

Joint CMCS and SAMHSA Informational Bulletin

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FROM: Vikki Wachino
Acting Director
Center for Medicaid and CHIP Services

Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Services Administration

SUBJECT: Coverage of Behavioral Health Services for Youth with Substance Use Disorders

This informational bulletin, based on evidence from scientific research and the results of a Substance Abuse and Mental Health Services Administration (SAMHSA)-supported technical expert panel consensus process,¹ is intended to assist states to design a benefit that will meet the needs of youth with substance use disorders (SUD) and their families and help states comply with their obligations under Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. The services described in this document are designed to enable youth to address their substance use disorders, to receive treatment and continuing care and to participate in recovery services and supports. This bulletin also identifies resources that are available to states to facilitate their work in designing and implementing a benefit package for these youth and their families.

Background

“Brain development during adolescence and emerging adulthood is one element that makes youth a period of particularly high vulnerability to SUDs.”² Adolescence is the time most of the people who become addicted develop their addiction. More than 90 percent of adults with SUDs started using before age 18; half of those began before age 15. Individuals who begin drinking before age 14 are seven times more likely to develop alcohol dependence than those who begin

¹ Substance Abuse and Mental Health Services Administration. (2013). *What does the research tell us about good and modern treatment and recovery services for youth with substance use disorders?* Report of the SAMHSA Technical Expert Panel, December 5–6, 2011. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. 07/01/13 Draft.

² SAMHSA, *What does the research tell us*, p. 44

drinking at age 21.³ The earlier a person begins using, the more likely the substance use disorder will develop and continue into adulthood.⁴

About 6.1 percent of adolescents between the ages of 12 and 17 were classified as substance abusive or dependent (alcohol or illicit drugs) in 2012.^{5,6} The rate of substance abuse or dependence among young adults aged 18–25 was 18.9 percent⁷ in 2012. In addition, abuse of prescription drugs is high among youth aged 12 to 17. In 2010, 3.0 percent of youth reported past-month nonmedical use of prescription medications. Youth who abuse prescription medications are also more likely to report use of other drugs. Multiple studies have revealed associations between prescription drug abuse and higher rates of cigarette smoking; heavy episodic drinking; and marijuana, cocaine, and other illicit drug use among adolescents, young adults, and college students.

Youth with SUDs also have high rates of co-occurring mental health disorders. SUDs increases the risk for mental health disorders and vice versa, and the majority of youth with SUDs have a co-occurring mental health disorder. In a study of data from the Global Appraisal of Individual Needs (GAIN), approximately 90 percent of substance-dependent adolescents under age 15 had at least one mental health problem in the past year.⁸ Furthermore, approximately 88 percent of the substance-dependent adolescents between ages 15 and 17 and 84 percent of the young adults aged 18–25 had co-occurring mental health issues.⁹

Youth with SUDs also face considerable academic, health-related, relational, and legal challenges. These issues also bring costs and consequences to families, communities, and society.¹⁰

Technical Expert Panel

Unlike other populations with behavioral health conditions, there is a lack of guidance regarding the treatment, continuing care and recovery supports needed for youth with SUDs or youth with SUDs and co-occurring mental health disorders. Because the growing body of research on youth with SUDs had not been systematically collated, reviewed and translated into practice guidelines, SAMHSA convened a technical expert panel comprised of nationally-recognized researchers to review the existing literature and utilize a structured process to identify what the research tells us about treatment and recovery services for youth with SUDs.

