THIRD EDITION

TRENDS IN BEHAVIORAL HEALTH

TRENDS IN BEHAVIORAL HEALTH A REFERENCE GUIDE

on the US Behavioral Health Financing and Delivery System

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FOREWORD

One billion people worldwide suffer from some form of mental illness, according to the Lancet Global Health.[1] They estimate that lost productivity due to anxiety and depression, the two most common behavioral health issues, cost the global economy about $1 trillion annually. In 2010, lost productivity and health issues stemming from mental health disorders cost the global economy about $2.5 trillion per year. This cost is expected to rise to $6 trillion by 2030.

In the United States, the U.S. National Institute of Mental Health (NIMH) estimates that 51.5 million adults aged 18 and older live with a mental illness – 20.6% or one in five of all adults.[2] However, mental health care has been chronically underfunded, unaffordable, and inaccessible in the U.S. for many individuals.[3] A national shortage of behavioral health providers combined with lack of medical insurance for mental health services have made it difficult for many Americans to receive care for mental health concerns. NIMH reports that in 2019, only 44.8% of American adults with mental health issues received adequate treatment.[2] Investing in mental health treatments makes economic sense as reports say every $1 spent on effective treatments for anxiety and depression return $4 due to better health and economic productivity.[1]

Then in 2020, the SARS-CoV-2 (COVID-19) pandemic took root, causing widespread fear, bereavement, isolation, and economic disruption, exacerbating the world's strained mental health, and putting additional pressures on the existing network of mental health resources. All those challenges combined had led to the acceleration of many trends occurring before COVID-19, such as the implementation of telehealth, digital health tools, and moving treatment from long-term care facilities and hospitals to the home.

State and national regulators, payers, advocacy groups, and private companies like Otsuka Pharmaceuticals, Inc., (OAPI) continue to seek ways to improve mental health access to effective, evidence-based care. It is in that spirit that Otsuka and Lundbeck, LLC, compiled our first guidebook in 2017 to provide an overview of U.S. health care policy, financing, and delivery trends. This 2021 Guidebook (The Guide) builds upon the 2017 and 2019 guidebooks as well as the 2020 Trends in

Behavioral Health update that was published to help providers during the early days of the COVID-19 pandemic.

Our goal with this Third Edition is to continue to make a positive contribution to the national conversation among key stakeholders, including commercial and government payers, integrated delivery networks, and providers, about the disproportionate effect that behavioral health disorders place on Americans. While there has been much progress, there is still much work to be done to address mental health issues on a more systemic basis.

This Third Edition begins with an overview of the U.S. Health care system, including federal policy updates, federal health care programs, the evolution of the Affordable Care Act (ACA), federal safety net systems, and a brief legislative outlook. The Guide then moves on to look at the states, specifically Medicaid behavioral health financing and delivery models, Medicaid expansion among the states, population distribution by payer segments, Medicaid financing for people with serious mental illness (SMI), and behavioral health innovation initiatives.

The Guide then pivots to a review results of a national payer survey addressing current and future plans for behavioral health. The Third Edition closes with an analysis of consumer access to care and delivery, including telehealth, value-based care benefit plans, integrated care coordination, social determinants of health, and managing long-term support services. Throughout the Guide, we will look at how COVID-19 has changed the behavioral health landscape, most notably, the swift switch from in-person behavioral health to telehealth and the current and future impacts of serving a growing population.

Sincerely,

Bret Paulson | Vice President, Market Access, Otsuka America Pharmaceutical, Inc.

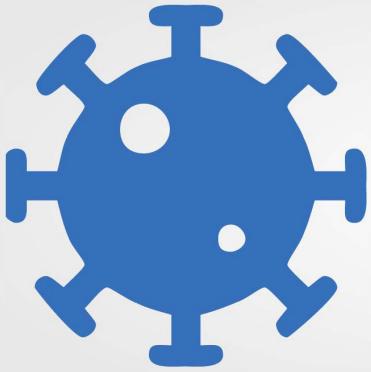
EXECUTIVE SUMMARY

Since our last full Guide published in 2019 and the subsequent update in 2020, we have witnessed the acceleration of trends which were occurring prior to the COVID-19 pandemic. The difference is that the pandemic has rapidly accelerated of the trends that were already happening, such as the implementation of telehealth, use of digital health tools like wearables and artificial intelligence (AI), and treatment moving from long-term care and hospitals to the home. In addition, the pandemic has put higher demands in terms of access to mental health and substance treatment systems as additional individuals now need care due to depression, anxiety, and substance use disorders caused by illness, job loss, bereavement, and isolation. The impacts have aggravated a growing problem of limited access to behavioral health care and have the potential to worsen as the recovery from COVID-19 lingers. The expectation is that many more individuals will seek mental health and substance use disorder treatment as the pandemic's impact will be felt by an increased demand brought on by a societal opening for individuals.

We have also seen growth in Medicaid waivers with much focus on the highest costs in the system. Many of those 1115 demonstration waivers focus on treatment for severe mentally ill individuals who often have comorbidities, higher use of emergency treatment, and barriers created by social determinants of health (SDOH). Also creating a level of uncertainty is the ongoing polarizing dialogue about Medicaid Expansion and the political positioning by the two major parties.

With the added pressure experienced over the last year, provider organizations have seen significant decreases in revenue. The March 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act, as well as other public funding, provided needed relief for providers to remain solvent. What remains ahead is the ultimate financial impacts, how much more funding will be required to stave-off organizational failure as part of a rapidly changing system of care.

Another key area of interest is whether regulatory relief granted during the pandemic will continue once the public health emergency ends. Before 2020, health care was poised to start using more technology to allow consumers to make appointments, share records, and connect with their providers electronically. However, COVID-19



COVID 19 - Pandemic

The March 2020 Coronavirus Aid, Relief, and Economic Security (CARES) provided needed relief for providers to remain solvent.

forced the adoption of many of these services, particularly telehealth. It turns out, patients appreciate the ease of telehealth, allowing them to avoid traffic and waiting rooms. Providers, too, have found that telehealth allows them to see how their patients are living day-to-day. Another advantage to telehealth is it removes barriers to care, such as time away from work and the stigma associated with seeking care.[1]

Swift Shift To Telehealth

Mental health services were among the quickest health care specialties to switch to online treatment. With data collected between November 2020 and February 2021, 33% of all mental health appointments were conducted virtually.[2] Primary care followed holding 17% of visits virtually. Pediatrics held 9% of visits virtually, cardiology 7%, and OB/GYN visits were at 4%.

Pre-pandemic, providers were often paid less for telehealth services than in-person visits. However, many of those rules were relaxed during the pandemic to make it easier for individuals to find and pay for much needed mental health care. So far, U.S. Centers for Medicare and Medicaid Services (CMS) has indicated that many of the telehealth expansions allowed during COVID will be made permanent. There were 144 telehealth services temporarily covered by Medicare in 2020 during the height of the emergency, nine of which—such as group psychotherapy, some home visits for an established patient and care planning services—will be covered permanently.[3]

Rise Of The Under-Insured

While many models of value-based payment exist, the ultimate goals remain the same: to increase the quality of care while decreasing the cost. It is evident that more risk for quality and cost is being shifted toward provider organizations. Early figures estimate that despite the pandemic,

The financing system has undergone rapid changes with the accelerating implementation by most health plans and governmental programs toward value-based payment models.

the number of Americans who reported having health insurance all year in 2020 (77.9%) remained statistically the same as in 2018 (77.7%), according to biennial data collected in the Commonwealth Fund Biennial Health Insurance Survey.[4] Overall, people of color, small business workers, low-wage workers, and young adults were the most likely to be uninsured. There were also differences in insurance by ethnicity relative to the population. Of those who reported being uninsured at any point during the past year, 40% identified as Latino, 24% said they were Black, and 17% were White.

A larger story revealed in this data is that 43% of working-age adults are considered "under-insured." The number of people who are under-insured has grown steadily since 2010 due to changes in employer-sponsored health plans. Under-insurance can lead to problems with medical debt. Among adults who reported any medical bill or debt problem, 37% said they exhausted all their savings to pay their bills, 40% reported receiving a lower credit rating because of medical debt, and 26% said medical bills left them unable to pay for basic necessities such as rent, food, heat, or water.

4.5 Million

The U.S. needs about 4.5 million additional behavioral health professionals to provide care for the current population with mental illness and substance abuse issues.

Looming Workforce Shortage In Mental Health

A huge challenge for behavioral health initiatives going forward will be having the proper workforce trained and in position to help treat additional individuals diagnosed with mental health issues. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports the U.S. needs about 4.5 million additional behavioral health professionals to provide care for the current population with mental illness and substance abuse issues. The current behavioral health professional workforce is about 700,000 individuals, based on the latest current workforce estimates. The estimated need for that workforce is 5.17 million more professionals, a staggering shortage of 87%.[5]

Shortages are most pronounced among behavioral health counselors and peer support specialists with a shortage of full-time professionals of about 1.4 million and 1.1 million, respectively. In terms of the severity, the professions with the greatest proportion of workforce shortage were peer support specialists and addiction psychiatrists, with shortages of 98% and 97%, respectively.[5]

There are also shortages of licensed psychiatrists, the medical doctors specializing in the diagnosis, treatment, and prevention of mental health issues who often take the lead on such issues. Of the roughly 30,000 board-certified psychiatrists in the United States, nearly 60% are age 55 or older, placing psychiatrists as third out of 23 on the list of the oldest types of physicians (only pulmonology and oncology have higher percentages over age 55).[6] This means many psychiatrists practicing today will be retiring soon. In addition, the number of new psychiatrists entering practice has not kept up with population growth and demand. Between 1995 and 2014, the number of psychiatrists in the United States increased 12% while the population grew nearly 20%.[10] There are also geographic discrepancies, as 8.7% of the population lives in rural areas; however, only 1.6% of psychiatrists practice in those areas. It is estimated that 60% of all counties in the United States have even one practicing psychiatrist.[7]

The End Of Behavioral Health Carve-Outs?

The year 2021 marks the end of an era in health care financing. With the Centene Corporation's acquisition in 2021, there are no more standalone companies focused solely on managing behavioral health benefits. In 2002, there were more than 800 organizations that offering managed behavioral health and employee assistance programs. At the time, Magellan Behavioral Health had the largest enrollment with 30% of the market.[8]

As one looks further to the past, behavioral health was intentionally "disconnected" from primary care health services. There was no parity for behavioral health disorders and consumers with severe illnesses were often excluded from coverage because they had preexisting conditions or had maxed out their benefits and were referred to public programs. Most often, benefits for mental health and addictions treatment simply were often not included in other quality improvement and cost containment initiatives.

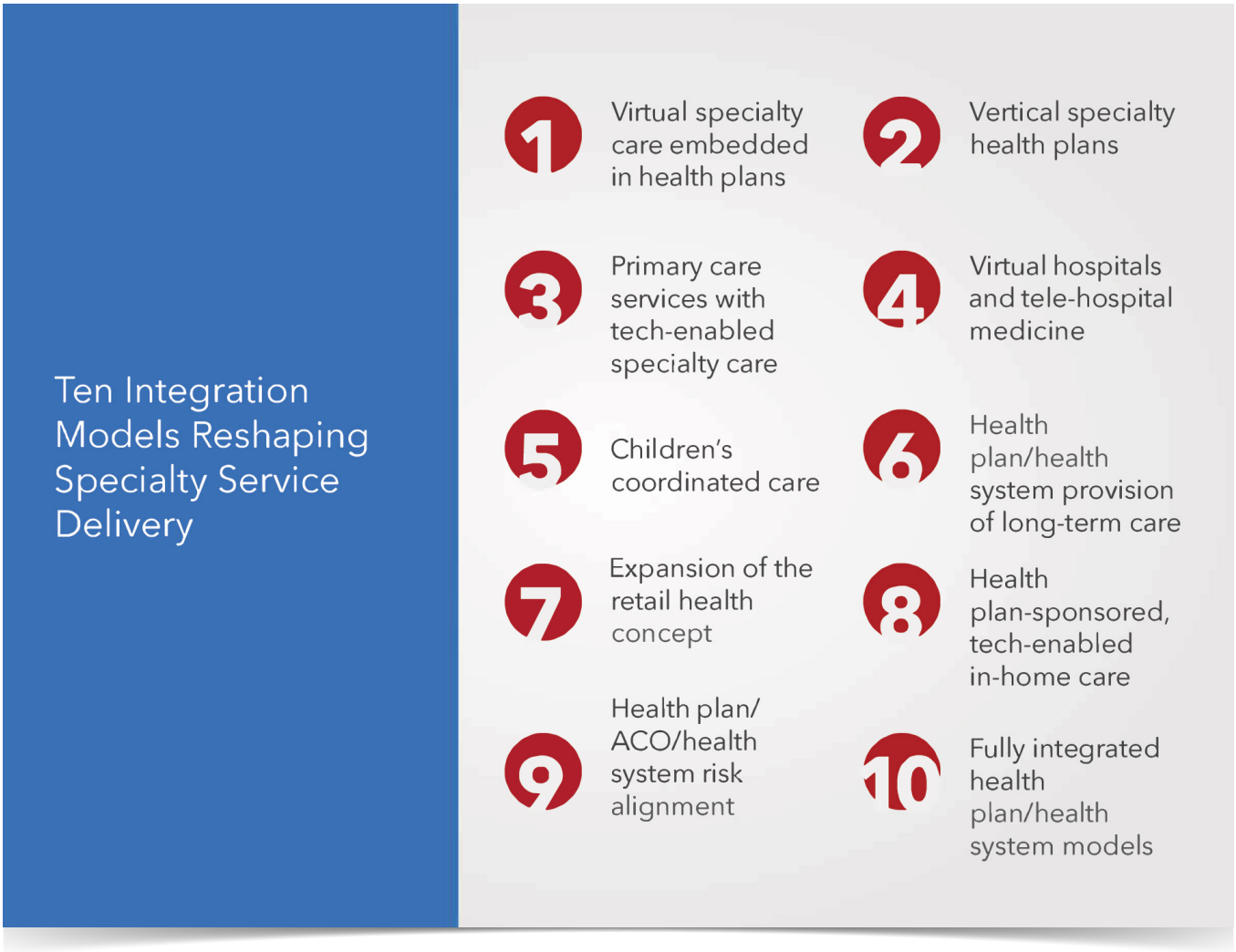
Beyond value-based benefit design, health plans are implementing multiple technology/digital tools as part of their strategies to promote member access and engagement such as mobile applications, wearables, and online engagement tools.

The Patient Protection and Affordable Care Act (ACA) of 2010 marked the beginning of the end of the horizontal benefits model of behavioral health carve-outs. Parity, broader coverage, no preexisting limitations, and no annual and lifetime limits forced health insurers to connect the cost of mental health, mental illnesses, and addictive disorders. It became clear that in many cases, the costs of treating behavioral health disorders were less than the medical costs of the untreated behavioral disorders. The reason being, medical costs for treating people with chronic medical and comorbid behavioral health conditions can be two to three times as high as for consumers without behavioral health conditions.

The question is what has replaced the behavioral health carve-out as a delivery system for behavioral health benefits? The field appears to be moving to two tiers of behavioral health services. For consumers with mild to moderate conditions, the use of "on-demand" services via retail locations, asynchronous artificial intelligence-driven tools, and/or telehealth is growing (although the pandemic has undoubtedly kick-started these efforts). For consumers with more complex conditions, the approach generally is more vertical or integrated with specialty care coordination programs/health homes and specialty/vertical health plans managing all services. These are all changes that point toward systemic change toward a more retail model of service delivery. Consumers are more empowered today and are utilizing search engines, social media platforms, and personal recommendations to drive their health care decision-making.

Understanding Integration

Integration is changing the competitive advantage for health and human service provider organizations—and with it, changing the parameters of financial sustainability. Integration brings with it value-based reimbursement, consolidation, and leverage of technology. Providers are finding new ways to provide old services, and the COVID-19 pandemic has undoubtedly hurried some of these new technologies to market. However, there is no specific definition or a single type of integration. Integrated care models vary in how information is shared, how services are delivered, and the financial incentives among the stakeholders. For this reason, integration models often vary significantly from one market to the next.[9]



ACO: Accountable Care Organization

Addressing Social Determinants Of Health

Social determinants of health (SDOH) are the conditions into which people are born, grow, live, study, work, and age that shape a person's overall health. Researchers are realizing that addressing health symptoms is not enough to create a healthy person. Rather, all these factors must be addressed when hoping to improve someone's whole health.[10]

COVID-19 has brought to the forefront some key health disparities. Statistics show that adverse SDOH can partially explain differences in death rates due to COVID-19. Compared to Whites, the likelihood of COVID-related deaths for Blacks is 37% higher, for Asians 53% higher, for Native Americans and Alaskan Natives 26% higher, and for Hispanics 16% higher.[11]

There are many factors that contribute to these disparities. People of color are more likely to be uninsured. Minorities are more likely to work in service roles that expose them to more people every day. The ability to participate virtually in work, school, and health care is also not evenly distributed. Lower-income groups of parents are 36% more likely for their kids to be unable to complete schoolwork because they have no computer at home. Another 40% of lower income parents say their children must use public Wi-Fi to finish schoolwork due to lack of reliable internet connection at home. Additionally, Medicare beneficiaries without digital access are more likely to be 85 or older, widowed, have a high school education or less, be Black or Hispanic, have a disability, and/or be covered by Medicaid.

Executive Summary

Over the past year, we have witnessed trends that were occurring prior to the COVID-19 pandemic. The pandemic has accelerated many of the trends such as the implementation of telehealth, use of digital health tools, treatment moving from long-term care and hospitals to the home. In addition, the pandemic has put higher demands on the mental health and substance treatment systems as many additional individuals need care due to depression, anxiety, and substance use disorders caused by job loss and isolation. The impacts have aggravated a growing access to care problem that still has the potential to worsen.

We have also seen growth in Medicaid waivers with much focus on the highest costs in the system. Many of those demonstration waivers focus on treatment for the severe mentally ill individuals who often have comorbidities, higher usage of emergency treatment, and barriers, created by social determinants of health.

With the added pressure experienced over the last year, provider organizations have seen significant decreases in revenue with very little cash-on-hand. Additionally, many community health providers were ill prepared for any type of financial crisis. During the past year, the March 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act, as well as other public funding, provided needed relief for providers to remain solvent. What remains ahead is the ultimate financial impacts, how much more funding will be required to stave-off organizational failure as part of a rapidly changing system of care.

Another key area of interest is whether previous regulatory relief granted during the pandemic will extend beyond. One in particular that is highlighted is the interstate regulatory changes granted last March that allows providers to practice across state lines without being licensed in another state–thus giving opportunity for rapid growth in telehealth services.

The financing system has also undergone rapid change with the accelerating implementation by most health plans and governmental programs toward value-based payment models. While many models of value-based payment exist, the ultimate goals remain the same: to increase the quality of care while decreasing the cost. It is quite evident that more risk for quality and cost is being shifted toward provider organizations. There has also been a significant increase in transparency between providers and payers as the system shifts to quality models that will ultimately yield a more retail health care landscape.

American Health Care Coverage

Despite the COVID-19 pandemic, the number of Americans who reported having health insurance all year in 2020 (77.9%) remained statistically the same as in 2018 (77.7%), according to biennial data collected in the Commonwealth Fund Biennial Health Insurance Survey.[1] The survey began January 14, 2020–shortly before the initial disruption of coronavirus pandemic 2019 (COVID-19) in March 2020 and ended June 5, 2020; however, researchers saw no meaningful change in health insurance rates during this time. This information may change once figures for the entire year are collected, calculated, and analyzed.

People of color, small business workers, low-wage workers and young adults were the most likely to be uninsured. There were also differences in insurance by ethnicity relative to the population. Of those who reported being uninsured at any point during the past year, 40% identified as Latino, 24% said they were Black, and 17% were White. People with incomes below 133% of the federal poverty level ($16,971 for an individual and $34,846 for a family of four) reported uninsured rates three times higher than adults with incomes 400% of the poverty level or higher ($51,040 for an individual, $104,800 for a family of four).

Under-insurance can lead to problems with medical debt. Among adults who reported any medical bill or debt problem, 37% said they used up all their savings to pay their bills, 40% reported receiving a lower credit rating as a result of medical debt, and 26% said medical bills left them unable to pay for basic necessities such as rent, food, heat, or water.

The larger story this data reveals is that 43% of working-age adults report that they are under-insured. That means they do not have stable health insurance due to either a gap in coverage (often due to unstable employment) or that they had such high out-of-pocket costs and/or deductibles compared to their income that they were considered under-insured.

The number of people who are under-insured has grown steadily since 2010 due to changes in employer-sponsored health plans. In 2010, only 7% of people in private plans had deductibles that amounted to 5% or more of their income. By 2016, this number had doubled to 15%. In the last 10 years, the share of privately insured adults with annual deductibles of $1,000 or more doubled, from 22% in 2010 to 46% in 2020.

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Figure 1 U.S. Health Care Coverage, 2011, 2014, 2016, 2018 & 2020[2,3,4]

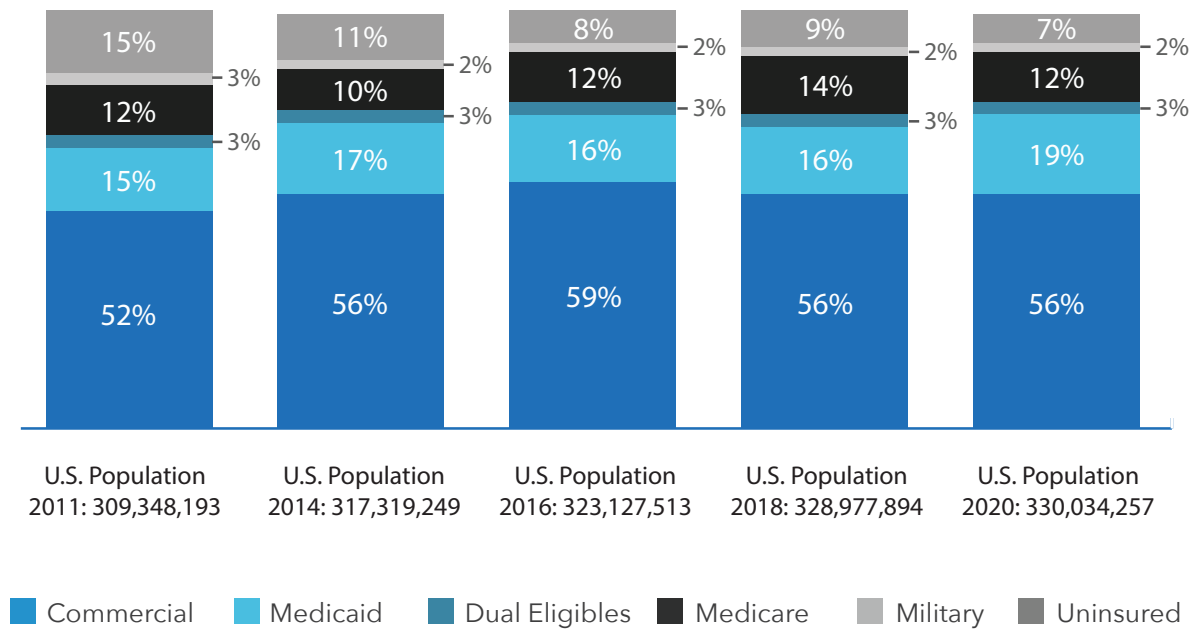
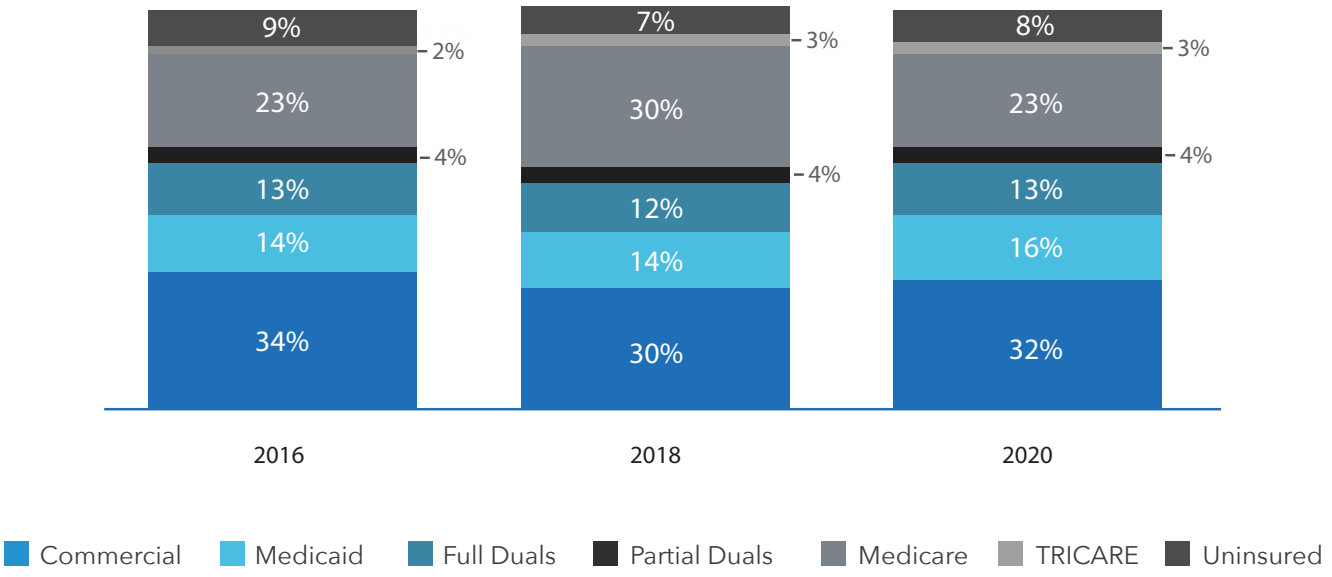


Table 1 Percent Of Insured Population Enrolled In Managed Care By Payer Type, 2011, 2016, 2018 & 2019/2020[2,5]

Payer Type	Percent of U.S. Population Insured				Percent of Insured Population Enrolled in Managed Care			
	2011	2016	2018	2020	2011	2016	2018	2019
Commercial	52%	54%	55%	56%	93%	98%	99%*	99%
Medicaid	18%	23%	23%	19%	50%	68%	74%	85%
Dual Eligibles	3%	3%	3%	3%	NA	NA	NA	NA
Medicare	16%	18%	18%	12%	25%	33%	40%	36%
Military	3%	3%	3%	2%	57%	49%	100%*	100%
Uninsured	15%	9%	9%	7%	N/A	N/A	N/A	NA

Figure 2 U.S. Health Care Coverage for Consumer with SMI, 2016, 2018 & 2020[2]



*2016 SMI uninsured rate is based on 2015 data. 2020 SMI uninsured rate is based on 2019 data.

Health Insurance Coverage & The SMI Population

One of the biggest changes among health insurance for the serious mental illness (SMI) population is who insures them. In 2016, 31% of the 326 Americans recorded in 2018, about 21.2 million adults (9%) reported a diagnosis of an SMI.[6] This is relatively unchanged from 2016, when 17.9 million adults (also 9% of the population) reported an SMI diagnosis.

OPEN MINDS defines SMI as a behavioral, mental, or emotional disorder that results in serious impairment of an individual or interferes with one or more activities of daily living for individuals over the age of 18. SMI can impact functioning ranging from no impairment, mild impairment, moderate impairment, or serious impairment. The level of impairment determines the individual's need for health care services. Frequently, people with SMI are also diagnosed with physical and behavioral health disorders. Together, these comorbidities often lead to higher instances of health care utilization among the SMI population.

Most people with an SMI are insured by commercial health plans (32%, 6.33 million) or Medicare (23%, 4.58 million). This is a change from 2016, when 34% of adults with an SMI were covered by commercial insurance and 23% had Medicare coverage. The number of military members, retirees, and their dependents with an SMI covered by TRICARE health insurance has increased from 2% in 2016 to 3%. Those with SMI who are uninsured decreased from 9% in 2016 to 8% in 2020.

One of the biggest changes among health insurance for the serious mental illness (SMI) population is who insures them.

Table 2 Adults Reporting Unmet Need For Mental Health Treatment, 2018-2019[7]

Location	Adults Reporting Unmet Need For Mental Health	Adults Reporting Unmet Need For Mental Health Treatment	Proportion Of Adults Reporting Unmet Need For Mental Health
Alabama	292,000	141,000	51.00%
Alaska	35,000	16,000	44.20%
Arizona	368,000	120,000	33.10%
Arkansas	127,000	62,000	48.80%
California	1,698,000	614,000	36.30%
Colorado	408,000	170,000	41.80%
Connecticut	147,000	37,000	24.80%
Delaware	53,000	16,000	29.50%
District of Columbia	63,000	19,000	29.50%
Florida	835,000	374,000	45.80%
Georgia	457,000	214,000	47.60%
Hawaii	36,000	9,000	25.90%
Idaho	109,000	53,000	48.90%
Illinois	531,000	204,000	38.80%
Indiana	367,000	154,000	42.30%
Iowa	181,000	48,000	26.30%
Kansas	166,000	87,000	52.40%
Kentucky	227,000	79,000	34.70%
Louisiana	181,000	55,000	30.50%
Maine	73,000	32,000	43.30%
Maryland	314,000	92,000	29.80%

Table 2 Adults Reporting Unmet Need For Mental Health Treatment (cont.)

Location	Adults Reporting Unmet Need For Mental Health	Adults Reporting Unmet Need For Mental Health Treatment	Proportion Of Adults Reporting Unmet Need For Mental Health
Massachusetts	343,000	111,000	32.30%
Michigan	516,000	180,000	34.90%
Minnesota	226,000	85,000	37.80%
Mississippi	138,000	58,000	42.10%
Missouri	394,000	166,000	42.10%
Montana	44,000	21,000	48.50%
Nebraska	90,000	37,000	40.80%
Nevada	176,000	73,000	41.20%
New Hampshire	71,000	29,000	40.70%
New Jersey	327,000	129,000	40.00%
New Mexico	93,000	33,000	35.60%
New York	850,000	277,000	33.20%
North Carolina	525,000	255,000	49.50%
North Dakota	34,000	12,000	36.30%
Ohio	664,000	252,000	38.00%
Oklahoma	181,000	74,000	42.90%
Oregon	291,000	111,000	38.20%
Pennsylvania	681,000	212,000	31.50%
Rhode Island	58,000	16,000	27.70%
South Carolina	180,000	74,000	41.10%
South Dakota	35,000	14,000	40.30%

Table 2 Adults Reporting Unmet Need For Mental Health Treatment (cont. part 2)

Location	Adults Reporting Unmet Need for Mental Health	Adults Reporting Unmet Need for Mental Health Treatment	Proportion of Adults Reporting Unmet Need for Mental Health
Tennessee	298,000	160,000	54.10%
Texas	1,037,000	478,000	46.40%
Utah	206,000	102,000	50.20%
Vermont	37,000	10,000	28.50%
Virginia	390,000	156,000	40.40%
Washington	457,000	199,000	43.70%
West Virginia	96,000	39,000	41.00%
Wisconsin	262,000	89,000	34.40%
Wyoming	28,000	15,000	53.10%
United States	**15,398,000**	**6,063,000**	**39.70%**

Section 1115 Demonstration Waivers

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. These demonstrations give states additional flexibility to design and improve their programs with the goal of evaluating state-specific policy approaches that may better serve Medicaid populations.[8]

Demonstrations must also be budget neutral to the Federal government. CMS policy requires the demonstration's budget ceiling to be rebased using recent cost data and growth trends at every extension and will also limit carry-forward of accumulated savings. Currently, 37 states have approved Section 1115 waivers for behavioral health, up from 25 in 2019. There are also 13 states that have approved 1115 waivers for Medicaid managed long-term services and supports (MLTSS).[9]

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program.

Table 3 Medicaid Waiver Tracker: Approved & Pending Section 1115 Waivers By State[9]

Location	Waiver Name	Waiver Expiration Date	Behavioral Health	MLTSS
Alaska	Alaska Medicaid Section 1115 Behavioral Health Demonstration	12/31/2023	X	
Arizona	Arizona Health Care Cost Containment System	9/30/2021	X	X
Arkansas	Arkansas Works	12/31/2021		
Arkansas	Arkansas' Tax Equity and Fiscal Responsibility Act (TEFRA-like)	12/31/2022		
California	California Medi-Cal 2020	12/31/2021	X	X
Colorado	Expanding the Substance Use Disorder Continuum of Care	12/31/2025	X	
Delaware	Delaware Diamond State Health Plan	12/31/2023	X	X
District of Columbia	District of Columbia Section 1115 Medicaid Behavioral Health Transformation	12/31/2024	X	
Florida	Florida Managed Medical Assistance	6/30/2030	X	
Georgia	Pathways to Coverage	9/30/2025		
Hawaii	Hawaii QUEST Integration	7/31/2024	X	X
Idaho	Idaho Behavioral Health Transformation	3/31/2025	X	
Illinois	Continuity of Care and Administrative Simplification	12/31/2025		
Illinois	Illinois Behavioral Health Transformation	6/30/2023	X	
Indiana	Healthy Indiana Plan (HIP) 2.0	12/31/2030	X	
Indiana	Indiana End Stage Renal Disease (ESRD)	12/31/2021		
Iowa	Iowa Wellness Plan	12/31/2024		
Kansas	KanCare	12/31/2023	X	X
Kentucky	KY HEALTH	9/30/2023	X	
Louisiana	Healthy Louisiana Substance Use Disorder	12/31/2022	X	

Table 3 Medicaid Waiver Tracker: Approved & Pending Section 1115 Waivers By State (cont.)

Location	Waiver Name	Waiver Expiration Date	Behavioral Health	MLTSS
Maine	Maine Section 1115 Demonstration for Individuals with HIV/AIDS	12/31/2028		
Maryland	Maryland Health Choice	12/31/2021	X	
Massachusetts	MassHealth	6/30/2022	X	
Michigan	Healthy Michigan	12/31/2023		
Michigan	Flint MI	2/28/2022		
Michigan	Pathway to Integration	9/30/2024	X	
Minnesota	Minnesota Reform 2020	1/31/2025		
Minnesota	Minnesota Prepaid Medical Assistance Project Plus	12/31/2021		
Minnesota	Minnesota Substance Use Disorder System Reform	6/30/2024	X	
Mississippi	Healthier Mississippi	9/30/2023		
Missouri	Missouri Gateway to Better Health	12/31/2022		
Montana	Montana Health Economic Livelihood Partnership (HELP)	12/31/2021		
Montana	Montana Additional Services and Populations	12/31/2022	X	
Nebraska	Nebraska Heritage Health Adult 1115 Demonstration	3/31/2026		
Nebraska	Nebraska Substance Use Disorder Demonstration Program	6/30/2024	X	
New Hampshire	Building Capacity for Transformation	12/31/2020	X	
New Hampshire	New Hampshire SUD Treatment and Recovery Access	6/30/2023	X	
New Jersey	New Jersey Comprehensive Waiver	6/30/2022	X	X

Table 3 Medicaid Waiver Tracker: Approved & Pending Section 1115 Waivers By State (cont. part 2)

Location	Waiver Name	Waiver Expiration Date	Behavioral Health	MLTSS
New Mexico	Centennial Care 2.0	12/31/2023	X	X
New York	New York Medicaid Redesign Team	3/31/2021	X	X
North Carolina	North Carolina's Medicaid Reform Demonstration	10/31/2024	X	X
Ohio	Ohio Group VIII Work Requirement and Community Engagement	2/29/2024		
Ohio	Substance Use Disorder Demonstration	9/30/2024	X	
Oklahoma	Oklahoma Institutions for Mental Disease Waiver for Serious Mental Illness/Substance Use Disorder	12/31/2025	X	
Oklahoma	Oklahoma SoonerCare	12/31/2023		
Oregon	Oregon Health Plan	6/30/2022		
Pennsylvania	Pennsylvania Medicaid Coverage for Former Foster Care Youth from a Different State and Substance Use Disorder Demonstration	9/30/2022	X	
Rhode Island	Rhode Island Comprehensive Demonstration	12/31/2023	X	X
South Carolina	Healthy Connection Works	12/30/2024		
South Carolina	Palmetto Pathway to Independence	12/30/2024		
Tennessee	TennCare III	12/31/2030		X
Texas	Healthy Texas Women	12/31/2024		null
Texas	Texas Health care Transformation and Quality Improvement Program	9/30/2030		X
Utah	Primary Care Network	6/30/2022	X	
Vermont	Vermont Global Commitment to Health	12/31/2021	X	X

Table 3 Medicaid Waiver Tracker: Approved & Pending Section 1115 Waivers By State (cont. part 3)

Location	Waiver Name	Waiver Expiration Date	Behavioral Health	MLTSS
Virginia	Building and Transforming Coverage, Services, and Supports for a Healthier Virginia	12/31/2024	X	
Washington	Washington Medicaid Transformation Project	12/31/2021	X	
West Virginia	West Virginia Creating a Continuum of Care for Medicaid Enrollees with a Substance Use Disorder	12/31/2022	X	
Wisconsin	Badger Care Reform	12/31/2023	X	
Wisconsin	Wisconsin SeniorCare	12/31/2028		
United States	**61 Approved (Across 45 States)**	**N/A**	**37 Approved**	**13 Approved**

* Data as of January 26th, 2021

Table 4 Medicaid 1115 Waiver Work Requirements By State[9]

Location	Waiver Status	Expansion Adults	Traditional Adults	Age Exemptions	Hours Required
Alabama	Pending		X (parents 0-18% FPL)	60+	35/week (or 20/week for parents or caretakers with a child under age 6)
Arizona	Approved/Not Implemented	X		50+	80/month

Table 4 Medicaid 1115 Waiver Work Requirements By State (cont.)

