



# Access to Mental Health Services for Adults

Draft chapter and recommendations



**Medicaid and CHIP Payment and Access Commission**

Erin K. McMullen

# Overview

- Draft chapter for the June report to Congress
  - Prevalence, treatment rates, and disparities
  - Mental health, mortality, and rising rates of suicide
  - Mental illness and the criminal justice system
  - Components of a mental health continuum and Medicaid coverage of mental health services
  - Access to mental health providers
  - Efforts to address behavioral health crises
  - Next steps
- Draft recommendations

# Need and Use of Services by Medicaid Beneficiaries

- In 2018, when compared to privately insured peers, Medicaid beneficiaries age 18–64 with any mental health condition were:
  - nearly four times as likely to receive inpatient treatment for their mental health condition
  - more likely to report that they needed but did not receive mental health treatment in the past year
- Beneficiaries with mental illness who are Black, Hispanic, and two or more races were less likely to receive treatment compared to their white peers

Source: SHADAC 2020 and 2021, MACPAC analysis of the 2018 National Survey on Drug Use and Health.

April 8, 2018

# Medicaid Coverage of Mental Health Services

- Medicaid coverage of mental health services varies considerably by state; on average, states cover 12 out of 15 mental health services
- This leaves gaps in the continuum of services that should include crisis, supportive, clinical, and other interventions
- Largest gaps are for residential and supportive services (e.g., supported employment, skills training and development)

# Access to Mental Health Providers

- Beneficiaries have difficulty accessing mental health services due to:
  - shortage of providers
  - geographic maldistribution
  - low Medicaid participation
- Concerns have been well documented for over a decade

# Consequences of Inadequate Access to Mental Health Treatment

- Individuals with mental health conditions often die prematurely
- Suicide is the 10<sup>th</sup> leading cause of death for all ages in the U.S., and the second leading cause of death for individuals age 10–34
- People with mental health conditions are overrepresented in the nation's prisons and jails
- Medicaid beneficiaries are more likely to experience involvement with the criminal justice system than their privately insured peers

Source: Hedegaard et al. 2020. SHADAC 2020, MACPAC analysis of the 2018 National Survey on Drug Use and Health.

April 8, 2021

# Current Efforts to Address Behavioral Health Crises

# Implementation of 988

- Substance Abuse and Mental Health Services Administration (SAMHSA) funds the National Suicide Prevention Lifeline, a network of 170 crisis hotlines linked by a tollfree number
- In July 2022, 988 will become the nationwide three-digit code for the National Lifeline
- Funding for hotlines is often a state and local responsibility
- There are multiple funding strategies states may pursue to enhance hotline capacity



# National Guidelines for Crisis Care

- In 2020, SAMHSA issued *National Guidelines for Behavioral Health Crisis Care Best Practices Toolkit*
- Establishes three core elements of a crisis system:
  - Regional or statewide crisis call centers
  - Mobile crisis response
  - Crisis receiving and stabilizing facilities

# Medicaid's Role

- Many states pay for crisis services, but most services are not fully aligned with SAMHSA's guidelines
- Medicaid programs in some states are playing a growing role in supporting the crisis continuum
- American Rescue Plan Act (ARP, P.L. 117-2) offers an 85 percent federal matching assistance percentage (FMAP) for certain community-based mobile crisis intervention services offered under the state plan or a Medicaid waiver; also made available \$15 million for state planning grants to provide qualifying mobile crisis intervention services

# Current Federal Guidance

- Current federal guidance does not fully address how states can use Medicaid to support a crisis continuum
- Identifies some ways Medicaid can pay for crisis services:
  - administrative match for hotlines
  - enhanced federal match for behavioral health IT (e.g., bed registries, establishing a crisis call center)
  - Medicaid authorities to pay for portions of mobile crisis services
- CHIP Health Services Initiatives could be used to support the crisis continuum and other suicide prevention activities
- Ultimately, guidance lacks necessary detail for states to use various Medicaid authorities to support crisis systems

# Coordinating Federal Programs

- Improving access to crisis services requires effective coordination between CMS and SAMHSA
- A 2014 report by the U.S. Government Accountability Office (GAO) documented lack of coordination and absence of high-level federal leadership for programs supporting individuals with serious mental illness
- GAO study prompted congressional action in the 21<sup>st</sup> Century Cures Act of 2016 (P.L. 114-255)

# Next Steps

- Draft report signals areas for additional work:
  - Medicaid and criminal justice
  - Availability of home-and-community based services for beneficiaries with behavioral health conditions
  - Access to behavioral health services for beneficiaries who identify as gay, lesbian, bisexual, or transgender

# Recommendations

# Draft Recommendation 2.1

- The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, and the Substance Abuse and Mental Health Services Administration, to issue joint subregulatory guidance that addresses how Medicaid and the State Children's Health Insurance Program can be used to fund a crisis continuum for beneficiaries experiencing behavioral health crises

# Draft Recommendation 2.1: Rationale

- Subregulatory guidance could clarify how Medicaid and CHIP can be used to pay for the three core components of a behavioral health crisis continuum: (1) statewide or regional crisis call centers; (2) mobile crisis response; and (3) crisis receiving and stabilizing facilities
- Guidance could identify Medicaid authorities states can use to pay for these services, offer a road map to design services, and describe how to braid funding to pay for services that cannot be supported by Medicaid
- In developing new guidance, the Secretary should invite participation of all relevant agencies with a role in implementing the National Lifeline and agencies affecting children and families



# Draft Recommendation 2.1: Implications

- **Federal spending.** No direct effect on Medicaid and CHIP spending.
- **States.** Improve state capacity to address the needs of beneficiaries with behavioral health conditions. Guidance could help states overcome barriers to design and implement crisis services.
- **Beneficiaries.** Recommendation could enhance access to community-based care. These gains could be particularly important for beneficiaries of color.
- **Plans and providers.** No direct effect on plans or providers.

# Draft Recommendation 2.2

- The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, and the Substance Abuse and Mental Health Services Administration, to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in crisis in real-time. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of crisis services.

# Draft Recommendation 2.2: Rationale

- Technical assistance and planning opportunities could assist states in:
  - overcoming delivery system barriers;
  - identifying appropriate Medicaid authorities; and
  - identifying how to braid funding to achieve broader objectives
- Congress has increased funding for the Mental Health Services Block Grant, and separately allocated \$15 million in planning funds for mobile crisis services. The Secretary of HHS could use this funding, and grant award requirements, to support planning efforts and ensure participation of the state Medicaid agencies.

# Draft Recommendation 2.2: Implications

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