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November 15, 2021

The Honorable Ron Wyden  
Chairman  
Committee on Finance  
U.S. Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Mike Crapo  
Ranking Member  
Committee on Finance  
U.S. Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

I am writing in response to your September 2021 request for input on opportunities to enhance behavioral health care in the areas of strengthening the workforce; increasing integration, coordination, and access; ensuring parity between behavioral health and physical health care; furthering the use of telehealth; and improving access to behavioral health care for children and young people. The Medicaid and CHIP Payment and Access Commission (MACPAC), a nonpartisan legislative branch agency charged with making recommendations and providing advice to Congress, the Secretary of Health and Human Services (HHS), and the states on policy affecting Medicaid and the State Children's Health Insurance Program (CHIP), appreciates this opportunity to share insights from our work over the last several years.

As the Committee on Finance considers policy options to improve access to behavioral health care, we urge you to address the needs of the adults and children enrolled in Medicaid and CHIP. In addition, we stress the need to address the barriers to care that result in disparities in access to care and behavioral health outcomes for Black, Hispanic, and Asian American beneficiaries, as well as people with disabilities and those living in rural areas.

Medicaid is the nation's largest payer for behavioral health services, but Medicaid beneficiaries with behavioral health conditions often struggle when accessing treatment. In 2018, 50 percent of adult Medicaid beneficiaries with serious mental illness reported that they needed but did not receive treatment (MACPAC 2021a). In 2018, just 36 percent of Black, 35 percent of Hispanic, and 27 percent of Asian American beneficiaries age 18–64 with past year mental illness received any mental health care compared to 52 percent of white beneficiaries (MACPAC 2021c). Moreover, in 2015, only about 32 percent of Medicaid beneficiaries with opioid use disorder (OUD) were receiving treatment (MACPAC 2017a). Children with Medicaid and CHIP coverage also face barriers accessing behavioral health services. In 2018, 54 percent of non-



institutionalized youth enrolled in Medicaid or CHIP who experience a major depressive episode (MDE) received mental health treatment (MACPAC 2021c). In addition, less than half (48 percent) of Black beneficiaries age 12–17 with a major MDE and severe role impairment received some form of specialty mental health treatment compared to 68 percent of their white peers (MACPAC 2021c).

The priorities raised in your letter affect all payers, including Medicaid and CHIP, and may require systemwide solutions. New policies should carefully consider the needs of Medicaid beneficiaries as well as the policy and programmatic features of Medicaid, many of which differ from other payers. MACPAC has a long track record of examining the factors affecting access to behavioral health care for Medicaid and CHIP beneficiaries. Since 2011, we have published numerous briefs and chapters in our reports to Congress with analytic and policy findings from our analyses of behavioral health in Medicaid and CHIP.

This letter summarizes key findings from MACPAC’s work, describes our ongoing behavioral health work, and notes pertinent recommendations in the issue areas identified in your letter. Specifically, MACPAC has made the following recommendations:

- **Related to privacy rules for patient records for substance use disorder (SUD)**
  - The Secretary of Health and Human Services should direct relevant agencies to issue joint subregulatory guidance that addresses Medicaid and CHIP provider and plan needs for clarification of key 42 CFR Part 2 provisions (MACPAC 2018b).
  - The Secretary should direct a coordinated effort by relevant agencies to provide education and technical assistance on 42 CFR Part 2. Such efforts should target state Medicaid and CHIP programs, health plans, primary care and specialty providers, patients and their families, and other relevant stakeholders (MACPAC 2018b).
- **Related to crisis services**
  - The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, and the Substance Abuse and Mental Health Services Administration, to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in crisis in real-time. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of crisis services (MACPAC 2021 a).
  - The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, and the Substance Abuse and Mental Health Services Administration, to issue joint subregulatory guidance that addresses how Medicaid and the State Children’s Health Insurance Program can be used to fund a crisis continuum for beneficiaries experiencing behavioral health crises (MACPAC 2021 a).
- **Related to access to behavioral health services for children and youth**
  - The Secretary of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services



- Administration, and the Administration for Children and Families to provide education and technical assistance to states on improving access to home and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and the State Children’s Health Insurance Program. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services (MACPAC 2021c).
- The Secretary of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to issue joint subregulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and the State Children’s Health Insurance Program (MACPAC 2021c).

