ICRC | Integrated Care Resource Center

Working with Medicare: Coordination of Medicare and Medicaid Behavioral Health Benefits

April 30, 2024
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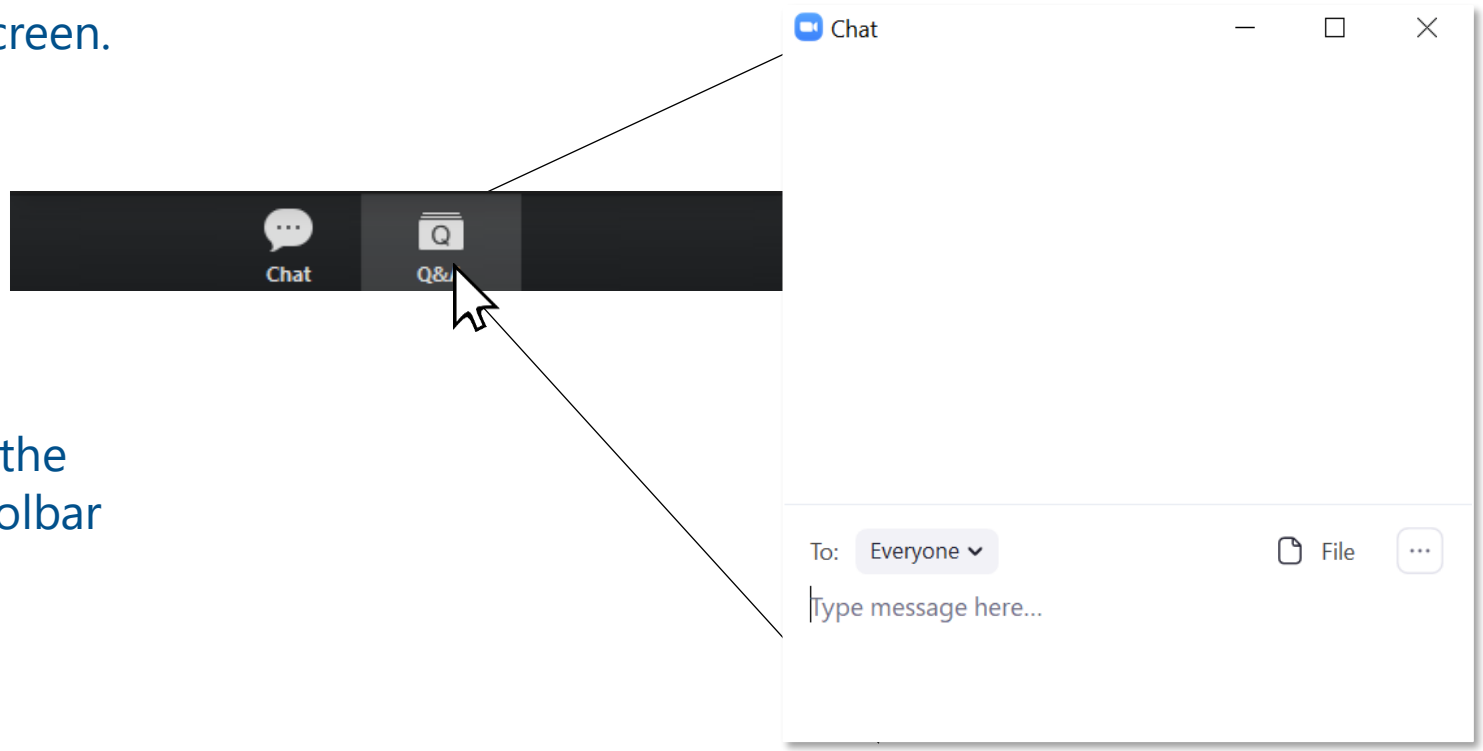

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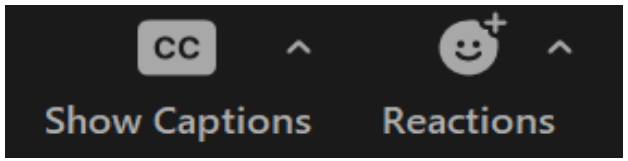

Integrated Care Resource Center (ICRC) "Working with Medicare" Webinars

- ICRC is an initiative of the Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO) that helps states develop integrated programs for people who are dually eligible for Medicare and Medicaid.
- Sign up for our email list and view past ICRC e-alerts: https://www.integratedcareresourcecenter.com/about-us/e-alerts
- ICRC Working with Medicare Webinars are designed for all states interested in improving coordination of Medicare and Medicaid benefits for dually eligible individuals.
- Webinars in the series include:
  - Medicare 101 and 201
  - Coordination of Medicare and Medicaid Behavioral Health Benefits
  - Medicare and Medicaid Nursing Facility Benefits
  - State Contracting with D-SNPs

Agenda

- Behavioral Health Conditions and Expenditures for Dually Eligible Individuals
- Medicare and Medicaid Behavioral Health Benefits
- Coordination of Behavioral Health Benefits: State Approaches and Options
- Questions and Answers

Presenters

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Behavioral Health Conditions and Expenditures for Dually Eligible Individuals

Behavioral Health Conditions Are Highly Prevalent Among Dually Eligible Individuals

- Half of full-benefit dually eligible individuals report having a mental health condition.
- Mental health conditions are more prevalent among dually eligible individuals under age 65 than among those age 65 and older.

