

State Mental Health Agency Use of Medicaid



NRI's 2020-2021 State Profiles

December, 2021

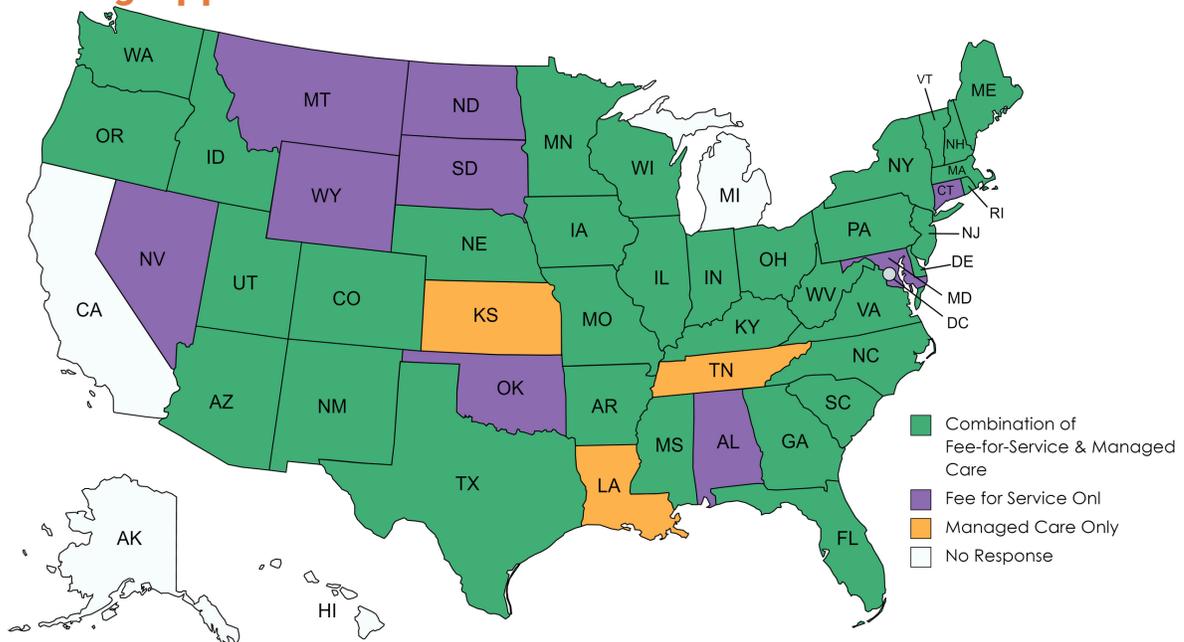
HIGHLIGHTS BASED ON 47 STATES RESPONDING TO THE FINANCE COMPONENT OF NRI'S 2020-2021 STATE PROFILES

NOTE: although 47 states responded to the finance component; not All States answered all questions, therefore, some of the information presented in this report is based on responses from less than the total number of reporting states

Every state uses Medicaid to reimburse providers for some of the mental health services provided. Medicaid is the single largest funding source for mental health services, surpassing state general revenues. In fiscal year 2020, Medicaid represented over 50% of the \$45.9 billion dollars the State Mental Health Agency (SMHA) systems expended to provide mental health services to over 8 million clients, of whom 69% had Medicaid pay for some or all of their services. (2020 SAMHSA Uniform Reporting System). The SMHA is responsible for setting Medicaid rates for mental health services in SMHA-operated mental health programs in 12 states, in SMHA-funded mental health programs in 13 states, and in non-SMHA funded mental health programs in 2 states.

How SMHAs use Medicaid to pay for mental health services varies from state to state, with states using different combinations of Medicaid options, waivers, managed care, and fee-for service approaches. In 35 states, the SMHA uses a combination of fee for service and managed care approaches to pay for mental health services (see Figure 1).

