



Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care

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Executive Summary

Medicaid's role in purchasing and delivering substance abuse services is changing dramatically. Prior to the implementation of the Affordable Care Act (ACA), most state Medicaid programs did not cover childless adults and covered only a limited number of parents. Moreover, coverage of substance abuse services has traditionally been an optional Medicaid benefit and, as a result, many states have provided only limited substance abuse service coverage. Twenty-five states plus Washington, DC, are expanding Medicaid in 2014 and will collectively cover as many as 5 million adults with incomes up to 133 percent of the federal poverty level (FPL).¹ Benefits extended to these newly covered adults must include mental health and substance abuse services that meet the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). Taken together, these changes are a major catalyst for transformation of substance abuse service coverage and delivery in Medicaid.

This issue brief explores state strategies with respect to purchasing substance abuse services for adult Medicaid beneficiaries, with a particular focus on states that use managed care for the purchase and delivery of physical health services. The brief reviews the current landscape of substance abuse coverage in Medicaid managed care states and the paradigm shift created by the ACA Medicaid expansion in terms of substance abuse eligibility, benefits, and provider capacity.

The brief discusses current and planned approaches to substance abuse benefit delivery for adults in six states using managed care delivery systems: Arizona, Maryland, Massachusetts, New Mexico, New York, and Washington. While these states share the same goal – purchasing cost-effective, quality integrated care for a vulnerable population – they are pursuing different pathways to reach it. Some closely integrate substance abuse services with physical health care through a full “carve-in” to the managed care organization (MCO) benefit package, others carve out these services and contract with a separate entity that is responsible for behavioral health service delivery and coordination, and others use a hybrid delivery system model. As other states examine redesign of their Medicaid substance abuse systems through managed care, they can learn from key takeaways observed in these six states:

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- 1. State managed care models for substance abuse service delivery continue to evolve.** Even states that already cover adults at expanded income levels and provide more generous mental health and substance abuse benefits are substantially modifying, or in some cases replacing, previously implemented models for substance abuse benefit management. In most cases, they are moving substance abuse benefits into integrated managed care models with physical health benefits, mental health benefits, or both. States see these arrangements, with a single financing stream and contracting entity for multiple provider types, as supporting better care integration including primary care in behavioral health settings, behavioral health services in primary care settings, care tailored to co-occurring substance use disorders (SUDs) and mental illness, and coordination of services across settings.
- 2. States are investing in substance abuse provider capacity and providing technical assistance to substance abuse providers.** States are expanding substance abuse service provider capacity, particularly diversionary and step-down programs that provide less costly alternatives to inpatient care. Additionally, as they expand their benefit packages and provider networks, states are beginning to develop outreach and training resources for substance abuse providers that for the most part have little previous experience with Medicaid or health insurance.
- 3. States are beginning to develop strategies to integrate social services for beneficiaries with SUDs.** While state Medicaid agencies' and MCOs' experience interfacing with social services organizations is generally limited, they are beginning to develop initiatives to coordinate and facilitate access to social services and housing supports for Medicaid beneficiaries with SUDs.
- 4. States, plans, and other stakeholders have begun to focus on implications of the expansion for individuals coming out of jail or prison, most of whom will be eligible for Medicaid for the first time.** A significant number of individuals in the Medicaid expansion group with SUDs have connections to the criminal justice system. Some states are beginning to make progress in bridging Medicaid and corrections through: cooperation among MCOs, social service organizations and correctional facilities; fostering relationships among local substance abuse agencies, police and jails; and development of protocols addressing crisis services, jail diversion and safety.

Introduction

The ACA Medicaid expansion is bringing new beneficiaries into state Medicaid programs, including large numbers of childless adults and some newly eligible parents. In 2010, when the ACA was signed into law, state Medicaid programs covered parents up to a national average of 60 percent of the FPL, and by the end of 2010, just seven states covered childless adults up to an average eligibility level of 123 percent of the FPL.² As of March 2014, 25 states plus Washington, DC, have opted to expand adult Medicaid eligibility to 133 percent of the FPL, making 4.6 million adults eligible for Medicaid for the first time in 2014.³ Newly eligible adults are expected to have significant needs with respect to substance abuse services. Overall, about 14.6 percent of the Medicaid expansion population is estimated to have an SUD, compared to 11.5 percent of the current Medicaid population.⁴ States that already cover childless adults report significant substance abuse treatment needs among such individuals.⁵

States are preparing to deliver a broader range of mental health and substance abuse services to the expansion population. Newly eligible Medicaid beneficiaries must receive an Alternative Benefit Plan (ABP) covering 10 categories of essential health benefits

(EHBs), including mental health and substance abuse services.⁶ By contrast, only certain substance abuse service types fall into mandatory coverage categories for a non-ABP State Plan, such as physician services, inpatient services (including medically necessary inpatient detoxification), and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children and adolescents 21 years of age and under. Coverage of most substance abuse services is optional.

Substance Abuse Treatment Needs of Childless Adults

In Oregon, childless adults in the State's expansion population up to 100 percent of the FPL had three times as many mental health and substance abuse-related visits as adults with children.

