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United States Senate Finance Committee

Policy Solutions for Addressing Mental Health

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Chairman Wyden, Ranking Member Crapo and members of the Senate Finance Committee, thank you for the opportunity to testify today on Policy Solutions for Addressing Mental Health.

I had the privilege of serving as the Arizona Medicaid Director for almost a decade and for a portion of the time, as the Mental Health Commissioner.

Medicaid serves over 70 million members, offering comprehensive mental health benefits to some of our country's most complex populations. In 2020, the Medicaid and CHIP Payment and Access Commission (MACPAC) published mental health statistics that showed, for non-institutionalized adults, 27.6% of the Medicaid population had an indicator of mental illness compared to 18.7% of the commercially insured population. And for individuals with Serious Mental Illness, the numbers were 8.2% for Medicaid, and 4.3% for commercial populations. [1]

As you formulate health policy options, state Medicaid programs should be a critical component of the discussion. Understanding the system and the forces prevailing on it should be at the core of discussion.

The last year brought to light the extreme fragmentation of our healthcare delivery system at all levels. Our policy and program structures are in silos. Funding streams to support these populations follow those siloed program and policy structures. Providers gravitate towards these funding streams creating more complexity at the point of care. The very beneficiary the system is designed to serve is forced navigate the maze we created.

Fragmentation is often discussed, so I would like to explain how that fragmentation manifests in our system. When I became Medicaid director, individuals with Serious Mental Illness had up to four different payers to navigate. Forty percent of that population were Medicaid and Medicare dual eligible members. An individual had a Medicaid plan for physical health, a Medicaid plan

for behavioral health, traditional Medicare and a Part D plan or a Medicare Advantage plan. Unfortunately, this level of fragmentation is common. The result is misaligned incentives and the bureaucracies of Medicare and Medicaid spending considerable time and resources creating payment rules and refereeing rather than focusing on improving care for our populations.

Now, in addition to fragmentation, Medicaid leaders are contending with the impact that the pandemic has had on an individual's mental health. It has been well documented that the pandemic has had a more negative impact on individuals with less means, both in terms of health and financial stress.

This last year has brought important issues such as social justice and health equity to the surface and at the same time there was rapid innovation. For example, the use of telehealth and the deployment of the 988 crisis hotline. Both will require much work ahead to ensure long-term success.

Today's environment has challenges. But States and Medicaid programs now have access to considerable investment resources to address these challenges and advance the delivery of mental health services.

1. Congress has authorized a 5% set aside funding from the Mental Health Block Grant to be used for Crisis Systems.
2. Congress has authorized an 85% enhanced match in Medicaid for community mobile response teams.
3. Additional resources are now available for states that use the rehabilitation option to cover behavioral health services, which was included in the 10% increased federal funding for home and community-based services.
4. Finally, additional resources are available for expanding Certified Community Behavioral Health Clinics.

In February 2021, The National Association of Medicaid Directors (NAMD) published *Medicaid Forward: Behavioral Health*, outlining a series of strategies Medicaid programs are pursuing to advance mental health services for members. The strategies varied based on the unique populations served by Medicaid. This report highlighted initiatives such as, expanding access and improving timeliness to care, integrating physical health and behavioral health, and expanding access for the full continuum of care including crisis services.

Populations identified included children with complex needs, individuals experiencing homelessness, older adults, individuals with intellectual and developmental disabilities and individuals involved in criminal justice.

The NAMD report provided proof that when implemented, the highlighted strategies make a difference.

Further, a March 2021 Bipartisan Policy Council Report concluded that "integrating primary and behavioral health care is necessary and would ensure that individuals with behavioral health conditions and comorbid physical health problems receive high-quality access to care. Comorbid behavioral and physical health diagnoses are common. Addressing them together through integration can provide a patient-centered approach that can be cost-effective for payers and providers, reduce health disparities, and improve patient outcomes." [2]

Arizona provides a strong example of this, in 2011, we pursued a strategy to better integrate services for Individuals with Serious Mental Illness. This strategy was focused on driving integration at three levels.

1. Policy integration – Arizona merged behavioral health policy expertise into the Medicaid program and reviewed all policies that limited integrated services.
2. Payer integration – Arizona braided multiple funding streams including Medicaid, SAMHSA block grants and local dollars to support housing and other non-Medicaid compensable services.
3. Provider Integration – Arizona created new incentives and supported providers in developing more coordination and integration at a provider level. This included opening up new codes to support the collaborative care model. This model has been shown to improve clinical outcomes and reduce costs by further integrating care at the primary care provider.

