mhpa Medicaid Health Plans of America

Issue Brief

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Facilitating Access to Behavioral Health Care through Medicaid Managed Care

In 2020, nearly 40% of the nonelderly adult Medicaid population (13.9 million enrollees) had a mental health (MH) condition or substance use disorder (SUD).[i] Individuals with a behavioral health disorder(s) are more likely to have high general medical health needs and are high utilizers of health care services. Co-occurring behavioral and general medical health conditions result in increased functional impairment and health care costs.[ii]

Federal law mandates Medicaid coverage of many behavioral health benefits with states having the flexibility to cover additional optional behavioral health benefits. However, behavioral health services are not a specifically defined category of Medicaid benefits. For example, psychiatrist services may be covered as "physician services" as a mandatory Medicaid benefit and outpatient prescription drugs may be covered under a state's optional benefit categories.[iii] States maintain flexibility in determining the coverage, delivery, and payment of behavioral health services; this can lead to variation with the Medicaid behavioral health services available and accessible to Medicaid enrollees among states.

Medicaid is the single largest payer of behavioral health services in the United States.[iv] Approximately, one-fifth of Medicaid enrollees have a behavioral health diagnosis and the services used by these enrollees account for almost half of all Medicaid spending (including physical and behavioral health services).[v] A recent study found considerable geographic variation in emergency department visits from Medicaid enrollees for mental health conditions, calling for additional research on "how prevalence, access, and quality might vary among Medicaid beneficiaries" seeking mental health care.[vi]

BEHAVIORAL HEALTH DELIVERY MODELS – MOVING TOWARD MEDICAID MANAGED CARE

States have increasingly moved away from full FFS models and toward models that use managed care organizations (MCOs) or use a combination of fee-for-service (FFS) and managed care arrangements to deliver behavioral health care to Medicaid enrollees. Medicaid services delivered through the managed care model provide the optimal infrastructure to meet the physical and behavioral health needs of Medicaid enrollees.

Recognizing that the range of care and services needed by Medicaid enrollees with behavioral health needs varies among individuals and over time, Medicaid MCOs utilize a whole-person approach that is integrated, data-informed, flexible, and innovative. Medicaid MCOs also work to coordinate care that includes engaging with enrollees, their families, their providers, and state and local social service agencies.

MHPA POLICY POSITION

MHPA supports efforts to facilitate access to care and services for individuals with behavioral health care needs through the delivery of care and services that utilize a whole-person care approach that is coordinated, that promotes high quality care and better outcomes, and that improves equity by addressing barriers to care and services.

Recent federal guidance and the launch of a new Biden-Harris Administration initiative have increased the opportunities for states and stakeholders to support SDOH in the Medicaid program.

COORDINATION OF PHYSICAL & BEHAVIORAL HEALTH CARE

Evidence suggests that physical health and behavioral health conditions and/or substance use disorders are best addressed in a coordinated manner to facilitate access to care and services and to improve outcomes.[vii]

MCOs can provide integrated care management programs for Medicaid enrollees that conduct holistic care coordination for their members. Coordination of behavioral health and medical health benefits can support high quality care for members and provide MCOs opportunities to work with different provider types, such as primary care and behavioral health providers, to co-locate or coordinate services.

The Collaborative Care Model (CoCM), an evidence-based model of care for the delivery of MH/SUD services in primary care, is a proven and effective model that integrates care, expands access, and improves outcomes. MHPA encourages efforts to support the adoption and expansion of CoCMs by primary care practices including more detailed federal guidance, reimbursement for the collaborative care codes, and incentives for state Medicaid plans.

Continued Flexibility for the Use of Telehealth to Provide Behavioral Health Services

States have significant flexibility to provide telehealth services, and all 50 States and the District of Columbia currently provide some Medicaid coverage of telehealth. During the COVID-19 pandemic, states took advantage of broad authority to expand Medicaid telehealth policies, resulting in increased telehealth utilization. In particular, states reported that telehealth helped maintain and expand access to behavioral health care during the pandemic.[ix]

TeleBehavioral Health (TeleBH) allows members to continue behavioral health treatment safely and in their own homes, which is particularly important in rural and underserved areas. TeleBH connects members with providers who can meet their unique cultural needs and improve access to specialists. Additionally, TeleBH helps reduce barriers that can be present with in-person care including lack of reliable transportation, stigma, and time away from work. MHPA encourages policies that support state efforts to embrace telehealth, including continued state flexibility to determine how telehealth services are delivered and mutual recognition compacts for professional licenses that make it easier for health care providers to practice telehealth in multiple states. For example, polices that support cross state licensure for providers and increased investments in broadband and telehealth infrastructure would facilitate access to care that is not limited by geographical location.