Location	Waiver Status	Expansion Adults	Traditional Adults	Age Exe.	Hours Required
Georgia	Approved/Not Implemented		X (parents 35-100% FPL and childless adults 0-100% FPL)	65+	80/month
Idaho	Pending	X		60+	20/week average
Indiana	Approved/ Implemented	X	X	60+	Ramps up to 20/ week
Kentucky	Set Aside by Court	X	X	65+	80/month
Michigan	Set Aside by Court	X		63+	80/month
Mississippi	Pending		X (parents 0-27% FPL)	65+	20/week
Montana	Pending	X		>55	80/month
Nebraska	Approved/Not Implemented	X		60+	80/month
New Hampshire	Set Aside by Court	X		65+	100/month
Ohio	Approved/Not Implemented	X		50+	80/month
Oklahoma	Pending		X (parents 0-45% FPL)	>50	Ramps up to 80/ month
South Carolina	Approved/Not Implemented		X (parents 0-100% FPL and certain targeted adults)	65+	80/month (quarterly average)
South Dakota	Pending		X (parents 0-50% FPL, in Minnehaha or Pennington County)	60+	80/month or achieve monthly milestones in individualized plan
Tennessee	Pending		X (parents 0-98% FPL)	65+	20/week average
Utah	Approved/ Implemented	X		60+	No ""hour"" requirement; specified job search

* Data as of March 26th, 2021

Medicaid 1115 Waiver Work Requirements By State (cont. part 2)

Populations, exemptions, penalties or consequences, and other details vary significantly by waiver.

For the Traditional Adults group, other groups such as Transitional Medical Assistance (TMA), family planning only, or former foster care youth, may be included in some states.

See text above table for information on the status of work requirement waivers under the Biden Administration. For more information on the status of Section 1115 waiver litigation across states, see [this KFF explainer] (https://www.kff.org/policy-watch/medicaid-work-requirements-at-u-s-supreme-court/).

ME: On December 21, 2018, CMS approved a Section 1115 waiver for Maine that included a work requirement and other eligibility restrictions. On January 22, 2019, the new Governor Janet Mills informed CMS that the state is not accepting the terms of the approved waiver.

OK: Oklahoma submitted its SoonerCare 2.0 Health Adult Opportunity (HAO) waiver application in May 2020 and thus far is the only state to have requested an HAO 1115 demonstration. This waiver requested authority for a work requirement and other eligibility and benefit restrictions that would apply to a new expansion adult population. Oklahoma requested the authority to modify its policies related to premiums, work requirements, ED copays, and benefits over time during the demonstration without seeking CMS approval (i.e., through the submission of waiver amendments). In June 2020, Oklahoma voters approved a ballot measure that adds Medicaid expansion to the state's Constitution and prohibits the imposition of any additional burdens or restrictions on eligibility or enrollment for the expansion population. Subsequently, in August 2020 the state withdrew its HAO application.

VA: On November 20, 2018, VA submitted a waiver extension request that included a work requirement, premiums and other eligibility and enrollment restrictions, and healthy behavior incentives. In December 2019, Governor Ralph Northam announced that he was pausing VA's pursuit of these provisions, and the state formally withdrew them from its waiver application on July 1, 2020.

The End Of Behavioral Health Carve-Outs?

The biggest change in the health landscape in 2021 will be the continued fallout from the COVID-19 pandemic and changes to health care delivery brought on by changes from the incoming Biden Administration. As more and more individuals become vaccinated against COVID-19, the health care industry will begin to make decisions about which policies and procedures adopted during the pandemic will continue into the future. Emergency changes that relaxed the rules and reimbursement around telehealth will all be analyzed for effectiveness and provider and patient satisfaction, although it will take months and years before that data is mature.

The Health and Human Services (HHS) agency is also making changes to how providers can manage funds they received as part of the March 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act.

Some changes expected at the federal level are updates to section 1115 demonstrations. These pilot programs are generally approved for an initial five-year period and can be extended for up to an additional three to five years, depending on the populations served. However, in February 2021, CMS notified all states with approved work requirements to begin the process of withdrawing these waiver authorities as CMS has preliminarily determined that work requirements do not promote Medicaid program objectives. In March 2021, CMS sent letters notifying Arkansas and New Hampshire of its final decision to withdraw work requirement waiver authorities in these states. Medicaid work requirements had been a key Section 1115 waiver priority under the Trump Administration.[9]

The Health and Human Services (HHS) agency is also making changes to how providers can manage funds they received as part of the March 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act. With an appropriation of $100 billion in funding, the fund was intended to replace about 2% of provider organization revenues during the previous year, and the Provider Relief Fund (PRF) payments were to be included in the recipients' gross income for tax purposes.[10]

Another change coming at the federal level will start on January 1, 2023, when CMS will begin requiring Medicare Part D drug plans to offer a real-time drug benefit comparison tool. The program will allow enrollees to research cost sharing and utilization management requirements for prescription drugs, and to research lower cost alternative therapies to specific prescribed drugs. This real-time benefit tool will allow enrollees to view accurate, timely, and clinically appropriate information included in the prescriber's system in real time. Additionally, plans are required to make this information available to enrollees who call the plan's customer service call center.

In January 2021, CMS implemented new opioid-related provisions enacted in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018.[10]

New requirements are as follows:

Medicare Part D plans must educate beneficiaries on opioid risks, alternate pain treatments, and safe disposal of prescription drugs that are controlled substances, including opioids. Part D plans will expand drug management programs to review provider organization opioid utilization trends that may put beneficiaries at risk. They will also review medication therapy management programs through which Part D plans provide beneficiary-centric interventions.

Part D plan sponsors must report certain payment suspensions taken based on credible allegations of fraud against pharmacies when they are based on the SUPPORT Act authority (rather than previously existing bases such as contracts). In a new requirement, Medicare Advantage and Part D plans must report certain information related to inappropriate prescribing of opioids and any plan corrective actions to CMS via a secure internet portal.

Impact Of COVID-19 Pandemic

COVID-19 disrupted every aspect of life in 2020 and the business of health care was front and center of many of the rapid transformations. What will be the lasting impacts of this crisis will be unfolding for several years, but the roadmap for 2021 is becoming clear. Most certainly, an acceleration of trends that were in motion before COVID, such as virtual delivery, integrated care coordination, payer/provider partnerships, and pressure on cost and value will continue.

CMS has already said that many of the telehealth expansions allowed during COVID will be made permanent. There were 144 telehealth services temporarily covered by Medicare in 2020 during the height of the emergency, nine of which—such as group psychotherapy, some home visits for an established patient, and care planning services—will be covered permanently. The rule also provides higher reimbursement for evaluation and management (E/M) visits (including general practice and family practice)—but those increases are offset by decreases in a number of specialties. This is likely just the tip of iceberg. The pandemic-driven turmoil and the change for health and human service organizations will continue for the foreseeable future.[13] The following outlines a possible trajectory of the pandemic's impact on health and human services:

The events of the past months will help inform the outlook for 2021 and answer the questions—what will be the lasting impact of these crises on the health and human service landscape?

Operational & Financial Impact

Nursing Homes Costs Up & Revenues Down Due To COVID-19

Many nursing homes are in a financial crisis due to the effects of the economic distress created by COVID-19. According to the American Health Care Association/National Center for Assisted Living (AHCA/NCAL), the pandemic has increased operating costs for most nursing homes at the same time that revenues have dropped as residents have left. Skilled nursing facilities have seen a big drop in census due to the pandemic. The Centers for Disease Control and Prevention (CDC) reported that 100,000 residents had left nursing homes between the end of 2019 and May 2021, a 10% drop. The pandemic has changed thinking about nursing homes and other congregate consumer communities, making home care the preferred default.[11] The AHCA/NCAL estimates that occupancy rates have dropped from 71% to 67% since November 2020. And without immediate assistance, AHCA/NCAL predicts that more than 1,600 nursing homes could close in 2021—more than 10 times the number of facilities that closed the prior year.[12] But even with financial assistance, this doesn't mean that nursing home occupancy will return to pre-pandemic levels.[14]

COVID-19 Pandemic Intensifies Workforce Shortage Of I/DD Direct Support Professionals

COVID-19 has compounded the workforce shortage of direct support professionals who assist people with intellectual and developmental disabilities (I/DD). During 2018, the turnover rate of I/DD staff was about 50%. A recent survey of I/DD staff conducted between April 23 and May 27, 2020, found that 26% reported their employers were more short-staffed than before COVID-19. About 42% of respondents reported having a colleague who quit their position due to COVID-19.[15]

Behavioral Health Financing & Delivery System

Two-Thirds Of Addiction Treatment Provider Organizations Report Lower Revenue

About 66% of addiction treatment provider organizations reported that their revenue after February 2020 has been lower than the previous year. About 21% of organizations reported no change to revenue, and nearly 10% reported an increase in revenue. Of the facilities reporting decreased revenue, about 27% reported losing between 25% and 50% of revenue and about 16% reported losing more than 75% of revenue compared to 2019. These were the findings of an October 2020 survey conducted by National Association of Addiction Treatment Providers (NAATP).[16]

Many I/DD Providers Closed Service Lines Due To COVID-19

About 68% of provider organizations that serve people with I/DD reported that they have closed one or more service lines by government order due to COVID-19, according to 689 organizations that responded to a survey. Those that closed service lines reported that revenue dropped by an average of 32%. About 63% of small organizations (defined as those employing fewer than 200 direct support professionals) and 78% of large organizations reported closing service lines.[17]

Primary Care Practices Could Lose Over $15 Billion In Revenue Due To COVID-19

Over the 2020 operating year, primary care practices in the United States were expected to lose a total of $15.1 billion in revenue due to COVID-19. This equals a loss of $67,774 in gross revenue per full-time physician, from an anticipated base gross revenue of $542,190 per physician had COVID-19 not happened.[18]

COVID-19 in March and April 2020

COVID-19 Resulted In Reductions In Use Of Preventive & Elective Services

During the early months of COVID-19, consumers reduced their use of preventive and elective health care services by more than 40% in March and April 2020 alone. Although telemedicine encounters increased by 4,000%, the volume of telemedicine encounters was not enough to compensate for an overall 25% drop in ambulatory visits.[19]

Service Utilization Changes

Eighty Percent Of Behavioral Health Providers Using Telehealth For Most Consumer Visits

About 80% of behavioral health provider organizations are using telehealth for at least 60% of consumer visits, according to a national survey. About 70% of the respondents said that going forward they believe that at least 40% of their services will be provided using telehealth and virtual care technologies. Regarding revenue, about 64% reported lower revenue during the COVID-19 public health emergency, and most reported a decrease in no-show rates.[20]

More Than 70% Of Americans Changed Health Care Utilization During Pandemic

About 72% of adults in the United States changed their use of traditional in-person health care services, according to a survey conducted in May 2020. Nearly 41% said they delayed use of health care services, and 38% said they intended to delay future care, treatment, and procedures for at least six months. Approximately 28% received some sort of virtual care, such as a telehealth visit, the majority (89%) said they were satisfied with the experience.[21]

Adults in the United States changed their use of traditional in-person health care.

Primary Care Patterns During COVID-19—Fewer Visits, More Virtual

Total primary visits declined by 21.4%, and 35% of those visits took place via telehealth during the second quarter of 2020. There were 99.3 million primary care visits during the quarter, down from 122.4 million (a 21.4% decrease) and 130.3 million quarterly visits during the second quarters of 2018 and 2019, respectively. Of those visits, 59.1 million visits were in office, and 35 million were virtual.[22]

Nearly Half Of Medicare Primary Care Visits Conducted Over Telehealth During COVID-19 Emergency

About 43.5% of all Medicare Part B fee-for-service (FFS) primary care visits in April 2020, during the height of the COVID-19 public health emergency, took place via telehealth compared to less than 1% via telehealth in February 2020 before the pandemic started. The number of weekly primary care telehealth visits rose 350%, from 2,000 in February to 1.28 million in April. About 30% of primary care visits in May were provided via telehealth, representing about 700,000 per week.[23]

During COVID-19, Half Of Families Who Sought Child Mental Health Services Used Telehealth Talk Therapy

About 49% of parents surveyed who said they sought mental health services for their children during COVID-19 used talk therapy telehealth services. Nearly 72% of parents who sought help said they had witnessed a decline in their child's emotional well-being as a result of extreme stress from the pandemic, such as a death or illness due to COVID-19 of a loved one, social isolation, school closures, and financial and housing insecurity. Close to 68% of parents said their child was experiencing behavior problems, and 68% said the child's physical health declined due to decreased changes in activities and exercise.[24]

Average Senior Housing Occupancy Rate Fell To 84.9% Due To The Pandemic

Combined occupancy for independent living and assisted living communities fell during the second quarter of 2020, from 87.7% in March to 84.9% in July, largely as a result of COVID-19. This is the largest quarter-to-quarter decline recorded since 2005 when the National Investment Center (NIC) MAP Data Service began monitoring senior housing occupancy rates. The largest senior housing occupancy decline in the quarter occurred in April, falling 1.5 percentage points to 86.2%.[25]

Combined occupancy for independent living and assisted living communities fell during the second quarter of 2020.

Impact Of The COVID-19 Pandemic On Emergency Department Visits

To quantify the effect of COVID-19 on U.S. emergency department (ED) visits, the CDC compared the volume of ED visits during four weeks early in the pandemic March 29-April 25, 2020, to that during March 31-April 27, 2019. During the early pandemic period, the total number of U.S. ED visits was 42% lower than during the same period a year earlier, with the largest declines in visits in persons aged 14 years or older, females, and the Northeast region.[26]

Regulatory & Policy Updates

NCQA HEDIS Quality Measures Adjusted For Increased Telehealth Use In Pandemic Crisis

On June 5, 2020, the National Committee for Quality Assurance (NCQA) announced adjustments to 40 Health care Effectiveness Data and Information Set (HEDIS) measures to support the use of video telehealth, telephonic telehealth, and e-visits that take place virtually over a portal during COVID-19 and after.[27]

Rhode Island Unveils A $25 Million Plan To Expand Home-Based Care Options

On July 1, 2020, Rhode Island Governor Gina Raimondo announced a plan to invest $25 million to change the long-term care system to create more home- and community-based service options and strengthen the quality of care provided by nursing facilities. Before COVID-19, about 61% of the state residents needing long-term care services lived in a congregate care facility or nursing facility. This initiative would allow more consumers to live at home with family while receiving medical care rather than in a group facility.[28]

COVID-19 Brings Telehealth Mainstream

While virtual care with a health care provider over the phone or via web camera existed before 2020, the practice absolutely took off once medical offices, schools, houses of worship, and workplaces closed, and social distancing became the new way of life.

Pre-pandemic, CMS reported that only about 15,000 Medicare beneficiaries received telehealth services per week.[29] Through April 2020, just a month after the public health emergency was declared in mid-March, more than 40% of Medicare fee for service primary care visits had shifted to be conducted via telehealth. By October 2020, more than 24 million seniors reported they had participated in a virtual visit with a health care provider.

Similarly, Blue Cross Blue Shield of Massachusetts reported it received about 200 claims for telehealth services each day before COVID-19. That number climbed to 40,000 claims a day in April and May. By March 2021, when many offices had reopened and vaccines were becoming more available, that number had dropped to 30,000 claims per day—still a far cry from 200 just one year before.[30]

Mental Health Dominates Telehealth

With data collected between November 2020 through February 2021, 33% of all mental health appointments were conducted virtually.[31] Primary care followed, holding 17% of its visits virtually. Pediatrics held 9% of its visits virtually, cardiology 7%, and OB/GYN visits were at 4%.

The Ohio Department of Medicaid reported that following a March 2020 rule change from Governor Mike DeWine regarding greater access to telehealth services, telehealth paid claims rose from less than 1% of Medicaid services to about 22% by the end of December 2020. This equals more than 5.8 million claims since March 2020, benefiting more than 860,000 Ohio Medicaid members.

During this time, about 3.3 million services were rendered from Ohio Department of Mental Health and Addiction Services by Medicaid behavioral health provider organizations. Prior to March 2020, Medicaid provider organizations averaged fewer than 1,000 telehealth claims per month for physical health services and 4,000 telehealth claims per month for mental health and addiction services.

In areas equipped with broadband infrastructure in the state, Medicaid use of telehealth services grew 35 times, from an average of less than 8,000 per month prior to COVID-19, to 273,698 per month in December 2020. Medicaid provider organizations that billed for telehealth services increased approximately almost 22 times, from 250 providers in January 2020 to 5,537 by December 2020.[32]

33%

of all mental health appointments were conducted virtually.

Advantages To Telehealth

One of the advantages to virtual care for behavioral health is that providers are twice as likely to offer appointments after hours and on weekends via telehealth.[33] This added flexibility may allow patients to fit mental health care into their lives around work and family caregiving responsibilities. Another advantage of telehealth is that visits can often be quick, less than 15-minute appointments, according to the Telehealth Insights dashboard that tracks the telehealth activities of more than 60,000 health providers.

Providers are twice as likely to offer appointments after hours and on weekends via telehealth.

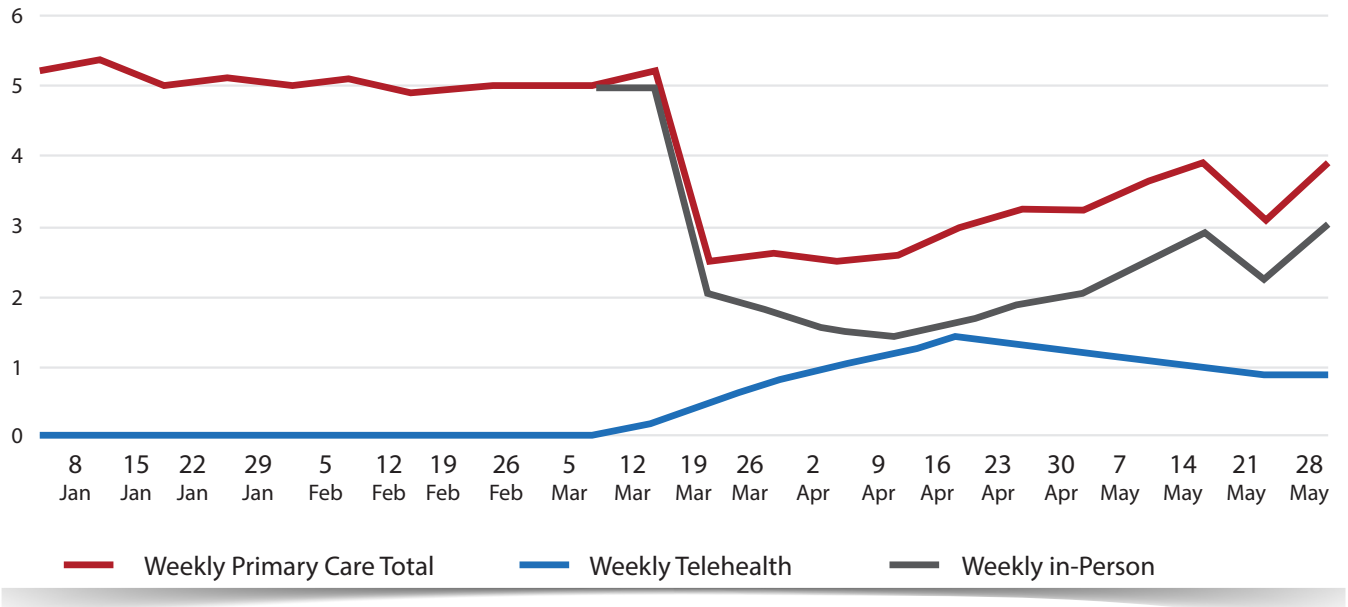
Typical behavioral health visits are longer than 15 minutes in duration. However, these shorter visits can be helpful for a patient trying to combat an acute problem. Provider data recorded between November 2020 and February 2021 showed that 22% of virtual mental health appointments took 15 minutes or less compared to 18% of in-person visits. Telehealth has also been a way for behavioral health providers to continue to engage their established patients. More than 40% of mental health providers said they continue to see existing clients virtually, compared to seeing only 10% of new clients virtually. One potential advantage of telehealth over in-person visits is it may allow some patients to see a provider the same day they call to make an appointment. However, early data shows only 4% of virtual visits are scheduled for the same day which is the same as in-person appointments.

Cost Differences For Telehealth Compared To In-Person Medical Visits

One of the biggest barriers to telehealth adoption in medicine overall has been concerns from policymakers that telehealth will lead to higher utilization and costs in all of medicine (not just mental health).[34] According to the National Committee on Quality Assurance's Taskforce on Telehealth Policy (TTP), a rare positive impact of the pandemic has been all the telehealth claims data generated over the past year. This will allow analysts with the Congressional Budget Office (CBO), the Office of Management and Budget (OMB), and the CMS Actuary to begin to scientifically explore the pros and cons of telemedicine. Previously, traditional Medicare had said it believes telehealth leads to increased costs and utilization for payers. Telehealth proponents have said that the CBO and OMBD estimates lack real data and do not account for cost savings obtained through better management of chronic diseases, reduced re-admissions to the hospital after being discharged, and fewer urgent care visits. However, very little claims data existed before 2020 to support or refute these claims. Unfortunately, due to the pandemic, many individuals simply avoided medical visits completely so the numbers that will be analyzed will not be the same for a typical year.

A key to the future of telehealth will be determining when telehealth is used as a substitute for in-person care as opposed to an additional service added on. One 2020 study estimated that telemedicine could effectively take the place of up to $250 billion in current medical care spending.[35]

Figure 3 Primary Care Visits For Fee For Services Medicare Beneficiaries, Visits In Millions Per Week[36]



Legislative Issues For Telemedicine

The challenge for providers once the world fully reopens will be deciding what telehealth services to keep and how to manage them. Here are a few of the issues that legislators will have to work through once the pandemic's public health emergency ends:[37]

Geographic & Originating Site Restrictions

During the early days of the pandemic, Medicare relaxed its rules about telehealth. Before 2020, telehealth was only available to rural patients without access to local providers. Even then, patients could not take the appointment from home; they had to be physically present at another approved health care facility in order to virtually see an approved provider at another location. The rules were relaxed during the pandemic to allow patients and providers to receive and deliver care from home. The idea was that allowing these services to take place at home and not a facility would prevent the spread of COVID-19 in medical clinics during routine care. This home-based care allowed telehealth to really take off and it has been quite popular with patients as a way to avoid traffic and crowded waiting rooms.
Some behavioral health providers report that mental health patients who might have skipped an in-person appointment, never miss a virtual one.[38] Health practices have consistently reported lower no-show rates with telehealth especially in mental health where telehealth removes the stigma of visiting a behavioral clinic. For example, the baseline no-show rate for psychiatry services is between 19% and 22% of appointments while the MDLive telehealth platform reports no-show rates of 4.4% to 7.26% for its behavioral health telehealth visits.[36]

Provider Reimbursement For Telehealth

Through the pandemic, Medicare has reimbursed telemedicine visits at the same rates as in-person office visits. Outside of the public health emergency declaration, Medicare pays a lower rate for telehealth services compared to office visits. Congress and payers will have to decide on a long-term strategy for telehealth, weighing the popularity of its convenience with patients and the scientific evidence that will come out in the next few years regarding the efficacy and affordability of these services. [29]

Telehealth Platform

Medicare normally requires patients and medical providers to interact in real time over video technology. However, Medicare waived this requirement during the pandemic to allow for some visits to be conducted only exclusively over audio with no video component. During the emergency, CMS has been reimbursing audio-only visits at the same rate they do in-person office visits. Although there is debate among some providers about whether audio-only visits provide the same level of care as video or in-person visits, these telephone visits have definitively allowed many patients to have access to health care who might not have had it otherwise. [29]

State Licensing Laws

State medical laws usually require providers to be physically based in the same state as the patient they are treating. However, many of these laws have been relaxed during the pandemic to make it easier for patients to see any specialist, not just one in their immediate geographic area. These laws have the positive impact of allowing patients to receive care sooner due to shorter wait times to see providers. This also corrects some supply and demand imbalances of some types of specialists in different parts of the country. However, more data is needed still to know if telehealth is as effective long-term as in person care. It may be that a hybrid of in-person and telehealth may be the future for chronic conditions. [29]

NATIONAL BEHAVIORAL HEALTH LANDSCAPE (cont.)

Psychiatric inpatient bed availability is a high priority from Medicare where commercial insurance indicates a much lower priority. The difference is likely from the increasing needs of a growing Medicare population as it relates to psychiatric illness where the commercial insurance plans believe there is adequate inpatient psychiatric capacity for their members.

Telehealth can play an important role where the lack of in-person psychiatrists could be fulfilled, in part, by telehealth adoption.

The increasing pressure to recruit and retain psychiatrists presents additional pressure on inpatient psychiatric providers. Telehealth can play an important role where the lack of in-person psychiatrists could be fulfilled, in part, by telehealth adoption. Regulatory pressure and requirements for in-person evaluation will continue to create complexity in telehealth's usage in ultimately being an important part of the solution.

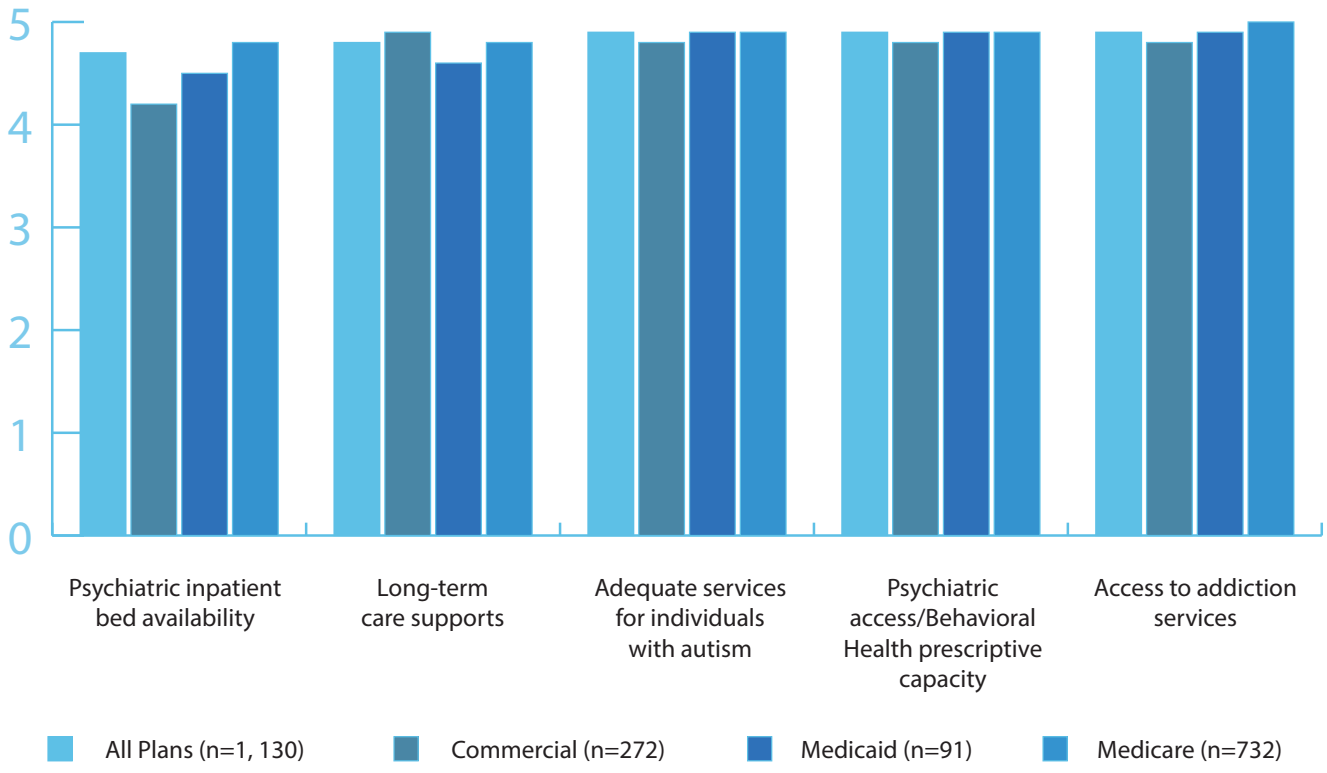
1. Long-term care supports see a difference between health plans, Medicare, and Commercial insurance contrasting to Medicaid where the needs are seen with much less importance. The likely difference in the long-term care trends is that the Medicaid population has lesser needs for longer term care as well as the movement to the usage of in-home care models. An important part of the in-home care model is telehealth usage. The regulatory hurdles that have plagued telehealth could either support this movement to in-home or create barriers that will create complexity in meeting the demand.

2. The needs of individuals with autism are seen by all of the constituent types surveyed as a significant priority. Care for individuals with autism continues to shift to community-based models. In these community-based models, telehealth plays a vital role in replacing institutional care. As care sophistication increases the needs of this growing population will also see an increase in demand. However, those with higher levels of acuity will continue to present problems with capacity of the system which is demonstrated by the extensive backlog of individuals on state waiting lists. Telehealth will offer component level relief for these individuals.

3. The needs for psychiatric prescriptive health care practitioners continue to grow while the number of individuals with prescriptive authority for psychiatric illness continues to decrease. Each constituent group surveyed clearly sees the ongoing problem of access to care as being a significant issue. The increased usage of telehealth and telepsychiatry will provide a level of relief for this increasing demand on the system.

4. Addiction treatment is seen as a very high priority by all those surveyed. The opioid epidemic has increased the needs of addiction treatment very significantly in the United States and abroad. Clearly, the industry still sees ongoing need from this population and how telehealth regulation could impact the delivery of these highly needed services.

Figure 4 Future Of Telehealth Regulation Expectations By Plan, 2021, On A 5-Point Scale Where 1 = No Importance & 5 = Required[38]



The Rise Of Integrated Care & Care Coordination

Simply put, integrated health care is the systematic coordination of mental health care with physical health care services. This means aligning behavioral health care, care for ailments such as depression, autism or addiction treatments, with primary care, such as treatments for broken bones and seasonal flus. The significance for patients and their families with more than one health condition or comorbidity is that they can now have their health needs met by a central provider organization that has all these services available instead of having to make many different appointments with different offices. This is especially important for marginalized communities that often lack access to high-quality health care.[39]

A November 2020 survey of behavioral health and intellectual development and disability provider organizations found that more than half (52%) of providers surveyed report they have already started the process of integrating behavioral health and primary care. A third of provider organizations (33%) indicated they are considering an initiative to integrate behavioral health and primary care, while 15% of provider organizations said they are not considering an integration initiative currently.

Of the organizations that are already integrating services, many have chosen established designations to guide their implementations. About a quarter (23%) said they are considering, or already pursuing, designation as a Federally Qualified Health Clinic (FQHC) or Look-Alike while 30% are considering, or

already pursuing, designation as a Certified Community Behavioral Health Clinic (CCBHC). About 14% said they are considering, or already pursuing, designation as a Patient Centered Medical Home (PCMH).

These care coordination models are not the only ones available. A report conducted in 2019 found there are about seven main models providers use to integrate physical and behavioral health. The models range from those that change provider roles within the existing system such as PCMH, health homes, and CCBHCs to models that restructure the basic financing of benefits like accountable care organizations (ACOs), managed long-term services and supports (MLTSS) plans, dual-eligible integration initiatives, and vertical/specialty health plans.[40]

The most common model was PCMHs in 30 state Medicaid plans. There are MLTSS plans in 22 states and health homes in 21 state Medicaid plans. The models that are least common are Medicaid ACOs, dual demonstration initiatives, and CCBHCs (note that CCBHCs are limited to the states that received grants). The Substance Abuse and Mental Health Services Administration (SAMHSA) is furthering integrated care by funding CCHBC expansion grants. In January 2020, it offered $197 million in annual funding to help providers combine behavioral health services with physical health services. The total funding per award was up to $2 million per year for up to two years.[41] Then in January 2021, the federal COVID relief bill included $4.25 billion to SAHMSA to address mental health concerns. Of those funds, $600 million was ear marked for CCHBC grants.[42]

Figure 5 Medicaid Care Coordination Initiatives, 2018-2019 [40,43]

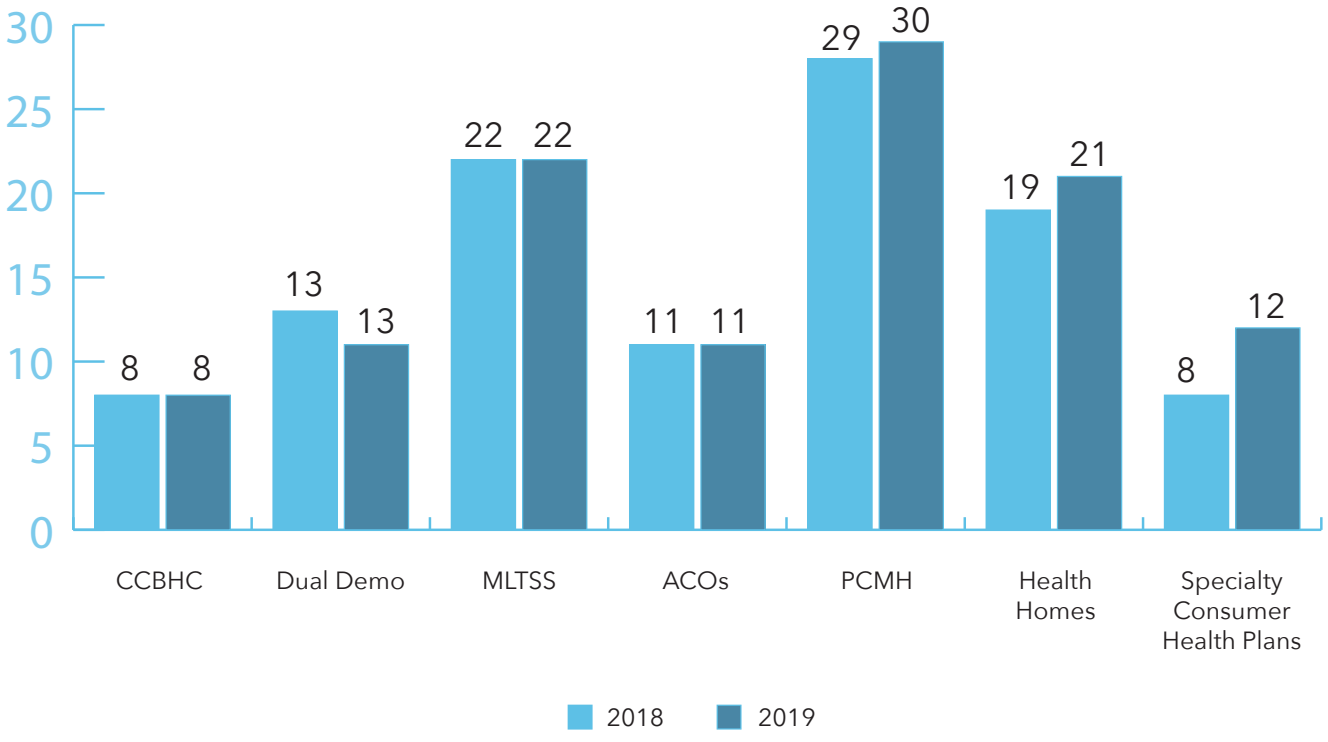


Table 5 Care Coordination Initiative Implementation By State, 2019[43]

	ACOs	CCBHC	Dual Demo	MLTSS	Health Homes	PCMHs	Specialty Consumer Health Plans	Other Care Coordination Initiative
Alabama						X		
Alaska						X		X
Arizona				X			X	
Arkansas				X		X	X	
California			X	X	X		X	
Colorado	X					X		
Connecticut	X				X	X		
Delaware				X	X			
District Of Columbia					X		X	
Florida				X		X	X	
Georgia						X	X	
Hawaii				X	In Future			
Idaho	In Future		X*	X		X		
Illinois			X	X	On Hold	X	X	
Indiana							Considering	
Iowa				X	X			
Kansas				X	In Future			
Kentucky								
Louisiana						X		
Maine	X				X			
Maryland					X			
Massachusetts	X		X	X				
Michigan			X	X	X	X		
Minnesota	X	X	X	X	X	X		

Table 5 Care Coordination Initiative Implementation By State, 2019 (cont.)

