Chapter 2:

Access to Mental Health Services for Adults Covered by Medicaid

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Recommendations

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.

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.

Key Points

- Many Medicaid beneficiaries with mental health conditions have difficulty accessing treatment. In 2018, 50 percent of beneficiaries with serious mental illness reported that they needed but did not receive treatment.
- Access to treatment is affected by a variety of factors including the extent to which states cover services and the willingness of providers to accept new Medicaid patients.
- Limited access to care has serious consequences for beneficiaries with mental illness. They are more likely than their privately insured peers to receive inpatient treatment and to report involvement with the criminal justice system.
- Crisis services can help reduce inappropriate use of psychiatric hospital beds and facilitate access to ongoing care. They can also divert individuals from the criminal justice system.
- Implementation of 9-8-8, the three-digit dialing code for the National Suicide Prevention Lifeline, is expected to increase demand for crisis services as well as mental health services more broadly. States and localities are now grappling with how to fund infrastructure changes that will be needed to cover increased demand.
- Medicaid programs can play a critical role in financing crisis services but states have little guidance on how to implement crisis services in accordance with federal guidelines.
- The Commission recommends that the Secretary of Health and Human Services (HHS) provide additional subregulatory guidance to states to address how Medicaid and CHIP can be used to fund a crisis continuum for beneficiaries with behavioral health conditions. The Commission also recommends that HHS provide technical assistance to states to support planning and cross-agency coordination.
- Looking forward, the Commission plans to further examine the needs of beneficiaries who report involvement with the criminal justice system.

CHAPTER 2: Access to Mental Health Services for Adults Covered by Medicaid

In 2018, roughly one in five non-institutionalized adults age 18–64 had a mental illness, and about half of all Americans will experience mental illness in their lifetime (SHADAC 2020, Kessler et al. 2007). Some are living with mild to moderate conditions while others have serious mental illness (SHADAC 2020).

Regardless of their insurance status, many individuals with mental illness report difficulty accessing services, particularly those with serious mental illness. In 2018, approximately half of adults with serious mental illness reported that they needed but did not receive treatment. In comparison, approximately one in five adults with mild to moderate mental illness reported that they needed but did not receive treatment during the same year (SHADAC 2020). (For discussion of access to mental health care for children and youth, see Chapter 3.)

Many state Medicaid programs do not cover the full continuum of mental health care. This continuum includes ongoing access to outpatient treatment, supportive services, such as supported employment and peer supports—supportive services delivered by a trained and certified individual who has lived experience with a mental health condition—as well as crisis services (e.g., hotline services, mobile crisis care, and crisis receiving and stabilization centers) (AACP 2020). The absence of a full continuum, including a sufficient number of psychiatric beds and real-time access to community-based care, has serious consequences for beneficiaries. It has resulted in the criminalization of mental illness, as law enforcement is often first to respond when individuals experience mental health crises (Hepburn 2020). As a result, a disproportionate share of individuals with mental illness, including Medicaid beneficiaries, wind up in jail or prison (SHADAC 2020).

In accordance with the Americans with Disabilities Act of 1990 (ADA, P.L. 101-336), Medicaid beneficiaries with serious mental illness are entitled to receive necessary mental health treatment in the most integrated setting possible.[1] As a result of the Supreme Court's ruling in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), states must provide treatment for individuals with disabilities, including serious mental illness, in community-based settings if the individuals are not opposed to such services and such placement is appropriate and can be reasonably accommodated by the state.[2]

Although *Olmstead v. L.C.* generally requires states to provide community-based services to individuals with disabilities, it did not create an immediate right to services or to a community placement in lieu of institutional care. As such, Medicaid beneficiaries with mental illness still have difficulty accessing services in the community (MACPAC 2019a). Medicaid beneficiaries with mental illness are less likely than their privately insured peers to receive treatment from a private therapist and more likely to receive inpatient psychiatric treatment (SHADAC 2020).

While Medicaid beneficiaries with mental illness have multiple needs that could be addressed through changes in public policy, in this chapter the Commission focuses on policy to define the role of Medicaid in improving access to care for individuals in crisis. The goal of crisis services is not just to resolve behavioral health crises so that a higher level of care is not necessary, these services also triage and assess individuals and connect them with the appropriate level of care in real time. As such, crisis services can be used to address many problems faced by state behavioral health delivery systems, including inappropriate use of psychiatric hospital beds and boarding—that is, prolonged stays—in emergency departments. Such services can also help divert individuals from the criminal justice system.

National initiatives to address rising rates of suicide, specifically, implementation of 9-8-8, the three-digit dialing code for the National Suicide Prevention Lifeline (National Lifeline), is due to be completed by July 2022, and is expected to increase demand for behavioral health services (FCC 2020). States and localities are now grappling with how this will affect the ability of existing crisis hotlines to engage with individuals who are in crisis or at imminent risk of suicide and how to fund the needed changes in infrastructure (FCC 2020).

As the largest payer of behavioral health services in the United States, Medicaid plays an important role in supporting individuals in crisis. We examine the role of Medicaid (and that of the State Children's Health Insurance Program (CHIP)) in supporting 9-8-8, and how these programs can support state crisis systems more broadly. In particular, it is the Commission's view that Medicaid's critical role in supporting 9-8-8 implementation and state crisis systems needs to be more clearly defined. We therefore recommend the following actions be taken as an important first step toward improving access to mental health services for adults and youth in Medicaid and CHIP:

- 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.
- 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.

To set the context for the recommendations in this chapter and future work on improving access for Medicaid beneficiaries with mental illness, this chapter begins by discussing the prevalence of mental health conditions among Medicaid beneficiaries and the rates at which they receive treatment, comparing the experience of Medicaid beneficiaries to individuals with private coverage. We also examine racial and ethnic health disparities among individuals with mental health conditions. The Commission found that Black and Hispanic beneficiaries with mental health conditions receive treatment at lower rates than their white counterparts. Moreover, they are less likely to receive treatment in a private therapist's office and take a prescription medication for their mental health condition (SHADAC 2021). We also discuss how rising rates of suicide and the criminalization of mental illness affect beneficiaries.

Next, the chapter addresses Medicaid's role in supporting a mental health continuum of care. We summarize state coverage policies and explore the availability of such services, including access at the state level and the rates at which providers participate in Medicaid.

Finally, we turn to current issues regarding implementation of 9-8-8 and how it will affect state and local crisis response systems. We examine national guidelines for crisis care, issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), including how Medicaid can support the three components of state crisis systems: (1) crisis hotlines; (2) mobile crisis services; and (3) crisis stabilization and receiving facilities. The degree to which state Medicaid programs currently support these components, as well as current federal guidance, are also discussed. We conclude that Medicaid's role in supporting these components is critical, yet largely undefined, and that states have little guidance

to implement crisis services in accordance with SAMHSA's national guidelines. The chapter ends with a discussion of planned Commission work on improving access to mental health services.

Mental Health: Prevalence, Treatment Rates, and Disparities

Below, we describe the prevalence of mental health conditions among adults covered by Medicaid and the rates at which they receive treatment, comparing their levels of access, where possible, to access for individuals with mental illness with other sources of coverage. Where possible, we also examine prevalence and treatment rates for Medicaid beneficiaries by race and ethnicity. Estimates are reported where sample size permits. This analysis is based on the National Survey on Drug Use and Health (NSDUH), a federal survey of approximately 70,000 individuals conducted annually in all 50 states and the District of Columbia (SAMHSA 2019a). NSDUH collects information from residents of households and non-institutionalized group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases, age 12 and older. The survey excludes those experiencing homelessness who are not residing in shelters, military personnel on active duty, and residents of institutional group quarters, including jails, nursing homes, mental institutions, and long-term care hospitals (SAMHSA 2019a). (Additional analysis of NSDUH and mental health conditions among adults is discussed in Chapter 4.)

For adult respondents, the NSDUH captures prevalence of mental health conditions that vary in terms of severity.[3] Prevalence estimates for mental health conditions are reported in three categories:

- Any mental illness—This category includes adults age 18–64 who currently have or at any time in the past year reported having had a diagnosable mental, behavioral, or emotional disorder.[4] Mental illnesses in this category can vary in severity.
- Mild to moderate mental illness—This category includes adults age 18–64 with any mental illness except serious mental illness who currently have or at any time in the past year reported having had a diagnosable mental, behavioral, or emotional disorder resulting in less than substantial impairment in carrying out major life activities.[5, 6]
- Serious mental illness—This category includes adults age 18–64 who currently have or at any time in the past year reported having had a diagnosable mental, behavioral, or emotional disorder resulting in substantial impairment in carrying out major life activities.[7, 8] Major life activities include activities of daily living, such as eating or dressing; instrumental activities of daily living, including managing money and taking prescribed medication; and functioning in social, family, and vocational or educational contexts (SAMHSA 2019a).

It is important to note that NSDUH may over- or underreport certain variables related to mental health and substance use disorder (SUD). Specifically, information obtained through this survey is self-reported; these responses are subjective and are not validated using psychiatric diagnostic information. Individual responses are likely influenced by a variety of social and cultural factors, including beliefs and perceptions of mental health issues that may vary culturally (Ward et al. 2013). Moreover, emerging evidence suggests that women are more likely to underreport a past year major depressive episode than men (Tam et al. 2020).

Prevalence

In 2018, 41.5 million adults (21 percent of U.S. civilian, non-institutionalized individuals age 18–64) had a mental health condition (SHADAC 2020). The share of adults reporting any mental illness was higher for those enrolled in Medicaid than for adults with private coverage and those without insurance (Table 2-1). In part, this may be because many individuals qualify for Medicaid based on a disability, including those with serious mental illness, such as schizophrenia. In 2019, among those qualifying for Supplemental Security Income, 6 out of 10 were diagnosed with a mental disorder (SSA 2020). Generally, across all racial and ethnic categories, adults who are enrolled in Medicaid are more likely to report that they had any mental illness than those with private coverage. (See Appendix 2A, Table 2A-1 and Table 2A-2, for additional information on the prevalence of mild to moderate mental illness and serious mental illness among non-institutionalized adults, respectively.)

TABLE 2-1. Reported Prevalence of Mental Illness in the Past Year among Non-Institutionalized Adults Age 18–64, by Demographic Characteristics, 2018

Demographic characteristics	Percentage of adults 18–64 with any mental health condition	Percentage of adults age 18–64 in each coverage category with any mental health condition		
		Medicaid	Private coverage	Uninsured
Total	**21.0%**	**27.6%**	**18.7%**	**21.3%**
Age				
18–25	26.1	26.2	27.4	22.2*
26–34	26.3	33.6	23.9*	25.1*
35–49	19.8	28.3	17.2*	19.7*
50–64	16.0	21.4	13.1*	17.9
Sex				
Male	16.8	21.6	14.9*	17.5*
Female	25.1	31.4	22.5*	26.2*
Race and ethnicity				
White, non-Hispanic	23.6	34.0	20.7*	28.9*
Black, non-Hispanic	16.7	20.0	12.9*	17.9
Hispanic	16.7	22.8	15.6*	13.4*
Asian American, non-Hispanic	15.5	25.2	13.9*	14.6
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander, non-Hispanic	20.6	22.8	16.1	25.2
Two or more races, non-Hispanic	27.9	36.4	24.6*	38.1

TABLE 2-1. (continued)

Demographic characteristics	Percentage of adults 18–64 with any mental health condition	Percentage of adults age 18–64 in each coverage category with any mental health condition		
		Medicaid	Private coverage	Uninsured
Education				
Less than high school	17.9	24.4	13.9*	13.6*
High school graduate	20.1	24.7	16.3*	21.2
Some college or associate degree	24.6	33.2	21.8*	25.3*
College graduate	19.3	29.4	18.2*	29.6
Employment				
Working full time	18.1	23.6	17.5*	19.0*
Working part time	25.3	28.4	23.6*	27.0
Unemployed	26.5	24.7	30.8	22.9
Other	25.1	31.0	18.8*	21.7*

Notes: Estimates for any mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

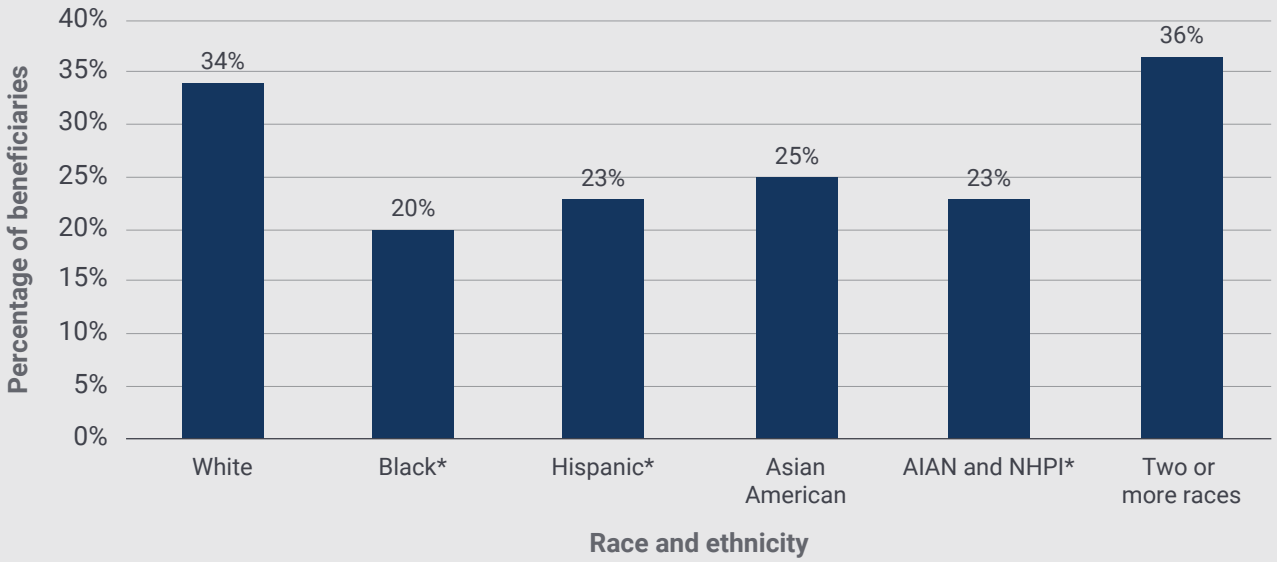
We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: SHADAC 2020.