³ Substance Abuse and Mental Health Services Administration. (2013). Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 6

⁴ Lynskey, M.T. et al. (2003). Escalation of drug use in early-onset cannabis users vs co-twin controls. *JAMA* 289:427-33

⁵ Dependence or abuse is based on definitions found in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

⁶ *2012 National Survey on Drug Use and Health*, Table 5.4B

⁷ *2012 National Survey on Drug Use and Health*, Table 5.4B

⁸ Chan, Y., Dennis, M., & Funk, R.. (2008) Prevalence and comorbidity of major internalizing and externalizing problems among adolescents and adults presenting to substance abuse treatment. *Journal of Substance Abuse Treatment* (34), p. 19

⁹ Chan, Dennis, & Funk, R.. Prevalence and comorbidity, p. 19

¹⁰ Crowe, A., & Bilchik, S. (1998). Drug identification and testing in the juvenile justice system. Washington, DC: Office of Justice Programs, U.S. Department of Justice. Available from <http://www.ojjdp.gov/pubs/drugid/contents.html>

In discussing the optimal benefit design to provide effective treatment for youth with SUDs, technical expert panel members affirmed that practice must be rooted in the emerging neuroscience research in conjunction with the ever-growing psychosocial treatment effectiveness research. They stressed that treatment approaches must be developmentally appropriate and incorporate an understanding of the importance of family.

Selected Components of a Continuum of Services and Supports

The consensus findings from the technical expert panel suggest a continuum of treatment and recovery services and supports for youth with SUDs. The following section identifies selected components of a continuum of services to identify, treat, maintain gains and support recovery for youth with substance use or substance use and co-occurring mental health disorders.

Identification

There is evidence that “the short- and long-term impact of substance use on the brain suggests priority must be given to the screening and early identification of SUDs in youth.”¹¹ Because of the high rate of co-occurring disorders, every youth should be screened for both substance use and mental health disorders wherever they present. Youth with positive screens must be assessed with an evidence-based, comprehensive psychosocial assessment instrument that assists in identifying the level of severity of substance use disorder and/or substance use and mental health disorder and suggests the appropriate level of care.¹²

Screening

Screening is essential for identifying and addressing SUDs as early as possible. Screening tools are brief self-reports or interviews used as the first step in the process of evaluating whether a youth may or may not have an alcohol or drug problem. The outcome of a screening is to determine the need for further, more comprehensive assessment. Significant advancements in early detection of substance use conditions (including co-occurring mental health conditions) have taken place over the past decade. Numerous validated screens are available for use by medical professionals, and extensive research has proven them effective. Recommended screening tools for adolescents and young adults can be found at:

<http://store.samhsa.gov/product/Identifying-Mental-Health-and-Substance-Use-Problems-of-Children-and-Adolescents-A-Guide-for-Child-Serving-Organizations/SMA12-4700>

Assessment

An assessment is an integrated series of procedures conducted to provide the basis for an individualized treatment or service plan. An assessment should include an intensive evaluation of a youth’s clinical and psychosocial needs and functional level. This service may be conducted by an individual provider or by a multi-disciplinary team and should include face-to-face interviews with the youth and his/her family and/or significant others, and collateral contacts to determine the individual’s problems and strengths and to identify natural supports. The assessment should

¹¹ SAMHSA, *What does the research tell us*, p. 45

¹² SAMHSA, *What does the research tell us*, p. 66

inform the development of an initial treatment or service plan, which should include treatment, level of care, continuing care and recovery support recommendations and discharge criteria.¹³

Outpatient Treatment for Youth with Substance Use Disorders

There is evidence that “the neurobiology of youth requires unique approaches to treatment for SUDs.”¹⁴ The panel identified evidence that both psychotherapeutic and behavioral interventions affect the neurobiology of SUDs in youth. Panelists agreed that “The body of controlled studies clearly shows that evidence-based psychosocial treatment for youth with SUDs is effective (e.g., reduces substance use for youth with SUDs).”¹⁵ Motivational enhancement therapy, motivational enhancement therapy/cognitive behavioral therapy, and family-based treatments each show effectiveness for treating youth with SUDs. “The fidelity to and degree of implementation of evidence-based practices improves outcomes for youth with SUDs.”¹⁶ They concluded that treatment approaches for youth with SUDs should be individualized to the youth’s specific developmental stage.¹⁷

Outpatient treatment for youth with SUDs or substance use and co-occurring mental health disorders may be delivered through a number of traditional modalities. Examples of outpatient services include:

Individual Counseling/Therapies

Individual counseling and therapies assist a youth in achieving specific objectives of treatment or care for substance use or substance use and co-occurring mental health disorders through a one-to-one therapeutic relationship. Individual therapy helps to resolve symptoms, increase functioning, and facilitate emotional and psychological well-being. Therapy is generally directed toward reducing psychosocial stress and teaching coping and problem-solving skills, using supportive and cognitive-behavioral approaches that assist the youth in achieving a level of functioning capable of supporting and sustaining recovery.