	ACOs	CCBHC	Dual Demo	MLTSS	Health Homes	PCMHs	Specialty Consumer Health Plans	Other Care Coordination Initiative
Mississippi								
Missouri		X			X	X		
Montana						X		
Nebraska						X		
Nevada		X						
New Hampshire								
New Jersey	X	X		X	X	X		
New Mexico				X	X	X		
New York	X	X	*	X	X	X	X	
North Carolina				X		X	In Future	
North Dakota								
Ohio			X			X		On Hold
Oklahoma		X			X	X		
Oregon	X	X				X		
Pennsylvania		X		X		X		X
Rhode Island	X		X		X	X		X
South Carolina			X			X		
South Dakota					X			
Tennessee				X	X	X		X
Texas			X	X		X	X	
Utah	X							
Vermont	X				X	X		
Virginia				X		X		

Table 5 Care Coordination Initiative Implementation By State, 2019 (cont. part 2)

	ACOs	CCBHC	Dual Demo	MLTSS	Health Homes	PCMHs	Specialty Consumer Health Plans	Other Care Coordination Initiative
Washington			X		X		X	
West Virginia					X		X	
Wisconsin				X	X		X	
Wyoming						X		X

Alternative Payment Models In Medicare & Medicaid

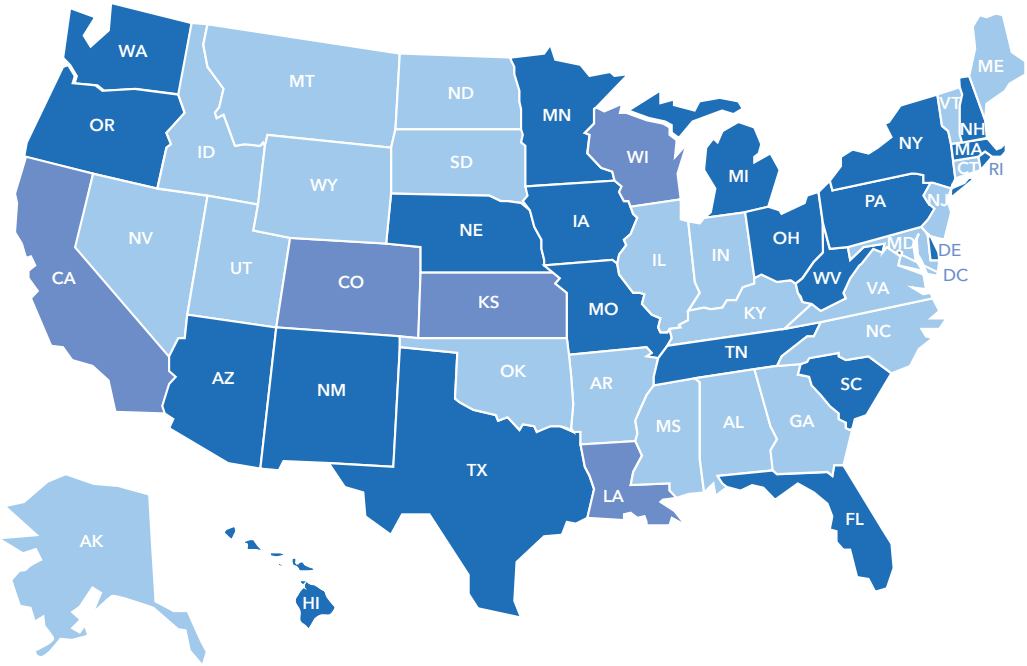
More Medicaid spending is moving to health plans—and more of those dollars are being paid to provider organizations in the form of some type of value-based reimbursement. That evolution has been happening for a while, but the extent of the change over the past decade has been significant. Currently, 67% of Medicaid consumers are enrolled in some type of health plan, with 55% of Medicaid budgets going to health plan payments. Approximately 93% of Medicaid managed care organizations (MCOs) reported using value-based payments (VBPs) or alternative payment models (APMs) during 2019. About 79% of the plans reported that their state contracts required them to implement VBP contracting with provider organizations.[44]

The Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC) reported that, in 2019, $299 billion (more than half of the total Medicaid spending of $594 billion) was for managed care capitation and premium assistance payments. And capitated payments to comprehensive Medicaid managed care plans accounted for more than 90% of the $299 billion spending for managed care. In 22 states, the share of Medicaid spending for managed care capitation and premium assistance payments was higher than the 50.3% national average. Across these states, the share ranged from 51% in Nebraska to 88% in Kansas. MACPAC noted that fee-for-service (FFS) spending, at $284.4 billion, accounted for 48% of the $594 billion Medicaid spending in 2019.

These payment increases are driven by increases in enrollment. Medicaid managed care enrollment increased from 49% of the Medicaid population of 74 million consumers in 2010 to 73% of the Medicaid population in 2019. The number of states with any type of managed primary care and acute care services grew from 37 states in 2010 to 42 states in 2019. In 2019, 37 states had the majority of their population enrolled in managed care, compared to only 25 states in 2010.

The populations that are required to enroll in each delivery system vary by state. Some states, like Tennessee and Hawaii, have comprehensive managed care delivery systems that require all eligible individuals to enroll in managed care. Today, more than 50% of all Medicaid managed care consumers are covered by four health insurance companies—Centene, Anthem, UnitedHealth care, and Molina Health care.

Figure 6 States With APM Requirements In 2017/2018 vs. 2019[43]



At the same time, Medicaid health plans are changing how they reimburse provider organizations for services. The Institute for Medicaid Innovation reported that all Medicaid MCOs covering more than 250,000 consumers reported using VBPs or APMs; about 80% of MCOs with up to 250,000 consumers also used VBPs and APMs.

The most common payment strategies were payment incentives based on access to care (about 64%), incentives for availability of same-day or after-hours appointments (43%), enhanced payment rates for hard-to-recruit provider types (29%), and other strategies (29%) including the integration of behavioral health care into primary care. In 2018, 33% of Medicaid payments were linked to value: 10% were predominantly pay-for-performance; 17% were APMs built on FFS architecture; and 6% were population-based payments. This is due to state mandates in many cases; twenty-eight state Medicaid plans require their health plan contractors to reimburse provider organizations using APMs.

Where are we headed next? The federal government has ambitious plans to have half of Medicaid and commercial plan payments and all of Medicare payments be value-based by 2025. In September 2020, CMS issued a guidance to states on how to advance value-based care across their health care systems, with an emphasis on Medicaid populations. CMS encouraged states to align payment incentives and performance measures across their health care systems to reduce the burden on providers who participate in multiple programs.

Table 6 Alternative Payment Models (APMs) In Medicare & Medicaid[44]

Category 1 FEE-FOR-SERVICE – NO LINK TO QUALITY & VALUE	
Category 2 FEE-FOR-SERVICE LINK TO QUALITY & VALUE	• Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for Honesty Integrity Trust [HIT] investments) • Pay for Reporting (e.g., bonuses for quality performance) • Pay-For-Performance (e.g., bonuses for quality performance)
Category 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	• APMs with Shared Savings (e.g., shared savings with upside risk only) • APMs with Shared Savings & Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)
Category 4 POPULATION-BASED PAYMENT	• Condition-Specific, Population-Based Payment (e.g., per member per month payments and payments for specialty services, such as oncology or mental health) • Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments) • Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)

Table 7 Percentage Of Payments Through APMs To Organizations, By Health Plan Size, 2019[45]

Percentage Of Payments Through APMs To Primary Care Provider Organizations, By Health Plan Size, 2019				
Percentage of Payment	Medicaid MCOs with 250,000 or fewer covered lives	Medicaid MCOs with 250,001 to one million covered lives	Medicaid MCOs with over one million covered lives	All Medicaid MCO respondents
1-15%	50%	33%	50%	43%
16-30%	0%	33%	0%	14%
More than 30%	50%	33%	0%	43%
None	0%	0%	0%	0%

Percentage Of Payments Through APMs To Hospitals, By Health Plan Size, 2019				
Percentage of Payment	Medicaid MCOs with 250,000 or fewer covered lives	Medicaid MCOs with 250,001 to one million covered lives	Medicaid MCOs with over one million covered lives	All Medicaid MCO respondents
1-15%	25%	50%	50%	43%
16-30%	0%	17%	25%	14%
More than 30%	25%	17%	0%	14%
None	50%	17%	25%	29

Table 8 MCO VBP Implementation With Specific Provider Organization Types, 2019[45]

MCO VBP Implementation With Specific Provider Organization Types, 2019			
Provider Organization Type	MCO worked with a majority of this Provider Organization Type	MCO worked with Select Provider Organizations	MCO did not work with this Type of Provider Organization
Behavioral Health	0%	43%	57%
Dentists	14%	7%	79%
Home and Community-Based Service Providers	0%	21%	79%
Long-Term Care Facilities	0%	21%	79%
Nurse-Midwives	0%	14%	86%
Obstetricians/ Gynecologists	7%	57%	36%
Orthopedics	7%	14%	79%
Primary Care Professionals (i.e., Physicians, Advanced Practice Nurses, Physician Assistants)	50%	36%	14%
Other Specialists	7%	29%	64%

Institution For Mental Disease (IMD) Medicaid Exclusion

Despite a decades-old statutory provision that largely prohibits federal Medicaid payments to institutions for mental diseases (IMDs), states can and do legitimately pay for mental health or substance use disorder (SUD) services in these facilities.

The goal of this exclusion was to encourage states to build community-based behavioral health capacity to shift the financial responsibly from the federal government to the states.[46,47]

The federal Medicaid program defines an IMD 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, including medical attention, nursing care, and related services." The term IMD is only relevant to Medicaid; they are not singled out by other payers, state licensure agencies, or accrediting bodies. For licensing purposes, IMDs can provide inpatient or residential mental health and addiction treatment as needed.

MACPAC found that states use a variety of federal Medicaid authorities to pay for services in IMDs. These include Section 1115 Demonstration Waivers and in-lieu-of services in managed care, as well as statutory exceptions to the exclusion for services provided to adults aged 65 and older and children and youth under age 21. Most recently, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 allowed states to make payments under their state plans to IMDs for services provided to beneficiaries with a substance use disorder.

The report also found that state licensure agencies, accrediting bodies, and other payers do not have standards specific to IMDs, given that the designation is unique to Medicaid. States regulate inpatient and residential treatment facilities separately and standards vary according to whether a facility provides addiction treatment or mental health care. Federal standards for IMDs are largely determined by whether or not facilities are Medicare providers, but because Medicare does not pay for substance use treatment services in most freestanding facilities, there is no federal certification process for these providers.

Public Health Care Safety Net

The ACA has no doubt helped more Americans have access to health insurance. However, many people still do not have adequate care either because they are underinsured with a high-deductible plan they cannot afford or because they lack U.S. citizenship. Currently, undocumented immigrants are not eligible to buy health insurance through the ACA.[34] For those individuals, many states, localities, and non-profit organizations have created safety-net programs to ensure health care access to all residents.

For example, New York City and San Francisco both have city-wide programs to make health care services available to residents regardless of citizen, employment, or health status. The city of Houston also operates a program called "Harris Health" that provides health services on a sliding scale to residents. In 2020, Harris Health provided about 1.7 million outpatient visits, seeing an average of 546 patients a day. Harris Health is a good example of a safety net serving minority populations. About 60% of the patients seen identified themselves as Latino (compared to 44% of the Latino population of Houston) while 25% were Black (compared to 20% of the Harris population).[49,50,51]

Federal Legislation & Rules

Some of the main changes to health care coverage have come through various federal COVID-19 relief bills. Federal legislation enacted

on December 27, 2020, to address the pandemic provided $4.25 billion in emergency funding to SAMHSA. At least $125 million of the emergency funding will be allocated to tribes, tribal organizations, urban Indian health organizations, or health service provider organizations to tribes across a variety of programs.[41,42]

The $4.25 billion emergency funding is allocated to the following SAMHSA programs:

- $1.65 billion for the Substance Abuse and Prevention Treatment Block Grant.
- $1.65 billion for the Mental Health Services Block Grant.
- $600 million for Certified Community Behavioral Health Clinics (CCBHC).
- $50 million for suicide prevention programs.
- $50 million for Project AWARE to support school-based mental health services for children.
- $240 million for emergency grants to states.
- $10 million for the National Child Traumatic Stress Network.

The emergency funding to SAMHSA was part of the total $900 billion that the legislation allocated for COVID-19 relief provisions. The legislation also included $1.4 trillion to federal agencies for their fiscal year 2021 budgets.

SAMHSA's 2021 budget is $6 billion, up 2.2% ($133 million) over the 2020 enacted budget.

SAMHSA received increased funding for the following programs:

- Mental health resources: including a new $35 million crisis care initiative within the Mental Health Block Grant; and expanded services and support for mental health for children and youth including $107 million for Project AWARE, an increase of $5 million; and $72 million for the National Child Traumatic Stress Initiative, an increase of $3 million.
- Suicide prevention: including $21 million for the Zero Suicide program, an increase of $5 million; and $24 million for the Suicide Lifeline, an increase of $5 million.
- Addiction treatment: $3.8 billion, an increase of $17 million, including continued funding of $1.7 billion for the Substance Abuse Prevention and Treatment Block Grant and $1.5 billion for State Opioid Response Grants.
- Addiction prevention: $208 million, an increase of $2 million.

The subsequent pandemic relief bill signed into law on March 11, 2021 makes changes to the federal Health Insurance Marketplace to increase access and eligibility for financial assistance. Consumers in non-Medicaid expansion states with incomes of $12,880, 100% of the federal poverty level (FPL), and those earning more than 400% FPL ($51,520) who would pay more than 8.5% of income on premiums for individual or family coverage are eligible for the new subsidies.

Before the bill, subsidies were limited to consumers earning $51,520 or less. Those earning up to 150% FPL were required to pay premiums equivalent to 2% of income. Households contributed up to 9.83% of their income to pay for health insurance premiums to be eligible for tax credits based on the cost of the benchmark plan. Households with income greater

than 400% FPL were not eligible for tax credits to defray the cost. Under the American Rescue Plan, there is no longer an upper bound on income to qualify for subsidies in 2021 and 2022. Zero-dollar benchmark Marketplace coverage will be available for people earning up to 150% FPL.

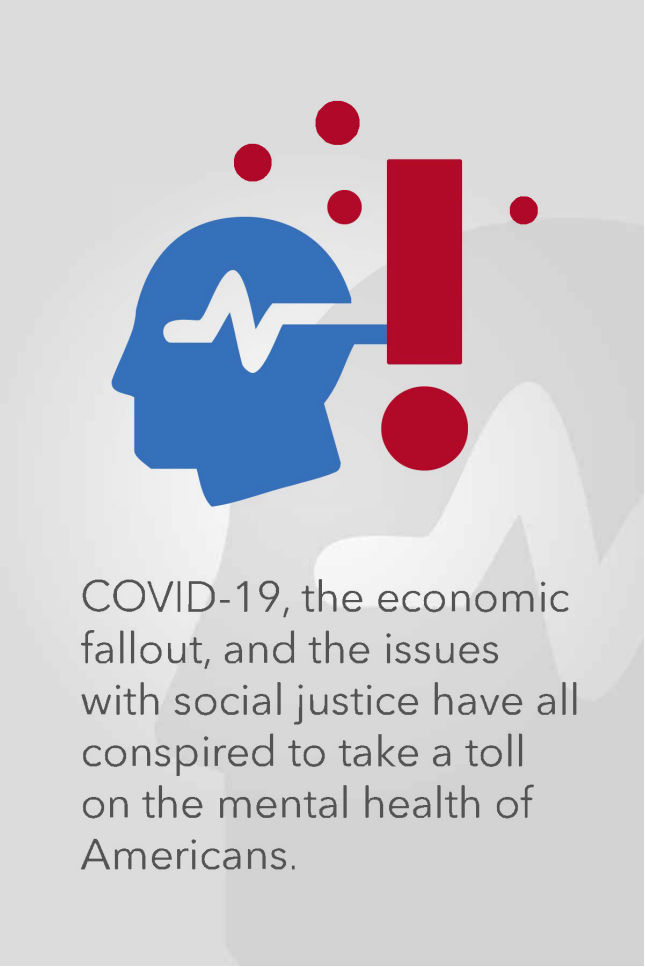
HHS estimates that 14.9 million uninsured Americans will now be able to find the coverage they need at a price they can afford. About 3.6 million uninsured people are estimated to be newly eligible for health care coverage savings. Another 1.8 million uninsured people are estimated to be eligible for zero-dollar benchmark Marketplace coverage. An additional 9.5 million uninsured people with incomes between 150% and 400% of the FPL are estimated to potentially qualify for additional financial support to reduce out-of-pocket costs for Marketplace premiums. CMS projects that 80% of enrollees will be able find a plan for $10 or less per month after premium tax credits.[52]

Looking Forward At The Health Care Landscape

COVID-19, the economic fallout, and the issues with social justice have all conspired to take a toll on the mental health of Americans, causing spikes of anxiety, depression, and other behavioral health issue.[53] This rise in cases has put pressure on behavioral health providers to innovate to better serve more people.

Fortunately, there is a renewed interest at the federal level to significantly increase access to mental health care through additional subsidies. This will allow citizens to purchase insurance through the ACA, and grant funding to agencies like SAMHSA, who will continue to press for more integrated care solutions that marry behavioral health and physical health.

There will also be changes due to technology. The rise of telehealth has been swift and generally well received. The challenge going forward will be to ensure that these treatments are effective and that providers are adequately reimbursed for their services. Several scientific studies on telehealth outcomes have already been published and there will be many more to come as providers and health systems are able to analyze and share their results. Mental health visits via telehealth spiked during the pandemic so much of the research published will focus on those patients, providing valuable efficacy data to inform future care.



But it is not the use of technology that will have the market impact. It's the fact that the use of technology has changed customer expectations and reduced-price points for many services. Those factors will change the competitive advantage of almost all behavioral health providers.

Figure 7 Technology-Driven Changes To Market Metrics[54]

NATIONAL BEHAVIORAL HEALTH LANDSCAPE (cont.)

Customer expectations have changed dramatically. Consumers have grown to expect convenient, on-demand, personalized service experiences that use their clinical history and service preferences. The new Digital Health Consumer Adoption Report 2020 from the Center for Digital Health at Stanford University School of Medicine and Rock Health noted that from 2019 to 2020, telehealth visits increased by 11% overall (from 32% to 43%); use of wearables increased by 10% (from 33% to 43%); and digital health tracking went up by 12% (from 42% to 54%). But perhaps more importantly, 67% of consumers search for health care information online and 60% search for provider reviews online—although these numbers dropped slightly from 2019, likely because of health care underutilization during the pandemic.

Another study, by Healthgrades, found that when given a choice between providers with similar experience, proximity, availability, and patient satisfaction ratings, the vast majority of consumers—81% for primary care and 77% for specialists—choose the provider who offers online scheduling. The study also found that text and email reminders for appointments can help to reduce no-shows by as much as 25%.

Payers and health plans have expectations of quick access, hybrid service delivery capacity, interoperability and data sharing, measurable performance, and the ability to accept value-based payments with downside risk. While customer expectations are on the rise, price points are declining. Virtual service systems and retail service systems are delivering care for low rates (for example, Walmart charges $45 for a counseling session for existing consumers and $60 for a new consumer). Organizations that can use technology to streamline administrative and clinical processes have a distinct cost advantage. The market is responding to virtual sessions that cost less than $100 and affordable subscription models. As a result, much of the service for consumers with mild and moderate conditions will move to tech-enabled options. The question for health and human service provider organizations will be how to maintain revenue, margins, and sustainability in a post-pandemic landscape reshaped by technology.[54]

Executive Summary

Overview of State Behavioral Health Systems

Individual states hold significant power in making decisions about the mental health systems serving their residents which is why mental health regulations and available services can look very different from state to state and even from county to county within the same state. The federal government sets certain minimum standards, but states are free to expand beyond what exists at the federal level and improve services, access, and protections for consumers. The hope is that this flexibility to innovate will allow providers to tailor their services to the specific needs of their local population as well as pilot new services and delivery models.[1]

In general, state laws create changes and provide oversight to health programs within each state. Regulations are rules issued by state agencies to help carry out laws created by state and local jurisdictions. In terms of mental health, state regulators tackle a variety of issues including treatment facilities, medical records, and standards for involuntary treatment. These rules help states implement their mental health plans and give guidance on local laws that may impact individuals with mental health concerns and their caregivers.

States also must follow the protections established by the federal government. States are not allowed to offer fewer protections than the federal government. However, they can strengthen laws to add additional protections where they deem necessary. States have the power to increase standards, such as adding more regulations around protecting patient privacy, preventing fraud and abuse, and ensuring the civil rights of residents are upheld. These additional laws range from discretion over civil commitment standards to determining duty-to-warn laws to supporting access to the least restrictive services that keep people in the community and not in a hospital or incarcerated. Public schools and workplaces are generally guided by state laws.

How much or how little a state spends on behavioral health services varies greatly. While all states receive federal support via Mental Health Block Grants and partial funding of services provided through Medicaid and CHIP (Children's Health Insurance Program), individual states are free to design and fund their local mental health system as they see fit. In addition to funding state hospitals, state funding is typically funneled to county and local levels where services are offered. The political beliefs of the majority of members of state legislatures can greatly impact budgets for behavioral health services, with more conservative states favoring lower tax burdens that provide fewer safety net services compared to their more progressive counterparts who are in favor of larger tax burdens in exchange for more services.

Due to many different services provided by each state, the role each state plays in the academic medical research conducted by state facilities also varies widely. Some states share detailed data to allow researchers to analyze the pros and cons of certain treatments. This is especially helpful when looking at pilot projects to see what might be effective in another part of the country as projects that work well on a smaller scale are replicated at larger municipalities to see if the success can be mirrored. Public universities also play a varying role in the research of a state, often leading pilot projects and analyzing results. These universities also work with behavioral health organizations to train and recruit the next generation of care providers.

STATE BEHAVIORAL HEALTH LANDSCAPE (cont.)

Mental Health America's 2021 "The State of Mental Health in America" publishes rankings of how all the states compare in terms of how many people have mental illness and the access to care for those individuals. An overall ranking 1-13 indicates lower prevalence of mental illness and higher rates of access to care. An overall ranking 39-51 indicates higher prevalence of mental illness and lower rates of access to care. The combined scores of all 15 measures make up the overall ranking. The overall ranking includes both adult and youth measures as well as prevalence and access to care measures.[2]

The 15 measures that make up the overall ranking include:

1. Adults with mental illness.
2. Adults with substance abuse issues in the past year.
3. Adults with suicidal ideation.
4. Youth with at least one major depressive episode in the past year.
5. Youth with substance abuse issues in the past year.
6. Youth with at least one major depressive episode in the past year.
7. Adults with mental illness who did not receive treatment.
8. Adults with mental illness who reported having an unmet need for their mental health treatment.
9. Uninsured adults with mental illness.
10. Adults with cognitive disabilities who could not see a doctor due to cost.
11. Youth with major depressive episodes who did not receive mental health treatment.
12. Youth with severe depression who received some consistent services.
13. Children with insurance that did not cover behavioral health problems.
14. Students with a diagnosed emotional disturbance receiving services through an individualized education program (IEP).
15. Availability of mental health professionals in the state to care for these patients.

The following chart is a visual representation of the sum of the scores for each state. It provides an opportunity to see the difference between ranked states.[2]

A few states are notable for their large changes in overall rankings in 2021 compared to 2020.

- Montana jumped from 43 to 30 on the list in the overall state rankings. The indicator having the largest effect on their overall score was because the number of youths with major depression who did not receive treatment dropped from 63.2% to 55.6%.
- Washington moved from 45 to 31 mostly because the number of youths with major depression who did not receive treatment dropped from 59.1% to 47.0%.
- Kansas moved from 42 to 29 mostly because the number of youths with major depression who did not receive treatment fell from 70.8% to 54.7%.
- Iowa dropped from 9 to 23 as the number of adults reporting unmet needs went from 18.2% to 25.5%. The number of adults without insurance also rose from 3.3% to 8.4%.
- Missouri also fell in the rankings due as the number of youths receiving treatment for their severe depression dropped from 36.7% to 19%. The number of adults who did not receive any treatment for their behavioral health issues rose from 50.9% to 55.3%.

Table 1 Mental Health America's 2021 State Rankings[2]

State	Ranking 2021	Ranking 2020	State	Ranking 2021	Ranking 2020
Vermont	1	3	Connecticut	13	10
Pennsylvania	2	1	Maine	14	19
Massachusetts	3	7	Michigan	15	17
Maryland	4	5	South Dakota	16	24
New Jersey	5	8	Kentucky	17	21
New York	6	2	New Hampshire	18	14
Minnesota	7	6	Wisconsin	19	13
Hawaii	8	12	Nebraska	20	23
District of Columbia	9	16	Louisiana	21	30
Delaware	10	11	Illinois	22	20
Ohio	11	18	Iowa	23	9
Rhode Island	12	4	North Dakota	24	15

Table 1 Mental Health America's 2021 State Rankings[2] (cont.)

State	Ranking 2021	Ranking 2020	State2	Ranking 2021	Ranking 2020
California	25	22	Idaho	50	49
Virginia	26	27	Georgia	37	36
Texas	27	38	Missouri	38	25
Tennessee	28	39	West Virginia	39	37
Kansas	29	42	Arizona	40	28
Montana	30	43	North Carolina	41	35
Washington	31	45	Arkansas	42	33
Mississippi	32	34	South Carolina	43	44
Indiana	33	26	Wyoming	44	47
New Mexico	34	31	Oklahoma	45	41
Florida	35	32	Utah	46	48
Alabama	36	36	Colorado	47	29
Alaska	49	46	Oregon	48	50

State Behavioral Health Systems Typology Chart

Table 2 Medicaid Behavioral Health Financing Models[3]

Medicaid Behavioral Health Financing Model Definitions

A carve-out is a managed care financing model where some portion of benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed.

- Primary Carve-Out To Private BHOs: The state Medicaid program delegates some or all behavioral health benefits to a separate private behavioral health organization (BHO) that is at-risk for this subset of services.
- Primary Carve-Out To Governmental/Regional BHOs: The state Medicaid program delegates some or all behavioral health benefits to a separate governmental or regional BHO that is at-risk for this subset of services.
- Behavioral Health Service Financing In Private Health Plans: The state Medicaid program contracts with private health plans that are responsible for all behavioral health services, as well as physical health services.
- Behavioral Health In Medicaid FFS Plans: The state Medicaid program retains responsibility for some or all behavioral health benefits without delegation to a separate management entity. Other Medicaid services may also be delivered through the Medicaid fee-for-service (FFS) plan or through a health plan.
- Consumer-Specific Specialty Health Plans: The state Medicaid program delegates responsibility for all benefits (physical health and behavioral health) for consumers with behavioral health disorders (or other specific disorders or needs) to a specialty Medicaid health plan.

There are two key factors that characterize the Medicaid behavioral health market: who is being served, and how behavioral health services are financed.

This year marks the end of an era in health care financing. With the January 2021 announcement that the Centene Corporation was purchasing Magellan Health for $2.2 billion, there are no more standalone companies focused solely on managing behavioral health benefits. In 2002, there were more than 800 organizations that offered managed behavioral health and employee assistance programs. At the time, Magellan Behavioral Health had the largest enrollment with 30% of the market.[4]

These horizontal carve-outs were once a growing phenomenon. This was also a time when we saw the growth of national specialty hospital chains focused on behavioral disorders, which increased the average length of an individual's stay in impatient clinics. The number of private psychiatric hospitals in the United States increased from 180 in 1970 to nearly 250 in 1985. The number of psychiatric beds in the nation's hospitals rose by 37% in 1985 alone. Back then, behavioral health was intentionally disconnected from primary care health services. There was no parity for behavioral health disorders and consumers with severe illnesses were often excluded from coverage because they had preexisting conditions or had exhausted their benefits and were referred to public programs. Most often, benefits for mental health and addiction treatment simply were often not included in other quality improvement and cost containment initiatives.

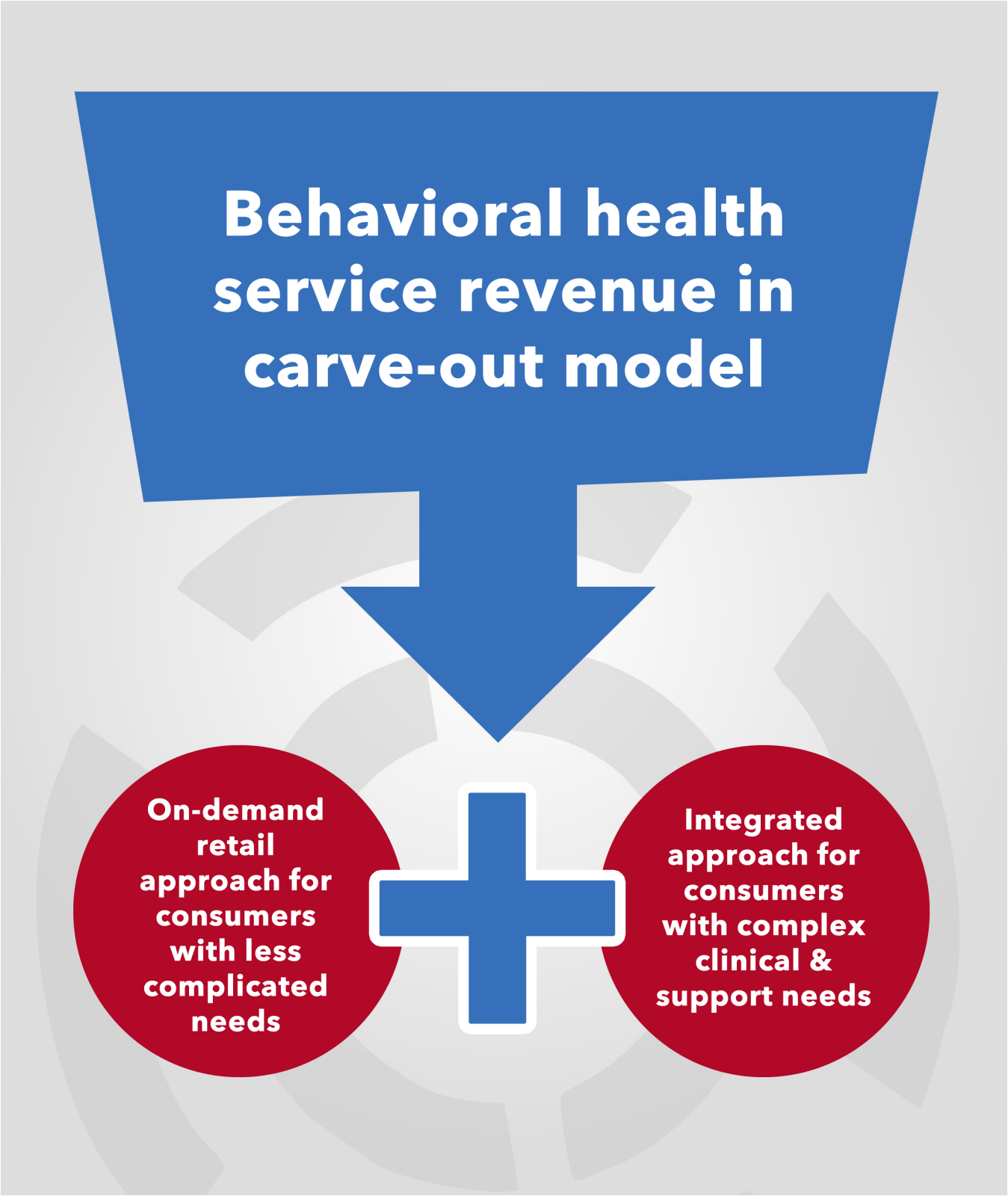
First employers and then health plans and state Medicaid plans began adopting a financing strategy to fund behavioral health separately from physical health care. The proof is in the numbers. Enrollment in managed behavioral health programs rose by 170% over two decades, from 63.2 million in 1993 to 171.2 million in 2012.

The Patient Protection and Affordable Care Act (ACA) enacted in 2010 was the beginning of the end of the horizontal benefits model of behavioral health carve-outs. Parity, broader coverage, no preexisting limitations, and no annual and lifetime limits forced health insurers to connect the cost of mental health, mental illnesses, and addictive disorders. It became clear that in many cases, the costs of treating behavioral health disorders were less than the medical costs of the untreated behavioral disorders; reason being, medical costs for treating people with chronic medical and comorbid behavioral health conditions can be two to three times as high as for consumers without behavioral health conditions.

The number of private psychiatric hospitals in the United States increased from 180 in 1970 to nearly 250 in 1985. The number of psychiatric beds in the nation's hospitals rose by 37% in 1985 alone.

The question is what has replaced the behavioral health carve-out as a delivery system for behavioral health benefits. The field appears to be moving to two tiers of behavioral health services. For consumers with mild to moderate conditions, the use of "on demand" services via retail locations, asynchronous artificial intelligence-driven tools, and/or telehealth is growing (although the pandemic has undoubtedly kick-started these efforts). For consumers with more complex conditions, the approach generally is more vertical or integrated with specialty care coordination programs/health homes and specialty/vertical health plans managing all services. These are all changes that point toward systemic change toward a more retail model of service delivery. Consumers are more empowered today and are utilizing search engines, social media platforms, and personal recommendations to drive their health care decision-making.

Figure 1 Behavioral Health Spending Evolution[4]



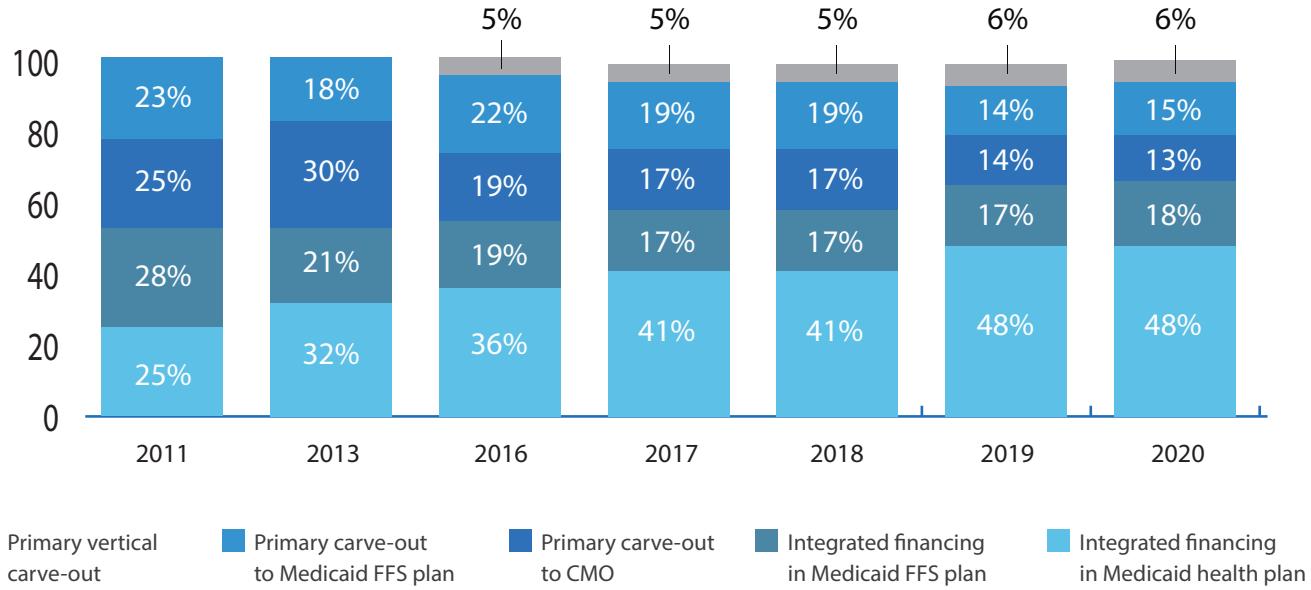
But the end of horizontal behavioral health carve-outs has not automatically created integration from a consumer health management perspective. Integrated service delivery has three dimensions—clinical information integration and access, integration of financial incentives, and integrated consumer service delivery. The current delivery system does not score well on any of these three dimensions—real-time consolidated consumer health information is spotty at best and shared financial incentives are rare. Without those dimensions, whether or not behavioral health and primary care are delivered at the same location is almost irrelevant.

And there is the issue of the move toward value-based reimbursement of specialty provider organizations to align incentives between health plan financial risk management and the management of clinical outcomes. Some predict the future will be in new health plan and provider partnerships for consumers who have complex needs. The health plans do not want the performance risk. The provider organizations do not want—and cannot afford—the financial risk. That means they will come together to find benefits for each. Most likely, larger, more financially stable provider organizations with good information infrastructure will have a distinct advantage—and that provider organization executives would be well advised to consider mergers, acquisitions, affiliations, or coalitions to get the shared infrastructure and administrative support needed to be competitive.

Medicaid Behavioral Health Financing Arrangements

There have been significant changes in behavioral health financing arrangements between 2011 and 2019. States are moving away from the primary behavioral health carve-out model to integrated financing in Medicaid plans. Additionally, states have developed vertical consumer specific specialty health plans for consumers with SMI, which did not exist in 2011.[5]

Figure 2 State Medicaid Behavioral Health Carve-Outs[5]



Between 2011 and 2020, the number of state Medicaid programs with integrated behavioral health financing arrangements in Medicaid health plans steadily increased from 25% to 48%. The number of states with integrated financing in Medicaid FFS plans decreased from 28% to 18% in 2020. Overall, integrated behavioral health financing arrangements grew from 53% to 66%.

At the same time, the number of primary carve-outs to CMOs decreased from 25% to 13% between 2011 and 2020. The number of primary carve-outs to Medicaid FFS has decreased from 23% to 15%. Primary vertical carve-outs for consumers with SMI are a relatively new model. In 2011, there were no states utilizing this model. But by 2020, 6% of states were using the integrated care model. While the number of states participating in this model is small, it represents a growing trend towards new financing models for medically complex populations.

As of January 2020, approximately 69% (50.2 million) of the 72.8 million individuals in Medicaid were enrolled in integrated behavioral health financing arrangements, 31% (22.3 million) were enrolled in traditional specialty carve-outs, and less than 1% (326,000) were enrolled in a vertical consumer-specific specialty health plan carve-out. This is a slight increase compared to 2019 when 64% of the Medicaid population was enrolled in integrated financing arrangements and 36% was enrolled in traditional specialty carve-outs.

Table 3 Behavioral Health Financing Models By State, 2020[5]

	Primary Carve-Out to CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing in Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Alabama				X	
Alaska				X	
Arizona – Acute Care			X		
Arizona – SMI Population					X
Arkansas – PCCM/ FFS				X	
Arkansas – PASSE					X

Table 3 Behavioral Health Financing Models By State, 2020[5] (cont.)

