



Joint Informational Bulletin

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SUBJECT: Coverage of Early Intervention Services for First Episode Psychosis

INTRODUCTION:

This Informational Bulletin is intended to assist states in designing a benefit package to guide early treatment intervention options that will meet the needs of youth and young adults experiencing first episode psychosis.

The National Institute of Mental Health (NIMH), Centers for Medicare & Medicaid Services' Center for Medicaid and CHIP Services (CMCS) and Substance Abuse and Mental Health Services Administration (SAMHSA) are engaged in an ongoing partnership to further efforts to support early intervention services for youth and young adults that experience first episode psychosis.

Schizophrenia is associated with high rates of morbidity and mortality. In the U.S., people diagnosed with psychotic disorders such as schizophrenia die an average of 11 years earlier than the general population, typically due to co-occurring medical conditions.¹ Up to 10 percent of individuals with schizophrenia die by suicide, often in the early years of illness.^{2,3}

¹Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604

²Meltzer H. Suicidality in schizophrenia: a review of the evidence for risk factors and treatment options. *Curr Psychiatry Rep*. 2002;4:279-83

Eighty to 90% of people with schizophrenia are unemployed,^{4,5} 20% are homeless,⁶ and 17% live in prison or jail.⁷ Approximately 100,000 adolescents and young adults in the U.S. experience first episode psychosis each year.⁸ Psychotic symptoms usually emerge during late adolescence or early adulthood, and derail important developmental milestones such as completing school or entering the workforce. The early stages of psychotic illness are tumultuous, and may place tremendous strain on a family's emotional and financial resources.

Untreated psychosis increases a person's risk for suicide, involuntary emergency care, and poor clinical outcomes. Often individuals experience long periods of untreated psychosis and treatment delays are between one and three years following the onset of psychotic symptoms.⁹ In the U.S., a recent study of the duration of untreated psychosis reported a median rate of 74 weeks across 34 geographically diverse community mental health centers, a level more than six times the World Health Organization standard for effective early psychosis intervention.¹⁰

Early intervention can alter this illness trajectory and enable individuals experiencing first episode psychosis to live in community settings and participate fully in family and community life.

Evidence-based services such as the integrated, team-based mental health services described in this document support clinical and functional recovery by reducing the severity of first episode psychotic symptoms, keeping individuals in school or at work, and putting them on a path to better health.

Compared to traditional treatment approaches, specialty care programs that provide coordinated, targeted treatment in the early stages of illness and integrate medical, psychological, and

³ Palmer B, Pankratz V, Bostwick J. The lifetime risk of suicide in schizophrenia: a reexamination. *Arch Gen Psychiatry*. 2005;62:247-53.

⁴ Rosenheck R, Leslie D, Keefe R, McEvoy J, Swartz M, Perkins D, Stroup S, Hsiao J K, Lieberman J. (2006). Barriers to employment for people with schizophrenia. *American Journal of Psychiatry*, 163, 411-17.

⁵ Salkever DS, Karakus MC, Slade EP, Harding CM, Hough RL, Rosenheck RA, Swartz MS, Barrio C, Yamada AM. (2007). Measures and predictors of community-based employment and earnings of persons with schizophrenia in a multi-site study. *Psychiatric Services*, 58, 315-24.

⁶ Folsom DP, Hawthorne W, Lindamer L, Gilmer T, Bailey A, Golshan S, et al. Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *Am J Psychiatry*. 2005 Feb;162(2):370-6.

⁷ DiCataldo F, Greer A, Profit WE. (1995). Screening Prison Inmates for Mental Disorder: An Examination of the Relationship Between Mental Disorders and Prison Adjustment. *Bulletin of the American Academy of Psychiatry and the Law*, 23 (4), 573–585.

⁸ Computed from Kirkbride JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, et al. (2012) Incidence of Schizophrenia and Other Psychoses in England, 1950–2009: A Systematic Review and Meta-Analyses. *PLoS ONE* 7(3): e31660. doi:10.1371/journal.pone.0031660

