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Medicaid Handbook: Interface with Behavioral Health Services

Module 1

Medicaid's Importance to Mental Health & Substance Use Services

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Module 1: Medicaid's Importance to Mental Health and Substance Use Services

What is Medicaid's Role in Behavioral Health Services?

Medicaid plays a significant role in the financing of treatment for mental or substance use disorders (M/SUDs). Together, services to treat mental and substance use conditions are referred to as *behavioral health services*. Although spending on behavioral health services is a small portion of all-health care spending (7.3 percent in 2005), it has a large impact on Medicaid spending. This is expected to increase under the Affordable Care Act's[A] expansion of Medicaid coverage that is discussed more thoroughly in Module 7.

The Federal-State Medicaid program is currently the single largest funder of behavioral health services.[B] Nationally, Medicaid paid for 26 percent of behavioral health services, but only 17 percent of total all-health spending in 2005 (see Figure 1-1). "All-health spending" is the total spending on all behavioral health and physical health acute and long-term care services.[C]

In addition to Medicaid paying for a large share of behavioral health services, behavioral health services account for a larger share of Medicaid benefits than it does of all health care services. Spending on behavioral health services accounted for 11 percent of Medicaid spending in 2005, but only 7 percent of spending by all-health care payers, as illustrated in Figure 1-2.

How Has Medicaid Spending on Behavioral Health Changed Over Time?

Medicaid spending on behavioral health treatment has increased from $6.6 billion in 1986 and to $35.7 billion in 2005. Along with the increase in spending, Medicaid's share of funding for behavioral health services has risen—from 16 percent to 26 percent of behavioral health spending (see Figure 1-3). Although other non-Medicaid state and local spending on behavioral health treatment has also increased (from $11.5 billion in 1986 to $28.2 billion in 2005), it has

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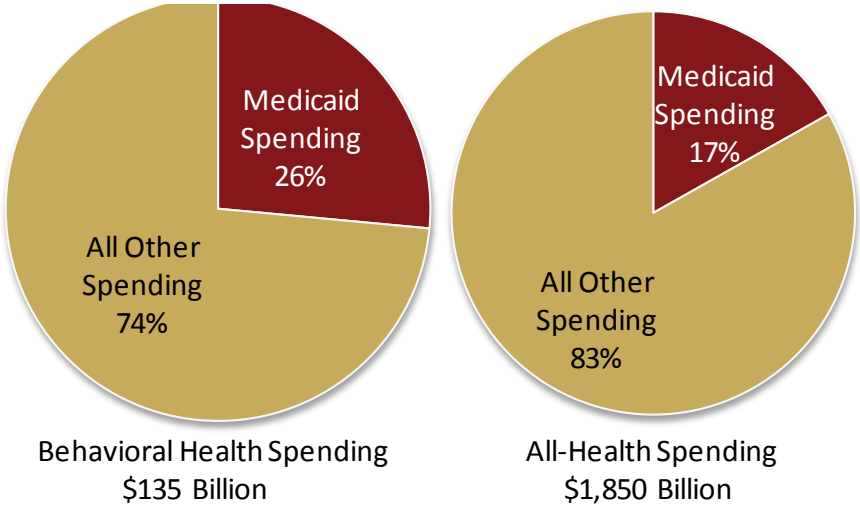
[A] Throughout this handbook we refer to the federal health care legislation as the Affordable Care Act. In so doing, we mean both pieces of federal legislation (Public Law No: 111-148 and Public Law No: 111-152) that, together, are generally referred to as the Affordable Care Act or Patient Protection and Affordable Care Act.

[B] International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes for mental disorders were used to identify provider services reported in this module when they were listed as the principle diagnosis. The ICD-9 codes used to define behavioral health were 291, 292, 295-304, 3050, 3052-3059, 306-314, 6483, 6484. Certain mental disorders were excluded: intellectual disabilities, developmental delays, dementias (e.g., Alzheimer's disease), and tobacco abuse. Psychotropic prescription medications purchased in retail pharmacies were captured by therapeutic class, including antianxiety agents, sedatives and hypnotics, antipsychotics, and antidepressants. Certain central nervous system stimulants and anticonvulsants were included if they had an accompanying behavioral health diagnosis. For treatment of SUDs, spending was included for buprenorphine to treat opioid addiction and for acamprosate, disulfiram, and naltrexone to treat alcohol addiction. Spending on methadone was captured as part of spending for specialty substance abuse centers where methadone is dispensed.