Group Counseling

Group counseling is a service to assist two or more individuals in achieving treatment objectives through the exploration of substance use and/or mental health disorders and their ramifications, including an examination of attitudes and feelings and, in the case of SUDs, considering alternative solutions and decision making with regard to alcohol and other drug related problems. This service focuses on the individual’s adaptive skills, involving social interactions to facilitate emotional or psychological change, utilizing the shared experiences of the group’s members.

Family Therapy

Family therapy involves the youth and members of his or her family. Family may involve members of a biological family or may include extended family members (e.g. grandparents), or members of a step-family, foster or adoptive family. This therapy assists families to address important issues that may interfere with the youth’s functioning in the family and the home

¹³ Draft Good and Modern Continuum of Care Service Definitions, p. 2-3

¹⁴ SAMHSA, *What does the research tell us*, p. 44

¹⁵ SAMHSA, *What does the research tell us*, p. 46

¹⁶ SAMHSA, *What does the research tell us*, p. 47

¹⁷ SAMHSA, *What does the research tell us*, p. 44

environment. Family therapy is designed to enhance the individual’s insight into family interactions, facilitate emotional support and develop alternative strategies to address issues, problems and needs.

Intensive Outpatient Treatment

Intensive outpatient programs (IOPs) differ from regular outpatient treatment as discussed on page 4, in terms of the amount of hourly involvement of the youth per week. Intensive outpatient treatment generally provides 6-19 hours per week of services such as “individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and other therapies. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the treatment plan.”¹⁸ Examples of IOP programs are “after-school, day or evening and/or weekend intensive outpatient programs.”¹⁹ IOP program services “may be offered in any appropriate setting that meets state licensure or certification criteria.”²⁰ Co-occurring enhanced intensive outpatient programs “offer psychiatric services appropriate to the patient’s mental health condition. Such services are available by telephone and on site, or closely coordinated off site.”²¹

Occasionally the youth’s progress in IOP no longer requires six hours of treatment per week, but the youth “has not yet made enough stable progress to be referred to” a less intensive outpatient program.²² “In such cases, less than [. . .] six hours per week for adolescents as a transition step down in intensity should be considered as a continuation of the IOP program for one or two weeks. Such continuity allows for a smoother transition to [an outpatient level of care] to avoid exacerbation and recurrence of signs and symptoms.”²³

“Intensive outpatient treatment differs from partial hospitalization programs in the intensity of clinical services that are directly available. Specifically, most intensive outpatient programs have less capacity to effectively treat patients who have substantial unstable medical and psychiatric problems than do partial hospitalization programs.”²⁴

Partial Hospitalization

“Partial hospitalization programs, known in some areas as ‘day treatment,’ generally feature 20 or more hours of clinically intensive programming per week, as specified in the patient’s treatment plan.”²⁵ “Partial hospitalization programs typically have direct access to psychiatric, medical and laboratory services, and thus are better able than [IOPs] to meet needs [. . .] which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting.”²⁶ “Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and other therapies. These are provided in the amounts, frequencies, and intensities

¹⁸ American Society of Addiction Medicine (ASAM). (2013). The ASAM Criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions. 3rd ed., p. 199