Mental Health Condition	Under Age 65	Age 65 and Older
Anxiety disorders	**34%**	22%
Bipolar disorder	**15%**	5%
Depression	**32%**	25%
Schizophrenia and other psychotic disorders	**14%**	6%

- More than one in ten (11.2%) dually eligible individuals have a substance use disorder.

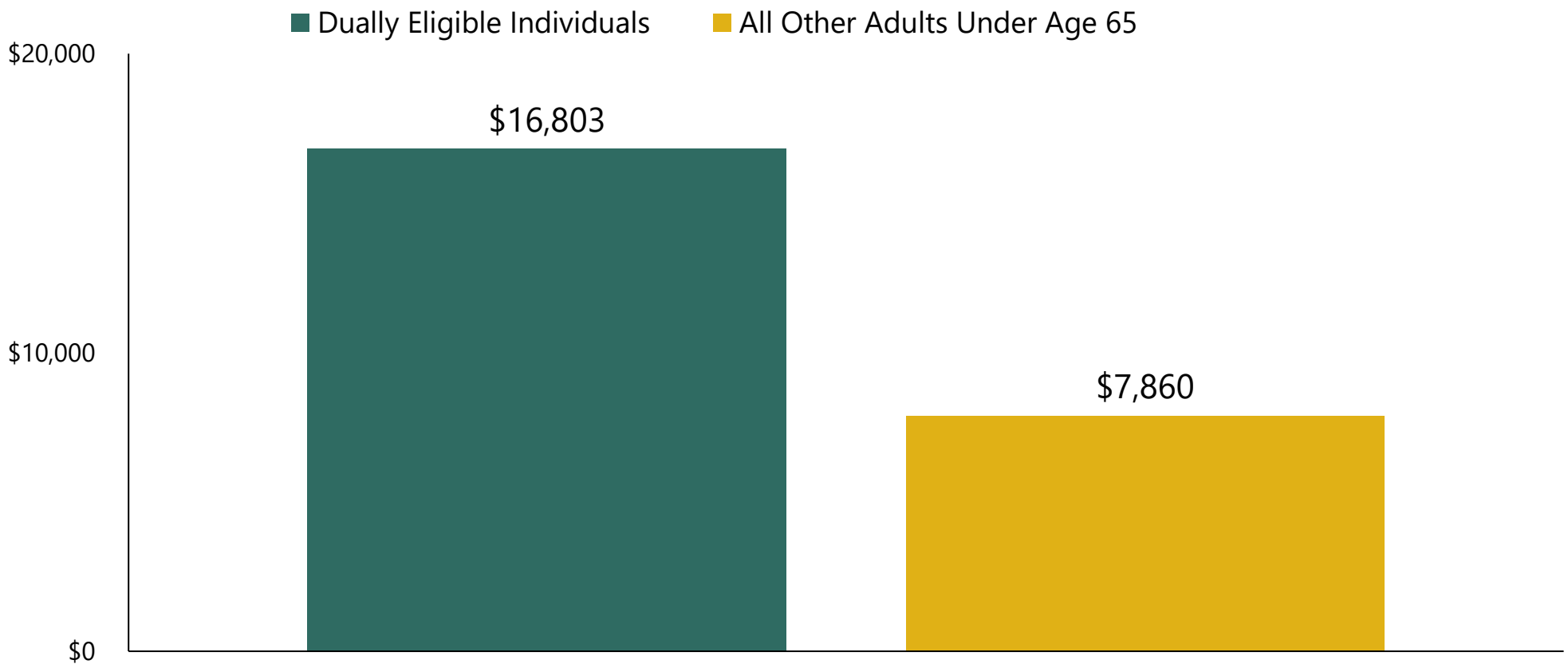
Source: Kaiser Family Foundation (KFF). "A Profile on Medicare-Medicaid Enrollees (Dual Eligibles)." January 2023. Figure 3. Available at: https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/; MedPAC-MACPAC. "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." January 2024. Exhibit 8. Available at: https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf; Legal Action Center (LAC). "Two Plans Are Not Always Better Than One: Barriers to Substance Use Disorder Treatment for Dual-Eligible Individuals." January 2024. Available at: https://www.lac.org/assets/files/Duals-Issue-Brief-2024.01.19_MAPP-Branded.pdf.
In the resource, the data was based on the 2021 National Survey on Drug Use and Health (NSDUH).

Comorbid Physical Health Conditions Among Dually Eligible Individuals with a Mental Health Condition

Chronic Physical Health Comorbidity (CY 2008)	Prevalence
Heart Condition	75%
Musculoskeletal Disorder	42%
Anemia	36%
Diabetes	36%
Lung Disease	30%

Source: CMS. "Physical and Mental Health Condition Prevalence and Comorbidity among FFS Medicare-Medicaid Enrollees." 2014. Table 25. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf

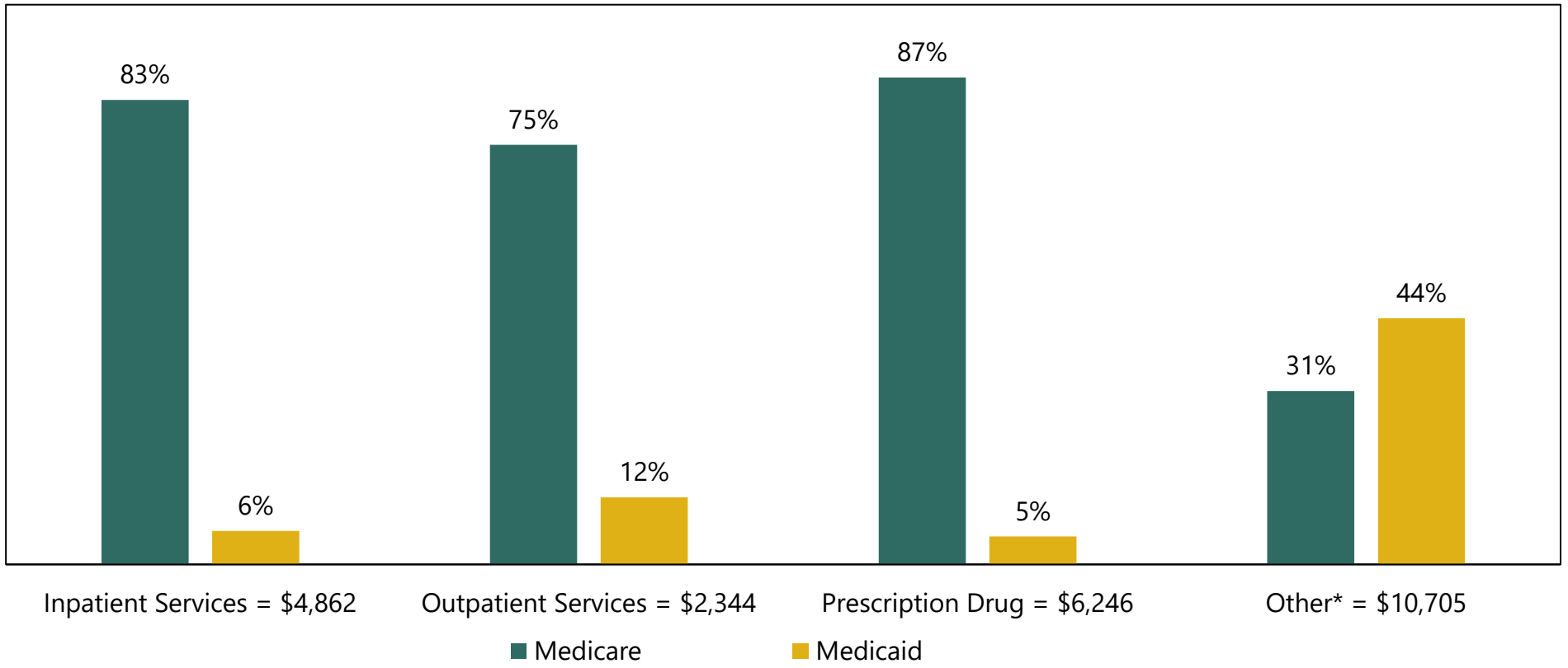
Average Annual Health Care Spending for Dually Eligible Individuals and Non-Dually Eligible Individuals Under Age 65 who Received Behavioral Health Treatments, 2008-2011



Source: AHRQ, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey (MEPS), 2008 to 2011. Figure 2. Available at: https://www.samhsa.gov/data/sites/default/files/SR180/SR180.html

Average Annual Medicare and Medicaid Health Care Spending For Dually Eligible Individuals Under Age 65 with Mental Health Conditions, 2006-2009

Medicare covered 60% and Medicaid covered 23% of total health care spending for dually eligible individuals under age 65 with a mental health condition.



Note: Other includes residential, case management, and partial hospital spending. Analysis of data from the Medicare Current Beneficiary Survey, 2006–09.

Source: Frank, R., Epstein, A. 2014. Factors Associated with High Levels of Spending for Younger Dually Eligible Beneficiaries with Mental Disorders. Health Affairs. 33(6): 1006-1013. https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0769.

Key Takeaways

- Dually eligible individuals experience high rates of mental health conditions and/or substance use disorders.
- Dually eligible individuals under age 65 experience higher prevalence of mental health conditions compared to dually eligible individuals age 65 and older.
- Among adults under age 65 who received behavioral health services, health care spending was twice as high for dually eligible individuals compared to all other adults who were not dually eligible.

Medicare and Medicaid Behavioral Health Benefits

Medicaid Mental Health Services Coverage

- Many mental health services fall within mandatory Medicaid benefit categories that states must cover (e.g., psychiatrist services, rehabilitative services).
- States can elect to cover additional mental health services through optional home- and community-based state plan services or waivers.
- All states cover prescription drugs for mental health treatment.
  - Medicare covers those drugs for dually eligible individuals.

States Covering Mental Health Services, 2022	
Individual Therapy	45
Inpatient Psychiatric Hospital	39
Telemedicine	44
Day Treatment	33
Partial Hospitalization	35
Peer Support	40
Case Management	32
Psychosocial Rehabilitation	34
Psychiatric Residential Treatment	22

Source: Kaiser Family Foundation. "State Options for Medicaid Coverage of Inpatient Behavioral Health Services." 2019. Available at: https://www.kff.org/report-section/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services-report; KFF State Health Facts. "Medicaid Behavioral Health Services Database." 2022. Available at: https://www.kff.org/data-collection/medicaid-behavioral-health-services-database/; and Kaiser Family Foundation "Telehealth Delivery of Behavioral Health Care in Medicaid: Findings from a Survey of State Medicaid Programs." 2023. Available at: https://www.kff.org/mental-health/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/#:~:text=As%20of%20July%202022%2C%20states,to%20the%20COVID%2D19%20pandemic

Medicaid Coverage of Substance Use Disorder (SUD) Services

- Medicaid covers certain medications for medication-assisted treatment of:
  - Alcohol Use Disorder (acamprosate, disulfiram, naltrexone) and
  - SUD (buprenorphine, naloxone, methadone).
- Many states provide SUD services, such as detoxification, psychotherapy, peer support, and crisis intervention through Medicaid state plan services and/or Section 1115 demonstrations (see Appendices for more information).