Prevalence of any mental illness among beneficiaries across racial and ethnic groups. Medicaid beneficiaries report experiencing mental health conditions at higher rates than individuals with other forms of insurance, and rates of mental illness among Medicaid beneficiaries vary across racial and ethnic groups (Figure 2-1). Reported rates of any mental illness among Medicaid beneficiaries are highest for those who identify as white, and individuals who identify as two or more races. Beneficiaries who identify as Black, Hispanic, or American Indian, Alaska Native, Native Hawaiian, or Pacific Islander report having mental health conditions at rates significantly lower than their white counterparts (SHADAC 2021).

FIGURE 2-1. Reported Prevalence of Any Mental Illness in the Past Year among Non-Institutionalized Adults Covered by Medicaid, Age 18–64, by Race and Ethnicity, 2018



Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AIAN and NHPI combines data for respondents who identified as American Indian or Alaska Native or Native Hawaiian or other Pacific Islander and are not of Hispanic origin. White, Black, Asian American, and two or more races do not include respondents of Hispanic origin.

Estimates for any mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview.

* Difference from white beneficiaries is statistically significant at the 0.05 level.

Source: SHADAC 2021.

Effects of the COVID-19 pandemic on mental health. The COVID-19 pandemic has created additional mental health challenges for adults (Ahmad et al. 2021, Czeisler et al. 2020). From April to June 2020, symptoms of anxiety disorder and depressive disorder increased considerably in comparison with the same period in 2019. A representative survey of adults over the age of 18 conducted in June 2020 found that 40 percent of adults were struggling with mental health or substance use conditions. These conditions disproportionately affected young adults age 18–25, individuals identifying as Hispanic or Black and individuals with less than a high school education, and adults reporting less than $25,000 in household income. Rates of mental health conditions and substance use were also high among unpaid adult caregivers and essential workers (Czeisler et al. 2020). Preliminary data regarding drug overdose deaths occurring in the 12-month period leading up to September 2020 indicate that overdose deaths increased by nearly 30 percent over the prior year (Ahmad et al. 2021).

Use of mental health treatment by insurance status

Medicaid beneficiaries with mental health conditions, regardless of the severity of their illness, receive treatment at similar rates as their peers with private coverage (Appendix 2A, Table 2A-3). This includes taking prescription medication for their mental illness and receiving services at outpatient medical clinics at the same rate as adults with private coverage.

Nonetheless, beneficiaries with any mental illness received treatment in different settings than those with private insurance:

- **Inpatient psychiatric treatment.** Adults with any mental illness enrolled in Medicaid were nearly four times as likely to receive inpatient treatment for their mental health condition as those with private coverage. Medicaid beneficiaries with mild to moderate mental illness were nearly five times as likely to receive inpatient treatment as their privately insured peers. Those with serious mental illness who were enrolled in Medicaid were more than twice as likely to receive treatment in an inpatient setting than those with private coverage (SHADAC 2020).[9]
- **Outpatient treatment.** Adults with any mental illness enrolled in Medicaid were nearly three times more likely to receive treatment in an outpatient mental health center or a day treatment program than those with private coverage. But they were less likely to receive treatment in a private therapist's office. Specifically, adults with any mental illness with private coverage received treatment in a private therapist's office at nearly twice the rate of their Medicaid-enrolled peers. This was consistent for individuals with mild to moderate mental health conditions and for those with serious mental illness (SHADAC 2020).

Unmet treatment needs. Adults with any mental illness enrolled in Medicaid were more likely to report that they needed but did not receive mental health treatment or counseling in the past year than those with private coverage (Table 2-2). Moreover, Medicaid beneficiaries with serious mental illness were more than twice as likely to report that they needed but did not receive treatment than Medicaid beneficiaries with mild to moderate mental illness.

TABLE 2-2. Needed but Did Not Receive Mental Health Treatment or Counseling among Non-Institutionalized Adults Age 18–64 with Past Year Mental Illness, by Insurance Status, 2018

Condition	Percentage of adults 18–64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
Any mental illness	26.0%	30.2%	24.5%*	28.2%
Mild to moderate mental illness	18.7	22.0	18.5	17.5
Serious mental illness	47.1	49.5	44.8	55.5

Notes: Estimates for any mental illness, mild to moderate mental illness, and serious mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: SHADAC 2020.

Treatment rates across racial and ethnic groups. Among Medicaid beneficiaries, treatment rates for individuals with any mental illness vary across racial and ethnic groups (Table 2-3). In 2018, beneficiaries identifying as American Indian, Alaska Native, Native Hawaiian, or Pacific Islander reported receiving mental health treatment at the same rate as white beneficiaries. In contrast, Black beneficiaries with mental illness were less likely to receive treatment than their white peers; 52 percent of white beneficiaries reported receiving mental health treatment in the past year, while 36 percent of Black beneficiaries received treatment. When compared to white beneficiaries, similar disparities are observed for receipt of treatment among Hispanic beneficiaries and beneficiaries who report two or more races.

Some beneficiaries of color were less likely to receive treatment in certain settings than their white counterparts. Specifically, Black and Hispanic beneficiaries were less likely to receive treatment in a private therapist's office than white beneficiaries. White beneficiaries were also more likely to take a prescription medication for their mental health condition than beneficiaries who identified as Black, Hispanic, and two or more races.

TABLE 2-3. Reported Use of Mental Health Treatment among Non-Institutionalized Adult Medicaid Beneficiaries Age 18–64 with Past Year Mental Illness, by Racial and Ethnic Group, 2018

Treatment characteristics	Percentage of Medicaid beneficiaries age 18–64 in each racial and ethnic group with any mental illness					
	White	Black	Hispanic	Asian American	AIAN and NHPI	Two or more races
Received any mental health treatment in the past year	52.3%	35.5%*	35.0%*	27.2%*	51.3%	31.9%*
Received treatment in a private therapist's office	14.8	7.0*	9.4*	–	–	–
Took any prescription medication for a mental health condition	46.2	30.6*	27.5*	–	–	24.6*

Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AIAN and NHPI combines data for respondents who identified as American Indian or Alaska Native or Native Hawaiian or other Pacific Islander and are not of Hispanic origin. White, Black, Asian American, and two or more races do not include respondents of Hispanic origin.

Estimates for any mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview.

* Difference from white beneficiaries is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

Mental Health, Mortality, and Rising Rates of Suicide

Among Medicaid beneficiaries with mental health conditions, low treatment rates, the criminalization of mental illness, and stigma associated with their disease have serious health consequences. While data specific to Medicaid are not available, individuals with mental health conditions often die prematurely (Insell 2011, Parks et al. 2006). Based on mortality data from eight states, one study concluded that on average, Americans with a major mental illness die 14 to 32 years earlier than the general population. In these states, the average life expectancy for people with major mental illness ranged from 49 to 60 years (Insel 2011).

Comorbid medical conditions are often cited as the main factor contributing to shortened life expectancy for those with mental illness; however, other factors, including rising rates of suicide, also result in premature mortality (Roberts et al. 2017). (For additional information on comorbid conditions and mortality among beneficiaries with mental health conditions, see Chapter 4.) Suicide is one of the most widely acknowledged contributors to premature mortality among individuals with mental

illness (Roberts et al. 2017). It is the 10th leading cause of death for all ages in the United States, and the second leading cause of death for individuals age 10–34 (Hedegaard et al. 2020).

While there are no national statistics on suicide-related death in the Medicaid population, overall deaths by suicide increased nearly 35 percent from 1999 to 2017. Over this time period, the suicide rate among men was nearly four times the rate of suicide among women (Curtin et al. 2019). However, suicide rates grew significantly for women of all racial and ethnic groups over this time period, with the exception of those identifying as Asian, or Pacific Islander.[10] One study from Ohio found higher rates of suicide among Medicaid beneficiaries with multiple co-occurring conditions. Overall, this study found that the suicide rate among Medicaid beneficiaries (18.9 per 100,000) was higher than that of the general U.S. population (12.6 per 100,000) and in Ohio (16.3 per 100,000) (Fontanella et al. 2017).

Suicide rates vary by geography and population characteristics. For example, suicide rates tend to be higher in rural counties than in urban counties. This is true for both males and females (Hedegaard et al. 2020). Youth who identify as lesbian, gay, bisexual, or transgender also attempt suicide at higher rates than the general population (NAMI 2020a). (See Chapter 3 for additional information on suicidal thoughts and behaviors among children and youth covered by Medicaid and CHIP.)

Mental Illness and the Criminal Justice System

In many parts of the United States, the absence of a robust mental health system has resulted in the criminalization of mental illness, given that law enforcement is often the de facto mental health crisis system. When police are first responders, persons in mental health crisis are often taken into custody, rather than taken to mental health treatment centers. Law enforcement response to mental health crises often contributes to the anxiety and fear experienced by individuals in crisis. This can occur solely based on the presence of police vehicles and armed officers (SAMHSA 2020a). Such fears are well founded; from 2015–2020, one in four individuals shot and killed by police officers had a mental health condition (Hepburn 2020).

People with mental health conditions are overrepresented in the nation's prisons and jails. In 2018, an estimated 6.4 million individuals were under the supervision of the adult correctional system, including 4.4 million on probation or parole, and 2.1 million under the custody of state or federal prisons or local jails (BJS 2020). Approximately 40 percent of individuals in prison or jail have a history of mental illness, with higher rates for those in jail (44 percent) than for those in federal prison (37 percent) (BJS 2017). Among incarcerated individuals, rates of mental illness are higher among women than men (NAMI 2020b).

Most (63 percent) individuals with a history of mental illness do not receive treatment while incarcerated in prison, and fewer than half (45 percent) receive treatment while held in local jails. People of color are disproportionately affected.[11] Among those incarcerated, people of color with a mental health condition are more likely to be held in solitary confinement, to sustain injuries, and to stay in jail longer. Moreover, suicide is the leading cause of death for people held in local jails (NAMI 2020b).

Beneficiary involvement with the criminal justice system

Individuals enrolled in Medicaid are more likely to experience involvement with the criminal justice system than their privately insured peers. In 2018, one in three non-institutionalized adults with any mental illness who were enrolled in Medicaid reported that they had been arrested or booked for breaking the law at some point in their lives (Table 2-4). This is nearly double the rate of individuals with private coverage. In addition, adults with any mental illness who were enrolled in Medicaid were

more than three times as likely to report that they were on probation or parole in the past year than those with private coverage (SHADAC 2020). Due to sample size issues, we were unable to provide estimates of involvement with the criminal justice system among beneficiaries by race and ethnicity (SHADAC 2021, 2020).