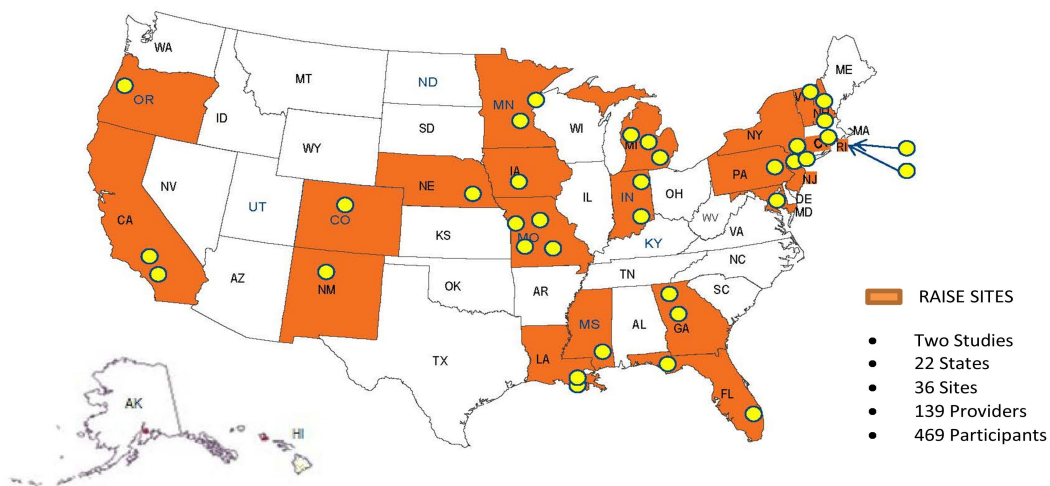
⁹ Marshall M; Lewis S; Lockwood A; Drake R; Jones P; Croudace T. (2005). Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: A systematic review. *Archives of General Psychiatry*, 62:975-983.

¹⁰ Addington J, Heinssen RK, Robinson DG, Schooler NR, Marcy P, Brunette MF, Correll CU, Estroff S, Mueser KT, Penn D, Robinson JA, Rosenheck RA, Azrin ST, Goldstein AB, Severe J, Kane JM. (2015). Duration of Untreated Psychosis in Community Treatment Settings in the United States. *Psychiatric Services*. 66(7), 753-756.

rehabilitation interventions, are an effective means for treating first episode psychosis.¹¹ Without such interventions during a first episode, the typical course of psychotic disorder involves multiple episodes of acute mental illness, with accumulating disability between periods of active psychosis and increased long-term health care costs.

NIMH launched the Recovery After an Initial Schizophrenia Episode (RAISE) research initiative in 2008 with the aim of developing, testing, and implementing Coordinated Specialty Care (CSC) programs for first episode psychosis in “real world” community clinics. Under RAISE, NIMH funded two research investigations: the RAISE Early Treatment Program (RAISE-ETP) and the RAISE Implementation and Evaluation Study (RAISE-IES). Figure 1 illustrates the 22 states in the RAISE initiative, which included 36 geographically diverse community clinics.

Figure 1: Location of NIMH RAISE Sites in the United States



The RAISE-ETP randomized control trial involved 404 young people with first episode psychosis in 34 community clinics. Community-based clinicians were trained to deliver a team-based approach to CSC that included four core interventions: resilience-focused individual therapy, family psychoeducation and support, supported education and employment, and personalized medication management.

Compared to patients who received usual care, participants in CSC experienced significantly greater improvements in total symptoms, social functioning, work or school involvement, and overall quality of life.

¹¹ Bird, V., Premkumar, P., Kendall, T., Whittington, C., Mitchell, J. & Kuipers, E. (2010). Early intervention services, cognitive-behavior therapy and family intervention in early psychosis: systematic review. *British Journal of Psychiatry*, 197, 350-356.

Individuals with a shorter duration of untreated psychosis benefited most from CSC treatment, demonstrating that receipt of appropriate care early in the course of a first episode of psychotic disorder is essential to improved outcomes.¹²

RAISE-IES was conducted with 65 young adults in two publically funded CSC mental health clinics in Maryland and New York. RAISE-IES used a CSC model incorporating medication, supported employment and education, family support and education, skills training and support based on cognitive-behavioral methods, substance abuse treatment, and suicide prevention. Participants achieved a range of positive outcomes over two years, including total symptom reduction, better occupational functioning, and greater participation in school or work.¹³

In partnership with state mental health authorities in New York and Maryland, RAISE-IES established the feasibility of CSC teams in routine practice settings and the success of such teams in engaging and retaining youth and young adults in treatment.