States Covering Continuum of SUD Services, 2022	
Early Intervention	31
Outpatient Services	44
Intensive Outpatient	41
Partial Hospitalization	34
Medically Managed Intensive Inpatient Services	39

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). "Medicaid Coverage of Medications to Reverse Opioid Overdose and Treat Alcohol and Opioid Use Disorders." 2024. Available at: https://store.samhsa.gov/sites/default/files/medicaid-coverage-reverse-overdose-pep22-06-01-009.pdf., and KFF State Health Facts. "Medicaid Behavioral Health Services Database." 2022. Available at: https://www.kff.org/data-collection/medicaid-behavioral-health-services-database/.

Medicare Coverage of Mental Health and SUD Services

Mental Health and SUD Services	Medicare Coverage
Inpatient care mental health and substance use disorder (SUD) services in general and psychiatric hospitals	Part A
Outpatient mental health and SUD services provided by approved health care professionals[1] • May include individual and group psychotherapy, psychiatric diagnostic interviews, medication management, and other services and therapies including Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Part B
Prescription drugs, including drugs to treat mental health and SUD conditions[2]	Part D

[1] Approved health care professionals include: psychiatrists and other physicians, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, and physician assistants); includes depression and alcohol misuse screenings. Part B may cover partial hospitalization, a structured program of psychiatric services provided in community mental health centers, or hospital outpatient settings. Standard copay amounts apply for both Part A and Part B coverage, which Medicaid covers for dually eligible individuals.

[2] Medicare covers Medication-Assisted Treatment (MAT) through a combination of Part A, B and/or D, depending on the setting in which the MAT was administered.

Source: CMS. "Medicare & Your Mental Health Benefits." 2023. Available at: https://www.medicare.gov/Pubs/pdf/10184-Medicare-and-Your-Mental-Health-Benefits.pdf. CMS Medicare Learning Network. "Medicare Mental Health" 2024. Available at: https://www.cms.gov/files/document/medicare-mental-health.pdf; and SAMHSA. "Medication-Assisted Treatment." Available at: https://www.samhsa.gov/medication-assisted-treatment.

Recent Updates to Medicare Coverage

- The Comprehensive Addiction and Recovery Act of 2016 (CARA) included provisions that give **Medicare Part D and Medicare Advantage plans flexibilities to address opioid overutilization** through Drug Management Programs.
- In 2020, CMS began **making bundled payments for opioid use disorder (OUD) treatment services** provided by Opioid Treatment Programs (OTP) to people with Part B coverage.
- As of January 1, 2024, the **OTP benefit covers intensive outpatient program services** in addition to services already covered at the time of the program's inception.

Sources: CMS. "Opioid Treatment Programs." 2023. Available at: https://www.cms.gov/medicare/payment/opioid-treatment-program, Public Law 114-198, 114th Congress. §704(a)(5). July 22, 2016. Available at: https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf.

Expansion of Medicare Coverage of Behavioral Health Providers

- As of January 1, 2024, **marriage and family therapists (MFTs) and mental health counselors (MHCs) are now able to bill for Medicare Part B services**.
  - Addiction counselors and drug/alcohol counselors who meet requirements can enroll in Medicare as an MHC.
- Expansion of these provider types who can bill for Medicare Part B services also applies to **rural health clinics (RHCs) and federally qualified health centers (FQHCs).** Additionally, "direct supervision" changes increase the ability of these new provider types to furnish services.
- **Clinical social workers, MFTs, MHCs, and clinical psychologists**, can now bill Health Behavior Assessment and Intervention (HBAI) codes.
- Providers can bill Medicare Part B for services **rendered by Community Health Workers (CHWs), care navigators, and peer support specialists**.

Source: CMS. "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program." 2023. Available at: https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other.

Expansion of Medicare Coverage of Behavioral Health Services

- Medicare now covers **intensive outpatient program (IOP) services** rendered at a hospital, community mental health center (CMHC), FQHC, or RHC.
  - IOP services may also be furnished in Opioid Treatment Programs for the treatment of opioid use disorder.
- The Medicare **payment amount for psychotherapy for crisis services has been increased to 150%** of the fee schedule amount only when furnished in certain settings other than the office setting (e.g., mobile crisis teams or in the home).
- To protect access to mental health services, **telehealth continues to be furnished to people in their homes**.
  - Starting in 2024, telehealth will be paid at non-facility physician fee schedule rates.

Source: CMS. "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program." 2023. Available at: https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other.

Key Takeaways

- Through Medicaid, states are required to cover mental health services and substance use disorder services that fall within mandatory Medicaid benefit categories and can elect to cover additional services through state plans or waivers.
- Medicare coverage of behavioral health services spans Medicare Parts A, B, and D with each part covering different types of mental health and SUD services.
- The recent change of behavioral health coverage within Medicare expands both the types of providers and types of services covered, allowing for improved patient access to behavioral health care.