In Maine's childless adult expansion population, mental health and substance abuse diagnoses accounted for four of the top ten, and nine of the top 20 most costly diagnoses over a seven-year period.

Sources:

Haber, SG, G Khatutsky, and JB Mitchell. 2000. Covering Uninsured Adults Through Medicaid: Lessons from the Oregon Health Plan. *Health Care Financing Review* 22(2). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00winterpg119.pdf>.

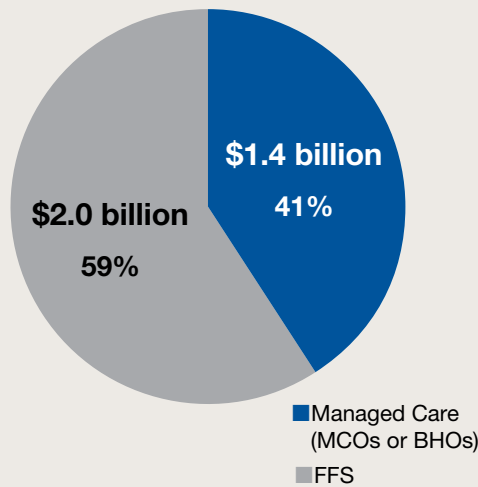
Somers et al., 2010.

Federal rules also extend the statutory parity requirements of MHPAEA to Alternative Benefit Plans, meaning that states must apply similar strategies for covering and managing substance abuse services on the same basis as medical/surgical benefits.⁷ Cost-sharing requirements, quantitative treatment limitations (e.g., visit limits), and non-quantitative treatment limitations (e.g., prior authorization procedures) must be no more restrictive for substance abuse services than for medical/surgical benefits.⁸ Parity for the new adult population represents a major change from current Medicaid coverage requirements. Fee-for-service (FFS) coverage of services under Section 1905(a) of the Social Security Act is not subject to MHPAEA parity requirements, although the MHPAEA statute does apply to managed care programs.⁹

With the expansion of Medicaid to single and childless adults, Medicaid for the first time will also cover a significant number of individuals released from jail or prison, many of whom have SUDs. One source estimates that 20 to 30 percent of new Medicaid enrollees in 2014 are likely to be individuals reentering the community from jails.¹⁰ Of the 2.3 million inmates in U.S. prisons in 2010, 1.5 million (65 percent) met the DSM-IV medical criteria for alcohol or other drug abuse or addiction.¹¹ Sixty-eight percent of jail inmates have substance dependence or abuse.¹² About 90 percent of jail detainees and inmates are uninsured prior to entry, with SUDs, mental illness, and chronic health conditions often treated for the first time while in the system.¹³ Coordination with the criminal justice system and ensuring continuity of coverage will present state Medicaid programs and their managed care contractors with unique challenges.

Substance abuse providers will also face challenges in transitioning to new models of delivery and payment, particularly related to participation in Medicaid and contracting with insurance companies. Historically, many substance abuse providers have relied

Sources of Estimated Spending on Medicaid Substance Abuse Services, 2008



Source: Bouchery, E, R Harwood, R Malsberger, E Caffery, J Nysenbaum, and K Hourihan. September 28, 2012. Medicaid Substance Abuse Treatment Spending: Findings Report. Washington, DC: U.S. Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy. <http://aspe.hhs.gov/daltcp/reports/2012/MSATspend.pdf>.

on grant funding and have had only limited interaction with the Medicaid and health insurance systems. As of 2008, about 40 percent of nonprofit substance abuse facilities did not accept private insurance or Medicaid. About half had no contracts with managed care plans.¹⁴ About 20 percent of substance abuse treatment facilities have no information systems to support appointment scheduling, billing, or medical records functions.¹⁵

The expansion of Medicaid coverage for new adults, a significant proportion of whom have SUDs, coupled with substance abuse benefit and parity requirements will impose new pressures on the substance abuse treatment delivery system at the state, managed care plan, and provider levels. As Medicaid's role in the coverage and delivery of substance abuse services expands, states, plans, and providers are considering how best to position themselves to take on their expanded responsibilities.

State Managed Care Models for Substance Abuse Benefit Administration: Key Takeaways from Six States

Twenty-two of the 26 Medicaid programs that are set to expand Medicaid under the ACA currently contract with MCOs to serve their Medicaid beneficiaries, and most of these states plan to use their existing managed care delivery system to serve new enrollees.¹⁶ To better understand states' experiences with delivering substance abuse services, and their perspectives on and planned approaches to address emerging challenges, we reviewed managed care programs in six Medicaid expansion states: Arizona, Maryland, Massachusetts, New Mexico, New York, and Washington State. Recognizing the unique considerations states face in covering substance abuse services for children and adolescents, we focused our review on coverage of services for adults. Sources included public reports, news articles, waiver documents, state plan amendments, and contracts, as well as interviews with state Medicaid leaders and subject matter experts. All of these states continue to develop, reform and adjust their approaches to substance abuse (and mental health) service delivery for their managed care enrollees, and following are key takeaways with respect to their efforts:

1. State managed care models for substance abuse service delivery have changed over time in order to improve care delivery and coordination.