Conducted in a public sector mental health center from 2006-2013, the NIMH-supported Specialized Treatment in Early Psychosis (STEP) randomized control trial compared the effectiveness of CSC for 120 youth and young adults experiencing first episode psychosis. After one year of treatment, the participants in CSC experienced significantly greater improvements in psychopathology, fewer hospitalization episodes, and better school and work participation compared to those in usual treatment.¹⁴

RAISE-ETP, RAISE-IES, and STEP demonstrate convincingly (1) the feasibility of first episode psychosis specialty care programs in U.S. community mental health settings, (2) that young people with psychosis and their family members accept these services, and (3) that CSC results in better clinical and functional outcomes than typical treatment.

BENEFIT DESIGN

Early intervention services for individuals experiencing first episode psychosis include the following evidence-based treatments: recovery-oriented psychotherapy, family psychoeducation and support, supported employment and education, pharmacotherapy and primary care coordination, and case management.¹⁵ These services are delivered in a coordinated fashion by the CSC team. Each of these treatment elements is described below:

¹² Kane JM, Robinson DG, Schooler NR, Mueser KT, Penn DL, Rosenheck RA, et al. Comprehensive versus usual care for first episode psychosis: two-year outcomes from the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry*. 201 (in press).

¹³ Dixon LB, Goldman HH, Bennett ME, Wang Y, McNamara KA, Mendon SJ, et al. (2015). Implementing coordinated specialty care for early psychosis: the RAISE Connection Program. *Psychiatric Services*, 66(7),691-698.

¹⁴ Srihari VH, Tek C, Kucukgoncu S, Phutane VH, Breitborde NJK, Pollard J, et al. (2015). First-Episode Services for Psychotic Disorders in the U.S. Public Sector: A Pragmatic Randomized Controlled Trial. *Psychiatr Serv*. Feb 2, 2015: doi: 0.1176/appi.ps.201400236. 66(7), 705-712.

¹⁵ Heinssen RK, Goldstein AB, Azrin ST. Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care (2014) http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf (last accessed June 2, 2015).

Team-based Care – All CSC providers are trained in the principles of team-based care for youth and young adults with first episode psychosis and participate in weekly team meetings to improve coordination and quality of care. Team members receive ongoing supervision and/or consultation to maintain fidelity to the CSC model.

Recovery-Oriented Psychotherapy – Individual psychotherapy for first episode psychosis is based on cognitive-behavioral treatment principles and emphasizes resilience training, illness and wellness management, and general coping skills pertinent to young adults experiencing a first psychotic episode. Psychological interventions are essential for symptomatic and functional recovery, and may aid in the prevention of comorbidities, such as nicotine addiction and substance abuse.

Family Psychoeducation and Support – First episode psychosis can have a devastating impact on the individual's relatives and other support persons, who struggle to adjust to changed circumstances and new demands. Family psychoeducation and support teaches family members or other individuals providing support about psychosis and its treatment and strengthens their capacity to aid in the individual's recovery.

Supported Employment Services – For young adults, first episode psychosis can impede attempts to obtain or maintain employment. Supported employment services are offered to all clients who want to work in order to help them choose and get a job that aligns with their career goals. Supported employment emphasizes rapid job placement in the client's preferred work setting. Ongoing supports are also available to help the individual maintain employment.

Supported Education Services – The experience of first episode psychosis can disrupt school attendance and academic performance. Supported education services facilitate an individual's return to school, as well as attainment of expected educational milestones. Supported education emphasizes rapid placement in the individual's desired school setting and provides active coaching and support to ensure the individual's educational success.

Pharmacotherapy and Primary Care Coordination – Guideline-based use of medication optimizes the speed and degree of symptomatic recovery by individuals with first episode psychosis, and minimizes the likelihood of side effects. Pharmacotherapy is best initiated following a thorough medical evaluation to assess for all possible causes of psychosis. Pharmacotherapy typically begins with a low dose of a single antipsychotic medication and involves monitoring for symptom response, side effects, and attitudes towards medication at every visit.

CSC places special emphasis on monitoring and managing cardiometabolic risk factors such as smoking, weight gain, hypertension, dyslipidemia, and pre-diabetes. Prescribers maintain close contact with primary care providers to assure optimal medical treatment for risk factors related to cardiovascular disease and diabetes.

Case Management – Case management assists clients with solving practical problems and coordinates services across multiple areas of need. Case management involves frequent in-person contact between the clinician and the young person and their family, with sessions occurring in clinic, community, and home settings, as required.