Coordination of Behavioral Health Benefits: State Approaches and Options

Multiple Layers of Fragmentation

Dually eligible individuals with behavioral health conditions often must navigate across several different delivery systems.

- Medicare and Medicaid covered services and program rules are different.
  - Some behavioral health services may be covered through federal, state, or local grant programs that are separate from Medicare and Medicaid.
- Depending on the state, there may be separate managed care entities for physical and behavioral health services.
- Physical health and behavioral health services and related supports may be provided by separate providers.
  - Mental health and SUD services are often provided by different systems and provider types.

Implications of Medicare and Medicaid Behavioral Health Coverage Differences

- Challenges in coordinating prescription drug utilization.
- Coverage limitations in each program; gap-filling coverage from each program is often not coordinated.
  - **Medicare**
    - Limited SUD services (e.g., no coverage of community-based treatment facilities for intermediate levels of SUD care, residential treatment).
    - Limited longer-term and/or rehabilitative mental health service coverage.
    - Increasingly more "step-down" options in lieu of costly inpatient psychiatric services; however, still limited compared to most Medicaid programs.
  - **Medicaid**
    - Institutions for mental disease (IMD) exclusion; coverage for optional benefits varies by state.
    - Behavioral health benefits may be carved in or out of managed care programs.

Implications of Medicare and Medicaid Behavioral Health Coverage Differences, continued

- Limits on certain types of behavioral health providers under Medicare.
- Administrative and operational challenges due to gaps in data (e.g., for care coordination).
- Potential duplication of services that could be unnecessary and costly for states (and Medicare).

Challenges to Physical and Behavioral Health Integration

- **Data-sharing challenges** related to privacy concerns and compatibility of information systems used by mental health and SUD providers with providers of physical health care.
- **Quality measures** and **payment incentives** are needed to promote provider accountability.
- **Administrative barriers** to program monitoring and quality improvement.
- Different **cultures of care delivery**, such as the medical model vs. recovery-focused model.
- Separate and varying levels and types of **professional training** of physical and behavioral health providers.

Challenges to Information Sharing for SUD

- Challenges associated with information sharing for SUD:
  - Concerns about interpretation of federal regulations and state-specific mental health codes around sharing substance-use data.
  - Logistics around obtaining consent for information sharing.
  - Limited financial and staff resources to enhance capacity.
  - Limited adoption of electronic health records by mental health and SUD providers.
- February 2024 CMS final rule modified the Confidentiality of SUD Patient Records regulations at 42 CFR Part 2.
  - Allows a single consent for all future uses and disclosures for treatment, health care operations, and payment.
  - Allows HIPAA covered entities and business associates to redisclose records received under this consent in accordance with HIPAA regulations.
  - Aligns requirements of the Part 2 Patient Notice with HIPAA Notice of Privacy Practices.

Source: U.S. Department of Health and Human Services. "Fact Sheet 42 CFR Part 2 Final Rule." Feb 2024. Available at: https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html.

Levels of Integration of D-SNPs

CO D-SNPs

Coordination-Only D-SNPs

- Must meet minimum CMS requirements for D-SNPs.
- Must notify the state Medicaid agency or its designee of hospital and skilled nursing facility admissions for at least one designated group of "high-risk," full-benefit dually eligible (FBDE) enrollees.

HIDE SNPs

Highly Integrated D-SNPs

- Must cover Medicaid **behavioral health benefits, long-term services and supports (LTSS), or both.**
- Contract for coverage of Medicaid benefits may be with the D-SNP, the D-SNP's parent company, or another entity owned and controlled by the D-SNP's parent company.
- In 2025, a HIDE SNP's capitated contract with the state Medicaid agency must cover entire service area of the D-SNP.

FIDE SNPs

Fully Integrated D-SNPs

- In 2025, **must cover** Medicaid primary and acute care services and LTSS (including at least 180 days of nursing facility coverage during the plan year) while also covering all of the following additional Medicaid benefits: Medicare cost-sharing; **behavioral health services**; home health services; and medical equipment, supplies and appliances.
- Must use specialized care management and network methods to coordinate care for high-risk beneficiaries.
- Entity contracted to cover Medicaid benefits must be the same legal entity that holds the D-SNP contract with CMS.
- In 2025, must operate with exclusively aligned enrollment and cover additional Medicaid benefits, and FIDE SNP's capitated contract with the state Medicaid agency must also cover the entire service area of the D-SNP.

For more information, see Weir Lakhmani, E. "Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025." Integrated Care Resource Center. June 2023. Available at: https://www.integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023.

Behavioral Health Coverage Requirements for D-SNPs

- States vary in the behavioral health services they cover and the ways those services are delivered to full-benefit dually eligible individuals.
- Per 42 CFR 422.107(h), a D-SNP meets the FIDE SNP or HIDE SNP definition as defined at 42 CFR 422.2, even if its contract with the state has carve-outs of behavioral health services, as approved by CMS, that—
  - Apply primarily to a minority of the beneficiaries eligible to enroll in the dual eligible special needs plan who use behavioral health services; or
  - Constitute a small part of the total scope of behavioral health services provided to the majority of beneficiaries eligible to enroll in the dual eligible special needs plan.