TABLE 2-4. Reported Rates of Involvement with the Criminal Justice System among Non-Institutionalized Adults Age 18–64 with Past Year Mental Illness, by Insurance Status, 2018

Involvement with the criminal justice system	Percentage of adults 18–64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
Ever been arrested and booked for breaking the law				
Any mental illness	24.0%	33.7%	17.6%*	33.3%
Mild to moderate mental illness	22.9	31.2	17.3*	32.3
Serious mental illness	27.4	39.6	18.6*	35.7
On probation or parole, past year				
Any mental illness	3.1	5.8	1.8*	5.5
Mild to moderate mental illness	2.6	5.3	1.4*	5.3
Serious mental illness	4.7	7.1	3.2*	5.9

Notes: Estimates for any mental illness, mild to moderate mental illness, and serious mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: SHADAC 2020.

Forthcoming federal guidance may allow Medicaid agencies to play a larger role in community reentry. Section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) requires the Centers for Medicare & Medicaid Services (CMS) to issue guidance for demonstration waivers under Section 1115 of the Social Security Act (the Act) targeting beneficiaries leaving jail or prison. This guidance must be based on best practices to improve care transitions for Medicaid-eligible individuals leaving jail or prison. Under the SUPPORT Act, care transition services can be provided up to 30 days prerelease and may include providing education about and assistance with Medicaid enrollment, as well as providing health care services. This guidance was supposed to have been issued in October 2019; as of May 2021, it has yet to be released.

Components of a Mental Health Continuum

Appropriate mental health treatment varies with the severity of an individual's condition. As noted above, some individuals experience mild to moderate mental illness, while others have serious mental illness that substantially interferes with or limits their ability to perform one or more major life activity (e.g., eating, bathing, or dressing) or instrumental activities of daily living (e.g., maintaining a household or taking prescribed medications). Moreover, mental health conditions are often episodic and the severity of symptoms can vary over time. Adults with mental illness need access to a continuum of care, with services that vary in intensity. This includes both clinical services—such as outpatient treatment, partial hospitalization, and inpatient psychiatric treatment—and supportive services, such as peer support and supported employment (CMS 2018).

Established by the American Association for Community Psychiatry (AACP), the *Level of Care Utilization System for Psychiatric and Addiction Services* (LOCUS) describes a continuum of care, characterized by the amount and scope of resources available at each of six levels of care (AACP 2020). These range from monthly treatment for clients who are living independently with minimal support in the community to around-the-clock inpatient psychiatric care (Box 2-1).

BOX 2-1. Level of Care Utilization System for Psychiatric and Addiction Services

The *Level of Care Utilization System for Psychiatric and Addiction Services* (LOCUS) identifies six levels of care that vary in intensity. Each level includes an array of services, combining crisis, supportive, clinical, and environmental interventions, based on individual need. At each level, basic services, often referred to as crisis resolution or emergency services, should be available to all individuals regardless of the severity of their disease.

Basic services. These services can prevent the onset or limit the magnitude of morbidity associated with a preestablished disease. They should include outreach to special populations, including individuals experiencing homelessness, screening of high-risk individuals, consultation with other community providers, and use of crisis hotlines to support individuals with behavioral health conditions.

Recovery maintenance and health management (Level 1). This level of care includes treatment for clients who are living independently with minimal support in the community. Clinical services should be available up to one hour per month, and usually no less than one hour every three months.

Low-intensity community-based services (Level 2). Services at this level are for individuals in need of ongoing treatment who are living independently. Services are usually offered in clinic-based programs up to two hours per week, but no less than one hour every four weeks.

High-intensity community-based services (Level 3). This level includes intensive treatment for individuals that live independently with minimal support in the community. Treatment should occur three days per week for two to three hours per day.

BOX 2-1. (continued)

Medically monitored non-residential services (Level 4). Services at this level include intensive community-based treatment provided by a multidisciplinary treatment team for most of the day, on a daily basis. This level of care includes partial hospitalization and assertive community treatment.

Medically monitored residential services (Level 5). Services are provided in a 24-hour residential treatment setting in the community. Clinical care is available at all times and psychiatric care should be available on site or by remote communication 24 hours a day, 7 days a week.

Medically managed residential services (Level 6). This level is considered 24-hour hospital-based psychiatric care. Psychiatric, nursing, and medical services must be available at all times and treatment must be provided daily (AACP 2020).

Medicaid Coverage of Mental Health Services

State Medicaid programs are required to cover certain mental health services for adults, including medically necessary inpatient hospital services, outpatient hospital services, rural health clinic services, nursing facility services, home health services, and physician services. However, many other services important for the treatment of mental health conditions are optional, including other diagnostic, screening, preventive, and rehabilitative services; case management; and personal care services (SAMHSA 2013).

Medicaid's role in financing mental health services for adults varies considerably at the state level and many states do not offer a full complement of services (Appendix 2B, Table 2B-1).[12] Most states have gaps in mental health coverage, covering on average 12 out of 15 mental health services. There are particularly large gaps for residential services (covered by 27 states and the District of Columbia) and crisis residential services (covered by 28 states and the District of Columbia).[13,14] Supportive services, including supported employment (covered by 24 states and the District of Columbia), and skills training and development (covered by 33 states) are offered less frequently. All states cover mental health screening and assessment services, some form of outpatient mental health treatment, and inpatient psychiatric care.[15]

Access to Mental Health Providers

In addition to gaps in coverage, there are a number of other reasons Medicaid beneficiaries with mental health conditions do not receive treatment. They may have difficulty finding mental health providers—concerns about such shortages have been well documented over the past decade (Hoge et al. 2013; SAMHSA 2013, 2007). General shortages and geographic maldistribution of behavioral health providers, coupled with the unwillingness of some providers to serve individuals enrolled in Medicaid, limit access to mental health treatment (MACPAC 2016).

In addition, lack of diversity in the workforce may affect access, given that minority health professionals are more likely than white peers to treat people of color (Hoge et al. 2013). Minorities account for only 21.3 percent of psychiatrists, 6.2 percent of psychologists, 5.6 percent of

advanced practice psychiatric nurses, and 12.6 percent of social workers (Hoge et al. 2013). There is also evidence that when physicians and patients share the same race or ethnicity, patients experience improved health outcomes, such as better medication adherence (Huerto 2020). Still, differences in beliefs about culture, health, and health care may exist even when providers and patients identify as the same race or ethnicity (Hoge et al. 2013).

Because there is no single, uniform data source providing information on the U.S. mental health workforce, we examined multiple data sources to illustrate the availability of several components of the specialty mental health treatment system including: freestanding specialty mental health facilities; office-based, solo, and small group practices, comprised of psychiatrists and other mental health providers (e.g., counselors and therapists); and other providers, including community health centers. Below we describe the availability of these components of the mental health treatment system. We also discuss provider participation in Medicaid, as well as the types of services provided by the specialty mental health treatment system. Where possible, we describe availability at the state level.

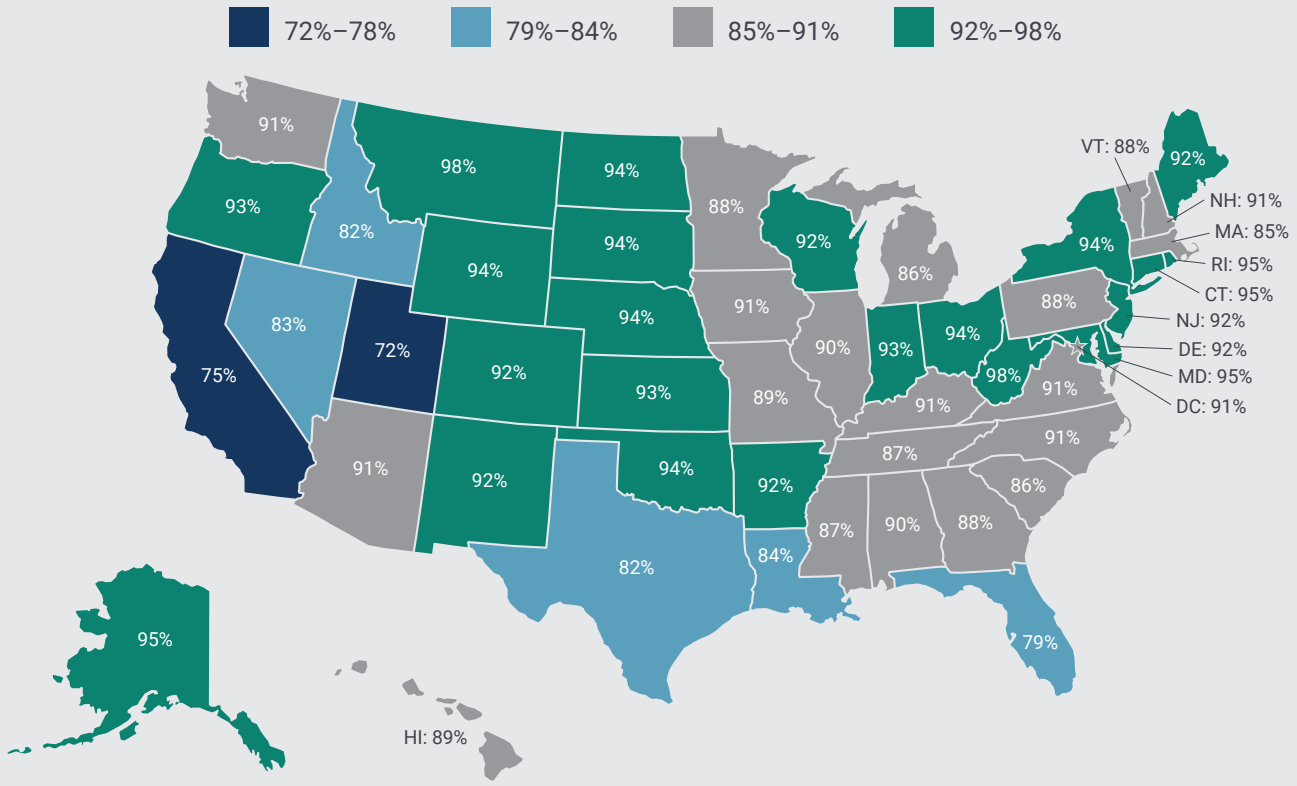
Supply of specialty mental health facilities

Using the 2018 National Mental Health Services Survey (N-MHSS), we examined the availability of specialty mental health treatment facilities and their participation in Medicaid.[16] These treatment facilities provide services ranging from outpatient mental health services, to partial hospitalization, to inpatient psychiatric services. Most commonly, these facilities offer a variety of treatment approaches, including psychotherapy, cognitive behavioral therapy, group therapy, and psychotropic medication (SAMHSA 2019b).

In 2018, there were nearly 12,000 specialty mental health treatment facilities in the United States; 89 percent of these facilities reported accepting Medicaid, which was higher than the acceptance rate for private insurance (81 percent) (SAMHSA 2019b). However, Medicaid participation varies by state, ranging from 72 percent in Utah to 98 percent in Montana (Figure 2-2).

Most specialty mental health treatment facilities report offering outpatient mental health services; of these facilities, the majority report acceptance of Medicaid (Appendix 2C, Figure 2C-1). It is worth noting that the availability of the most intensive community-based mental health services varies at the state level (SAMHSA 2019b). In addition, nearly half of specialty mental health facilities report offering on- or off-site crisis services (Appendix 2C, Figure 2C-1). However, these facilities offer intensive services—such as partial hospitalization, assertive community treatment, and residential treatment—less often than traditional outpatient services.[17]

FIGURE 2-2. Share of Mental Health Treatment Facilities Accepting Medicaid by State, 2018



Sources: MACPAC, 2020, analysis of SAMHSA 2019b.

Recovery-oriented services. Few specialty mental health treatment facilities offer supportive services, such as peer support, supported employment, and vocational rehabilitation. In 2018, one in four specialty mental health treatment facilities reported offering peer support services and nearly all these facilities reported acceptance of Medicaid (Appendix 2C, Figure 2C-2).[18] Even fewer facilities reported offering supported employment or vocational rehabilitation services.[19]

Telehealth. About 28 percent of specialty mental health facilities reported offering telehealth services and accepting Medicaid in 2018 (SAMHSA 2019b). The availability of such services varies widely across states, ranging from 3 percent of facilities in Connecticut to 71 percent of facilities in North Dakota (SAMHSA 2019b). While use of telehealth for behavioral health has increased during the COVID-19 pandemic, we do not have data to document if the number of specialty mental health facilities offering telehealth services also grew. However, given their high Medicaid participation, and the fact that all states and the District of Columbia expanded use of telehealth during the pandemic, it is likely the percentage of facilities has increased.

Crisis services and emergency psychiatric services. In 2018, 44 percent of facilities reported accepting Medicaid and having a crisis intervention team to handle acute mental health issues on- or off-site (SAMHSA 2019b). Fewer facilities offered psychiatric emergency walk-in services and accepted Medicaid (28 percent). Facilities that offered psychiatric emergency walk-in services had specially trained staff to provide services such as

crisis intervention. These services enable individuals, family members, and friends to cope with an emergency while helping the individual function as a member of the community (SAMHSA 2019b).

