>25,30,31</sup>

Due to these differing requirements, mental health coverage under the ABPs has the potential to be both broader and narrower than that provided under traditional Medicaid plans. Thus, while most states have tried to align their ABPs with their traditional Medicaid plans, some noteworthy differences do exist. 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.<sup>14</sup> 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.

### Additional ACA Medicaid Reforms

The ACA also mandates that states, regardless of their stance on Medicaid expansion, implement a number of other significant changes to their Medicaid programs. Many of these changes focus on streamlining Medicaid enrollment and enhancing the role of preventive services in Medicaid plans. For example, the ACA has required all states to establish a “no wrong door” enrollment system, whereby applicants can use a single, straightforward application to apply not only for Medicaid, but also for private plans offered on the healthcare marketplaces, the Children's Health Insurance Program (CHIP), and marketplace subsidies.<sup>32-34</sup>

The impact of some of these reforms differs between traditional Medicaid plans and ABPs. For example, adult preventive services remain optional in traditional Medicaid plans. However, the ACA established an incentive program that provides additional funding to states that voluntarily include certain preventive services in their Medicaid plans.<sup>35</sup> In contrast, all ABPs must provide coverage of the services incentivized in the traditional plans without cost-sharing.<sup>36</sup> While some of these preventive services—such as depression screenings

recommended by the United States Preventive Services Task force (USPSTF)<sup>37</sup>—may directly impact beneficiaries coping with mental illness, others may help them to obtain comprehensive whole-person care by identifying and addressing comorbid medical conditions.

In addition to establishing certain mandatory reforms, the ACA also provides 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 to individuals coping with chronic conditions such as serious mental illness.<sup>38</sup> Health home programs are required to provide a number of core services related to coordination of care, promotion of behavioral health care, and connection of beneficiaries to key social supports and services.<sup>39</sup> States that establish Medicaid health homes receive substantial financial incentives from the federal government, including enhanced federal funding to cover 90% of spending for core Medicaid health home services for the first eight quarters of their programs.<sup>38,39</sup>

## The Changing Landscape: Mental Health Parity

Under the Mental Health Parity Act of 1996 (MHPA) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), most health plans must offer comparable coverage of physical and mental health services, also known as “mental health parity.”<sup>40</sup> To do so, these plans must provide equal access to the mental and physical health benefits that they offer. For example, plans may not charge higher copays for mental health benefits than they typically charge for physical health benefits.

The MHPA and MHPAEA (referred to collectively here as the “MHPAEA”), in conjunction with the ACA, have therefore 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.

### Historical Overview of Mental Health Parity

Prior to the enactment of the ACA, the MHPAEA applied only to large, employer-sponsored health plans (and associated insurance issuers) that chose to offer both mental health or substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits.<sup>41,42</sup> The MHPAEA required these plans to provide comparable access to MH/SUD and M/S benefits in four areas: (1) annual aggregate lifetime limits, (2) financial requirements, (3) treatment limitations, and (4) out-of-network benefits.<sup>43</sup> Specifically, in each of these four areas, relevant plans could not place more restrictive limits on access to MH/SUD benefits than they imposed on medical/surgical (M/S) benefits.

Although it did not alter the parity requirements established by the MHPAEA,<sup>44</sup> the enactment of the ACA in 2010 then expanded the MHPAEA's 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.<sup>45,46,47</sup> 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.<sup>25,46,47</sup> Thus, the ACA went beyond the MHPAEA by actually mandating coverage—and therefore parity—in many plans,<sup>k</sup> rather than only applying parity requirements to those plans that already provided mental health benefits.

<sup>l</sup> The ACA expanded the reach of parity laws to the markets through a number of provisions.<sup>25,43,45</sup>

<sup>k</sup> The ACA and MHPAEA 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 (e.g., large employment-based group plans).

## Ongoing Issues to Monitor

Despite recent promising reforms, the work of ensuring meaningful access to appropriate mental health care is far from over. Advocates must therefore continue to be vigilant in addressing the remaining barriers to care.

On November 13, 2013, the Department of Health and Human Services (HHS) issued final rules explaining how relevant private plans should implement the provisions of the MHPAEA (78 Fed. Reg. 68240). The preamble to these final rules confirms that the broad statutory provisions of the MHPAEA apply to two types of Medicaid programs—ABPs and Medicaid MCOs.<sup>25,30,31,48,49</sup> However, the preamble explains that the *final rules* issued on November 13, 2013 apply only to *private* plans.<sup>49</sup>

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.<sup>50</sup> Until then, 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.<sup>49</sup> 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.<sup>125,51</sup>

### *Parity in Medicaid Programs*

In its January 2013 guidance, CMS confirms that Medicaid MCOs are subject to the provisions of the MHPAEA. For the purposes of determining compliance, CMS divides 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. With respect to the first category, CMS indicates that compliance with the state plan/contract requirements is sufficient for compliance with the MHPAEA. However, with respect to benefits or restrictions outside the scope of the state plan/contract, CMS states that Medicaid MCOs must comply with mental health parity requirements. In listing these requirements, CMS largely echoes the statutory language of the MHPAEA.<sup>31</sup>

In its guidance, CMS also confirms that MHPAEA requirements apply to all ABPs. As with Medicaid MCOs, CMS does not provide detailed instructions regarding how ABPs must go about meeting those requirements, but instead largely echoes the MHPAEA.<sup>31</sup>

Although Medicaid MCOs and ABPs are subject to the provisions of the MHPAEA, as of the date of this publication, CMS has yet to issue specific rules regarding the implementation of the MHPAEA in these programs. The forthcoming rules are particularly important for Medicaid beneficiaries living with mental illness, because they will provide further guidance on the application of parity laws to MCOs and ABPs and will, hopefully, provide some of the additional protections included in the final rules applicable to private plans.