State D-SNP Contracting Strategies to Improve Coordination

- States with any type of D-SNP can implement the following strategies:
  - Behavioral health training requirements for D-SNP care coordinators, peer support staff, and other providers.
  - Behavioral health-specific Interdisciplinary Care Team (ICT) requirements.
  - Early intervention through D-SNP Health Risk Assessments (HRAs).
  - Care coordination during crisis response and transitions of care.
  - Inclusion of Medicaid behavioral health providers in provider directories and aligning behavioral health provider networks.
  - Collaborative data-sharing platforms and procedures.

For more information, see ICRC's TA tip sheet, "Tips for States on Working with Dual Eligible Special Needs Plans to Improve Coordination of Physical and Behavioral Health Services for Dually Eligible Individuals" (April 2024) available at https://www.integratedcareresourcecenter.com/resource/tips-states-working-dual-eligible-special-needs-plans-improve-coordination-physical-and

Behavioral Health Training Requirements

- D-SNP care coordinators, peer support staff, and other providers may be required to have certain professional backgrounds and/or training in behavioral health.
- Opportunity to improve screening and better identify enrollees who may have behavioral health service needs early on and continually and offer referrals to behavioral health services.
- Examples:
  - Massachusetts requires specialized training for staff supporting older adults with behavioral health needs. Topics include cultural competence, anxiety, depression, trauma, substance use, and behavior change.
  - In 2026, Massachusetts will require training for PCPs on the use of mental health and substance use disorder screening tools, instruments, and procedures.

Sources: Massachusetts Executive Office of Health and Human Services (EOHHS). Appendix R, Exhibit 2, "Application for a §1915(c) Home and Community-Based Services Waiver." March 1, 2023. Available at: https://www.mass.gov/doc/sco-appendix-r-exhibit-2-frail-elder-waiver-20230301/download; and Massachusetts EOHHS SCO Medicaid Contract, 2026, Section 2.9.10.3.1 and Massachusetts EOHHS One Care Medicaid Contract, 2023 Section 2.9.10.3.1. Available at: https://www.mass.gov/doc/2023-sco-model-contract-0/download

Behavioral Health-specific Interdisciplinary Care Team (ICT) Requirements

- States can require D-SNPs to include certain types of providers in their ICTs for enrollees with behavioral health needs using an integrated clinical model and/or the inclusion of behavioral health clinicians.
- Opportunity to streamline and ensure communication and collaboration between an enrollee's providers and reduce duplication in care planning.
- Example: Tennessee requires FIDE SNPs to operate an integrated clinical model and ICTs with nurse practitioners, social workers, registered nurses and/or licensed practical nurses, and licensed behavioral health clinicians who coordinate care across enrollees' Medicare and Medicaid benefits.

Source: Tennessee Department of Finance and Administration, Division of TennCare and UnitedHealthcare Plan of the River Valley, Inc. State Medicaid Agency Contract, 2023, Attachment F.4.d. Available at: https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html.

Early Intervention Through D-SNP Health Risk Assessments (HRAs)

- D-SNPs can be required to incorporate behavioral health-related assessment questions into their HRAs.
- Early recognition and treatment for behavioral health conditions can prevent complications, improve quality of life, and help reduce health care costs and ensure enrollees are connected to appropriate care.
- Example: Minnesota requires HIDE SNPs to include questions about behavioral health needs in their annual HRA.

Source: Minnesota Department of Human Services. State Medicaid Agency Contract, 2024, Section 6.1.5. Available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp

Care Coordination During Crisis Response and Transitions of Care

- States can require D-SNPs to develop crisis response protocols to respond to urgent behavioral health needs and connect enrollees to the appropriate behavioral health providers during and after a crisis event.
- Enrollees will be given timely care and collaborative discharge planning, which can result in improved health outcomes.
- Examples
  - Idaho requires its D-SNPs' nurse advice lines to assist and triage callers who may be in crisis by "warm transferring" plan enrollees to a licensed behavioral health clinician.
  - Oregon requires D-SNPs to work with Medicaid managed care plans and discharging facilities to have a "collaborative discharge plan" to prevent avoidable hospitalizations or unnecessary readmissions.

Sources: Idaho Medicare Medicaid Coordinated Plan, 2023 Additional Terms to Medicaid Provider Agreement, State Medicaid Agency Contract H1350, 2023, Appendix C. Section M. (Not available online.); Oregon Health Authority and ATRIO Health Plans, Inc. State Medicaid Agency Contract H3814, 2023, Section 4.H.7.d. (Not available online.)

Medicaid Behavioral Health Provider Requirements

- States can simplify an enrollee's search for providers by requiring D-SNPs that are aligned with Medicaid managed care plans to develop and maintain a single provider directory that includes both Medicaid and Medicare behavioral health providers.
- Having an aligned Medicare and Medicaid network of providers to choose from may streamline an enrollee's process of identifying the right providers for them, allowing them to access behavioral health providers more easily.
- Example: Washington requires its D-SNPs to have 80% of the D-SNP's affiliated Medicaid managed care plan's network providers in the D-SNP's Medicare network to support the coordination of Medicare and Medicaid benefits, as well as continuity of care for people who transition from having only Medicaid benefits (and only Medicaid managed care plan coverage).

Source: ICRC conversations with Washington State Medicaid agency staff.

Collaborative Data-sharing Platforms and Procedures

- Require D-SNPs to use collaborative data-sharing practices and platforms to document behavioral health referrals and prescription medication and make timely data entries.
- Opportunity to improve monitoring and sharing of physical and behavioral health claims, provider information across Medicare and Medicaid, and identifying dangerous drug interactions or improper/inadequate medication use.
- Example: Massachusetts requires its D-SNPs to document and monitor behavioral health referrals in the enrollee's Centralized Enrollee Record (CER) and make timely data entries about the behavioral health assessment, determined diagnosis, prescribed medications, and any individualized plan of care to promote collaboration across provider types.