Certified community behavioral health clinics. The certified community behavioral health clinic demonstration (CCBHC) initially allowed eight state Medicaid programs to make enhanced, prospective payments to behavioral health clinics that meet federal standards designed to support comprehensive, high-quality, accessible care for adults with serious mental illness and children with serious emotional disturbance (SED), as well as individuals with SUD (SAMHSA 2018b). In 2020, Congress expanded the demonstration to two additional states (HHS 2020). Results from the national evaluation are pending, but initial assessments show that CCBHCs have hired additional staff, offered new services—including 24-hour mobile crisis services—and invested in health information technology to support care coordination and quality reporting (ASPE 2020, SAMHSA 2018b). Several states have taken steps to sustain this effort beyond the demonstration period, which was initially scheduled to end in 2019 and has been extended by Congress multiple times. In Missouri, the CCBHC model has led to fewer interactions with law enforcement among individuals treated by CCBHCs. Emergency department visits and hospitalizations in Missouri have also declined (Schuffman 2020).

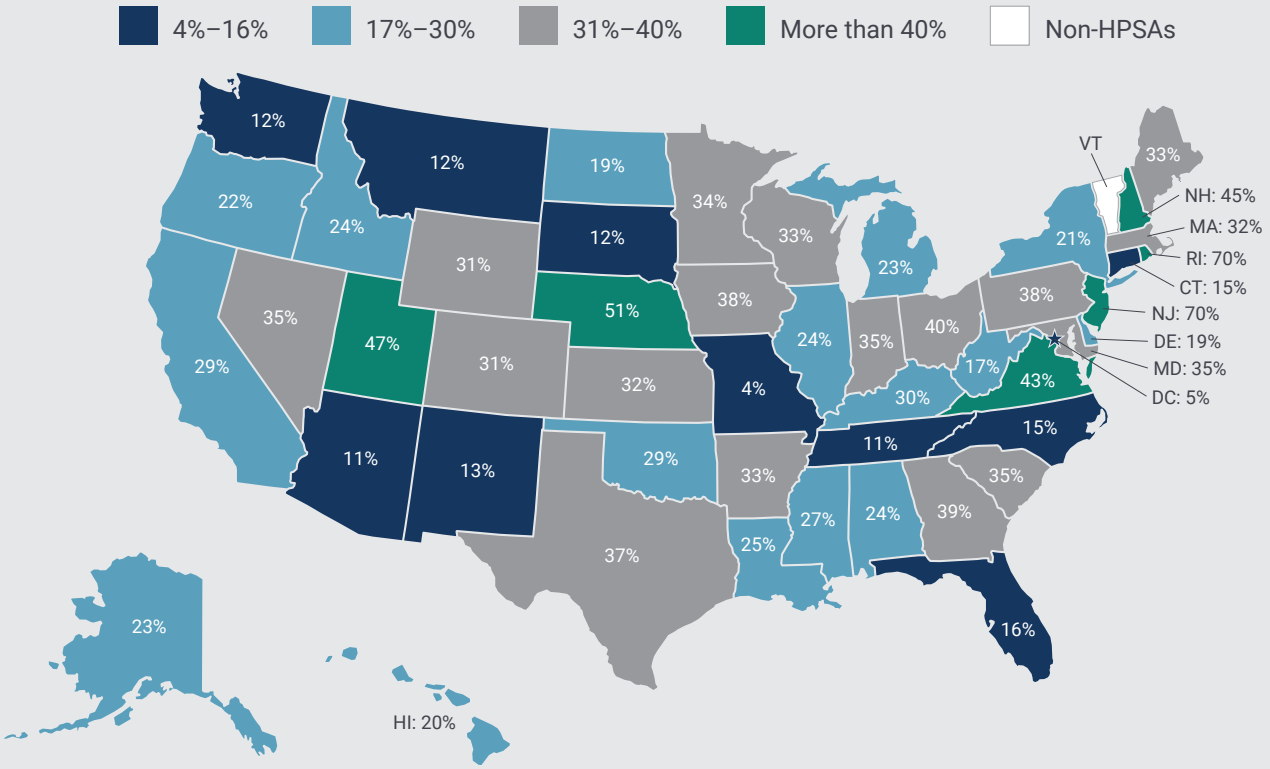
Office-based mental health services and other providers

Many different types of providers, including social workers, psychologists, psychiatrists, psychiatric nurse practitioners, and professional counselors, deliver office-based mental health services. Given data limitations, we used information from other federal programs to assess the availability of mental health providers at the state level.

The Health Resources and Services Administration (HRSA) oversees Health Professional Shortage Area (HPSA) designations, which identify geographic areas with provider shortages, including mental health provider shortage areas.[20] These designations are not specific to Medicaid but rather reflect the overall need of a geographic area. To be considered a provider shortage area for mental health, the population-to-provider ratio must be at least 30,000 to 1, or 20,000 to 1 for certain high-need communities.

As of September 2019, nearly 6,200 mental health practitioners were needed to remove all mental health HPSA designations (KFF 2019).[21] Most states (47 states) fall short of meeting even 50 percent of the estimated mental health need in these HPSAs, with a range of 4 percent in Missouri to 100 percent in Vermont (Figure 2-3) (KFF 2019).[22]

FIGURE 2-3. Share of Met Need in Designated Mental Health Professional Shortage Areas, 2019



Note: HPSA is Health Professional Shortage Area. Share of met need is the number of psychiatrists that would be necessary to eliminate the mental health HPSA in the state (based on a ratio of 30,000 to 1, or 20,000 to 1 in high-need areas).

Source: KFF 2019.

Access to office-based mental health services is also affected by provider participation in Medicaid. A recent MACPAC study found that providers are less likely to accept new patients with Medicaid than patients with other forms of insurance. Just 35 percent of psychiatrists accepted new patients enrolled in Medicaid in 2014–2015, in contrast with 62 percent accepting new patients covered by Medicare and private insurance (Heberlein and Holgash 2019).

Low Medicaid participation among psychiatrists may reflect low payment rates. One study using 2014 Medicaid claims data from 11 states found that in 10 of the 11 states, psychiatrists were paid less than primary care physicians (ranging from $1–$34) for an established patient office visit for individuals with moderate severity mental health needs (Mark et al. 2020).[23] It should be noted that the disparity in payment rates between psychiatrists and primary care physicians documented in this study appears to be inconsistent with federal mental health parity requirements set out by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343).[24] However, this study included data prior to the application of MHPAEA requirements for Medicaid, which occurred in October 2017.[25] Moreover, in many states, Medicaid physician fees are well below rates paid by Medicare and private insurance (Zuckerman et al. 2021).

Community health centers. Community health centers play an important role in the health care of Medicaid beneficiaries and a growing number are providing behavioral health services

(NACHC 2020). In 2019, community mental health centers employed nearly 13,600 full-time equivalent professionals providing mental health services. This includes a variety of mental health practitioners, such as psychiatrists, licensed clinical psychologists, licensed clinical social workers, and other licensed mental health providers. Combined, these practitioners conducted almost 12 million clinic visits in 2019 (HRSA 2020).

Federal programs to address behavioral health workforce shortages. Though not specific to the Medicaid program, several federal programs are addressing behavioral health workforce shortages. The National Health Service Corps (NHSC), overseen by HRSA, provides loan repayment or scholarships to clinicians who agree to treat patients in HPSAs. In 2020, NHSC membership included more than 16,000 clinicians who provided care to 17 million individuals. More than 60 percent of NHSC members work at community health centers. Moreover, behavioral health is a top discipline among NHSC clinicians (HRSA 2020). There is a similar loan assistance repayment program, Nurse Corps, for registered nurses, advanced practice nurses, and nurse faculty (HRSA 2021).

The American Rescue Plan Act of 2021 (ARP, P.L. 117-2) includes a number of provisions to address workforce shortages, including additional funding for training opportunities to improve the distribution and supply of the behavioral health workforce. The law includes funding increases for the NHSC ($800 million) and Nurse Corps ($200 million). It also allocates $80 million to HRSA for behavioral health training for health care professionals, paraprofessionals, and public safety officers. Such funding must be used to plan, develop, operate, or participate in evidence-informed strategies to reduce and address suicide, burnout, mental health conditions, and SUD among health care professionals. Finally, ARP provides an additional $100 million for the Behavioral Health Workforce Education Training Program, administered by HRSA, to expand access to behavioral health services through focused training.

Current Efforts to Address Behavioral Health Crises

Medicaid agencies are playing a growing role in building a coordinated continuum of behavioral health care. To ensure beneficiaries receive the right care at the right time, some states have developed crisis systems to intervene when an individual is experiencing a behavioral health crisis (Gordon 2020). Crisis systems also triage and assess individuals and connect them with the appropriate level of care (SAMHSA 2020a).

Ultimately, the goal of crisis services is to resolve behavioral health crises so more intensive services are not needed (SAMHSA 2020a). Offering such care is a key strategy to reduce inappropriate use of psychiatric hospital beds, decrease boarding in emergency departments, and reduce the need for law enforcement to respond to behavioral health crises (SAMHSA 2020a). These services help individuals, and their families and friends, cope in emergencies while helping the individual function as a member of the community (SAMHSA 2020a).

Several national and state efforts are underway to address rising rates of suicide and to ensure access to behavioral health care for individuals in crisis. The implementation of 9-8-8, a new national three-digit dialing code for a national suicide prevention and mental health crisis hotline, is scheduled for July 2022. SAMHSA has also established national guidelines for crisis care (SAMHSA 2020a). However, the role of Medicaid remains undefined in both initiatives, and CMS guidance does not address how to pay for crisis services. Below we discuss these initiatives and the degree to which state Medicaid programs currently support crisis continuums. We also discuss the need for collaboration between SAMHSA and CMS and prior congressional action to improve interagency coordination on issues related to serious mental illness.

Implementation and financing of 9-8-8

SAMHSA funds the National Lifeline, a national network of approximately 184 crisis centers linked by a toll-free number that is available 24 hours a day, 7 days a week.[26] In September 2020, the Federal Communications Commission (FCC) designated 9-8-8 as the national three-digit dialing code for a suicide prevention and mental health crisis hotline. This will go into effect by July 16, 2022, and link to the current network of crisis call centers. Designating a three-digit code for the National Lifeline is meant to send the message that addressing mental health crisis and suicide prevention are as important as medical emergencies, and will improve resources to respond to behavioral health crises at a local level (FCC 2020).

Many stakeholders are concerned that there will not be sufficient capacity and funding to meet increased demand when 9-8-8 goes live (FCC 2020).[27] In part, this is because funding for crisis hotlines is typically a state and local responsibility and the resources necessary to operationalize 9-8-8 have not been fully identified. The National Suicide Hotline Designation Act of 2020 (P.L. 116-172) requires the Assistant Secretary for Mental Health and the Assistant Secretary of Veterans Affairs to submit a joint report that details the resources. Although this report was due to Congress on April 15, 2021, as of May 2021, it had not been submitted.

There are multiple ways states may finance hotline services. The National Suicide Hotline Designation Act of 2020 allows states to assess a fee on cell phone bills to recover 9-8-8 implementation costs for state and local crisis hotlines. A similar fee supports 9-1-1 in most states (MHA and VEH 2020). As discussed below, Medicaid may play a role in supporting crisis hotlines because some states are billing Medicaid for a portion of hotline services delivered to beneficiaries.

Core crisis services

In February 2020, SAMHSA issued the *National Guidelines for Behavioral Health Crisis Care — A Best Practice Toolkit,* establishing for the first time, the three core elements of a crisis system as outlined below (SAMHSA 2020a).[28]

Regional or statewide crisis call centers. Crisis call centers connected to the National Lifeline are staffed by clinicians providing intervention services via telephone, text, or chat. Staff conduct risk assessments and engage with individuals who are in crisis or at imminent risk for suicide. They also coordinate crisis care in real time, communicating with mobile teams and providing so-called warm handoffs—the transfer of care between two members of a care team—to facility-based care if necessary.[29, 30] Ideally, call centers use real-time regional bed registry technology to connect individuals to residential or inpatient care, when needed, and employ caller ID and GPS-enabled technology to dispatch mobile teams (SAMHSA 2020a).

Crisis mobile response. Community-based mobile crisis teams operate 24 hours a day, 7 days a week, and can reach individuals in their homes, workplaces, and other community locations. They can evaluate and stabilize individuals and, if needed, take them to short-term stabilization facilities or acute care settings (SAMHSA 2020a).[31] Per SAMHSA guidelines, mobile crisis teams should include peer support specialists. In addition, they should respond without law enforcement unless special circumstances warrant the inclusion. This is needed to support true diversion from the criminal justice system (SAMHSA 2020a).