[C] All health spending includes spending on hospital, physician, dental, other professional, home health, nursing home and public health services in addition to spending on prescription drugs, durable medical equipment, administrative costs for operating public programs and the net cost of private health insurance.

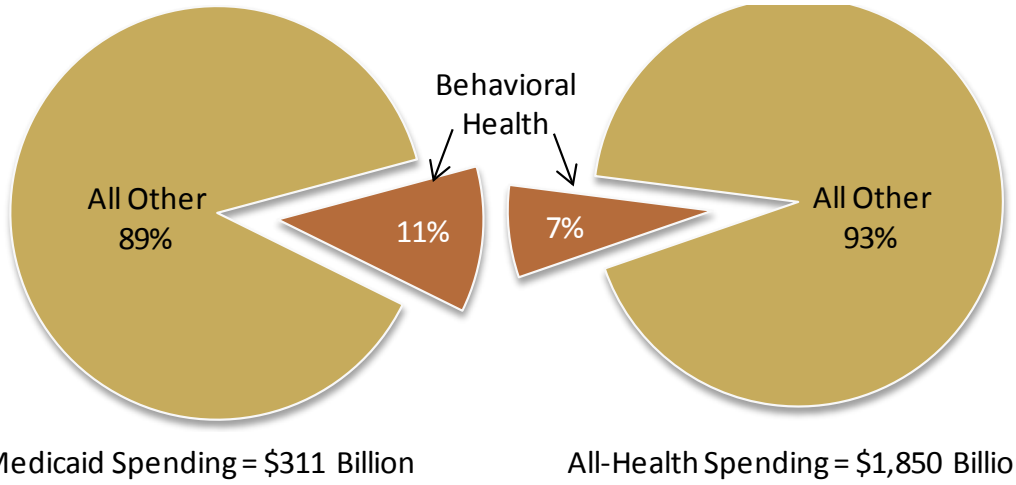
not risen as rapidly as overall behavioral health spending. This has resulted in non-Medicaid state and local spending falling as a share of behavioral health spending from 28 percent in 1986 to 21 percent in 2005, as illustrated in Figure 1-3.

Figure 1-1 Medicaid Paid for a Larger Share of Behavioral Health Spending Than All-Health Spending, 2005



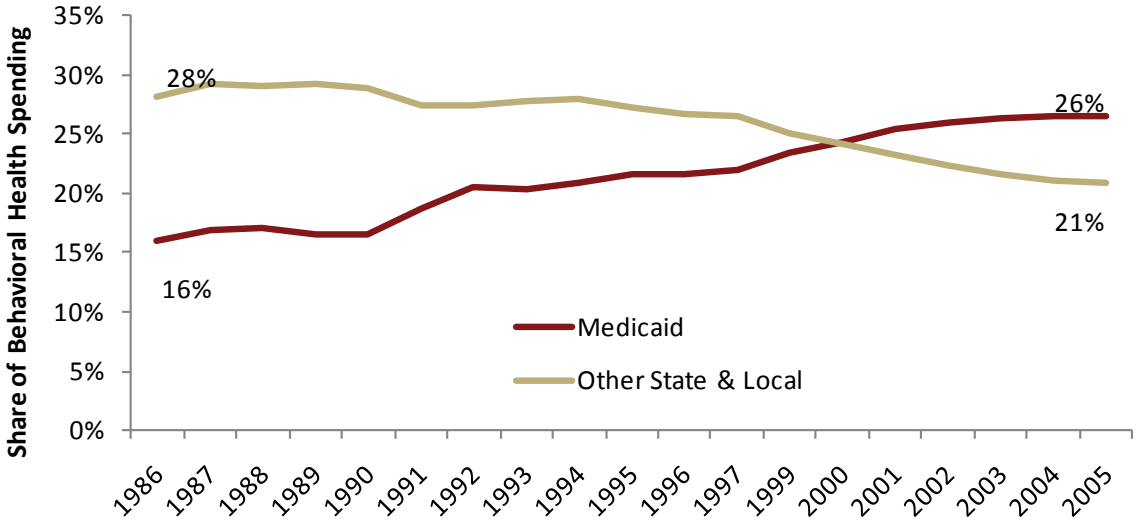
Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

Figure 1-2 Compared to All-Health, Medicaid Spends a Larger Share on Behavioral Health Services, 2005



Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

Figure 1-3 Behavioral Health Spending Share from Medicaid Increased While the Share From Other State and Local Funds Fell



Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

Because states vary greatly in services required by their populations, availability of behavioral health facilities and providers, and economic factors, the mechanisms states employ to leverage funding for behavioral health services also vary. For example, there is variation in the types of treatment services for M/SUDs covered under the *rehab option* and other Medicaid State Plan services across states, as well as waiver services. These options are discussed as part of the behavioral health benefit package section in Module 3.