Source: Massachusetts EOHHS SCO Medicaid Contract State Medicaid Agency Contract 2026, Section 2.15.5.6 and Massachusetts EOHHS One Care Medicaid Contract (State Medicaid Agency Contract, 2026, Section 2.15.5.6), available at: https://www.mass.gov/doc/2023-sco-model-contract-0/download.

Key Takeaways

- Dually eligible individuals often navigate separate systems for physical and behavioral health services with varying covered services and program rules affecting mental health and SUD services.
- Differences in Medicare and Medicaid behavioral health coverage can challenge the coordination of prescription drug utilization, result in unaligned services and covered providers, and cause administrative and operational challenges due to data gaps.
- States vary in the behavioral health coverage for dually eligible individuals. Carve-outs may affect HIDE SNP and FIDE SNP designation.
- States can use D-SNP contracting strategies to improve physical and behavioral health coordination for dually eligible individuals.

Questions?

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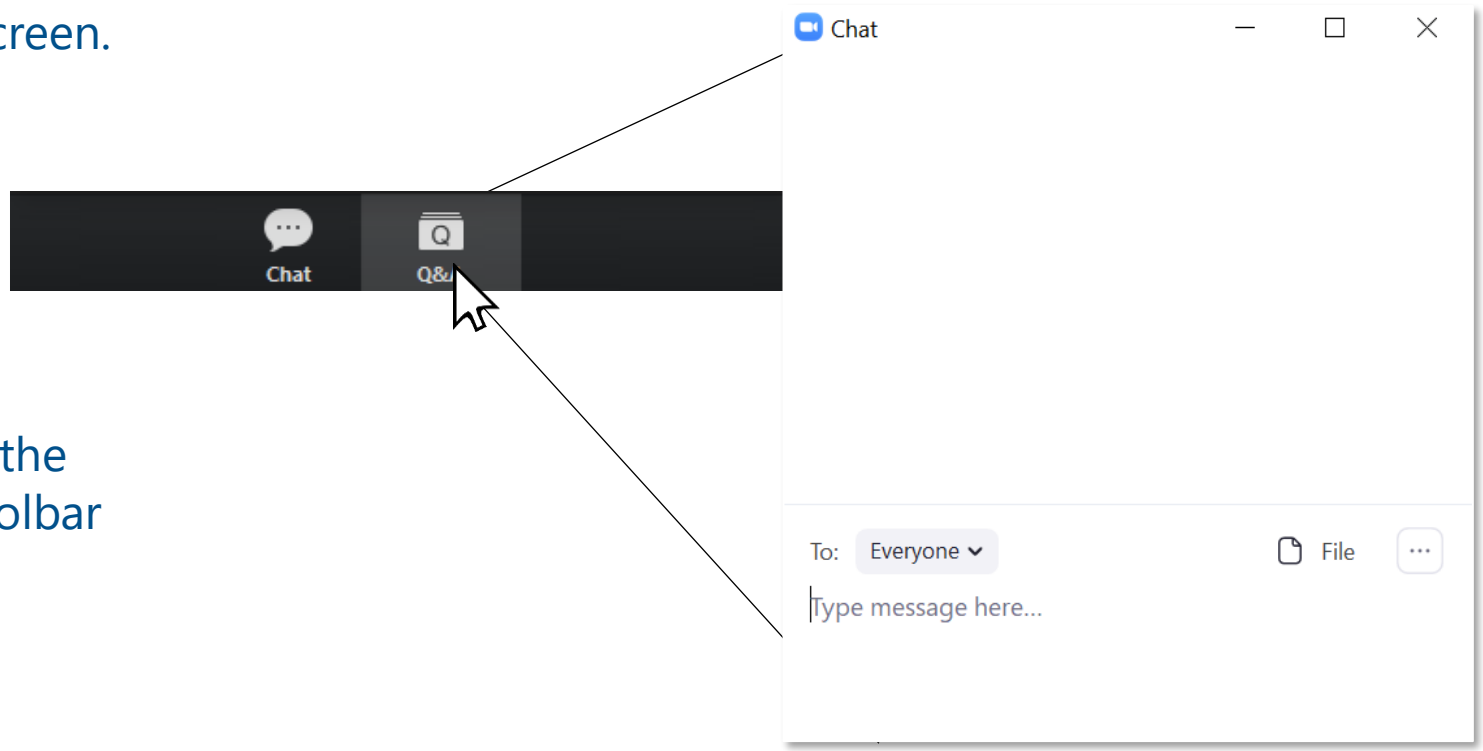

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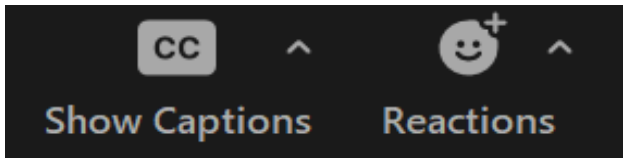

About ICRC

- Established by CMS to advance integrated care models for dually eligible individuals.
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica and the Center for Health Care Strategies.
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges.
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org.