States' approaches to substance abuse benefit administration continue to evolve. Even states that already cover adults at expanded levels and provide more robust substance abuse and mental health benefits appear to be substantially modifying, and in some cases replacing, previously implemented models for substance abuse benefit management (See Table 1).

Table 1. Select States' Delivery System Models for Coverage of Substance Abuse Services for Medicaid Managed Care Beneficiaries

State	Old Delivery System Model	New Delivery System Model
<i>Arizona</i>	<ul style="list-style-type: none"> Behavioral health services carved out to regional BHOs under contract with state behavioral health agency 	<ul style="list-style-type: none"> Physical and behavioral health services for people with serious mental illness (SMI) delivered through regional BHO in Maricopa County under contract with behavioral health agency (April 2014)
<i>Maryland</i>	<ul style="list-style-type: none"> Specialty mental health services carved out to ASO on managed FFS basis under contract with Mental Hygiene Administration Substance abuse services carved in to MCO, but beneficiaries may access services out-of-network 	<ul style="list-style-type: none"> Substance abuse and specialty mental health services carved out to ASO on managed FFS basis under contract with Medicaid agency (January 2015)
<i>Massachusetts</i>	<ul style="list-style-type: none"> Behavioral health services carved in for coverage through MCO program, under contract with Executive Office of Health and Human Services Behavioral health services carved out to single, statewide BHO for coverage through primary care case management (PCCM) program, under contract with Executive Office of Health and Human Services 	<ul style="list-style-type: none"> Primary care clinicians take on risk for some behavioral health services, including substance abuse screening, assessment, outpatient crisis intervention, and brief intervention (March 2014)
<i>New Mexico</i>	<ul style="list-style-type: none"> Behavioral health services carved out to single statewide BHO under contract with New Mexico Behavioral Health Purchasing Collaborative 	<ul style="list-style-type: none"> All behavioral health services carved in to MCOs under contract with Human Services Department and New Mexico Behavioral Health Purchasing Collaborative (January 2014)
<i>New York</i>	<ul style="list-style-type: none"> Limited behavioral health services carved in to MCOs, under contract with Department of Health: <ul style="list-style-type: none"> For Supplemental Security Income (SSI)-related beneficiaries, all substance abuse services except detoxification services carved out and provided FFS For other beneficiaries, all substance abuse services except detoxification and inpatient rehabilitation and treatment carved out and provided FFS Most mental health services carved out and provided FFS 	<ul style="list-style-type: none"> All behavioral health services carved in to MCOs under contract with Department of Health (January 2015) <ul style="list-style-type: none"> Specialized managed care product (Health and Recovery Plans) covers physical and behavioral health services for beneficiaries with serious SUDs or SMI
<i>Washington</i>	<ul style="list-style-type: none"> Limited mental health services carved in to MCOs, under contract with Health Care Authority Specialty mental health services carved out to regional BHOs, under contract with Department of Social and Health Services Substance abuse services carved out and provided FFS 	<ul style="list-style-type: none"> Mental health and substance abuse services integrated in BHOs, or carved in with physical health services to “accountable risk bearing entities,” depending on individual regions’ readiness (April 2016)

States' approaches to substance abuse service delivery in managed care and level of physical and mental health benefit integration vary and are influenced by state culture and experience with respect to funding, administration, and delivery of substance abuse services.

- The least integrated delivery system models are those in which physical health, mental health, and substance abuse services are siloed in three separate delivery systems; that is, substance abuse and mental health services are “carved out” of the MCO benefit package, with each provided through a separate delivery system. In some states, both mental health and substance abuse services are provided on an unmanaged FFS basis, while in others, either mental health or substance abuse services are provided through a BHO or administrative services organization (ASO).
- In other states, BHOs manage mental health benefits for a defined population; in some cases, these managed care plans are responsible for both mental health and substance abuse services. Some BHOs also manage employment and housing, and other social needs (e.g., child welfare system involvement) of people with serious behavioral health conditions. States that use BHOs generally provide physical health services through a separate managed care delivery system.
- More integrated delivery system models are those in which managed care plans provide mental health care, substance abuse services, and physical health benefits through a single contract with a state Medicaid agency to coordinate and manage all services needed by each patient.¹⁷
- Some states establish a “hybrid” delivery system by integrating basic behavioral health services in the MCO benefit package but carving out specialty behavioral services, or by creating a specialized delivery system for those Medicaid beneficiaries with the most significant mental health or substance use needs.