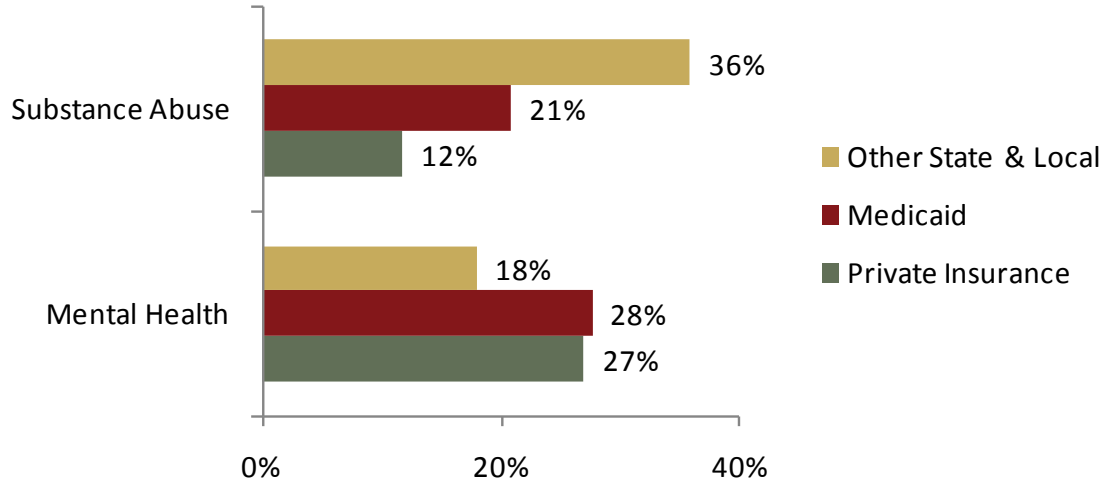
Historically, inpatient hospitalization in state hospitals was the main treatment option for many behavioral health conditions. Over time, state behavioral health agencies have moved aggressively to develop a robust array of community services and relationships to serve those with mental or substance use disorders. Medicaid financing has been a key to this shift. In many cases, the increasing reliance on Medicaid has facilitated the expansion of many needed and evidenced-based behavioral health services. For example, the number of Assertive Community Treatment (ACT) programs generally did not grow until states took steps to fund ACT through the Medicaid State Plan *rehab option*. Other behavioral health services that expanded under Medicaid include crisis intervention, case management, and partial hospitalization, as well as paying for medications. Despite dramatic expansion of community-based services and supports aided by Medicaid funding, Medicaid still has limits. For example, although Medicaid can pay for treatment, medications, and some recovery support services, it cannot pay for housing and some residential treatment.

How Does Medicaid Spending on Behavioral Health Compare to Spending by Other Payers?

Services designed to treat SUDs are more likely to be financed by state and local governments, along with federal block grants, than by other payers, such as private insurance and Medicaid.

The total demand and aggregate costs are much higher for mental health services than for treating SUDs; however, state and local governments pay for a larger share of all substance use treatment services than mental health services, as shown in Figure 1-4.

Figure 1-4 Financing Treatment of Substance Use Disorders is Concentrated in State and Local Governments, 2005