¹⁹ ASAM, p. 198

²⁰ ASAM, p. 198

²¹ ASAM, p. 198

²² ASAM, p. 198

²³ ASAM, p. 198

²⁴ ASAM, p. 198

²⁵ ASAM, p. 208

²⁶ ASAM, p. 208

appropriate to the objectives of the treatment plan.”²⁷ “For adolescents, partial hospitalization often occurs during school hours; such programs typically have access to educational services for their adolescent patients [. . .] Partial hospitalization program services may be offered in any appropriate setting that meets state licensure or certification criteria.”²⁸

“In addition to the support systems just described for co-occurring capable programs, [partial hospitalization] co-occurring enhanced programs offer psychiatric services appropriate to the patient’s mental health condition. Such services are available by telephone and on site, or closely coordinated off site, within a shorter time than in a co-occurring capable program. Clinical leadership and oversight may be offered by a certified addiction medicine physician with at least the capacity to consult with an addiction psychiatrist. Some partial hospitalization services are specifically designed to be ‘co-occurring disorders’ programs in distinction from addiction specialty services.”²⁹

Medication-Assisted Treatment

There is evidence that in studies with youth, medication-assisted treatment has been shown to work best in conjunction with psychosocial treatments and they supported that both counseling and case management should be used to facilitate symptom monitoring and medication adherence in youth with SUDs.³⁰

Medication-assisted treatment is the treatment of disease with medication(s) that is intended to provide a holistic, patient-centered approach to treating substance use and/or mental health disorders. Medication must be prescribed by a licensed physician, or other professionals working within their scope of practice to prevent, stabilize or ameliorate symptoms arising from a behavioral health condition or its treatment. The nature of the services provided (such as dose, level of care, and length of service or frequency of visits) is determined by the patient’s clinical needs. Medication-assisted treatment should be considered for adolescents with SUDs when clinically indicated, for example, in the situation of relapsive addictive disorders.

There is evidence that “pharmacotherapy is promising for treating youth with SUDs;” however, they cautioned “the neurobiology of youth requires unique approaches to pharmacotherapy for this population.”³¹ It should be noted that the FDA has approved buprenorphine for opioid dependent adolescents age 16 and older. Methadone may also be used in youth ages 16-18 with special parameters in place. SAMHSA permits methadone for treatment of opioid use disorders in 16-17 year olds with parental consent and in programs specially licensed to provide treatment to this age group.

Case Management/Targeted Case Management

The technical expert panel found that “low case load, higher fidelity to case management models and more time spent on key case management functions are associated with better outcomes for

²⁷ ASAM, p. 210

²⁸ ASAM, p. 208

²⁹ ASAM, p. 208

³⁰ SAMHSA, *What does the research tell us*, p. 45

³¹ SAMHSA, *What does the research tell us*, p. 45

youth with SUDs.”³² “Case management should be developmentally appropriate and should include linkage to and monitoring of” the youth’s access to needed medical, social, therapeutic, employment, transportation, education or other services that will support his/her overall health and wellness.³³ The panel also found that “case management should also include linkage to services for the parents and caregivers as needed.”³⁴ They cautioned that “the effectiveness of case management may depend on the quality and availability of services in the community.”³⁵

Using a family-centered, youth-guided, strengths-based case management approach that promotes the active participation of the youth, a case management plan should be developed after an initial assessment of skills, abilities and needs. The assessment may include consultations with families and caregivers and collaboration with physicians or other medical professionals. Monitoring and follow-up activities by the case manager ensure that a treatment or recovery plan is effectively implemented and adequately addresses the needs of the youth and those adjustments are made to the plan when necessary. More information on case management models may be found at:

<http://www.ncbi.nlm.nih.gov/books/NBK64863/pdf/TOC.pdf>

Continuing Care

The technical expert panel members found that “Continuing care should be provided for all youth who enter treatment for SUDs regardless of treatment completion” and that “continuing care initiation within two weeks of leaving treatment improves outcomes for youth with SUDs.”³⁶ The panel stated that “there should be an emphasis on providing youth a choice of continuing care services provided in a variety of settings.”³⁷

Continuing care may involve home- or community-based weekly meetings with a clinician to discuss goals and activities; therapeutic sessions to assess status of use and motivation to change, to identify problem areas, and to provide skills or guidelines to address problems; and/or support and education for youth and their families. A number of continuing care service models, such as Assertive Continuing Care or other assertive outreach efforts are delivered during the first 90 days after discharge. Assertive outreach approaches improve continuing care initiation and retention and enhance positive outcomes of treatment for youth with SUDs.

