

## **Guidance for use of the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG) and Community Mental Health Services Block Grant (MHBG) Funds for Cost-Sharing Assistance for Private Health Insurance**

**Scope of Coverage:** Title XIX, Part B of the Public Health Service Act (PHS Act), as amended, establishes the MHBG and SABG programs.

**Purpose of this Guidance:** This guidance to states and providers regarding the use of SABG and MHBG funds (block grant funds) for cost-sharing assistance (copayments, coinsurance, and deductibles) for the maintenance of private health insurance coverage for behavioral health services.<sup>1</sup>

**Background:** Under the Affordable Care Act, beginning January 1, 2014, options for health care coverage have been expanded through private insurance coverage options available through Health Insurance Marketplaces (also referred to as Exchanges) and the expansion of Medicaid in states that choose to expand. Health insurers are also prohibited from denying coverage because of a pre-existing condition, including mental/substance use disorders (M/SUD).<sup>2</sup> An overview of these health care coverage options may be reviewed at: [www.healthcare.gov](http://www.healthcare.gov). Plans and issuers subject to the Mental Health Parity and Addiction Equity Act (MHPAEA) that offer mental health and substance abuse coverage as part of the overall health benefits packages must comply with the requirements regarding coverage of M/SUD benefits in relation to medical/surgical benefits. Parity requires that the plans that offer M/SUD benefit do so at the same level of benefit as for physical conditions; it does not require a plan to offer an M/SUD benefit. M/SUD disorder services are among the ten categories of service elements that serve as components of the essential health benefits package that are offered in marketplaces.

States are asked to work with their providers to pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, the Children's Health Insurance Program (CHIP), Medicare, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite block grant resources to new clients and/or needed services. In addition, states are encouraged to work with their providers to ensure that individual clients are enrolled in health care coverage whenever possible or applicable, and informed about any potential penalties for not enrolling.<sup>3</sup>

Block grant funds are designed to provide support for specific populations and authorized services. SABG funds must be used for the purpose of planning, carrying out, and evaluating

---

<sup>1</sup> Cost Sharing: The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

<sup>2</sup> Under the Affordable Care Act, starting in 2014, if someone can afford it but does not have health insurance coverage in 2014, they may have to pay a fee. See [HealthCare.gov](http://HealthCare.gov).

<sup>3</sup> What if someone doesn't have health insurance? <https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014>. Under no circumstances may block grant funds be used to pay this fee for a client's failure to enroll in minimum essential coverage.

activities to prevent and treat substance abuse and related activities. MHBG funds must be used for the purpose of planning, carrying out, and evaluating comprehensive community mental health services for adults with serious mental illness and children with serious emotional disturbance and related activities. All expenditures under the Block Grants are subject to Title XIX, Part B, Subpart II, and Subpart III of the Public Health Service (PHS) Act, as amended, including the requirements for state reports and audits.

In addition, the block grant funds should be directed toward four purposes: (1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; (2) to fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance and that demonstrate success in improving outcomes and/or supporting recovery; (3) for SABG funds, to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. As Affordable Care Act implementation continues, clients will become eligible for and enroll in qualified health plans offered in the Marketplace. If a state chooses, it may consider helping individual clients pay for cost-sharing for SABG and MHBG authorized services, if appropriate and cost-effective.

**Block Grant Cost-Sharing Assistance and the Affordable Care Act:** The Affordable Care Act increases access to affordable health insurance by establishing a Health Insurance Marketplace in every state where eligible individuals may purchase private health insurance. Many individuals may be eligible for premium tax credits and cost-sharing reductions to help pay for private health insurance offered in the Marketplace. Consequently, states and providers using block grant funds should take into consideration the availability of other sources of funding for medical coverage (i.e., Medicaid, CHIP, workers compensation, SSI, Medicare, VA) and cost-sharing assistance when determining how to operationalize a cost-sharing assistance program, as discussed below.

**Requirements and Expectations for states and providers using block grant funds:** If a state chooses to do so, and the provider has the ability to determine the cost-sharing amounts, block grant funds may be used to cover the cost-sharing assistance for behavioral health insurance deductibles, coinsurance, and copayments to assist eligible clients in meeting their cost-sharing responsibilities under a health insurance or benefits program, including high risk pools. States should include the policies and procedures concerning their proposed use of block grant funds for cost-sharing assistance in their block grant plan. Payments are to be made directly to the provider of service. The block grant laws and regulations prohibit the provision of financial assistance to any entity other than a public or nonprofit entity and require that the funding be used only for authorized activities.<sup>4</sup> These block grant provisions also prohibit cash payments to intended recipients of health services.

In order to use block grant funds for cost-sharing, the individual has to be eligible for block grant reimbursement, the service has to be a block grant authorized service, and the provider has to be a

---

<sup>4</sup> <http://www.samhsa.gov/grants/block-grants/laws-regulations>.

block grant sub-recipient. In addition, the provider must be able to determine the amount due and payable. Because of the complexities and unique characteristics of the exchanges and medical assistance options in each state, the following examples are provided to guide decisions regarding the appropriate use of block grant funds.

An individual eligible for block grant authorized services goes to a block grant eligible provider to get psychosocial rehab services or substance use disorder counseling services and has private insurance through the Marketplace. However, his insurance requires a \$10 co-pay for each visit. Block grant funds could be used to pay the co-payment.

An individual, who has purchased insurance through the exchange and has a \$1000 deductible, goes to a block grant eligible provider for an authorized service. That provider could use block grant funds to cover that portion of the individual's deductible for the authorized services if the provider is able to determine the balance of the deductible owed. A provider may request the individual contact their insurer upon check in to confirm the deductible amount owed. Documentation of such amount should be maintained to allow for subsequent verification.

An individual, who has purchased insurance through the exchange and has a \$1,000 deductible, goes to an integrated primary care and behavioral health clinic for care for a broken arm. The individual requests their block grant provider to cover the deductible for that visit. The provider may NOT cover that deductible, as it is not for a block grant authorized service.

**Conclusion:** Block Grant funds may be used to help clients satisfy cost-sharing requirements for block grant authorized M/SUD services, if cost-effective and in accordance with block grant laws and regulations. It is important for states and providers using block grant funds to understand the range of insurance options available to clients under the Affordable Care Act. Many clients may also be eligible to receive advance payments of premium tax credits and/or cost-sharing reductions to help pay for private health insurance in the Marketplace. States and providers using block grant funds should take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a cost-sharing assistance program.

To learn more about the Affordable Care Act, grantees are encouraged to visit SAMHSA's website on health care and health systems integration (<http://www.samhsa.gov/health-care-health-systems-integration>) and HealthCare.gov (<http://www.healthcare.gov>). If a state has any questions about using block grants to cover cost-sharing requirements, they should contact their State Project Officer.

12/7/15