Coordinated Specialty Care Implementation Models

A variety of CSC models have been developed for delivering evidence-based treatment to individuals in early stages of psychosis. In April 2014, the NIMH released “*Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care*,” which provides several examples of staffing models implemented successfully in the RAISE-ETP and IES projects.¹⁶ In February 2015, the National Association of State Mental Health Program Directors with support from SAMHSA released “*An Inventory & Environmental Scan of Evidence-Based Practices for Treating Persons in Early Stages of Serious Mental Disorders*,” which includes state examples of CSC model programs for individuals with first episode psychosis.¹⁷

FINANCING APPROACHES

Individuals experiencing first episode psychosis receive services from numerous systems through a variety of funding sources. These individuals are best served when services meet individual needs, gaps and duplication are eliminated, and payers communicate effectively to coordinate and reimburse providers for the right services and treatments. Among individuals with a first episode of psychosis entering the RAISE-ETP study, 20% had private or both public and private insurance, 28% had Medicaid, 5% had CHIP, 2% had Medicare, and 43% had no insurance; for 5% insurance status was unknown.¹⁸

The following section describes how comprehensive approaches for serving individuals with first episode psychosis can be funded or reimbursed by federal sources through SAMHSA's Mental Health Block Grants and Medicaid.

Mental Health Block Grants

SAMHSA supports the development and implementation of promising practices for the early detection and intervention of individuals with and at clinical high risk for psychosis. States may want to consider how these developing practices may fit within their system of care.

Mandated by Congress, SAMHSA's Mental Health Block Grants are noncompetitive and provide funding for community-based mental health services. The Mental Health Block Grant funds must be directed toward adults with serious mental illness or children with serious emotional disturbance.

In its FY 2014 and FY 2015 appropriations, SAMHSA was directed to require that states set aside five percent of their Mental Health Block Grant allocation to support evidence-based programs that provide treatment to those with early serious mental illness, including but not

¹⁶ Ibid.

¹⁷ National Association of State Mental Health Program Directors (NASMHPD); *An Inventory & Environmental Scan of Evidence-Based Practices for Treating Persons in Early Stages of Serious Mental Disorders*, (2015) (last accessed June 30, 2015)

http://www.nasmhpd.org/sites/default/files/Environmental%20Scan%20%202.10.2015_1%285%29.pdf

¹⁸ Robinson DG, Schooler NR, John M, Correll CU, Marcy P, Addington J, et al. Medication prescription practices in the treatment of first-episode schizophrenia spectrum disorders: Data From the national RAISE-ETP study. *Amer J Psychiatry* 2015;172(3): 237-248.

limited to psychosis. The Congressional language “notes that the majority of individuals with severe mental illness experience their first symptoms during adolescence or early adulthood.” The language also notes that “[d]espite the existence of effective treatments, there are often long delays – years and sometimes decades – between the first onset of symptoms and when people receive help.”

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Congress specifically provided an increase to the Mental Health Block Grant allocation over the FY 2013 level to help states meet this new requirement without losing funds for existing services.

Using these principles, regardless of the amount of investment, and leveraging inclusion of services reimbursed by Medicaid or private insurance, every state and territory has begun to move their system toward earlier intervention, or to enhance such services already being implemented.

Medicaid

The Medicaid program is one of several sources of reimbursement to states for mental health and related services and supports. Medicaid’s federal authorities offer states the flexibility to transform their systems and improve coverage for individuals experiencing first episode psychosis. The federal Medicaid program may reimburse for services to address first episode psychosis through a variety of authorities.

1905(a) Authority

Services for individuals experiencing first episode psychosis may be covered under several different Medicaid state plan 1905(a) benefit categories, providing that the services fit within the Medicaid definition of coverable services.

These categories include: section 1905(a)(6) services of other licensed practitioners; section 1905(a)(13)(c) and (d) - preventive and rehabilitative services; and section 1905(a)(19) (as defined in section 1915(g)(2)) - case management services.

Since the CSC approach may be new to Medicaid agencies, state should consider the best way to configure and reimburse services under 1905(a) to ensure the model is delivered appropriately. States may want to consider coverage and reimbursement strategies that are similar to ACT.

The following section describes how services for individuals experiencing first episode psychosis can be funded or reimbursed through the Medicaid state plan 1905(a) benefit categories:

Targeted Case Management Services – Targeted case management services, defined at 42 CFR 440.169, includes services that assist eligible individuals to gain access to needed medical, social, educational, and other services.

Targeted case management services are comprehensive and must include all of the following: assessment of an eligible individual, development of a specific care plan, referral to services, and monitoring activities. Targeted case management includes services provided to specific defined target groups of individuals, or to individuals who reside in specified areas of the state (or both).