	Primary Carve-Out to CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing in Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Arkansas – AR WORKS			X		
California	X				
Colorado – RAEs			X*		
*On July 1, 2018, Colorado transitioned from a primary carve-out to an integrated model. However, while the Regional Accountable Entity (RAE) is responsible for coordinating physical and behavioral health services, the RAE's are at-risk for behavioral health services, but not physical health services. For individuals enrolled in FFS, the RAEs are responsible for behavioral health services.					
Connecticut				X	
Delaware		X			
District Of Columbia		X			
Florida			X		
Florida – SMI Population					X
Georgia			X		
Hawaii			X		
Hawaii – SMI Population	X				
Idaho	X*				

Table 3 Behavioral Health Financing Models By State, 2020[5] (cont. part 2)

	Primary Carve-Out to CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing in Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Idaho – Duals Program			X		
*While Idaho carves-out outpatient services to the CMO, the state retains responsibility for psychiatric inpatient stays.					
Illinois			X		
Indiana		X			
Iowa			X		
Kansas			X		
Kentucky			X		
Louisiana – Managed Care			X*		
*Individuals who are enrolled in FFS receive behavioral health services through the Louisiana health plans.					
Maine				X	
Maryland		X			
Massachusetts – MCO Delivery System			X		

Table 3 Behavioral Health Financing Models By State, 2020[5] (cont. part 3)

	Primary Carve-Out to CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing in Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Massachusetts – PCCM/ACO Delivery System	X				
Michigan	X				
Minnesota			X		
Mississippi			X		
Missouri		X			
Montana				X	
Nebraska			X		
Nevada			X		
New Hampshire			X		
New Jersey		X*			
*In October 2018, New Jersey integrated most behavioral health services for the populations who receive managed long-term services and supports, are enrolled in a Fully Integrated Dual Eligible Special Needs Plan (FIDE D-SNP), or receive services through the Division of Developmental Disabilities (DDD) waivers. Community support services, Assertive Community Treatment (ACT), behavioral health homes, targeted case management, and CCBHC services remain in the FFS system.					
New Mexico			X		
New York			X		

Table 3 Behavioral Health Financing Models By State, 2020[5] (cont. part 4)

	Primary Carve-Out to CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing in Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
New York – SMI Population					X
New York – Long-Term Care		X			
North Carolina	X				
North Dakota				X	
North Dakota – Medicaid Expansion			X		
Ohio			X		
Oklahoma				X	
Oregon			X		
Pennsylvania	X				
Rhode Island			X		
South Carolina			X		
South Dakota				X	
Tennessee			X		

Table 3 Behavioral Health Financing Models By State, 2020[5] (cont. part 5)

	Primary Carve-Out To CMO	Primary Carve-Out To Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing In Medicaid FFS Plan	Primary Vertical Carve-Out
Texas			X		
Utah	X*				
*Utah covers most behavioral health services through the CMOs; however, some counties finance services FFS. Wasatch County finances all behavioral health services FFS. Box Elder, Cache, and Rich counties use a CMO for mental health services, while addiction services are financed FFS. These counties represent approximately 7% of the Medicaid population.					
Vermont				X	
Virginia			X		
Washington			X		
West Virginia			X		
Wisconsin		X			
Wisconsin – Family Care Program			X		
Wyoming				X	

State Health Care Coverage

To date, 37 states and the District of Columbia have adopted the Medicaid expansion and 13 states have not adopted the expansion.[6] Here are a few key state updates:

States That Have Adopted & Implemented Expansion

Arkansas – The Arkansas Legislature passed a bill in March 2021 to replace the state's Medicaid expansion program, Arkansas Works, with the Arkansas Health and Opportunity for Me (HOME) program. The governor is expected to sign the bill. If ultimately approved by the federal government, HOME would allow expansion enrollees who comply with work requirements and pay monthly premiums to enroll in private marketplace plans. Those who do not participate in work requirements will receive traditional FFS Medicaid coverage. Arkansas Works is due to expire at the end of 2021.[6]

In addition, the Provider-led Arkansas Shared Savings Entity (PASSE) model of organized care, was created by Act 775 of 2017 to manage the services of individuals with high levels of acuity with developmental disabilities and behavioral health needs. For each PASSE, local Arkansas providers entered partnerships and chose an experienced organization to perform administrative functions, such as claims processing. These groups function similar to insurance companies.

PASSEs are a Medicaid provider type program approved by the Centers for Medicare & Medicaid Services (CMS). They are regulated by the Arkansas Insurance Department (AID) and held accountable to the Department of Human Services (DHS) under federal managed care rules. In this program, the PASSE entities take full risk for their assigned individuals. This particular model is watched carefully by other states as managing these individuals that experience the highest cost to the Medicaid system is a significant challenge and financial burden.

Idaho – After a successful ballot measure from the residents, the Idaho legislature voted to expand Medicaid in 2019. Enrollment began on January 1, 2020. The governor charged the Idaho Department of Health and Welfare to seek waivers to make changes to the expansion program and specified if the changes were not approved by January 1, 2020, then all individuals up to 138% of the federal poverty level would be enrolled in Medicaid. The state has submitted four waivers. However, so far, only one has been approved.[6]

Kentucky – In December 2019, Kentucky's governor signed an executive order rescinding the Kentucky HEALTH waiver that had included a number of provisions including a work requirement, monthly premiums up to 4% of income, and coverage lockouts if enrollees forgot to renew or report a change in circumstances that would affect enrollment. Kentucky's expansion program continues to operate under state plan amendment (SPA) authority.[6]

STATE BEHAVIORAL HEALTH LANDSCAPE (cont.)

States That Have Adopted & Implemented Expansion

Maine – After a ballot initiative from residents, Maine implemented expansion on January 10, 2019.[6]

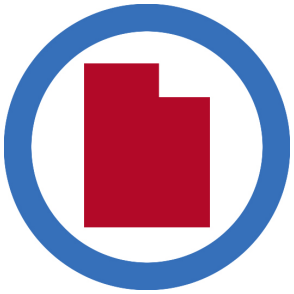
Montana – In April 2019, the Montana Legislature passed, and the governor signed a bill to continue the state's Medicaid expansion program with changes to include work requirements through 2025. This came after Montana citizens voted against a bill on the November 2018 ballot that would have extended Medicaid expansion beyond its original June 2019 sunset date and raised taxes on tobacco products to finance the expansion. Montana submitted a section 1115 waiver proposal to CMS in August 2019 and the request is still pending.[6]

Nebraska – Nebraska voters approved Medicaid expansion in November 2018 and enrollment began in August 2020. The state delayed implementation until October 1 2020, to allow time for the state to seek a section 1115 waiver requiring enrollees to meet healthy behavior and work requirements to access coverage. CMS approved that waiver with implementation to begin in April 2021. However, the Biden administration has begun to withdraw requirements for work requirements to access Medicaid so in February 2021, Nebraska's Health and Human Services department indicated it would delay implementation from April 2021 to a later date pending federal review.

States That Have Adopted But Not Yet Implemented Expansion

Missouri – Residents voted in August 2020 to amend the Missouri constitution to add Medicaid expansion. The amendment requires expansion to begin on July 1, 2021. However, some state legislators are still trying to block the adoption.[7]

Oklahoma – Residents voted in June 2020 to amend the Oklahoma constitution to add Medicaid expansion with coverage to begin no later than July 1, 2021. However, there is some debate at the state legislative level about how the program will be funded.[8]

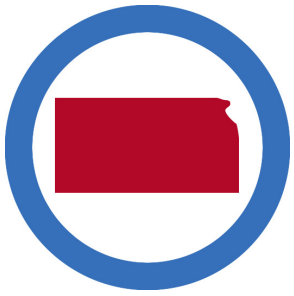


Utah – Utah voters approved Medicaid expansion in November 2018 and enrollment began in January 2020. There are currently work requirements for adults wanting to enroll in Medicare.[6]

States That Have Not Adopted Expansion

Florida – An initiative to add Medicaid expansion to the 2020 ballot was delayed by the organizers until 2022.[6]

Georgia – In October 2020, CMS approved a section 1115 waiver to expand Medicaid to parents and childless adults at 100% of the federal poverty level so long as they complied with work and other requirements. Coverage was to begin July 2021. However, the Biden administration has recently begun to withdraw work requirement waivers.[6]



Kansas – Despite bipartisan support, a 2020 expansion bill failed when it was tied to a separate anti-abortion bill. However, in February 2021, the governor announced a new Medicaid expansion bill and included it in her fiscal 2022 budget. The bill would include a work requirement and be funded by taxes levied on sales from marijuana legalization.[6]

States That Have Not Adopted Expansion

Mississippi – Medicaid expansion was a key issue in the 2020 Mississippi governor's race. A Republican who adamantly refuses to expand Medicaid won the race, making it unlikely the state will consider expansion until 2024.[6]

North Carolina – The Democratic governor of North Carolina continues to ask the legislature to add Medicaid expansion to the state budget. However, the Republican-controlled legislature has so far ignored those requests.[6]

South Carolina – In December 2019, CMS approved two separate 1115 waivers for South Carolina. One extended Medicaid coverage to people making 100% of the federal poverty level for parents and caretakers. A new targeted group of adults in South Carolina are also now eligible based on work requirements. However, the Biden administration has begun to withdraw support for waivers to include work requirements.[6]

South Dakota – The organizing committee Dakotans for Health is circulating two petitions–one is for a constitutional amendment adding Medicaid expansion and the second is a state statue also supporting expansion. Advocates have until November 2021 to get enough signatures to appear on the next ballot.[6]

Wisconsin – In February 2021, the Democratic governor included Medicaid expansion in his budget proposals for state fiscal year 2022-2023. The governor had previously included expansion in his fiscal 2021-2022 budget, but the Republican-controlled legislature did not include it in the final budget. Wisconsin currently covers adults up to 100% of the federal poverty level in Medicaid, but it has so far not adopted the ACA expansion.[6]

Wyoming – The Wyoming House passed a bill in March 2021 to expand Medicaid. However, the bill was voted down by the Senate Labor, Health, and Social Service Committee. The legislature rejected several Medicaid expansion bills in 2020 and in previous legislative sessions.[6]

Table 4 Expansion & Health Plan Enrollment, By State, 2020[6,9,10]

State	Medicaid Expansion	Total Pop	Commercial %	Medicaid & CHIP %	Full Duals %	Partial Duals %	Medicare %	Uninsured %	TRICARE %
Alabama	Not Adopted	4,630,366	59%	15%	2%	3%	15%	6%	1%
Alaska	Adopted	799,608	39%	26%	2%	0%	9%	4%	20%
Arizona	Adopted	6,014,173	47%	26%	3%	1%	15%	7%	1%
Arkansas	Adopted	3,138,753	49%	22%	2%	2%	13%	6%	5%
California	Adopted	40,861,400	53%	25%	3%	0%	10%	8%	1%
Colorado	Adopted	5,492,948	52%	22%	1%	1%	12%	8%	3%
Connecticut	Adopted	3,819,376	56%	17%	2%	3%	11%	11%	1%
Delaware	Adopted	1,070,562	54%	18%	1%	2%	14%	9%	2%
Florida	Not Adopted	19,914,323	58%	15%	2%	2%	15%	5%	3%
Georgia	Not Adopted	9,661,709	61%	16%	2%	2%	12%	4%	4%
Hawaii	Adopted	1,675,845	49%	18%	2%	0%	11%	12%	7%
Idaho	Adopted	1,493,836	53%	19%	2%	1%	16%	6%	2%
Illinois	Adopted	13,159,977	58%	20%	2%	0%	12%	8%	0%
Indiana	Adopted	6,122,822	50%	23%	2%	1%	14%	7%	2%
Iowa	Adopted	3,097,862	49%	19%	2%	1%	14%	12%	2%
Kansas	Not Adopted	2,735,161	62%	12%	1%	1%	14%	7%	3%
Kentucky	Adopted	4,717,373	44%	27%	2%	2%	13%	9%	2%
Louisiana	Adopted	4,411,074	42%	31%	3%	2%	12%	7%	2%
Maine	Adopted	1,174,709	51%	10%	4%	3%	18%	9%	5%
Maryland	Adopted	6,642,709	58%	18%	2%	0%	11%	9%	3%
Massachusetts	Adopted	8,618,216	54%	14%	3%	0%	10%	18%	0%
Michigan	Adopted	11,251,266	56%	18%	2%	0%	13%	10%	1%
Minnesota	Adopted	5,721,653	55%	17%	2%	0%	13%	13%	1%
Mississippi	Not Adopted	2,450,651	50%	18%	3%	3%	15%	5%	5%
Missouri	Adopted	4,963,373	62%	15%	3%	1%	17%	0%	2%
Montana	Adopted	1,031,033	50%	21%	2%	1%	16%	7%	3%
Nebraska	Adopted	1,968,414	48%	11%	2%	0%	13%	6%	20%
Nevada	Adopted	2,737,653	54%	23%	1%	2%	14%	6%	1%
New Hampshire	Adopted	1,351,608	55%	12%	2%	1%	16%	11%	4%
New Jersey	Adopted	8,984,249	60%	17%	2%	0%	13%	8%	0%

Table 4 Expansion & Health Plan Enrollment, By State, 2020[6,9,10] (cont.)

State	Medicaid Expansion	Total Population	Commercial %	Medicaid & CHIP %	Full Duals %	Partial Duals %	Medicare %	Uninsured %	TRICARE %
New Mexico	Adopted	1,933,578	37%	34%	3%	2%	14%	6%	3%
New York	Adopted	22,314,647	53%	23%	3%	1%	10%	10%	0%
North Carolina	Not Adopted	8,436,353	55%	17%	3%	1%	16%	7%	1%
North Dakota	Adopted	805,315	52%	10%	1%	0%	12%	7%	17%
Ohio	Adopted	12,217,842	55%	20%	2%	1%	13%	8%	1%
Oklahoma	Adopted	3,709,928	57%	19%	3%	1%	14%	4%	3%
Oregon	Adopted	4,033,210	49%	22%	2%	1%	15%	9%	1%
Pennsylvania	Adopted	14,528,443	56%	17%	3%	1%	13%	9%	1%
Rhode Island	Adopted	1,169,929	47%	22%	3%	1%	12%	14%	2%
South Carolina	Not Adopted	4,571,925	51%	19%	3%	1%	17%	6%	4%
South Dakota	Not Adopted	801,862	61%	11%	2%	1%	16%	6%	3%
Tennessee	Not Adopted	6,161,277	53%	19%	2%	2%	15%	6%	3%
Texas	Not Adopted	23,244,096	62%	16%	2%	1%	12%	4%	3%
Utah	Adopted	2,398,986	64%	13%	1%	0%	13%	7%	3%
Vermont	Adopted	1,260,249	26%	10%	2%	1%	8%	8%	46%
Virginia	Adopted	7,849,669	60%	16%	2%	1%	14%	7%	0%
Washington	Adopted	7,944,681	53%	20%	2%	1%	12%	9%	3%
West Virginia	Adopted	1,778,374	42%	24%	3%	2%	16%	9%	3%
Wisconsin	Not Adopted	5,657,432	54%	16%	3%	0%	15%	11%	1%
Wyoming	Not Adopted	456,216	58%	10%	2%	1%	18%	7%	4%
Washington DC	Not Adopted	968,902	53%	21%	2%	1%	5%	15%	3%

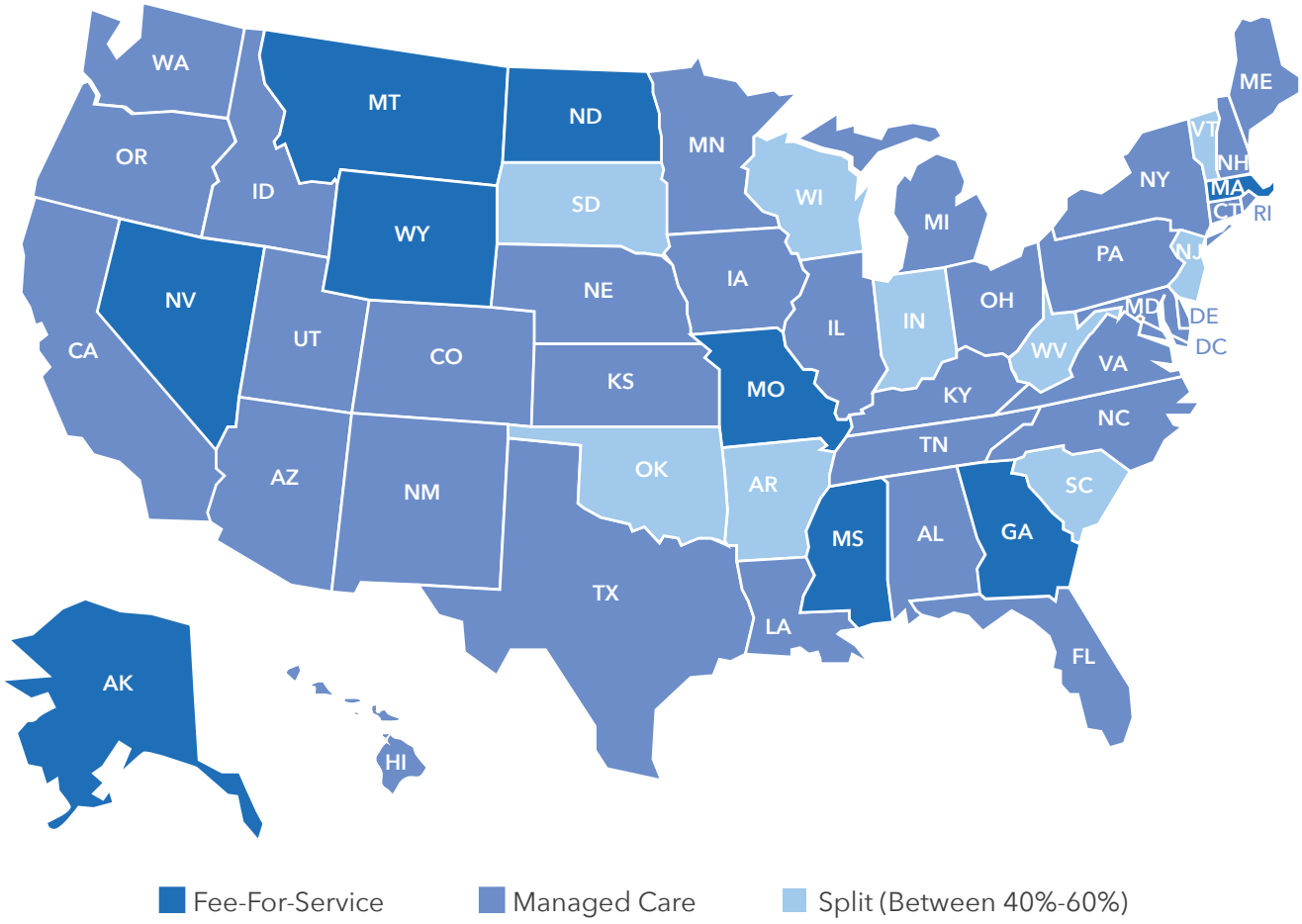
State Medicaid Financing System For The SMI Population

Medicaid is the single largest payer for mental health services in the United States and is increasingly playing a larger role in the reimbursement of substance use disorder services. Individuals with behavioral health disorders also use significant health care services—nearly 12 million visits made to U.S. hospital emergency departments in 2007 involved individuals with a mental health disorder, substance abuse problem, or both. Congress enacted several laws designed to improve access to mental health and substance use disorder services under health insurance or benefit plans that provide medical/surgical

benefits. Specifically, the Mental Health Parity and Addiction Equity Act (MHPAEA) passed in 2008, impacts the millions of Medicaid beneficiaries participating in Managed Care Organizations, state alternative benefit plans (as described in the Social Security Act), and the Children's Health Insurance Program.[11]

Since these behavioral health services have largely been delegated to the states to administer, states have been developing and implementing care coordination and integration initiatives that aim to improve quality, cost, and outcomes for individuals. These programs are geared to better address the more complex populations served through state Medicaid programs, who tend to have multiple chronic conditions and/or high levels of behavioral health needs.

Figure 3 Primary Medicaid Financing For The SMI Population By State, 2020[12]



State Behavioral Health Innovation Initiatives

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 has resulted in an increase in the number of state Medicaid programs implementing care coordination initiatives with the goal of improving the quality of consumer care while controlling rising costs. Some initiatives were either created

by or as a result of the ACA while others were born organically out of the need to lower costs and improve care. The adoption of these initiatives has created new opportunities and challenges for provider organizations.[13] These are the most common types of initiatives:

1. Medicaid Patient Centered Medical Homes (PCMHs): A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is both culturally and linguistically appropriate. Medical homes exist across multiple payers.[13]
2. Health Homes: A health home is a care coordination model that specifically targets populations with chronic conditions. Health homes provide six essential functions:
    - Comprehensive care management.
    - Care coordination and health promotion.
    - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up care.
    - Individual and family support
    - Referral to community and social support services.
    - Use of health information technology to link services.
3. In order to implement a health home, the state must submit a Medicaid plan amendment to CMS and receive approval.
4. Medicaid Accountable Care Organizations (ACOs): ACOs are a network of clinical professionals, hospitals, or insurers working together to care for a set group of individuals. The purpose of integrating care for these patients is to improve health while lowering the cost of care. If the ACO is successful, they receive a share of the savings.
5. Dual Eligible Demonstrations: In an effort to expand access to integrated programs that coordinate Medicaid and Medicare benefits, CMS launched state demonstrations in April 2011 to integrate Medicare and Medicaid financing for full-benefit dual eligible individuals (people eligible for Medicare and Medicaid). The demonstration tests two models of care—a capitated model and a managed fee-for-service model.
6. Certified Community Behavioral Health Clinics (CCBHCs): Authorized as part of the Protecting Access to Medicare Act of 2014, CCBHCs must utilize one of two prospective payment systems, and offer nine core services either directly, or through formal partnerships. These include:
    - Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
    - Screening, assessment, and diagnosis, including risk assessment.
    - Patient-centered treatment planning, or similar processes, including risk assessment and crisis planning.
    - Outpatient mental health and substance use services.
    - Outpatient clinic primary care screening and monitoring of key health indicators and health risks.
    - Targeted case management.
    - Psychiatric rehabilitation services.
    - Peer support and family support.
    - Intensive, community-based mental health care for members of the armed forces and veterans.
7. In 2020, Substance Abuse and Mental Health Services Administration (SAMHSA) set aside

nearly $200 million to be spending on CCHBC expansion grants.[14] Then in early 2021, SAMHSA released grants to another 134 clinics to become CCBHC certified. The new funds came as part of the $4.5 billion allocated to SAMHSA as part of the December 2020 COVID-19 relief bill.[15]

8. Provider-Led Entities (PLEs): A PLE is a national professional medical specialty society or other organization that is comprised primarily of providers or practitioners who, either within the organization or outside of the organization, predominantly provide direct patient care. Once a PLE is qualified, the appropriate use criteria (AUC) developed, modified, or endorsed by the entity are considered specified applicable AUC. All qualified PLEs must reapply to CMS every five years.[16]

Considerations

In conclusion, the system shifts are obvious. The need for mental health services is increasing from a combination of factors, including:

- Payers and health plans understanding the benefit of mental health treatment – especially in populations with comorbidities.
- States are rapidly shifting models that will require various types of value-based payment models.
- Those models are all forcing integration, quality, and accountability and risk sharing.
- In some cases, state government has forced the provider system into provider led joint ventures to manage the highest cost populations (severe mental illness and high acuity intellectual and developmental disabilities) such as in Arkansas.
- Those states with managed care in place, the managed care companies are rapidly carving mental health services back into their management to have a model by which the members can have better oversight towards integration and whole person care.

While these shifts in the health care reimbursement models will evolve, it is certain that providers, as well as payers, will be absorbing more risk in managing care as the system sees more innovation while consumers continue to demand more convenient, digital options.

Executive Summary

Figure 1 Utilization Of Predictive Modeling Tools To Identify High-Risk Patient Cohorts, By Plan, 2021[1]

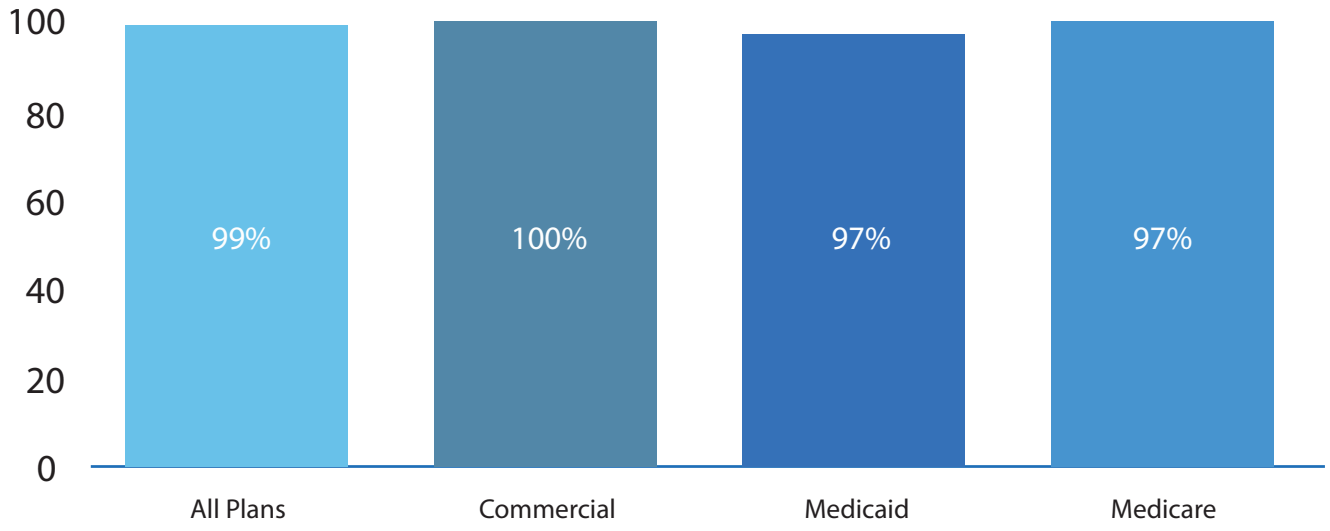
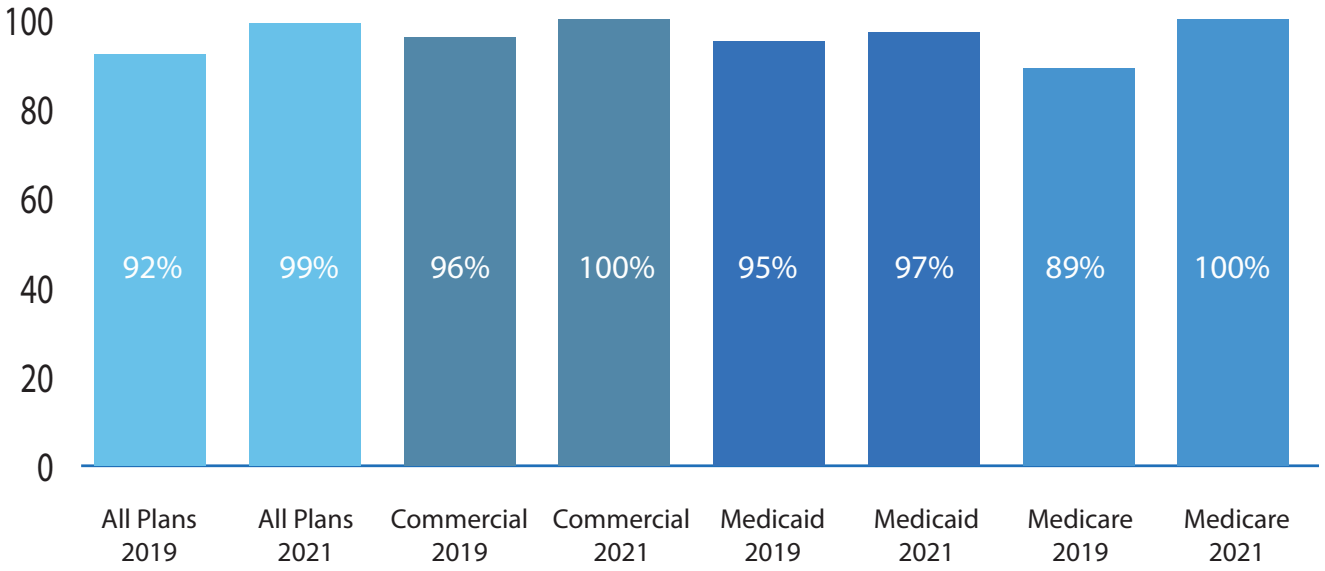


Figure 2 Utilization Of Predictive Modeling Tools To Identify High-Risk Patient Cohorts, By Plan, 2019 & 2021[1]



Health Plan Current & Future Use Of Models To Improve Coordination Of Care For Complex Members

In the 1980s and early 1990s, health services researchers documented that many of the individuals who saw primary care physicians were identified as having major depression. These individuals with major depression were found to be more likely to have high numbers of medically unexplained symptoms, more comorbid illnesses, and more functional impairment like diabetes and heart disease. These people also typically used twice as many health care services as their counterparts, costing insurers twice as much in resources.[3]

Studies during this time showed only a quarter to half of patients with depression were accurately diagnosed by these primary care physicians. Even if the individuals were accurately diagnosed, most of those patients did not receive the proper amount of prescribed psychotherapy or pharmacotherapy from their primary care doctors, causing many suffering individuals to discontinue therapies within the first few weeks, and never complete a referral to see a mental health provider.

These gaps in care between primary care and behavioral health are often more pronounced among minority populations and individuals living in poverty, two key demographics that already lack access to quality mental health services. Today, many behavioral health providers and primary care physician practices are working together to provide more integrated solutions for individuals. [1]

Figure 3 Coordination Of Care Strategies, 2017, 2019 & 2021, All Plans[1]

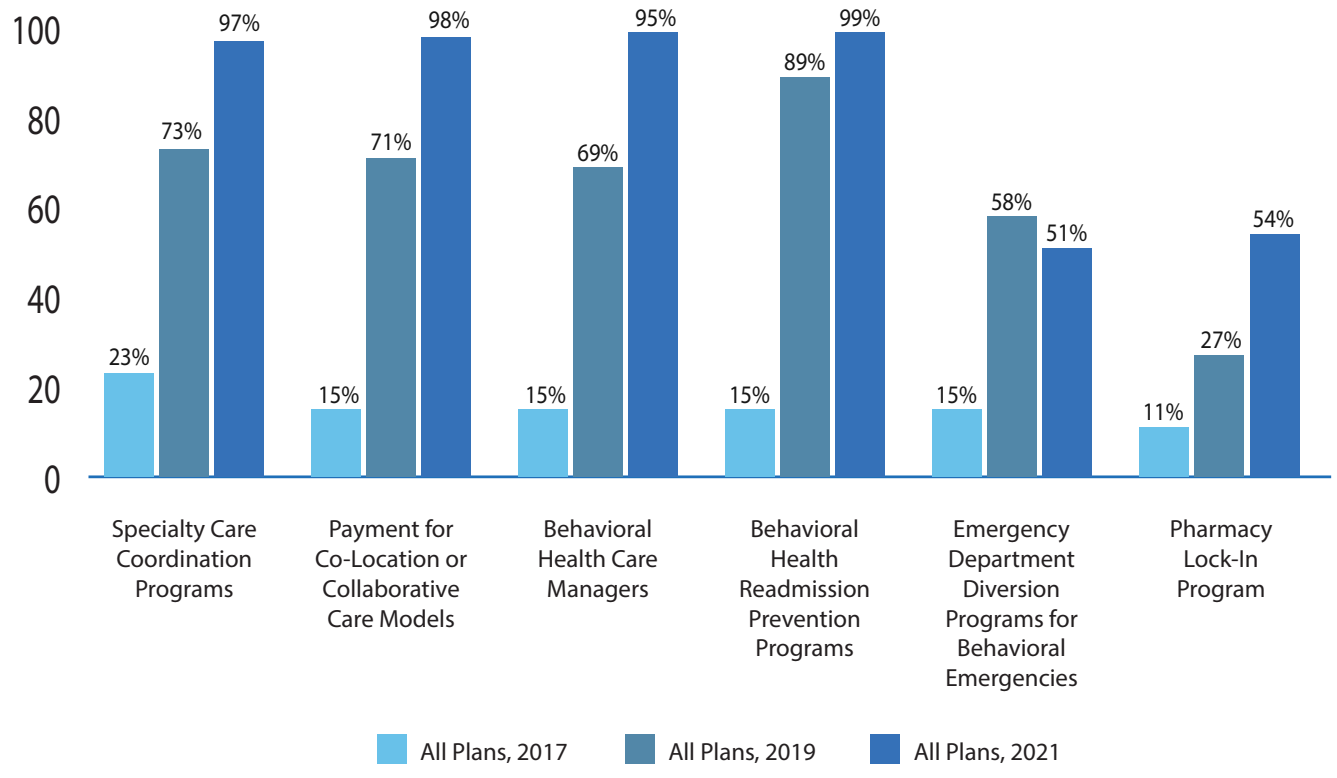
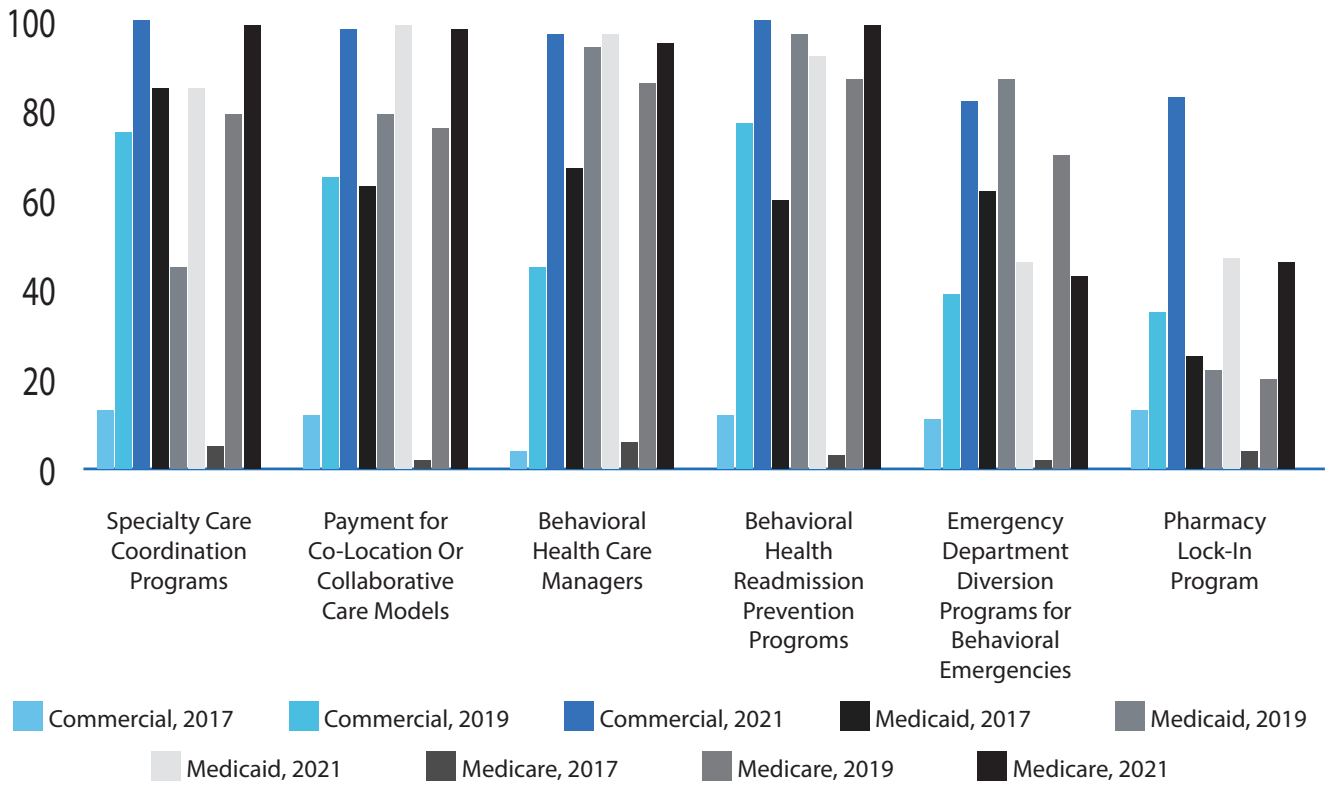


Figure 4 Coordination Of Care Strategies, 2017, 2019 & 2021, By Plan[1]

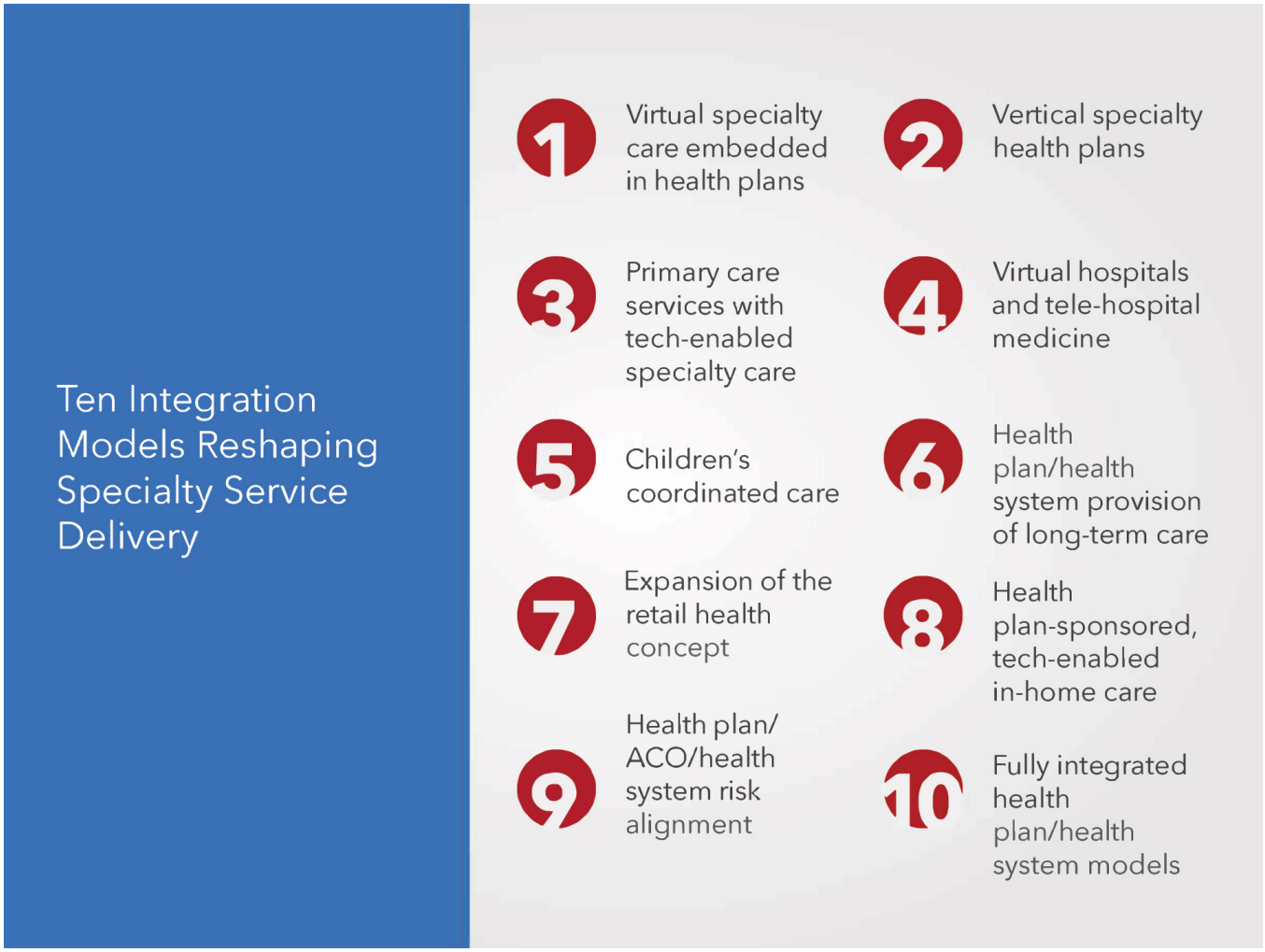


Understanding Integration

Integration is changing the competitive advantage for health and human service provider organizations—and with it, changing the parameters of financial sustainability. Integration brings with it value-based reimbursement, consolidation, and leverage of technology. Providers are finding new ways to provide old services in new ways and the COVID-19 pandemic has undoubtedly hurried some of these new technologies along to reach individuals whose mental health has been affected by the pandemic and its economic fallout.