## Strengthening the Workforce

One of the key tests of the effectiveness of a health care coverage program like Medicaid is whether providers are available to provide appropriate and high-quality health care services in a timely manner to Medicaid beneficiaries (MACPAC 2017b). Workforce challenges including the shortage and maldistribution of providers, lack of diversity, and unwillingness of some providers to serve individuals enrolled in Medicaid limit access to behavioral health services for Medicaid beneficiaries (MACPAC 2021a, MACPAC 2016). However, aside from provider payment rates, Medicaid policy levers to address workforce concerns are relatively limited. Thus, legislative options to address behavioral health workforce shortage and maldistribution should consider the needs of the Medicaid program.

### Provider shortages and maldistribution

Behavioral health provider shortages are persistent and have been well documented (Hoge et al. 2013; SAMHSA 2013, 2007). Shortages of providers such as psychologists, psychiatrists, and social workers are particularly pronounced in rural areas where residents also have difficulty gaining access to medical specialists (BPC 2020, KFF 2017, MACAPC 2021b).

Estimates of the behavioral health workforce vary based on provider type. The Health Resources and Services Administration (HRSA) estimates that by 2030, there will be a national shortage of psychiatrists and addiction counselors (BHW 2020a). In addition, as of June 2021, HRSA designated 5,834 mental health professional shortage areas (HPSAs), including 3,370 rural HPSAs, 1,986 non-rural HPSAs, and 478 partially rural HPSAs (BHW 2021b).<sup>1</sup> As of September 2021, an estimated 6,559 mental health practitioners are needed to remove all mental health HPSA designations (BHW 2021c).<sup>2</sup> Most states (47) do not meet even 50 percent of the estimated mental health need in these HPSAs, with a range of 4 percent in Missouri to 100 percent in Vermont (MACPAC 2021a, KFF 2019).<sup>3</sup>



The role of Medicaid in addressing workforce concerns, including for behavioral health, is relatively limited compared to that of the HRSA programs, which provide support for loan repayment, scholarship and training programs. While these programs certainly affect the workforce serving Medicaid beneficiaries, Medicaid's primary levers to influence workforce rests with states in the rates they pay to providers. In addition, some states, such as Massachusetts and New Hampshire, have incorporated relatively small workforce development and infrastructure initiatives into their Section 1115 Delivery System Reform Initiative Payment (DSRIP) demonstrations. In total, 12 states (Arizona, California, Kansas, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Texas, and Washington) have implemented DSRIPs or DSRIP-like programs (MACPAC 2020a). It is important to note that the Centers for Medicare & Medicaid Services (CMS) is no longer approving new DSRIP programs or renewing existing DSRIP programs when they expire. States wishing to continue workforce activities implemented as part of DSRIP would have to do so under different Medicaid authority (MACPAC 2020a).

Workforce development activities under DSRIPs are intended to prepare providers to work within new delivery and payment systems, as well as improve the adequacy of Medicaid provider supply. For example, the Massachusetts program provides loan repayment in exchange for service commitments for a range of behavioral health providers such as psychiatrists, psychologists, licensed behavioral health professionals, peer specialists, and recovery support professionals, as well as professional development grants to support the training and capacity of nonclinical professionals such as peer specialists and recovery coaches (CMS 2021a).<sup>4</sup> New Hampshire's DSRIP required participating regional provider groups to engage in behavioral health workforce development to increase community-based behavioral health service capacity (CMS 2016a).<sup>5</sup> For example, groups could use DSRIP funds to recruit, hire, train, and retain behavioral health and SUD professionals (CMS 2016a).<sup>6</sup> Final data on their effects are not yet available.

## Provider acceptance of Medicaid

Low rates of provider acceptance of Medicaid affect beneficiary access to office-based mental health services. A recent MACPAC study found that providers are less likely to accept new patients with Medicaid than patients with other forms of insurance. This is particularly the case for mental health providers. Just 35 percent of psychiatrists accepted new patients enrolled in Medicaid in 2014–2015, in contrast with 62 percent accepting new patients covered by Medicare and private insurance (Heberlein and Holgash 2019).

