



BEHAVIORAL HEALTH COVERAGE IN MEDICAID MANAGED CARE

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Approximately one in six adults in the United States lives with a behavioral health condition, with rates rising among children and adolescents. More than two-thirds (68.1%) of all Medicaid enrollees were enrolled in Medicaid health plans in 2016, an increase from 65.5 percent in 2015. Behavioral health continues to be a major focus for the Medicaid program, with many Medicaid health plans providing behavioral health coverage as part of their comprehensive benefits package. However, many individuals still do not seek or complete treatment. In this issue brief, we report findings from the Institute for Medicaid Innovation's annual Medicaid managed care survey that are specific to behavioral health, including trends in prevalence and disparities. We also outline opportunities to address research, clinical, and policy priorities for behavioral health.



The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity and the engagement of patients, families, and communities.

Approximately 44.7 million adults in the United States live with a behavioral health condition.¹ Although Medicaid covers only approximately 14 percent of the general adult population, the program covers 21 percent of all adults with behavioral health conditions, 26 percent of all adults with serious mental illness (SMI), and 17 percent of all adults with substance use disorder (SUD). SUD is another primary behavioral health concern for Medicaid, providing coverage for approximately three million individuals with SUD, of which nearly 1.8 million have a comorbid behavioral health condition.²

Individuals living with SMI are at an increased risk for chronic physical health conditions and on average live 25 years less than individuals without SMI. A substantial portion (40%) of the increase in mortality can be linked to either suicide or injury, while the remaining 60 percent of deaths are largely the result of co-occurring physical health conditions, including cardiovascular disease, diabetes (including related conditions of kidney failure), respiratory issues including pneumonia and the flu, and infectious diseases such as HIV/AIDS.³

Behavioral Health Disparities

Disparities by Race/Ethnicity & Sex

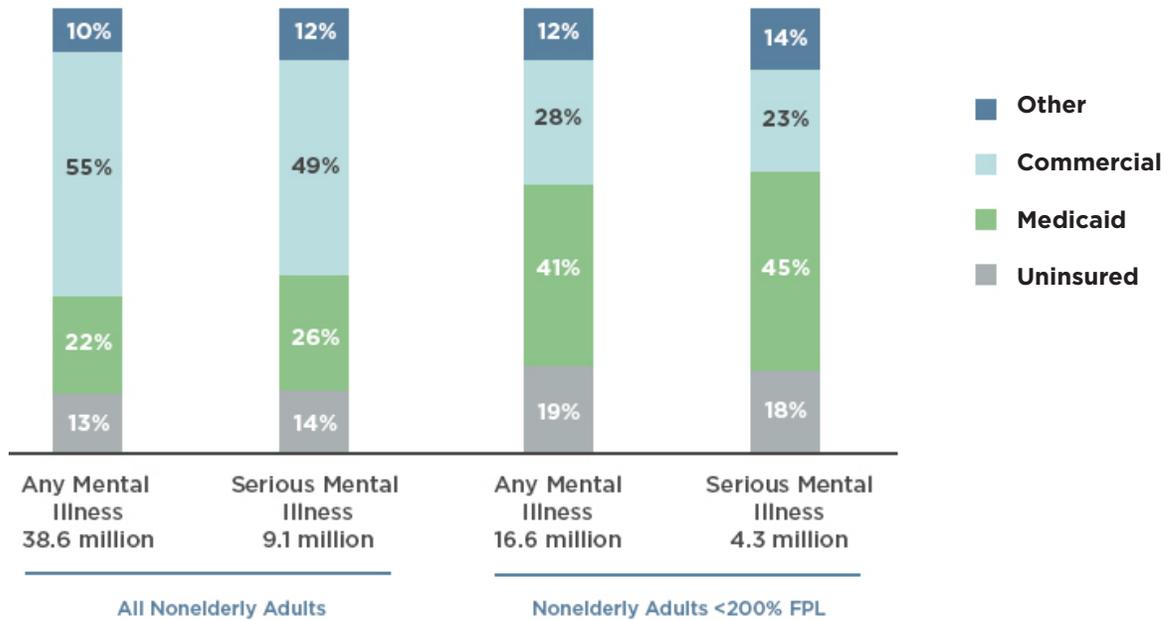
Women and racial/ethnic minorities are disproportionately affected by behavioral health conditions. For example, adult women who are white and under age 50 are more likely to have a behavioral health condition than men, racial/ethnic minorities, or those age 50 or older.⁴ It has been found that those who identify as Hispanic have a lower lifetime risk of SUD, whereas black and African American individuals have a lower lifetime risk of mood, anxiety, and substance use disorders than non-Hispanic and non-African American whites. However, if a mood or anxiety condition is present, lower-income Hispanics, blacks, and African Americans have a higher incidence of being persistently ill than non-Hispanic individuals or non-African American whites.⁵