However, there is no specific definition or a single type of integration. Integrated care models vary in how information is shared, how services are delivered, and the financial incentives among the stakeholders. For this reason, integration models often vary significantly from one market to the next.[3]

The types of integration models affect service lines, revenue, margins, and sustainability for providers and the patients they serve. *OPEN MINDS* analysts have identified 10 models of integration that are emerging in the U.S. health and human services field:



Model 1: Virtual Specialty Care Embedded In Health Plans

Definition: A health plan contracts with an organization or smartphone application company that provides health care services in a completely virtual delivery system. Examples of this include the many wellness teletherapy and e-counseling services advertised widely.

Market Implications: These virtual delivery systems, such as virtual behavioral health provider networks, have providers lined up and direct contracts with health plans, thus giving them an advantage in direct referrals and access for consumers. This raises the bar on performance as well as convenience and cost.

Model 2: Vertical Specialty Health Plans

Definition: A full-service health plan designed for a specific group of consumers with shared characteristics. An example of this is PASSE–Provider-Led Shared Savings Entity, a program that serves Arkansas' Medicaid clients with complex behavioral health, developmental, or intellectually disabilities.

Market Implications: Vertical specialty health plans can cover all health care services (not just specialty services) and typically require contracting with a managed care entity and formal collaboration with other health care organizations.

Model 3: Primary Care Services With Tech-Enabled Specialty Care

Definition: A primary care practice or community health center that offers specialty care through on-site virtual platforms. With this model, a primary care provider is able to provide mental health services to patients usually via web camera.

Market Implications: With specialty care delivered on a virtual platform, this opens up broad geographic competition for local specialty care provider organizations. This will allow regions without many mental health providers to tap into resources in other areas.

Model 4: Virtual Hospitals At Home & Telehospital Medicine

Definition: Acute care services provided at home with some on site and some virtual medical professionals. In November 2020, CMS implemented a waiver for its new Acute Hospital-At-Home program.[4] The program provided regulatory flexibilities allowing eligible hospitals to treat consumers in their homes through the duration of the COVID-19 Public Health Emergency. For fee-for-service Medicare beneficiaries eligible for the Acute Care Hospital-At-Home program, the sponsoring hospital will provide symptom and vital sign monitoring twice daily, and any ancillary services normally provided for the person's condition. All billing and coding requirements remain the same as those for inpatients treated at other alternative care locations operated by the hospital during the public health emergency. Medicare inpatient payment policies and rates have not changed because of this waiver. Medicare inpatient payments to a hospital will be the same as they would have been if the care were provided in a traditional inpatient setting.

Market Implications: CMS believes that, with proper monitoring and treatment protocols, treatment for more than 60 non-COVID-19, acute conditions (such as asthma, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease) can be treated appropriately and safely at the individual's home rather than being physically in the hospital. So far, the waiver is only for those consumers and only during the pandemic. However, outcomes research obtained during this waiver period will likely determine if the program continues post-pandemic.

Model 5: Children's Coordinated Care & The Pending CMS Children's Health Home Proposal

Definition: A specialty care coordination program for children with complex medical, behavioral, or social conditions.

Market Implications: Like medical homes for adults, these organizations contract controls care planning and referrals—presenting both a market opportunity and threat to traditional referral channels. CMS had initially planned for these awards to start in October 2022; however, COVID-19 may have altered that timeline.[5]

Model 6: Health Plan/Health System Provision Of Long-Term Care Services

Definition: Long-term care for people with complex and chronic conditions, included in performance-based and value-based reimbursement initiatives.

Market Implications: Organizations that want to deliver long-term care must be prepared to contract with larger organizations—and to create a collaborative care network, implement decision support, measure consumer experience, monitor financial performance, and master data collection and reporting.

Model 7: Expansion Of The Retail Health Concept

Definition: Medical clinics physically located inside pharmacies, grocery stores, and other large retail stores with weekend and evening hours, short wait times, telehealth services, and online registration.

Market Implications: Direct competition for face-to-face specialty service delivery at a low unit rate.

Model 8: Health Plan-Sponsored, Tech-Enabled, In-Home Primary Care

Definition: Consumers are able to access their primary care provider—and some specialty care services—in their homes via smartphone or web platform.

Market Implications: Service delivery for specialty services is often facilitated through primary care service delivery platforms—and these systems will control specialist referrals.

Model 9: Health Plan/ACO/Health System Risk Alignment

Definition: Health plans contract directly with accountable care organizations for all health services using value-based contracting models that share financial risk.

Market Implications: Because accountable care organizations (ACOs) are largely owned and operated by health systems and other provider organizations, referrals to independent specialist provider organizations are reduced in these arrangements.

Model 10: Fully Integrated Health Plan/Health System Models

Definition: A single organization is both the fiscal insuring organization and the clinical service delivery organization. An example of this is the Philadelphia Integrated Care Network that integrates primary care and behavioral health as a way to reduce costs, wait times, and stigma, with an emphasis on reaching low-income and minority groups.

Market Implications: These hybrid organizations have their own service delivery network and the volume of referrals to specialty provider organizations is reduced.

Figure 5 Medical Behavioral Integration Strategies, 2019 & 2021, All Plans[1]

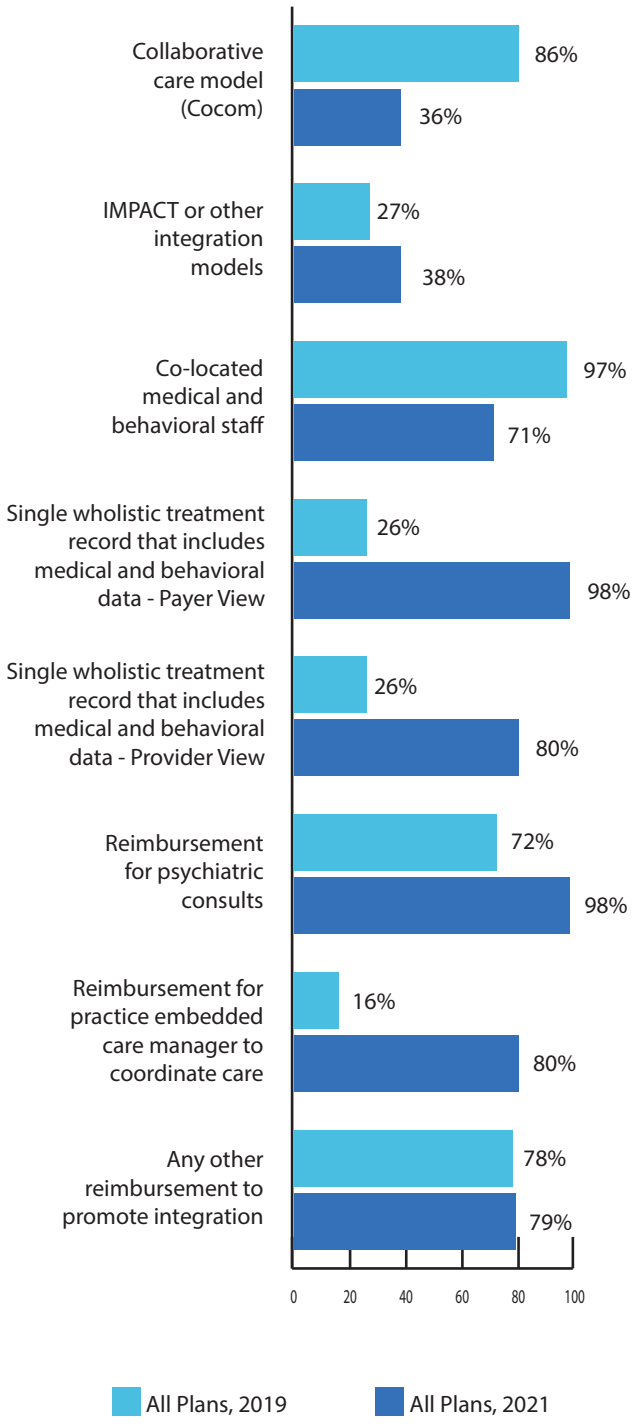
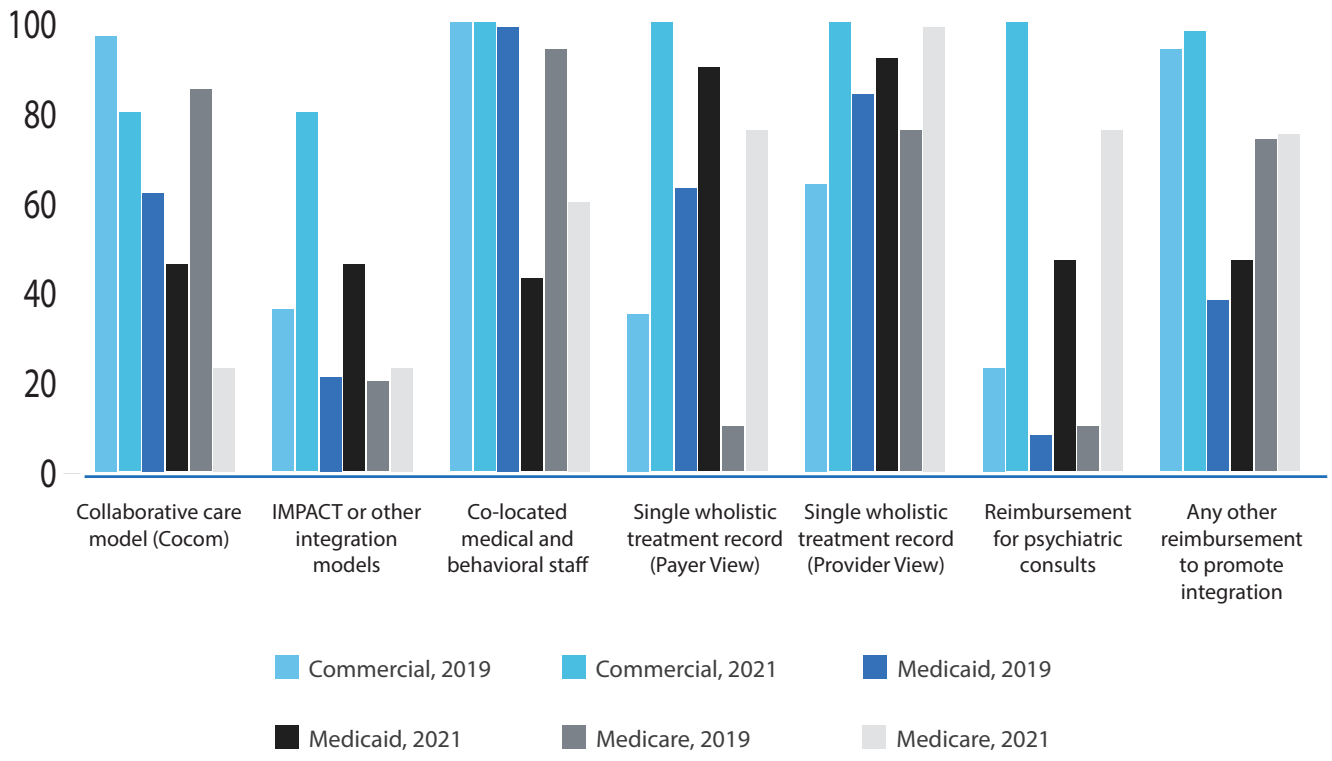


Figure 6 Medical Behavioral Integration Strategies, 2019 & 2021, By Plan[1]



Health Plan Current & Future Use Of Analytics In Identification & Early Intervention Of Individuals With Behavioral Health Needs

Before 2020, health care (behavioral health in particular) was poised to start using more technology to allow consumers to make appointments, share records, and connect with their providers electronically. However, the COVID-19 forced the adoption of many of these services, particularly telehealth. When it comes to remote services, the field is unlikely to return to the previous volume of face-to-face services. Patients like the ease of telehealth from home and some providers like to see how their patients are living day to day. These visits are not appropriate for all patients or in all circumstances, but the increased operating costs, reduced cash flow, staffing shortages, and reimbursement changes created by the pandemic push behavioral health toward continued virtual operations.[6]

The technology deployment is moving beyond telehealth. Behavioral health is seeing advances in artificial intelligence (AI), remote patient monitoring technologies, and wearables such as smart watches. Consumers and providers are also gravitating toward more mobile and tech-enabled care to meet the needs of payers, such as lowering costs, creating immediate access, and creating an overall better value.

Providers and payers are all struggling with how to prepare for a mobile and tech-enabled future. Here are several emerging technology competencies we will be seeing more of in the years ahead–telehealth, mobile tools for the workforce, electronic visit verification, and consumer conveniences.

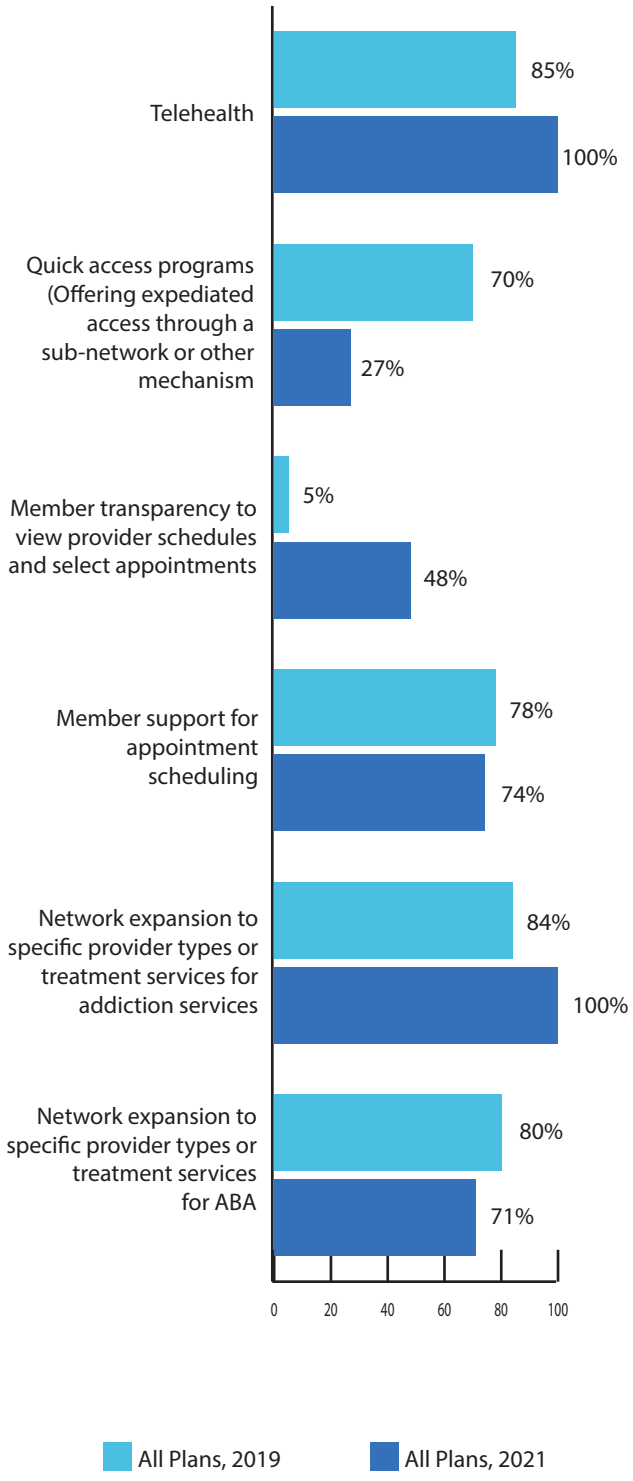
Telehealth: Telehealth is a foundational technology for mobile care. Not every service and every clinical professional needs to deliver services in-home. Rather, hybrid models of care will emerge that combine telehealth with face-to-face in-home care. For example, the behavioral health clinical professional paying a home visit can bring in a primary care clinical professional via telehealth or vice versa.

Tools To Support Mobile Work: Route optimization technology can help to determine which clinical professional to send to a specific location and the most efficient route to reduce travel time. Clinical professionals will need a disconnected solution that does not require internet access to be able to view consumer charts and documents in the field as well as securely manage and sync data when offline. Staff tools will need to be mobile optimized for laptops as well as tablets. Mobile and desktop enabled secure instant messaging between clinical professionals and supervisors is another critical tool. Ideally, messages about patients between providers can be saved back to the chart.

Electronic Visit Verification: Electronic visit verification (EVV) is a method used to verify home health visits and these systems were mandated for all mobile services starting January 2021.[7] The hope is EVV will help cut down on fraud and ensure that people receive the documented care they need. With an EVV system, organizations can track physical locations of staff, what tasks have been completed, what visits have been missed and why, and can capture electronic signatures for verification.

Consumer Access & Consumer Engagement: Another essential is a sophisticated call center that enables quick response to consumer requests and speedy access to care. Ideally, the call center can monitor the availability of all clinical professionals in the field, track all inbound calls, find and dispatch the nearest resources, and keep field staff informed about assignments and schedule changes.

Figure 7 Utilization Of Access Strategies, 2019 & 2021, All Plans[1]



Looking at the comparative survey results of utilization of access strategies between 2019 and 2021, we see the following trends of note:

- A solid 15% increase in telehealth driven by the pandemic of 2020. The trends for telehealth were already very strong in 2019; however, the COVID-19 pandemic caused the balance of the industry tip towards usage.
- Quick access programs saw a significant decrease in utilization most likely due to the decrease in utilization of facility-based services. One could expect quick access programs offered through a subnetwork to regain utilization as organizations begin offering a balance of facility-based services.
- Member transparency to view provider schedules and schedule appointments saw a significant increase from 5% to 48% over the course of the two years studied in the survey. This is likely a direct result of the of health care services moving too much more of a retail-oriented model as well as broader utilization of patient portals.
- The survey also illustrates the growth in network expansion to specific provider types for addiction treatment services as it relates to medication assisted treatment. This is a direct result of the ongoing opioid epidemic that was likely compounded by the pandemic and the related substance use disorder growth.
- Applied behavioral analysis (ABA) services saw a reduction in the two-year study from 80% down to 71% that was likely directly related to ABA services not being offered in an office setting. It should be expected that network expansion to specific provider types or treatment services for applied behavioral analytics to begin to increase once again as we move more toward an in-office model.
- As illustrated in the graph below, the survey also broke down the usage of the same elements by payer type. Of note, commercial plans saw the largest increase in all services discussed in terms of increasing access including telehealth, quick access programs, viewing provider schedules and making appointments, network expansion to specific types of treatment services for addictions including MAT, and network expansions for ABA.
- We saw significant change in member transparency to view provider schedules and select appointments by both commercial plans and Medicaid between 2019 and 2021. Again, this is indicative of the rapid technology evolution and development, implementation and utilization of provider portals that facilitate access to self-scheduling.

Member transparency to view provider schedules and schedule appointments saw a significant increase from

5% to 48%

This is likely a direct result of the of health care services moving too much more of a retail-oriented model as well as broader utilization of patient portals.

Figure 8 Utilization Of Access Strategies, 2019 & 2021, By Plan[1]

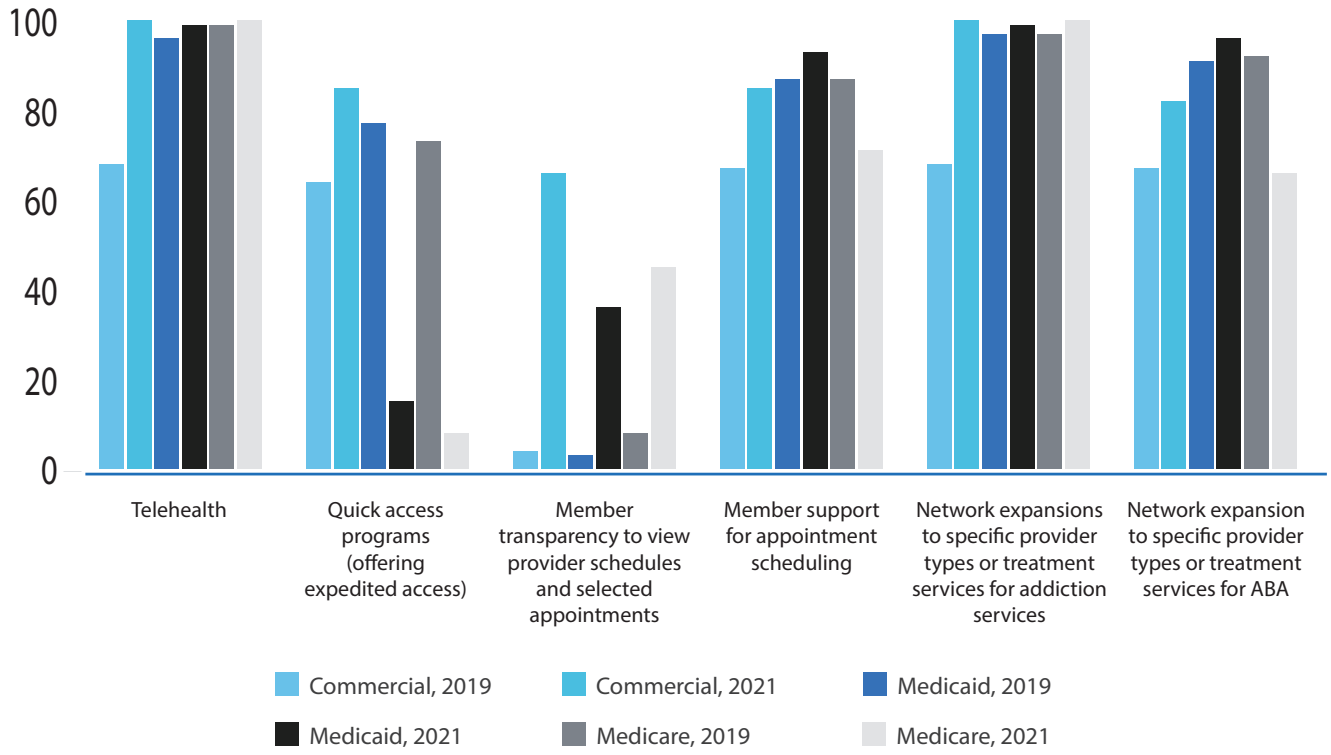


Figure 9 Utilization Of Digital Technologies 2021[1]

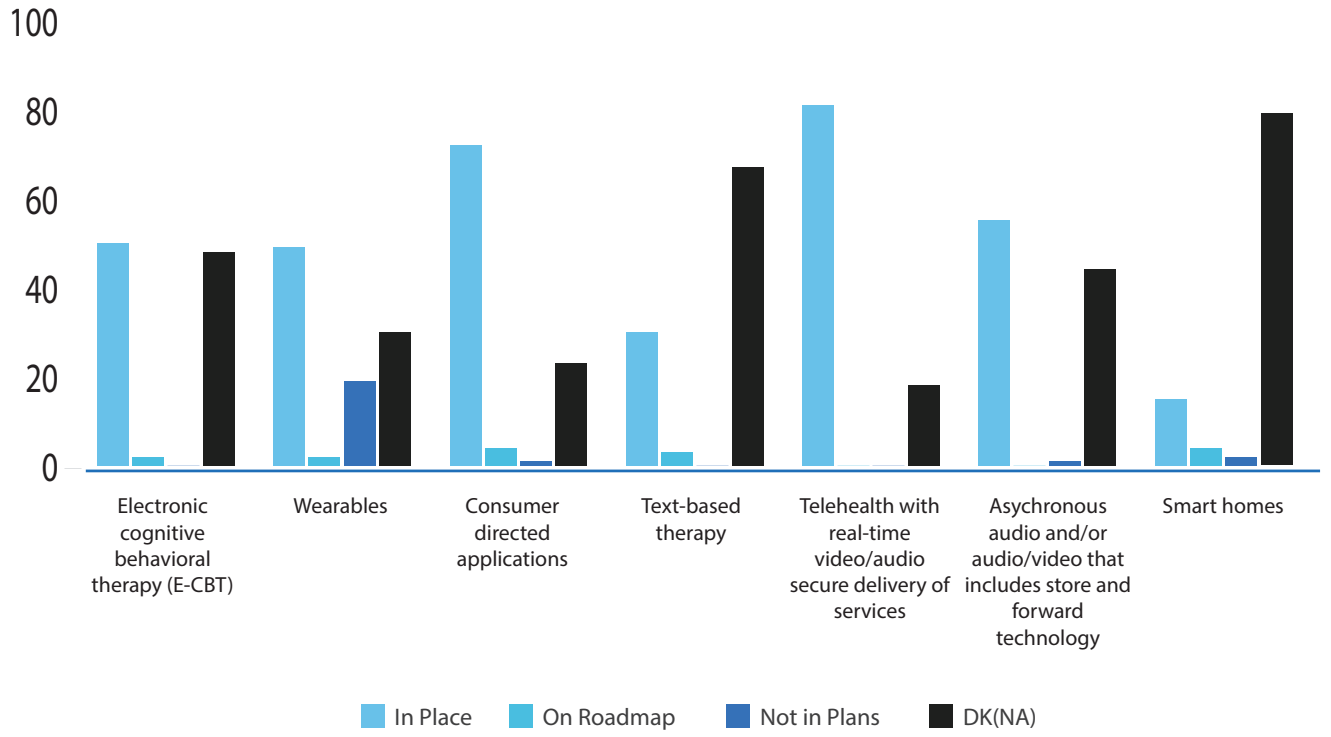


Figure 10 Utilization Of Digital Technology Strategies, 2019 & 2021, All Plans[1]

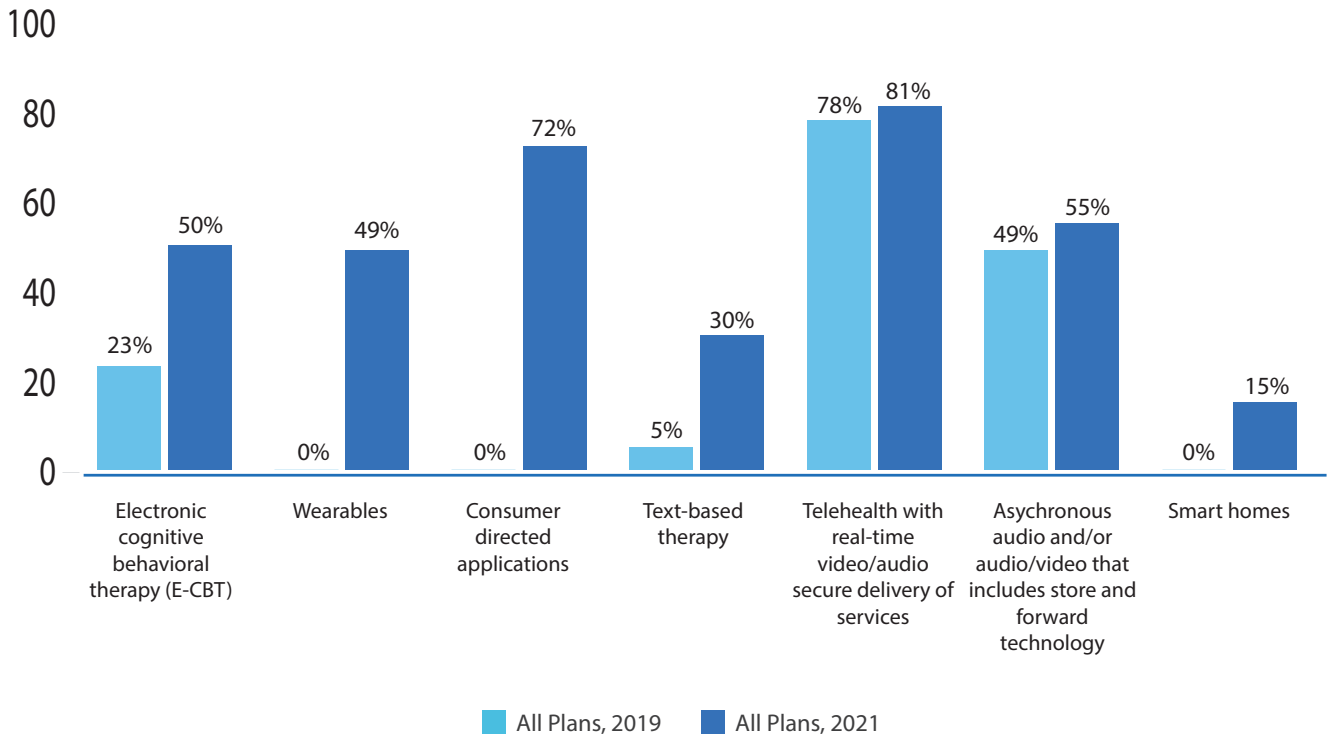


Figure 10, Utilization of Digital Technology Strategies, illustrates the significant increase, as well as the planned increase, of digital technology.

The most significant increases were seen in electronic cognitive behavioral therapies, wearables, consumer directed applications, and text-based therapies showing significant growth between 2019 and 2021. Also of note, the utilization of smart homes grew from 0% in 2019 to 15% in 2021 indicating that smart homes are becoming part of the health care ecosystem.

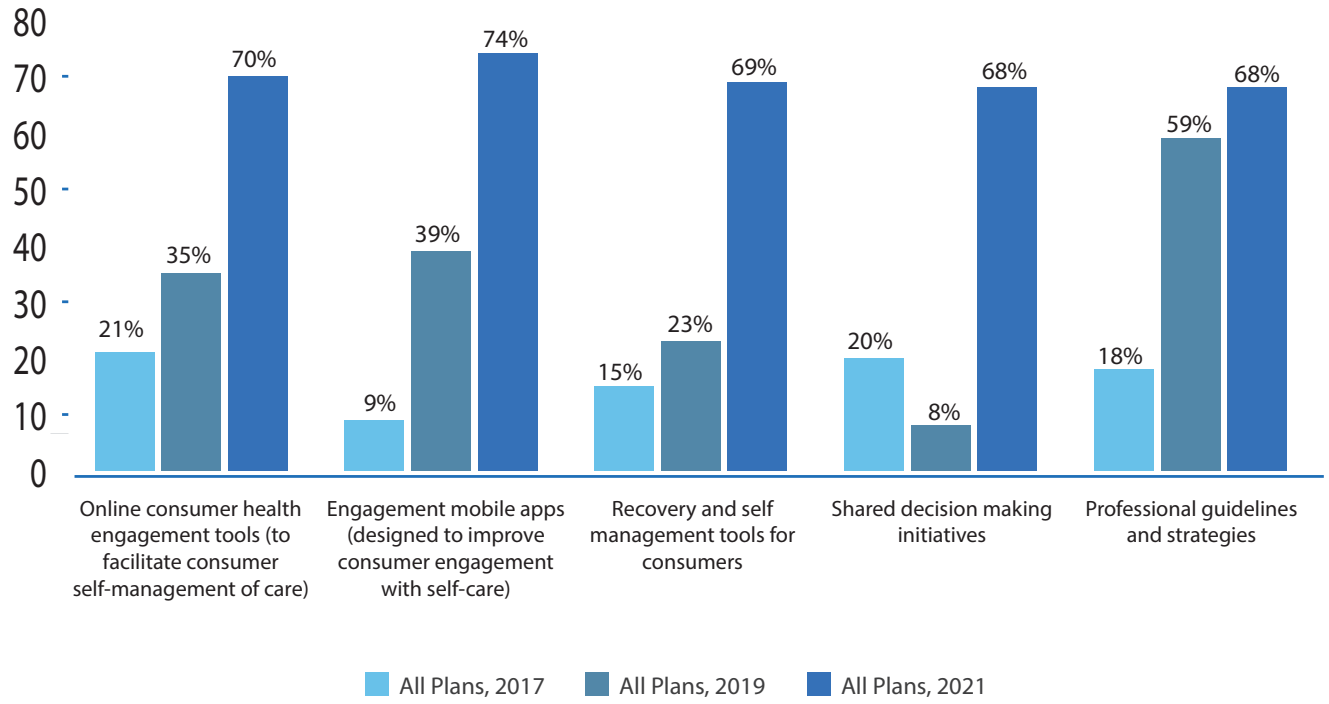
This is likely to continue to increase as care moves to an in-home model. Additionally, text-based therapy saw significant increase over the two-year period from 5% growing to 30%. Mini-therapy platforms have been utilizing text-based therapy as part of their product offering.

The most significant increases were seen in electronic cognitive behavioral therapies, wearables, consumer directed applications, and text-based therapies.

2019 and 2021

This is likely to continue to increase as care moves to an in-home model.

Figure 11 Utilization Of Consumer Engagement Strategies, 2017, 2019 & 2021, All Plans[1]



Health Plan Current & Past Use Of Models To Ensure Quality Of Care For Consumers With Behavioral Health Conditions

Approximately 93% of Medicaid health plans reported using value-based payment (VBP) or alternative payment models (APMs) in 2019, according to an analysis by the Institute for Medicaid Innovation (IMI).[8]

The most common payment strategies were payment incentives based on performance measures related to access to care (about 64%), incentives for availability of same-day or after-hours appointments (43%), enhanced payment rates for hard-to-recruit provider types (29%), and other strategies (29%, including enhanced payments to providers for a specific health outcome for reimbursement parity and to promote access, care coordination for members with misutilization of services and/or medications, quality-incentive based arrangements for primary and obstetrical care providers, and strategies that support the integration of behavioral health care into primary care).

About 50% of the health plans implemented VBP arrangements with primary care providers (i.e., physicians, advance practice nurses), while 14% implemented VBP arrangements with dentists. Most health plans did not implement VBP arrangements with behavioral health providers (57%), home and community-based service providers (79%), long-term care facilities (79%), or nurse-midwives (86%).

From 2017 to 2019, an increase in establishing VBP arrangements with dentists was seen. However, there was a decrease in implementation of arrangements with home- and community-based services providers, long-term care facilities, and orthopedics during this time. About 43% of health plans indicated that use of alternative payments to hospitals was less than 15%.

The most common operational barrier to using VBPs or APMs was data reporting to providers (about 86%). The most common external factors influencing adoption and innovation were providers' readiness and willingness (100%) and providers' information technology capabilities (79%).

Another popular service provided in behavioral health is the use of peer support specialists (PSS). A PSS is a person who has similar personal experience with mental illness and/or addiction recovery and, combined with specific training, has been proven to be successful at delivering behavioral health services. PSS provides a path to lower relapse rates, social support, social functioning, decreased psychotic symptoms, and reduced hospitalization rates. In 2019, about 51% of health plans used PSS. By 2021, that figure has jumped to 98%.[9]

A major driver of this uptake has been payment. Medicaid is the primary payer for PSS, although many state departments of behavioral health offer grant funding for these services as well. Currently, 39 state Medicaid programs provide reimbursement for some form of PSS services. States have two options for funding the reimbursement of peer support services under their Medicaid program—either adding peer support services through a Medicaid state plan amendment (usually under the Medicaid Rehabilitation Option) or as part of a waiver program.

Pre-pandemic reimbursement for PSS varied widely by state and there is no doubt that the COVID-19 crisis has altered this as well. Typically, if a state Medicaid program covers peer support under the FFS benefit, health plans are also required to cover these services. Some states have special provisions allowing them to only cover peer supports for limited groups of individuals, such as those enrolled in managed care. Some states also allow peer support specialists to act as qualified health care professionals for certain types of behavioral health services, but do not allow for the specific reimbursement of peer support services. A 2019 review of selective states' Medicaid FFS reimbursement found that group rates for a 15-minute period with a peer support specialist ranged from less than $2 to more than $5. Individual billing by peer support specialists ranged from $6.50 to $24.36 per 15 minutes. Most of the states also reported using SAMHSA grants and state general funds to develop and sustain peer support programs.