Carve-in Managed Care Models

A growing body of evidence indicates that emerging models of coordinated and integrated physical and behavioral health care improve outcomes and are cost-effective.^{18,19} And states that integrate substance abuse services into the MCO benefit package point to advantages including a single point of care management and fiscal and clinical accountability across the spectrum of services needed by Medicaid enrollees, many of whom have comorbid physical and behavioral health conditions. For example, many managed care beneficiaries with SUDs have physical health conditions directly attributable to SUDs, including alcoholic and drug-related polyneuropathy, acute alcoholic hepatitis and alcoholic cardiomyopathy, gastritis, and liver disease.²⁰ People with SUDs also have a greater risk for congestive heart failure and pneumonia than those without SUDs.²¹ Nearly 25 percent of Medicaid enrollees with SUDs report fair or poor health status, and 44 percent have serious psychological distress.²²

Until January 2014, New Mexico carved out substance abuse and mental health services to a single BHO that managed both Medicaid and non-Medicaid behavioral health services. New Mexico State officials note that a major drawback of this approach was that no single entity was responsible for the “whole person.” Despite care coordination requirements in State contracts with MCOs and the BHO, coordination had been limited in practice. Without financial and care management responsibility for the full Medicaid benefit, MCOs lacked financial and contracting leverage to drive provider behavior, coordinate care and obtain treatment plans from substance abuse providers. As a result, New Mexico is now changing course, integrating all behavioral health services into its MCOs with the rollout of its Centennial Care waiver program in 2014, under which the State will expand its Medicaid program to cover 170,000 newly eligible adults.²³ New Mexico anticipates better coordination and

data-sharing among substance abuse providers and the MCOs with which they contract, as well as more innovative approaches to “value-based” payment arrangements with providers. A State official from New Mexico said of the four Centennial Care MCOs, “It’s like having four different laboratories for new payment and delivery models.”

At the same time, states pursuing carve-ins are wary of potential pitfalls. A major concern for states exploring or pursuing carve-ins is the readiness of MCOs to care for individuals with serious SUDs or SMI. States have taken various measures to address these concerns, most notably creating or contracting with entities that will specifically target populations with the most complex behavioral health needs. New York State, which serves 3.9 million enrollees through 16 MCOs in its managed care program, has historically carved out most substance abuse services (including all outpatient services) and mental health services from its managed care benefit package, providing these services on a FFS basis.²⁴ But in 2015, New York intends to carve in all Medicaid substance abuse and mental health services to the MCO benefit package. The State will also introduce a specialty managed care plan option called Health and Recovery Plans (HARPs) for beneficiaries with serious SUDs or SMI; in addition to providing comprehensive physical and behavioral health services, HARPs will cover recovery-oriented home and community-based services and supports. Finally, while New York wants MCOs to take responsibility for managing all physical health, substance abuse and mental health services, if an MCO cannot meet state standards for behavioral health benefit management, the State will require the plan to subcontract with a BHO.

States also share concerns regarding reductions in funding for Medicaid substance abuse and mental health services if MCOs divert funds to cover non-behavioral health services, administrative expenses, or profits. To address this concern (and also to assure revenue stability for behavioral health providers) New York State is requiring MCOs to pay FFS rates to ambulatory substance abuse service providers for two years after implementation of its carve-in. New York will also impose a minimum medical loss ratio (MLR) for behavioral health services for all MCOs under its carve-in, and the MLR for HARPs will encompass both physical and behavioral health services.²⁵ In response to similar concerns, New Mexico’s MCOs are not permitted to subcontract with BHOs on an at-risk basis for management of behavioral health services.²⁶

Arizona is taking a somewhat different approach to “carving in,” though, like New York, with a goal of integrating all benefits for the most complex populations with SMI and SUDs. The State has implemented an integrated physical and behavioral health managed care program for Medicaid enrollees with serious mental illness (SMI) in Maricopa County (including Phoenix). Arizona covers just over 1 million beneficiaries through 11 MCOs in its managed care program.²⁷ The State expects an estimated 57,000 new enrollees in 2014 through its expansion.²⁸ Today, Arizona’s MCOs cover only physical health services for their beneficiaries. Four BHOs, known as Regional Behavioral Health Authorities (RBHAs), have risk-based contracts with the State to manage Medicaid and non-Medicaid behavioral health services. Through its most recent procurement in Maricopa County, Arizona implemented a RBHA that also covers physical health services for beneficiaries with SMI. A significant share of substance abuse treatment recipients in the county will likely be served by the integrated RBHA, given that about 24 percent of substance abuse treatment recipients in the State’s public behavioral health system had co-occurring SMI in state fiscal year 2013.²⁹

To ensure that MCOs and BHOs are held accountable for meeting the needs of their members with SUDs, states are examining the use of quality metrics tailored to SUDs, though current metrics are less robust than those related to physical and mental health.³⁰ Arizona’s new Maricopa County RBHA is subject to reporting requirements related to behavioral health inpatient utilization, behavioral health emergency department utilization, behavioral health hospital readmissions, follow-up after hospitalization for behavioral

health primary diagnoses, and access to behavioral health providers.³¹ The RBHA will be subject to financial sanctions if it does not meet minimum performance standards or does not demonstrate improvement in these measures over time. New York is still developing metrics for use under its carve-in but has signaled its intent to include metrics related to the social determinants of health (e.g., housing and employment status) due to their importance to the health and wellbeing of individuals with SUDs. While quality measurement related to SUDs is still maturing, states implementing carve-ins uniformly recognize that robust monitoring must accompany financial integration.