Disparities by Insurance/Income

Medicaid is often the sole source of funding for some specialized behavioral health services such as SMI and SUD.² Low-income individuals (32%) are more likely to have a behavioral health condition than are moderate-income individuals (24%) and higher-income individuals (21%).⁶ As illustrated in Figure 1 below, the majority of non-elderly adults with behavioral health conditions are covered by Medicaid or commercial insurance. Most nonelderly adults with behavioral health conditions are employed (63%), but more than 4 in 10 are low income, including 22 percent who are below the federal poverty level.⁴



Figure 1. Insurance Status of Nonelderly Adults with Behavioral Health Conditions and Serious Mental Illness, 2015



Source: Kaiser Family Foundation. (2017). "Facilitating access to mental health services: A look at Medicaid, private insurance, and the uninsured."

Child & Adolescent Disparities

Children from families living in poverty are three times more likely to have a behavioral health condition than those not living in poverty.⁷ Children and youth in single-parent families and families receiving social assistance, headed by teen mothers, transitioning from foster care, or with disabilities are at higher risk of having behavioral health conditions than are those who do not live in poverty.⁸

Historical Overview of Behavioral Health Care in the U.S.

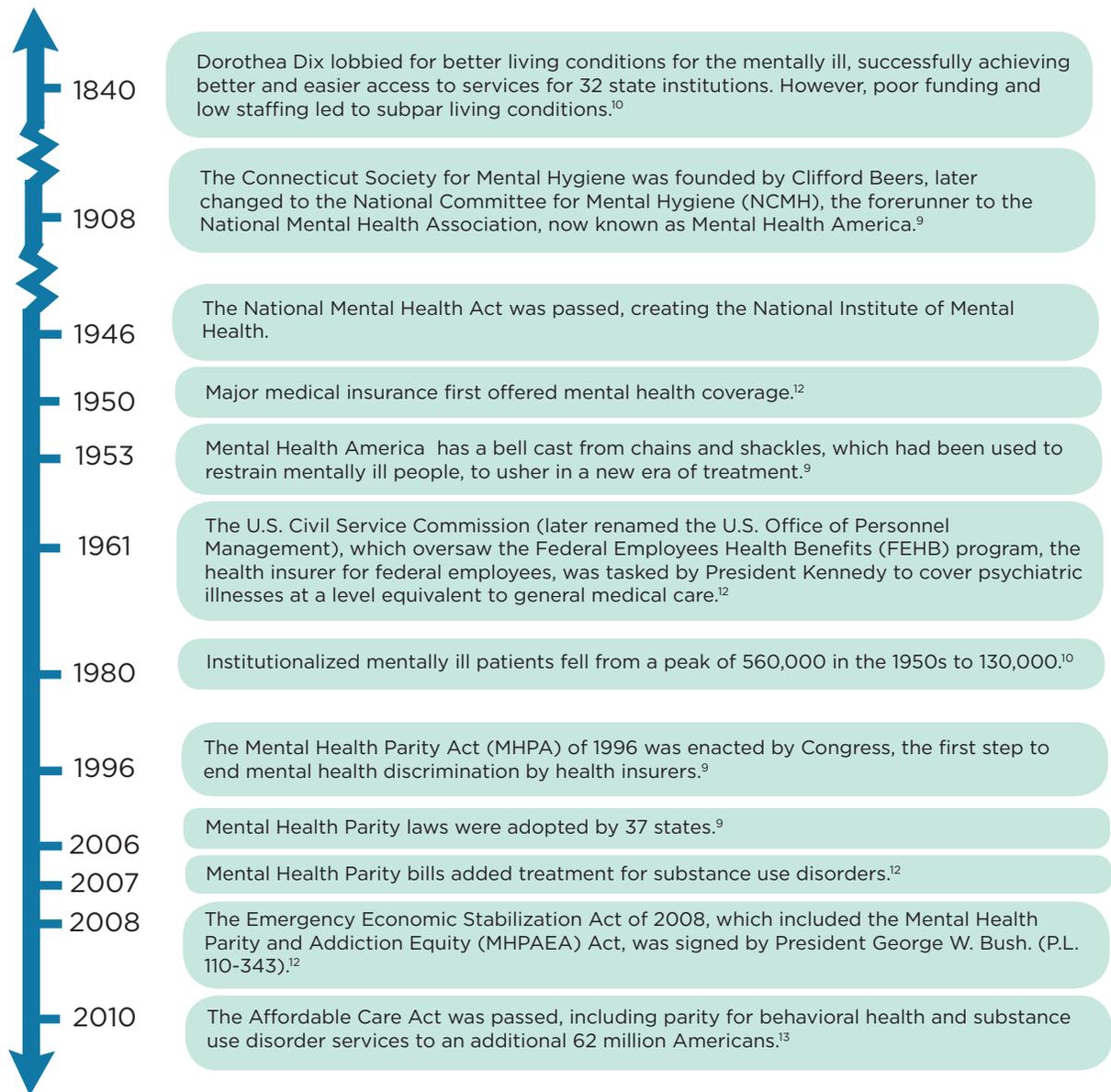
Prior to World War II, behavioral health care was not covered by insurance.^{9,10} By the mid-1950s, there was mounting pressure toward deinstitutionalization and a move toward outpatient care models. The development of antipsychotic drugs was also critical in deinstitutionalization.⁹ By 1980, the numbers of institutionalized individuals had dropped substantially.¹⁰ In 1996, The Mental Health Parity Act was enacted, signaling the end of behavioral health discrimination. By 2006, 37 states had adopted policies supporting parity. Substance use treatment was added to the Mental Health Parity Act the following year.¹¹ By 2008, as part of the Emergency Economic Stabilization Act, the Mental Health Parity and Addiction Equity Act (MHPAEA) was included, removing loopholes used by insurance companies and ending limitations on all aspects of behavioral health coverage.¹² Protections included the following:

- Removing a limit on the number of hospital days covered for behavioral health conditions.
- Removing a cap on the number of outpatient treatment sessions.
- Prohibiting higher co-payments and deductibles for behavioral health services.

With the passage of the Affordable Care Act in 2010, parity for behavioral health and substance use disorder services were extended, and in 2016, coverage was extended to individuals eligible for Medicaid or Children's Health Coverage.¹³ An extended timeline of behavioral health coverage can be found in Figure 2.



Figure 2. Expanded Timeline of Behavioral Health Coverage



Trends and Costs

In 2014, Medicaid covered 25 percent of all behavioral health and 21 percent of all SUD spending nationally. Findings from a 2015 report to Congress by the Medicaid and CHIP Payment and Access Commission (MACPAC)¹⁴ showed that in 2011, Medicaid spent nearly four times as much on individuals with behavioral health conditions than on those without (\$13,303 vs. \$3,564), accounting for 48 percent of all Medicaid spending.¹⁵

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), mental health and SUD treatment spending from all public and private sources is expected to total \$280.5 billion in 2020, an increase from \$171.7 billion in 2009. The estimates account for the potential impact of increased access and coverage as part of the Affordable Care Act.¹⁸

Utilization of behavioral health services among Medicaid enrollees is comparable to utilization among those with commercial insurance. Utilization for behavioral health and SUD emergency department (ED) services increased at a greater rate than the increased rate of ED utilization overall.² In addition, several service categories increased at greater levels than the overall increase (for example, 55.5 percent for depression, anxiety or stress reactions; 52 percent for psychoses or bipolar disorders; and 37 percent for SUD.² During the same time period, increases were the greatest in low-income communities (defined as ZIP codes with a median household income between \$1 and \$38,999), with SUD rising to 40.8 percent and depression, stress reactions, and anxiety rising to 79.4 percent. When comparing by payer type, utilization rates among those covered by commercial insurance decreased, while the percentage of Medicaid-insured increased from 2006 to 2013.¹⁶

