United States Government Accountability Office

Report to Congressional Requesters

June 2015

# BEHAVIORAL HEALTH

# Options for Low-Income Adults to Receive Treatment in Selected States

Accessible Version

GAO-15-449

June 2015

# BEHAVIORAL HEALTH

## Options for Low-Income Adults to Receive Treatment in Selected States

GAO Highlights

Highlights of GAO-15-449, a report to congressional requesters

## Why GAO Did This Study

Research has shown that low-income individuals disproportionately experience behavioral health conditions and may have difficulty accessing care. Expansions of Medicaid under PPACA raise questions about states' capacity to manage the increased demand for treatment. Additional questions arise about treatment options for low-income adults in non-expansion states.

GAO was asked to provide information about access to behavioral health treatment for low-income, uninsured, and Medicaid-enrolled adults. This report examines (1) how many low-income, uninsured adults may have a behavioral health condition; (2) options for low-income, uninsured adults to receive behavioral health treatment in selected non-expansion states; and (3) how selected Medicaid expansion states provide behavioral health coverage for newly eligible enrollees, and how enrollment in coverage affects treatment availability.

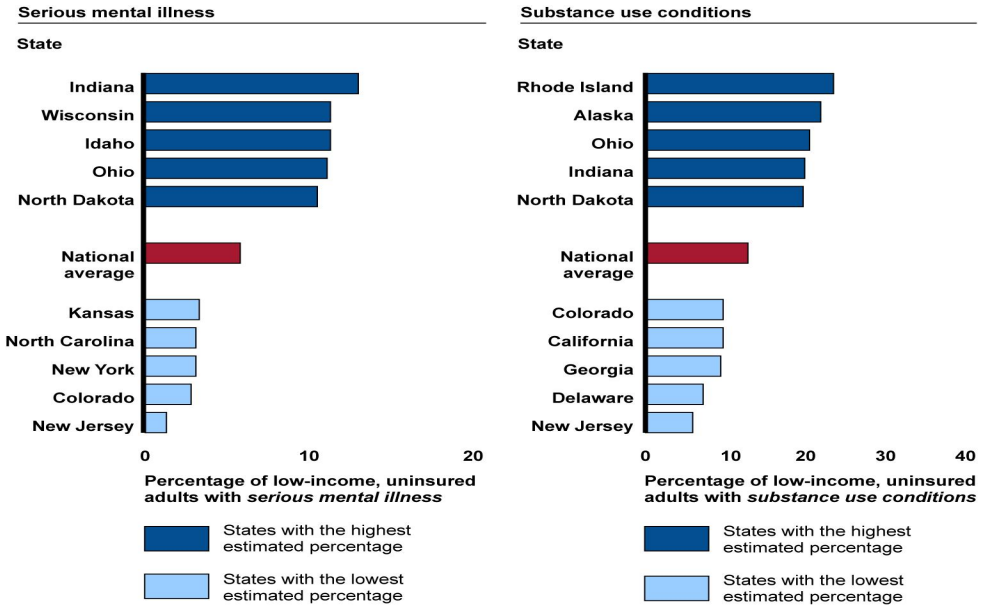
GAO obtained estimates of low-income adults who may have a behavioral health condition from the Substance Abuse and Mental Health Services Administration. GAO also selected four non-expansion and six expansion states based on, among other criteria, geographic region and adult Medicaid enrollment. GAO reviewed documents from all selected states, and interviewed state Medicaid and BHA officials to understand how uninsured and Medicaid-enrolled adults receive behavioral health treatment. The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-15-449. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

## What GAO Found

Nationwide, estimates using 2008-2013 data indicated that approximately 17 percent of low-income, uninsured adults (3 million) had a behavioral health condition, defined as a serious mental illness, a substance use condition, or both. Underlying these national estimates is considerable variation at the state level.

**Estimated Percentage of Low-Income, Uninsured Adults with Behavioral Health Conditions Based on 2008 to 2013 Data, Highest and Lowest Five States**




Source: Substance Abuse and Mental Health Services Administration analysis of data from the National Survey on Drug Use and Health for 2008 through 2013. | GAO-15-449

Note: Analysis of highest and lowest five states excludes four states that were not reported because percentages were estimated with low precision.

The estimated number of low-income, uninsured adults with behavioral health conditions was divided evenly between states that did and did not subsequently expand Medicaid under the Patient Protection and Affordable Care Act (PPACA).

Behavioral health agencies (BHA) in four selected non-expansion states offered various treatment options for low-income, uninsured adults, focusing care primarily on those with the most serious behavioral health needs. To do so, BHAs in all four selected states established priority populations of those with the most serious behavioral health needs. Also, BHAs in three of the four states maintained waiting lists for adults with less serious behavioral health needs.

Six selected states that expanded Medicaid generally managed behavioral health and physical health benefits separately for newly eligible enrollees, and state officials reported increased availability of behavioral health treatment, although some access concerns continue. Four of the six selected states explicitly chose separate contractual arrangements for behavioral health and physical benefits. Officials from all six selected states said that enrollment in Medicaid increased the availability of behavioral health treatment for newly eligible enrollees. Officials also reported some ongoing access concerns, such as workforce shortages.

# Contents



Tables

Figures



**Abbreviations**

| | |
|---|---|
| BHA | behavioral health agency |
| CMS | Centers for Medicare & Medicaid Services |
| FFS | fee-for-service |
| FPL | federal poverty level |
| HHS | Department of Health and Human Services |
| MCO | managed care organization |
| PPACA | Patient Protection and Affordable Care Act |
| SAMHSA | Substance Abuse and Mental Health Services Administration |

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

June 19, 2015

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Diana DeGette
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

Behavioral health conditions—mental health and substance use conditions—affect a substantial number of adults in the United States.[1] In 2013, an estimated 43.8 million adults (18.5 percent) had a mental health condition—including 10 million adults (4.2 percent) with a serious mental illness—and 20.3 million (8.5 percent) had a substance use condition.[2] Concerns about the availability of behavioral health treatment, particularly for low-income individuals, have been longstanding. Medicaid, a joint federal-state program that finances health care coverage for low-income

[1]We define mental health and substance use conditions as all mental, emotional, and behavioral disorders that are included in the Diagnostic and Statistical Manual of Mental Disorders. Examples of mental health conditions that are included are anxiety disorders, including post-traumatic stress disorder; mood disorders, including depression and bipolar disorder; and schizophrenia. Examples of substance use conditions are alcohol use disorder and opioid use disorder.

[2]See Substance Abuse and Mental Health Services Administration (SAMHSA), *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*, (Rockville, Md.: September 2014). SAMHSA's estimate of adults with a mental health condition excludes developmental disorders, such as autism, and other disorders typically identified in childhood, such as attention-deficit/hyperactivity disorder. Numbers of individuals with mental health and substance use conditions cannot be added together because there is substantial overlap between these conditions. The population of adults with a serious mental illness is a subset of the population of adults with a mental health condition. SAMHSA's National Survey on Drug Use and Health defines adults as having a serious mental illness if at any time during the past year, they had a diagnosable mental, behavioral, or emotional disorder that caused serious functional impairment that substantially interfered with or limited one or more major life activities. Developmental disorders and other disorders typically identified in childhood are not included.

and medically needy individuals, is the largest payer for behavioral health treatment in the nation. However, research has shown that individuals enrolled in Medicaid experience a higher rate of behavioral health conditions than those with private insurance, and may have difficulty accessing treatment.[3] Moreover, the demand for behavioral health treatment is likely to increase as 29 states have chosen to expand eligibility for Medicaid as allowed by the Patient Protection and Affordable Care Act (PPACA). Under PPACA, states are permitted to expand eligibility for Medicaid to certain adults with incomes up to 138 percent of the federal poverty level (FPL).[4] PPACA requires states that expand Medicaid to provide newly eligible enrollees with health care coverage that includes behavioral health benefits.[5] Expansions of Medicaid, coupled with high rates of need among low-income individuals, raise questions about the capacity of states that expanded Medicaid to handle the increased demand for behavioral health treatment. For states that have not expanded Medicaid, additional questions arise about what treatment options states are able to provide for low-income, uninsured adults with behavioral health conditions.

[3]See SAMHSA, *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. (Rockville, Md.: November 2014). See also GAO, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, GAO-13-55 (Washington, D.C.: Nov. 15, 2012).

[4]Under PPACA, states are permitted to expand eligibility for Medicaid to nonelderly, nonpregnant adults who are not eligible for Medicare and whose income does not exceed 133 percent of the FPL. PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility for this population, which effectively increases this income level to 138 percent of the FPL. In 2015, 138 percent of the FPL for an individual was $16,243. In this report, we refer to this population as “newly eligible enrollees.” For states that expand Medicaid, the federal government will pay an enhanced match—100 percent of the cost of covering newly eligible enrollees—in 2014, 2015, and 2016, with the federal match gradually reduced to 90 percent by 2020. PPACA also permitted an early expansion option, whereby states could expand eligibility for this population (or a subset of this population) starting on April 1, 2010, with the regular level of federal financial participation until 2014, when the enhanced match rate takes effect. States that choose not to expand Medicaid coverage forgo the enhanced federal matching funds associated with such expanded coverage.

[5]Under PPACA, most newly eligible enrollees must be covered under an alternative benefit plan, which must cover 10 essential health benefits categories. Mental health and substance use services, including behavioral health treatment, is one of the 10 essential health benefits categories.

Given the potential challenges states may face in providing behavioral health treatment to low-income adults, you asked us to provide information about access to and utilization of behavioral health treatments among low-income adults newly eligible for Medicaid, as well as options for behavioral health treatment for low-income, uninsured adults not eligible for Medicaid in states that have not expanded the program. This report describes (1) what is known about how many low-income, uninsured adults may have a behavioral health condition; (2) what options exist for low-income, uninsured adults to receive behavioral health treatment in selected states that have not expanded Medicaid; and (3) how selected Medicaid expansion states provide behavioral health coverage for newly eligible enrollees, and how enrollment in coverage affects treatment availability.[6]

To describe what is known about how many low-income, uninsured adults may have a behavioral health condition, we obtained national and state-level estimates of low-income, nonelderly adults who may have a behavioral health condition from the Substance Abuse and Mental Health

[6]In conjunction with this study, we are also separately examining the utilization of behavioral health treatments among newly eligible Medicaid enrollees in states that have expanded Medicaid. As we agreed with your staff, we plan to issue a separate report on this topic.

Services Administration (SAMHSA).[7] Low-income refers to individuals who are at or below 138 percent of the FPL, which reflects those who may be newly eligible for Medicaid in states that chose to expand their programs under PPACA. However, these estimates are based on the total low-income population in the state and do not differentiate between previously eligible and newly eligible adults. Furthermore, the methods used to produce the estimates do not account for variation in uptake rates for the Medicaid program, which is the proportion of eligible individuals who ultimately choose to enroll.[8] After reviewing the data sources and methods used to produce these estimates and checking for obvious errors, we determined that the estimates were sufficiently reliable for our purposes. For these estimates, we limited behavioral health conditions to

[7]We obtained national and state-level estimates from SAMHSA of the number of low-income, uninsured adults with a serious mental illness, a substance use condition, or co-occurring serious mental illness and substance use condition. We also obtained estimates of the number of individuals with any behavioral health condition, which we defined as having a serious mental illness, a substance use condition, or both conditions. SAMHSA's estimates were calculated by multiplying the estimated total number of uninsured adults ages 18 to 64 with incomes at or below 138 percent of the FPL by the estimated percentage of this population with a given type of behavioral health condition. Numbers of uninsured adults were drawn from the U.S. Census Bureau's 2013 American Community Survey and the percentages with behavioral health conditions were drawn from SAMHSA's National Survey on Drug Use and Health for years 2008 to 2013. Because SAMHSA's estimates are based on data from before 2014, they do not account for newly eligible enrollees in states that opted to expand Medicaid as of 2014. Furthermore, because the National Survey on Drug Use and Health does not include information on U.S. territories, SAMHSA's estimates exclude any U.S. territories that have expanded Medicaid.