Recovery Services and Supports

The technical expert panel concluded that “the field must focus on early initiation and engagement of youth with SUDs in recovery services” which “should be identified at the beginning of treatment, be included in the youth and family service plan, continue after discharge,”³⁸ and be offered in environments such as high schools, colleges, universities and

³² SAMHSA, *What does the research tell us*, p. 51

³³ SAMHSA, *What does the research tell us*, p. 51

³⁴ SAMHSA, *What does the research tell us*, p. 51

³⁵ SAMHSA, *What does the research tell us*, p. 51

³⁶ SAMHSA, *What does the research tell us*, p. 51

³⁷ SAMHSA, *What does the research tell us*, p. 51

³⁸ SAMHSA, *What does the research tell us*, p. 52

community youth recovery centers.³⁹ They stated that “Engagement in pro-social activities should be promoted as an essential component of youth treatment and recovery” and that the implementation of recovery services “should attract youth and be developmentally appropriate.”⁴⁰ While the panel acknowledged that studies have demonstrated differential effectiveness of recovery support services based on the initial severity of the substance use disorder, they concluded that research indicates recovery support services can enhance and sustain treatment gains for youth with SUDs.⁴¹

Some examples of recovery services for youth with SUDs and their families include but are not limited to:

Youth Peer-to-Peer Recovery Coaching/Peer Mentoring

The technical expert panel members agreed that peer-to-peer supports are promising for youth in recovery and stated that there is a need to increase the availability of both individual and group-based peer services.⁴² Peer supports are a set of peer-based activities that engage, educate and support a youth to successfully make behavioral changes necessary to recover from disabling substance use/mental health disorder conditions. This service is often used in conjunction with and in support of appropriate clinical interventions. Service activities include: assisting the individual in developing self-management strategies, conducting one-on-one support sessions, organizing structured pro-social activities, developing goals and recovery/wellness plans and providing crisis support and linkage to natural supports in the workplace and other environments. Youth should be matched to age- and developmentally-appropriate peer coaches or mentors who are stable in their recovery.

Technological Support Services

Technical expert panel members found that preliminary studies of the effectiveness of technology-based recovery supports are promising. They stated that research demonstrates the feasibility of implementing technology-based recovery supports for youth with SUDs and that the use of technology to deliver elements of treatment and recovery may result in resource (e.g., money, time) savings.⁴³

Technological support services consist of electronic activities designed to provide elements of a support system for youth in treatment/recovery that are accessible to youth and hosted in electronic platforms conducive to youth involvement. These services create and foster a moderated environment for support activities, and include but may not be limited to: making and maintaining connections and linkages; encouraging mutual assistance among those who have received services; facilitating peer-to-peer support; informing youth about recovery/wellness activities and improving retention in treatment/recovery service and supports.

Technological support services may take a variety of forms, including social media, social networking sites, texts or emails. Technological support services can be used to communicate directly between a provider and an individual to provide reminders or to facilitate

³⁹ SAMHSA, *What does the research tell us*, p. 53

⁴⁰ SAMHSA, *What does the research tell us*, p. 53

⁴¹ SAMHSA, *What does the research tell us*, p. 53

⁴² SAMHSA, *What does the research tell us*, p. 52

⁴³ SAMHSA, *What does the research tell us*, p. 53I

communication between multiple individuals for the purpose of supporting treatment, wellness and recovery. A clinician or therapeutic mentor may use technological support services to communicate directly with an individual client (ex. interactive text messaging, email, telephone calls, etc.) or on behalf of a client (e.g. texts and email reminders that do not require a personal reply). These electronic interactions need specific consent and must be done through secure mechanisms. For more information on confidentiality issues, please see 42 CFR information at: <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:1.0.1.1.2>