Low Medicaid participation may reflect low payment rates. One study using 2014 claims data from 11 states found that in 10 of these states, psychiatrists were paid less than primary care physicians (ranging from \$1–\$34) for an established patient office visit for individuals with moderate severity mental health needs (Mark et al. 2020).<sup>7</sup> In addition, in many states, Medicaid physician fees are well below rates paid by Medicare and private insurance (Zuckerman et al. 2021).

An effective Medicaid response to the opioid epidemic and other behavioral health needs requires a robust care delivery system. Just 62 percent of specialty SUD facilities reported accepting Medicaid in 2016, slightly lower than the acceptance rate for private insurance (68 percent).<sup>8</sup> SUD provider participation in Medicaid also varies greatly by state. For example, specialty SUD provider participation in Medicaid ranges



from 29 percent in California to 91 percent in Vermont. One study noted that 60 percent of U.S. counties have at least one outpatient SUD facility that accepts Medicaid, although this rate is lower in many southern and midwestern states. Counties with a higher percentage of Black, rural, or uninsured residents are less likely to have one of these facilities. About half of the specialty SUD treatment facilities that offer outpatient treatment participate in Medicaid, but providers of more intensive services are much less likely to be available to Medicaid beneficiaries (MACPAC 2018a).

Lower Medicaid participation rates among specialty SUD treatment providers may also reflect barriers other than payment. For example, different credentialing requirements across Medicaid managed care organizations (MCOs) may be burdensome, affecting provider participation. To address these concerns, some states, such as Virginia, have instituted uniform credentialing requirements across all MCOs. In addition, many SUD treatment providers do not hold the medical licenses required by some payers and traditionally, many of these providers have not contracted with insurers. For example, in 2012, 54 percent of direct care staff (e.g., peer specialists) were licensed (ASPE 2015). A 2012 survey also found that many specialty SUD treatment providers did not have adequate information technology systems needed to bill insurers, which posed a challenge to providing care to individuals newly covered under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (MACPAC 2018a, ASPE 2015).

## Integration, Coordination, and Access

Addressing integration, coordination, and access to behavioral health services are of particular importance in Medicaid given that adult beneficiaries suffer from higher rates of SUD and mental health conditions compared to their privately insured counterparts. They also experience other chronic conditions at higher rates (MACPAC 2021a, MACPAC 2018b). Many individuals with behavioral health conditions experience poor health outcomes (Miller 2012, Druss et al. 2011). For example, people with behavioral health conditions, especially those with serious mental illness, have a lower life expectancy than the general population (Roberts et al. 2017).

MACPAC has expressed concern that mental health and SUD treatment for Medicaid beneficiaries is not well coordinated with physical health care because of siloed and fragmented delivery systems (MACPAC 2021d, 2019a, 2018a, 2017, 2016). In addition, SUD treatment is generally not coordinated or integrated with mental health services or the treatment of other physical health conditions (MACPAC 2018a).

Limited or inefficient coordination and minimal data sharing affects the provision of effective treatments and may even cause patient harm (MACPAC 2021d, Roberts et al. 2017, MACPAC 2016). We have also pointed to concerns that federal SUD confidentiality regulations under 42 CFR Part 2 (referred to as Part 2) are meant to ensure patient privacy but have the unintended consequence of creating barriers to sharing SUD treatment information among providers (MACPAC 2018b).



## Integrating clinical care through health information technology

MACPAC is currently focused on how greater use of health information technology could improve clinical integration of physical and behavioral health, resulting in improved outcomes for patients. Electronic health records (EHRs) can foster integration by allowing providers to update, retrieve and electronically transfer patient information easily, share data, coordinate care, and make appropriate referrals (MACPAC 2021d, Falconer et al. 2018).

Adopting certified electronic health record technology (CEHRT) could facilitate better integrated care for beneficiaries and improve communication between physical and behavioral health providers.<sup>9</sup> But the latter were left out of large-scale federal efforts to promote clinical data sharing under the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act, Title XIII of P.L. 111-5) (ASPE 2013). As such, many behavioral health providers have been unable to invest in the technology and training necessary for EHR adoption, and instead continue to rely on phone, paper, or fax, relatively ineffective strategies for sharing information with other providers (MACPAC 2018b, Wolf et al. 2012). MACPAC analysis shows that in 2017–2018, among facilities accepting Medicaid, just 13 percent of mental health facilities and 8.5 percent of SUD treatment facilities electronically shared patient data with physical health providers compared to 82.4 percent of federally owned mental health facilities and 55.7 percent of federally owned substance use treatment facilities. Federally owned facilities are predominantly operated by the U.S. Department of Veterans Affairs and the U.S. Department of Defense, and have benefited from federal efforts to support EHR adoption (MACPAC 2021d).