Coverage Gap

More Americans now have access to insurance and treatment. States that expanded Medicaid as part of the Affordable Care Act have experienced the highest rates of reduction in uninsured adults with a behavioral health condition.¹⁷ However, 6.3 million adults (14.7%) with a behavioral health condition still lack insurance coverage. This suggests that key differences may exist in behavioral health coverage between expansion and non-expansion states. The largest increases in uninsured adults were in Kansas (2.4%), Missouri (7.7%), and South Carolina (2.7%), all of them states that did not expand Medicaid coverage. Prevalence data of adults with behavioral health conditions who lack insurance coverage ranges from a low of 3.3 percent in Massachusetts (an ACA Medicaid expansion state) to a high of 23.8 percent in South Carolina (an ACA Medicaid non-expansion state).

Barriers in Access and Coverage

Insurance coverage for behavioral health services does not equate to receiving treatment. In 2015 it was found that approximately 56 percent of adults with a behavioral health condition did not receive treatment, a slight decrease from 2011 (59%).¹⁷ The number of untreated adults ranged from 41.4 percent in Massachusetts to 66 percent in Nevada. The lack of an adequate behavioral health clinician workforce is a contributing factor in many states.¹⁸ States with the greatest shortage require clinicians to provide services to six times as many individuals as those in states with more qualified clinicians. For example, in states with high levels of access and clinician coverage, there is one clinician for every 250 individuals who require their care. In states with less access and coverage, there are about 1,100 individuals for every clinician. In Alabama, the state with the lowest level of access, there is one clinician for every 2,600 individuals who require care.¹⁸ As individuals covered by Medicaid are often from diverse backgrounds, it is critical that these providers are culturally competent in providing services to this population.

The Institute for Medicaid Innovation's (IMI's) 2018 Annual Medicaid Managed Care Survey¹⁹ included questions specific to behavioral health, including barriers that Medicaid health plans experience when attempting to provide behavioral health coverage, subcontracting, and physical and behavioral health integration. Results from the survey indicate that Medicaid managed care organizations (MCOs) experience a number of challenges.

The list below highlights the barriers and challenges Medicaid MCOs experienced in 2017, stratified by health plan size Table 1.¹⁹ Among Medicaid MCOs with fewer than one million individuals enrolled, the most significant barriers to addressing behavioral health was access to behavioral health clinicians in select regions (e.g., rural, underserved, etc.) and CFR 42 limitations on substance use disorder treatment information being shared.

Interestingly, the most significant barriers for MCOs were different when compared by size. For example, CFR 42 limitations on SUD treatment information sharing and access to behavioral health clinicians were the most significant barriers among larger plans, while access to data, clinician capacity to provide integrated care, and behavioral health clinician readiness for integrated care were the primary barriers in smaller plans.



Table 1. Barriers to Addressing Behavioral Health among Medicaid MCOs, by Rank with Enrollment by MCO Size, 2018

Medicaid MCOs with Less than One Million Members Enrolled

Top Policy Barriers:

- Fragmentation in program funding and contracting for physical and behavioral health services
- CFR 42 limitations on SUD treatment information being shared
- Institutions for Mental Disease (IMD) exclusion

Top Network Barriers:

- Provider capacity to provide integrated physical and behavioral health at point of care
- Behavioral health provider readiness for managed care
- Access to behavioral health providers in select regions (e.g., rural, underserved)
- Behavioral health provider adoption of electronic health records

Top Operational Barriers:

- Access to data between care management and behavioral health teams
- Staffing in care management to align skill sets with integrated care needs
- System differences with subcontractor
- Communication between care management and behavioral health

Medicaid MCOs with More than One Million Members Enrolled

Top Policy Barriers:

- CFR 42 limitations on SUD treatment information being shared
- Fragmentation in program funding and contracting for physical and behavioral health services
- Institutions for Mental Disease (IMD) exclusion

Top Network Barriers:

- Access to behavioral health providers in select regions (e.g., rural, underserved)
- Provider capacity to provide integrated physical and behavioral health at point of care

Top Operational Barriers:

- Communication between care management and behavioral health
- Staffing in care management to align skill sets with integrated care needs

Source: Institute for Medicaid Innovation. (2018). 2017 Annual Medicaid MCO Survey – Behavioral health. Washington, D.C.