Parent/Caregiver Support

Technical expert panel members agreed that “Services to families of youth with SUDs should include multiple delivery modes (e.g., individual or group meetings, parent-to-parent services, technology-based services).”⁴⁴ While panel members acknowledged variability in existing parent-to-parent support program components, measures, and results, they found that parent-to-parent support is a promising approach to enhance treatment and recovery services for youth with SUDs.⁴⁵

The Parent/Caregiver Support service provides a structured one-to-one relationship between a parent/caregiver with “lived experience” who has personally faced the challenges of coping with a youth with SUD and parents/caregivers of youth who currently have substance use and/or mental health disorders. Services are designed to improve the parent/caregiver’s capacity to ameliorate or resolve the child/youth’s emotional or behavioral needs and strengthen their capacity to parent through educational support, instructional skills, development support, emotional and affirmative support, concrete services and advocacy support. Outcomes for parents or caregivers are expected to include youth remaining at home and attending school, reduced caregiver strain and caregiver empowerment and satisfaction.

Residential Treatment

The technical expert panel found that “[residential treatment] is useful in interrupting the trajectory of increasing substance use in youth and may be important in addressing the exacerbation of substance use disorder symptoms linked to environmental triggers.”⁴⁶ It is effective for youth withdrawal management (detox) as well as for providing high intensity services for youth with substance use or co-occurring substance use and mental health disorders. “Residential treatment may aid in reducing youth substance use from a level that necessitates residential treatment to a level of substance use more consistent with youth in outpatient treatment.”⁴⁷

Residential treatment programs for SUDs offer organized treatment services that feature a planned and structured regimen of care in a residential setting. Staffed 24 hours a day, they are typically clinically managed and may be medically monitored and provide short-term, intensive treatment and stabilization. Treatment services adhere to defined policies, procedures and clinical protocols, emphasizing active treatment including individual and group therapy. They

⁴⁴ SAMHSA, *What does the research tell us*, p. 53

⁴⁵ SAMHSA, *What does the research tell us*, p. 53

⁴⁶ SAMHSA, *What does the research tell us*, p. 48

⁴⁷ SAMHSA, *What does the research tell us*, p. 49

are facilities where youth can reside safely. Special attention is paid to linkage with outpatient services so that appropriate handoffs to less intensive levels of care occur. Mutual/self-help group meetings are usually available on-site.

Residential treatment may coordinate and deliver a comprehensive array of therapeutic services which may include but not be limited to: individual, group, family or multi-family group therapies; medication-assisted withdrawal/treatment; crisis stabilization; peer to peer support; and case management.

Medicaid Financing

Youth with an SUD may be served by numerous systems through a number of funding sources when funders communicate effectively to coordinate and reimburse providers for the right services and treatments. A critical funding source for many of the interventions set forth in this informational bulletin is Medicaid. State Medicaid agencies have various options in the Medicaid program to cover services for youth with SUDs.

There are some important informational bulletins and guidance that states could use in constructing a benefit package for youth with SUD. For instance, states that are interested in developing peer supports for this population should review guidance sent to state Medicaid directors on peer supports. Information regarding coverage of Caregiver supports was provided to states last year on an informational bulletin regarding youth with significant mental health conditions. Early identification of youth with SUD was included in another informational bulletin. In addition CMS and its federal partners released information regarding medication assisted treatment for individuals (including youth with SUD). The Resource Section of this informational bulletin provides links to these informational bulletins and State Medicaid Directors.

There are some important policies that currently exist that may limit a state's ability to fully provide all of the components of the interventions in this informational bulletin. For instance, payments for individuals in residential facilities should be consistent with CMS policies regarding room and board and the payment exclusion for Institutions for Mental Diseases. In addition, educational services are not a Medicaid reimbursable service.