Therefore, it is possible that the case management activities targeted to individuals with first episode psychosis could be included in a state's targeted case management approach. Direct services, such as counseling during the course of a home visit, are not covered under the case management benefit. However, the state may cover direct services under a different service category.

States may also use targeted case management services to link individuals to employment services. For example, a case manager could work with an individual interested in employment to gain access to vocational or job placement services through the state vocational rehabilitation agency, state workforce services, or SSA-funded employment networks.

Preventive Services – Preventive services, defined at 42 CFR 440.130(c), are services recommended by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health efficiency. Preventive services must involve direct patient care and be for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health. As of January 1, 2014, preventive services may be furnished by non-licensed practitioners who meet qualifications set by the state. Some common services for individuals experiencing first episode psychosis that may meet the preventive frame include counseling, screening and evaluation to determine pathways to care for untreated psychosis.

Rehabilitative Services – Medicaid's rehabilitative services benefit defined at 42 CFR 440.130(d), includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of practice under state law for maximum reduction of physical or mental disability and restoration of a recipient to best possible functional level.

Rehabilitative services may cover interventions such as pharmacotherapy, crisis management services, peer supports or family therapy. These rehabilitative services may be beneficial in addressing the first episode of psychosis.

Supported employment is not itself a mandatory or optional section 1905(a) benefit and CMS cannot reimburse for certain supported employment activities under the state plan. However, states may be able to use section 1905(a) state plan services to cover some component services of supported employment that assist or support individuals who are working or desire to work. For example, under section 1905(a) rehabilitative services option, a state may cover services such as individual therapy or behavior modification that help individuals manage their behavior in the work environment, develop strategies for resolving workplace issues, and address their symptoms while at work. States can implement the full breadth of the supported employment model through 1915(c) and (i) authorities discussed below.

Other Licensed Practitioner Services– Other Licensed Practitioner services, defined at 42 CFR 440.60, are “medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law.”

If a state licenses practitioners who furnish services to address First Episode Psychosis, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan. For example, psychologists, social workers, mental health counselors, and rehabilitation counselors, provide a variety of services, within their practitioner scope of practice, in CSC programs for First Episode Psychosis. A state would need to submit a state plan amendment to add these licensed practitioners to their Medicaid plan, if they are not reflected there already.

Prescription Drugs - Coverage of prescription drugs is an optional benefit 1905(a) state plan benefit. All states currently provide coverage for outpatient prescription drugs, including those to treat psychosis, to all eligible individuals within their state Medicaid programs.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)— Individuals experiencing first episode psychosis under age 21 are entitled to periodic screening services (well-child exams) as defined by the statute. Under EPSDT, states are required to provide any medically necessary service coverable under section 1905(a) of the Act, regardless of whether the service is provided in the Medicaid state plan. The purpose of EPSDT is to provide eligible children and adolescents with age appropriate screenings and services to detect and treat illnesses and conditions before they become more serious. This includes any mental health screenings and services that are necessary and coverable under section 1905(a), including services to meet the needs of youth experiencing first episode psychosis. Therefore, states should be providing a robust set of services for individuals under the age of 21 who are experiencing a first episode psychosis, regardless of whether the services are packaged together to form the models described in this guidance.

Home and Community-Based Services—many of the services identified in this informational bulletin can be included in the Home and Community Based Services Program. This includes 1915(c) Waiver Authority and 1915(i) State Plan Authority. 1915(c) waivers allow a state to design a comprehensive package of community-based services for individuals who meet an institutional level of care, so long as there is cost-neutrality between the HCBS and institutional services. 1915(c) waiver services may be made available only to certain groups of people who are at risk of institutionalization. States can propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Services that have been provided under the 1915(c) program for older adolescents and young adults include respite and supported employment. Section 1915(c) waiver programs also require that participants must live and receive services in home and community-based settings.

The Section 1915(i) state plan amendment provides an opportunity for states to amend their state Medicaid plans to offer intensive home and community-based behavioral health services that were previously provided primarily through 1915(c) HCBS waivers programs. Intensive care coordination, respite, and supported employment can be offered under 1915(i) and serve youth and young adults with significant mental health conditions. Under 1915(i) states may not waive the requirement to provide services statewide, nor can they limit the number of participants in the state who may receive the services if they meet 1915(i) eligibility requirements. Unlike the 1915(c) waiver program, the 1915(i) delinks the provision of services with participants meeting an institutional level of care. In order to target the initiative and limit costs, states may identify a

specific population based on age, disability, diagnosis, and/or Medicaid eligibility group, and establish additional needs-based criteria.