Peer support service credentialing also varies by state. A 2016 national overview of PSS providers conducted by The University of Texas at Austin found that 41 states and the District of Columbia have programs to certify PSS. The issue is that these certifications are just as unique to the states as the array of mechanisms the states use to reimburse for them. Most states require some type of formal application process with references, training, and a competency exam. Some of these training programs are short (such as Kansas' program, which is just five days) and include establishing healing relationships and understanding the role of trauma. Other programs are longer (Oregon's program takes two weeks) and include core competency training that includes chronic disease management, health promotion, and health literacy.

Pre-pandemic reimbursement for PSS varied widely by state and there is no doubt that COVID-19 crisis has altered this as well.

In Florida, services provided by a certified peer specialist are billable to Medicaid. To become certified, Florida requires a minimum of a high school diploma or GED, attestation of lived experience, 40 hours of training within the past five years, 500 hours of supervised work or volunteer experience providing peer-to-peer recovery support services, and letters of recommendation—as well as passing the Florida Certified Recovery Peer Specialist Exam.

A recent review from the Government Accountability Office (GAO) highlights that as the PSS workforce grows, there is a need for "increased attention to standardizing the competencies of peer support specialists through certification." To achieve this, the GAO looked at several states and identified six practices that researchers said should become a standard part of certifying PSS competency, including:

- Systematic and objective screening of the PSS' understanding of recovery and the peer role.
- Ensuring in-person core training to strengthen PSS interpersonal and relationship building skills.
- Incorporating physical health and wellness into PSS training or continuing education.
- Educating provider organization staff about the peer support role, and how to effectively use and supervise PSS.
- Requiring that PSS participate in continuing education specific to peer support.
- Engaging PSS in the development of certification programs for applicants.
- Continuation of provider organizations to adopt peer support in the future, especially considering that VBM focuses on positive outcomes, like those achieved when using PSS.

A proper workforce trained and in position to help treat all the additional individuals diagnosed with mental health issues is a huge challenge.

Behavioral Health Workforce Challenges

A huge challenge for behavioral health initiatives going forward will be having the proper workforce trained and in position to treat all the additional individuals diagnosed with mental health issues. SAMHSA reports the U.S. needs about 4.5 million additional behavioral health professionals to provide care for the current population with serious emotional disturbance and/or SMI, and those with SUD. The current behavioral health professional workforce is about 700,000 individuals, based on the latest current workforce estimates. The estimated need for that workforce is 5.17 million, a shortage of 87%.[10]

Shortages are most pronounced among behavioral health counselors and peer support specialists with a shortage of full-time professionals of about 1.4 million and 1.1 million, respectively. In terms of the severity of the shortage, the professions with the greatest proportion of workforce shortage were peer support specialists and addiction psychiatrists, with shortages of 98% and 97%, respectively.[10]

Table 1 Behavioral Health Workforce Need Estimates, By Occupation[10]

Behavioral Health Workforce Need Estimates (By Occupation)				
Occupation	Number In Workforce As Of Most Current Counts	Estimated Additional Workforce Needed	Optimal Workforce Size To Provide Adequate Care	Current Workforce Share Of Optimal Workforce Size
Psychiatrists (General)	33,364 to 38,205	105,705 to 110,546	143,910	15% to 27%
Addiction Psychiatrists	1,164	43,320	44,484	3%
Addiction Medicine Specialist Physicians	3,171	41,313	44,484	7%
Child and Adolescent Psychiatrists	8,181 to 9,204	48,293 to 49,316	57,497	14% to 16%
Psychologists (in Behavioral Health settings)	28,630	295,302	323,932	9%
Counselor (Behavioral Health)	283,540	1,436,228	1,719,768	16%
Social Workers (Behavioral Health) or Case Workers	117,770	96,614	214,384	55%

Table 1 Behavioral Health Workforce Need Estimates, By Occupation[10] (cont.)

Behavioral Health Workforce Need Estimates (By Occupation)				
Occupation	Number In Workforce As Of Most Current Counts	Estimated Additional Workforce Needed	Optimal Workforce Size To Provide Adequate Care	Current Workforce Share Of Optimal Workforce Size
Nurses (Psychiatric or Behavioral Health and Counseling)	110,275	548,482	658,757	17%
Prescriber (Mid-level profession, e.g., Physician Assistant/ Advanced Practice Nurse)	17,507	104,167	121,674	14%
Peer Support Specialist	23,507	1,103,338	1,126,845	2%
Nurse Assistant/ Tech/Aides (in Behavioral Health settings)	11,730	552,030	563,760	2%
Psychiatric or Behavioral Health Technicians/ Aides	43,880	106,209	150,089	29%

Table 1 Behavioral Health Workforce Need Estimates, By Occupation[10] (cont. part 2)

Behavioral Health Workforce Need Estimates (By Occupation)				
Occupation	Number In Workforce As Of Most Current Counts	Estimated Additional Workforce Needed	Optimal Workforce Size To Provide Adequate Care	Current Workforce Share Of Optimal Workforce Size
Education Support Specialist	1,320	N/A	1,125	N/A
Totals (Aggregate Workforce Needed is 5.17 million)	**684,039,** **(based on lowest current workforce estimates)**	**4,486,865,** **(based on highest estimated need)**	**5,170,709**	**13%**

Figure 13 Utilization Of Quality Initiatives, Benefit Design, Innovations, & Member Transparency Strategies, 2019 & 2021, All Plans[1]

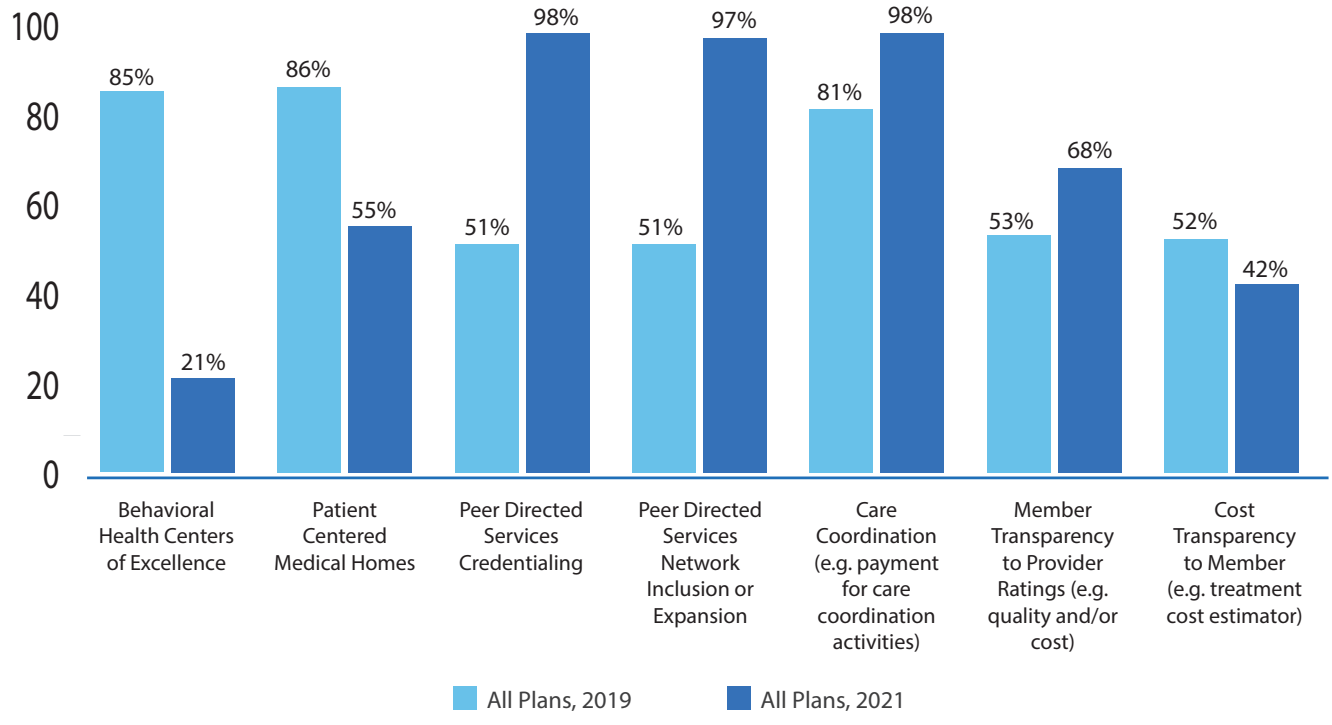
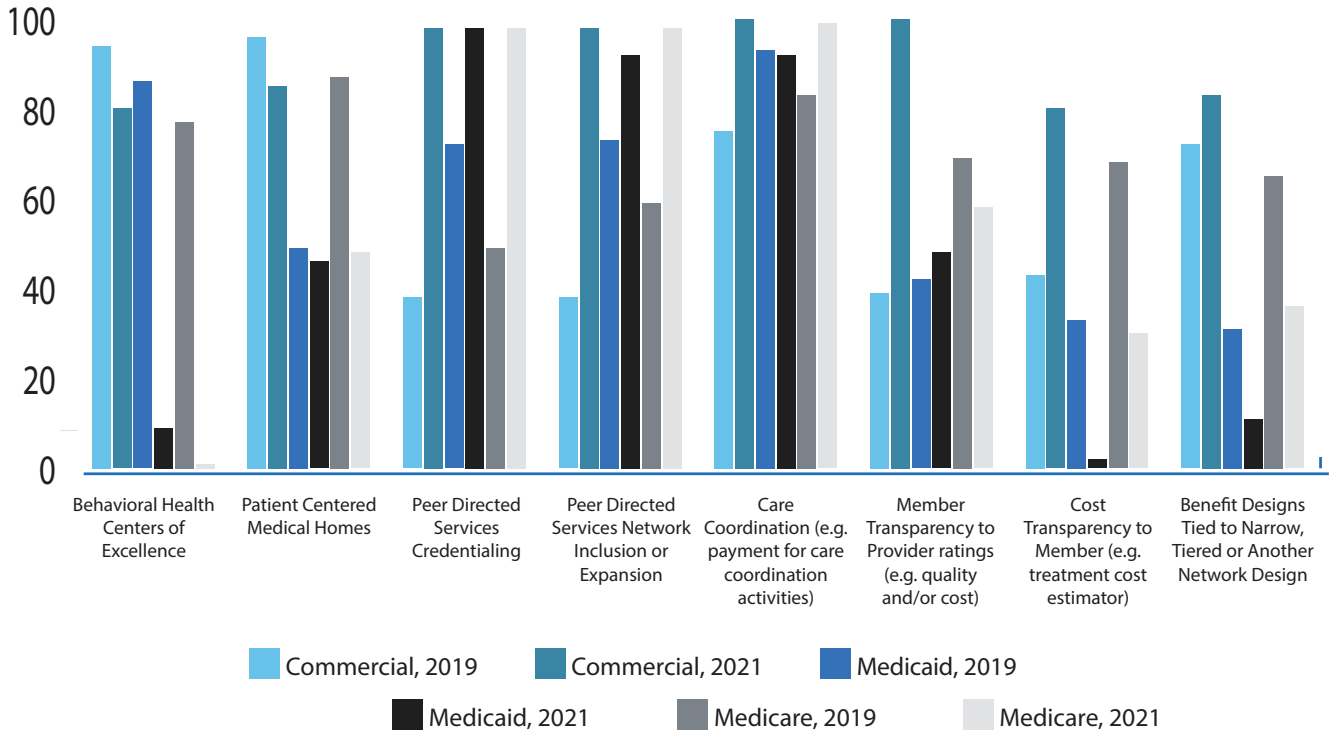


Figure 14 Utilization Of Quality Initiatives, Benefit Design, Innovations, & Member Transparency Strategies, 2019 & 2021, By Plan[1]



Health Plan Current & Future Use Of Behavioral Health Consumer

Alternative payment methods (APMs) for mental health and addiction disorder treatment are associated with lower behavioral health service utilization and lower spending, as well as improvements in process of care outcomes, according to a 2020 article from the *Journal of the American Medical Association*.[11] Of the 17 APM implementation evaluations studied, 11 assessed utilization changes and five found lower utilization. Eight evaluations assessed spending, and half found an association with lower spending. Fifteen evaluations assessed process of care, and 12 reported statistically significant improvements due to the APM.

Among the five APM evaluations that assessed clinical outcomes, three reported improvements. Although data on clinical outcomes was scarce in the APM evaluations, pay-for-performance APMs were associated with improved behavioral health outcomes. APMs with shared savings were not.

The 17 APMs spanned three broad types: fee-for-service (FFS) with links to quality and value, APMs built on FFS architecture, and population-based payments. Within each broad type, the implementations could take different approaches and serve different populations. Nine individuals with addiction disorder, four individuals with mental health disorders, and the remaining four targeted both mental health and addiction disorder. Eleven of the APM implementations specifically focused on adults, and two specifically targeted children and adolescents.

Table 2 Alternative Payment Methods Focused On Behavioral Health[11]

17 Alternative Payment Methods Focused On Behavioral Health			
Implementation	Type	Population	Outcomes Evaluated
FFS With Link To Quality & Value			
Sustaining Health care Across Integrated Primary Care Efforts Program	Foundational payments for infrastructure and operations	Medicare, Medicaid, and individuals with dual eligibility; all ages	Mental health and addiction treatment, processes of care and spending
Adolescent Community Reinforcement Approach	Pay-for-performance	Publicly funded SUD programs; child and adolescent	Addiction treatment, processes of care, clinical outcomes, and spending
Spectrum Addiction Services	Pay-for-performance	Medicaid and uninsured; adult	Addiction treatment, processes of care
Outpatient Psychosocial Counseling Treatment Center In Maryland	Pay-for-performance	Publicly funded addiction treatment programs; adult	Addiction treatment, processes of care, clinical outcomes, and adverse selection
Washington State Mental Health Integration Program	Pay-for-performance	Medicaid; adult	Mental health, processes of care, clinical outcomes, and adverse selection
Connecticut's Behavioral Health Partnership	Pay-for-performance	Medicaid; child and adolescent	Mental health and addiction treatment, process of care

Table 2 Alternative Payment Methods Focused On Behavioral Health[11] (cont.)

17 Alternative Payment Methods Focused On Behavioral Health			
Implementation	Type	Population	Outcomes Evaluated
APMs Built On FFS Architecture			
Medicare Shared Savings Program Accountable Care Organizations	APMs with shared savings	Medicare; adult	Mental health and addiction treatment; processes of care, clinical outcomes, spending, utilization, and adverse selection
Maine Medicaid Accountable Communities Initiative	APMs with shared savings	Medicaid; adult	Mental health and addiction treatment; processes of care, spending, and utilization
Vermont Medicaid Shared Savings Program	APMs with shared savings	Medicaid; all ages	Mental health and addiction treatment; processes of care, utilization, and adverse selection
Medicare Pioneer Accountable Care Organizations	APMs with shared saving and downside risk	Medicare; adult	Mental health; processes of care, clinical outcomes, spending, utilization, and adverse selection

Table 2 Alternative Payment Methods Focused On Behavioral Health[11] (cont. part 2)

17 Alternative Payment Methods Focused On Behavioral Health			
Implementation	Type	Population	Outcomes Evaluated
APMs Built On FFS Architecture			
Minnesota Integrated Health Partnerships Program	APMs with shared saving and downside risk	Medicaid; all ages	Mental health and addiction treatment; processes of care, spending, and utilization
Population-Based Payment			
Delaware Division of Substance Abuse and Mental Health-Outpatient Services APM	Condition-specific population-based payment	Publicly funded addiction treatment programs; adult	Addiction treatment; processes of care, utilization, and adverse selection
Delaware Division of Substance Abuse and Mental Health-Detoxification Care Transition APM	Condition-specific population-based payment	Publicly funded addiction treatment programs; adult	Addiction treatment; utilization, and adverse selection
Maine Addiction Treatment System, phase 1 of performance-based contracting	Condition-specific population-based payment	Publicly funded addiction treatment programs; adult	Addiction treatment; clinical outcomes, utilization, and adverse selection

Table 2 Alternative Payment Methods Focused On Behavioral Health[11] (cont. part 3)

17 Alternative Payment Methods Focused On Behavioral Health			
Implementation	Type	Population	Outcomes Evaluated
Population-Based Payment			
Maine Addiction Treatment System, Phase 2 of performance-based contracting	Condition-specific population-based payment	Publicly funded addiction treatment programs; adult	Addiction treatment; process, utilization, and adverse selection
BCBSMA Alternative Quality Contract	Comprehensive population-based payment	Commercial; adult	Mental health; process of care, spending, and utilization
Oregon Coordinated Care Organizations	Comprehensive population-based payment	Medicaid; adult	Addiction treatment; process of care

Current & Future Status Of Alternative Payment Models

There are currently more than 50 APMs with the newest, the Primary Care First Model, which debuted in January 2021.[12] CMS reports that participation in APMs has been high but that the net savings to Medicare has so far not lived up to expectations. As recently as October 2020, the Medical Payment Advisory Commission described APMs as a "limited success" and urged CMS to simplify its programs and financial risk sharing incentives with providers.

Although all APMs vary in design, what they have in common is they have been restructured from typical FFS to instead incentivize providers to provide low-cost, high-value care. The adoption of APMs has progressed well beyond their origins in Medicare. Adoption of APMs can now be found across the spectrum of payers, including Medicare, Medicaid, private health insurers, and large employers, and increases are expected.

A few changes are expected in the coming years with an increased emphasis on making APMs simpler to use. With so many models and variations of models, many providers find it challenging to accurately

measure quality, patient experience, cost-savings, and outcomes in a way that can be compared easily to each other. The regulations surrounding APMs are vital to prevent any kickbacks or illegal dealing. However, some of this red tape can also cause unnecessary complications as providers work to establish these new criteria. Up until now, many plans allowed voluntary participation although this may be changed to make participation mandatory. APM utilization is also expected to expand to other government health programs such as Medicaid, Veterans Health, Marketplace Plans, as well as to privately insured populations.

Figure 15 Utilization Of Alternative Reimbursement Strategies, 2017, 2019 & 2021, All Plans[1]

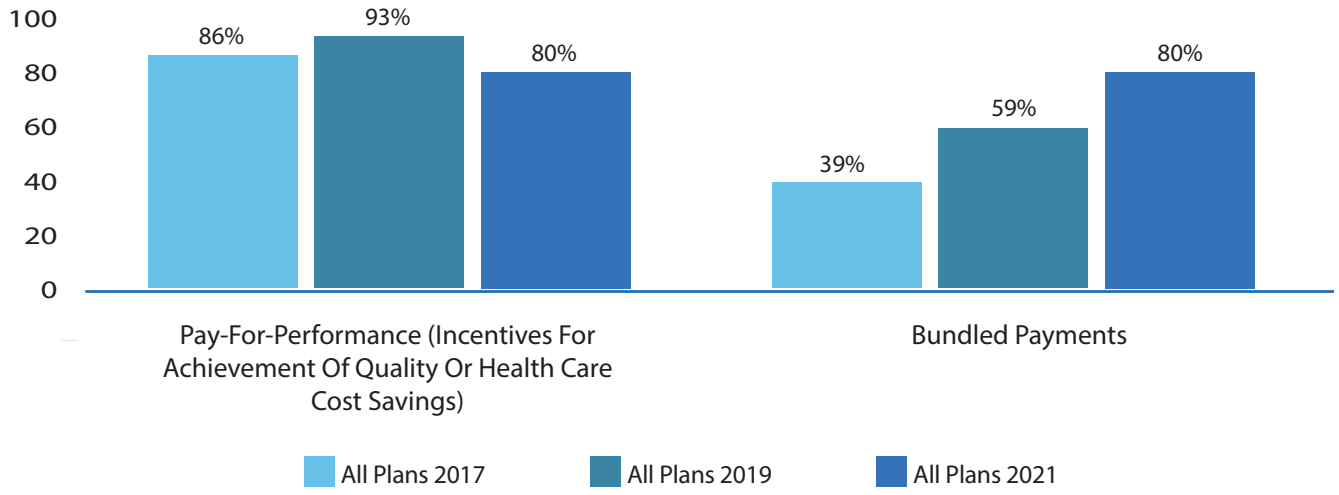


Figure 16 Utilization Of Alternative Reimbursement Strategies, 2017, 2019 & 2021, By Plan[1]

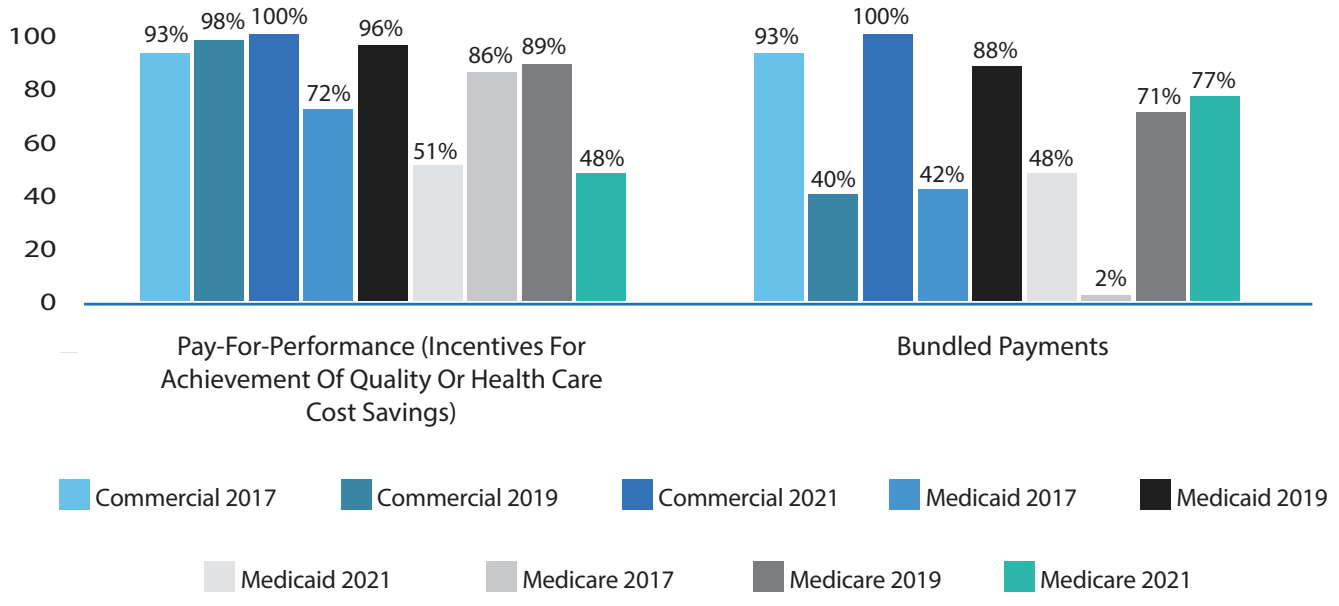


Figure 17 Utilization Of Provider Payer Partnerships, 2019 & 2021, All Plans[1]

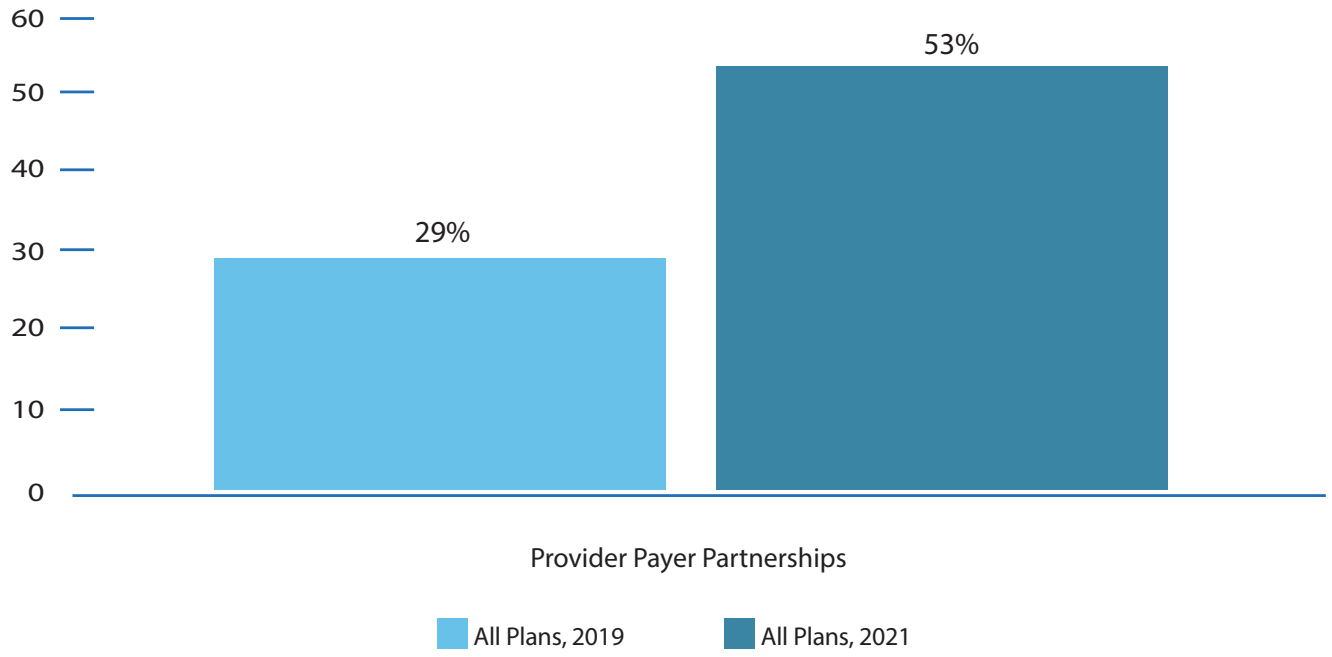
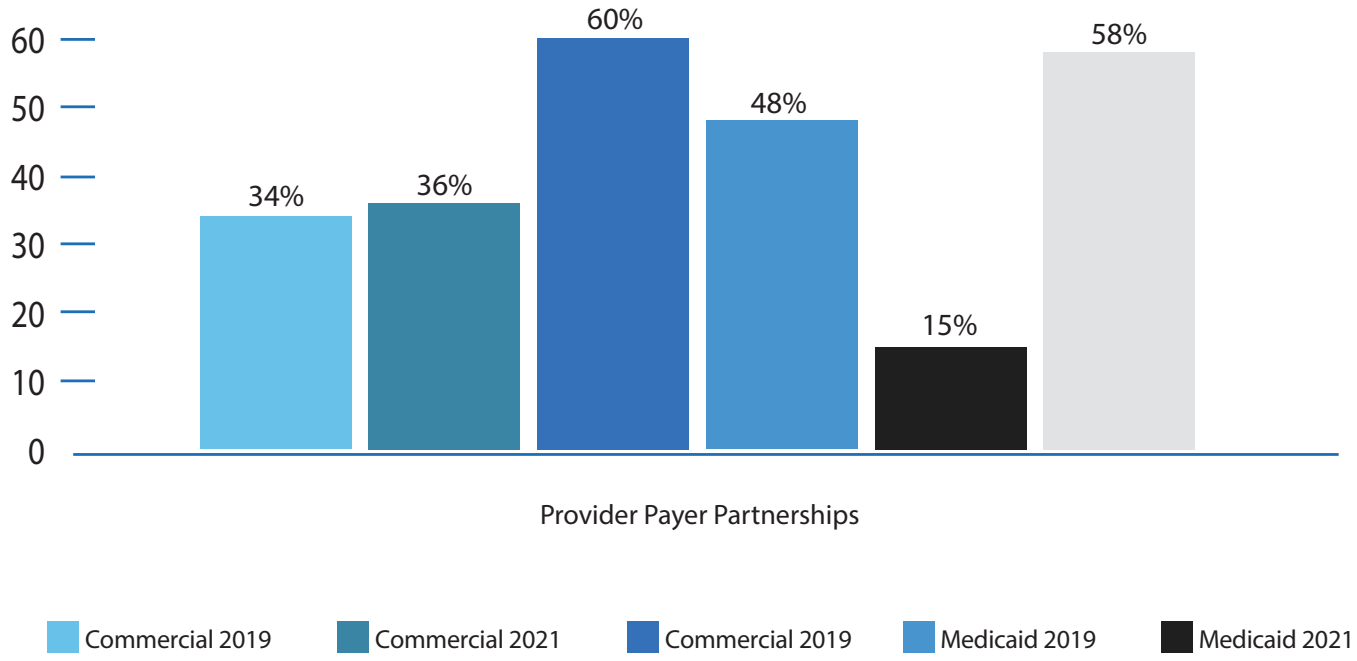


Figure 18 Utilization Of Provider Payer Partnerships, 2019 & 2021, By Plan[1]



Health Plan Current & Past Use Of Value-Based Benefit Design

A key post-pandemic issue expected to continue will be how health plans reimburse providers for their services whether they are conducted in person or via the internet. Analysts expect to see more health plan managers looking for provider organizations that accept value-based reimbursement (VBR) arrangements—particularly arrangements that share financial risk.[13] A September 2020 Medicare Payment Advisory Commission (MedPAC) meeting confirmed this general trend when it met to discuss telehealth post-pandemic reimbursement policy. Payers are generally concerned that unlimited and open use of telehealth services may potentially increase spending under the traditional FFS payment system. One proposed policy under discussion is to allow providers participating in APMs—such as accountable care organizations, episode-based payment models, and primary care focused models—to continue to benefit from telehealth expansions. However, providers using traditional FFS plans would revert to the pre-pandemic rules.

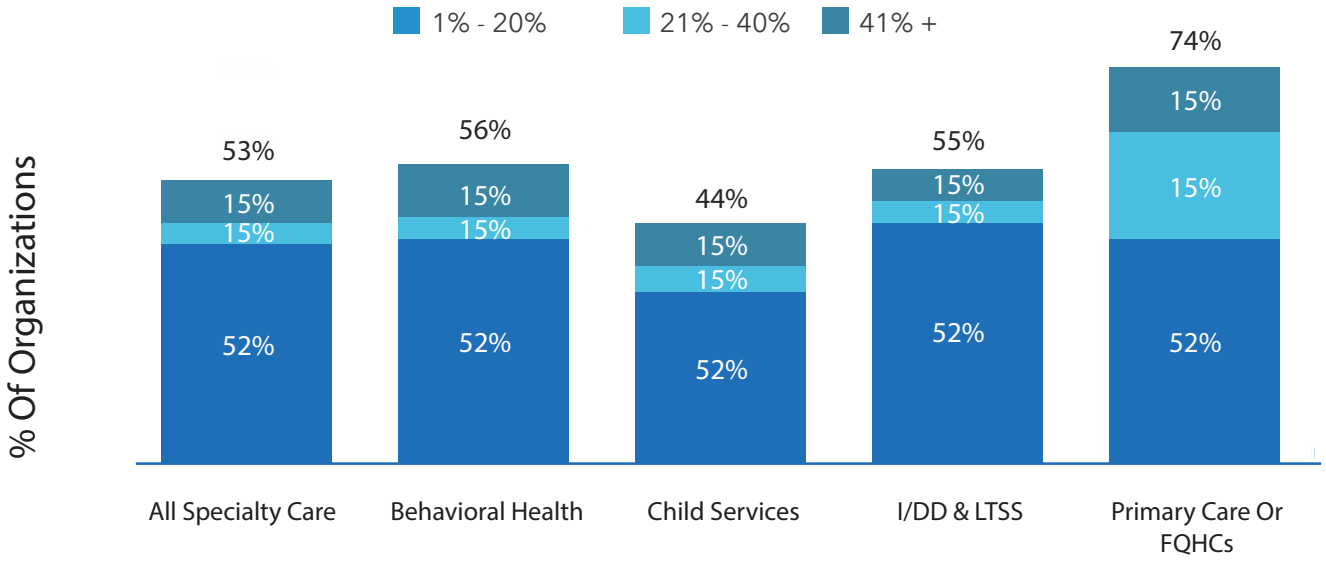
The additional support of telehealth may encourage more providers to transition from FFS to an APM. According to a 2020 *OPEN MINDS* survey, 58% of specialty provider organizations are participating in value-based arrangements.[13] Of these, 42% participate in a pay-for-performance arrangement with fee-for-service, 22% in capitation for specific services, 18% in capitation for care coordination, and 24% in case or bundled rates. The same survey found that 15% of organizations had more than 20% of their revenue from VBR contracts. An earlier survey of health plans found that 93% of health plans—including commercial plans, Medicaid, and Medicare—have implemented pay-for-performance reimbursement models. In addition, the use of episodic or bundled payments for specific acute care episodes is gaining traction, with 59% of plans using this model. While only 40% of commercial health plans use episodic payments, 71% of Medicare and 88% of Medicaid health plans use these payment arrangements for behavioral health.

A new report shows the continuation of this trend. VBR contracts now account for 26% of hospital revenue. The report notes that growth has been slow and the biggest factors limiting the adoption of VBR are uncertainty that there will be a return on investment and a lack of needed infrastructure.

Another recent survey found that 53% of specialty provider organizations (compared to 74% of primary care organizations) are participating in VBR arrangements, with the biggest increase among I/DD service provider organizations.[14] The most common model was pay-for-performance incentives in fee-for-service arrangements. Among specific reimbursement methodologies, the greatest year-over-year increase was in the use of capitation reimbursement—either for care coordination (a 33% increase) or for specific services (a 36% increase). While this represents an increase, only 12% of specialty provider have more than 20% of their revenue coming from VBR arrangements.

According to a 2020 *OPEN MINDS* survey, 58% of specialty provider organizations are participating in value-based arrangements. Of these, 42% participate in a pay-for-performance arrangement with fee-for-service, 22% in capitation for specific services, 18% in capitation for care coordination, and 24% in case or bundled rates.

Figure 18 Specialty Or Primary Care Provider Organizations' Revenue In Value-Based Arrangements, By Market, %, 2021[14]



Despite this movement, the management challenges remain the same—getting access to the data needed to optimize performance under VBR reimbursement arrangements—and setting up the systems and team members to report that data.

Another area to watch will be the Medicare Value in Opioid Use Disorder Treatment demonstration which launched in April 2021. The Value in Treatment initiative created two new payments for opioid use disorder (OUD) treatment services. The four-year demonstration program will serve up to 20,000 FFS Medicare beneficiaries diagnosed with OUD. Beneficiaries dually eligible for Medicare and Medicaid can also be served through the Value in Treatment demonstration.[15]

Participating provider organizations will establish an OUD care team and use that team to furnish or arrange for OUD treatment services, including medication assisted treatment (MAT) in the outpatient setting. Services furnished through this demonstration will be based on the beneficiary's individualized OUD treatment plan, aligned with OUD treatment services defined in statute, and have a reasonable expectation of improving or maintaining the health or overall function of eligible beneficiaries. The two new payments are as follows:

- A per beneficiary per month care management fee (CMF) of $125, which the participating provider organization may use to deliver additional services to applicable beneficiaries, including services not otherwise eligible for Medicare payment. The CMF will be paid to participants quarterly based on billed claims. A portion of the CMF payment will be subject to a quality withhold for a performance-based incentive. The CMF withhold amount will scale up from 0% in performance Year 1; 5% in performance Year 2; and 10% in each performance Years 3 and 4 thereafter.
- A performance-based incentive payable based on the participating provider organization's performance with respect to criteria specified by CMS, which may include evidence-based MAT for OUD, as well as beneficiary engagement and retention in treatment. Participants who meet quality

criteria, to be specified in the participation agreement during a given performance year, will be eligible to earn back withheld monies. Participant performance will be assessed on an annual basis during the second quarter following the performance year, after completing a claims run out during the first quarter following the performance year. The performance-based incentive will be paid to eligible participants in the third quarter following the performance year.

The Value in Opioid Use Disorder Treatment demonstration was authorized by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). Funding of $10 million was appropriated for each year for 2021 through 2024.

The purpose of the demonstration is to increase beneficiary access to OUD treatment, improve their physical and mental health outcomes, and to the extent possible, reduce Medicare program expenditures. Specifically, CMS seeks to test whether the new value-based payment structure has the following effects:

- Reduces hospitalizations and emergency department visits.
- Increases use of MAT for OUD.
- Improves health outcomes for individuals with OUD, including reducing the incidence of infectious diseases such as human immunodeficiency virus (HIV) and hepatitis C (HCV).
- Reduces deaths from opioid overdose; reduces utilization of inpatient residential treatment.
- Reduces Medicare program expenditures.

Health Plan Current & Past Use Of Models To Address Social Determinants Of Health

Social determinants of health (SDOH) are the conditions into which people are born, grow, live, study, work, and age that shape a person's overall health. Researchers have realized that addressing health symptoms is not enough to create a healthy person. Rather, all these factors must be addressed when hoping to improve someone's whole health.[16]

COVID-19 has brought to the forefront some key health disparities. Statistics show that adverse SDOH can partially explain differences in death rates due to COVID-19. Compared to Whites, the likelihood of COVID-related deaths for Black Americans is 37% higher, for Asians 53% higher, for Native Americans and Alaskan Natives 26% higher, and for Hispanics 16% higher.[17] There are many factors that contribute to these disparities. People of color are more likely to be uninsured; Hispanics, for example, are two and a half times more likely to be uninsured than Whites. People of color are more likely to have chronic diseases; Black Americans have a 77% higher risk than Whites of being diagnosed with diabetes, while the risk is 66% higher for Latinos.