1905(a) Authority

Many of the services that are essential to the implementation of a full continuum of care for youth with SUDs may be covered through Title XIX, 1905(a) authority. Identification and treatment for mental health and substance use issues and conditions is available under a number of Medicaid service categories, including hospital and clinic services, physician services, and services provided by a licensed professional such as a psychologist. States should also make use of rehabilitative services. While rehabilitative services can meet a range of children's treatment needs, they can be particularly critical for children with mental health and substance use issues. For services such as family therapy or parent/caregiver support, services must address the adolescent's goals in the treatment plan.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.” EPSDT entitles enrolled infants, children, and adolescents to any treatment or procedure they require (as determined through an EPSDT screen) that is covered within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to ‘correct or ameliorate’ defects and physical and mental illnesses or conditions.

1915(b) Authority

1915(b) waivers are one of several options available to states that allow the use of managed care in the Medicaid Program. When using the 1915(b) authority, states have various options for implementing managed care including the authority to restrict the types of providers that people can use to access Medicaid benefits and the ability to use the savings to the state from a managed care delivery system to provide additional services or selectively contract with providers who can provide specific Medicaid services. Utah has used the 1915(b) authority to use selected managed care providers for services for youth with SUDs or co-occurring substance use and mental health disorders. Information on this Waiver can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/UT_Utah-Prepaid-Mental-Health-Plan_UT-02.pdf

1915(c) Authority

Some states have used the 1915(c) Home and Community-Based Services (HCBS) waiver to develop comprehensive benefit designs that include additional supportive services for youth with co-occurring substance use and mental health disorders. States have used these waivers to expand their array of home and community-based services and supports for this population with a view towards improving outcomes and reducing costs. North Carolina uses combined 1915 (b) and (c) waivers for youth with substance use or co-occurring substance use and mental health disorders. Some of these services include respite and supported employment for older adolescents and young adults. More information is available from: <http://www.ncdhhs.gov/MHDDSAS/providers/1915bcWaiver/index.htm>

1915(i) State Plan Amendment

Section 1915(i) provides an opportunity for states to amend their state Medicaid plans to offer home and community-based behavioral health services that were previously provided primarily through 1915(c) HCBS waiver programs. A state plan amendment (SPA) can include care coordination, respite, and parent and youth support, and other services HCBS for youth with substance use, mental health or co-occurring substance use and mental health disorders. Under 1915(i) states may target services to particular population groups but cannot waive the requirement to provide services statewide, nor limit the number of participants in the state who

may receive services if they meet the population definition. Unlike the 1915(c) waiver program, the 1915(i) delinks the provision of services with the requirement that participants must meet an institutional level of care. In order to target the initiative and limit costs, states may identify a specific population and establish additional needs-based criteria.

Section 2703 Health Homes

Health homes (Affordable Care Act-Section 2703) are a Medicaid state plan option available for states to design programs to better serve persons with chronic conditions, including substance use or co-occurring substance use and mental disorders. Health homes must provide for an individual's primary care and disability-specific service needs, and must provide care management and coordination for all of the services needed by each enrolled individual. The major goal is to provide more comprehensive, coordinated, and cost-effective care for individuals with chronic conditions, including youth with substance use, mental health or co-occurring substance use and mental health disorders, than generally provided when services are fragmented across multiple health providers and organizations.