In 2018, Mercer consulting conducted an analysis of the integration efforts. Their final report for individuals with serious mental illness found that all measures of ambulatory care, preventive care, and chronic disease management demonstrated improvement. For example, Medication management for people with Asthma (75% compliance) increased 35%. Just as important, all indicators of patient experience improved, with 5 of the 11 measures exhibiting double digit increases. For example, Shared Decision Making improved 61%. [3]

Another opportunity highlighted by NAMD is to strengthen Crisis Systems. This issue is front and center with the implementation of 988. SAMHSA provided extensive thought leadership with the development of the Crisis Now model and the publication of the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. This document provides the details on how to establish a system to serve anyone, anywhere at any time.

The Crisis Now model is based on three critical components.

1. Call center capability
2. 24 by 7 Community Mobile Response Teams
3. 23 hour crisis receiving and stabilization units.

In Arizona this system was developed over 20 years and serves all Arizonans. The call centers answer thousands of calls every month, meeting the states expectations of three rings or less. Mobile response teams located throughout the state serve individuals in the community. Stabilization facilities provide services for individuals experiencing severe crisis episodes and offer continuous support for law enforcement to drop off individuals and to return to the field within 5 minutes. The financing for this system comes from creatively braiding multiple funding streams while leveraging Medicaid for support.

While we have seen improvement, there is clearly much more to do. We stand today at a unique moment with the power to address complex issues and continue the momentum of innovation by making strategic policy changes. To that end:

1. Congress and the Executive Branch need to develop and implement strategies holistically by ensuring Medicaid and Behavioral Health collaborate and partner in a meaningful manner. On several occasions Congress has leveraged the mental health expertise that lives at the Substance Abuse and Mental Health Services Administration (SAMHSA) to advance policy initiatives. This includes set aside funding for First Episode Psychosis and Crisis System planning. However, there does not appear to be sufficient expectations established by Congress that these important planning and investment dollars are to be linked to the Medicaid program. Unfortunately, the dollars often get siloed and the opportunity is suboptimal. SAMHSA traditionally works directly with its network of

Mental Health commissioners and Medicaid programs sometimes lack the expertise or bandwidth to leverage these opportunities. At the end of the day, Medicaid beneficiaries may or may not benefit from these forward-looking investments.

2. Congress should provide more flexibility with Block Grant funds for states to address social determinants of health as states look at ways to support these investments. As coverage has expanded, there may be opportunities for states to leverage block grants to support select social determinants for specific populations and improve outcomes.
3. Congress needs to legislate to establish payment parity between Medicare and Medicaid. Where Medicaid has led the way in developing para-professional staff such as peer support services and systems to support broader populations like Crisis, Medicare should follow. To achieve parity Congress must act to have Medicare cover these and similar services.
4. Congress should continue to provide financial incentives for states to modernize the mental health infrastructure. Programs like Money follows the Person worked well for home and community-based services. I am excited to see Congress using similar approaches for behavioral health services like community mobile response teams and CCBHCs. Congress should consider lending financial support towards models that improve care and access. This approach should also be expanded to dual eligible members as well.
5. Congress should continue to evaluate the impact of the IMD 16 bed limits. While there have been efforts made to allow for some payments in select instances, some states have not been able to avail themselves of these opportunities. A good place to start the policy discussion is looking at select settings like crisis stabilization.
6. Congress should rectify the fact that behavioral health providers were excluded from the electronic health records incentive program provided through the HITECH Act. Data aggregation and analytics are an important component of improved care coordination. This is an investment that should be made to advance integration.
7. Finally, Congress should evaluate how Graduate Medical Education financing policies negatively impact the ability to attract specialists, such as

child psychiatrists, to meet the needs of the Medicaid population. Many states, like Arizona, are punished as a result of the Medicare formulas that are locked in at 1996 allocations.

We are at a critical moment in time to advance the delivery of mental health services not only within Medicaid but for our entire country. Thank you for your time and interest in these topics.

Endnotes

1. Behavioral Health in Medicaid Presentation, MACPAC, September 2020
2. Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration. Bipartisan Policy Council, March 2021, Page 8
3. Independent Evaluation of Arizona's Medicaid Integration Efforts, Mercer, 2018