As part of our work, we also reviewed and compared published estimates from relevant literature and from professional organizations whose work focuses on mental health. For other estimates that we reviewed, see SAMHSA, *Behavioral Health Treatment Needs Assessment Toolkit for States*, SMA13-4757 (Rockville, Md.: 2013); R. L. Garfield, et al., "The Impact of National Health Care Reform on Adults With Severe Mental Disorders," *American Journal of Psychiatry*, vol. 168, no. 5 (2011); J. Miller, *Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion Will Punish Americans with Mental Illness* (Alexandria, VA: American Mental Health Counselors Association, 2014); J. Miller and N. Maududi, *NASMHPD Resource Management Guide: Impacts of Affordable Care Act on Coverage for Uninsured People with Behavioral Health Conditions* (Alexandria, VA: National Association of State Mental Health Program Directors, 2013); Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid for People with Behavioral Health Conditions* (Washington, D.C.: Kaiser Family Foundation, 2012); A. Shartzer, et al., *Who Are the Newly Insured as of Early March 2014?* (Washington, D.C.: Urban Institute, 2014).

[8]Prior to the expansion, researchers estimated that the percentage of low-income, uninsured adults who would enroll in Medicaid under the expansion could range from 57 percent to 95 percent.

substance use conditions and serious mental illnesses, as opposed to the more inclusive definition of behavioral health conditions used for the remainder of this report, which comprise substance use conditions and all mental health conditions.[9] To examine the options that exist for low-income, uninsured adults to receive behavioral health treatment in selected states that have not expanded Medicaid, we selected four states (Missouri, Montana,[10] Texas, and Wisconsin) to obtain variation among states in total population size, adult Medicaid enrollment, percent change in Medicaid enrollment from 2013 to 2014,[11] per capita number of behavioral health professionals, and geographic region. We reviewed documentation and conducted interviews with officials from state behavioral health agencies (BHA), which also play a role in funding behavioral health treatment.[12] To determine how states that expanded Medicaid provided behavioral health coverage and the extent to which Medicaid coverage affected the availability of treatment, we selected six states (Connecticut, Kentucky, Maryland, Michigan, Nevada, and West Virginia). We chose to select more expansion states than non-expansion states because of the greater policy and enrollment changes taking place in those states as they implemented the expansion of Medicaid. We selected expansion states to achieve variation in the same characteristics

[9]SAMHSA's National Survey on Drug Use and Health excludes developmental disorders, such as autism, and other disorders typically identified in childhood, such as attention-deficit/hyperactivity disorder, from its definition of serious mental illness.

[10]Since the time of our state selection, Montana has taken steps to expand its Medicaid program. Montana's governor signed legislation on April 29, 2015, to expand Montana Medicaid under PPACA. Montana's plan to expand its Medicaid program will need to be reviewed and approved by the Centers for Medicare & Medicaid Services.

[11]Change in Medicaid enrollment may reflect, in part, enrollment of previously eligible but unenrolled individuals, sometimes referred to as the "welcome mat effect." Change in Medicaid enrollment in our selected non-expansion states ranged from 1.1 percent in Missouri to 10.3 percent in Montana. Medicaid enrollment numbers include enrollment in the State Children's Health Insurance Program. Percent change was calculated by comparing enrollment from a pre-expansion baseline period of July through September 2013 to enrollment in December 2014.

[12]For the purposes of this report, we considered behavioral health treatment to comprise inpatient and outpatient or office mental health and substance use services and associated prescription drugs. We excluded smoking cessation services and drugs from our scope.

we used to select non-expansion states,[13] with one additional characteristic, which was the delivery system (e.g., fee-for-service (FFS) or managed care)[14] used in their Medicaid programs. For each state, we reviewed documentation regarding their state Medicaid programs, and conducted interviews with Medicaid and state BHA officials. The reported experiences of expansion and non-expansion states cannot be generalized to all states. To obtain contextual information about behavioral health treatment in both expansion and non-expansion states, we interviewed representatives from behavioral health professional and advocacy groups, and spoke with a behavioral health benefits manager, an organization that manages benefits for state Medicaid programs.

We conducted this performance audit from July 2014 through June 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# Background

## Behavioral Health Treatment

Access to behavioral health treatment—services and prescription drugs to address behavioral health conditions—is important because of the

[13]For Medicaid expansion states, we used percent change in Medicaid enrollment from 2013 to 2014 as an indicator of the extent to which expansion placed additional demands on Medicaid programs. Change in Medicaid enrollment in our selected expansion states ranged from 15.9 percent in Michigan to 76.9 percent in Kentucky. Medicaid enrollment numbers include enrollment in the State Children's Health Insurance Program. Percent change was calculated by comparing enrollment from a pre-expansion baseline period of July through September 2013 to enrollment in December 2014. Percent change was not available for Connecticut.

[14]Under an FFS model, states pay providers for each covered service for which the providers bill the state. Under a managed care model, states contract with managed care plans, such as health maintenance organizations, to provide or arrange for medical services, and prospectively pay the plans a fixed monthly fee per enrollee. This is also known as risk-based managed care because the managed care plan is at financial risk if the total cost of services provided to enrollees is greater than the amount generated from fixed monthly fees.

harmful consequences of untreated conditions, which may result in worsening health, increased medical costs, negative effects on employment and workplace performance, strain on personal and social relationships, and possible incarceration. Behavioral health treatment can help individuals reduce their symptoms and improve their ability to function. However, research suggests that a substantial number of individuals with behavioral health conditions may not receive any treatment or less than the recommended treatment, even among those with serious conditions. For example, in 2013, SAMHSA estimated that there were 3.9 million adults aged 18 or older with a serious mental illness who perceived an unmet need for mental health care within the last 12 months. This number includes an estimated 1.3 million adults with a serious mental illness who did not receive any mental health services. One potential barrier to accessing treatment is shortages of qualified behavioral health professionals, particularly in rural areas. SAMHSA noted that more than three-quarters of counties in the United States have a serious shortage of mental health professionals.

Behavioral health treatment includes an array of options ranging from less to more intensive, and may include prevention services, screening and assessment, outpatient treatment, inpatient treatment, and emergency services for mental health and substance use conditions. Prescription drugs may also be included as part of treatment for either substance use or mental health conditions. See table 1 for information on select behavioral health treatments.

**Table 1: Select Behavioral Health Treatments**

| Treatment | Description |
|---|---|
| Screening and assessment | Collection and evaluation of information to evaluate a client's need for behavioral health treatment. |
| Psychosocial therapy | Treatment through regular meetings with a health care provider with expertise in mental illness or substance use conditions. Therapy can be provided for an individual, family, or group. |
| Psychotropic drugs | Management of mental health conditions with medication; for example, the use of antidepressants to treat depression. |
| Medication-assisted treatment | Management of substance use conditions with medication; for example, the use of methadone or buprenorphine to treat opioid use disorder. |
| Crisis/emergency | Immediate treatment to stabilize and improve an individual's condition. |
| Hospitalization | Use of an inpatient setting to manage an acute episode. |

Source: GAO analysis of information from the Substance Abuse and Mental Health Services Administration. | GAO-15-449

In addition to these treatments, other supportive services exist for behavioral health conditions that are designed to help individuals manage mental health or substance use conditions and maximize their potential to live independently in the community. These supportive services are multidimensional—intended to address not only health conditions, but also employment, housing, and other issues. For example, they include recovery housing—supervised, short-term housing for individuals with substance use conditions or co-occurring mental and substance use conditions that can be used after inpatient or residential treatment.

## Medicaid

The Centers for Medicare & Medicaid Services (CMS)—a federal agency within the Department of Health and Human Services (HHS)—and states jointly administer the Medicaid program, which finances health care, including behavioral health care, for low-income individuals and families. States have flexibility within broad federal parameters for designing and implementing their Medicaid programs. States may use Medicaid waivers—which allow states to set aside certain, otherwise applicable federal Medicaid requirements—to provide health care, including behavioral health treatment, to individuals who would not otherwise be eligible for those benefits under the state's Medicaid program. For example, states may use waiver programs to target residents in a geographic region or to target individuals with particular needs, such as those with serious mental illness. States may also choose different delivery systems to provide benefits including behavioral health treatment to Medicaid enrollees, such as FFS or managed care. Some states with managed care delivery systems may elect to "carve out" behavioral health benefits, i.e., contract for them separately from physical health care benefits. For example, some states contract with limited benefit plans, which are managed care arrangements designed to provide a narrowly defined set of services. Similarly, states with FFS delivery systems may choose to contract with separate companies to administer behavioral health benefits than those administering physical health care benefits.[15] Our previous work has noted that while using a separate plan to provide mental health services may control costs, it can also increase the risk that

[15]States with FFS delivery systems may contract with administrative services organizations, which authorize and pay for treatment according to policies set by the state. Unlike managed care plans, these organizations are not risk-bearing.

treatment for physical and mental health conditions will not be coordinated.[16]

## Medicaid and Other Funding Sources for Public Behavioral Health Programs

A variety of sources provide funding for behavioral health treatment in public programs. Medicaid is the largest source of funding for behavioral health treatment, with spending projected to be about $60 billion in 2014.[17] Another significant source of revenue for state BHAs is state general revenues.[18] In contrast to Medicaid, for which payment of benefits to eligible persons is required by law, state general funding for the treatment of uninsured and underinsured residents is discretionary. The extent to which state-funded treatment is provided may depend on the availability of funding. States may also use SAMHSA mental health and substance use block grants to design and support a variety of treatments for individuals with behavioral health conditions.[19] See figure 1 for information on sources of state BHA revenues for mental health in 2013. (Similar figures for substance use were not available.)