The health home state plan optional benefit under section 1945 of the Social Security Act is statutorily-defined as services for “eligible individuals with chronic conditions” and does not allow for coverage to be limited the age of an individual. However, CMS recognizes that the service needs of individuals within a population may vary, and therefore that the treatment modalities, protocols and provider networks may involve different approaches for youth as compared to adults for key health home activities such as coordinating, managing and monitoring services. States may develop different approaches that serve different age groups, based on distinctions between the health home needs of the population. Therefore, CMS will allow states to submit separate SPAs for home health programs that target youth with substance use or co-occurring substance use and mental health disorders as long as another SPA for adults with substance use or co-occurring substance use and mental health disorders is submitted simultaneously. For more information visit [Medicaid.gov](http://www.medicaid.gov)'s Health Homes page: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>

1115 Authority

In general, the existing Medicaid authorities, described above, provide states the flexibilities necessary to implement their desired reforms. However, there may be instances when states may want to consider a Research and Demonstration Waiver under section 1115 of the Social Security Act. Section 1115 allows the Secretary of Health and Human Services to waive certain statutory provisions, allowing for states to test innovative policy and delivery approaches to individuals with a SUD, including those targeted to select populations or geographic areas, or those that use providers not otherwise covered under Medicaid. CMS is developing additional guidance on Section 1115 SUD policy (which will be released in a forthcoming publication) for a limited number of proposals to address comprehensive SUD system transformation, ensuring integrated and community-based care.

Quality Reporting

National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) measures set⁴⁸ includes two measures for alcohol and other drug treatment which apply to individuals age 13 and older as of December 31 of the measurement year. The initiation of alcohol and other drug (AOD) treatment measure is used to assess the percentage of adolescent and adult members with a new episode of AOD dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.⁴⁹ The engagement of AOD treatment measure is used to assess the percentage of adolescent and adult members with a new episode of AOD dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive).⁵⁰

National Outcome Measures

The National Outcome Measures (NOMs)⁵¹ were developed by SAMHSA to measure mental health services, substance abuse treatment, and substance abuse prevention. Each priority area is measured along ten dimensions to gauge an individual's health and pursuit of treatment. The measurements include morbidity, employment/education, crime, housing stability, social connectedness, service access and capacity, treatment and retention, perception of care, cost effectiveness, and use of evidence based practices.

Program Integrity

In designing a benefit package for youth with SUD, State Medicaid agencies need to give careful consideration to potential program integrity vulnerabilities in the system for delivering those benefits. States generally have the option of purchasing SUD benefits on behalf of Medicaid-eligible youth on a fee-for-service basis, through managed care organizations, or both. As the recent California State Auditor's report indicates, whatever purchasing approach a state elects to use, the risk of fraud needs to be taken seriously.⁵² This report identified major issues with how the state and the counties monitored the California Drug Medi-Cal program and set forth recommendations to improve the oversight of the program. At a minimum, State Medicaid agencies need to ensure that providers furnishing SUD services to youth are properly screened prior to enrollment in the program and, if currently enrolled, are periodically revalidated.

⁴⁸ National Committee for Quality Assurance (NCQA). (2013). HEDIS 2014: Healthcare Effectiveness Data and Information Set. Vol. 2, technical specifications for health plans. Washington (DC): National Committee for Quality Assurance (NCQA)

⁴⁹ National Quality Measures Clearinghouse. (2014). Measure summary: Initiation of alcohol and other drug (AOD) treatment. Available from <http://www.qualitymeasures.ahrq.gov/content.aspx?id=47231>.

⁵⁰ National Quality Measures Clearinghouse. (2014). Measure summary: Engagement of alcohol and other drug (AOD) treatment. Available from <http://www.qualitymeasures.ahrq.gov/content.aspx?id=47233>.

⁵¹ <http://media.samhsa.gov/co-occurring/topics/data/nom.aspx>

⁵² California State Auditor, California Department of Health Care Services: Its Failure to Properly Administer the Drug Medi-Cal Treatment Program Created Opportunities for Fraud, Report 2013-119 (August 19, 2014), <https://www.auditor.ca.gov/pdfs/factsheets/2013-119.pdf>

Resources:

Information regarding Early Identification and Screening for Youth with SUD may be found at:
<http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf>

Information on pharmacotherapy for youth with SUD may be found at:
<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-11-2014.pdf>

Information regarding coverage of Peer Supports may be found at:
<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf>

Information regarding Caregiver to Caregiver Support may be found at:
<http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>

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