State Variation

Although the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008,²⁰ requiring parity in aggregate lifetime and annual dollar limits for mental health benefits and medical surgical benefits,²¹ the practical application of the parity rules remains a work in progress.²² At the beginning of 2017, 11 states continued to carve out behavioral health coverage from Medicaid health plans.¹⁵ Carve-outs can lead to less-coordinated care for the individual enrolled in Medicaid, as they

often do not receive all of their physical and behavioral care from the same entity, leading to fragmentation, lack of coordination, and missed symptomology.¹⁵ In addition, carve-outs of pharmacy benefits that exist in some states increase the likelihood of unnecessary hospitalizations, lack of care coordination, timely clinician interventions, and lower quality of care. A recent report indicated that the cost of carving out pharmaceutical coverage, in whole or in part, led to increased costs for the state Medicaid programs and the federal government, undermining the objective of achieving optimal cost-effectiveness in the program.²³ Table 2 highlights the variation in state financing models for behavioral health coverage.



Table 2. Behavioral Health Financing Models by State, 2019

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Alabama				X	
Alaska				X	
Arizona- Acute Care			X		
Arizona- SMI Population					X
Arkansas- FFS/PCCM				X	
Arkansas- PASSE					X
Arkansas- AR WORKS			X		
California	X				
Colorado- RAEs			X		
Connecticut				X	
Delaware		X			
District of Columbia		X			
Florida			X		
Florida- SMI Population					X
Georgia			X		
Hawaii			X		
Hawaii- SMI Population	X				
Idaho	X				
Idaho- Duals Population			X		
Illinois			X		

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Indiana		X			
Iowa			X		
Kansas			X		
Kentucky			X		
Louisiana			X		
Maine				X	
Maryland		X			
Massachusetts-MCO Delivery System			X		
Massachusetts-PCCM/ACO Delivery System	X				
Michigan	X				
Minnesota			X		
Mississippi			X		
Missouri		X			
Montana				X	
Nebraska			X		
Nevada			X		
New Hampshire			X		
New Jersey		X			
New Mexico			X		
New York			X		
New York- SMI Population					X
New York-Long-Term Care		X			
North Carolina	X				
North Dakota				X	
North Dakota-Medicaid Expansion			X		
Ohio			X		
Oklahoma				X	
Oregon			X		
Pennsylvania	X				
Rhode Island			X		
South Carolina			X		
South Dakota				X	

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Tennessee			X		
Texas			X		
Utah	X				
Vermont				X	
Virginia			X		
Washington-Integrated Managed Care Counties			X		
Washington-Transitional Counties ⁷	X				
West Virginia			X		
Wisconsin		X			
Wisconsin-Family Care Program			X		
Wyoming				X	

Notes: The financing model presented in this table derived based on *OPEN MINDS*'s assessment of each state's Medicaid behavioral health financing system. Each state was assessed using the information contained in the OPEN MINDS Behavioral Health System State Profile Series.

Source: Open Minds. (2019). State Medicaid behavioral health carve-outs: The Open Minds 2019 annual update. <https://www.openminds.com/intelligence-report/state-medicare-behavioral-health-carve-outs-the-open-minds-2019-annual-update/>

The IMI found that in 2017, the majority of reporting health plans did not subcontract for behavioral health services, but instead coordinated and managed both physical and behavioral health.¹⁹ However, there were slight differences that emerged when the analysis was stratified by size of the Medicaid MCO. Medicaid MCOs serving more than one million individuals were split evenly between using a subcontractor with merged operations within the Medicaid MCO and not using a subcontractor and coordinating and managing physical and behavioral health themselves. Among Medicaid MCOs with fewer than one million individuals, the majority of health plans did not have a subcontract in 2017 and managed physical and behavioral health (66.6%). The remaining plans either managed behavioral health services separately (33.3%) or reported not using a subcontractor and not managing behavioral health benefits (33.3%).