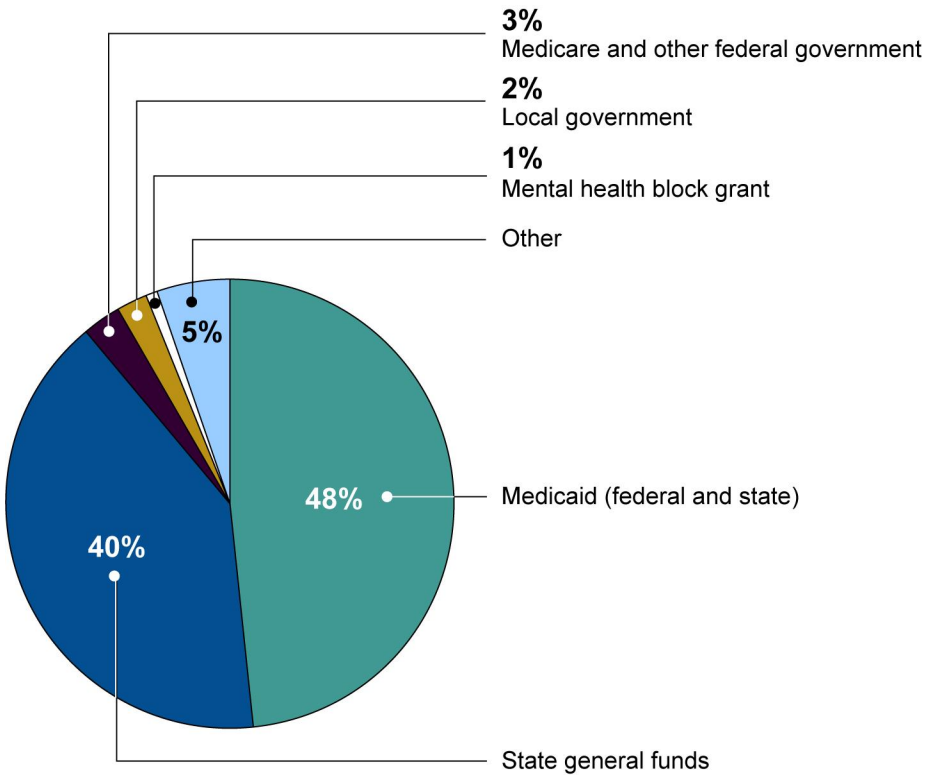
[16]GAO, *Medicaid Managed Care: Use of Limited Benefit Plans to Provide Mental Health Services and Efforts to Coordinate Care,* GAO-13-780 (Washington, D.C.: Sept. 30, 2013).

[17]See SAMHSA, *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020*, HHS Publication No. SMA-14-4883 (Rockville, Md.: October 2014).

[18]State general revenues are often used to support treatment at institutions that are excluded from funding by Medicaid. Specifically, Medicaid generally does not allow for the payment of claims for inpatient or residential behavioral health treatment for adults ages 21 to 64 years provided at an "institution for mental disease," a freestanding facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental health conditions. CMS guidance classifies substance use conditions as mental health conditions; therefore, substance use treatment facilities are also subject to this exclusion.

[19]In addition to these block grants, the federal government has other programs that support individuals with behavioral health needs. For more information on programs supporting individuals with serious mental illness—a subset of those with mental health conditions—see GAO, *Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness,* GAO-15-113 (Washington, D.C.: Dec. 18, 2014).

**Figure 1: Sources of State Mental Health Funding for Fiscal Year 2013**




Source: GAO analysis of National Association of State Mental Health Program Directors Research Institute data. | GAO-15-449

Note: For most states, fiscal year 2013 ended June 30, 2013. Total does not add to 100 percent due to rounding.

## Patient Protection and Affordable Care Act

PPACA made changes to Medicaid eligibility and benefit requirements that increase the role of Medicaid in financing behavioral health treatment for low-income adults. Historically, to qualify for Medicaid, individuals had to meet categorical requirements, meaning they had to be a member of a specific group, such as low-income children, pregnant women, or parents of dependent children, in addition to meeting financial requirements. Few states provided Medicaid coverage to childless nonelderly adults without disabilities. In addition, although all states historically included some behavioral health treatments in their Medicaid programs, there was no requirement that they do so. Under PPACA, states may expand Medicaid

eligibility to all nonpregnant, nonelderly adults not eligible for Medicare with incomes not exceeding 138 percent of the FPL.[20] In addition, PPACA specifies that most individuals who are newly eligible for Medicaid must be covered by alternative benefit plans, which must include behavioral health benefits.[21] Alternative benefit plans must also comply with the Mental Health Parity and Addiction Equity Act of 2008, which requires that no greater restrictions, such as treatment limitations or financial requirements, be imposed on behavioral health care than are in place for medical or surgical care.[22] In designing alternative benefit plans, states have the option to align them with their Medicaid state plans—that is, to provide at least the same benefits for newly eligible enrollees as existing enrollees received under the state plan, which must also meet certain essential health benefits requirements. If states choose to align their alternative benefit plans with their state plans, CMS requires that they provide the same benefits contained in the Medicaid state plan and that they meet or exceed the amount, duration, and scope of those benefits.[23]

As of February 2015, 29 states had chosen to expand Medicaid.[24] (See fig. 2.) Enrollment in Medicaid grew faster in states that expanded their programs than in states that did not. Specifically, Medicaid enrollment grew 12.2 percent in fiscal year 2014 for expansion states in contrast to 2.8 percent for states that did not expand Medicaid during the same

[20]Medicare is the federal program that provides coverage of health care services for individuals aged 65 years and older, certain individuals with disabilities, and individuals with end-stage renal disease.

[21]Alternative benefit plans (formerly known as benchmark or benchmark equivalent plans) generally provide the same level of benefits that must be provided to individuals enrolling in plans offered in health insurance exchanges, which must include behavioral health treatment as 1 of 10 essential health benefits.

[22]In April 2015, CMS issued a proposed rule that addresses the application of certain Mental Health Parity and Addiction Equity Act requirements to certain types of Medicaid coverage, including Medicaid alternative benefit plans. See Proposed Rule, Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 80 Fed. Reg. 19417 (April 10, 2015).

[23]According to CMS, states may change their Medicaid state plans to match their alternative benefit plans, but they are not required to do so to be considered in alignment. Consequently, alternative benefit plans may include benefits that state plans do not.

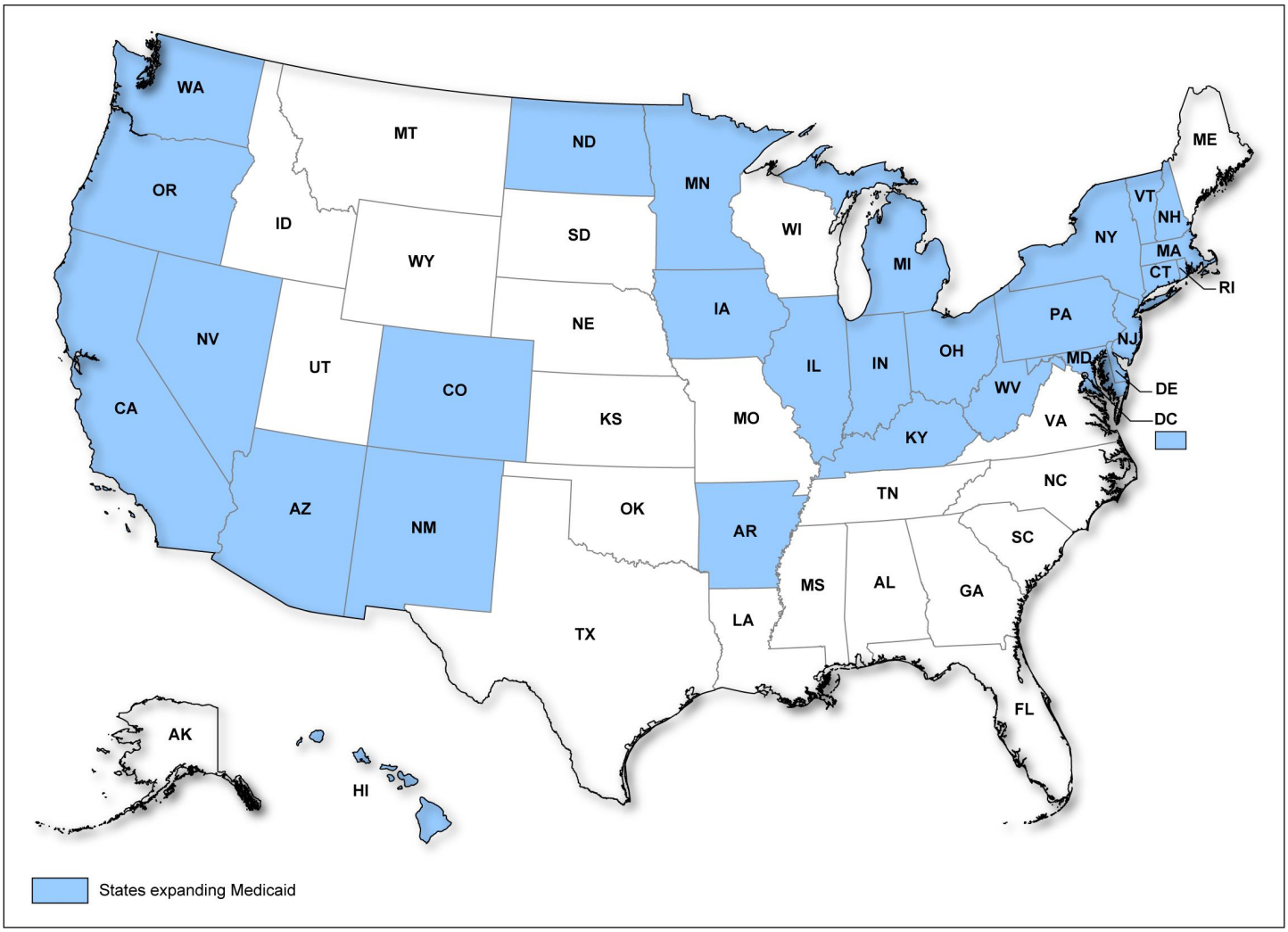
[24]The number of states that have expanded Medicaid includes the District of Columbia, which we refer to as a state of for the purposes of this report.

period.[25] Of the 22 states that had not expanded Medicaid, 11 had no Medicaid coverage available for childless adults, 10 offered coverage for a limited set of beneficiaries or benefits,[26] and 1 provided full Medicaid coverage (as of January 2014).

[25]See Kaiser Commission on Medicaid and the Uninsured, *Implementing the ACA: Medicaid Spending & Enrollment Growth for FY 2014 and FY 2015, Issue Brief* (Washington, D.C.: October 2014).

[26]For example, seven of these states had Medicaid waivers that included limits on eligibility (for example, enrollment caps) or limits to benefits.

**Figure 2: States Expanding Medicaid as of February 2015**




Source: GAO analysis of Centers for Medicare & Medicaid Services data. Map Resources (map) | GAO-15-449

PPACA includes other provisions relevant to behavioral health, as detailed below.

- Section 2703 of PPACA established a “health home” option under Medicaid to coordinate care for enrollees with chronic conditions. Eligibility is limited to Medicaid beneficiaries with two or more chronic conditions, one chronic condition and at risk for a second, or one

serious and persistent mental health condition.[27] As of May 2015, CMS approved amendments to the Medicaid plans of 19 states to implement this option.[28] Specific services provided under health homes include six core services such as health promotion and referral to community and social support services.

- Section 2707 of PPACA established a demonstration project that makes Medicaid funds available to private psychiatric hospitals to provide emergency inpatient psychiatric care for Medicaid enrollees aged 21 to 64; such care in a private psychiatric hospital would not otherwise be eligible for Medicaid reimbursement. This demonstration provided up to $75 million over 3 years to 12 states to examine whether the expansion of Medicaid coverage to include services provided by private psychiatric facilities improves access to and quality of medically necessary care, as well as what the impact is on Medicaid costs and utilization.[29]

## State Behavioral Health Agencies

State BHAs are the agencies responsible for planning and operating state behavioral health systems, and they play a significant role in administering, funding, and providing behavioral health treatment.[30] State BHAs manage behavioral-health-related federal grants and may work with other state agencies—such as state Medicaid agencies—to identify and treat mental health and substance use conditions. State BHAs may contract directly with providers to deliver behavioral health treatments or may contract with county or city governments, which are then responsible for the delivery of treatments within their local areas. State BHAs may

[27]The statute lists the following chronic conditions: mental health, substance abuse, asthma, diabetes, heart disease, and being overweight. States may also propose other conditions subject to approval by CMS.