Barriers to adoption of CEHRT by behavioral health providers include the cost of purchasing and installing the required technology and training staff; outdated EHR systems that do not comply with federal privacy rules under 42 CFR Part 2; and lack of guidance on which EHRs to purchase and how to incorporate EHRs into office workflows (MACPAC 2021d).

In the coming months, the Commission will examine potential solutions to address low rates of CEHRT adoption among behavioral health providers, including for example:

- incorporating Part 2 privacy requirements into EHR certification criteria;
- the role of enhanced federal financial participation for health IT;
- testing behavioral health EHR incentive payments via the Centers for Medicare and Medicaid Innovation; and
- whether states can use Section 1115 demonstration authority to make behavioral health IT improvements.

## Alignment of federal privacy rules

The federal privacy rules under 42 CFR Part 2, which govern the confidentiality of SUD patient records, can be a barrier to integrating physical and behavioral health services for Medicaid and CHIP enrollees with





SUDs. These regulations were first promulgated in 1975 and implement statutory requirements intended to encourage individuals to seek treatment for SUDs by addressing stigma and concerns that those receiving treatment could be subject to negative consequences.

Part 2 requirements are generally stricter than those under the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), and hinder the exchange of information among the providers who treat individuals with SUDs and the payers who finance that care. Under Part 2, SUD treatment information is subject to additional requirements that affect information sharing among providers. Part 2 does not allow providers to disclose or redisclose protected SUD treatment information for treatment purposes, including for care coordination and case management, without patient consent.<sup>10</sup> HIPAA governs use and disclosure of individually identifiable health information (i.e., information related to all health conditions, health care services, and payment). HIPAA generally allows information to be shared without patient consent among providers and payers for payment, treatment, and health care operations purposes. Some stakeholders view Part 2 rules as overly restrictive, confusing, and challenging to implement, and that they inadvertently can limit sharing of important patient information among providers and plans (SAMHSA 2018, Partnership 2017, McCarty et al. 2016, NAMD 2016).

MACPAC previously noted that lack of clarity about Part 2 impedes the ability of providers to share important treatment information. As noted above, in 2018, MACPAC recommended that the Secretary of HHS direct relevant agencies to issue joint subregulatory guidance to address Medicaid and CHIP provider and plan needs for clarification of key 42 CFR Part 2 provisions. The Commission also recommended that the Secretary direct a coordinated effort by relevant agencies to provide education and technical assistance on 42 CFR Part 2. Such efforts should target state Medicaid and CHIP programs, health plans, primary care and specialty providers, patients and their families, and other relevant stakeholders (MACPAC 2018b).

Differences in federal privacy rules also create challenges in the use of EHRs by behavioral health providers. SUD providers need to interact with other physical health providers, but EHR systems may be unable to segment Part 2 protected SUD treatment information from the rest of the patient's health record.<sup>11</sup> Most physical health providers have access to CEHRT. However, CEHRT standards were designed to comply with HIPAA, and as discussed there are no federal requirements that CEHRT include Part 2 privacy functionalities. There is also disagreement within the behavioral health community as to whether, and to what degree, widespread Part 2-compliant interoperability is even technically feasible (MACPAC 2021d).<sup>12</sup>

Recent changes in federal privacy laws may make it easier for providers to share this information. For example, Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) aligned the statutory basis for Part 2 more closely with HIPAA (MACPAC 2021d).<sup>13</sup> Even so, regardless of the provisions of the CARES Act, CEHRT requirements will need to include segmentation capabilities because an individual can still request restrictions on the use of their SUD treatment records.<sup>14</sup>



The CARES Act requires the Secretary to update federal regulations to align with statutory changes to SUD confidentiality standards, but HHS has not done so (MACPAC 2021d). We note, there is no timeline associated with this provision requiring the rulemaking. These rules, as well as any related subregulatory guidance and technical assistance, will be important for states, plans, and providers as they work to implement new and existing privacy provisions.