1115 Authority—Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that further the objectives of the Medicaid and the Children’s Health Insurance Program (CHIP). These demonstrations give states additional flexibility to design and improve their programs, to demonstrate and evaluate policy approaches, such as providing services not typically covered by Medicaid, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs. Some states are considering section 1115 demonstrations to address the needs of individuals experiencing a first episode psychosis.

QUALITY MEASURES:

Quality measures are critical to ensure that the CSC program is delivered with fidelity to the evidence-based CSC model and to maintain the treatment program’s integrity over time. RAISE-IES researchers demonstrated that treatment fidelity can be monitored using routinely collected administrative data (such as service logs, medication records and billing data), supplemented by interviews with individuals receiving services. CMS and SAMHSA have identified core quality measures that may be applicable for measuring the impact of services provided to individuals with First Episode Psychosis. Discussed below are various quality measures that states may want to consider when developing approaches to this population.

Centers for Medicare & Medicaid Services (CMS)

The CHIP Reauthorization Act of 2009 (CHIPRA), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and the Affordable Care Act all introduced new clinical quality reporting programs that apply to Medicaid and the Children’s Health Insurance Program.

CMS has adopted a core set of children’s and adult’s health care quality measures for Medicaid and Children’s Health Insurance Program beneficiaries that include a sub-set of measures that address behavioral health concerns (Figure 2).

Figure 2: CMS Behavioral Health Core Measures

Category	Measure
Child Behavioral Health Measures	<ul style="list-style-type: none"> • Follow-up After Hospitalization for Mental Illness • Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication • Behavioral Health Risk Assessment (for Pregnant Women)
Adult Behavioral Health Measures	<ul style="list-style-type: none"> • Adherence to Antipsychotics for Individuals with Schizophrenia • Medical Assistance With Smoking and Tobacco Use Cessation • Follow-up after Hospitalization for Mental Illness • Antidepressant Medication Management • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

SAMHSA Mental Health Block Grants (MHBG)

SAMHSA has been working with states and state representative organizations to identify and implement a core set of measures, which include approved quality measures, to assess outcomes and quality in programming across the SAMHSA portfolio, including the MHBG.

The National Behavioral Health Quality Framework, produced by SAMHSA and modeled after the National Quality Strategy, provides a mechanism for states to examine, prioritize, and report on approaches to prevention, treatment, and recovery processes through the MHBG grant. In addition to this tool, SAMHSA's quality measure efforts in this area have included offering guidance regarding core behavioral health measures, promoting a core set of measures, and seeking to align with the measurement requirements of other major service purchasers, such as Medicaid and Medicare, and thus facilitate efficiencies in state reporting of behavioral health quality measures to federal entities.

Assessing Impact of the MHBG Set Aside

SAMHSA, NIMH, and the Assistant Secretary for Planning and Evaluation have collaborated to conduct case studies on the Mental Health Block Grant set aside in several states to assess early implementation of the 5% set aside.

The findings from this project will give a better understanding of the impact of the 2014 set aside and future collaboration in the development of program evaluation resources. A comprehensive evaluation of the effort is being planned.

FITTING IT ALL TOGETHER

In designing an early intervention services program for individuals experiencing first episode psychosis, state agencies should work together to develop an appropriate package of services to be provided to their beneficiaries. Coordination and a focus on consumer-centered care are critically important if outcomes are to improve for this very vulnerable population.

CMS, SAMHSA and NIH are available to provide additional technical assistance as states approach funding of specialty programs and early intervention services for individuals experiencing first episode psychosis.

Additional Resources

This section includes other CMS guidance and federal resources that might be helpful:

Pathways for Covering Mental Health and Substance Use Disorder Services, a CMS resource document for states, describes a variety of federal authorities and service-delivery approaches to assist states in transforming their systems and improving coverage for individuals with mental health or substance use disorder conditions. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/pathways-2-9-15.pdf> (last accessed July 21, 2015)

Clarifying Guidance on Peer Support Services Policy, released by CMS (May, 2013) provides information regarding the use of peer to peer services in Medicaid. All requirements of SMDL #07-011 (August 15, 2007) must be met for peer support services to be reimbursable under the Medicaid program.

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>

(last accessed April 29, 2015)

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>

(last accessed July 20, 2015)

EPSDT resources:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf

(last accessed July 20,

2015) <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf> (last accessed June 2, 2015)