[28]States with approved Medicaid health home amendments are Alabama, Kansas, Idaho, Iowa, Maine, Maryland, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Dakota, Vermont, Washington, West Virginia, and Wisconsin. States are also required to consult with SAMHSA as they develop their health homes.

[29]Of the states in our sample, Connecticut, Maryland, Missouri, and West Virginia are participating in this demonstration; other participating states are Alabama, California, Illinois, Maine, North Carolina, Rhode Island, Washington, and the District of Columbia.

[30]See National Association of State Mental Health Program Directors *Assessment #9 Revenues* (Alexandria, VA: October 2014.)

also play a role in providing Medicaid enrollees with wraparound services—that is, services that state Medicaid programs do not cover, but that may aid in recovery, such as supportive housing.[31]

## An Estimated 3 Million Low-Income Uninsured Adults Had a Behavioral Health Condition, with Half Living in States that Have Not Expanded Medicaid

Nationwide, estimates using data from 2008 to 2013 indicated that of 17.8 million low-income, uninsured adults, approximately 3 million (17 percent) had a behavioral health condition prior to the Medicaid expansion in 2014.[32] Specifically, about 1 million low-income, uninsured adults (5.8 percent) were estimated to have a serious mental illness, while nearly 2.3 million low-income, uninsured adults (12.8 percent) were estimated to have a substance use condition.[33] Underlying these national estimates was considerable variation at the state level. In particular, the percentage of low-income, uninsured adults with a behavioral health condition ranged from 6.9 percent to 27.5 percent. Similarly, the percentage of low-income uninsured adults with serious mental illness ranged from 1.3 percent to 13 percent, while the percentage with a substance use condition ranged from 5.9 percent to 23.5 percent. See figure 3 for the states with the highest and lowest estimated percentages

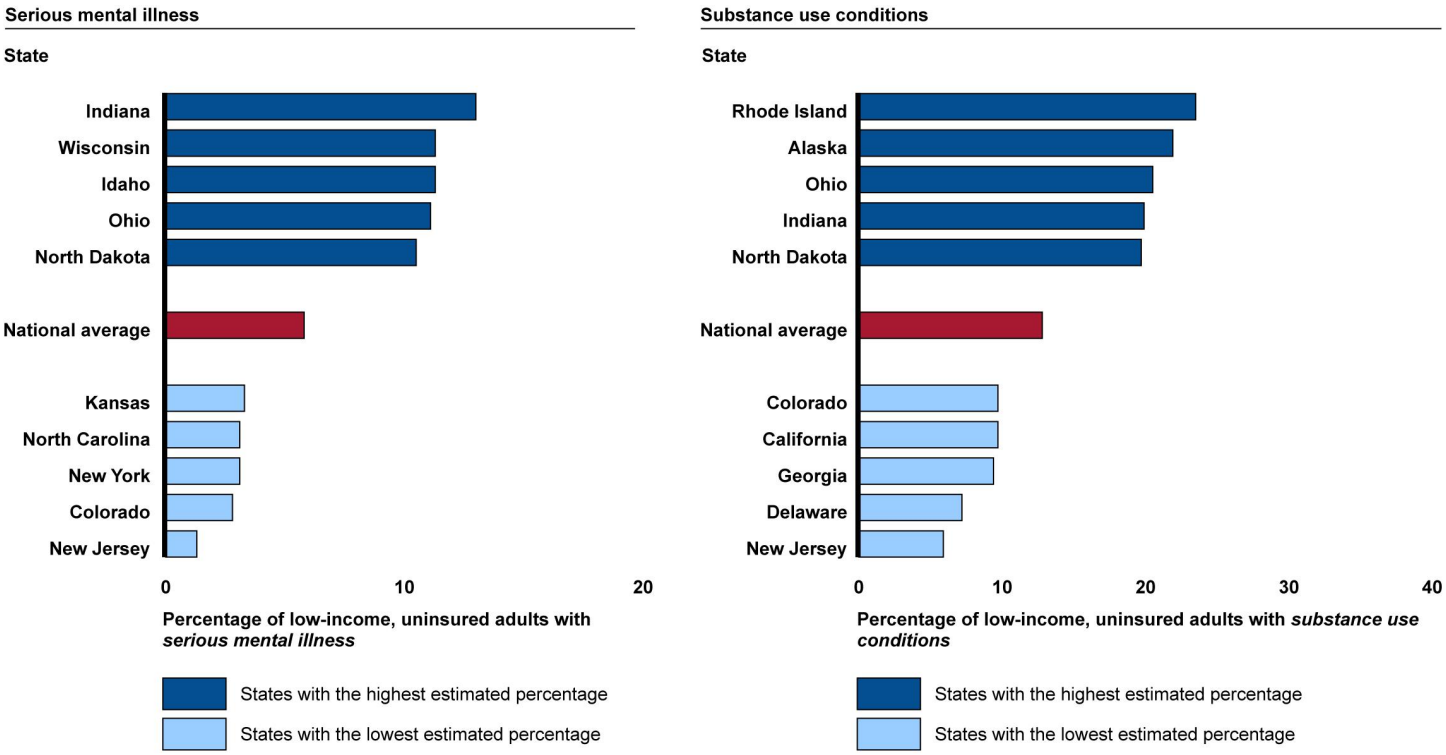
[31]SAMHSA defines supportive housing as a service helping homeless or disabled adults with behavioral health conditions obtain long-term, affordable, independent housing and providing ongoing support to help them maintain their housing situation.

[32]For this analysis, we defined adults with a behavioral health condition as those with serious mental illness, a substance use condition, or co-occurring serious mental illness and substance use condition.

[33]Numbers and percentages for serious mental illness and substance use conditions do not add to the total number and percentage with a behavioral health condition because the categories of serious mental illness and substance use condition are not mutually exclusive.

of low-income, uninsured adults with a serious mental illness or substance use condition. See appendix I for state-by-state estimates.[34]

**Figure 3: Estimated Percentage of Low-Income, Uninsured Adults with Behavioral Health Conditions Based on 2008 to 2013 Data, Highest and Lowest Five States**




Source: Substance Abuse and Mental Health Services Administration analysis of data from the National Survey on Drug Use and Health for 2008 through 2013. | GAO-15-449

Note: Analysis of highest and lowest five states excludes four states that were not reported because percentages were estimated with low precision.

Of the 3 million low-income, uninsured adults estimated to have a behavioral health condition, nearly half—approximately 1.4 million people, or about 49 percent—lived in the 22 states that had not expanded Medicaid as of February 2015, compared with the approximately 1.5 million people in the remaining 29 states that had expanded Medicaid. The estimated prevalence of behavioral health conditions overall among

[34]These estimates are based on survey data and are subject to sampling error. Appendix I includes the standard error—a measure of statistical precision—associated with each state's estimate.

low-income, uninsured adults was about 17 percent, on average, in both expansion and non-expansion states.

## Selected Non-Expansion States Offered Treatment Options for Uninsured Adults, but Primarily Provided Treatment to Those with the Most Serious Behavioral Health Needs

State BHAs in the non-expansion states we examined offered a variety of behavioral health treatments for low-income, uninsured adults. These states identified priority populations to focus care on adults with the most serious conditions and used waiting lists for those with more modest behavioral health needs.

### States Offered a Variety of Behavioral Health Treatments for Uninsured Adults

The non-expansion states we examined—Missouri, Montana,[35] Texas, and Wisconsin—offered a range of behavioral health treatments—inpatient and outpatient services and prescription drugs—for low-income, uninsured adults. These states used community mental health centers, state institutions, and contracts with providers to deliver treatments, and used a variety of sources, such as state general funds, federal block grants, and Medicaid to fund them.[36] For mental health and substance use conditions, outpatient services that these states offered included evaluation and assessment, visits with medical providers, and individual, family, and group counseling. Treatments also included emergency care, and in most of these states, partial hospitalizations and inpatient psychiatric care for mental health conditions. For substance use conditions, these states also offered detoxification and residential

[35]Since the time of our state selection, Montana has taken steps to expand its Medicaid program. Montana's governor signed legislation on April 29, 2015, to expand Montana Medicaid under PPACA. Montana's plan to expand its Medicaid program will need to be reviewed and approved by CMS.

[36]For non-expansion states, Medicaid funding refers to waivers that cover limited populations, types of services, or both.

treatment.[37] These states generally made prescription drugs available to uninsured adults as part of the treatment for behavioral health conditions. For example, Missouri, Texas, and Wisconsin included medication-assisted treatment for substance use conditions, and all four of the selected non-expansion states offered prescription drugs for mental health conditions. In addition to treatment, the non-expansion states also offered some supportive services, such as peer support or housing services, for uninsured adults.[38]

For two of the states we examined—Wisconsin and Texas—the availability of specific services for behavioral health may vary throughout the state. In particular, the responsibility for administering and providing treatment was divided between the state BHA and local entities, which receive both state and local funding to provide behavioral health treatment.[39] A Wisconsin official said that counties contribute their own funding for behavioral health, which they can use to fund services of their choosing. The Wisconsin BHA identified a core list of 30 services for behavioral health that it promotes and encourages counties to provide, but the official noted that it may be difficult for a single county to provide all of the services on the list. For example, the Wisconsin BHA reported that about a quarter of counties provided medication-assisted treatment for individuals with substance use conditions in 2013. As another example, Texas offers opportunities for local mental health authorities to compete for funding for specific types of services, such as housing.

Two of the states we examined used Medicaid waivers to provide certain low-income, uninsured adults not otherwise eligible for Medicaid coverage under their state plan with Medicaid benefits, including behavioral health treatment. In 2014, Montana obtained a Medicaid waiver to enable up to 6,000 individuals enrolled in a state-funded program—the Mental Health Services Plan, which provides evaluation and assessment, visits with a

[37]Residential treatment refers to a course of individual and group activities in a structured 24 hour live-in facility. Such programs are considered less intensive than inpatient hospitalization.

[38]Peers are individuals with personal experiences of recovery from mental health or substance use conditions who offer social support throughout treatment to facilitate long-term recovery in the community in which a recovering individual resides.

[39]Local entities are counties for Wisconsin and local mental health authorities in Texas. In contrast, the state BHA is solely responsible for administering behavioral health treatment in Missouri and Montana.

medical provider and prescription drugs—to receive basic Medicaid coverage.[40] In addition, Wisconsin obtained a Medicaid waiver effective January 2014 that made certain childless adults up to 100 percent of the FPL eligible for Medicaid, which gave them access to Medicaid-covered services and prescription drugs, including behavioral health treatments.[41]

Officials from the non-expansion states we examined noted initiatives relevant to low-income, uninsured adults, such as improving crisis response and coordinating care for individuals involved with law enforcement.

- Texas officials noted that 24 of the 33 local mental health authorities have a facility-based crisis option to treat individuals experiencing a crisis and that they would like to provide the remaining local mental health authorities with similar facilities, which are intended to avoid inpatient care.
- In Wisconsin, behavioral health treatment includes mobile crisis services to respond to individuals in the community experiencing a crisis. A Wisconsin official told us that there were legislative efforts underway to expand these services, particularly in rural areas.
- Missouri has hired community mental health liaisons to facilitate access to behavioral health services for individuals who are in frequent contact with law enforcement.