Crisis receiving and stabilizing facilities. These facilities provide short-term (less than 24 hours) observation and crisis stabilization services to all individuals outside of hospitals.[32] Ideally, these facilities offer trauma-informed and suicide-safer care, which is designed to monitor for suicide risk and intervene with specific, evidence-based approaches delivered by mental health professionals and peers with lived experience (SAMHSA 2020a). Among other things, receiving and stabilizing facilities should have dedicated first responder drop-off areas and crisis beds within a

real-time regional bed registry operated by the call center. Facilities should also coordinate ongoing care for individuals at discharge (SAMSHA 2020).

Medicaid's current role in the provision of crisis services

Although most states are using Medicaid to pay for some form of crisis services, most state crisis systems are not fully aligned with SAMHSA's national guidelines (SAMHSA 2020a, SAMHSA 2020b). For example, 46 states pay for emergency crisis services, but some states do not have crisis receiving and stabilizing facilities, or such facilities may serve only a particular region. Generally, crisis services are rarely available statewide because many states organize crisis services regionally or at the county level, and this means some communities have limited or no access to true crisis services. Where crisis receiving or stabilizing facilities do not exist, Medicaid may pay for individual practitioners to deliver stabilization services in office-based settings. Such providers likely lack the ability to treat all patients, including walk-ins and first responder drop-offs, and may only offer services during business hours. Many states (35) also pay for some form of mobile crisis services, but payment is often limited to the time the crisis team is with the beneficiary. Travel time to and from the beneficiary is not a billable service (SAMHSA 2020b).

The full continuum of crisis services cannot be supported solely by Medicaid, so many states use other state revenues, county and local monies, and donations and investments by insurers and private health care organizations to support such services (Gordon 2020). However, Medicaid programs in a handful of states are playing a growing role in supporting the crisis continuum (Box 2-2). It is important to note that even in these innovator states, crisis services may not always be provided in accordance with SAMHSA's guidelines. For example, states may operate a crisis hotline, but the hotline may lack caller ID and GPS capabilities to efficiently coordinate with mobile crisis teams.

BOX 2-2. Medicaid Support of Behavioral Health Crisis Services in Selected States

Arizona. Arizona's behavioral health crisis system is operated by the state Medicaid agency and administered by three regional behavioral health authorities that contract directly with community behavioral health providers. Crisis services include three regional 24-hour hotlines, mobile crisis response teams, and facility-based crisis stabilization. In fiscal year (FY) 2020, Arizona spent $245 million on these services. Medicaid funded the majority ($217 million) of these services while state and local funds were used to serve individuals who were not eligible for Medicaid ($28 million) (Gordon 2020). The state also generates funding for its crisis hotlines by billing Medicaid for crisis intervention and emergency management services rendered by mental health providers employed by the hotlines (AHCCCS 2020).

Georgia. In 2009, the U.S. Department of Justice sued the state of Georgia for violating the Americans with Disabilities Act of 1990 (ADA, P.L. 101-336) and the 1999 Supreme Court's decision in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), noting that people with serious mental illness or intellectual and developmental disability were stuck in institutional settings due to inadequate community-based care. Among other things, the settlement agreement gave Georgia roughly five years to integrate 9,000 people with serious mental illness into the community. This group included

BOX 2-2. (continued)

people in state hospitals, those with frequent emergency room or hospital stays, and those who were homeless or released from the criminal justice system. The settlement agreement also required the state to provide certain services, including mobile crisis teams and assertive community treatment (Hepburn 2021).

The Georgia Department of Behavioral and Developmental Disabilities operates the state's behavioral health crisis system which includes mobile crisis teams, statewide crisis hotlines, and crisis stabilization centers that include walk-in care and temporary observation. The state's crisis hotline has the capability to use GPS to dispatch mobile crisis teams (Gordon 2020). The state has also incorporated a psychiatric bed registry into its crisis continuum that operates in real time. Recently, the state expanded its bed registry to include 72-hour crisis residential programs and detoxification beds (Hepburn 2021). In FY 2019, Medicaid supported roughly 20 percent of costs for the state's crisis continuum ($12.8 million), while remaining costs were covered by state general funds ($45.4 million) (Gordon 2020).

The costs of implementing a crisis continuum are significant, but crisis services can lead to cost savings by reducing inpatient hospital and emergency department use, diverting individuals from the criminal justice system, and fostering more appropriate use of community-based behavioral health care (SAMHSA 2020a). The crisis system in Maricopa County, Arizona, which includes all three core components, led to an estimated $260 million reduction in inpatient spending after accounting for a $100 million investment in the crisis continuum (Gordon 2020).

Recently, Congress has taken several actions to increase funding for crisis services:

- The Consolidated Appropriations Act of 2021 (P.L. 116-260) includes a new 5 percent set-aside in SAMHSA's Mental Health Services Block Grant for evidence-based crisis care programs to address the needs of individuals with serious mental illness and children with SED.[33]
- Section 2701 of ARP appropriated $1.5 billion under the Mental Health Services Block Grant. States have until September 30, 2025, to spend these funds. These increases to the block grant are in addition to funding previously appropriated by Congress for FY 2021.
- Section 9814 of ARP offers an 85 percent federal matching assistance percentage (FMAP) for certain community-based mobile crisis intervention services offered under a state plan or a Medicaid waiver. The enhanced FMAP is available for five years, beginning in March 2022.[34] Congress also appropriated $15 million for state planning grants to develop a state plan amendment or waiver program under Sections 1115, 1915(b), or 1915(c) to provide qualifying mobile crisis intervention services.

Medicaid guidance to support crisis care and similarly structured services

Current federal guidance does not fully address how states can use Medicaid to support a crisis continuum. Below we discuss various Medicaid and CHIP authorities and identify areas where additional guidance to states would be useful.

Crisis hotlines and bed registries. CMS guidance aimed at improving systems of care for adults with serious mental illness and children with SED outlines how states can use existing authorities to support innovative service delivery systems for these populations. CMS also offers a separate demonstration opportunity to increase the availability of community-based mental health care, including non-hospital-based and non-residential crisis stabilization services. In paying for a full continuum of care, states are eligible to receive federal matching funds for mental health services provided in institutions for mental diseases (CMS 2018).

Current CMS guidance notes that states may be able to access Medicaid administrative match for crisis call centers as long as they use an appropriate methodology to allocate costs to Medicaid. However, it does not describe what constitutes an appropriate methodology, instead referring states to guidance on tobacco quitlines issued in 2011 (CMS 2018).[35, 36] Given that so few states currently use Medicaid to support crisis hotlines, it would be helpful for CMS to further advise states on how to properly allocate a portion of crisis hotline costs to Medicaid. Methods for cost allocation could include conducting a survey of crisis hotline callers to determine Medicaid eligibility (CMS 2018, 2011).

Current CMS guidance also indicates that states may be able to obtain an enhanced administrative match of up to 90 percent under Medicaid Information Technology Infrastructure (MITA) 3.0 to help support the crisis continuum in several ways. First, enhanced funding under MITA 3.0 may be used to establish crisis call centers to connect beneficiaries with treatment and develop technologies to link mobile crisis units to beneficiaries with serious mental illness. Such funding may also be used to develop capacity to use a bed registry to track the real-time availability of providers and to improve data sharing between the criminal justice system and specialty mental health service providers (CMS 2018).

Although CMS guidance indicates MITA funding may be used to support crisis systems, the current MITA framework does not address these types of projects. MITA planning tools and processes specific to behavioral health activities have not been updated since 2008 when they were created by SAMHSA and CMS with the goal of facilitating coordination, cooperation, and interoperability among state Medicaid and behavioral health agencies (CMS 2008).

Additional guidance regarding Medicaid's role in supporting hotlines and bed registries is needed. In anticipation of 9-8-8 implementation in July 2022, states are beginning to consider how to fund these services. As of May 2021, bills have been introduced in 20 states to fund local crisis hotlines in the 9-8-8 network (RI International 2021). In Utah, legislation was recently enacted requiring the Medicaid agency to submit a waiver or state plan amendment to allow payment for 9-8-8 services provided to Medicaid enrollees (Utah SB0155: 988 Mental Health Crisis Assistance (enacted March 11, 2021)).

Mobile crisis services. Current CMS guidance identifies existing authorities, such as those under the state plan, that could be used to pay for crisis stabilization services, including screening, assessment, and treatment services for beneficiaries in crisis (CMS 2018). However, states continue to face challenges in developing payment methodologies for mobile crisis services, because two components of mobile crisis services—provider costs for outreach and team supervision—may not be covered under the Medicaid state plan (Wilkniss 2020, CMS 2018). Additional CMS guidance would be useful to assist states in braiding funding among state agencies to support crisis-related outreach and engagement activities for which Medicaid cannot pay for. Moreover, guidance could further clarify whether states can pay for outreach and engagement activities under a Section 1115 demonstration or other Medicaid authorities.

CHIP health services initiatives

Additional CHIP guidance to states could also address how to pay for a crisis continuum for children. For example, CHIP allows states to use a

limited amount of CHIP funding to implement health services initiatives (HSIs) focused on improving the health of eligible children (§ 2105(a)(1)(D)(ii) of the Act).[37] Specifically, a state may use up to 10 percent of its total CHIP spending for certain allowable administrative activities such as outreach and HSIs after it covers all other CHIP state plan administrative expenses (§ 2105(c)(2)(A) of the Act). Permissible HSI activities include public health programs or the provision of certain services, including preventive care and other interventions, to improve the health of low-income children eligible for CHIP or Medicaid as well as other low-income children. To reiterate, although HSIs should have a direct impact on the health of low-income children, they may also serve other children (MACPAC 2019c, CMS 2017).[38] This authority is underutilized; only 27 states have an approved HSI.[39]

Some states use HSIs to support ongoing community needs to respond to individuals in crisis and various public health needs. For example, in 2019, 12 states used HSIs to support poison control centers (MACPAC 2019c).[40] Arkansas and California have used HSI funding for over 10 years to support such activities. Massachusetts uses HSI funding to support child abuse and neglect hotlines.

Other HSIs focus on particular populations or addressing acute public health issues, such as the opioid crisis. In 2016, Oklahoma used HSI funding to purchase naloxone rescue kits for youth at risk of opioid overdose in high-need counties, and in 2017, New York used HSI funding to train school staff to effectively administer medication used to treat an opioid overdose (MACPAC 2019c).

HSIs can also be used to fund public health initiatives to support the crisis continuum, including crisis hotlines, mobile crisis services, crisis receiving and stabilizing facilities, and other suicide prevention initiatives. To date, however, there has been relatively little guidance on the appropriate use of HSIs.[41]

Coordinating federal programs

Improving access to crisis services requires effective coordination between CMS and SAMHSA. However, a 2014 report issued by the U.S. Government Accountability Office (GAO) highlighted the lack of coordination among federal programs that serve individuals with serious mental illness. This was documented in several areas, including failure to call meetings of the Federal Executive Steering Committee for Mental Health, which is charged with coordination across the federal government. Moreover, GAO found that agencies relied on program-level staff for coordination, which, they argued, was important, but could not take the place of higher-level coordination. GAO noted that the absence of higher-level leadership hindered the federal government's ability to develop an "overarching perspective" of programs supporting individuals with serious mental illness. Without stronger leadership from the U.S. Department of Health and Human Services (HHS), GAO noted, it was difficult to determine whether there are gaps in services (GAO 2014).

GAO recommended that HHS establish a mechanism to facilitate interagency coordination across programs that support individuals with serious mental illness. However, HHS disagreed with this recommendation, noting that because Congress allocates specific programs to SAMHSA, that coordination should include coordination at the congressional level (GAO 2014).

These findings prompted congressional action to improve coordination among programs that serve individuals with serious mental illness. Specifically, as part of the 21st Century Cures Act of 2016 (Cures Act, P.L. 114-255) Congress established an Assistant Secretary for Mental Health and Substance Use within HHS. This law directed the Assistant Secretary, in addition to overseeing SAMHSA, to do the following: promote the dissemination of research findings and evidence-based practices; monitor and evaluate grants; collaborate with other federal departments to improve care for special populations, including

veterans and homeless individuals; and improve recruitment and retention of mental health and SUD professionals.