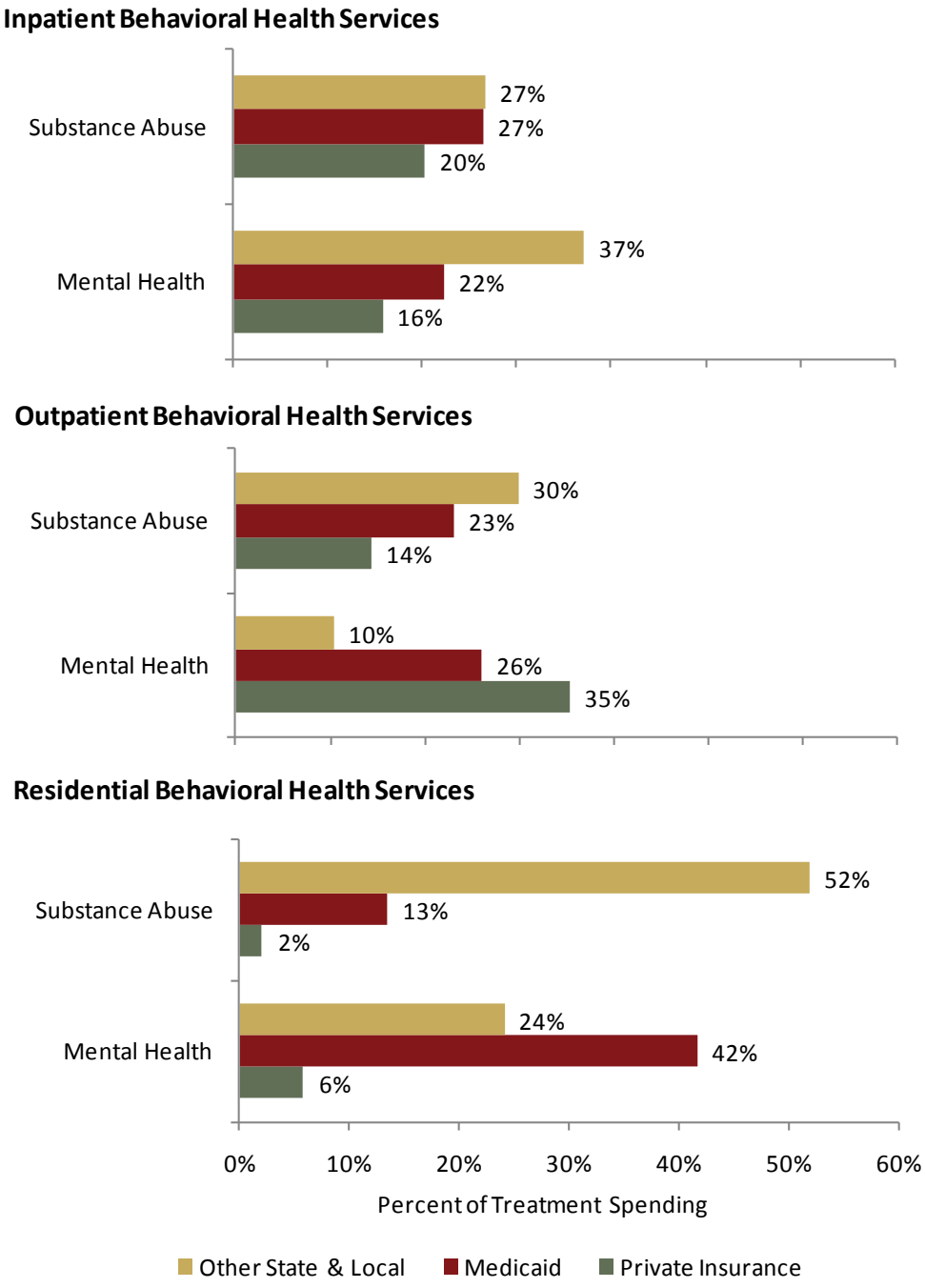
Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

The primary source of payments for similar behavioral health services may be quite different when comparing mental health services to treatment for SUDs. For instance, because of federal restrictions, residential treatment services for SUDs rely primarily on state and local government funding. On the other hand, Medicaid is the largest single financer of mental health residential support services. This sometimes reflects inclusion of different types of treatment professionals or variations in programmatic approaches that may be more or less "medical" in nature.

The disparity between private insurance coverage and Medicaid and other state and local funding is smaller for inpatient services, but much more substantial for residential treatment, as shown in Figure 1-5.

Historically, private health insurance has not covered inpatient hospitalization in state psychiatric hospitals, as well as some other services provided through the publicly funded behavioral health system. Thus, these publicly funded behavioral health services were primarily viewed as safety-net services. This has led to a disparity in funding from private health insurance for outpatient treatment of SUDs and of all residential services. In addition to changes resulting from the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 plays an important role in addressing this disparity, as discussed in Module 7.