Overall, the majority of Medicaid MCOs (90%) reported that care coordinators and medical directors had access to review medical records in at least some individual markets, inclusive of physical and behavioral health information, with some variation by the size of the Medicaid MCO.¹⁹ For example, a third of Medicaid MCOs with fewer than one million enrollees reported that care coordinators had this access in at least some markets, while only 16.7 percent did not have access. Finally, of the Medicaid MCOs that serve over a million individuals, 75 percent reported that care coordinators and medical directors had access to review medical records.

Behavioral and Physical Health Integration

There are a number of different approaches to physical and behavioral health integration, such as the following:²⁴

- Aggregation of care from separate settings and systems that often involve minimal communication.
- Co-located care with some coordination with screening and treatment plan development.
- Full care integration where providers operate as a team in a shared practice model with a whole-person focus.

In 2012, individuals with co-occurring behavioral and medical conditions generated an additional almost \$300 billion in health care costs.²⁵ According to the report, an estimate of between 9-16 percent of costs could have been avoided with effective integration of medical and behavioral services, an estimated savings of \$26-48 billion.²⁵

Coordination of physical and behavioral health has been a topic of research, policy, and clinical practice for more than 30 years. Over this time period, the approach that has been found to be the most efficient and effective, while consistently improving outcomes, is the Collaborative Care Model.²⁶ This model is team driven, measurement guided, evidence based, and population focused. In this model all team members are empowered to work at the top of their professional training and licensure in a coordinated manner. Measurement is based on patient reported outcomes.²⁶ In this model, a savings example for co-occurring depression and diabetes over a 24-month period when treated resulted in a savings of \$896, compared to those not treated at all or not treated in a coordinated model. In a 48-month period, depression treated in a primary care setting cost \$3,300 less.²⁷ Depression is the primary driver of overall health care costs when medical and medication costs and lost work productivity are all considered.²⁸ Fifty percent of all disability days are tied to a behavioral health disorder.²⁹

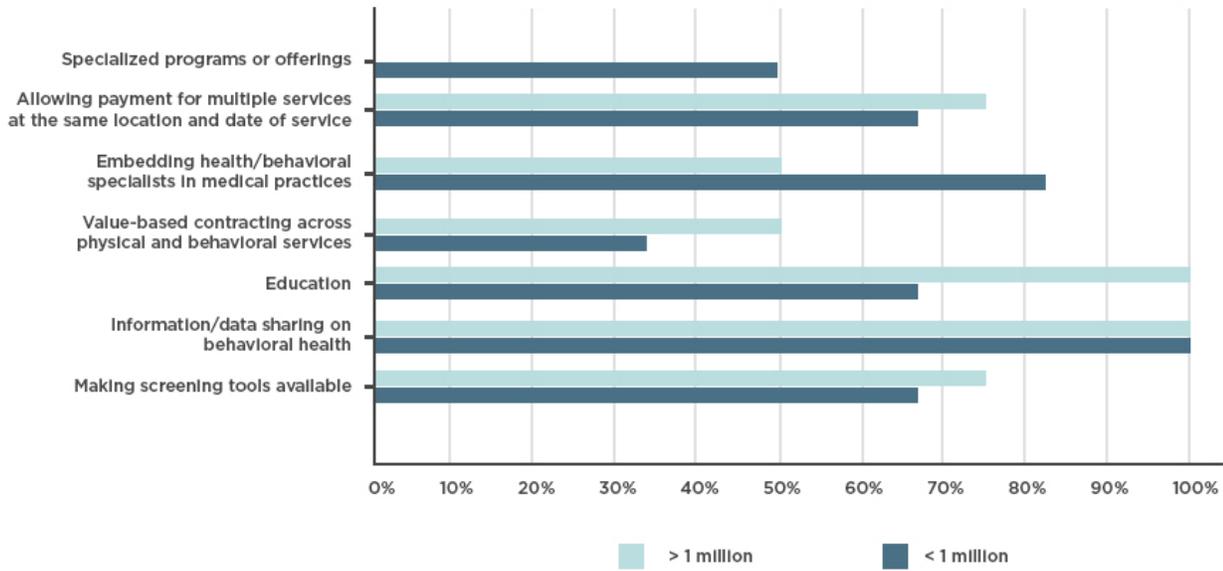
Total medical expenses overall--medical and behavioral combined--carry an annual cost of 46 percent more than chronic medical conditions alone.²⁹ These outcomes suggest that integrating behavioral health and primary care is beneficial to patients and health systems.³⁰ However, disparities remain between access and reimbursement between physical and behavioral health care.²⁵