The Cures Act also mandated the creation of an Interdepartmental Serious Mental Illness Coordinating Committee to enhance coordination across federal agencies to improve service access and care delivery for people with serious mental illness or SED. This committee includes members from several federal agencies and departments, including CMS, as well as mental health providers and individuals with lived experience. In December 2017, the committee issued a major report to Congress with various recommendations, including defining and implementing a national standard for crisis care. SAMHSA's national guidelines discussed earlier in this section were largely informed by this report, as were the agency's 15 years of experience in funding the National Lifeline (ISMICC 2017). Since the publication of the 2017 report, the committee has continued to meet, most recently in September 2020.

Recommendations

In this report, the Commission makes two recommendations to address the needs of Medicaid and CHIP beneficiaries experiencing a behavioral health crisis. These recommendations serve as an important first step in providing states with the appropriate guidance and technical assistance to leverage Medicaid and CHIP to support state crisis systems.

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.

Rationale

The role Medicaid and CHIP can play in supporting state and local crisis continuums needs to be further defined. Subregulatory guidance could further clarify how Medicaid and CHIP can be used to pay for the three core components of a behavioral health crisis continuum: (1) regional or statewide crisis call centers that coordinate in real time; (2) mobile crisis response; and (3) crisis receiving and stabilizing facilities. At a minimum, guidance should:

- address how Medicaid and CHIP can support the implementation of 9-8-8, the national three-digit dialing code for a national suicide prevention and mental health crisis hotline;
- address how states can design a crisis continuum to support the needs of children, youth, and families, including how to use the Medicaid state plan and CHIP HSIs to support the crisis continuum;
- explain how Medicaid administrative funding and the MITA 3.0 framework can be used to establish or enhance regional or statewide crisis call centers that coordinate in real time;
- include preprint templates to simplify state access to Medicaid and CHIP funding for crisis services, including administrative funding under MITA 3.0 and funding under the state plan;
- identify policies and practices to promote evidence-based suicide risk screenings and assessments and the provision of trauma-informed and culturally competent care;
- discuss the need for a multipayer approach to fund crisis services, including Medicaid, Medicare, and commercial insurers, as well as the role of federal block grants, state general funds, and local funding;
- identify how states can pay for outreach and engagement activities associated with crisis services, including combining funding streams

from various agencies, or using Medicaid authorities outside of the state plan;

- discuss how to meet the unique needs of urban, rural, and frontier communities, including how telehealth can be used to ensure access to crisis care; and
- include recent examples from innovator states.

In developing new guidance, the Secretary should invite the participation of other relevant HHS agencies, including but not limited to the Administration for Children and Families (ACF). Given its role in 9-8-8 implementation, the Secretary should also consult with FCC.

The Commission recognizes that significant improvements to state and local behavioral health systems are needed to address high rates of unmet mental health need among adult beneficiaries as well as children and adolescents covered by Medicaid and CHIP. Providing states with the appropriate guidance to leverage Medicaid and CHIP to support state crisis systems is an important first step to address unmet mental health need and enable real-time access to behavioral health care for beneficiaries of all ages. Moreover, such guidance could play a critical role in advancing state efforts to address disparities in mental health treatment access among communities of color.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid and CHIP spending. Depending upon how states respond to guidance by providing additional or different services, costs to the federal government could be affected. The extent to which spending will increase (due to more services being provided) or decrease (by diverting care from more expensive settings) is difficult to predict.

States. This recommendation would improve state capacity to address the needs of Medicaid and CHIP beneficiaries with behavioral health conditions, reducing a barrier to the expansion of a real-time crisis continuum. Providing guidance to state Medicaid and CHIP officials and other relevant agencies could help them overcome barriers to designing and implementing a crisis continuum that responds to behavioral health crises in real time.

Beneficiaries. To the degree that additional federal guidance supports states' ability to implement new or improved crisis services, it could enhance access to community-based behavioral health services and divert beneficiaries experiencing a behavioral health crisis from inpatient and emergency department settings as well as from the criminal justice system. These gains could be particularly important for beneficiaries of color who are generally less likely to receive mental health treatment than their white counterparts (SHADAC 2021).

Plans and providers. There would be no direct effect on plans and providers; however, additional guidance could assist states in setting clear expectations for plans and providers to ensure access to crisis services.

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.

Rationale

Additional subregulatory guidance is necessary but not sufficient to help states use Medicaid and CHIP to expand access to the full behavioral health crisis continuum. Support for the planning and implementation or enhancement of crisis hotlines, mobile crisis services, and crisis stabilization centers is needed, particularly in light of 9-8-8 implementation.

Dedicated planning efforts are needed to coordinate multiple state agencies and delivery systems involved in behavioral health care and to support collaboration with law enforcement and criminal justice agencies. Technical assistance and planning opportunities could assist states in streamlining systems and identifying the appropriate Medicaid authorities to support the crisis continuum. Technical assistance should be structured to facilitate both state-to-state learning opportunities, as well as individual technical assistance tailored to state-specific needs. State-to-state learning opportunities could be modeled after the Medicaid Innovation Accelerator Program, which used a variety of approaches to advance state efforts in selected program areas. These learning opportunities could disseminate best practices and lessons learned and serve as a forum for cross-state learning.

In addition, states would benefit from individualized technical assistance to support the design and implementation, or enhancement, of the crisis continuum. This should include technical support on how to use relevant Medicaid and other authorities, including the state plan, administrative funding, Section 1915(b) waivers, and the MITA 3.0 framework. CMS and other federal partners should encourage the involvement of state officials representing Medicaid, behavioral health, child welfare, and public safety and criminal justice agencies as needed to ensure the engagement and buy-in of key decision makers. Moreover, such assistance could help states consider how to combine funding streams from various agencies to achieve broader objectives, such as:

- reducing avoidable emergency department and inpatient hospital use for behavioral health conditions;
- eliminating barriers or mechanisms (e.g., state law, Medicaid state plan, or state budget restrictions) that prevent or restrict a state from investing in an appropriate and necessary crisis continuum;
- increasing use of non-hospital-based behavioral health services; and
- addressing provider capacity to offer evidence-based behavioral health care that is trauma-informed and culturally competent.

The Secretary should consider the use of existing federal grant programs, such as the Mental Health Services Block Grant, to support state planning efforts. Planning support is needed to help state behavioral health agencies dedicate staff time to engage relevant partners, including state Medicaid agencies, and develop a coordinated plan to address the behavioral health needs of beneficiaries and their families. Under current Mental Health Services Block Grant requirements, states must submit a plan to SAMHSA every two years explaining how they will use block grant funds to provide comprehensive community mental health services to adults with serious mental illness and children with SED (42 U.S. Code § 300x-1). This plan must be approved by the Secretary, who should consider whether such a plan is comprehensive if it does not include the active participation and input of the state Medicaid agency.

As with the first recommendation, the Secretary should work with other relevant agencies as needed, including but not limited to ACF and FCC, when providing technical assistance.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid and CHIP spending.

States. This recommendation would improve state capacity to address the needs of Medicaid and CHIP beneficiaries with behavioral health conditions, reducing a barrier to the expansion of a real-time crisis continuum. Providing technical assistance to state Medicaid and CHIP officials and other relevant agencies could help them overcome barriers to designing and implementing a crisis continuum that responds to behavioral health crises in real time.

Beneficiaries. To the degree that planning and technical assistance support states' ability to implement new or improved crisis services, this assistance could improve access to community-based behavioral health services and divert beneficiaries in crisis from inpatient and emergency department settings as well as from the criminal justice system. These gains could be particularly important for beneficiaries of color who are generally less likely to receive treatment than their white counterparts (SHADAC 2021).

Plans and providers. This has no direct effect on plans and providers; however, technical assistance and planning opportunities could help more states set clear expectations for plans and providers to ensure access to crisis services.

Next Steps

In the course of the Commission's work, several areas for further inquiry have emerged. First, the Commission is concerned about the high rates of involvement with the criminal justice system among Medicaid beneficiaries with mental health conditions. We expect future work to examine the health care needs of beneficiaries who have come into contact with the criminal justice system, the behavioral health services accessible to those leaving correctional settings, and strategies to ensure Medicaid or CHIP enrollment upon release for eligible individuals. This work will also examine linkages between behavioral health outcomes for children and youth and beneficiary involvement with the juvenile justice system.

The Commission is also interested in gaining insight into the availability of home- and community-based services (HCBS) for beneficiaries with behavioral health conditions. Future work will examine the behavioral health care needs of beneficiaries who would benefit from such services and barriers that states encounter when designing HCBS for beneficiaries with significant behavioral health conditions. Moreover, the Commission plans on examining whether existing federal authorities are suited to serving beneficiaries with significant impairment resulting from their behavioral health condition.

The Commission is also concerned about high rates of suicide and attempted suicide among individuals that identify as lesbian, gay, bisexual, or transgender. The Commission will examine the health care needs of these beneficiaries, the challenges they experience in accessing services, and state strategies to ensure access to care.

Finally, the Commission will continue to monitor states' ability to offer a continuum of mental health care that is aligned with SAMHSA guidelines. The recommendations offered in this report serve as a first step in improving access to care for beneficiaries with mental health needs. In accordance with ARP, the availability of enhanced FMAP for mobile crisis services offers states an opportunity to improve the availability of mobile crisis services. As states increase their activity in this area, the Commission will continue to monitor their successes and challenges.

Endnotes

[1] The ADA extends protections to individuals with a mental health condition that "substantially limits" one or more major life activities (e.g., bipolar disorder, schizophrenia, major depression) (42 USC § 12102).

[2] The *Olmstead v. L.C.* ruling was based on two conclusions. First, that institutionalization of individuals with disabilities able to live in community settings perpetuates the unwarranted assumption that such persons are unable to live in a community. Second, that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment" (119 S. Ct. 2176 (1999)).

[3] The NSDUH estimates of any mental illness and serious mental illness are generated from a prediction model created by clinical interview data collected for a subset of adult NSDUH respondents who completed an adapted version of the Structured Clinical Interview for DSM-IV-TR Axis I Disorders and was differentiated by level of functional impairment based on the Global Assessment of Functioning Scale. This assessment includes diagnostic modules that assess mood, anxiety, eating, impulse control, substance use, and adjustment disorders, as well as psychotic symptoms screening. The assessment does not include modules assessing adult attention deficit hyperactivity disorder, autism spectrum disorders, schizophrenia, or other psychotic disorders; however, the assessment does include a psychotic symptom screen (SAMHSA 2019a).

[4] Estimates for any mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main NSDUH interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age (SAMHSA 2019a).

[5] Estimates for mild or moderate mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main NSDUH interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age (SAMHSA 2019a).

[6] Less than substantial impairment is defined based on clinical interview Global Assessment of Functioning scores of 50 or less (SAMHSA 2019a).

[7] Estimates for serious mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main NSDUH interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

[8] Substantial impairment is defined based on clinical interview Global Assessment of Functioning scores of 50 or less (SAMHSA 2019a).

[9] The institutions for mental diseases (IMD) designation, which is unique to Medicaid, is defined in the Social Security Act (the Act) as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. These include a variety of residential and inpatient facilities providing mental health and SUD services. Even though federal statute largely prohibits payments to these facilities, in 2018, nearly all states made payments for services provided in IMD settings via one or more of the following statutory exemptions: exemptions related to older adults and children and youth; demonstration waivers under Section 1115 of the Act; a state plan option; and in managed care arrangements under certain conditions (MACPAC 2019b).

[10] The largest increase in suicide rates occurred for American Indian or Alaska Native females (139 percent increase). Suicide rates among American Indian and Alaska Native males grew by 71 percent over the same time period. It is likely that suicide rates for individuals identifying as American Indian, Alaska Native, and Pacific Islander are undercounted because they are sometimes misclassified to other race and ethnicity groups. This underestimation is also common among Hispanic persons (Curtin et al. 2019).

[11] In 2016, the incarceration rate of Black men was more than six times greater than that of white men. The incarceration rate of Black women was nearly double that of white women (MHA 2021).

[12] To determine what services are covered by states, staff reviewed Medicaid state plans, provider manuals, enrollee handbooks, fee schedules, Section 1115 and 1915(b) waivers, Section 1915(c) waivers, and other publicly available documents. We used this documentation to align state service descriptions with 15 clinical and supportive mental health services. State definitions of mental health services are not standardized and vary widely; as such, MACPAC's categorization of state-level coverage approximates the closest service description, which does not fully align with SAMHSA's definitions of crisis services. In part, this reflects the lack of an official Medicaid definition for crisis services (SAMHSA 2020b).

[13] For other populations, such as individuals with developmental disabilities, employment supports are typically covered under Section 1915(c) waivers. However, according to our analysis, few states use this authority to provide services to adults with mental illness.

[14] Gaps in coverage of residential services may reflect the IMD exclusion, especially in states where most mental health treatment facilities are considered IMDs.