### Medicaid Expansion

Changes to the Medicaid landscape under the ACA have the potential to improve mental health care for millions of Americans. Yet, as of the date of this publication, 22 states have not implemented Medicaid expansion.<sup>5</sup> As a result, millions of low-income adults still lack access to key mental and physical health services. Moving forward, advocates in non-expansion states must educate lawmakers as to the importance of Medicaid expansion to both improve health outcomes and reduce healthcare costs of our most vulnerable populations. In addition, a benefit of Medicaid expansion is the enhanced funding that the federal government will provide to support coverage of the expansion population (ie, 100% of federal medical assistance percentages

(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 implemented in Arkansas, Iowa, or Michigan—to achieve coverage.

Advocates must also closely monitor and defend against legal attacks that could undermine healthcare reforms that protect and promote access to mental health care and treatment. 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*,<sup>52</sup> a case which threatens the provision of tax

<sup>1</sup> 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.<sup>25,51</sup>

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.<sup>m</sup>

## Churning

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. This “churning” has been predicted to impact as many as 9 million people<sup>53,54</sup> over the course of a year<sup>n</sup>, and may be particularly problematic for individuals with mental health and substance use issues.<sup>53,55</sup> As these individuals experience fluctuations in income, they may be 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.<sup>53,55</sup>

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.<sup>53,54</sup> Other states have created programs to encourage companies to offer similar plans via both Medicaid and the exchanges.<sup>53</sup>

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.<sup>56</sup> This coverage is to be coordinated with coverage under other programs, including Medicaid, in order to ensure continuity of care.<sup>56,57</sup> Studies have indicated that Basic Health Programs could significantly reduce the number of individuals churning between healthcare coverage programs.<sup>58</sup>

## Cost Containment

Additionally, as Medicaid spending continues to rise, states may limit access to certain mental health services in order to control costs. Medication costs have historically been a major expense for Medicaid, so many states may restrict access to prescription medications—a crucial benefit for individuals living with mental illness—as part of these efforts. However, many of these strategies may ultimately prove not to be cost-effective, as beneficiaries may end up needing more expensive medical interventions because of inadequate access to medications.

Several of these strategies include:

- ▶ Implementing preferred drug lists (PDLs), restrictive drug formularies, and prior authorization requirements, all of which allow states to restrict the number and range of medications (the formulary) for which Medicaid will pay
- ▶ Implementing or increasing beneficiary cost-sharing arrangements
- ▶ Limiting the number of prescriptions allowed per month
- ▶ Requiring or incentivizing use of generic drugs
- ▶ Implementing “fail first” or step therapy policies, requiring providers to initially prescribe older/less expensive drugs to treat a given disease or condition

These are not the only cost-containment options approaches open to states. There are several examples of alternative cost-containment approaches that focus on improving the quality and effectiveness of pharmacy benefit use, rather than merely restricting prescription access. For example, states can implement Provider Education and Feedback Programs, which review pharmacy claims and prescribing patterns with the goal of educating providers about best practices. Alternatively, states can consider Prescription Case-Management, which monitors and ensures appropriate use of medications when prescribing activity is unusually high or outside of usual clinical practice. In addition, states can implement Disease Management Programs, which provide patient education on

disease management, medication usage, medication side effects, and self-care strategies.<sup>59</sup> By better managing medication use through these alternative approaches, patients may avoid lapses and problems leading to more expensive interventions, while still lowering costs.

## 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.<sup>23,60,61</sup> These rights must be explained in a notice provided to applicants or beneficiaries when they apply for benefits or when the state acts in a way that impacts their claims for benefits.<sup>60,61</sup>

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 an MCO appeal process prior to pursuing a hearing through the state agency.<sup>61,62</sup>

In order to maximize the effectiveness of these protections, advocates should work to ensure that these policies provide a fair and adequate opportunity to be heard and that a description of formal processes is provided to members in writing in a format that is easy to understand.

### Enforcement, Corrective Action, and Sanctions

Advocates should also 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 provide an incentive to comply.

<sup>m</sup> 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.

<sup>n</sup> 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.<sup>53,54</sup>



## 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. Several of these tools include:

- ▶ Social media
- ▶ Fact sheets and other reference documents
- ▶ Organization sign-on letters
- ▶ Action alerts
- ▶ Constituent letters
- ▶ Talking points
- ▶ Op-eds

For a more comprehensive look at each of these state and federal advocacy tools, as well as a more detailed analysis of all of the topics discussed in this Executive Summary, please consult the full Medicaid Managed Care Mental Health Services and Pharmacy Benefits Toolkit.

**APPENDIX: TABLE OF ACRONYMS**

ABP	Alternative Benefit Plan
ACA	Affordable Care Act
ACO	Accountable Care Organization
ARRA	American Recovery and Reinvestment Act of 2009
ASO	Administrative Service Organization
CMS	Centers for Medicare and Medicaid Services
EHB	Essential Health Benefit
EHR	Electronic Health Record
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
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
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PDL	Preferred Drug List
USPSTF	United States Preventive Services Task Force

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