Carve-Out Models

Maryland's managed care program, HealthChoice, currently serves approximately 926,000 beneficiaries,³² and the State anticipated nearly 110,000 newly eligible adults enrolling through its Medicaid expansion.³³ Today, Maryland covers substance abuse services through its HealthChoice MCOs and provides specialty mental health services on a managed FFS basis through an ASO that operates similar to a BHO. The State's ASO provides utilization management, claims payment, and data collection and management services but does not bear financial risk for the cost of covered services. After a lengthy stakeholder consultation process, the State decided to carve out substance abuse services from the MCO benefit package, as well, and provide them on a managed FFS basis, along with specialty mental health services, through a newly procured ASO. The new arrangement is anticipated to begin in 2015.

State officials cite several reasons for this decision.³⁴ The State anticipates reduced administrative burden for substance abuse service providers, through contracting with one ASO rather than seven MCOs (each with unique credentialing, prior authorization, utilization review, and payment practices). Maryland also sees the value of an ASO as a single point of contact for entities outside Medicaid interfacing with the Medicaid behavioral health system, including qualified health plans that will see members "churning" in and out of Medicaid eligibility, schools and social service entities, and the criminal justice system. The ASO will also interface with behavioral health treatment providers outside Medicaid (e.g., those funded by locally administered substance abuse treatment grants). As one state official put it, without the ASO, "baton passing would be multiplied immensely."

To address concerns about potential lack of coordination across physical and behavioral health systems, Maryland is implementing a "performance-based" payment model that holds the ASO and its contracted providers accountable for member's health outcomes. The new ASO will be required to report on quality metrics related to behavioral health, including Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, a measure included in the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS).³⁵ It will also have to report on the percentage of its population with primary care provider (PCP) visits in the previous year and all-cause hospital readmissions. The ASO will be subject to a financial penalty of up to 0.5 percent of its total payments if it fails to meet performance targets in these and other areas.

Eventually, the State intends to use financial incentives based on outcome measures (likely through a shared savings model) to promote coordination between MCOs and the ASO, as well as among primary care and behavioral health providers. Maryland's MCOs and the ASO will also be subject to data-sharing requirements and required to use the State's health information exchange. Finally, state officials indicate that there will be a structured adjudication process to resolve disputes between MCOs and the ASO over responsibility for services.

Hybrid Models

Massachusetts's Medicaid program, MassHealth, has long taken a hybrid approach to delivery of behavioral health services to its enrollees. As of July 2012, 486,000 MassHealth beneficiaries were enrolled in MCOs, and 389,000 individuals were enrolled in the Primary Care Clinician (PCC) Plan, a primary care case management program.³⁶ In the MCO program, five MCOs cover substance abuse services, including inpatient services, diversionary services, outpatient services, and emergency services.³⁷ Conversely, the Commonwealth carves behavioral health services including substance abuse treatment out of the PCC Plan, providing these services through the Massachusetts Behavioral Health Partnership (MBHP), a statewide BHO operated by ValueOptions. ValueOptions representatives believe that BHOs have a number of advantages in treating individuals with serious SUDs or SMI, including familiarity with intensive treatment needs, employment and housing needs, and other social needs (e.g., child welfare system involvement). In MassHealth, quality of substance abuse coverage and treatment is measured through the HEDIS Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure.³⁸

Massachusetts is allowing PCPs in the PCC Plan to take on greater responsibility (and risk) for a limited set of behavioral health services through the Primary Care Payment Reform initiative, which was implemented in March 2014. To support PCPs in this transition, ValueOptions is providing consultation and management services to primary care practices to ensure seamless hand-offs from PCPs to ValueOptions, with clear lines of communication, when patients require more intensive services than PCPs can provide. MCOs are also participating in the new payment methodology, which is intended to build on the State's existing Patient-Centered Medical Home Initiative and support provider transitions to alternatives to FFS reimbursement.³⁹

In Washington, another state with a hybrid delivery system model, the Health Care Authority contracted with five MCOs through its Healthy Options managed care program to serve 800,000 managed care enrollees in 2013;⁴⁰ the State expects roughly 250,000 newly eligible adults to enroll in the program in 2014.⁴¹ While Washington State currently carves out all substance abuse services for managed care enrollees on a FFS basis, the State received a State Innovation Model Pre-Testing award from the Center for Medicare & Medicaid Innovation (CMMI) to develop its State Health Care Innovation Plan, to pilot financing and payment systems that support integrated physical and behavioral health service delivery. The State envisions competitively procuring "accountable risk-bearing entities" (ARBEs)—potentially including MCOs, BHOs, accountable care organizations, risk-bearing public-private entities, or county governmental organizations—to provide Medicaid physical health and/or behavioral health services in regional service areas.⁴² In some regions, ARBEs would enter into contracts to take on risk for, provide, and manage an integrated benefit package including physical and behavioral health services. In others, separate ARBEs (i.e., MCOs and BHOs) would enter into contracts with the State to provide physical health services and both mental health and substance abuse services, respectively. ARBEs would be required to cooperate with newly formed "Accountable Communities of Health," locally governed public-private partnership organizations tasked with pursuing community health improvement goals and encouraging cross-sector resource sharing.