People of color are more likely to work in service roles that expose them to the more people every day. Pre-pandemic, nearly 30% of White workers surveyed said they could work from home, compared to 20% of Black and 16% of Latino workers. The ability to participate virtually in work, school, and health care is also not evenly distributed. Lower-income groups of parents are 36% more likely for their kids to be unable to complete schoolwork because they have no computer at home. Another 40% of parents say their child having must use public Wi-Fi to finish schoolwork due to lack of reliable internet connection at home. Additionally, Medicare beneficiaries without digital access are more likely to be 85 or older, widowed, have a high school education or less, be Black or Hispanic, have a disability, and/or be covered by Medicaid.

Solutions to these situations are complex and have been exacerbated by the economic crisis created by the pandemic. Plus, the reality is that

different parts of the economy will recover at different times, deepening the divide between the rich and the poor. About a third of the economy will recover rapidly, but the rest will have a slow return with lingering unemployment and under-employment. The workers most negatively affected will be low-wage workers and more likely to be women, mothers with school-age children, Black, Latino, and individuals without college degrees.

So why does this matter? First, individuals with chronic conditions are disproportionately people of color and people with social support needs. And, as provider organization are increasingly compensated based on value—their ability to improve specific health outcomes, reduce emergency room visits, and reduce hospital admissions—health disparities and social supports will matter much more to financial performance. This move to value-based reimbursement is occuring just as state and local budget deficits due to the pandemic is leading to cuts in public health and human service budgets. Understanding health disparities, SDOH, and new models for integrating health and social supports will be key to caring for the behavioral health of these individuals.

Addressing Racial Bias In Health Care: Practice & Organizational Perspectives

Racial bias is evident at both the health delivery system level and educational/organizational level. Addressing racial bias in health care is important in achieving health equity. For example, 13.2% of 12-year-old children in the U.S. have attention deficit hyperactivity disorder (ADHD). White children had the highest incidence of ADHD diagnosis at about 14.2%, while Black children had an 11.8% incidence, and Asian children had a 6.1% incidence.[18] White children were also more likely to receive treatment for ADHD, with Black children receiving treatment about 21.0% less often than White children, and Asian children receiving treatment about 46.0% less often than White children. Understanding and addressing these disparities will be a key element in improving our nation's mental health.

The Digital Divide: One More Strategic Challenge

The pandemic has pushed both the health and human service field and academic into virtual service models and both are still adapting. This pivot—with makeshift policies and procedures and patchwork infrastructure—has been fine for stopgap measures during a public health emergency. Further outcomes research must be conducted to determine long-term, effective solutions. However, a second problem is the broader problem—making sure consumers have the tools and the ability to participate in virtual services. The Federal Communications Commission reported that 21 million Americans—roughly 10% of the 209 million adults—lacked broadband internet.[19]

Will Investing In Social Determinants Pay Off?

Health care services account for only 20% of health outcomes, while health-related behaviors and socioeconomic factors like housing, food, physical environment, and employment can drive 80% of health outcomes. Research shows that individuals between the ages of 25 and 44 experiencing homelessness have a mortality risk 8.9 times higher than the risk of the general population. Plus, nearly 50 million people are food insecure, which is associated with increased risks of anemia, asthma, poor oral health, anxiety, depression, behavioral problems, and suicide ideation. Providers are recognizing they must address these non-health factors of health to properly address physical and emotional health. Value-based care where providers are sharing financing risks increases the likelihood that clinicians will work to address these non-health factors in order to improve health outcomes.[20,21,22]

Deep Social Inequities Exist In Counties With High Alzheimer's Disease Prevalence Among Blacks & Latinos

Counties with the highest prevalence of Alzheimer's disease and related dementias (ADRD) among Blacks and Latinos are more likely to have worse SDOH compared to counties with the lowest prevalence of ADRD among these populations. Medicare data combined with information from the U.S. Census Bureau determined the social determinants of health present in the counties most impacted by ADRD are Latino and Black individuals in the Medicare program. These social determinants include such things as higher levels of poverty, less household income, less access to exercise opportunities, and less educational attainment.[23]

Alzheimer's Burden Is Greater In Appalachian Ohio Areas Than Other Rural Areas

ADRD is more common in rural Appalachian Ohio communities compared to other rural areas in the state. Rural Appalachian counties had an average of between 2% and 3% higher prevalence of Alzheimer's disease, compared to rural non-Appalachian counties of Ohio. The researchers concluded that there is a varying prevalence of ADRD burden in Ohio, with higher prevalence in rural Appalachian counties. According to outside research, a reason for this higher prevalence is that Appalachian regions of the United States have greater inequities in terms of socioeconomic factors, morbidity and mortality.[24]

Racial Disparities – An Analysis Of Three Decision Points In Iowa's Juvenile Justice System

A November 2020 report by the Iowa Department of Human Rights Disproportionate Minority Contact Subcommittee discovered racial disparities in three key decision points: initial referral to Juvenile Court Services, detention for probation and parole violations, and juveniles being prosecuted as adults. The subcommittee was charged with reviewing racial disparities in juvenile detention and developing proposals to reduce disparity.[25]

Housing = Health: The Five Levers

Before the start of the pandemic, nearly 570,000 Americans were homeless. And now, as unemployment continues to struggle and moratoriums against evictions and foreclosures expire, an additional 30 to 40 million people could be at risk of homelessness. Even before the pandemic, leaders in the health care field had begun to acknowledge that housing insecure consumers use more health care resources. But the big question remains–what to do about it? How do health plans approach the issue of caring for housing insecure members?[26]

A November 2020 report by the Iowa Department of Human Rights Disproportionate Minority Contact Subcommittee discovered racial disparities in three key decision points: initial referral to Juvenile Court Services, detention for probation and parole violations, and juveniles being prosecuted as adults.

Figure 20 Utilization Of Social Determinants Of Health Strategies, 2019 & 2021, All Plans[1]

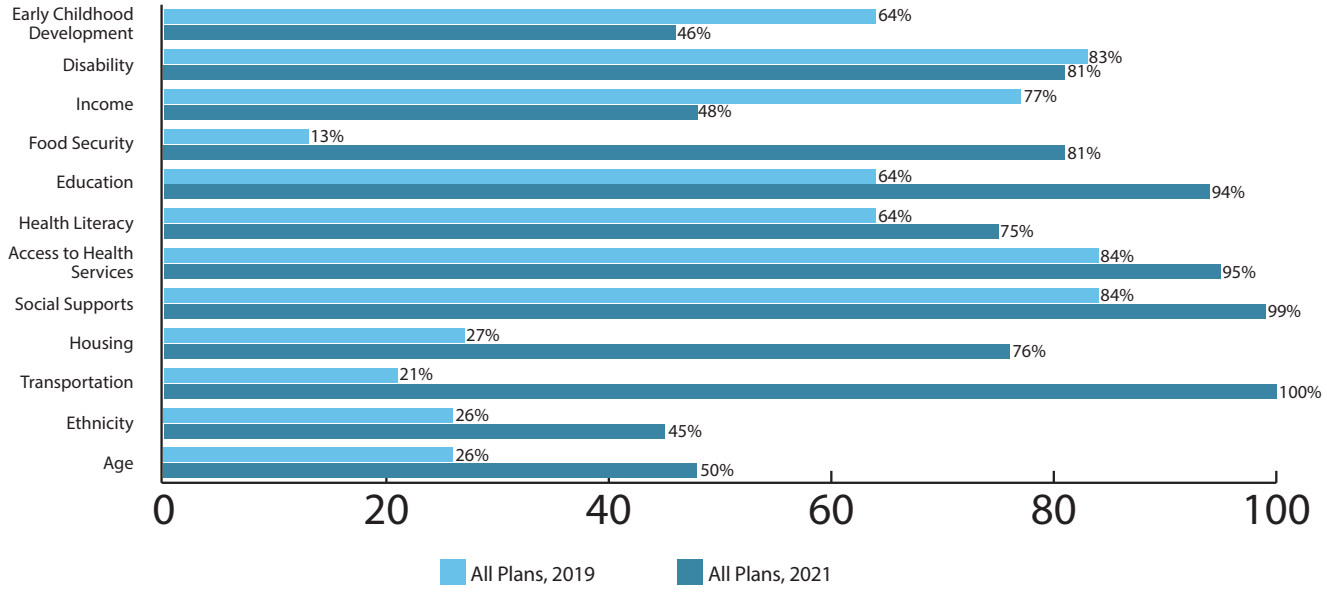
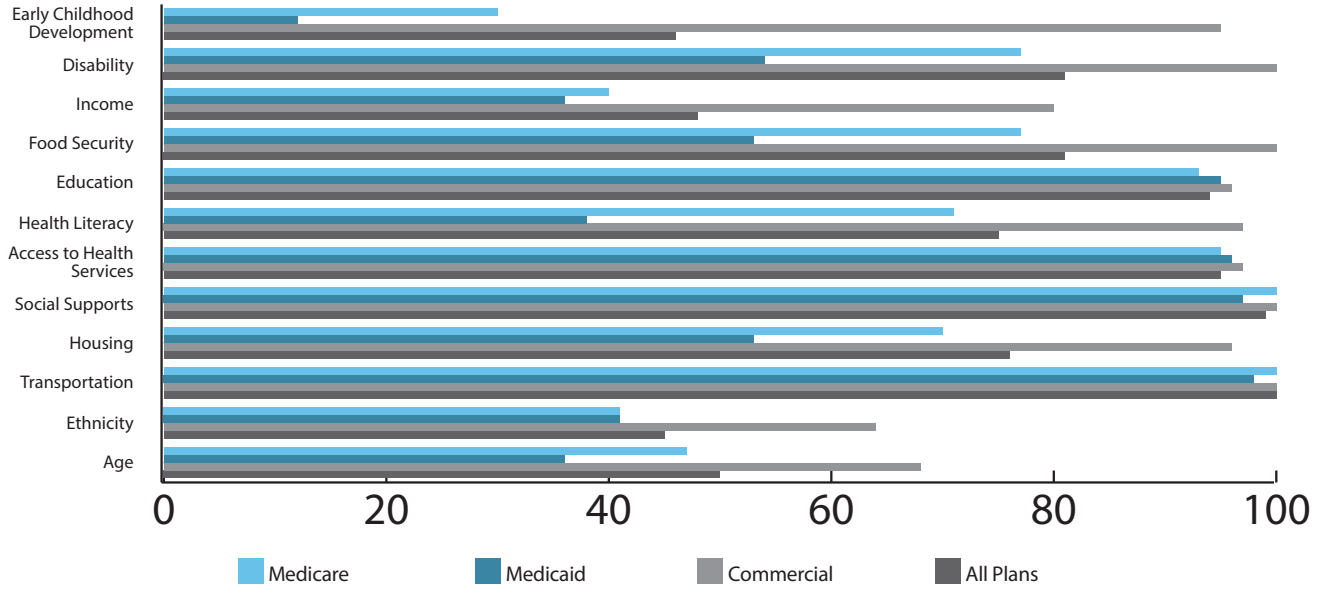


Figure 21 Utilization Of Social Determinants Of Health Strategies, 2019 & 2021, All Plans[1]



Managing Long-Term Services & Supports

In January 2021, CMS reported that total Medicaid long-term services and supports (LTSS) spending rose about 4% from 2017 to 2018, increasing from about $124 billion to about $129 billion. Approximately 56% of this spending was for home- and community-based services (HCBS), and another 23% of this spending was for managed LTSS (MLTSS).[27]

LTSS cover a wide range of medical and non-medical services and supports for people with physical, cognitive, mental, or other disabilities or conditions. These services can include institutional care like that services provided in nursing facilities and mental health facilities and HCBS, including personal care and home health.

Since 2008, overall Medicaid LTSS expenditures have grown by about 2% each year. This growth has been primarily driven by an increase in HCBS expenditures, which have increased by about 5% to 10% each year, while institutional LTSS expenditures have steadily decreased by about 2% to 4% in that same time period. The share of LTSS out of total Medicaid expenditures declined from 47% in 1988 to 32% in 2018. Nursing facilities represented the greatest share of institutional LTSS expenditures, accounting for 78.9% of these expenditures in 2017 and 2018. Section 1915(c) waiver programs represented the majority of HCBS expenditures in 2017 and 2018, accounting for just over 50% of these expenditures in both years.

Older adults and people with physical or other disabilities (PD or OD) accounted for the majority of total LTSS spending in 2017 and 2018, representing about 55% to 56% of total expenditures in these years. People with autism spectrum disorder (ASD), intellectual disorder (ID), developmental disorder (DD) accounted for about 25% to 26% of spending, while people with behavioral health conditions accounted for approximately 6% of spending, and multiple populations accounted for the remainder.

However, within these population subgroups, HCBS accounted for a majority of LTSS spending for people with ASD, ID, or DD and for multiple populations, but it accounted for a much lower share of LTSS spending for older adults and people with PD or OD and for people with behavioral health conditions.

MLTSS Expenditures

The amount spent on MLTSS programs has increased more than three-fold, climbing from $6.7 billion in 2008 to $30.1 billion in 2018. This growth reflects more states using MLTSS, rising from 8 in 2006 to 25 states in 2018, including the 10 states that operated Financial Alignment Initiative demonstrations, which cover Medicaid LTSS for dually eligible beneficiaries.

HCBS Spending

The percentage of HCBS expenditures of total Medicaid LTSS expenditures has steadily increased over the last 30 years until recently, when it has begun to plateau. The U.S. total surpassed the long-standing benchmark of 50% of LTSS expenditures in 2013 and has remained higher than 50% since then, reaching 55.4% in 2017 and 56.1% in 2018. In 2017, Oregon, Minnesota, and New Mexico spent more than 75% of their Medicaid LTSS expenditures on HCBS, and in 2018 these same three states, as well as Arizona and Wisconsin, did the same. Florida, Indiana, Louisiana, Mississippi, New Jersey, and Rhode Island all spent less than 40% of total Medicaid LTSS expenditures on HCBS in both 2017 and 2018.

MLTSS & HCBC Outcomes Data

There is some early data emerging about the success of these programs.[28] Dual eligibles in Florida and Medicaid-only beneficiaries in Kansas enrolled in Medicaid MLTSS programs had higher use of home- and community-based services HCBS than a comparison group of beneficiaries in fee-for-service (FFS) LTSS systems in a nearby state. A 2020 analysis compared outcomes over

a four-year period for MLTSS beneficiaries in three states (Florida, Kansas, and Tennessee) to outcomes for LTSS beneficiaries in nearby states with FFS LTSS systems. In Tennessee's MLTSS system, for some years the use of HCBS by duals and Medicaid-only beneficiaries was higher than in the FFS comparison state, but it was lower for other years. MLTSS enrollees in Florida, Kansas, and Tennessee were more likely to report better access to services and better experience of care and quality of life compared to FFS beneficiaries in the comparison states. However, no consistent pattern for MLTSS effects emerged.

The comparison analyzed MLTSS utilization trends and cost in 10 programs for 2017, and beneficiary experience for 2016 to 2018. The 10 programs were operated by five states: Florida, Kansas, Tennessee, New Mexico, and New York. Total enrollment and spending in the 10 MLTSS programs in 2017 represented about 53% of total MLTSS enrollment nationwide, and 79% of MLTSS spending. The MLTSS programs in the five study states spent 68.9% of their total MLTSS expenditures on HCBS. Other states with MLTSS programs spent 56.3% of MLTSS expenditures on HCBS.

The researchers conducted an in-depth program-level comparison for service use and quality of care in the Florida Statewide Medicaid Managed Care Long-Term Care Program (SMMC-LTC), Kansas KanCare (MLTSS component), and Tennessee TennCare CHOICES in Long-Term Care programs. They compared the MLTSS beneficiary outcomes to outcomes for a matched comparison group of LTSS beneficiaries in a nearby FFS state. Florida was compared to South Carolina; Kansas to Oklahoma; and Tennessee to Georgia. The New Mexico Centennial Care Program (MLTSS component) and New York Medicaid Advantage Plus (MAP) programs were not included in this analysis because neither state had a matched comparison group.

Table 4 Comparison Of MLTSS Program Impact On Four Medicaid Outcomes For Three State Programs, Compared To Matched Groups Of LTSS FFS Beneficiaries: Summary Findings Across All Years (Better, Worse, Or Mixed)[28]

	Florida SMMC-LTC, Compared To South Carolina FFS LTSS		Kansas KanCare MLTSS, Compared To Oklahoma FFS LTSS		Tennessee TennCare CHOICES in Long-Term Care Compared To Georgia FFS LTSS	
Outcome by Research Domain	Duals	Medicaid Only	Duals	Medicaid Only	Duals	Medicaid Only
Nursing Facility Use	Better	Worse	Better	Better	Worse	Worse
HCBS Use, Overall	Better	Mixed	Worse	Better	Mixed	Mixed

Table 4 Comparison Of MLTSS Program Impact On Four Medicaid Outcomes For Three State Programs, Compared To Matched Groups Of LTSS FFS Beneficiaries: Summary Findings Across All Years (Better, Worse, Or Mixed)[28] (cont.)

	Florida SMMC-LTC, Compared To South Carolina FFS LTSS		Kansas KanCare MLTSS, Compared To Oklahoma FFS LTSS		Tennessee TennCare CHOICES in Long-Term Care Compared To Georgia FFS LTSS	
Outcome by Research Domain	Duals	Medicaid Only	Duals	Medicaid Only	Duals	Medicaid Only
Inpatient Hospital Days	n/a covered by Medicare	Better	n/a covered by Medicare	Better	n/a covered by Medicare	Worse
Potentially Avoidable Hospitalizations	n/a covered by Medicare	Better	n/a covered by Medicare	Better	n/a covered by Medicare	Better
Round-The-Clock Services Use	Better	Better	Better	Worse	Worse	Worse
Day Services Use	Better	Mixed	Better	Better	Worse	Worse
Home-Delivered Meals Use	Worse	Worse	Worse	Worse	Worse	Worse
Home-Based Services Use	Better	Worse	Better	Better	Worse	Worse
Caregiver Support Services Use	Better	Better	Worse	Worse	Mixed	Mixed
Equipment, Technology, & Modifications Use	Better	Mixed	Worse	Worse	Worse	Better

The researchers conducted repeated cross-sectional (RCS) analysis for New Mexico and New York. In New Mexico nursing facilities and HCBS, use declined among the MLTSS enrollees. The MLTSS enrollees had a decline in inpatient hospital use and potentially avoidable hospitalizations. In New York, nursing facility and HCBS use remained steady among MLTSS enrollees, with no declines or increases compared to FFS.

The researchers examined beneficiary responses to 33 items from the National Core Indicators-Aging and Disabilities survey reported in 2016 to 2018 and focused on 10 domains and evaluated each as well as determining a pooled overall determination. The findings were as follows:

- Overall, MLTSS beneficiaries had better access to services, a better experience, and a better quality of life.
- Better outcomes for MLTSS beneficiaries in five domains: access, control, health care, relationships, and satisfaction.
- Mixed outcomes in the remaining five domains: care coordination, everyday living, rights and respect, safety, and service coordination.

Behavioral Managed Care

In recent years, many states have moved to carve behavioral health services, pharmacy benefits and long-term services and supports back into Medicaid managed care organizations (MCO). Before, many MCOs specifically excluded these services.[29] For example, in 2002, there were more than 800 organizations offering separate managed behavioral health and employee assistance programs.[30]

At the time, these horizontal carve-outs were a growing trend. Many national hospital chains focused on behavioral disorders and the number of private psychiatric hospitals in the United States increased from 180 in 1970 to nearly 250 in 1985. Behavioral health was considered disconnected from physical health services and many with behavioral health disorders were excluded from obtaining any insurance coverage because they had preexisting conditions or had maxed out their benefits.

However, the Patient Protection and Affordable Care Act (ACA) passed in 2010 spelled the beginning of the end for behavioral health carve-outs. Broader coverage, no limits on pre-existing conditions, and an end to annual or lifetime limits challenged many health insurers to reconnect mental illnesses and addiction disorders to the rest of the person's overall health. Many insurers then began to realize treating behavioral health disorders was less expensive than the forthcoming medical costs of the untreated behavioral disorders as medical costs for treating people with chronic medical and comorbid behavioral health conditions can be two to three times as high as for consumers without behavioral health conditions.

It appears that these behavioral health carve-out services will be replaced by a two-pronged approach to meeting behavioral health needs—an on-demand retail approach for consumers with less complicated mental health needs and an integrated approach for consumers with more complex conditions.

Network Expansions/Consolidation To Specific Provider Types Or Treatment Services

Consumers love the ease of many services they have become accustomed to during 2020 (and 2021) such as grocery pick-up and delivery, the ease of watching new movies at home, and teleworking. Another trend expected to continue is telemedicine—both for their cost and convenience.[31]

At the beginning of the pandemic lockdown in April 2020, behavioral health services pivoted to more than 80% online or over the phone. At the same time, onsite visits for primary care plummeted and it was estimated that primary

care organizations could lose over $15 billion in revenue in 2020 as consumers postponed office visits. Then over the year, consumers began to embrace virtual primary care visits. Health plans are also beginning to champion these virtual visits extending beyond the public health emergency. Many new technology start-ups have come to market to fill this niche while many traditional providers have expanded their offerings to include virtual services. Some employee-sponsored health plans have also joined the virtual primary care bandwagon offering consumers to access primary care providers with minimal co-pays.

Medication Assisted Treatment (MAT)

Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Medications used in MAT are approved by the FDA and MAT programs are clinically driven and tailored to meet each patient's needs.[32]

In recent years, research has shown that combining non-euphoric medications with therapy is a successful approach to treating substance use disorders and maintaining recovery. MAT is primarily used to treat addiction to opioids like heroin and prescription pain relievers containing opiates. The prescribed medication operates to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative and euphoric effects of the substance used.

In 2018, an estimated two million Americans had an opioid use disorder, including abuse of heroin and prescription pain medications containing opiates. MAT has proved to be clinically effective at reducing the need for inpatient detoxification services for these individuals. MAT provides a comprehensive, individually tailored program of medication and behavioral therapy to address the needs of most patients. The ultimate goal of MAT is full recovery, including the ability for the individual to live a self-directed life away from a hospital or a justice facility.

In addition to improving patient survival and lowering an individual's risk of contracting HIV or Hepatitis C, MAT has been proven to decrease criminal activity among people with substance abuse disorders. This has led more people to gain and sustain employment and improved birth outcomes for pregnant women with SUD.

Acamprosate, disulfiram, and naltrexone are the most common medications used to treat alcohol use disorder. They do not provide a cure for the disorder, but they are most effective in people who participate in a MAT program.

Buprenorphine, methadone, and naltrexone are used to treat opioid use disorders to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. These MAT medications are safe to use for months, years, or even a lifetime although all dose regimens should be coordinated with treatment providers.

The medication naloxone is used to prevent opioid overdose by reversing the toxic effects of the overdose. According to the World Health Organization (WHO), naloxone is one of a number of medications considered essential to a functioning health care system.

While these MAT medications are good alternatives to opioids and alcohol, they are still dangerous and must be properly secured for safety. In particular, liquid methadone can be brown in color and can be mistaken for a soft drink. Children who take MAT medications are at risk of overdose and death.

Applied Behavioral Analysis (ABA)

Applied behavior analysis is a type of therapy used with autism spectrum disorder (ASD) individuals focusing on improving certain

behaviors, such as social skills, communication, and reading. ABA is also be used to teach individuals skills to live a more independent life, such as fine motor skills, grooming, hygiene, punctuality, and academic and job performance. The goal of ABA is to help people with ASD learn skills to help them adapt and thrive in the world. ABA has been proven to be successful at helping people with ASD to improve their social interactions and control negative situations so that they are less dependent on special services.[33]

Currently, all 50 states have mandates requiring some level of insurance coverage for people with ASD. However, not all states or private insurance companies specifically pay for ABA. In 2019, seven states had no age or reimbursement cap for ASD treatment, 10 states had varying annual reimbursement caps based upon a consumer's age, and five states had limits on the number of hours per week available for behavioral interventions. In states requiring ASD coverage, evidence-based approaches—such as applied behavior analysis (ABA), augmentative and alternative communication, and psychotropic medication—are most commonly reimbursed. One common frustration among provider organization executives has been that reimbursement models do not cover telemedicine or other technology-enabled approaches.[34] Time will tell if the pandemic has changed this permanently.

Some states are adding ABA coverage, though. Pennsylvania Medicaid released new regulations in January 2021 to reimburse for one-to-one individual and applied behavioral analysis services provided to children at a behavioral health center.[35] Oklahoma's SoonerCare Medicaid program also added coverage of ABA in 2020 so long as the services are provided by a registered behavioral technician certified by the Behavior Analyst Certification Board.[36]

New Jersey's FamilyCare Medicaid began reimbursing for ABA for children with autism under age 21 in 2020 under a new approach launched in collaboration with the Division of Children and Families. For New Jersey residents enrolled in a Medicaid MCO, the MCO is responsible for providing all ABA services through their contracted network of provider organizations. For those enrolled in Medicaid but waiting to be enrolled with an MCO, the state covers ABA through the FFS system.[37]

Virtual Behavioral Health Provider Networks

The investment news in 2020 was full of coverage of health care unicorns. So, what is a unicorn? It is a privately held, startup company valued at over $1 billion. Such ventures are as rare as the mythical creature for which they are named. From less than 40 in 2013, when the term was coined, the number of unicorns worldwide has grown to 450 as of October 2020. Of them, 30 are decacorns (valued at over $10 billion), and some are even hectocorns (valued at over $100 billion).[38]

Technology, big data analytics, finance, vacation rentals, and transportation are the common themes for unicorns. But perhaps for the first time, 12% (or 53 of the global unicorns) are health tech companies—six of which were started in 2020. The U.S. is home to 34 of these health tech unicorns, sharing a small corner of the stage with the likes of Airbnb and SpaceX. These health care unicorns provide a variety of services including virtual talk therapy, sleep and wellness advice, and artificial intelligence (AI) to diagnose common ailments. There are new companies offering affordable and convenient prescriptions, virtual or in-home medical care, and in-home lab tests.

One of the big disruptions brought about by these companies is how consumers' fundamental expectations about health care are changing. The services they offer are easy to access and easy to use, and laser-focused on the consumer experience. And often they are shifting services to online platforms or consumer homes. The new unicorns are also bypassing the middleman, allowing consumers to access services directly, offering choice and transparency.

The other disruption to the health and human service landscape brought by these companies is the outsized investment in technology that has changed the value equation at many levels. Remote care coordination, primary care professionals dispatched remotely, clinical decision support at the point of care, passive consumer condition monitoring, centralized appointment scheduling, and AI-driven consumer assistance are just a few of the ways that health care is changing.

The good news for consumers is many health insurers are seeing the value of these convenient tools and are adding them to their networks of available providers. Partnering with these commercial virtual services allows consumers easy access to mental health providers, often in their own home. This removes barriers to patients obtaining those first, crucial mental health appointments, allowing consumers to build a rapport and develop comfort with the process to allow them to begin to heal.

There are many for-profit virtual behavioral health companies that consumers can pay for on their own either individually or through a subscription. Sometimes patients can access these virtual therapy services and have them paid for through a partnership with their health plans. In other instances, insurers are creating their own virtual health networks for their customers. Some pharmacies are getting in the game by offering private counseling sessions on site or via telehealth.[39]

Considerations

During the pandemic, health plans saw an overall decrease in utilization due to social isolation. The pandemic has created an overall increase in need for mental health services as well as substance use disorder treatment. We see a marked decrease in fee-for-service being replaced by value-based payment arrangements. These value-based payment arrangements are designed to decrease overall cost while increasing quality. It is important to note that all health care services are moving toward a much more retail model.

Still, one of the major pain points for health plans is access for mental health and substance use disorder treatment services. In addition, there has been a significant focus placed upon social determinants of health by all payers, both public and private, which have significant potential impacts in treatment of mental health and substance use disorders.

Digital health will continue to play a key role in both service delivery as well as supporting providers with tasks such as screening and treatment adherence.

We also see different models where payers and providers have come together to form partnerships and joint ventures. The pace at which these relationships are forming is only likely to increase as the system shifts both economically and with regard to service delivery methodologies.

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Executive Summary

Consumer access to care remains one of the most significant challenges for the industry. The issues related to access are multi-faceted and are discussed in the survey for our trends guide. Access remains a very high priority and focus for payers across the industry is seen as one of the biggest pain points. Quality measures continue to dominate the requirements as the industry shifts to a value-based payment model. Health care effectiveness data and information set (HEDIS) measures are playing an important role in contracts between payers and providers, and follow-up care after psychiatric hospitalization (both 7- and 30-day follow-up) are the two most significant challenges the industry faces as it relates to quality.

Access to care is coupled with the delivery availability of care and the complexity added by rural health services. Much progress has been made toward bridging the gap of need versus availability, utilizing digital health and availability via retail care delivery; further, the growing need for mental health services compounds an already significant issue for the industry.

On a positive note, digital solutions are being embraced by large, self-insured employers meeting some of the pent-up demand. Many new digital health organizations with significant investment capital are changing the landscape in all areas of mental health service delivery. Growing solutions that address both access and delivery will likely dominate and accelerate in the coming years.

In general, significant opportunity exists for treating mental health in the United States. The number of people who are uninsured and, as such, have limited access to mental health services, is rising. During 2019, 8% (26.1 million people) of the civilian non-institutionalized population did not have health insurance at any point during the year. Plus, it was estimated that 10 million people lost employer-sponsored insurance during the pandemic. Of these, a third regained employer-sponsored insurance by being added to a family member's policy, nearly half were eligible for Medicaid, and 10% were eligible for marketplace subsidies. The balance of about 1.6 million consumers will likely be uninsured, raising the rate of the uninsured to 8.5%.[1] Early signs are the Biden Administration will work to get more people insured in such ways as extending enrollment to Health care.gov by three months and increasing subsidies.[2, 3] However, time will tell how successful these efforts will be at lowering the uninsured rate.

For people seeking mental health services, new patients today must currently wait an average of 25 days for their first appointment. It will still be months before we have accurate data on how the pandemic lockdowns, combined with the rapid adoption of telehealth services, have impacted time to treatment. However, we do know that HEDIS measures for behavioral health are mediocre, compared to measures for other medical conditions. The average performance on four behavioral health measures—antidepressant medication management in the acute phase, seven-day follow-up after hospitalization for mental illness, initiation of alcohol and drug abuse treatment, and 30-day follow-up for children prescribed medications for attention deficit hyperactivity disorder—was 48%, compared to an average of 72% for six cardiovascular and diabetes measures. Less than half of consumers covered by Medicare and Medicaid receive adequate follow up after mental health hospitalization, according to HEDIS measures. These measures have not improved in recent years and we still do not know how the pandemic has affected them.[1]

A 2021 report from the Rand Corporation, "Transforming Mental Health Care in the United States," recommended three key initiatives to improve performance across the system by improving care pathways to identify consumer mental health needs: make consumers better aware of the available options for care, accelerate access to care, and improve the quality of care.[4]

Improve Early Identification Of Mental Health Care Issues

Rand has four recommendations to speed identification of mental health needs. One is focused on improving consumer mental health education, starting by embedding it into the school curriculum. The other three are focused on behavioral health delivery system design changes, such as integrating mental health into primary care settings, providing supportive housing for homeless consumers with serious mental illness, and diverting consumers with mental illness away from the criminal justice system and moving them instead into community-based care.

Speeding Access To Care

It is not enough just to identify the people who need behavioral health care. Rather, patients suffering with behavioral health issues need to actually see a provider and receive treatment to start their recovery. Rand has seven recommendations to improve speed: enhance enforcement of equality for all individuals, reimburse treatment at cost in Medicaid, expand the mental health crisis response system, support early intervention for serious mental illnesses, address the mental health workforce shortage by attracting and supporting students into relevant fields of study, strengthen peer support services, extend telehealth, and align care planning to the outcomes that consumers want.

Promoting The Use Of Evidence-Based Treatments

Mental health treatments must also be effective and evidence-based so that consumers can get better. Rand recommends three actions to establish evidence-based care across the system. The first action is to define an explicit and mandated framework for levels of care to avoid confusion about who should provide care and at what intensity. They also recommend care coordination where primary care, mental health, and other clinical professionals caring for a consumer work together in teams. Finally, policymakers, advocates, and administrative officials should form learning collaboratives to develop innovative financing and service delivery models.

How to implement these recommendations into the current behavioral health system continues to be the challenge. Numerous commissions and system reviews have convened to identify problems and suggest solutions; however, little action has taken place. Implementing these recommendations require concrete action in two areas. First, more financial investments must be made by federal, state, local, and tribal governments to support mental health treatments. Second, and equally important, the new requirements and incentive-based payments for the private health plans and health systems must be encouraged and supported.

Among these recommendations, there are overarching policy changes that need to occur outside the private financing and delivery system. These will require federal and state government action. Education curriculum reform, housing reform, and justice system reform are systemic changes that governments must drive. Research—and more importantly, the rapid dissemination of results to the field, combined with steady funding and technical assistance for provider organizations—is essential to drive the adoption of evidence-based practices, technology improvements for access to care and outcomes measurement, integrated whole-person care, and care coordination. Another area of intervention for government would be to enable the standardization of care and reporting across payers, and to help establish and disseminate appropriate benchmarks for outcomes. Federal and state governments must also address workforce shortages in behavioral health by providing incentives for education to those who will serve high-needs populations and/or in high-needs occupations.

At the health plan level, more value-based

reimbursement models are needed to support the adoption of evidence-based practices and early interventions, integrated care models, and care coordination. Providers also need more clarity on how to measure their performance and ways to incorporate person-centered treatment goals. Health plans and health systems would be smart to take the lead in defining and codifying a continuum of care in states. Providers would be wise to establish some uniform types of data recording to allow for outcomes research. Data showing how effective and economical treatments are will be key to asking governments and non-profits for continued funding.

Better Oversight Needed For Medicaid Managed Long-Term Services & Supports

Another issue plaguing mental health services is proper oversight to ensure patients get the care they need. A November 2020 federal review of Medicaid managed long-term services and support (LTSS) programs in six states found tremendous problems.[5] Arizona, Florida, Iowa, New York, Texas, and Virginia were selected for comparison as these states collectively represent about 50% of all Medicaid beneficiaries in MLTSS programs.

The report found both significant problems in managed care organization (MCO) performance of care management and lax oversight by states and the federal government. MCO care management was generally found to be inconsistent. Certain care management activities were routinely conducted, but the MCO's follow-up actions to address needs were often erratic. In some MCO health assessments, the relationship was unclear between the consumer's identified needs and the service hours and type of services that the MCO authorized. All six states identified MCO performance problems ranging from failure to comply with assessment and care planning, inadequate care coordination, and inadequate monitoring of the level of services provided.[6]

The review of MCO MLTSS care management was based on records for 37 beneficiaries receiving LTSS from the same MCO in one state. The beneficiaries were selected to reflect varied experiences with the MCO's authorization of personal care services. Across the 37 beneficiaries, the following key themes emerged:

- The MCO routinely conducted certain required care management activities.
- The MCO did not consistently follow-up on beneficiary needs identified by the care coordinator.
- There was incongruence between health assessments and the number of personal care hours authorized for a number of cases.

The review of documentation of state MLTSS monitoring spanned a non-generalizable sample of six states for fiscal years 2017 through January 2020. The following key themes emerged:

- Through various monitoring approaches, all six states identified performance problems within an element of MCO care management ranging from MCO non-compliance with assessment and care planning to inadequate care coordination and monitoring of service provision to beneficiaries.
- The selected states may not be identifying all care management problems due to limitations in the information they collect or use to monitor MCOs.
- The states sometimes do not report problems they uncover to CMS. In some cases, CMS first learned about problems from beneficiary complaints, media reports, or from other quality reviews.

CMS oversight of MLTSS access and quality so far has been limited, which has hindered its ability to hold states and MCOs accountable for providing appropriate access and ensuring top quality services. Based on its review of the six states, the GAO concluded that CMS lacks a national oversight strategy for MLTSS. Further, CMS has

not assessed the nature and extent of access and quality problems across states. As a result, CMS risks being unable to identify and help address problems facing beneficiaries.

In July 2020, CMS convened a new workgroup focused on MLTSS oversight, but the GAO said CMS's efforts were in the early stages, and the goals and time frames for this work were unclear. The GAO recommended that CMS develop a national oversight strategy for MLTSS, and it has advised CMS to assess the nature and prevalence of MLTSS quality and access problems. CMS disagreed with the GAO recommendations.

The COVID-19 pandemic combined with years of under-funding for mental health services drastically cut into the availability of in-patient psychiatric services in 2020 and 2021. Clinics around the country have been forced to reduce their already limited inpatient psychiatric capacity to meet social distancing requirements, stem outbreaks of the virus, or repurpose psychiatric units to care for a surge of COVID-19 patients.[7]

That said, there has been a shortage of psychiatric beds in the U.S. long before COVID-19.[8] According to the non-profit Treatment Advocacy Center, emergency departments have been consistently crowded with acutely psychotic patients—some of whom must wait for beds nearly a month. The pressure on existing beds can be so intense that patients often are discharged prematurely only to be readmitted or end up homeless or incarcerated.

A 2021 study from researchers at the New York State Psychiatric Institute examined the relationships among changes in local psychiatric bed capacity, local jail inmate populations, and the psychiatric burden in local hospitals. Between 1955 and 2000, the number of psychiatric beds at state-run hospitals declined from 339 to 22 per 100,000 people. At the same time, the number of inmates housed within the criminal justice system rose from 16% of inmates in 1976 to 44% of inmates in 2011-2012.[9]

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Using American Hospital Association Survey and Medicare Provider of Services data, researchers aggregated to the hospital referral region-year level and matched to the National Inpatient Sample of hospital discharges 1988-2015 and the Annual Survey of Jails 1985-2014. Subsequent analysis by event study examined the effect of abrupt bed changes on numbers of jail inmates.

The study found that decreases in local psychiatric bed capacity were associated with an average increase of 256 jail inmates. Similarly, increases in psychiatric bed capacity were associated with an average decrease of 199 jail inmates. The study found limited evidence for spillovers to general hospitals immediately following decreases in psychiatric beds.