[40]This waiver was originally approved in 2010 for up to 800 Mental Health Services Plan participants. Participants for the waiver are randomly selected from the list of Mental Health Services Plan participants starting with individuals with schizophrenia, then bipolar disorder, then major depressive disorder, and finally other diagnoses. Basic Medicaid coverage includes inpatient and outpatient behavioral health services and associated prescription drugs, but does not include some benefits, such as hearing aids, in Montana's Medicaid state plan. Beneficiaries are required to pay co-pays for certain services.

[41]As of March 2015, 159,711 childless adults were enrolled through Wisconsin's waiver. Medicaid coverage under this waiver includes inpatient and outpatient behavioral health services and associated prescription drugs. Beneficiaries are required to pay co-pays for certain services. While enrollment of childless adults increased, Wisconsin limited Medicaid eligibility for parents from 200 percent of the FPL to 100 percent of the FPL, a reduction of approximately 59,793 previous Medicaid enrollees as of April 2014.

## States Set Priorities to Focus Care on Those with the Most Serious Behavioral Health Needs and Used Waiting Lists for the Remaining Individuals

The selected non-expansion states established priority populations for providing behavioral health treatment to those with the most severe behavioral health needs. For the states we examined, priority populations for mental health treatment included individuals with serious mental illness and those presenting in crisis. Similarly, all the non-expansion states we examined identified priority populations for receiving treatment for substance use conditions. Specifically, pregnant women and individuals abusing drugs intravenously were among the priority groups that the states identified to receive treatment.[42]

As part of setting priorities for those with the most serious behavioral health needs, the non-expansion states included specific eligibility requirements based on diagnosis or impairment, in addition to financial status, for behavioral health treatment for the uninsured.

- In Montana, individuals aged 18 to 64 diagnosed with a severe, disabling mental illness, and incomes up to 150 percent of the FPL may qualify for the state-funded Mental Health Services Plan. Montana officials told us that their Mental Health Services Plan does not provide treatment to individuals with more moderate behavioral health needs, but that these individuals may get some treatment through community-based "drop-in" centers.[43]
- In Texas, local mental health authorities are required to provide services to adults with diagnoses of schizophrenia, bipolar disorder, or clinically severe depression, and may, to the extent feasible, provide services to adults experiencing significant functional impairment due

[42]For block-grant-funded services, SAMHSA specifies certain priority populations, and states are required to report on their performance serving these populations. For example, states are required to ensure that each pregnant woman who seeks or is referred for and would benefit from substance use treatment services is given preference in admission to treatment facilities that receive block grant funding.

[43]Drop-in centers are informal locations where individuals with mental health conditions may receive services such as support groups and assistance with telephone and computer access, laundry facilities, and meals.

to other diagnoses. Individuals who are not members of the identified priority groups are generally not eligible to receive treatment.

Three of the states we examined maintained waiting lists for individuals with more modest needs for behavioral health treatment.[44]

- Texas officials said that they triage individuals eligible for behavioral health treatment, and those with less urgent needs may have to wait. In some cases, individuals may receive a lower level of care than recommended while waiting for treatment due to resource limitations. For example, an individual might receive medication-related services and crisis services as needed, but not recommended rehabilitation services. Texas officials told us that there were over 5,000 individuals waiting for behavioral health treatment as of February 2013, although they were able to move most individuals off waiting lists when they received additional state funding for fiscal years 2014 and 2015. They described this additional funding as "historic," and they reduced the number of individuals waiting to fewer than 300 as of May 2014. In addition to reducing the waiting list, Texas moved 1,435 adults from lower levels of care to more appropriate levels in 2014.
- A Wisconsin official told us if county agencies run out of funding, they are permitted to establish waiting lists or may only serve clients with Medicaid coverage. The official said there were 1,656 individuals waiting for substance use treatment and 242 individuals waiting for a specific mental health service in 2013, prior to Wisconsin extending Medicaid coverage to certain low-income adults through a Medicaid waiver.[45] The official said that county agencies do not have to provide all services if they run out of funding, but must always provide emergency care.

[44]Information on waiting lists was reported from state officials, and we did not verify the specific number of individuals on these waiting lists.

[45]The Wisconsin BHA conducts annual surveys of counties to determine the extent of waiting lists for the Community Support Program, which provides psychosocial rehabilitative services for individuals with a severe and persistent mental illness living in the community. Counties may offer other behavioral health services, such as case management, to individuals waiting for the Community Support Program.

- Missouri officials said there were 3,723 individuals on the waiting list for substance use treatment as of January 2015.[46]

# Selected Expansion States Generally Managed Behavioral Health Separately from Other Benefits, Reporting Increased Treatment Availability, but Some Continuing Access Concerns

Selected states generally managed behavioral health benefits for newly eligible Medicaid enrollees separately from physical benefits through carve-outs or separate contracts. Health plans for these enrollees were generally aligned with Medicaid state plans, resulting in comparable behavioral health benefits for newly eligible and existing Medicaid enrollees. According to state officials, expanding Medicaid has increased the availability of behavioral health treatment, although some access concerns continue.

## Selected States Generally Managed Behavioral Health Coverage for Newly Eligible Enrollees Separately from Other Benefits

The expansion states we examined generally managed behavioral health benefits separately from other benefits through carve-outs or separate contracts. Four of the six states included in our study—Connecticut, Maryland, Michigan, and West Virginia—explicitly carved out or contracted for the administration of behavioral health services or prescription drugs separately from other services and drugs. For example, in Maryland, specialty mental health services have been carved out of its contracts with managed care organizations (MCO) since 1997 and are paid for on an FFS basis.[47] Michigan carved behavioral health

[46]Missouri state BHA officials noted that Missouri does not maintain a waiting list for mental health services.

[47]Maryland defines specialty mental health services as those services provided by a mental health professional or a mental health service agency that are not performed as part of a primary practitioner's office visit.

services out of its MCO contracts and moved them to a limited benefit plan in 1998.[48] Connecticut, which has an FFS delivery system for newly eligible enrollees, contracted with a behavioral health benefits manager to administer behavioral health services.[49] The other two states contracted with MCOs to provide both physical and behavioral health coverage, but several of these MCOs chose to subcontract with behavioral health benefits managers. See table 2 for information on the expansion states' coverage designs for behavioral health services and prescription drugs.

**Table 2: Selected States' Coverage of Behavioral Health Benefits for Newly Eligible Medicaid Enrollees in 2014**

| n/a | Delivery systems | | | |
|---|---|---|---|---|
| **State** | **Physical health services** | **Mental health services** | **Substance use services** | **Behavioral health prescription drugs** |
| Connecticut | Fee-for-service (FFS) | FFS; contracted separately from physical services | FFS; contracted separately from physical services | FFS; contracted separately from physical and behavioral health services |
| Kentucky | Managed care (MC) | MC[a] | MC[a] | MC[a] |
| Maryland | MC | Carved out; FFS | MC[b] | Carved out; FFS[c] |
| Michigan | MC | Carved out; limited benefit plan | Carved out; limited benefit plan | Carved out; FFS |
| Nevada[d] | FFS and MC[e] | FFS and MC[e] | FFS and MC[e] | FFS and MC[e] |
| West Virginia[f] | FFS | FFS | FFS | FFS; contracted separately from physical and behavioral health services |

Source: GAO analysis of information from state Medicaid programs. | GAO-15-449

Notes: For states with FFS delivery systems, the term "contracted separately" refers to arrangements where states contract with different companies to administer behavioral health benefits than those administering physical health care benefits. These arrangements are generally contracts with administrative services organizations, which administer benefits according to policies set by the state, and which are not risk-bearing. The term "carve-out" refers to states with Medicaid managed care contracts that choose to have a separate company manage or administer behavioral health benefits apart from medical or other benefits.

[a]Three of Kentucky's five MCOs subcontracted behavioral health services and drugs to a behavioral health benefits manager.

[48]In Michigan, MCO contracts include the management of mild and moderate behavioral health conditions. Enrollees seeking more than 20 outpatient visits to address their behavioral health needs are enrolled in a limited benefit plan.

[49]In an FFS context, behavioral health benefits managers can act as administrative services organizations, which administer benefits according to policies set by the state, and which are not risk-bearing.

[b]Maryland carved substance use services out of its managed care contracts as of January 1, 2015. The behavioral health benefits manager that has been managing mental health services now also manages substance use services. Prescription drugs to treat substance use conditions have also been carved out of managed care contracts and are paid for on an FFS basis.

[c]Maryland carved out mental health prescription drugs and paid for them on an FFS basis. Prescription drugs for substance use conditions were not carved out until 2015.

[d]Enrollment in managed care is mandatory for newly eligible enrollees in Nevada in areas where there is a choice of two or more plans and optional where only one plan exists. Enrollees not in a managed care plan are served by FFS Medicaid. Officials estimated 78 to 80 percent of Medicaid enrollees were enrolled in a managed care plan in 2014.

[e]According to Nevada officials, both MCOs subcontract behavioral health services and drugs to a behavioral health benefits manager.

[f]West Virginia is in the process of moving to a comprehensive managed care plan for newly eligible enrollees that will include behavioral health services. Officials have not determined a date when it will be implemented but they are aiming for state fiscal year 2016.

State officials cited various reasons for separately managing behavioral health benefits, including concerns about access, ensuring appropriate expertise, and state law.

- Maryland officials told us they chose to carve out mental health services and pay for them on an FFS basis through a behavioral health benefits manager due to concerns about beneficiary access under managed care, particularly for more intensive services generally not covered by commercial insurance plans. Maryland also separately carved out mental health prescription drugs on an FFS basis, which officials said was so that the state could align policies for these drugs with the behavioral health benefits manager administering the mental health services carve-out.
- In Kentucky, three of the five Medicaid MCOs subcontracted behavioral health benefits to a behavioral health benefits manager. Kentucky officials told us that one of the MCOs decided to subcontract these benefits due to a lack of expertise in managing behavioral health prescription drugs.
- Michigan and Connecticut officials told us that state laws prohibit their Medicaid programs from using certain utilization management techniques for some types of behavioral health prescription drugs.[50] Michigan officials told us that given the lack of utilization management tools available, they decided to pay for behavioral health prescription drugs on an FFS basis rather than to include these drugs in the state's limited benefit plan contracts.

Providers have raised concerns about managing behavioral health benefits separately from medical benefits, and some states reported making efforts to make sure care is coordinated. Behavioral health physician groups we spoke with told us that paying for physical and behavioral health care separately makes it difficult to assess the total cost of care for individuals with behavioral health conditions, and does not

[50]Michigan's law prohibits its Medicaid program from applying prior authorization—which the law defines as a process that conditions, delays, or denies prescription medications to Medicaid enrollees upon application of predetermined criteria—to certain classes of drugs, including some that may be used to treat behavioral health conditions. Mich. Comp. Laws § 400.109h. State law in Connecticut restricts the Medicaid program from applying step therapy—which the law defines as requiring that a patient try and fail on one prescribed drug from the Medicaid preferred drug list before another drug can be prescribed and eligible for payment—to mental-health-related prescription drugs. Conn. Gen. Stat. § 17b-274f.

provide adequate incentives to make investments in one type of care that may reduce costs for another type of care. For example, provider groups said that lack of investment in substance use services could lead to additional costs for emergency medical care.[51] In addition, one physician group raised concerns about managing behavioral health services separately from prescription drugs because of the potential for conflicting utilization management policies to create barriers to care. For example, a pharmacy benefits manager may require outpatient counseling as a condition for receiving medication-assisted treatment for substance use, but such counseling may not be covered by the managed care company that authorizes behavioral health services. The four states we spoke with that explicitly manage behavioral health care separately—Connecticut, Michigan, Maryland, and West Virginia—noted that they were engaged in care coordination efforts.

