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Background on Behavioral Health in Medicaid and the State Children's Health Insurance Program

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Medicaid and CHIP Payment and Access Commission

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Overview

- Background
- Forthcoming MACPAC behavioral health claims data analysis
- Considerations for claims data analysis
- Looking ahead

Background

Behavioral Health Conditions and Prevalence

- Behavioral health is a term that includes mental health conditions and substance use disorder (SUD)
  - Mental health conditions include anxiety disorders, mood disorders, personality disorders, and schizophrenia, among others
  - SUD includes opioid use disorder (OUD), alcohol use disorder, and other drug use disorders
  - Co-occurring disorders refer to the coexistence of a mental health disorder and an SUD
- Medicaid covers:
  - Nearly one-third of adults with mental health disorders
  - Around one-fifth of adults with an SUD

Behavioral Health Services and Care Settings

- There is no federal, standardized definition for behavioral health services
- Federal law makes certain behavioral health services mandatory and others optional for adults enrolled in Medicaid
  - **Mandatory**: medically necessary inpatient hospital services, outpatient hospital services, rural health clinic services, nursing facility services, home health services, physician services, and FDA-approved medications used to treat opioid use disorder
  - **Optional**: case management; respite; high fidelity wraparound supports; personal care services; and certified community behavioral health clinic (CCBHC) services, etc.
- Medicaid beneficiaries receive behavioral health services in a number of care settings:
  - Inpatient or emergency department (ED)
  - Outpatient
  - Residential
  - Community

Federal Medicaid Authorities and Policies

- Early and periodic screening, diagnostic, and treatment (EPSDT)
  - States must provide beneficiaries age 21 and younger access to any treatment for physical or mental conditions listed in Section 1905(a) of the Social Security Act if that treatment or service is medically necessary
  - States with separate CHIP must provide behavioral health services
- State plans
  - States can use the state plan authorities, including the state plan rehabilitative services option and the Section 1915(i) state plan option, to cover certain behavioral health services
  - Section 9813 of the American Rescue Plan Act (ARPA, P.L. 117-2) introduced a state plan option that offers an enhanced federal match if states provide qualifying community-based mobile crisis intervention services

Federal Medicaid Authorities and Policies

- Institutions for Mental Diseases (IMD) exclusion
  - Prohibits Medicaid payment for any individual under 65 receiving care in an IMD, defined 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"
- Exceptions to the IMD exclusion
  - Psych under 21 benefit
  - State plan option for beneficiaries with SUD
  - "In lieu of services or settings" in Medicaid managed care
  - Section 1115 demonstrations

Federal Medicaid Authorities and Policies

- Section 1115 demonstrations
  - SUD (37 states and the District of Columbia approved, 2 states pending)
  - Serious mental illness (SMI)/serious emotional disturbance (SED) (16 states and the District of Columbia approved, 9 states pending)
  - Reentry (19 states approved, 8 states and the District of Columbia pending)

- CCBHC demonstration
  - 19 states and the District of Columbia have participated in the demonstration to receive federal funding to reimburse CCBHCs through a prospective payment system

Federal Medicaid Authorities and Policies

- Section 1915(b) waivers
  - Provides states with the flexibility to implement and modify their managed care delivery systems
  - Allows CMS to waive certain requirements for comparability, statewideness, and freedom of choice

- Section 1915(c) waivers
  - Allows states to offer home- and community-based services (HCBS) as an alternative to care in institutional settings

Delivery Systems

- Fee-for-service (FFS)
  - 8 states offer behavioral health services through FFS

- Medicaid managed care
  - 42 states and the District of Columbia offer behavioral health services through some type of managed care arrangement
  - Managed care arrangements include (1) comprehensive risk-based managed care plans and (2) limited-benefit plans, including prepaid inpatient health plans and prepaid ambulatory health plans

Forthcoming Behavioral Health Claims Data Analysis

Prior and Forthcoming Claims Analysis

- Chapter 4 of the June 2015 Report to Congress: *Behavioral Health in the Medicaid Program – People, Use, and Expenditures*
  - Used Medicaid Statistical Information System (MSIS) data to examine the prevalence of behavioral health conditions, use of and spending on services
  - In 2011, 1 in 5 Medicaid beneficiaries had behavioral health diagnoses but accounted for almost half of total Medicaid expenditures
  - In 2011, 16 percent of non-dually eligible enrollees under age 65 had a mental health diagnosis and 4 percent had an SUD diagnosis
- The forthcoming analysis uses 2023 Transformed Medicaid Statistical Information System (T-MSIS) data to update and expand upon the June 2015 chapter on behavioral health use and spending

Research Questions

- What are the demographic characteristics of Medicaid enrollees with behavioral health diagnoses?
- What is their total spending? What is their spending and utilization on behavioral health services?
  - How does it differ by beneficiary characteristics and by delivery system?
- How many enrollees used acute (inpatient, residential, ED) behavioral health care? How many used behavioral health services in other care settings?

Key Variables

- Demographics:
  - Age group
  - Race and ethnicity
  - Gender
  - Urban/rural geographic location
- Patient characteristics:
  - Dual eligible status
  - Eligibility group
- Condition categories:
  - Mental health
  - SUD
  - Intellectual/developmental disabilities (I/DD)
- Delivery system (spending only):
  - FFS
  - Managed care

Considerations for Claims Data Analysis

- T-MSIS data cannot be used to identify enrollees with a behavioral health condition who did not seek treatment or received treatment not paid for by Medicaid or CHIP
  - Using claims data to estimate the prevalence of certain behavioral health conditions can result in an underestimate
- When relevant diagnosis codes are missing from the claim, we can identify service type but not the reason for receiving that service
- In August 2025, CMS issued its first data book on behavioral health using T-MSIS data from 2022
  - Staff will review how the two methodologies compare

Looking Ahead

Next Steps

- Commissioner feedback
  - Are there factors that should be considered when analyzing the data?
  - Is there any background information that is particularly important for contextualizing the findings?
- Staff will return with preliminary findings from the T-MSIS claims data analysis in future meetings
- The analysis will form the basis of forthcoming publication

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