Figure 1-5 Residential Treatment for Substance Use Disorders are Largely the Responsibility of State and Local Governments, 2005



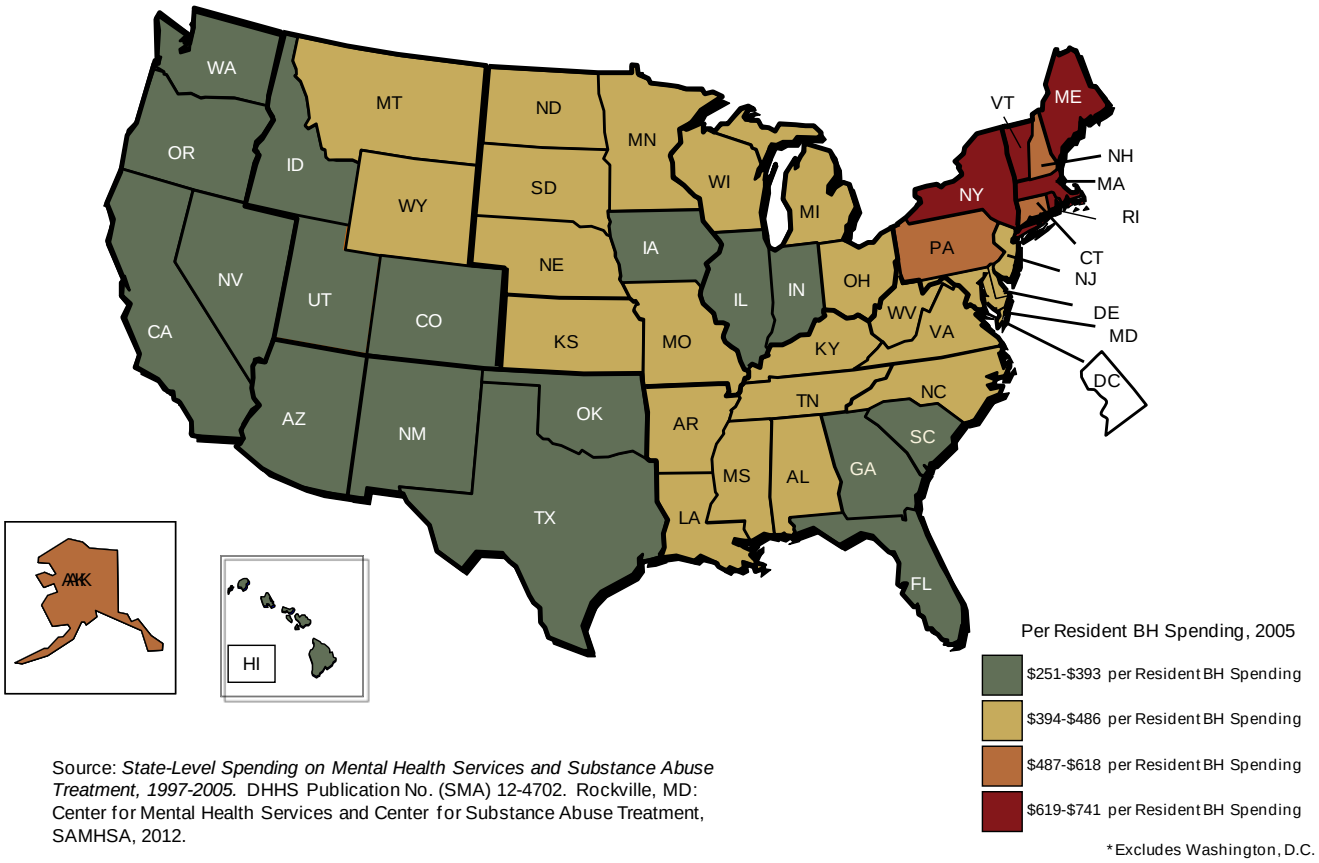
Source: SAMHSA. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005. DHHS Pub. No. (SMA) 10-4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2010.

What Is the Impact of Behavioral Health Spending by State?

Spending per person on behavioral health services varies considerably by state. This reflects a number of factors, including the behavioral health services needs of the population, accessibility of behavioral health care facilities and providers, size of the behavioral health workforce, availability of funding, regional variations in health care payments, and other economic and noneconomic factors.