- Connecticut officials said that although they have multiple contracts for benefits administration, all claims are processed through a single vendor and the state uses these data to help identify individuals in need of care management.
- Michigan officials said that the state has implemented claims sharing between the MCOs managing physical health care and the limited benefit plans that manage behavioral health benefits. Michigan is currently working on a demonstration program with CMS that would allow for real-time sharing of clinical information for individuals dually eligible for Medicare and Medicaid.
- Maryland included financial incentives related to physical health, such as the number of patients who have an annual primary care visit, in the contract with its behavioral health benefits manager.
- West Virginia officials said that they were working on creating a comprehensive managed care plan for newly eligible Medicaid enrollees that would offer both physical and behavioral benefits, including prescription drugs, under the same plan in order to better coordinate care.

[51]Research has shown that Medicaid enrollees with untreated substance use conditions incur greater medical costs than individuals without these conditions. See, e.g., L. Gerson et al., "Medical Care Use by Treated and Untreated Substance Abusing Medicaid Patients," *Journal of Substance Abuse Treatment*, vol. 20, no. 2 (2001).

In addition, Michigan, Maryland, and West Virginia have established Medicaid health homes to coordinate care for individuals with chronic conditions, including behavioral health conditions.[52] As of January 2015, Connecticut was in the process of developing Medicaid health homes for individuals with behavioral health conditions.

## Selected States Provided Comparable Behavioral Health Benefits for Newly Eligible and Existing Medicaid Enrollees

Five of the six expansion states included in our study chose to align their alternative benefit plans with their Medicaid state plans—providing at least the same benefits for newly eligible enrollees as existing enrollees received under the state plan—and some states made alignment-related coverage changes.[53]

- Connecticut, Kentucky, Maryland, Michigan, and Nevada aligned their alternative benefit plans with their Medicaid state plans, which required these states to add to their alternative benefit plans any state plan benefits that were not already included. For example, Michigan officials said they added additional recovery-oriented substance use services, such as peer support services, to the alternative benefit plan to match existing state plan benefits.
- Although not required, states may also choose to add benefits to their Medicaid state plans to match their alternative benefit plans. As part of the alignment process, Kentucky chose to extend substance use treatment—previously limited to children under 21 and pregnant and postpartum women—to all Medicaid enrollees under its state plan to match the substance use coverage in its alternative benefit plan.

[52]For example, West Virginia's Medicaid health homes serve individuals with bipolar disorder who also have hepatitis.

[53]All six expansion states in our study confirmed that they offer coverage for inpatient and outpatient mental health and substance use services, and associated prescription drugs for newly eligible Medicaid enrollees. However, subject to federal requirements, states may establish the amount, duration, and scope of the benefits covered in their Medicaid programs. For example, states may limit the number of visits or the days of care that are provided. According to CMS, states that chose to align their alternative benefit plans were required to meet or exceed the amount, duration, and scope of benefits contained in the Medicaid state plan.

- West Virginia did not align its alternative benefit plan with its Medicaid state plan, but there were no differences in coverage for behavioral health services and associated prescription drugs.[54]

## Selected Expansion States Reported Increased Availability of Behavioral Health Treatment, but Cited Some Ongoing Access Concerns

Officials we interviewed from the six expansion states generally reported that Medicaid expansion had resulted in greater availability of behavioral health treatment, and changes were greater in states without previous coverage options for low-income adults. Kentucky, Nevada, and West Virginia did not have any coverage available for low-income childless adults prior to expansion and primarily relied on their states' BHAs to provide behavioral health treatment for the uninsured.[55]

- Kentucky officials reported a substantial increase in the availability of behavioral health treatment for individuals when they enrolled in Medicaid, as individuals were no longer limited to what state-funded community mental health centers could provide, and could access additional services, such as peer support services.
- Nevada officials stated that while the state BHA and the state's Medicaid program provide the same array of behavioral health treatments, some uninsured individuals experienced long delays in receiving care prior to enrolling in Medicaid coverage under the expansion.
- West Virginia officials cited the increased availability of prescription drugs. West Virginia's BHA did not pay for prescription drugs for uninsured individuals except in limited circumstances, whereas newly eligible Medicaid enrollees gained access to the full array of covered drugs under the state's Medicaid program.

[54]Differences between the two plans included coverage of nursing home and personal care services, which the traditional Medicaid program covers and the alternative benefit plan does not.

[55]Similar to the non-expansion states in our study, officials from some of the expansion states reported that their BHAs set priorities to focus care on individuals with the most serious behavioral health needs.

In contrast, Connecticut, Maryland, and Michigan all had limited coverage available for certain low-income adults prior to expanding Medicaid that paid for some behavioral health services and prescription drugs. For example, Maryland's Primary Adult Care program paid for outpatient mental health and substance use services and prescription drugs for adults up to 116 percent of the FPL.[56] Officials from these three states reported that while the availability of treatment increased when individuals enrolled in Medicaid, the changes were small; for example, officials from two states reported that Medicaid beneficiaries had a greater choice of providers.[57] Individuals not enrolled in these coverage programs experienced larger changes; for example, Michigan officials reported that enrollment in Medicaid had resulted in improved access to substance use services, including access to case management, which officials said could help individuals live more successfully in the community.

Officials from the expansion states in our study did report some access concerns for new Medicaid enrollees due to behavioral health professional shortages, which they attempted to address in a variety of ways. Officials from all six states cited behavioral health workforce shortages as a challenge to providing behavioral health treatment for low-income adults in their states.[58] The state officials specifically highlighted shortages of Medicaid-participating psychiatrists and psychiatric drug prescribers.[59]

[56]Connecticut's program, the State Administered General Assistance program, offered health care coverage to childless adults with incomes up to 56 percent of the FPL. Michigan's program, the Adult Benefits Waiver program, provided ambulatory and prescription drug benefits for childless adults up to 35 percent of the FPL and was subject to enrollment caps. These three state programs were terminated when Medicaid was expanded and participants were automatically enrolled in Medicaid.

[57]For example, Connecticut officials said that State Administered General Assistance enrollees were limited to receiving care at federally qualified health centers and similar settings and did not have access to independent practitioners.

[58]The four non-expansion states included in our study (Missouri, Montana, Texas, and Wisconsin) also mentioned behavioral health workforce shortages as an obstacle to providing behavioral health treatment to low-income adults in their states.

[59]Officials from two states—Connecticut and Michigan—commented that despite the shortage, access to psychiatrists was likely better for Medicaid enrollees than for some privately insured adults in their states.

- Nevada officials reported conducting a secret shopper study of psychiatrists in the state's Medicaid program in 2014 that found only 22 percent of Medicaid-enrolled psychiatrists were accepting new Medicaid patients.
- Maryland and Connecticut officials reported difficulties providing Medicaid enrollees with access to certain prescription drugs used for medication-assisted treatment for substance use conditions due to a lack of physicians willing to prescribe these drugs for Medicaid enrollees.[60]

States reported taking several steps to address workforce shortages, such as providing reimbursement for telehealth services, expanding the types of providers who can receive reimbursement for providing services in Medicaid, and using peers and other non-licensed providers to deliver some services under the supervision of licensed providers. Michigan chose to address behavioral health needs of its new Medicaid enrollees by leveraging its primary care workforce. The state used a health assessment tool as part of the enrollment process for its alternative benefit plan that included questions about potential behavioral health conditions. Health assessment information was conveyed to each enrollee's primary care provider, who could then address any behavioral health needs or refer for specialty care if needed.[61]

State officials reported additional concerns regarding access to behavioral health treatment due to expansion-related budget reductions for state BHAs, which fund treatment for uninsured individuals, as well as non-Medicaid covered treatments for Medicaid enrollees. Officials from four of the six expansion states we spoke with—Connecticut, Kentucky, Michigan, and Nevada—reported that their state's BHA budget had been reduced based on the expectation that uninsured individuals would enroll

[60]Officials reported shortages of prescribers for buprenorphine/naloxone, a medication-assisted treatment for opioid dependence. Federal law limits prescribers of buprenorphine to treating 100 patients at a time, and Connecticut officials said that this limitation provided an incentive for these prescribers to fill those patient slots with commercially insured individuals to maximize revenue.

[61]Michigan officials told us that their MCO contracts require a sufficient number of primary care providers taking new patients to be in close proximity to where an individual lives for an MCO to be able to enroll that individual. Once enrolled, the MCO must ensure an appointment with the assigned primary care provider is made within 60 days and completed within 150 days.

in Medicaid. For example, Michigan officials reported that the state reduced its state general fund contribution for its BHA by about 10 percent ($116 million) from fiscal year 2013 to fiscal year 2015, and Nevada reported a $33 million reduction to its BHA budget over fiscal years 2014 and 2015 related to the expansion. Some state officials raised concerns about having enough state BHA funding for individuals who would remain uninsured or underinsured following expansion, including individuals who are eligible but do not enroll or re-enroll in Medicaid, immigrants,[62] and certain individuals under 65 who are enrolled in Medicare because of a disability.[63] Officials from two states also expressed concerns about the adequacy of funding for wraparound services—services that are not covered by their states' Medicaid programs, such as supportive housing—for Medicaid enrollees. Officials from the four states that reported BHA budget reductions noted that there were subsequent adjustments to their budgets to lessen the impact of the reductions based on these concerns. For example, Michigan's BHA received an additional $25 million for fiscal year 2015 to address behavioral health needs in certain populations that remain ineligible for Medicaid. (See appendix II for more information on expansion-related changes in state BHA budgets.) Despite concerns about budget reductions, officials from two states noted that when additional Medicaid funds from the expansion were considered as part of the behavioral health budget, much more funding was available overall.

Other continuing access problems mentioned by state officials related to inpatient behavioral health treatment.

- Nevada officials said that lack of psychiatric inpatient capacity has led to patients who were considered a risk to themselves or others being kept in emergency rooms for up to several days before they could secure a bed in a psychiatric hospital. Officials said that an average of 90 to 110 patients per day, predominately Medicaid enrollees, were waiting in emergency rooms. Nevada has made efforts to address the problem, for example, by sending teams of psychiatrists to emergency rooms to assess psychiatric patients to determine whether they could

[62]Although not eligible for Medicaid, legal permanent residents within their first five years in the country with incomes from 0 to 400 percent of the FPL are eligible for premium tax credits for coverage purchased through health care exchanges established under PPACA.

[63]Individuals enrolled in Medicare are not eligible for coverage under the Medicaid expansion option in PPACA.

be discharged and treated on an outpatient basis. However, officials noted that discharging such patients carries risks and has led to poor outcomes in the past.

- Kentucky officials said that they were working to expand capacity for residential treatment programs for substance use. Officials said that given Medicaid's exclusion of payment for treatment for adults at "institutions for mental disease" with 16 or more beds, they were encouraging providers to design any new residential substance use programs to be under that limit. However, they noted that doing so can prevent providers from taking advantage of economies of scale and may make it more difficult to operate some residential treatment programs shown to be effective for substance use conditions. Officials said that the state was working to develop alternatives to inpatient care for Medicaid enrollees, such as transitional housing combined with an intensive outpatient program.

# Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review. HHS provided technical comments, which we incorporated as appropriate.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff members have any questions, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix III.

Carolyn L. Yocom
Director, Health Care

# Appendix I: Estimated Number and Percentage of Low-Income, Uninsured Adults with Behavioral Health Conditions

**Table 3: Estimated Number and Percentage of Low-Income, Uninsured Adults with Behavioral Health Conditions Based on 2008 to 2013 Data, by State**

| n/a | n/a | Estimated number of low-income, uninsured adults | | |
|---|---|---|---|---|
| State | State expanded Medicaid as of February 2015 | Total | Behavioral health condition[a] (Number) | Behavioral health condition[a] (Percent (standard error)) |
| Alabama | | 337,414 | 68,495 | 20.3 (2.6) |
| Alaska | | 32,188 | 8,015 | 24.9 (4.6) |
| Arizona | yes | 462,620 | 96,688 | 20.9 (2.7) |
| Arkansas | yes | 220,970 | 42,868 | 19.4 (2.2) |
| California | yes | 2,373,672 | 296,709 | 12.5 (1.2) |
| Colorado | yes | 234,326 | 28,119 | 12.0 (2.0) |
| Connecticut | yes | 95,135 | not reported | not reported |
| Delaware | yes | 33,720 | 4,384 | 13.0 (3.6) |
| District of Columbia[c] | yes | 13,235 | not reported | not reported |
| Florida | | 1,457,579 | 228,840 | 15.7 (1.2) |
| Georgia | | 835,099 | 101,882 | 12.2 (1.8) |
| Hawaii | yes | 33,155 | 6,996 | 21.1 (4.5) |
| Idaho | | 99,385 | 23,554 | 23.7 (3.6) |
| Illinois | yes | 625,228 | 103,163 | 16.5 (1.4) |
| Indiana | yes | 390,230 | 107,313 | 27.5 (3.1) |
| Iowa | yes | 102,092 | 19,602 | 19.2 (3.1) |
| Kansas | | 151,288 | 24,055 | 15.9 (3.3) |
| Kentucky | yes | 314,783 | 49,736 | 15.8 (2.3) |
| Louisiana | | 367,715 | 74,646 | 20.3 (2.4) |
| Maine | | 43,509 | 8,658 | 19.9 (3.8) |

| n/a | n/a | Estimated number of low-income, uninsured adults | | |
|---|---|---|---|---|
| State | State expanded Medicaid as of February 2015 | Total | Behavioral health condition[a] (Number) | Behavioral health condition[a] (Percent (standard error)) |
| Maryland | yes | 155,991 | not reported | not reported |
| Massachusetts | yes | 80,772 | not reported | not reported |
| Michigan | yes | 469,145 | 99,459 | 21.2 (1.6) |
| Minnesota | yes | 127,135 | 24,791 | 19.5 (4.4) |
| Mississippi | | 262,001 | 42,968 | 16.4 (1.7) |
| Missouri | | 337,997 | 58,135 | 17.2 (2.4) |
| Montana | | 66,859 | 14,040 | 21.0 (3.2) |
| Nebraska | | 80,632 | 16,610 | 20.6 (3.3) |
| Nevada | yes | 208,125 | 44,747 | 21.5 (3.3) |
| New Hampshire | yes | 42,663 | 8,703 | 20.4 (4.2) |
| New Jersey | yes | 389,619 | 26,884 | 6.9 (2.3) |
| New Mexico | yes | 183,738 | 24,253 | 13.2 (2.5) |
| New York | yes | 679,004 | 85,555 | 12.6 (1.6) |
| North Carolina | | 681,646 | 98,157 | 14.4 (2.1) |
| North Dakota | yes | 25,599 | 7,040 | 27.5 (4.1) |
| Ohio | yes | 517,750 | 141,864 | 27.4 (2.1) |
| Oklahoma | | 261,113 | 47,261 | 18.1 (2.7) |
| Oregon | yes | 228,856 | 47,373 | 20.7 (3.3) |
| Pennsylvania | yes | 483,618 | 91,404 | 18.9 (2.0) |
| Rhode Island | yes | 42,114 | 10,486 | 24.9 (4.0) |
| South Carolina | | 323,019 | 72,033 | 22.3 (2.7) |
| South Dakota | | 48,360 | 8,463 | 17.5 (3.4) |
| Tennessee | | 402,151 | 88,473 | 22.0 (2.5) |
| Texas | | 2,223,516 | 304,622 | 13.7 (1.0) |
| Utah | | 130,007 | 21,581 | 16.6 (3.2) |
| Vermont | yes | 10,210 | not reported | not reported |
| Virginia | | 367,450 | 85,983 | 23.4 (4.6) |
| Washington | yes | 364,226 | 85,229 | 23.4 (3.8) |
| West Virginia | yes | 114,445 | 20,715 | 18.1 (2.3) |
| Wisconsin | | 195,506 | 41,838 | 21.4 (3.8) |
| Wyoming | | 23,897 | 4,684 | 19.6 (3.4) |
| **Total[d]** | | **17,750,507** | **2,964,335** | **16.7 (0.4)** |
| **Expansion states[d]** | | **9,022,176** | **1,524,748** | **16.9 (0.5)** |
| **Non-expansion states[d]** | | **8,728,331** | **1,448,903** | **16.6 (0.5)** |

Source: Substance Abuse and Mental Health Services Administration (SAMHSA) analysis of data from the National Survey on Drug Use and Health for 2008 through 2013, and data from the American Community Survey for 2013. | GAO-15-449.

Notes: The estimated number of low-income uninsured adults with a behavioral health condition was calculated by multiplying the estimated total number of uninsured adults ages 18 to 64 with incomes at or below 138 percent of the federal poverty level by the estimated percentage of this population with a behavioral health condition. Numbers of uninsured adults were drawn from the U.S. Census Bureau's 2013 American Community Survey, and the percentages with behavioral health conditions were drawn from SAMHSA's National Survey on Drug Use and Health for years 2008 to 2013.

[a]For purposes of this table, individuals are defined as having a behavioral health condition if they have a serious mental illness, a substance use condition, or co-occuring serious mental illness and substance use condition.

[b]Not reported because percentage was estimated with low precision. However, totals include data for states that are not reported in this table.

[c]For the purposes of this report, we refer to the District of Columbia as a state.

[d]Totals include data for states that are not reported in this table. Numbers of low-income uninsured adults in expansion and non-expansion states with a behavioral health condition do not sum to the total because the percentages used to calculate these numbers were rounded.

**Table 4: Estimated Number and Percentage of Low-Income, Uninsured Adults with a Serious Mental Illness, a Substance Use Condition, or Both Conditions, Based on 2008 to 2013 Data, by State**

| n/a | n/a | Estimated number of low-income, uninsured adults | | | | | | |
|---|---|---|---|---|---|---|---|---|
| n/a | n/a | n/a | Serious mental illness | | Substance use condition | | Serious mental illness and substance use condition | |
| State | State expanded Medicaid as of February 2015 | Total | Number | Percent (standard error) | Number | Percent (standard error) | Number | Percent (standard error) |
| Alabama | | 337,414 | 33,067 | 9.8 (2.3) | 39,477 | 11.7 (1.9) | 4,049 | 1.2 (0.5) |
| Alaska | | 32,188 | 3,251 | 10.1 (3.5) | 7,049 | 21.9 (4.5) | not reported | not reported |
| Arizona | yes | 462,620 | 29,145 | 6.3 (1.7) | 78,645 | 17.0 (2.3) | 11,103 | 2.4 (1.1) |
| Arkansas | yes | 220,970 | 21,655 | 9.8 (1.8) | 28,947 | 13.1 (1.9) | 7,734 | 3.5 (1.4) |
| California | yes | 2,373,672 | 94,947 | 4.0 (0.6) | 230,246 | 9.7 (1.0) | 28,484 | 1.2 (0.3) |
| Colorado | yes | 234,326 | 6,561 | 2.8 (1.0) | 22,730 | 9.7 (1.9) | 1,172 | 0.5 (0.3) |
| Connecticut | yes | 95,135 | not reported | not reported | not reported | not reported | not reported | not reported |
| Delaware | yes | 33,720 | 2,495 | 7.4 (2.8) | 2,428 | 7.2 (2.4) | not reported | not reported |
| District of Columbia[b] | yes | 13,235 | not reported | not reported | not reported | not reported | not reported | not reported |
| Florida | | 1,457,579 | 87,455 | 6.0 (0.8) | 173,452 | 11.9 (1.1) | 32,067 | 2.2 (0.5) |
| Georgia | | 835,099 | 30,064 | 3.6 (1.2) | 78,499 | 9.4 (1.8) | 6,681 | 0.8 (0.5) |
| Hawaii | yes | 33,155 | 2,122 | 6.4 (2.1) | 6,001 | 18.1 (4.3) | 1,094 | 3.3 (1.7) |
| Idaho | | 99,385 | 11,231 | 11.3 (2.1) | 15,703 | 15.8 (3.3) | 3,379 | 3.4 (1.4) |
| Illinois | yes | 625,228 | 24,384 | 3.9 (0.7) | 86,907 | 13.9 (1.3) | 8,128 | 1.3 (0.3) |
| Indiana | yes | 390,230 | 50,730 | 13.0 (2.7) | 77,656 | 19.9 (2.8) | 21,072 | 5.4 (1.5) |

| n/a | n/a | Estimated number of low-income, uninsured adults | | | | | | |
|---|---|---|---|---|---|---|---|---|
| n/a | n/a | n/a | Serious mental illness | | Substance use condition | | Serious mental illness and substance use condition | |
| State | State expanded Medicaid as of February 2015 | Total | Number | Percent (standard error) | Number | Percent (standard error) | Number | Percent (standard error) |
| Iowa | yes | 102,092 | 6,534 | 6.4 (2.3) | 13,680 | 13.4 (2.5) | 715 | 0.7 (0.3) |
| Kansas | | 151,288 | 4,993 | 3.3 (1.3) | 19,365 | 12.8 (2.8) | 303 | 0.2 (0.2) |
| Kentucky | yes | 314,783 | 19,202 | 6.1 (1.5) | 42,181 | 13.4 (2.0) | 11,647 | 3.7 (1.2) |
| Louisiana | | 367,715 | 22,798 | 6.2 (1.5) | 59,938 | 16.3 (2.2) | 8,090 | 2.2 (0.9) |
| Maine | | 43,509 | 3,829 | 8.8 (3.0) | 6,961 | 16.0 (3.6) | 2,132 | 4.9 (2.2) |
| Maryland | yes | 155,991 | 9,515 | 6.1 (2.9) | not reported | not reported | 2,496 | 1.6 (1.2) |
| Massachusetts | yes | 80,772 | not reported | not reported | not reported | not reported | not reported | not reported |
| Michigan | yes | 469,145 | 34,248 | 7.3 (1.0) | 75,063 | 16.0 (1.3) | 9,383 | 2.0 (0.5) |
| Minnesota | yes | 127,135 | not reported | not reported | 14,875 | 11.7 (2.6) | 2,670 | 2.1 (1.0) |
| Mississippi | | 262,001 | 18,864 | 7.2 (1.5) | 29,082 | 11.1 (1.6) | 4,978 | 1.9 (0.7) |
| Missouri | | 337,997 | 20,618 | 6.1 (1.6) | 43,602 | 12.9 (2.2) | 6,084 | 1.8 (0.7) |
| Montana | | 66,859 | 4,346 | 6.5 (1.9) | 10,898 | 16.3 (2.9) | 1,270 | 1.9 (0.8) |
| Nebraska | | 80,632 | 4,435 | 5.5 (1.6) | 12,740 | 15.8 (3.2) | 484 | 0.6 (0.3) |