Appendices

Coverage of Institutions for Mental Diseases (IMD) Services for Dually Eligible Individuals

- **IMDs:** Inpatient facilities of more than 16 beds in which 51 percent or more of patients are being treated for mental diseases.
- Medicare covers medically necessary **inpatient psychiatric facility** services through Part A (up to 90 days and a total of 190 days in a lifetime) but does not cover SUD treatment services in non-hospital-based residential facilities.
  - 44% of patients at inpatient psychiatric facilities are dually eligible individuals.
  - Not all IMDs necessarily qualify as inpatient psychiatric hospitals.
- **IMD Exclusion:** Historically, federal law has prohibited the use of federal Medicaid matching payments for IMD services used by Medicaid beneficiaries between the ages of 22 and 64. States therefore had to fund these services with state-only dollars, limiting their availability.

Source: MedPAC. "Assessing Medicare's Payments for Services Provided in Inpatient Psychiatric Facilities." October 4, 2018. Available at: http://www.medpac.gov/docs/default-source/default-document-library/psych-pps-october-2018-public-final.pdf?sfvrsn=0; and MACPAC. "Report to Congress on Oversight of Institutions for Mental Diseases." December 19, 2019. Available at: https://www.macpac.gov/wp-content/uploads/2020/01/Report-to-Congress-on-Oversight-of-Institutions-for-Mental-Diseases-December-2019.pdf

States Using IMD Coverage Options

- Nearly every state is using some form of federal flexibility to use Medicaid funds to cover IMD services for non-elderly adults.
- States also use a mix of these coverage exceptions.

Number of States Using the Various IMD Coverage Exceptions for Non-Elderly Adults, FY 2022	
1115 Waivers	34
Managed Care "in-lieu-of" Authority	32[1]
DSH Payments	32
SUPPORT Act (State Plan Option)	3[2]

Number of States Using A Combination of IMD Coverage Exceptions, as of Feb. 2023	
0 Exceptions	2
1 Exception	9
2 Exceptions	24 (+DC)
3 Exceptions	15

[1]As of 2020.

[2]The SUPPORT Act was available to states on a temporary basis, effective October 1, 2019 to September 30, 2023. A reauthorization has recently passed in the House of Representatives and is advancing through the Senate.

Source: Congressional Budget Office. "Budgetary Effects of Policies to Modify or Eliminate Medicaid's Institutions for Mental Diseases Exclusion." 2023. Available at: https://www.cbo.gov/system/files/2023-04/58962-Medicaid-IMD-Exclusion.pdf

Section 1115 Demonstrations: Substance Use Disorders, Serious Mental Illness, and Serious Emotional Disturbance

- In 2017 and 2018, CMS provided guidance to states on using the authority of Section 1115(a) of the Social Security Act to develop demonstrations that aimed to improve the continuum of care for:
  - Individuals with substance use disorder (SUD)
  - Individuals with serious mental illness (SMI) or serious emotional disturbance (SED)
- Allow states to receive federal financial participation (FFP) for services provided to Medicaid enrollees residing in settings that qualify as institutions for mental diseases (IMDs)
  - The SMI/SED demonstration also focuses on improvements to community-based mental health care
- 35 states and the District of Columbia have approved demonstrations for these Section 1115 initiatives

Sources: CMS. "Section 1115 Demonstrations: Substance Use Disorders, Serious Mental Illness, and Serious Emotional Disturbance." Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-substance-use-disorder-demonstrations/section-1115-demonstrations-substance-use-disorders-serious-mental-illness-and-serious-emotional-disturbance/index.html", and CMS. "Evaluation Design Guidance for Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance and Substance Use Disorders." Available at: https://www.medicaid.gov/sites/default/files/2020-02/smi-sed-sud-1115-eval-guide.pdf

Resources

Resources for Integrated Behavioral Health Benefits

- **Tips for States on Working with Dual Eligible Special Needs Plans (D-SNPs) to Improve Coordination of Physical and Behavioral Health Services for Dually Eligible Individuals:** https://www.integratedcareresourcecenter.com/resource/tips-states-working-dual-eligible-special-needs-plans-improve-coordination-physical-and
- **Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working with Managed Care Delivery Systems:** http://www.integratedcareresourcecenter.com/PDFs/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

Resources on D-SNP Integration

- **CMS Resources on D-SNP Integration Requirements:** https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs
- **Working with Medicare Webinar on State Contracting with D-SNPs**: https://www.integratedcareresourcecenter.com/webinar/working-medicare-webinar-state-contracting-d-snps-introduction-d-snps-and-d-snp-contracting
- **Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans.** ICRC TA Tools: January 2024: https://www.integratedcareresourcecenter.com/resources-by-topic/sample-smac-language
- **Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025**: https://www.integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023

Resources Continued

Resources on Medicare Opioid Treatment Benefit

- **December 2019 CMCS Informational Bulletin:** https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib121719.pdf
- **Information about the Medicare Part B Opioid Treatment Program:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Medicaid

Resources on Medicaid Coverage of IMD Services

- **November 2019 State Medicaid Director letter regarding implementation of SUPPORT Act and Medicaid Coverage of Care Provided in IMDs:** https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19003.pdf
- **MACPAC Releases Report to Congress on Oversight of Institutions for Mental Diseases:** https://www.macpac.gov/news/macpac-releases-report-to-congress-on-oversight-of-institutions-for-mental-diseases
- **State Options for Medicaid Coverage of Inpatient Behavioral Health Services:** https://www.kff.org/medicaid/report/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services/