[15] In order to determine state coverage policies for all 50 states and the District of Columbia, MACPAC analyzed Medicaid state plans, provider manuals, enrollee handbooks, fee schedules, Section 1115 and 1915(b) waivers, Section 1915(c) waivers, and other publicly available documents (Appendix 2, Table 2B-1).

[16] The N-MHSS, administered by SAMHSA, is an annual survey that collects data on the location, characteristics, and utilization of mental health treatment services for all known specialty mental health treatment facilities in all 50 states and the District of Columbia.

[17] Facilities may offer multiple and different services; therefore, the percentage of facilities accepting Medicaid is not necessarily indicative of the share of facilities that accept Medicaid payment for a specific service. For example, a provider offering two services, partial hospitalization and psychosocial rehabilitation, may report accepting Medicaid, but the state Medicaid program may only cover one of these services.

[18] Mental health peer support services are delivered by consumers of mental health services and include mental health treatment or support services (e.g., social clubs, peer support groups) and other organized activities such as peer-driven consumer satisfaction evaluations of mental health services (SAMHSA 2018a).

[19] Supported employment includes services such as assisting individuals with finding work; assessing individuals' skills, interest, and attitude relevant to work; providing training; and providing work opportunities. Vocational rehabilitation includes assistance with job seeking and assessment and enhancement of work-related skills, attitudes, and behavior (e.g., writing a resume, taking part in an interview). It also includes providing patients with on-the-job experience and transitional employment (MACPAC 2019b).

[20] There are three categories of HPSA designations: primary medical, dental, and mental health. These designations are determined based on the number of providers in a geographic area relative to the population (HRSA 2020). They may be specific to any of the following:

- a geographic area, where it is determined a shortage of providers exists for an entire population within a defined geographic area;
- a population group, where it is determined there is a shortage of providers for a specific population group within a defined geographic area; or a facility, including correctional facilities or state psychiatric hospitals with a shortage of psychiatric professionals. Certain facilities are automatically designated as HPSAs by HRSA, including federally qualified health centers (FQHC) and FQHC look-a-likes, Indian Health Service facilities and tribal hospitals, dual-funded community health centers or tribal clinics, and CMS-certified rural health clinics that meet the National Health Service Corps site requirements (HRSA 2020).

[21] The majority of these designations are specific to a facility, while fewer HPSAs are designated for entire geographic areas or specific population groups within a defined area (HRSA 2020).

[22] The percentage of met need was calculated by dividing the number of psychiatrists available to serve the population of area, group, or facility, by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1, or 20,000 to 1 in high-need areas) (KFF 2019).

[23] This analysis only reflects non-facility claims.

[24] MHPAEA requires that provider payment rates for the treatment of behavioral health conditions be based on criteria that are comparable to the criteria for setting payment rates for medical providers and applied more stringently. CMS guidance further notes that disparities in provider payment can lead to parity violations (CMS 2016).

[25] Mandatory compliance with such requirements did not take effect until October 2017.

[26] Using the caller's area code, calls to the National Lifeline are routed to the closest certified local crisis center. If the call center is overwhelmed, the system automatically routes callers to a backup center. The National Lifeline network is staffed with trained counselors who assess callers for suicide risk, provide crisis counseling and crisis intervention, engage emergency services as needed, and offer referrals to behavioral health care (FCC 2020).

[27] In the final rule, the FCC indicated that these issues fall outside of the agency's jurisdiction, and that other federal partners are aware of the effects of 9-8-8 on community-based crisis capacity (FCC 2020).

[28] Other elements of a system of crisis care include short-term residential treatment facilities and peer-operated respite programs (SAMHSA 2020a).

[29] Tracking the status and disposition of referrals to treatment is also needed, including requirements for service approval and transportation. Best practices for operating crisis call centers include use of real-time bed registry technology that includes the number of beds in crisis stabilization programs and private psychiatric hospitals (SAMHSA 2020a).

[30] SAMHSA does not define what a warm handoff entails, but the Agency for Healthcare Research and Quality (AHRQ) notes that a warm handoff is a transfer of care between two members of a health care team. Such handoffs occur in front of the patient, and if applicable, their family. This transparency gives patients and their families an opportunity to ask questions about their care as they are transitioning from one service to another (AHRQ 2017).

[31] Essential functions of mobile crisis services including screening, assessment, de-escalation and resolution, peer support, coordination with medical and behavioral health services, and crisis planning and follow-up. Services are delivered in a timely manner by teams that include a licensed clinician capable of assessing the needs of individuals in crisis. These teams are equipped to transition individuals to facility-based care if warranted. Best practices also indicate peers should be incorporated into crisis teams and schedule outpatient follow-up to support ongoing care. Finally, teams should respond without law enforcement in order to support true diversion from the criminal justice system (SAMHSA 2020a).

[32] These facilities must accept all referrals and not require medical clearance prior to admission. Assessment and support for medical stability occurs while the individual is at the facility, along with services to address mental health and substance use crisis, as well as the capacity to assess physical health needs and deliver care for minor physical health concerns with the ability to transfer the individual to another facility if needed. Facilities should be staffed with a multidisciplinary team including psychiatrists or psychiatric nurse practitioners, nurses, licensed clinicians, and peers. Facilities must offer walk-ins and first responder drop-offs. Facilities must be able to screen for suicide risk, complete comprehensive suicide assessments and planning when clinically indicated, and screen for violence risk. Facilities should also offer some form of intensive support beds with a partner program and coordinate connection to ongoing care (SAMHSA 2020a).

[33] The set-aside will be funded by $35 million of the $96 million increase in SAMHSA funding over FY 2020, $83 million of which is designated for mental health programs. The Mental Health Services Block Grant is a non-competitive formula grant awarded to all 50 states, the District of Columbia, the territories, and 1 tribal entity to provide community mental health services. Among other requirements, states must use this grant to target certain populations, including children with emotional disorders and adults with serious mental illness.

[34] Enhanced FMAP must be used to supplement, and not supplant, the level of state funds expended for such services. To qualify for enhanced FMAP, mobile crisis services must be offered outside of a hospital or facility and be available 24 hours a day, 365 days a year, and must respond to crises in a timely manner. Mobile crisis services must be delivered by a multidisciplinary team that includes at least one behavioral health professional capable of conducting an assessment of an individual in crisis in accordance with state law. Other individuals, including peer support specialists, nurses, and social workers, may also provide services via a mobile crisis team. Where appropriate, mobile crisis providers must also provide screening and assessment, stabilization, and de-escalation services, and offer coordination with and referrals to health, social, and other services as needed. Team members must be trained in trauma-informed care, de-escalation strategies, and harm reduction.

[35] Tobacco quitlines follow evidence-based protocols and are considered an allowable Medicaid administrative activity for the "proper and efficient" administration of the state plan, to the extent that they provide support to beneficiaries. In order for states to claim such expenditures as an administrative cost at the 50 percent federal Medicaid matching rate, such claims may not duplicate costs that have been, or should have been, paid through another source. States can only claim Medicaid matching funds to the degree that the quitline serves Medicaid beneficiaries as documented using several permissible methods (CMS 2020b).

[36] As of 2015, 16 states (Alabama, Arizona, California, Colorado, Connecticut, Georgia, Iowa, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Montana, North Carolina, Oklahoma, and Texas) received Medicaid funding to support their tobacco quitlines (NAQC 2015).

[37] Federal rules define HSIs as activities that protect the public health, protect the health of individuals, improve or promote a state's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children, including targeted low-income children and other low-income children (42 CFR 457.10).

[38] CHIP HSIs may be used for a number of activities. Permissible activities include public health programs or the provision of certain services, including preventive care and other interventions, to improve the health of low-income children eligible for CHIP or Medicaid, and other low-income children. Although HSIs should have a direct impact on the health of low-income children, they may also serve other children (CMS 2017). Under the CHIP HSI option, states may use part of their annual allotments and receive the federal CHIP matching rate for expenditures associated with HSIs. Funding for HSIs is subject to the CHIP 10 percent administrative cap.

[39] In 2020, 24 states had not adopted an approved HSI; 25 states had approved HSIs; 15 states had multiple initiatives. In some cases, states may choose not to claim CHIP funds for an approved HSI.

[40] Arkansas, California, Indiana, Iowa, Maryland, Michigan, Nebraska, New Jersey, New York, Oregon, Washington, and Wisconsin use CHIP HSIs to support poison control centers (MACPAC 2019c).

[41] In 1997, the Health Care Financing Administration (the prior name of CMS) issued guidance on implementing CHIP, including guidance on HSIs (HCFA 1997). This guidance focused on what activities could be included in the 10 percent administrative cap and how the cap would be calculated (HCFA 1997). In 2017, CMS issued subregulatory guidance on HSIs that addressed general questions about what activities or populations could be included and highlighted steps states would need to take to implement HSIs focused on lead poisoning prevention (MACPAC 2019c).

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Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on access to behavioral health services for adults. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendations 2.1 and 2.2 on April 9, 2021.

Behavioral Health Services for Adults

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.

Yes:	Bella, Barker, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes

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.

Yes:	Bella, Barker, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes

APPENDIX 2A: Prevalence and Treatment Rates Among Non-Institutionalized Adults with Mental Health Conditions

TABLE 2A-1. Reported Prevalence of Mild or Moderate Mental Illness in the Past Year among Non-Institutionalized Adults Age 18–64, by Demographic Characteristics, 2018

Demographic characteristics	Percentage of adults 18–64 with mild or moderate mental illness	Percentage of adults age 18–64 in each coverage category with mild or moderate mental illness		
		Medicaid	Private coverage	Uninsured
Total	**15.6%**	**19.4%**	**14.5%**	**15.3%**
Age				
18–25	18.4	18.7	19.0	16.5
26–34	19.1	22.0	18.6*	17.7*
35–49	14.9	20.3	13.9*	13.1*
50–64	12.4	16.1	10.5*	14.3
Sex				
Male	12.9	16.4	11.7*	13.7
Female	18.2	21.3	17.2*	17.3*
Race and ethnicity				
White, non-Hispanic	17.1	22.9	15.8*	19.6*
Black, non-Hispanic	12.9	14.5	10.2*	18.6
Hispanic	12.9	16.8	12.5*	12.7*
Asian American, non-Hispanic	13.3	21.1	12.0	18.1
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander, non-Hispanic	14.9	17.5	11.1	–
Two or more races, non-Hispanic	19.5	22.5	17.1	17.4
Education				
Less than high school	13.2	17.2	10.7*	10.6*
High school graduate	14.4	17.0	12.4*	14.6
Some college or associate degree	17.5	23.0	15.9*	18.1*
College graduate	15.4	23.2	14.8*	21.7

TABLE 2A-1. (continued)

Demographic characteristics	Percentage of adults 18–64 with mild or moderate mental illness	Percentage of adults age 18–64 in each coverage category with mild or moderate mental illness		
		Medicaid	Private coverage	Uninsured
Employment				
Working full time	14.0	18.2	13.7*	14.3*
Working part time	18.5	20.0	17.9	18.0
Unemployed	18.7	16.7	22.9*	16.3
Other	17.4	20.8	13.9*	15.2*

Notes: Estimates for mild or moderate mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

TABLE 2A-2. Reported Prevalence of Serious Mental Illness in the Past Year among Non-Institutionalized Adults Age 18–64, by Demographic Characteristics, 2018

Demographic characteristics	Percentage of adults 18–64 with serious mental illness	Percentage of adults age 18–64 in each coverage category with serious mental illness		
		Medicaid	Private coverage	Uninsured
Total	**5.4%**	**8.2%**	**4.3%**	**6.0%**
Age				
18–25	7.6	7.4	8.4	5.7
26–34	7.2	11.6	5.3*	7.4*
35–49	4.9	8.0	3.3*	6.6
50–64	3.6	5.3	2.6*	3.6
Sex				
Male	3.9	5.2	3.2*	3.9
Female	6.9	10.1	5.3*	8.8

TABLE 2A-2. (continued)

Demographic characteristics	Percentage of adults 18–64 with serious mental illness	Percentage of adults age 18–64 in each coverage category with serious mental illness		
		Medicaid	Private coverage	Uninsured
Race and ethnicity				
White, non-Hispanic	6.5	11.1	4.9*	9.6
Black, non-Hispanic	3.8	5.5	2.7*	3.9
Hispanic	3.8	6.0	3.1*	2.9*
Asian American, non-Hispanic	2.3	–	1.9	–
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander, non-Hispanic	5.7	–	–	–
Two or more races, non-Hispanic	8.4	13.9	7.5	–
Education				
Less than high school	4.7	7.2	3.3*	3.0*
High school graduate	5.7	7.7	3.9*	6.7
Some college or associate degree	7.0	10.2	5.8*	7.3*
College graduate	3.9	6.2	3.4*	7.9
Employment				
Working full time	4.1	5.4	3.8*	4.7
Working part time	6.8	8.5	5.7*	9.0
Unemployed	7.7	8.1	7.9	6.6
Other	7.7	10.2	4.9*	6.5*