Figure 1: Funding Approaches for Medicaid-Funded Mental Health Services



\$23.3 Billion

Medicaid funding of SMHA System in FY 2019

49.4%

Medicaid's Share of total SMHA Funding for Mental Health Services in FY 2019

35 STATES

Medicaid Pays for MH with a Combination of Fee-for-Service and Managed Care

SMHA Use of Medicaid to Fund Mental Health Services

Medicaid is a joint state-federal program that provides health insurance to low income and disabled individuals (such as adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED)). Every state has a unique configuration of Medicaid that pays different rates for services, that varies regarding the eligible patient populations, that use various managed care approaches to control costs, and that select from a variety of available Medicaid options and waivers to provide behavioral health services.

A 2019 report by Kaiser Family Foundation (KFF)/Health Management Associates (HMA) for the National Association of State Medicaid Directors found that in states that use managed care approaches, persons with SMI/SED are always included in managed care (“always mandatory”), while in 5 states patients can choose to be in a managed care plan or not and participation in managed care delivery systems varied in 7 states. Only two states reported that individuals with SMI/SED are excluded from Medicaid managed care (See Table 1).

Table 1: Medicaid Managed Care Organization Enrollment of Persons with SMI/SED: 2019

| MCO Enrollment of Persons with SMI/SED | Number of States |
|--|------------------|
| Always Mandatory | 26 States |
| Always Voluntary | 5 States |
| Varies | 7 States |
| Always Excluded | 2 States |

Source: <https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-delivery-systems/>

The types of managed care organizations that provide behavioral health services also varies across states. Table 2 from the KFF/HMA report shows that most often mental health and substance use services are “carved-in” managed care plans (that is, the same managed care organizations that provide overall Medicaid managed care services cover behavioral health services. In carved-out managed care arrangements, specialty managed care organizations devoted to covering mental health and/or substance use services are responsible for providing those services—separately from primary health care services. Table 2 shows that slightly more states carve-out specialty outpatient mental health services than they do for other behavioral health services.

Table 2: Managed Care Organization Coverage of Behavioral Health, July 1, 2019 (# of States)

| | Specialty Outpatient MH | Inpatient MH | Outpatient SUD | Inpatient SUD |
|--------------------------|----------------------------|--------------|-------------------|---------------|
| Always Carved-In | 7 States | 7 States | 7 States | 7 States |
| Always Carved-Out | 7 States | 7 States | 7 States | 7 States |
| Varies | 7 States | 7 States | 7 States | 7 States |

Source: <https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-delivery-systems/>

The KFF/HMA report found eight states in FY 2019 and nine states in FY 2020 reported changes in how behavioral health benefits are delivered under MCO contracts:

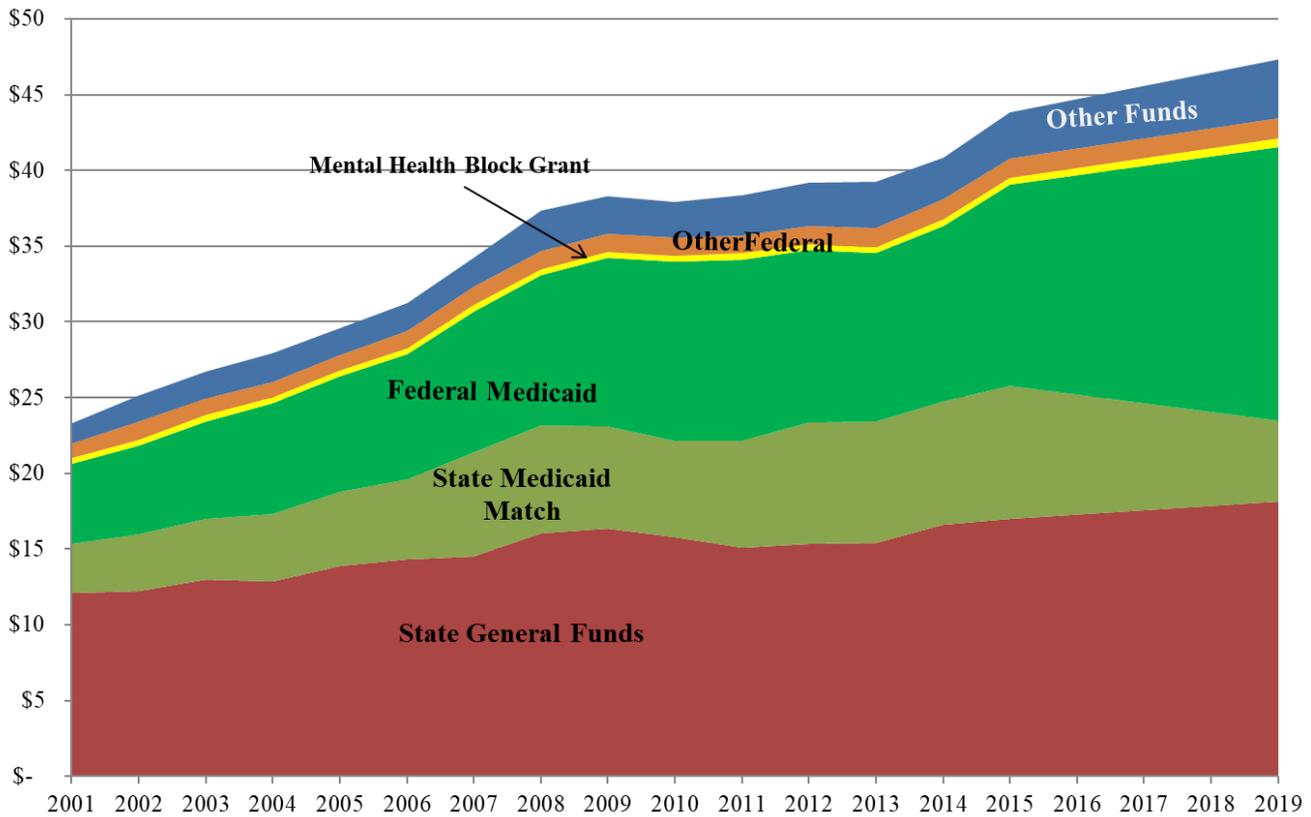
- Mississippi, New Jersey, New York, and Virginia in FY 2019 and New Jersey in FY 2020 reported actions to carve certain behavioral health services into their MCO contracts.
- Kentucky, Nebraska, West Virginia, and Wisconsin reported plans to add SUD waiver services to their MCO contracts in FY 2020. South Carolina added “in lieu of” SUD Institutions for Mental Disease (IMD) services to its MCO contracts in FY 2019 and other SUD services in FY 2020.
- Arizona and Washington reported implementing, or plans to implement, additional integrated MCO contracts in both FY 2019 and FY 2020.
- Mississippi added “in lieu of” free standing psychiatric hospital services to its MCO contracts in FY 2019.
- North Carolina’s “Standard” MCO plans implemented in FY 2020 will cover some behavioral health services, other than certain high intensity services that will continue to be provided by the state’s current behavioral health plans.

Medicaid Funding of SMHA Services

In FY 2019, Medicaid accounted for 49.4% (\$23.7 billion) of SMHA funds for mental health services (the median for Medicaid supported SMHA funds was 37% of all funds). SMHAs have been increasing their use of Medicaid to support expansion of mental health services for the past 20 years and the 49.4% of SMHA system funding from Medicaid in FY 2019 is an increase from FY 2001, when Medicaid was only 35.8% of all SMHA funds.