2. States are investing in expanding substance abuse provider capacity and providing technical assistance to substance abuse providers.

Addressing the substance abuse treatment needs of the Medicaid expansion population will require expanded provider capacity and states are beginning to use several levers to increase substance abuse provider and service capacity. In New York, a State work group

focused on Medicaid behavioral health redesign recommended that MCOs focus on expanding access to office-based and ambulatory services as less costly alternatives to inpatient care.⁴³ Other states are turning their attention to similar efforts.

Providers and managed care plans (MCOs and BHOs) appear to be primary drivers of substance abuse service and program innovation and capacity development. Representatives of Beacon Health Strategies, a BHO working with MCOs in several states including Massachusetts and New York, advocate for states to ensure the availability of diversionary and step-down programs including community-based detoxification, partial hospitalization, intensive outpatient programs, and structured residential programs and are working with providers to develop these programs.

In Massachusetts, Beacon has developed specifications for a number of program types including service components, staffing requirements, required linkages to other services and resources, and quality management approaches. For example, Crisis Stabilization Service programs are expected to offer 24-hour residential care in a protected and structured environment to stabilize individuals in early recovery, generally for less than 30 days.⁴⁴ While these programs are currently used primarily as a “step-down” service for individuals receiving inpatient detoxification services, Beacon is interested in supporting more direct admissions for individuals with residual withdrawal symptoms who are not in need of medication, as an alternative to inpatient detoxification. Structured Outpatient Addiction Programs (SOAPs) in Massachusetts offer structured, primarily group-oriented treatment services in half- or full-day units, generally for less than 10 days. SOAPs may provide services to individuals returning to the community from medically managed detoxification or acute treatment programs, or to individuals needing more intensive treatment than other outpatient programs may provide.⁴⁵ To encourage greater use of SOAPs through direct admissions for the latter category of patients, Beacon recently removed its SOAP prior authorization requirements. Notably, Beacon has not seen an increase in average length of stay, suggesting that SOAPs are still being used as intended.

Another example of service innovation to divert enrollees from costly utilization of inpatient services is ValueOptions’ MBHP which received a three-year, \$2.8 million Health Care Innovation Award from CMMI for a project aimed at reducing repeated utilization of detoxification services by individuals with two or more detox admissions.⁴⁶ Four providers are implementing the MBHP project, which relies on patient navigators, recovery planning, and other support services to ensure that enrollees are linked to appropriate and coordinated care. In addition to the improvements in care, and in alignment with CMMI’s remaining two “Triple Aim” goals (better health and lower costs), ValueOptions anticipates improved health outcomes and savings of \$7.8 million over three years, through reductions in preventable emergency room visits and hospitalizations.

State licensing requirements and regulations for facilities may create barriers to providers expanding into new service types and mixes, especially as they move toward integration of physical and behavioral health services. States are modifying certification and licensing requirements (for individual professionals and for facilities) to address these issues. In Washington State, for example, providers report that certification requirements related to supervised experience for chemical dependency professionals (a minimum of 1,000 hours) can be a disincentive for mental health counselors who might otherwise become dually certified to treat mental illness and SUDs. To bridge gaps and ease the transition between the fields, Washington and other states have adopted credentialing or certification processes for treatment of co-occurring disorders; at least 15 states have adopted the International Certification and Reciprocity Consortium’s Certified Co-Occurring Disorders Professional and Certified Co-Occurring Disorders Professional Diplomate credentials.⁴⁷

Arizona recently revised its licensing rules to allow outpatient treatment centers and other provider types to offer both physical health and behavioral health services under the same license.⁴⁸ Maryland is in the process of transitioning to accreditation-based regulation of behavioral health providers to promote administrative simplicity, support the use of evidence-based interventions, and advance an integrated approach to care of people with SUDs and/or mental illness.^{49,50}

As states move to give providers a wider range of options around licensing and credentialing, Beacon Health Strategies reports working cooperatively with providers to develop new service capacity—and new service modalities—for which there is unmet need among managed care enrollees. In order to support development of new modalities, Beacon provides technical assistance to providers that wish to take advantage of new state flexibility and waives its own network contracting requirements where necessary. When such “waivers” include relaxed educational standards for practitioners (e.g., in order to include peer counseling in the continuum of care), Beacon notes that there is simultaneous pressure on MCOs and BHOs to provide rigorous provider oversight, in order to ensure that appropriate standards of care are met.