In New Hampshire, Vermont, Maine, Massachusetts, and Minnesota, behavioral health clinicians were paid less than 50 percent of the medical clinician rate for the same services. In New Jersey, 45 percent of behavioral health office visits were conducted by out-of-network clinicians, while in Washington D.C., the number was found to be a staggering 63 percent.²⁵ Behavioral health services typically have higher out-of-pocket copays and percentage of coinsurance obligations for out-of-network clinicians than in-network clinicians, which increases the financial burden for an individual accessing an out-of-network clinician.³¹

IMI's annual Medicaid managed care survey collected data from health plans to determine approaches that they were working on with physical health clinicians to address behavioral health needs.¹⁹ Regardless of health plan size, all Medicaid MCOs were engaged in information and data sharing on behavioral health services and education (Figure 3). Other common approaches included making screening tools available, embedding health and behavioral specialists in medical practices, and allowing payment for multiple services at the same location and date of service.



Figure 3. Approaches Medicaid MCOs Worked with Physical Health Providers to Address Behavioral Health Needs, Stratified by Medicaid MCO Size, 2017



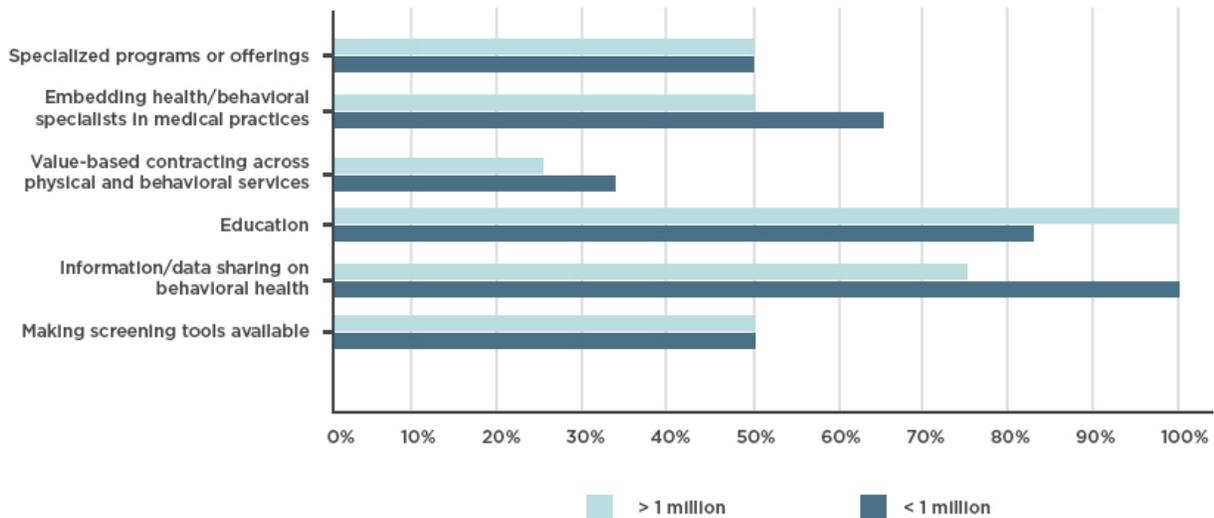
Note: For > 1 million and < 1 million refers to the total number of Medicaid covered lives for the managed care organization and not the number of covered lives for behavioral health.

Source: Institute for Medicaid Innovation. (2018). 2017 annual Medicaid MCO survey - Behavioral health. Washington, D.C.

Conversely, the survey also assessed how Medicaid MCOs were working with behavioral health clinicians to address physical health needs. Again, nearly all Medicaid MCOs reported engaging in information and data sharing on behavioral health and education (Figure 4). Making screening tools available was reported by half of Medicaid MCOs, regardless of size.