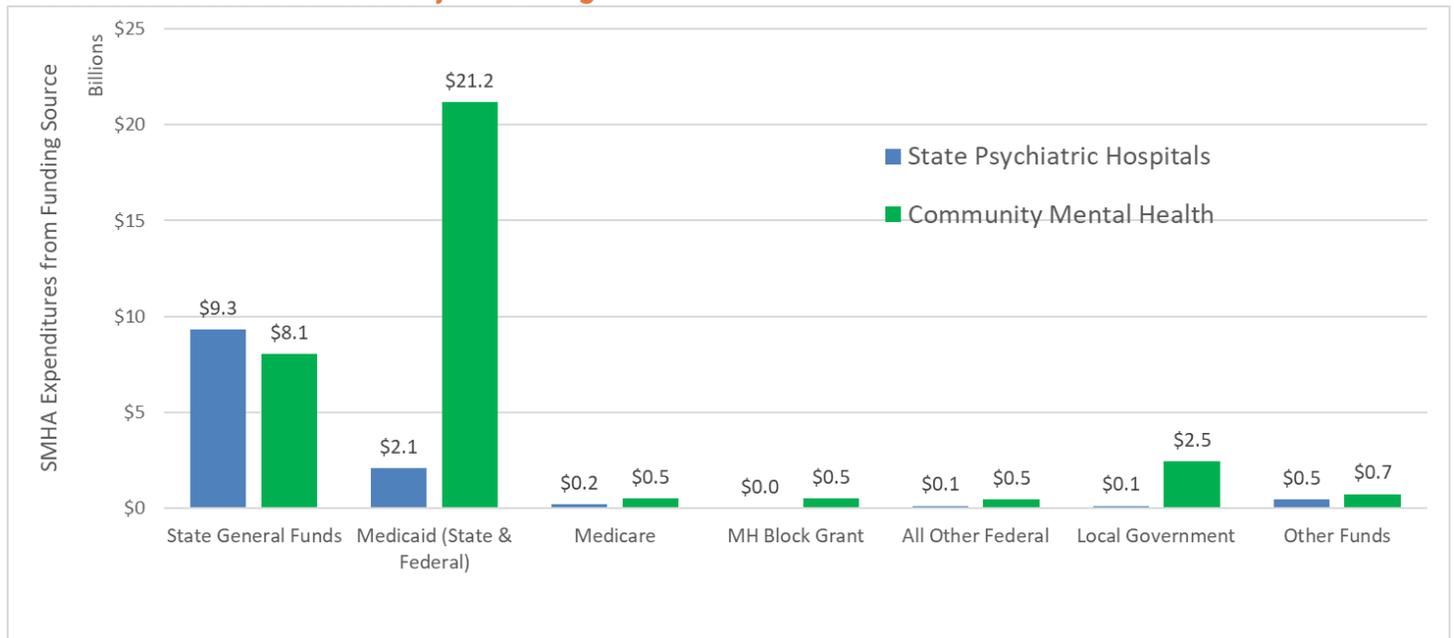
From FY 2010 to 2019 Medicaid provided over half (55%) of all new funds to SMHA system, while 25% of new funds came from state general and special funds. From FY 2001 to FY 2019, Medicaid funds to SMHAs grew by an average of 5.8% per year (an increase of 174.5% over 18 years). State general funds, the next largest source of funding for mental health services grew by only 2.3% per year, the Mental Health Block Grant grew at an annual rate of \$2.2% per year, and other federal funds grew at an average annual rate of 1.3% per year.

Figure 2: SMHA-Controlled Revenues for Mental Health, FY 2001 to FY 2019



Medicaid is a much larger share of funding for community mental health services than for state psychiatric hospitals. In FY 2019, Medicaid accounted for 62.4% (\$21.2 billion) of community mental health funding (the median was 45%), while Medicaid accounted for only 17% (\$2.1 billion) of state psychiatric hospital funding (the median was 18%).

Figure 3: SMHA-Funding Sources for State Psychiatric Hospitals and Community Mental Health Services, FY 2019



SMHA Use of Medicaid to Fund Mental Health Services

SMHAs use many different Medicaid options and waivers to pay for a variety of community-based services. Table 3 shows the number of states using different Medicaid options or waivers to pay for a variety of community-based mental health services. For example, Assertive Community Treatment is reimbursed by Medicaid in 27 states, with 15 states using the Rehabilitation option, 8 states using a 1915(b) waiver, 4 states use a 1115 waiver (note: several states use multiple Medicaid waivers/options, therefore, total number of states for individual options can be more than the total number of states responding).