Many states continue to decrease the number of state hospital beds. One major reason is that there are currently no accepted standards regarding how many psychiatric beds are needed. A 2015 study looked at a 25-county region of North Carolina with a population of 3.4 million.[10] The total psychiatric bed capacity in those regions consisted of 398 beds in a state hospital; 494 adult psychiatric beds in 14 general or private psychiatric hospitals; and 66 nonhospital crisis beds in five facilities. Combined, this totaled 958

psychiatric beds, or approximately 28 adult beds per 100,000 population. The average emergency room pre-admission wait time for psychiatric beds in this region at the time of the study was 3.3 days.[11]

The authors used a computer simulation to model different scenarios to see how many additional psychiatric beds would be needed to achieve an average pre-admission wait time of less than a day. Their answer was 356 additional beds, bringing the total bed capacity to 1,314 or about 39 adult beds per 100,000 population. This calculation included only adult patients and assumed a median duration of stay in the psychiatric facility of 20 days.

Another issue to consider is that psychiatric units in general hospitals and psychiatric hospitals sometimes admit individuals who have the most severe forms of mental illness, but hospitals, especially general hospitals, often lack the adequate specialized staffing needed to care for these individuals effectively. In addition, many of the individuals presenting with severe forms of mental illness often lack health insurance and are considered less desirable by private psychiatric hospitals and psychiatric units in general hospitals, the majority of which are privately owned.

The Treatment Advisory Center recommends establishing a standard for what percentage of the beds per 100,000 population should be available in state psychiatric hospitals, but there is no such standard at this time. Currently, their data shows there are about 35,000 state psychiatric beds available, or about 11 beds per 100,000 population. However, even this figure is misleading because in most states the existing state psychiatric hospital beds are largely occupied by court-ordered long-stay patients and therefore not available for the admission of acutely psychotic patients.[8]

Although the absolute figure of psychiatric beds per 100,000 people varies depending on who you ask (for example, WHO says the number of psychiatric beds in the U.S. is about 18.6 per 100,000 compared to the Treatment Advisory Center's 11 per 100,000), America definitely lags behind similar wealthy nations. Germany, by comparison, averages about 55 psychiatric beds per 100,000 people, while Norway has about 73 psychiatric beds per 100,000 population. Japan leads the pack with about 197 psychiatric beds per 100,000 people.[12]

Rather than just adding new beds, the Treatment Advocacy Center recommends other measures can be taken to decrease the need for psychiatric beds.[8] For example, they recommend assertive community treatment and the use of assisted outpatient treatment (AOT) to ensure medication adherence. Studies of AOT have shown a decrease in violent behavior by 36% to 66% and can reduce the chances of an individual being arrested for a violent offense by 88%.[13] But despite the best outpatient efforts, some severely ill patients will continue to need the ultimate safety net of the state psychiatric hospital. It is important that for providers to ensure there are enough beds available for when patients need them.

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Retail Health care & Non-Traditional Companies In The Market

Over the past decade, urgent care centers and health clinics within grocery stores, pharmacies, and other retail establishments have popped up to deliver an increasing amount of care to adults and children.[14] These retail health centers can be a great place to deliver preventive care, like vaccines, and non-emergency acute or after-hours care.

The CDC estimates that in 2019, 26% of children had at least one visit to a retail health clinic over the previous 12 months. Nearly 14% of children had one urgent care or retail health clinic visit, while 8.2% had two visits and 4.5% had three or more visits. Most of the children who visited these clinics had insurance—28% had private insurance and 25% reported public insurance. Only 19% of the children were reported to be uninsured.

Children with parents who had more than a high school education (28%) were more likely than children with parents who had a high school diploma or GED or less (22%) to have had one or more urgent care or retail health clinic visits in the previous 12 months. Children living in families with incomes equal to or greater than 200% of the federal poverty level (FPL, 28%) were more likely to have had one or more urgent care or retail health clinic visits than children living in families below 200% of FPL (24%).

Behavioral health is also seeing shifts in how health care is delivered to consumers. In part due to the pandemic shifting everything virtual, there was a big uptick in digital mental health start-up funding from investors in 2020, with $588 million invested in the first six months of 2020, compared to $539 million in all of 2019, $658 million in 2018, and $273 million in 2017. In the first half of 2020, there were 27 venture funding deals in behavioral health alone.[15]

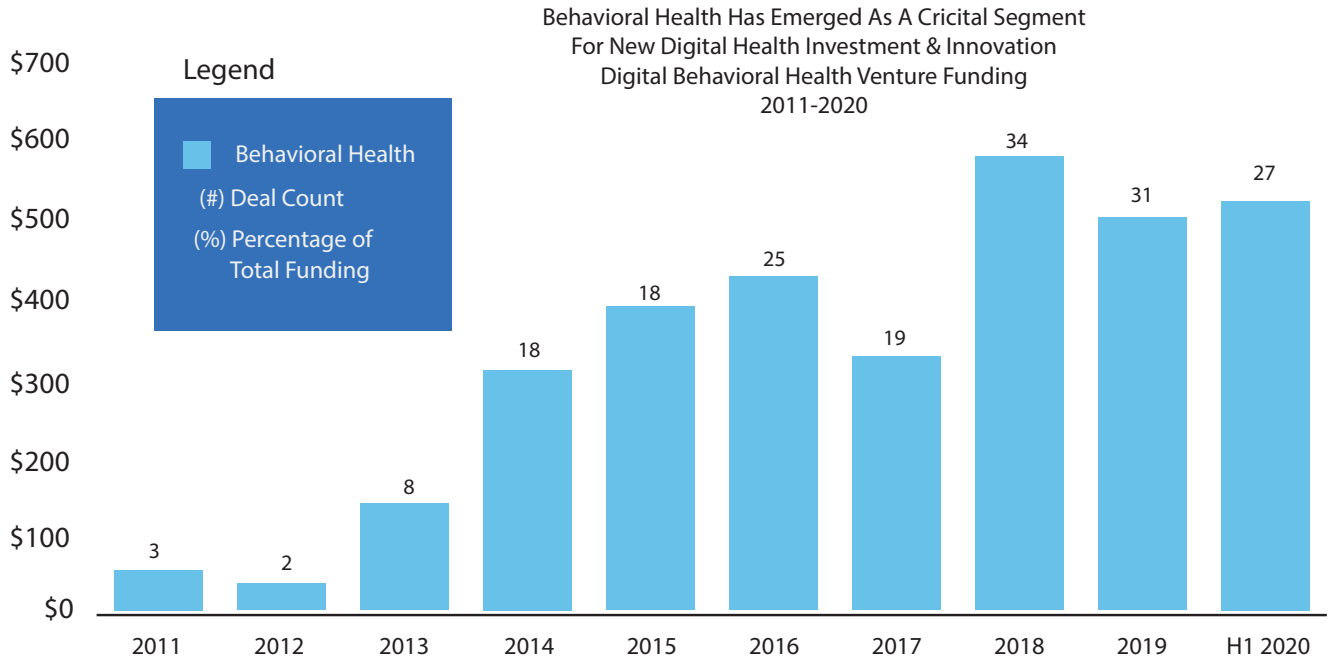
The majority of funding went to companies offering three types of solutions: digital treatment, digital therapeutics, and non-clinical behavioral health adjacent apps for uses like meditation and wellness. The companies funded offer a range of product features, from fully automated chatbots to video chat platforms, and other tools to enhance consumer-clinician interactions.

The interest in the behavioral health sectors is not surprising. Google searches for virtual mental health started to spike early in the pandemic. In mid-July 2020, 53% of adults in the United States reported that their mental health was negatively impacted due to worry and stress over the coronavirus—up from 32% in March. Mental Health America reported that more than 88,000 additional consumers developed anxiety or depression during the public health emergency while more than 21,000 consumers who took online depression screenings reported thinking of suicide or self-harm on more than half the days. All this points to a need for increased behavioral health services, and Wall Street is hoping to solve this need and receive healthy financial returns in exchange.

One of the reasons for this increased interest in mental health is that the stigma of mental health has diminished greatly during the pandemic with everyone talking openly about stress and anxiety, making it more likely that consumers will seek help. The ease of virtual service has also made it easier by removing barriers to care that help individuals stay engaged in their care.

Regardless of whether these start-ups succeed, they are causing significant disruption in behavioral health. These start-ups present competition for consumers, competition for therapists, and competition for health plan contracts. The products they offer are often well-suited for meeting the needs of consumers who are tech-savvy, have access to high-speed internet, and have mild and moderate behavioral health conditions. The question is how to succeed and provide care to the (very significant) rest of the consumer market.

Figure 1 Behavioral Health Has Emerged As A Critical Segment For New Digital Health Investment & Innovation[15]



*Behavioral health includes solutions that address a spectrum of needs from basic mental wellness through treatment of disease; it includes mental health (e.g., depression and anxiety), developmental disorders (e.g., autism spectrum disorder, ADHD), and substance use disorder.

Note: Only includes U.S. deals >$2M; data through June 2020

Source: Rock Health Funding Database

Considerations

Many of the new models are being supported by non-traditional players entering the market. We see significant increase in mergers and acquisitions on both the digital health and supporting technologies that extend care delivery. There is also a great deal of activity on the service side of the industry, where venture-capital and private equity are investing heavily in behavioral health service provider organizations, as well as substance use disorder treatment organizations. What this means to legacy provider organizations remains to be seen. However, it can easily be projected to create a level of market uncertainty that should drive a tremendous amount of innovation. The net effect will be increased capacity resulting in solving some of the access to care issues currently being experienced today as well as, hopefully, increasing quality while at the same time reducing cost.

The movement toward in-home treatment models will continue to grow exponentially in the coming years. This is signaled by the significant investment seen from the largest health plans in the in-home care portion of the health care market. This movement impacts the physical health side of the market but also will substantially change the behavioral health and human services market including substance use disorder treatment, as many of those services move to utilizing digital health or in-home treatment.

SOURCES

Foreword

1. The Lancet Global Health (2020). Mental health matters. The Lancet. Global health, 8(11), e1352. https://doi.org/10.1016/S2214-109X(20)30432-0

2. Mental illness. (n.d.). Retrieved May 06, 2021, from https://www.nimh.nih.gov/health/statistics/mental-illness

3. Rapfogel, A. (n.d.). Mental health care was Severely Inequitable, then came the Coronavirus Crisis. Retrieved May 06, 2021, from https://www.americanprogress.org/issues/disability/reports/2020/09/10/490221/mental-health-care-severely-inequitable-came-coronavirus-crisis/

Executive Summary

1. What you should be thinking about now. (2021, April 08). Retrieved May 06, 2021, from https://www.psychu.org/what-you-should-be-thinking-about-now/

2. Athenahealth creates online telehealth insights dashboard to help practices benchmark their performance and find opportunities to better meet provider and patient needs. (2021, March 09). Retrieved May 06, 2021, from https://www.businesswire.com/news/home/20210309005235/en/athenahealth-Creates-Online-Telehealth-Insights-Dashboard-to-Help-Practices-Benchmark-Their-Performance-and-Find-Opportunities-to-Better-Meet-Provider-and-Patient-Needs

3. The Next Normal Health and Human Service Landscape – What Can We Expect? (2020, Dec 29). Retrieved May 06, 2021, from https://psychu.org/the-next-normal-health-human-service-landscape-what-can-we-expect.

4. Collins, S. R., Gunja, M. Z., & Aboulafia, G. N. (2012). US health insurance coverage in 2020: A looming crisis in affordability: Findings from the commonwealth fund biennial health insurance survey, 2020.

5. 4.5 million more behavioral health Professionals needed In U.S., a shortage of 87%. (2021, February 01). Retrieved May 06, 2021, from https://psychu.org/4-5-million-more-behavioral-health-professionals-needed-in-u-s-a-shortage-of-87/

6. Hawkins, M. (2018). The silent shortage–a White paper examining supply, demand and recruitment trends in psychiatry.

7. The Silent Shortage: How immigration can help address the large and Growing Psychiatrist shortage in the United States. (2017, November 01). Retrieved May 06, 2021, from https://research.newamericaneconomy.org/report/the-silent-shortage-how-immigration-can-help-address-the-large-and-growing-psychiatrist-shortage-in-the-united-states/

8. End of an era: The last of the standalone behavioral health carve-outs. (2021, January 13). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/executive-briefings/end-of-an-era-the-last-of-the-standalone-behavioral-health-carve-outs/

9. Oss, M. (2020, April 30). Ten integration MODELS Reshaping specialty service delivery. Retrieved May 06, 2021, from https://openminds.com/market-intelligence/editorials/ten-integration-models-reshaping-specialty-service-delivery/)

10. Rudowitz, R. M. (2021, January 15). Medicaid: What to watch in 2021. Retrieved May 06, 2021, from https://www.kff.org/medicaid/issue-brief/medicaid-what-to-watch-in-2021/

11. The health disparities challenge that lies ahead. (2021, April 29). Retrieved May 06, 2021, from https://psychu.org/the-health-disparities-challenge-that-lies-ahead/

National Behavioral Health System Landscape

1. Collins, S. R., Gunja, M. Z., & Aboulafia, G. N. (2012). US health insurance coverage in 2020: A looming crisis in affordability: Findings from the commonwealth fund biennial health insurance survey, 2020.

2. OPEN MINDS. (2021). OPEN MINDS Market Intelligence Payers Proprietary Database

3. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. (n.d.). Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial

4. U.S. and world Population clock. (n.d.). Retrieved May 06, 2021, from https://www.census.gov/popclock/.

5. Managed care fact sheets national managed care penetration. (n.d.). Retrieved May 06, 2021, from https://www.mcol.com/managed_care_penetration.

6. Distribution of The U.S. adult population with a serious mental illness by payer: An Open Minds market intelligence report. (2021, March 27). Retrieved May 06, 2021, from https://openminds.com/intelligence-report/distribution-of-the-u-s-adult-population-with-a-serious-mental-illness-by-payer-an-open-minds-market-intelligence-report/

7. Adults reporting unmet need for mental health treatment in the past year because of cost. (2021, March 10). Retrieved May 06, 2021, from https://www.kff.org/other/state-indicator/adults-reporting-unmet-need-for-mental-health-treatment-in-the-past-year-because-of-cost/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D%29

8. About Section 1115 Demonstrations. (n.d.). Retrieved May 9, 2021, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

9. Medicaid Waiver Tracker: Approved and Pending SECTION 1115 waivers by state. (2021, April 16). Retrieved May 06, 2021, from https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table6

10. HHS no longer limiting use of provider relief fund payments for covering lost revenue due to

SOURCES

covid-19. (2020, November 17). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/news/hhs-no-longer-limiting-use-of-provider-relief-fund-payments-for-covering-lost-revenue-due-to-covid-19/

11. New needs when nursing homes close. (2021, January 27). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/executive-briefings/new-needs-when-nursing-homes-close/

12. Long-term care faces worst financial crisis in years; closures loom without additional funding. (2021, Feb 11). Retrieved May 06, 2021, from https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Long-Term-Care-Faces-Worst-Financial-Crisis-In-Years;-Closures-Loom-Without-Additional-Funding.aspx

13. The Next Normal Health and Human Service Landscape – What Can We Expect? (2020, Dec 29). Retrieved May 06, 2021, from https://psychu.org/the-next-normal-health-human-service-landscape-what-can-we-expect.

14. New service lines: What's hot? What's not? (2021, February 25). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/executive-briefings/new-service-lines-whats-hot-whats-not/

15. COVID-19 Intensifies Workforce Shortage Of I/DD Direct Support Professionals. (2020, November 25). Retrieved from https://openminds.com/market-intelligence/news/during-covid-19-pandemic-emergency-many-i-dd-direct-support-professionals-left-their-jobs/

16. 66% Of Addiction Treatment Provider Organizations Report Lower Revenue During COVID-19. (2021, January 12). Retrieved from https://openminds.com/market-intelligence/news/66-of-addiction-treatment-provider-organizations-report-lower-revenue-during-covid-19/

17. A Community of Providers for People with Disabilities. (n.d.). Retrieved from https://www.ancor.org/

18. King, R. (2020, June 26). Study: Primary care practices could lose $15B in 2020 due to COVID-19. Retrieved from https://www.fiercehealth care.com/practices/study-primary-care-practices-could-lose-15b-2020-due-to-covid-19

19. Christopher, M., & Whaley, P. (2020, November 05). Changes in Health Services Use During the COVID-19 Pandemic. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772537

20. 80% of behavioral health provider organizations are using telehealth for more than half of consumer visits, according to Qualifacts & National Council survey. (2020, August 27). Retrieved from https://openminds.com/market-intelligence/bulletins/80-of-behavioral-health-provider-organizations-are-using-telehealth-for-more-than-half-of-consumer-visits-according-to-qualifacts-national-council-survey/

21. COVID-19 shifts health care consumer behavior. (2020, September 16). Retrieved from https://achp.org/release-covid-19-shifts-consumer-behavior-attitudes-toward-health care-services/

22. Despite surge in telehealth, primary care visits drop 21% amid COVID-19. (n.d.). Retrieved from https://www.healio.com/news/primary-care/20201002/despite-surge-in-telehealth-primary-care-visits-drop-21-amid-covid19

23. Medicare beneficiary use of telehealth visits: early data from the start of the covid-19 pandemic. (2021, January 15). Retrieved from https://aspe.hhs.gov/

24. During COVID-19, Half Of Families Who Sought Child Mental Health Services Used Telehealth Talk Therapy. (2021, January 05). Retrieved from https://openminds.com/market-intelligence/news/during-covid-19-pandemic-half-of-families-who-sought-telemental-health-services-for-a-child-used-talk-therapy/

25. Average Senior Housing Occupancy Rate Fell To 84.9% Due To COVID-19. (2020, November 25). Retrieved from https://openminds.com/market-intelligence/news/average-seniors-housing-occupancy-fell-2-8-percentage-points-in-one-quarter-to-84-9/

26. Impact of the COVID-19 Pandemic on Emergency Department Visits - United States, January 1, 2019–May 30, 2020. (2020, June 11). Retrieved from https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm

27. COVID-Driven Telehealth Surge Triggers Changes to Quality Measures. (2020, June 05). Retrieved from https://www.ncqa.org/programs/data-and-information-technology/telehealth/covid-driven-telehealth-surge-triggers-changes-to-quality-measures/

28. RI.gov. (2020, January 07). Raimondo Announces Changes to the Long Term Care System; Investments to Create More Home-Based Care Options Amidst Spread of COVID-19 in Congregate Living Facilities. Retrieved from https://www.ri.gov/press/view/38751

29. Emper, C. (2021, March 17). Congress considers the future of Telehealth. Retrieved May 06, 2021, from https://www.nextgen.com/blog/2021/march/nextgen-advisors-blog-congress-considers-future-of-telehealth

30. Rodriguez, A. (2021, March 22). The pandemic ushered in 'a new era of medicine': These telehealth trends are likely here to stay. Retrieved May 06, 2021, from https://www.usatoday.com/story/news/health/2021/03/21/telehealth-trends-covid-19-mental-health-primary-care-coronavirus/4699979001/

31. Athenahealth creates online telehealth insights dashboard to help practices benchmark their performance and find opportunities to better meet provider and patient needs. (2021, March 09). Retrieved May 06, 2021, from https://www.businesswire.com/news/home/20210309005235/en/athenahealth-Creates-Online-Telehealth-Insights-Dashboard-to-Help-Practices-Benchmark-Their-Performance-and-Find-Opportunities-to-Better-Meet-Provider-and-Patient-Needs

32. Ohio Medicaid Makes COVID-19 Telehealth RULES Permanent. (2021, April 13). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/news/one-year-after-expansion-ohio-medicaid-provider-organizations-their-consumers-continue-to-embrace-telehealth/).

SOURCES

33. Athenahealth telehealth Adoption Report. (2021, March 8). Retrieved May 06, 2021, from https://www.athenahealth.com/knowledge-hub/clinical-trends/the-athenahealth-telehealth-insights-dashboard

34. Taskforce on telehealth policy. (2020, September 16). Retrieved May 06, 2021, from https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/

35. Bestsennyy, O., Gilbert, G., Harris, A., & Rost, J. (2020, June 01). Telehealth: A quarter-trillion-dollar post-COVID-19-reality? Retrieved May 06, 2021, from https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality#

36. Taskforce on telehealth policy findings and recommendations – telehealth effect on total cost of care. (2020, September 15). Retrieved May 06, 2021, from https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-findings-and-recommendations-telehealth-effect-on-total-cost-of-care/

37. Post-COVID-19 Pandemic: Behavioral health providers declare telemedicine is here to stay. (2021, April 29). Retrieved May 06, 2021, from https://psychu.org/post-covid-19-pandemic-behavioral-health-providers-declare-telemedicine-is-here-to-stay/

38. OPEN MINDS. (2021). Behavioral Health Delivery System, OPEN MINDS Proprietary Database

39. Intentional Approaches to Integrated Care. (2021, February 21). Retrieved May 06, 2021, from https://s30502.pcdn.co/wp-content/uploads/2021/02/Intentional-Approaches-to-Integrated-Care-White-Paper-FINAL.pdf)

40. Mandros, A. (2020, February 18). The Medicaid care Coordination models driving strategy in your state. Retrieved May 06, 2021, from https://openminds.com/market-intelligence/executive-briefings/the-medicaid-care-coordination-models-driving-strategy-in-your-state/

41. SAMHSA accepting applications for CCBHC Expansion Grants. (2020, March 05). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/news/samhsa-accepting-applications-for-ccbhc-expansion-grants/

42. COVID relief bill Provides SAMHSA $4.25 billion for behavioral health. (2021, January 29). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/news/covid-relief-bill-provides-samhsa-4-25-billion-to-provide-increased-behavioral-health-services/

43. State Medicaid care coordination initiatives: The 2019 Update. (2019, November 25). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/reference-guide/state-medicaid-care-coordination-initiatives-the-2019-update/

44. Medicaid health plans & VBR pick up steam. (2021, January 22). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/executive-briefings/medicaid-health-plans-vbr-pick-up-steam/

45. 93% of Medicaid health plans reported using value-based payment or alternative payment models.

(2021, January 06). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/news/93-of-medicaid-health-plans-reported-using-value-based-payment-or-alternative-payment-models-in-2019/

46. MACPAC releases report to Congress on oversight of institutions for mental diseases. (2021, January 06). Retrieved May 06, 2021, from https://www.macpac.gov/news/macpac-releases-report-to-congress-on-oversight-of-institutions-for-mental-diseases/.

47. States use multiple legal authorities to use Medicaid to pay for behavioral health treatment in IMDS. (2020, April 11). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/news/most-states-use-multiple-legal-authorities-to-use-medicaid-funds-to-pay-for-residential-inpatient-behavioral-health-treatment-in-imds-despite-federal-imd-exclusion

48. Health coverage for immigrants. (n.d.). Retrieved May 06, 2021, from https://www.health care.gov/immigrants/coverage/

49. Hagan, A., & Nguyen, C (2019, October 01). Health care safety-net programs continue to serve most vulnerable. Retrieved May 06, 2021, from https://ldi.upenn.edu/healthpolicysense/health-care-safety-net-programs-continue-serve-most-vulnerable

50. Just and accountable culture //. (n.d.). Retrieved May 06, 2021, from https://www.harrishealth.org/about-us/who-we-are

51. United States Center: Quick Facts Harris County, Texas. (n.d.). Retrieved May 06, 2021, from https://www.census.gov/quickfacts/fact/table/harriscountytexas/PST045219.

52. American rescue plan COVID-19 stimulus bill boosts subsidies for health insurance marketplace plans. (2021, March 31). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/news/american-rescue-plan-covid-19-stimulus-bill-boosts-subsidies-for-health-insurance-marketplace-plans/

53. The future of behavioral health. (2021, January 7). Retrieved May 06, 2021, from https://www2.deloitte.com/us/en/insights/industry/health-care/future-of-behavioral-health.html

54. Oss, M. (2021, March 29). Specialty care strategy for a tech-enabled future. Retrieved May 06, 2021, from https://openminds.com/market-intelligence/editorials/specialty-care-strategy-for-a-tech-enabled-future/

State Behavioral Health Landscape

1. The federal and state role in mental health. (n.d.). Retrieved May 07, 2021, from https://www.mhanational.org/issues/federal-and-state-role-mental-health.

2. Reinert, M., Nguyen, T., & Fritze, D. (2020.) 2021: The State of Mental Health in America. Retrieved May 07, 2021, from https://mhanational.org/sites/default/files/2021%20State%20of%20Mental%20Health%20in%20America_0.pdf.

SOURCES

3. Financing strategies for behavioral Health integration and COLLABORATIVE Care. (n.d.). Retrieved May 07, 2021, from https://aims.uw.edu/collaborative-care/financing-strategies-behavioral-health-integration-and-collaborative-care.

4. End of an era: The last of the standalone behavioral health carve-outs. (2021, January 13). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/executive-briefings/end-of-an-era-the-last-of-the-standalone-behavioral-health-carve-outs/.

5. State Medicaid Behavioral Health Carve-Outs: The OPEN MINDS 2020 Annual Update. 2020, January). Retrieved May 07, 2021, from https://openminds.com/wp-content/uploads/OM_MarketIntelReport_Medicaid_BHCarveout_10920.pdf.

6. Status of state medicaid expansion decisions: Interactive map. (2021, 13 April). Retrieved May 07, 2021, from https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

7. Sebastián Martínez Valdivia, K. (2021, April 06). Missouri Voted for This Lie,' Says state rep trying to block Medicaid expansion. Retrieved May 07, 2021, from https://khn.org/news/article/missouri-medicaid-expansion-legislative-budget-hurdle/.

8. Brown, T., Brown, T., Bryen, W., Sridhar, S., & Howe, J. (2021, February 22). Lawmakers: Gov. Stitt's managed care plan complicates Medicaid expansion funding plan. Retrieved May 07, 2021, from https://oklahomawatch.org/2021/02/19/lawmakers-gov-stitts-managed-care-plan-complicates-medicaid-expansion-funding-plan/

9. *OPEN MINDS*. (2021). OPEN MINDS Market Intelligence Payers Proprietary Database

10. Health insurance coverage of the total population. (2020, October 23). Retrieved May 07, 2021, from https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D

11. Behavioral health services. (n.d.). Retrieved May 07, 2021, from https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html

12. *OPEN MINDS*. (2020). OPEN MINDS State Profiles Proprietary Database

13. State Medicaid care coordination initiatives: The 2019 Update. (2019, November 25). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/reference-guide/state-medicaid-care-coordination-initiatives-the-2019-update/.

14. SAMHSA accepting applications for CCBHC Expansion Grants. (2020, March 05). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/samhsa-accepting-applications-for-ccbhc-expansion-grants/.

15. SAMHSA released grants to 134 clinics to become Certified Community behavioral health clinics.

(2021, February 08). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/bulletins/samhsa-released-grants-to-134-clinics-to-become-certified-community-behavioral-health-clinics/

16. Provider led entities. (n.d.). Retrieved May 07, 2021, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/PLE

Health Plan Population Management & Innovation

1. Behavioral Health Delivery System, *OPEN MINDS* Proprietary Database

2. Intentional Approaches to Integrated Care. (2021, 21 February). Retrieved May 06, 2021, from https://s30502.pcdn.co/wp-content/uploads/2021/02/Intentional-Approaches-to-Integrated-Care-White-Paper-FINAL.pdf)

3. Oss, M. (2020, April 30). Ten integration MODELS Reshaping specialty service delivery. Retrieved May 07, 2021, from https://openminds.com/market-intelligence/editorials/ten-integration-models-reshaping-specialty-service-delivery.

4. CMS launches new acute Care hospital-at-home waiver program. (2021, February 15). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/cms-launches-new-acute-care-hospital-at-home-waiver-program/.

5. CMS to Launch Health homes for children with Medically complex conditions. (2019, May 12). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/via-medicaid-services-investment-accountability-act-cms-to-launch-health-homes-for-children-with-medically-complex-conditions.

6. What you should be thinking about now. (2021, April 08). Retrieved May 07, 2021, from https://www.psychu.org/what-you-should-be-thinking-about-now/.

7. Technology for the next normal-your ehr plus what? (2021, January 05). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/executive-briefings/technology-for-the-next-normal-your-ehr-plus-what/.

8. 93% of Medicaid health plans reported Using Value-Based payment or alternative payment models. (2021, January 06). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/93-of-medicaid-health-plans-reported-using-value-based-payment-or-alternative-payment-models-in-2019/

9. Bringing peer support to scale in service delivery. (2019, January 04). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/executive-briefings/bringing-peer-support-to-scale-in-service-delivery/

10. 4.5 million more behavioral health Professionals needed In U.S., a shortage of 87%. (2021,

SOURCES

February 01). Retrieved May 07, 2021, from https://psychu.org/4-5-million-more-behavioral-health-professionals-needed-in-u-s-a-shortage-of-87/.

11. Alternative payment methods for behavioral health associated with lower utilization & spending. (2021, April 08). Retrieved May 07, 2021, from https://psychu.org/alternative-payment-methods-for-behavioral-health-associated-with-lower-utilization-spending/

12. The future of alternative payment models in Health care: A strategic perspective. (2020, November 03). Retrieved May 07, 2021, from https://www.lumeris.com/the-future-of-alternative-payment-models-in-health care-a-strategic-perspective/

13. Value-based reimbursement in the next normal. (2021, April 08). Retrieved May 07, 2021, from https://psychu.org/value-based-reimbursement-in-the-next-normal/.

14. The VBR trickle down effect. (2021, February 16). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/executive-briefings/the-vbr-trickle-down-effect/

15. Medicare launching 'VALUE IN opioid use Disorder Treatment' demonstration In April 2021. (2021, January 25). Retrieved May 07, 2021, from https://psychu.org/medicare-launching-value-in-opioid-use-disorder-treatment-demonstration-in-april-2021/

16. Rudowitz, R. M. (2021, January 15). Medicaid: What to watch in 2021. Retrieved May 07, 2021, from https://www.kff.org/medicaid/issue-brief/medicaid-what-to-watch-in-2021/

17. The health disparities challenge that lies ahead. (2021, April 29). Retrieved May 06, 2021, from https://psychu.org/the-health-disparities-challenge-that-lies-ahead/

18. 13.2% of 12-year-olds in The U.S. have ADHD, Racial/ethnic disparities are evident in diagnosis & treatment. (2021, April 07). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/13-2-of-12-year-olds-in-the-u-s-have-adhd-racial-ethnic-disparities-are-evident-in-diagnosis-treatment/

19. 21 Million Americans Still Lack Broadband Connectivity. (n.d.). Retrieved from https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2019/07/21-million-americans-still-lack-broadband-connectivity

20. Social Determinants of Health: The Variable for 80% of Health Outcomes. (2021, March 31). Retrieved from https://carejourney.com/social-determinants-of-health/

21. Bhardwaj, N. (2020, December 20). 50 million Americans, including 17 million children, to be food insecure by the end of 2020, according to Feeding America. Retrieved from https://www.businessinsider.com/54m-americans-to-be-food-insecure-by-end-of-year-2020-12#:~:text=50 million Americans, including 17,2020, according to Feeding America&text=50 million or one in,hunger organization in the US

22. Morrison, D. S. (2009, March 21). Homelessness as an independent risk factor for mortality: Results from a retrospective cohort study. Retrieved from https://academic.oup.com/ije/article/38/3/877/686657

23. UsAgainstAlzheimer's. (2021, May 06). Retrieved from https://www.usagainstalzheimers.org/

24. Alzheimer's Burden Is Greater In Appalachian Ohio Areas Than Other Rural Areas. (2020, September 25). Retrieved from https://openminds.com/market-intelligence/news/alzheimers-burden-is-greater-in-appalachian-ohio-areas-than-other-rural-areas/

25. Racial Disparities – An Analysis of Three Decision Points in Iowa's Juvenile Justice System. (2021, May 12). Retrieved from https://humanrights.iowa.gov/

26. Housing = Health: The Five Levers. (2020, December 28). Retrieved from https://openminds.com/market-intelligence/executive-briefings/housing-health-the-five-levers/

27. Total Medicaid LTSS spending rose 4% from 2017 to 2018. (2021, February 04). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/total-medicaid-ltss-spending-rose-4-from-2017-to-2018/

28. Medicaid MLTSS linked to Higher Hcbs use for Duals In Florida & medicaid-only In Kansas. (2021, February 06). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/medicaid-mltss-linked-to-higher-hcbs-use-for-some-but-not-all-populations-compared-to-ffs-systems/

29. Hinton, E. R. (2020, November 02). 10 things to know about MEDICAID managed care. Retrieved May 07, 2021, from https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

30. End of an era: The last of the standalone behavioral health carve-outs. (2021, January 13). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/executive-briefings/end-of-an-era-the-last-of-the-standalone-behavioral-health-carve-outs/

31. What virtual primary care means for specialist strategy. (2021, April 07). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/executive-briefings/what-virtual-primary-care-means-for-specialist-strategy/

32. Medication-assisted treatment (MAT). (n.d.). Retrieved May 07, 2021, from https://www.samhsa.gov/medication-assisted-treatment

33. Applied behavior analysis. (n.d.). Retrieved May 07, 2021, from https://www.psychologytoday.com/us/therapy-types/applied-behavior-analysis

34. A new autism program in your future? What to consider. (2019, December 06). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/executive-briefings/a-new-autism-program-in-your-future-what-to-consider/

35. Pennsylvania Medicaid will reimburse FOR center-based ABA under certain circumstances. (2021, January 30). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/pennsylvania-medicaid-clarifies-policy-on-access-to-center-based-one-to-one-autism-therapy

36. Oklahoma Medicaid Adds Registered Behavior technicians as new professional type for autism treatment. (2020, March 04). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/oklahoma-medicaid-adds-registered-behavior-technicians-as-new-provider-type-for-autism-treatment/

37. New Jersey Medicaid now reimburses for applied behavior analysis. (2020, May 06). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/new-jersey-medicaid-now-reimburses-for-applied-behavior-analysis

38. How 34 health care unicorns are changing your world. (2021, March 05). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/executive-briefings/how-34-health-care-unicorns-are-changing-your-world/

39. CVS HealthHUBs To Pilot Behavioral Health Services In 34 Locations. (2021, April 07). Retrieved from https://openminds.com/market-intelligence/bulletins/cvs-healthhubs-to-pilot-behavioral-health-services-in-34-locations/

Consumer Access & Delivery of Care

1. Mental health system transformation: From ideas to action. (2021, April 28). Retrieved May 07, 2021, from https://psychu.org/mental-health-system-transformation-from-ideas-to-action/

2. Executive order on strengthening medicaid & the affordable care act. (2021, April 15). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/resources/012821eomedicaidppaca

3. American rescue plan COVID-19 stimulus bill boosts subsidies for health insurance marketplace plans. (2021, March 31). Retrieved May 06, 2021, from https://openminds.com/market-intelligence/news/american-rescue-plan-covid-19-stimulus-bill-boosts-subsidies-for-health-insurance-marketplace-plans/

4. McBain, R., Eberhart, N., Breslau, J., Frank, L., Burnam, M., Kareddy, V., & Simmons, M. (2021, January 11). How to transform mental health care in the United States. Retrieved May 07, 2021, from https://www.rand.org/pubs/research_briefs/RBA889-1.html

5. Federal review finds lax oversight of Medicaid managed long-term services & supports programs. (2021, January 17). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/news/state-oversight-monitoring-for-medicaid-managed-term-services-supports-fails-to-detect-quality-access-problems/

6. United States Government Accountability Office Report to the chairman, committee on energy and commerce, house of Representatives: Medicaid Long-term Services and Supports: Access and quality problems in managed care demand improved oversight. (2020, November). Retrieved May 07, 2021,

https://openminds.com/wp-content/uploads/121520medicaidltssaccessproblems.pdf.

7. Rapoport, R. (2021, December 23). 'Every day is an emergency': The pandemic is worsening psychiatric bed shortages nationwide. Retrieved May 07, 2021, https://www.statnews.com/2020/12/23/mental-health-covid19-psychiatric-beds/.

8. How many psychiatric beds does America need? (2016, March). Treatment Advocacy Center. Retrieved May 07, 2021, from https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how-many-psychiatric-beds-does-america-need.pdf.

9. Gao Y. N. (2021). Relationship Between Psychiatric Inpatient Beds and Jail Populations in the United States. Journal of psychiatric practice, 27(1), 33–42. https://doi.org/10.1097/PRA.0000000000000524.

10. Carroll, H. (n.d.). RESEARCH WEEKLY: Psychiatric Hospital Beds: A 'National Disconnect'. Retrieved from https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/2985research-weekly-psychiatric-hospital-beds-a-national-disconnect

11. Carroll, H. (n.d.). Psychiatric Bed Supply Need Per Capita. Retrieved from https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3696

12. World Health Organization: Global Health Observatory Data Repository, Beds Data by Country. (n.d.). Retrieved May 07, 2021, from https://apps.who.int/gho/data/node.main.MHBEDS?lang=en.

13. Torrey, E. F. (n.d.) Does assisted outpatient treatment (AOT) decrease violence? Retrieved May 07, 2021, from https://mentalillnesspolicy.org/wp-content/uploads/2016/11/aot_reduces_violence-1.pdf.

14. Black, L. I. & Zablotsky, B. (2020, December). Urgent Care Center and Retail Health Clinic Utilizations among Children: United States, 2019. Retrieved May 07, 2021, from https://www.cdc.gov/nchs/data/databriefs/db393-H.pdf.

15. What did investors spending $588 million see in behavioral health? (2021, February 02). Retrieved May 07, 2021, from https://openminds.com/market-intelligence/executive-briefings/what-did-investors-spending-588-million-see-in-behavioral-health/

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