In 2005, behavioral health spending on services averaged $423 per person across all U.S. residents. As shown in Figure 1-6, regional spending per resident ranged from $309 in the Southwest to $646 in New England. In the Southeast, Great Lakes, and Plains, behavioral health spending per resident was closer to the U.S. average ($394, $401, and $435 per person, respectively). By state, spending ranged from $251 per resident in Nevada to almost three times as much in Vermont ($741 per person).

Figure 1-6 Behavioral Health Spending per Resident was Highest in New England and Lowest in the Southwest and West in 2005



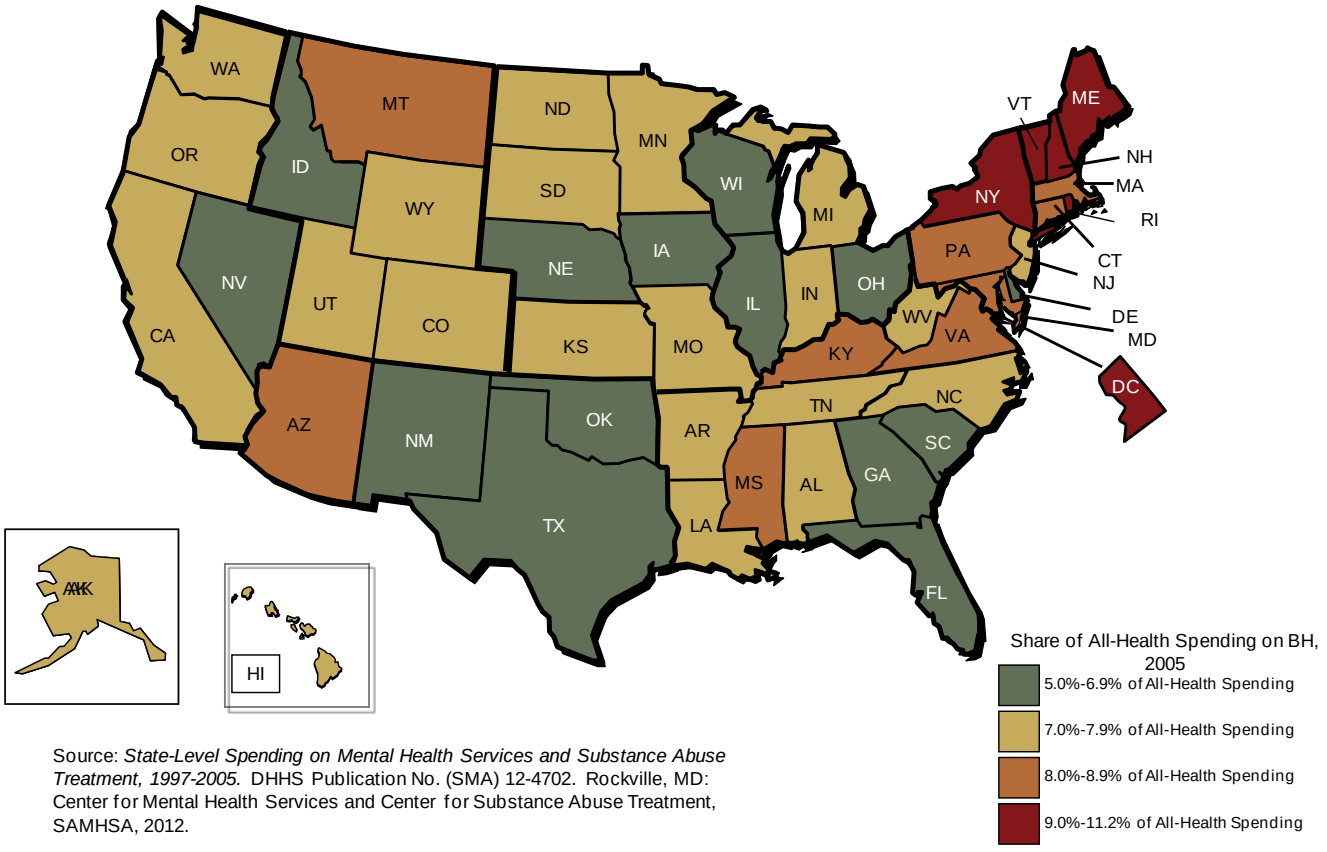
Source: *State-Level Spending on Mental Health Services and Substance Abuse Treatment, 1997-2005.* DHHS Publication No. (SMA) 12-4702. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2012.