Addressing Behavioral Workforce Challenges to Facilitate Access to Care & Services

» **Increasing the Behavioral Health Care *Workforce***

Nearly half of the US population – 47% or 158 million people – live in a behavioral health workforce shortage area.[x] The COVID-19 pandemic exacerbated the pre-existing behavioral health workforce shortage. Rural and underserved areas (including densely populated areas with high Medicaid eligibility) face unique challenges in recruiting and retaining health professionals. Medicaid enrollees seeking behavioral health care services are particularly impacted. On average, only 36% of psychiatrists accept new Medicaid patients. Even when providers accept Medicaid, they may only take a few patients or may not be taking new Medicaid patients at all.

MHPA supports efforts at the federal level (e.g., the Consolidated Appropriations Act) and the state level (e.g., reimbursing new provider types, changing scope of practice policies) to address behavioral workforce shortages impacting Medicaid enrollees. In addition, MHPA recommends several policy changes at the federal and state level:

» **Integrate peer support specialists into the mental health and SUD system.** Peer support specialists are individuals who use their own experience recovering from mental health and/or SUD challenges to support others. While peer support services are an evidence-based mental health model of care, varied background screening laws across states can create barriers for peer support specialists being able to provide support.

We support efforts to address inconsistencies across states and work to ensure peer support specialists are integrated into the mental health and SUD system.

» **Expand the types of providers and services eligible to receive federal/state funds.** This could help address workforce shortage issues and help minimize long waits for care and services. For example, Federally Qualified Health Centers (FQHCs) could be allowed to bill Medicaid for visits enrollees have with a marriage and family therapist, licensed professional counselor, or a licensed addiction counselor. In addition, payment of asynchronous care, coaching, texting, and wellness services are effective treatment options, particularly for the treatment of mild to moderate conditions like depression or generalized anxiety disorder. By allowing expansion of nontraditional reimbursable services, the capacity for in-person treatment for complex conditions and the seriously mentally ill population can be expanded.

» **Revise provider scope of practice rules, where appropriate.** Scope of practice rules promote safety, but can also place limitations on the ability of well-qualified health care providers to provide safe and effective care. We encourage states to revisit current practice/physician oversight/supervision rules to increase access to a broad array of providers and services and to further support opportunities for providers to practice at the top of their level of licensure.

» **Allow for a medical visit to be billed the same day as a behavioral health and/or oral health visit.** Removing limitations on payments for same-day billing for a physical health and a mental health service/visit can facilitate access to care for individuals who may have issues with childcare, transportation, or being able to take time off from work for appointments.

» **Increasing Funding to Address Workforce Availability and Retention**

* MHPA supports increased funding to address workforce availability and retention (e.g., financing for behavioral health degreed programs) and refer to the National Council for Mental Wellbeing/Health Management Associates study[xi] for more information on capacity issues related to the behavioral workforce and potential state policy actions.

» **Promoting Behavioral Health Care Workforce Diversity**

* Medicaid serves a disproportionate number of people of color who studies have found to have worse access to mental health care and receive lower quality mental health care compared to whites.[xii] MHPA supports federal and state actions to build and grow a diverse behavioral health workforce as part of a broader effort to address barriers to care and promote health equity for underserved

communities that include increasing access to education and offering incentives for people of color, people from rural communities, and people with disabilities to pursue career goals in healthcare and health equity.

* MHPA also believes that mental health literacy is the basis for prevention, stigma reduction, and increased awareness for both behavioral health issues and available treatment options. Promoting mental health literacy through education, community awareness, and outreach that incorporates an understanding of cultural norms of underserved communities can encourage greater participation in the behavioral health care workforce from traditionally underrepresented groups, including participation in peer support.

Addressing the National Opioid Crisis

* Medicaid plays a critical role in addressing the national opioid crisis.[xiii] Taking steps to improve coordination between physical and behavioral health providers is essential to facilitating access to opioid-use disorder (OUD) treatment, including medication assisted treatment (MAT). We believe increased SUD and OUD education for all appropriately licensed prescribers would increase early identification and treatment and be particularly impactful in rural areas where access to behavioral health services is limited. We support further examination of ways to promote innovations in OUD treatment, including implementation of harm reduction strategies.

[i]https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/

[ii]https://ps.psychiatryonline.org/doi/10.1176/appi.ps.20220478

[iii]https://www.kff.org/statedata/collection/medicaid-behavioral-health-services/

[iv]https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html

[v]https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf

[vi]McConnell KJ, Watson K, Choo E, Zhu JM. Geographical Variations In Emergency Department Visits For Mental Health Conditions For Medicaid Beneficiaries. Health Affairs (Millwood). 2023 Feb;42(2):172-181.

[vii]https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/.

[viii]https://aims.uw.edu/collaborative-care/evidence-base-cocm

[ix]https://www.kff.org/medicaid/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/#:~:text=In%20particular%2C%20states%20report%20that,telehealth%20utilization%20among%20Medicaid%20enrollees.

[x]https://data.hrsa.gov/topics/health-workforce/shortage-areas

[ii]https://www.healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf

[xii]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8842821/#:~:text=African%20Americans%20and%20other%20ethnic,for%20depression%20are%20understudied1.

[xiii]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9578596/