States are also considering changes to their Medicaid State Plans as they implement new approaches to coverage of substance abuse services for managed care beneficiaries. State officials in New York have indicated their intent to submit a State Plan Amendment to move substance abuse services currently covered under the clinic services benefit category to the rehabilitative services benefit category, to allow providers to deliver substance abuse services outside of clinic sites.⁵¹

As part of implementing new approaches to substance abuse coverage for managed care enrollees, states, MCOs, BHOs, and provider systems are also taking steps to ensure that substance abuse providers are prepared for managed care contracting. New York envisions that MCOs will develop and implement a comprehensive behavioral health provider training and support program, addressing topics including: billing, coding, and documentation; data interfaces between providers and MCOs; utilization management requirements; and co-occurring physical and behavioral health conditions.⁵² Beacon Health Strategies is also offering continuing education and training for New York substance abuse and mental health providers participating in managed care. In advance of New York’s full behavioral health carve-in, Beacon is developing a “road show” for providers in the State, which will provide an overview of managed care contracting issues including credentialing, claims, and reimbursement. Beacon has recommended to New York State that a common curriculum be developed among MCOs, state agencies, providers, and advocates to prepare behavioral health providers for the State’s carve-in, in order to ensure consistent messaging and avoid contradictory provider information. Provider associations and private foundations have similarly held forums for state representatives, MCOs, and providers around New York’s carve-in, addressing issues including infrastructure and organizational changes needed for treatment agencies to thrive under managed care. In addition to education and technical assistance, organizers of these events emphasize the importance of plans, BHOs, and providers (including physical health, mental health and substance abuse providers) working together outside of contract negotiations to develop relationships and become more familiar with each other.

As New Mexico transitions to its Centennial Care program (integrating coverage of physical health, mental health, substance abuse, and long-term services and supports in a single managed care benefit package), the State has contractually required its MCOs to develop an annual provider training and outreach plan for their networks.⁵³ The State requires plans to develop provider training and educational materials that address topics including: billing requirements and rate structures; credentialing and re-credentialing; prior authorization and referral processes; integrated physical and behavioral health care; and MCO care coordination processes and systems. The State may also develop a common

prior authorization form to ensure that no matter what MCOs' internal prior authorization procedures are, providers can follow common procedures for requesting service authorizations across all MCOs.

3. States are beginning to develop strategies to integrate social services for beneficiaries with SUDs.

Among the states reviewed, the need for strategies to address social service needs of Medicaid beneficiaries with SUDs and/or SMI is a consistent theme. State Medicaid agency and MCO experience interfacing with social services providers is generally limited. Even BHOs, while having more experience and exposure to social service needs among individuals with SUDs and other serious behavioral health conditions, report that attempting to identify social issues while enrollees are in substance abuse treatment is complex. This is due in part to providers' reluctance to contact MCOs or BHOs for assistance in addressing social issues. However, targeted initiatives to coordinate and facilitate access to social services for Medicaid beneficiaries with SUDs are beginning to emerge in the states we reviewed. In Massachusetts, Neighborhood Health Plan (NHP), an MCO serving 155,529 MassHealth members as of June 2012, has developed a Social Care Management program.⁵⁴ NHP Social Care Managers assist members with identifying and obtaining services including income assistance, housing, food, and transportation.⁵⁵ They provide phone numbers, assist members with placing calls, provide application assistance, and write referrals as necessary. NHP uses administrative funding to support the program, with the expectation that avoided inpatient admissions will cover the cost of these resources.

New York State implemented a Health Home program, as authorized by the ACA, to manage and coordinate care for beneficiaries with multiple chronic conditions, including SUDs. Health Homes in New York are provider-led, with each consisting of a lead entity and a network of subcontracted providers; MCOs are required to have contracts with and pass through per-member per-month (PMPM) payments to at least one Health Home in their service areas. New York's Health Homes are currently the primary avenue for linkages between managed care enrollees and social services. The State envisions that all HARP enrollees will be enrolled in Health Homes, and the Health Home will act as the care manager for all HARP services. In addition, under New York's carve-in, the State will require MCOs and HARPs to sign agreements with newly established Regional Planning Consortia, in part to facilitate linkages between Medicaid and social services.⁵⁶

In parallel with changes to Medicaid coverage of substance abuse services, New York has invested state funds in supportive housing for high-risk Medicaid beneficiaries with SUDs. In its 2013 fiscal year, New York State allocated \$75 million in state-only Medicaid funds for supportive housing, including \$25 million for expansion of rental and service subsidies targeting high-need, high-cost Medicaid recipients.⁵⁷ A portion of the funding supported 300 housing units for chronically addicted Medicaid recipients who are homeless or at risk of becoming homeless.⁵⁸ Washington is facing similar challenges to New York's, with nearly half of residential chemical dependency treatment recipients homeless or unstably housed in the 12 months after their discharge.⁵⁹ Counties have historically coordinated social service needs, including housing, for managed care enrollees receiving substance abuse services, largely because the counties administer many of those social services. In addition, Washington has implemented a Health Home program, similar to New York's. In Washington, the vast majority of Health Home lead entities are MCOs that receive per-member per-month Health Home payments from the Health Care Authority. Given MCOs' prominent role in the Health Home program, they may now take on greater responsibility for coordination of their members' social services.