Notes: Estimates for serious mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

TABLE 2A-3. Treatment for Mental Health Conditions among Non-Institutionalized Adults Age 18–64 with Past Year Mental Illness, by Insurance Status, 2018

Treatment characteristics	Percentage of adults 18–64 with past year any mental illness	Percentage of adults age 18–64 in each coverage category with any mental illness		
		Medicaid	Private coverage	Uninsured
Received any mental health treatment				
Any mental illness	44.3%	44.2%	44.9%	28.4%*
Mild to moderate mental illness	37.8	36.2	39.6	20.1*
Serious mental illness	63.2	63.1	62.7	49.5*
Received inpatient treatment for mental health				
Any mental illness	3.6	7.1	1.9*	4.4*
Mild to moderate mental illness	2.3	5.3	1.1*	2.8*
Serious mental illness	7.5	11.3	4.7*	8.5
Received treatment in an outpatient mental health center or a day treatment program				
Any mental illness	8.1	13.7	4.9*	6.9*
Mild to moderate mental illness	4.9	8.8	3.1*	3.1*
Serious mental illness	17.5	25.3	11.2*	16.6*
Received treatment in a private therapist's office				
Any mental illness	16.4	11.9	20.3*	6.3*
Mild to moderate mental illness	13.4	9.3	16.9*	3.8*
Serious mental illness	25.1	17.9	32.1*	12.6
Received treatment in a non-clinic doctor's office				
Any mental illness	4.3	3.2	5.2*	2.0
Mild to moderate mental illness	3.1	1.9	3.8*	1.7
Serious mental illness	7.8	6.2	9.8	–
Received treatment in an outpatient medical clinic				
Any mental illness	1.9	2.4	1.5	0.7*
Mild to moderate mental illness	1.5	2.3	1.1	0.6*
Serious mental illness	3.1	2.7	3.0	–

TABLE 2A-3. (continued)

Treatment characteristics	Percentage of adults 18–64 with past year any mental illness	Percentage of adults age 18–64 in each coverage category with any mental illness		
		Medicaid	Private coverage	Uninsured
Received treatment in some other place				
Any mental illness	1.7	1.4	1.4	1.6
Mild to moderate mental illness	1.1	0.9	1.0	0.8
Serious mental illness	3.3	–	2.7	–
Took any prescription medication for a mental health condition				
Any mental illness	37.1	37.6	36.8	23.4*
Mild to moderate mental illness	30.8	30.1	31.7	15.7*
Serious mental illness	55.2	55.5	54.2	42.9*

Notes: Inpatient treatment settings for mental health include a public or private psychiatric hospital, a psychiatric unit or medical unit of an acute care hospital, a residential treatment facility, or some other inpatient setting. A private therapist's office includes a psychologist, psychiatrist, social worker, or counselor that was not part of a clinic. Estimates for any mental illness, mild to moderate mental illness, and serious mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019a).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

APPENDIX 2B: Medicaid Coverage of Mental Health Benefits for Adults

TABLE 2B-1. Medicaid Coverage of Clinical and Supportive Services for Adult Beneficiaries with Mental Illness, 2020

Mental health service	Medicaid coverage
Case management or care coordination	
Includes targeted case management, transitional case management, and care coordination.	45 states and the District of Columbia cover some form of case management or care coordination.
Mental health screening and assessment services	
Concise testing, which evaluates the existence of a mental health condition, and assessment services, which are more in depth and include diagnosing a mental health condition and identifying appropriate treatment.	50 states and the District of Columbia cover some type of mental health screening and assessment services.
Outpatient mental health services	
Include individual and group therapy, psychotherapy, and family counseling.	50 states and the District of Columbia cover some form of outpatient mental health services.
Partial hospitalization or day treatment services	
Intensive mental health treatment provided during the day. They allow the beneficiary to live in the community while commuting to a hospital or outpatient mental health center a certain number of times each week.	43 states and the District of Columbia cover partial hospitalization or day treatment services.
Assertive community treatment	
An evidence-based multidisciplinary team approach that provides intensive services where and when consumers need them (at home, work, or other community settings), 24 hours a day, 7 days a week.	40 states and the District of Columbia cover assertive community treatment.
Psychosocial rehabilitation services	
Sometimes referred to as the clubhouse model, these services include, but are not limited to, reducing symptoms through appropriate pharmacotherapy, psychological treatment, and psychological intervention. The approach provides a restorative environment as well as therapeutic intervention services to support daily and community-living skills.	42 states and the District of Columbia cover psychosocial rehabilitation services.
Residential services	
Mental health services, such as counseling, medication management, and psychiatric services are provided to a beneficiary in a residential setting. Such settings may include clinically managed 24-hour non-hospital-based care or less intensive treatment.	27 states and the District of Columbia cover residential services.

TABLE 2B-1. (continued)

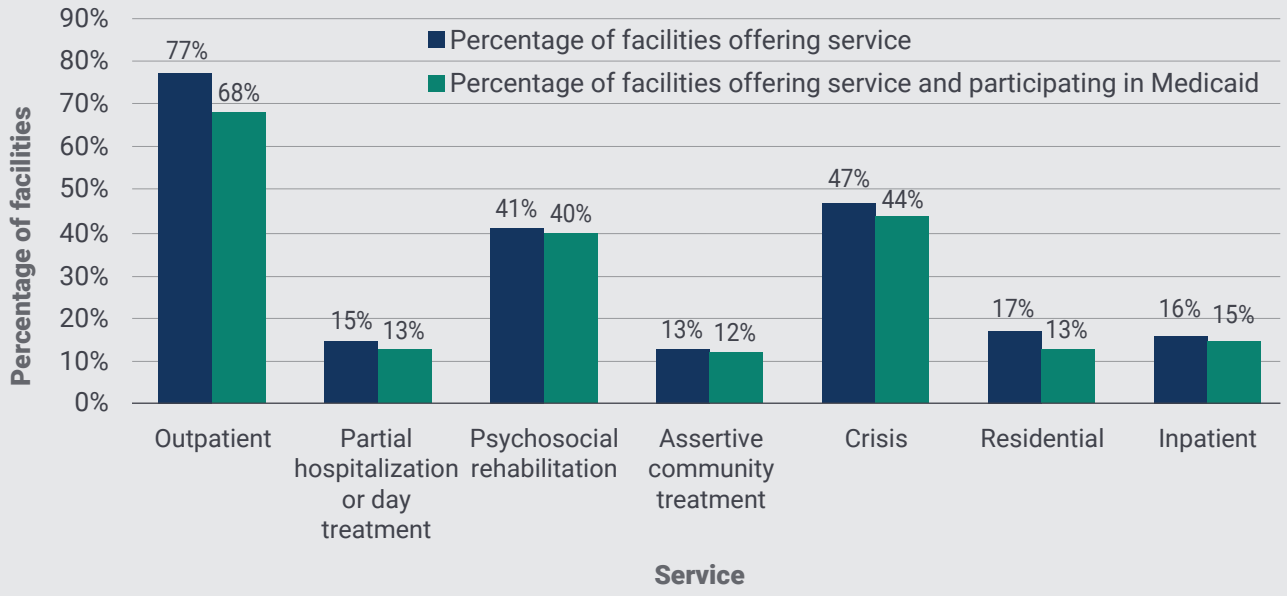
Mental health service	Medicaid coverage
Inpatient psychiatric treatment	
Psychiatric treatment, including close monitoring by staff, psychiatric evaluation, and other services are provided in an inpatient hospital setting. Hospital settings may include acute care hospitals as well as institutions for mental diseases (under certain authorities).	50 states and the District of Columbia cover inpatient psychiatric treatment.
Peer support	
Supportive services delivered by a trained and certified peer (someone with lived experience with a mental health condition). Peer support can be delivered to an individual or a group of beneficiaries.	42 states cover some form of peer support.
Supported employment	
Helps individuals achieve competitive employment in a community setting. This can include job development, career planning, and ongoing supportive services.	24 states and the District of Columbia cover supported employment.
Skills training and development	
Services that help a beneficiary with mental illness acquire new skills, ranging from basic living skills to restoration in the community.	33 states cover some form of skills training and development.
Emergency crisis services	
Includes crisis intervention or stabilization services as well as crisis management services. Services may be delivered in a freestanding facility or by an individually licensed provider.	45 states and the District of Columbia cover some form of emergency crisis services.
Mobile crisis services	
Psychiatric and supportive services meant to stabilize a beneficiary having a psychiatric crisis. Services are delivered in a community setting, which may include a beneficiary's natural environment, such as their home, a shelter, or work. It is often provided to individuals for whom more traditional forms of outpatient treatment have been ineffective.	34 states and the District of Columbia cover mobile crisis services.
Residential crisis services	
Short-term, intensive mental health support in a community-based setting. Services are provided to prevent psychiatric inpatient admission, to provide an alternative to inpatient admission, or to shorten an inpatient length of stay.	28 states and the District of Columbia cover some form residential crisis services.

Notes: Analysis includes all 50 states and the District of Columbia. State definitions of mental health services are not standardized and vary widely; as such, MACPAC's categorization of state-level coverage approximates the closest service description. In instances where publicly available information was insufficient to determine coverage, staff contacted states for clarification. Services provided only to health home beneficiaries or as an in-lieu-of service were excluded for the purposes of this analysis.

Sources: MACPAC, 2020, analysis of Medicaid state plans, provider manuals, enrollee handbooks, fee schedules, Section 1115 and 1915(b) waivers, Section 1915(c) waivers, and other publicly available documents. MACPAC 2016, SAMHSA 2015, NAMI 2013, and WHO 1997.

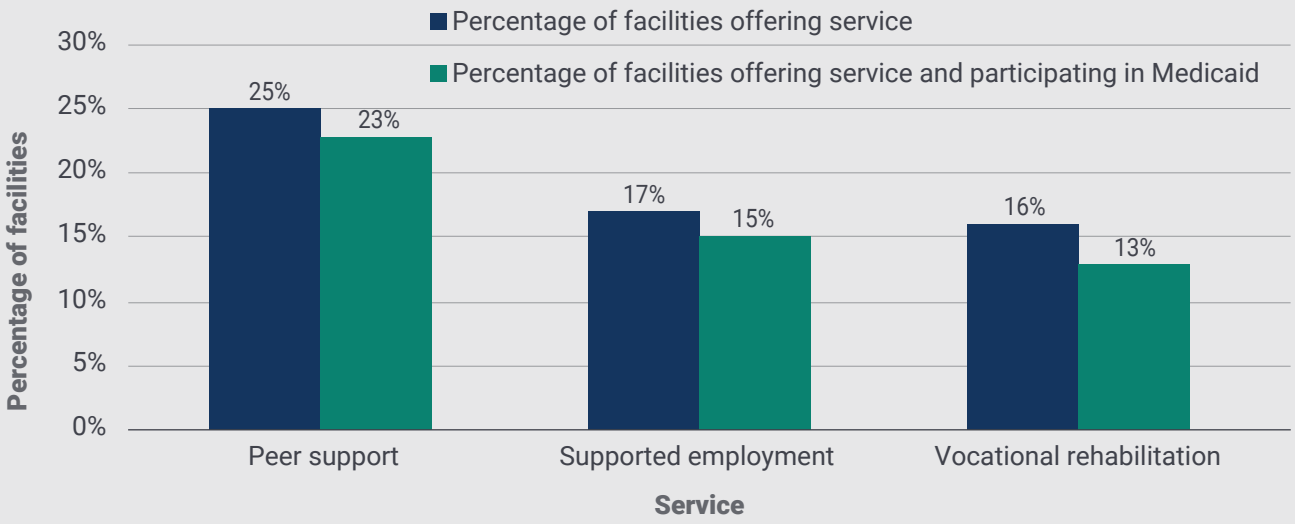
APPENDIX 2C: Specialty Mental Health Treatment Facilities Offering Certain Services

FIGURE 2C-1. Percentage of Specialty Mental Health Treatment Facilities Offering Certain Services and Accepting Medicaid, 2018



Sources: MACPAC, 2020, analysis of, SAMHSA 2019b.

FIGURE 2C-2. Percentage of Facilities Offering Certain Recovery-Oriented Services and Accepting Medicaid, 2018



Sources: MACPAC, 2020, analysis of SAMHSA 2019b.