Table 3: Number of States Where Community Mental Health Services Are Reimbursed by Medicaid: By Service Type: 2020

| Funding Sources | Inpatient Hospital | Residential: Room & Board | Residential: Support Services | Outpatient: Testing and Treatment | Extensive/Intensive Outpatient | Collateral Treatment | Case Management | Crisis Services | Assertive Community Treatment | Supported Employment | School-Based Services | Wraparound (Children) | In-Home Services | Peer/Consumer Run Services | Co-Occurring MH/SUD Services |
|--------------------------|--------------------|---------------------------|-------------------------------|-----------------------------------|--------------------------------|----------------------|-----------------|-----------------|-------------------------------|----------------------|-----------------------|-----------------------|------------------|----------------------------|------------------------------|
| Medicaid (federal) | 23 | 6 | 24 | 32 | 32 | 19 | 35 | 34 | 27 | 19 | 27 | 28 | 27 | 24 | 24 |
| Clinic option | 6 | 1 | 1 | 10 | 5 | 4 | 6 | 6 | 2 | 0 | 4 | 0 | 2 | 1 | 11 |
| Rehabilitation option | 5 | 0 | 13 | 18 | 17 | 9 | 12 | 18 | 15 | 7 | 15 | 9 | 15 | 13 | 5 |
| Targeted case management | 1 | 0 | 1 | 2 | 1 | 1 | 19 | 3 | 2 | 1 | 0 | 2 | 2 | 1 | 14 |
| 1915(i) option | 0 | 0 | 3 | 0 | 2 | 0 | 6 | 2 | 1 | 3 | 1 | 3 | 3 | 1 | 2 |
| 1115 waiver | 11 | 2 | 8 | 8 | 8 | 5 | 6 | 8 | 4 | 8 | 3 | 5 | 5 | 5 | 0 |
| 1915(b) waiver | 8 | 0 | 8 | 9 | 9 | 4 | 9 | 10 | 8 | 4 | 9 | 9 | 10 | 7 | 7 |
| 1915(c) waiver (HCB) | 0 | 0 | 6 | 2 | 1 | 1 | 5 | 4 | 2 | 3 | 1 | 5 | 7 | 3 | 9 |
| EPSDT | 8 | 3 | 7 | 12 | 11 | 7 | 10 | 10 | 5 | 5 | 11 | 7 | 10 | 7 | 0 |
| Other Medicaid | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 9 |

44 SMHAs responding

Medicaid Coverage of Services in IMDs

As noted above, Medicaid pays for a much smaller share of state psychiatric hospitals services than it does for community mental health services. This reduced role paying for psychiatric inpatient care is due to Medicaid's IMD rule. Under Medicaid IMD rules, services to adults ages 21 to 64 in an IMD, such as a state or private psychiatric hospital are not reimbursed by Medicaid. However, to address behavioral health issues, the Centers for Medicare & Medicaid Services (CMS) and Congress have recently provided states with increased flexibility to reimburse for services in IMDs using a (1) managed care "in lieu of" authority coverage of inpatient IMD services for up to 15 days a month, (2) Section 1115 Waivers of IMD payment exclusion (as part of provision of a broad array of services across the care continuum), or (3) State Medicaid Plan amendment using provisions of the SUPPORT for Patients and Communities Act (that allows coverage for up to 30 days per year for SUD services).

SMHA Use of Medicaid to Fund Mental Health Services

The KFF/HMA survey identified that 31 states are using the “in lieu of” authority with their managed care plans to provide inpatient services. Thirteen states have applied for or were planning to apply to use Section 1115 IMD waivers for services for individuals with SMI or SED. Only 5 states reported plans to use the SUPPORT for Patients and Communities Act IMD state plan amendment option in FY 2020, while 21 states reported they had not determined whether they would use the option, and 24 states reported they determined to not adopt this option.

SMHA Responsibility for Paying Medicaid State Match

Medicaid, a joint state-federal program, requires a state match of federal dollars. In 20 states, the SMHA is responsible for paying the state match for Medicaid funded mental health services in state-operated programs. The SMHA is responsible for the state Medicaid match payments for state-funded mental health programs in 21 states. The SMHA retains Medicaid revenues of SMHA-operated psychiatric hospitals in 18 states and of state-operated community mental health programs in 15 states. Medicaid revenues of SMHA-operated state psychiatric hospitals and SMHA-operated community mental health programs revert back to the state treasury in 17 states and 12 states, respectively.

Analyzing SMHA Patient Data with Medicaid Claims Data

Medicaid systems have detailed claims as well as enrollment data for all persons receiving Medicaid reimbursed services. Every SMHA has its own data system that tracks clients that received services under the purview the SMHA. To facilitate a more comprehensive understanding of the services clients receive, SMHAs are working to combine SMHA data systems with Medicaid claims data.