Finally, RBHAs in Arizona are required to develop and manage a continuum of housing options for people with SMI.⁶⁰ RBHAs are also required to administer vocational, employment, and business development services.

Underlying the policy development for addressing the social service needs of managed care enrollees is a persistent question: who pays? Some social services central to the health of individuals with SUDs are not covered by Medicaid. For example, while Medicaid may cover services provided in supportive housing settings, as well as referrals to and coordination with supportive housing providers, the program cannot cover direct housing costs. Medicaid may cover employment supports and educational supports (often through waivers or state plan amendments under Section 1915 of the Social Security Act), but states use other funding sources for such services, in addition to or instead of Medicaid funding.⁶¹ Medicaid may also cover referrals to and coordination with social services, notably through Targeted Case Management and the Health Home option under the ACA. However, time spent on less formal approaches to coordination (e.g., phone calls to social service providers) are often not billable; providers may be hard pressed to invest in these activities absent financial resources to do so. Similarly, to the extent that social services and related coordination are not covered by states' Medicaid programs, MCOs and BHOs may be hesitant to spend limited administrative funds to invest in them, even when investments in such services are returned through medical cost savings.

Health Home funding under the ACA, including two years of 90 percent federal matching, offers one avenue for states to finance referrals to community and social support services. In New York, a State-led stakeholder workgroup has recommended that savings under the forthcoming behavioral health carve-in be reinvested in supportive services for people with behavioral health needs, such as housing, peer, employment, and family services.⁶² For individuals with serious SUDs or SMI, the State's HARPs will offer an enhanced benefit package including "1915(i)-like" home and community-based services (e.g., individual employment support services) for people with serious SUDs and SMI, subject to a functional assessment.⁶³ The State has indicated that only a subset of those services will be available at the outset of the program; the State intends to reinvest Medicaid savings generated through the behavioral health carve-in and HARPs in expanding the 1915(i)-like service benefit package.

4. States, plans and other stakeholders are considering strategies to bridge Medicaid and corrections.

For individuals cycling out of the criminal justice system, delivery of substance abuse services can improve health outcomes—by ensuring continuity of care for treatment begun behind bars—and prevent arrest. In Washington State, SSI clients receiving substance abuse treatment see a 16 percent reduction in their likelihood of arrest and a 34 percent reduction in the likelihood of a felony conviction.⁶⁴

Some states are beginning to make progress in bridging Medicaid and the corrections system. Healthfirst, a New York City-based MCO with 757,000 enrollees, has developed a relationship with Rikers Island, the city's main jail complex, to explore transferring information when members are incarcerated and interfacing with Health Homes upon their release.⁶⁵ New York's Health Homes have also implemented six pilot programs to establish linkages with the criminal justice system.⁶⁶ In Maryland, a nonprofit agency, HealthCare Access Maryland, has developed a program to place case managers at Baltimore City Detention Center, to assist inmates with applications for benefits (including Medicaid) 45 to 90 days prior to their release.⁶⁷ In Washington, many county substance abuse agencies responsible for carved out Medicaid substance abuse services report strong relationships with law enforcement and jails in their communities. These county agencies suggest that their community presence and

the financial incentive to the county to minimize criminal justice costs assist in developing those relationships. Under Arizona's new Maricopa County RBHA procurement, the RBHA is required to establish collaborative protocols with local law enforcement and first responders. Those protocols must address crisis services, jail diversion and safety, strengthening relationships with providers, and addressing joint training needs.

Despite these examples, state stakeholders agree that the potential to develop relationships between Medicaid and the criminal justice system remains largely untapped. States, MCOs, and BHOs will all be challenged to meet the significant, often long untreated needs of individuals with SUDs leaving jail or prison confinement to re-enter society.

Conclusion

The expansion of Medicaid under the ACA represents a sea change for states with respect to coverage of substance abuse services. As they prepare to cover a broadened scope of substance abuse services for a population with a greater prevalence of SUDs than current Medicaid enrollees, managed care states are facing, and will continue to face, important questions with respect to their delivery system models substance abuse services. Those questions include:

- How to best achieve better coordination among primary care and substance abuse providers;
- Whether to “carve in” or “carve out” substance abuse services from MCO benefit packages;
- In carve-out states, whether to use a BHO, an ASO, or the FFS Medicaid system to deliver substance abuse services;
- How to ensure that MCO or BHO networks include sufficient substance abuse provider capacity;
- How to ensure that substance abuse treatment providers are prepared to meet Medicaid requirements and contract with MCOs and BHOs;
- How to measure the quality of the care that beneficiaries with SUDs receive;
- How to address the social service needs of managed care enrollees with SUDs; and
- How to create an interface between managed care and the criminal justice system.

There is no magic bullet—states' answers to these questions are dependent on their unique culture, politics, infrastructure, and capacity. However, the experiences of the six states examined in this brief provide useful insights for other states reexamining their approaches to covering managed care enrollees with SUDs. Medicaid expansion presents states with a long list of challenges and opportunities. Improving coverage and delivery of substance abuse services for managed care enrollees is among the greatest of each.

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