## Access to care

MACPAC has expressed the need to address gaps in the continuum of behavioral health services, in particular for SUD. State Medicaid and CHIP programs and the MCOs under contract to them are not required to offer a full continuum of mental health or SUD services for adults. In 2018, only 12 states offered the full continuum of care, that is, each of the nine American Society of Addiction Medicine (ASAM) levels of care.<sup>15</sup> The largest gaps in state clinical service coverage are for partial hospitalization and residential treatment (MACPAC 2021f, 2018a). In 2020, we found that most states covered just 12 out of 15 mental health services on average.<sup>16</sup> All states cover mental health screening and assessment services, some form of outpatient mental health treatment, and inpatient psychiatric care. The largest gaps in coverage exist for supported employment (covered by 25 states), residential services (covered by 28 states), and crisis residential services (covered by 29 states) (MACPAC 2021f).

States can comprehensively improve access to clinically appropriate SUD care under Section 1115 demonstration authority, but not all states have taken advantage of this opportunity or other Medicaid authorities to reduce gaps in the continuum of care. As evaluation results from Section 1115 SUD demonstrations are made available, lessons learned from states may provide insight to states that have yet to expand their SUD Medicaid benefit (MACPAC 2018a).

**Institutions for mental diseases.** The IMD exclusion has been cited as a contributing factor to gaps in coverage for residential SUD treatment because it can sometimes prevent individuals from accessing residential treatment services even if their treatment plan indicates that it is the most appropriate setting for care (MACPAC 2018a, 2017a). Since its inception in 1965, Medicaid has largely prohibited Medicaid payments for services provided to beneficiaries in institutions for mental diseases (IMDs) to assure that states, rather than the federal government, are responsible for funding inpatient psychiatric services.<sup>17</sup> The exclusion encompasses several different types of facilities, including inpatient SUD and mental health treatment facilities, as well as residential SUD and mental health programs (MACPAC 2020b).

Despite the statutory exclusion, nearly all states are making payments for services provided in IMD settings via various exemptions and authorities, including: statutory exemptions related to older adults and children and youth; demonstration waivers under Section 1115; a state plan option; and managed care arrangements under certain conditions.<sup>18</sup> Our examination of IMDs in seven states found great variation in the mental health and SUD services provided, but because of the many different types of IMDs, it is difficult to identify and draw conclusions about IMDs as a group (MACPAC 2020b).<sup>19</sup>





**Crisis services.** Some states do not pay for the full continuum of crisis services described in the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for behavioral health crisis care. Most state Medicaid programs cover some forms of crisis services (e.g., hotline services, mobile crisis care, and crisis receiving and stabilization centers) (MACPAC 2021a). Crisis services are important for resolving crises so more intensive services, such as psychiatric hospital services, are not needed (MACPAC 2021a). Providing crisis services may also help to decrease boarding in emergency departments and reduce the need for law enforcement to respond to behavioral health crises.

MACPAC has noted that current federal guidance does not fully address how Medicaid can be used to support a crisis continuum (MACPAC 2021a). The absence of a full continuum, including a sufficient number of psychiatric beds and real-time access to community-based care, has serious consequences for beneficiaries. It has resulted in the criminalization of mental illness, as law enforcement is often first to respond when individuals experience a mental health crisis. As a result, a disproportionate share of individuals with mental illness, including Medicaid beneficiaries, wind up in jail or prison (MACPAC 2021a).

In June 2021, the Commission recommended that the Secretary of HHS (1) direct CMS and SAMHSA to issue joint subregulatory guidance that addresses how Medicaid and the CHIP can be used to fund a crisis continuum for beneficiaries experiencing behavioral health crises, and (2) direct a coordinated effort by the CMS and SAMHSA to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in crisis in real time. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of crisis services (MACPAC 2021a).