| n/a | n/a | Estimated number of low-income, uninsured adults | | | | | | |
|---|---|---|---|---|---|---|---|---|
| n/a | n/a | n/a | Serious mental illness | | Substance use condition | | Serious mental illness and substance use condition | |
| State | State expanded Medicaid as of February 2015 | Total | Number | Percent (standard error) | Number | Percent (standard error) | Number | Percent (standard error) |
| Nevada | yes | 208,125 | 14,361 | 6.9 (2.8) | 33,508 | 16.1 (2.8) | 3,122 | 1.5 (0.6) |
| New Hampshire | yes | 42,663 | 2,218 | 5.2 (1.8) | 7,637 | 17.9 (4.0) | 1,152 | 2.7 (1.5) |
| New Jersey | yes | 389,619 | 5,065 | 1.3 (0.8) | 22,988 | 5.9 (2.1) | 1,558 | 0.4 (0.3) |
| New Mexico | yes | 183,738 | 11,208 | 6.1 (1.7) | 19,660 | 10.7 (2.1) | 6,615 | 3.6 (1.2) |
| New York | yes | 679,004 | 21,049 | 3.1 (0.9) | 70,616 | 10.4 (1.5) | 6,111 | 0.9 (0.4) |
| North Carolina | | 681,646 | 21,131 | 3.1 (1.1) | 89,296 | 13.1 (1.9) | 12,270 | 1.8 (0.6) |
| North Dakota | yes | 25,599 | 2,688 | 10.5 (3.1) | 5,043 | 19.7 (3.8) | not reported | not reported |
| Ohio | yes | 517,750 | 57,470 | 11.1 (1.5) | 106,139 | 20.5 (1.7) | 21,746 | 4.2 (0.9) |
| Oklahoma | | 261,113 | 19,583 | 7.5 (1.7) | 32,378 | 12.4 (2.2) | 4,439 | 1.7 (0.8) |
| Oregon | yes | 228,856 | 15,562 | 6.8 (1.9) | 36,388 | 15.9 (2.9) | 4,577 | 2.0 (0.9) |
| Pennsylvania | yes | 483,618 | 29,984 | 6.2 (1.3) | 74,477 | 15.4 (1.9) | 13,058 | 2.7 (0.9) |
| Rhode Island | yes | 42,114 | 2,906 | 6.9 (2.5) | 9,897 | 23.5 (3.8) | 2,316 | 5.5 (2.3) |
| South Carolina | | 323,019 | 33,594 | 10.4 (2.4) | 51,683 | 16.0 (2.5) | 13,244 | 4.1 (2.0) |
| South Dakota | | 48,360 | 2,708 | 5.6 (1.9) | 7,012 | 14.5 (3.1) | 1,257 | 2.6 (1.3) |
| Tennessee | | 402,151 | 34,183 | 8.5 (1.8) | 63,942 | 15.9 (2.5) | 9,652 | 2.4 (1.0) |
| Texas | | 2,223,516 | 93,388 | 4.2 (0.6) | 233,469 | 10.5 (0.8) | 22,235 | 1.0 (0.3) |
| Utah | | 130,007 | 9,621 | 7.4 (2.0) | 13,781 | 10.6 (2.3) | 1,820 | 1.4 (0.7) |
| Vermont | yes | 10,210 | 1,041 | 10.2 (3.2) | 1,603 | 15.7 (3.9) | 255 | 2.5 (1.2) |
| Virginia | | 367,450 | 26,824 | 7.3 (2.4) | 62,099 | 16.9 (4.2) | 2,940 | 0.8 (0.4) |
| Washington | yes | 364,226 | 36,787 | 10.1 (3.0) | 65,561 | 18.0 (3.2) | 17,119 | 4.7 (1.8) |
| West Virginia | yes | 114,445 | 10,414 | 9.1 (2.1) | 14,535 | 12.7 (1.9) | 4,120 | 3.6 (1.4) |
| Wisconsin | | 195,506 | 22,092 | 11.3 (3.8) | 30,108 | 15.4 (3.7) | not reported | not reported |
| Wyoming | | 23,897 | 1,888 | 7.9 (2.4) | 2,963 | 12.4 (2.3) | 167 | 0.7 (0.3) |
| **Total**[c] | | **17,750,507** | **1,029,529** | **5.8 (0.2)** | **2,272,065** | **12.8 (0.3)** | **337,260** | **1.9 (0.1)** |
| **Expansion states**[c] | | **9,022,176** | **523,286** | **5.8 (0.3)** | **1,190,927** | **13.2 (0.5)** | **180,444** | **2.0 (0.2)** |
| **Non-expansion states**[c] | | **8,728,331** | **506,243** | **5.8 (0.3)** | **1,082,313** | **12.4 (0.5)** | **148,382** | **1.7 (0.2)** |

Source: Substance Abuse and Mental Health Services Administration (SAMHSA) analysis of data from the National Survey on Drug Use and Health for 2008 through 2013, and data from the American Community Survey for 2013. | GAO-15-449

Notes: The estimated number of low-income uninsured adults with a given type of behavioral health condition was calculated by multiplying the estimated total number of uninsured adults ages 18 to 64 with incomes at or below 138 percent of the federal poverty level by the estimated percentage of this population with a behavioral health condition. Numbers of uninsured adults were drawn from the U.S. Census Bureau's 2013 American Community Survey, and the percentages with behavioral health

conditions were drawn from SAMHSA's National Survey on Drug Use and Health for years 2008 to 2013.

[a]Not reported because percentage was estimated with low precision. However, totals include data for states that are not reported in this table.

[b]For the purposes of this report, we refer to the District of Columbia as a state.

[c]Totals include data for states that are not reported in this table. Numbers of low-income uninsured adults in expansion and non-expansion states with a given type of behavioral health condition may not sum to the total because the percentages used to calculate these numbers were rounded.

# Appendix II: State-Reported Information on Effects of Medicaid Expansion on State Behavioral Health Agency Budgets

| State | State-reported information |
|---|---|
| **Connecticut** | Connecticut officials reported that the budget for its state behavioral health agency (BHA) was reduced in fiscal years 2014 and 2015. However, amid concerns about the effects on providers, the BHA absorbed some of these reductions.<br>• In fiscal year 2014, the BHA's budget was reduced by $15.2 million, but the agency absorbed this reduction rather than decreasing the amount of grant funding for providers for the treatment of uninsured and underinsured individuals.<br>• In fiscal year 2015, there was a $25.5 million reduction in the BHA's budget. The BHA used a one-time $10 million appropriation from the Connecticut legislature plus other sources to limit the reduction in grant funding for providers to $5.4 million. |
| **Kentucky** | • Kentucky officials reported that the BHA's budget was reduced by $9 million in fiscal year 2014. However, one-time funds allowed the BHA to avoid reducing funding for its contracts with community mental health centers.<br>• In fiscal year 2015, there was a $21 million decrease in the BHA's budget, which was taken from contracts with community mental health centers. |
| **Maryland** | Maryland officials reported that the state has not reduced state general fund support for its BHA due to the expansion of Medicaid. |
| **Michigan** | Michigan officials reported that the state reduced the budget for its state BHA due to the Medicaid expansion, but then added some funds based on concerns about certain populations that remain ineligible for Medicaid.<br>• Michigan officials reported that state general revenue contributions to its BHA were reduced by $116 million from fiscal year 2013 to fiscal year 2015 (from $1.153 billion in fiscal year 2013 to $1.037 billion for fiscal year 2015).<br>• Michigan officials reported that their legislature had appropriated an additional $25 million for fiscal year 2015 to address the needs of individuals ineligible for Medicaid, such as individuals younger than 64 enrolled in Medicare based on a disability and commercially insured children. |
| **Nevada** | Nevada officials reported that the state reduced the budget for its BHA, but used one-time funds to ease the transition from state funding to Medicaid reimbursement for substance use providers in fiscal year 2014.<br>• Nevada officials reported a reduction of $33 million in the BHA's budget in fiscal years 2014 and 2015.<br>• Nevada officials said one-time funds totaling about $690,000 were used in fiscal year 2014 for substance use service providers to maintain services during the transition from state funding to Medicaid reimbursement. |

| State | State-reported information |
|---|---|
| **West Virginia** | • West Virginia officials reported that its charity care fund, which reimburses its network of comprehensive community behavioral health centers for the care of the uninsured, was funded at about $15.4 million per year in fiscal years 2013, 2014, and 2015.<br>• Officials said that the governor's fiscal year 2016 budget had recommended a $3 million reduction in the charity care fund due to Medicaid expansion. |

Source: GAO analysis of information from states. | GAO-15-449

Note: The term "fiscal year" refers to state fiscal year (as opposed to federal fiscal year). State fiscal years vary, but most run from July 1 to June 30.

# Appendix III: GAO Contact and Staff Acknowledgments

## GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

## Staff Acknowledgments

In addition to the contact named above, William Black, Assistant Director; Manuel Buentello; Hannah Locke; Drew Long; Hannah Marston Minter; and Emily Wilson made key contributions to this report.

# Appendix IV: Accessible Data

## Data Tables

**Accessible Data for Estimated Percentage of Low-Income, Uninsured Adults with Behavioral Health Conditions Based on 2008 to 2013 Data, Highest and Lowest Five States**

| State | Percentage of potentially newly eligible population with serious mental illness |
|---|---|
| New Jersey | 1.3 |
| Colorado | 2.8 |
| New York | 3.1 |
| North Carolina | 3.1 |
| Kansas | 3.3 |
| North Dakota | 10.5 |
| Ohio | 11.1 |
| Idaho | 11.3 |
| Wisconsin | 11.3 |
| Indiana | 13.0 |

| State | Percentage of potentially newly eligible population with substance use disorders |
|---|---|
| New Jersey | 5.9 |
| Delaware | 7.2 |
| Georgia | 9.4 |
| California | 9.7 |
| Colorado | 9.7 |
| North Dakota | 19.7 |
| Indiana | 19.9 |
| Ohio | 20.5 |
| Alaska | 21.9 |
| Rhode Island | 23.5 |

**Accessible Data for Figure 3: Estimated Percentage of Low-Income, Uninsured Adults with Behavioral Health Conditions Based on 2008 to 2013 Data, Highest and Lowest Five States**

| State | Percentage of potentially newly eligible population with serious mental illness |
|---|---|
| New Jersey | 1.3 |
| Colorado | 2.8 |
| New York | 3.1 |
| North Carolina | 3.1 |
| Kansas | 3.3 |
| North Dakota | 10.5 |
| Ohio | 11.1 |
| Idaho | 11.3 |
| Wisconsin | 11.3 |
| Indiana | 13.0 |

| State | Percentage of potentially newly eligible population with substance use disorders |
|---|---|
| New Jersey | 5.9 |
| Delaware | 7.2 |
| Georgia | 9.4 |
| California | 9.7 |
| Colorado | 9.7 |
| North Dakota | 19.7 |
| Indiana | 19.9 |
| Ohio | 20.5 |
| Alaska | 21.9 |
| Rhode Island | 23.5 |

## GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

## Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."

### Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

## Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube. Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts. Visit GAO on the web at www.gao.gov.

## To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

## Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

## Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548