Thirty-nine SMHAs responded to the Profiles Information Technology Component with information about analyzing Medicaid claims data:

- 23 SMHAs (Alabama, Arizona, Colorado, District of Columbia, Georgia, Illinois, Iowa, Maryland, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Virginia, and Washington) receive and analyze Medicaid claims data.
- 11 SMHAs (Arkansas, Arizona, Florida, Maryland, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, and South Carolina) use a state data warehouse run by a different agency that combines SMHA and Medicaid data.
- 12 SMHAs (Delaware, Kentucky, Massachusetts, Minnesota, New Hampshire, New York, Ohio, Oregon, Rhode Island, South Dakota, Virginia, and Wisconsin) have other mechanisms that combine Medicaid and SMHA data.
 - For example, in Kentucky, the SMHA uses a university contractor to match SMHA data with Medicaid claims records; and in Massachusetts, New Hampshire, Rhode Island, and South Dakota, the SMHA has direct access to their state’s Medicaid data system.
 - Many states use multiple approaches to analyze Medicaid data to understand mental health services.

SMHAs link SMHA data with Medicaid claims and encounter data to conduct analyses of mental health services across systems (32 SMHAs), for policy analyses or administrative purposes (31), and to identify potential fraud or abuse in billing (18 SMHAs).

SMHA Use of Medicaid to Fund Mental Health Services

In 14 states, the SMHA is working with the State Medicaid agency to combine data systems. For example:

- In Arizona, the SMHA has been located within the Arizona Medicaid Agency and is building a single integrated data system.
- In Florida, the SMHA's database includes a master person index that matches clients across different programs (mental health, substance use, child welfare, etc.) with Medicaid eligibility. Clients submitted as a result of receiving services are shared via interface with the Access system which returns a Medicaid ID if one exists. The database also includes a Medicaid interface that uses the Medicaid ID to return eligibility, but not claim, data.
- In Maryland, The Administrative Service Organization (ASO) overseeing the Public Behavioral Health System (PBHS) is managed by both Medicaid and the SMHA.
- In Montana, the Department of Public Health and Human Services (DPHHS) is in the middle of its Medicaid Management Information System (MMIS) modularity initiative, to completely replace its legacy Medicaid infrastructure. A major component of this initiative is the consolidation of Department systems to increase efficiencies and provide more holistic care for members. Critical modules that will be implemented as part of this effort include a claims module that will process claims for Medicaid, Substance Use, Mental Health, Development Disabilities Program, and other programs administered by the Department. In addition, a comprehensive care management solution that will coordinate care for members enrolled in these programs, collect data and report on treatment outcomes. The care management module will support member outreach, capturing and monitoring of assessments and screenings, treatment plans, and incidents. It will provide comprehensive case management and workflow to track a member's care from inception to conclusion with the tracking of key events being triggered based on the member's condition or type of services required.
- In Nebraska, the SMHA, in coordination with Nebraska's Department of Health and Human Services (DHHS), is helping to design an interagency platform to support a more customer-centric data collection and reporting system, which is expected to integrate data across DHHS divisions, including Medicaid. Currently, the only data sharing agreement with Medicaid is through an eligibility file received from Medicaid to avoid duplication of payers authorizations, etc.
- In New Mexico, the New Mexico Human Services Department is currently in the process of replacing its decades old MMIS to include SMHA data. The system is in the development phase and the SMHA has participated with requirements gathering and providing input as a stakeholder of the replacement system.
- In New York, through a weekly feed, Medicaid data are integrated with SMHA databases. In addition, SMHA databases are shared with Medicaid authority (e.g., ACT data). SMHA has full access to the Medicaid data warehouse.
- In North Carolina, Medicaid and SMHA use the same billing system and data warehouse.
- In Virginia, the SMHA is working with the state Medicaid agency to create access to systems and information. The SMHA has requested direct access to the Medicaid data warehouse data mart. The Medicaid warehouse is not fully operational at this time but the SMHA continues to meet with the state Medicaid agency on a regular basis around access.

**For additional information about this report, or the SMHA Profiles Project,
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