**SUD services.** Congress has taken a number of steps to address concerns about limited access to SUD treatment. First, the Comprehensive Addiction and Recovery Act of 2016 (CARA, P.L. 114-198) expanded prescribing authority for buprenorphine to nurse practitioners and physician assistants. This action helped expand access to buprenorphine for Medicaid beneficiaries. In 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act (SUPPORT Act, P.L. 115-271) temporarily expanded behavioral health benefits related to SUD, requiring states to cover medication used to treat OUD (MOUD).<sup>20</sup> The SUPPORT Act also expanded the list of eligible practitioners to include clinical nurse specialists, certified nurse-midwives, and certified registered nurse anesthetists, allowing them to prescribe through October 2023. However, few practitioners have obtained a waiver to prescribe buprenorphine under the SUPPORT Act provision (MACPAC 2020c).

The Biden Administration has removed certain barriers to buprenorphine prescribing. Current law allows the Secretary of HHS, in consultation with the U.S. Drug Enforcement Administration (DEA), SAMHSA, National Institute on Drug Abuse, and the Food & Drug Administration, to create exemptions from certification requirements by issuing practice guidelines. In April 2021, the Administration issued *Practice guidelines for the administration of buprenorphine for treating opioid use disorder*, which took immediate effect (HHS 2021a). Under certain conditions, physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, and certified nurse midwives may be exempted from current



buprenorphine prescribing requirements. Specifically, this exemption allows prescribers to treat up to 30 patients with OUD with buprenorphine without obtaining a federal waiver. Prescribers wishing to treat more than 30 patients at any given time still must obtain a waiver (HHS 2021a).

**Opioid treatment program services.** Prior to the current public health emergency (PHE), access to treatment for individuals with OUD was limited in part due to federal rules that tightly regulate the supply of take-home doses of MOUD.<sup>21</sup> Specifically, many patients receiving methadone had to travel daily to an opioid treatment program (OTP), which dispense and administer methadone and buprenorphine to treat OUD, sometimes having to wait in line to receive their daily medication (Trad, Wen, and Saloner 2020).<sup>22</sup>

In response to the COVID-19 pandemic, federal and state policymakers acted to ensure that individuals could initiate treatment with MOUD, and for those in recovery, continue treatment as discontinuation can lead to relapse, overdose, and death (ASAM 2020). On March 16, 2020, SAMHSA issued guidance allowing all states to request blanket exceptions to take home dose limits for all stable patients currently participating in OTPs. Generally, take-home doses are limited to a single dose for a day that the clinic is closed for business (e.g., state and federal holidays, Sundays). Under the blanket waivers, during the PHE, additional take-home doses may be provided based on how long an individual has been in treatment.<sup>23</sup>

These flexibilities are in place through the end of the PHE. Considerations for future policies for OTP and access to OUD treatment include:

- whether SAMHSA and the DEA should modify requirements related to limits on take-home doses, and which individuals can qualify for take home doses;<sup>24</sup>
- how to weigh the convenience of take-home doses against the concern about potential misuse of medications or diversion;
- how to ensure that patients receiving take-home dosages can obtain counseling through telehealth or other means;
- how to pay for take-home doses and the financial implications for the state and OTPs;<sup>25</sup>
- whether to make other changes to improve access to methadone, such as expanding the settings that methadone for the treatment of OUD may be prescribed and dispensed in; and<sup>26</sup>
- whether prescribing flexibilities put in place in response to the COVID-19 pandemic should be extended beyond the PHE or made permanent.

**Coverage and services for adults involved in the criminal justice system.** Given the physical and behavioral health needs of Medicaid eligible and enrolled individuals involved in the criminal justice system, and racial and ethnic disparities in receipt of treatment, it will be important to address the coverage and access concerns for this population. Medicaid is the payer of health care services for eligible and enrolled individuals who are under community supervision, such as parole and probation, while correctional institutions, including federal and state prisons and local jails, must pay for health care costs while individuals are confined to their facilities. More than half (54 percent) of adults under community supervision were either enrolled in Medicaid or lacked health insurance (MACPAC 2021e). We found that:



- Relative to their privately insured peers, Medicaid beneficiaries under community supervision were more likely to be Black or Hispanic, and female.
- With few exceptions, Medicaid beneficiaries under community supervision reported higher rates of behavioral health conditions than their privately insured or uninsured peers. They also reported receiving mental health or SUD treatment at higher rates. However, Black beneficiaries with behavioral health conditions reported receipt of treatment at lower rates than their white peers (MACPAC 2021e).
- Generally, beneficiaries under community supervision report higher rates of drug dependence or abuse than their privately insured peers, as well as their peers without insurance. They are also more likely to report experiencing co-occurring mental health and SUD.