Figure 4. Approaches Medicaid MCOs Used to Work with Behavioral Health Providers to Address Physical Health Needs, Stratified by Medicaid MCO Size, 2017



Note: For > 1 million and < 1 million refers to the total number of Medicaid covered lives for the managed care organization and not the number of covered lives for behavioral health.

Source: Institute for Medicaid Innovation. (2018). 2017 annual Medicaid MCO survey - Behavioral health. Washington, D.C.

In addition, Medicaid MCOs also reported qualitative information on barriers that they experienced in 2017 specific to coverage for physical and behavioral health integration. For instance, they indicated the following challenges:¹⁹

- Cultural differences and fragmentation between physical and behavioral health and delivery systems.
- Funding fragmentation from the federal, state, and county levels affect how programs are delivered.
- Obtaining appropriate consents and ensuring that clinicians will accept these consents are barriers to care coordination.
- States have exclusions and benefit exhaustion parameters that negatively impact the MCO's ability to serve the behavioral health and related care coordination needs for these members.

Looking Ahead: Implications for the Future of Behavioral Health in Medicaid

Behavioral health continues to be a critical focus for the Medicaid program, as it serves a number of populations who are at-risk for behavioral health conditions. Prior research has demonstrated that behavioral health and physical health are closely linked, which suggests that improvements in behavioral health may be associated with improvements in physical health and vice versa. Despite a number of advances in access to behavioral health services, many individuals still do not initiate or complete treatment.

Additionally, policies and health systems have not been able to sufficiently address the barriers and needs of the population. Future potential efforts in behavioral health should consider opportunities to promote health equity among all populations (e.g., people of color, women, low-income individuals), improve access to evidence-based treatment models (e.g., integrated care), as well as remove policy barriers that prevent individuals from accessing or completing treatment. Based on the findings of this report, the following clinical, research, and policy priorities are provided.



Clinical Priorities

Promote the use of care models that integrate physical and behavioral health, such as the collaborative care model.

Research has demonstrated that collaborative care models lead to improved outcomes for individuals as well as reduce costs. Educating and training clinicians in these models may further encourage their adoption.

Address the shortage of behavioral health workers, particularly in underserved areas.

There are an insufficient number of behavioral health clinicians to address the growing needs of individuals seeking treatment. Encouraging clinicians to receive specialty training in behavioral health may serve to alleviate access problems surrounding small-workforce issues.

Integrate cultural competency in education and training.

Individuals in the Medicaid program may come from diverse cultural backgrounds, and significant disparities among a number of groups have been documented. Further, these diverse backgrounds may influence their willingness to disclose and discuss their behavioral health needs. Training behavioral health clinicians and other clinicians in cultural competency may serve to promote discussion in a culturally relevant, sensitive manner.

Improve screening efforts for behavioral health conditions.

Screening for behavioral health conditions in settings such as primary care may serve to identify individuals who would benefit from treatment, including psychotherapy or pharmacological treatment. The stigmatization of behavioral health may prevent individuals from initiating conversations with clinicians. The utilization of screening tools might better identify individuals in need of treatment as well as promote conversations.



Research Priorities

Conduct further research on collaborative care models in order to determine the efficacy and effectiveness of these models.

Research on these models should also focus on outcomes as well as quality improvement, particularly for low-income and racial/ethnic minorities who are oftentimes underrepresented in this type of research.

Provide financial support to encourage behavioral health research.

Researchers rely on funding from major, national funders (e.g., National Institutes of Health, National Science Foundation, Institute of Education Sciences) in order to support studies that advance our understanding and treatment of behavioral health conditions.



Policy & Advocacy Priorities

Improve efforts to support reimbursement for collaborative care models.

For Medicaid MCOs to adopt new collaborative care models, reimbursement needs to be provided to sustain these models.

Address Medicaid MCO concerns surrounding CFR 42 limitations on SUD treatment information sharing.

Restrictions on information sharing on SUD precludes sharing between behavioral health and physical health clinicians. This may lead to poor care coordination and unmet needs for the individual living with SUD.

Address Medicaid MCO concerns surrounding fragmentation in program funding and contracting for physical and behavioral health services.

Fragmentation in program funding creates a number of barriers for Medicaid MCOs. For example, it leads to a decreased focus on population health and has been shown to be costlier than providing integrated care. As such, funding for innovative integrated models should be pursued.

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