Nationwide, 7.4 percent of all-health spending was allocated to behavioral health services in 2005. Regionally, the behavioral health share of all-health spending ranged from 6.2 percent in the Southwest to 9.1 percent in New England. The regions with the highest share of all-health

spending allocated to behavioral health services (New England and the Mid-Atlantic states) also had the highest levels of behavioral health spending per resident.

By state, the behavioral health share of all-health spending ranged from 5.0 percent in Nevada to 11.7 percent in Vermont. In general, states that tend to spend more per resident on health care overall tend to allocate a larger share of those dollars to behavioral health services, as shown in Figure 1-7.

Figure 1-7 States with High Behavioral Health Spending per Resident Generally Spend a Higher Share on Behavioral Health Services



Source: *State-Level Spending on Mental Health Services and Substance Abuse Treatment, 1997-2005.* DHHS Publication No. (SMA) 12-4702. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA, 2012.

How Will Medicaid and Non-Medicaid Spending on Behavioral Health Change Under the Affordable Care Act?

The Affordable Care Act provides states with the option of extending Medicaid eligibility to individuals with incomes below 133 percent of the federal poverty guideline.[D] Many of these uninsured individuals have mental illnesses and substance use disorders. In addition, behavioral health services are required as essential health benefits under the Affordable Care Act. These services must be covered at parity for health plans offered in the individual and small group markets and for Medicaid benchmark plans for the expansion population. This is especially

[D] The option to extend Medicaid eligibility includes a five percent income disregard. Therefore, states may extend Medicaid eligibility to individuals with incomes below 139 percent of the federal poverty guideline.

important for treatment services for SUDs that have historically been covered in a very limited manner. In addition to eligibility and benefit changes, new options for care coordination, health homes with enhanced federal funding, new options for Medicare-Medicaid enrollees, and other initiatives hold promise for improving the quality and cost effectiveness of these services.

Thus, Medicaid is expected to increase its share of spending for behavioral health services under health care reform due to increased Medicaid enrollment in states that expand Medicaid coverage, as well as to provide better coverage and care options for those in need of behavioral health services. Until the Medicaid expansion is implemented in 2014, and indefinitely for states that choose not to expand Medicaid, uninsured individuals needing or receiving services are likely to be supported by state and local funds and federal block grants.

In 2010, there were approximately 18.3 million uninsured people in the United States. Data from the 2008–2010 National Survey on Drug Use and Health suggest that if every state were to expand Medicaid, an additional 1.3 million currently uninsured adults below 133 percent of the federal poverty level would have a serious mental illness (SMI) and would become eligible for Medicaid. This population is characterized by:

- Female sex (64 percent)
- Non-Hispanic, White (67 percent) race
- Metropolitan residence (42 percent)
- High school education (39 percent) or less (31 percent)
- Fair or poor health status (37 percent).

In addition, 2.7 million uninsured adults below 133 percent of the federal poverty level who had serious psychological distress would become eligible for Medicaid.

If every state were to expand Medicaid coverage, an additional 2.5 million currently uninsured adults below 133 percent of the federal poverty level would have a substance use disorder and would become eligible for Medicaid. This population is characterized by:

- Male sex (73 percent)
- Age 18 to 34 years (63 percent)
- Non-Hispanic, White (51 percent) or Hispanic (28 percent) race/ethnicity
- High school education (32 percent) or less (43 percent)
- Metropolitan residence (47 percent)
- Good (36 percent) or very good (28 percent) self-rated health.

Why Should State Behavioral Health Authorities Understand Medicaid?

In summary, Medicaid funding has been essential to the financing of behavioral health services in the United States. In recent years, Medicaid has become the largest financing source of behavioral health services as state governments rely increasingly on Medicaid to expand services by leveraging limited state revenue. However, within behavioral health services financing overall, state and local funding along with federal government block grant funds continue to be important payers of treatment for SUDs, particularly in residential treatment services.

As the Affordable Care Act extends Medicaid coverage to potentially millions of formerly uninsured adults—many of whom have mental illness and substance use disorders—it is important to understand Medicaid financing, in its own right, and to consider it in combination with other state and federal funds and programs. Collaboration and shared understanding between state Medicaid and behavioral health authorities is fundamental to designing effective, efficient, and coordinated behavioral health services for those who need them. Without this holistic view, it will be difficult for state policymakers to accomplish their goals of improved health and behavioral health outcomes for those they serve.

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SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities

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