Many state Medicaid programs are collaborating with correctional agencies on reentry programs. Key services of reentry programs include Medicaid enrollment assistance and care coordination to ensure that individuals released from jail or prison have access to needed prescription drugs (MACPAC 2021e). MACPAC has work underway to examine the behavioral health care needs and treatment rates of Medicaid-eligible individuals leaving jail or prison, and state approaches for reinstating Medicaid benefits and coordinating care upon reentry. We anticipate findings from this work in 2022.

## Mental Health Parity

MACPAC's examination of implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343) found that this law does not appear to have substantially improved access to behavioral health care for Medicaid and CHIP beneficiaries. Reasons for this include the MHPAEA's focus and the complexity of implementation.

The focus of MHPAEA is reducing inequities in coverage between behavioral and physical health services, requiring that if states cover physical health services in any classification (e.g., outpatient, inpatient), then some type of behavioral health benefit must be covered in every classification in which medical surgical benefits are covered (MACPAC 2021f). But it does not require states or MCOs to document and facilitate access to behavioral health services, instead focusing on discrete barriers that may limit access to care (e.g., prior authorization, step therapy). Parity analyses conducted to assess compliance with MHPAEA have resulted in only modest changes (e.g., changing the type of quantitative limits used) rather than large-scale changes to benefits (MACPAC 2021f).

In addition, MHPAEA does not require coverage of behavioral health services (MACPAC 2021f, CRS 2011). As noted above, most state Medicaid programs have gaps in their coverage of SUD and mental health services. MHPAEA also does not address historically low payment rates for behavioral health services. CMS does not necessarily consider a disparity in payment rates to be out of compliance with parity requirements. States and MCOs may set payment rates for behavioral health services lower than medical and surgical services if the factors used to develop such rates (e.g., demand for services, Medicare payment rates, and experience and licensure of providers) are comparable (MACPAC 2021f, CMS 2016).



## Expanding Telehealth

Telehealth has played a prominent role in state Medicaid program responses to the COVID-19 pandemic, including maintaining access to behavioral health services. Although many states had previously covered telehealth for these services, some expanded coverage to include additional services, modalities, and providers. An analysis conducted for MACPAC of state Medicaid telehealth policies changes in early 2020 found that 47 states and territories covered some behavioral health services via telehealth prior to the pandemic and that by May 2020, 5 additional states and territories permitted such coverage. In addition, 41 states and territories allowed some behavioral health providers to deliver services via telehealth before the pandemic and by May 2020, 9 additional states and territories began allowing behavioral health providers to use telehealth. Notably, prior to the pandemic, just 9 states covered telephonic telehealth but this grew to 44 additional states and territories by May 2020.<sup>27</sup> In addition, some states made federally qualified health centers (FQHCs) eligible to provide Medicaid-covered services using telehealth, including some states that began allowing FQHCs to be distant site providers (Libersky et al. 2020, CCHP 2021). Many states are now examining telehealth policies to make decisions about post-pandemic policies.

MACPAC has noted that in addition to the substantial state flexibility within Medicaid to cover services provided using telehealth, other non-Medicaid specific flexibilities have been important to state efforts to maintain access to SUD during the pandemic (Jee et al. 2020, Jee 2020). This includes federal flexibilities related to prescribing of controlled substances over telehealth. For example, early in the pandemic, the DEA invoked flexibility under the Ryan Haight Act Online Pharmacy Consumer Protection Act of 2008 (Ryan Haight Act, P.L. 110-425) to permit prescribing of controlled substances via telehealth without requiring that an in-person visit occur first. As a result, DEA-registered practitioners can prescribe controlled substances, including buprenorphine without an in-person medical evaluation as long as a two-way audio-visual telehealth visit has occurred. In addition, the SAMHSA issued guidance allowing OTPs to prescribe buprenorphine to new patients via telehealth, including audio-only telehealth.

Prior to the PHE, Congress, through the Ryan Haight Act and again in the SUPPORT Act (P.L. 115-271) directed the DEA to establish a permanent pathway via special registration process that would broadly permit providers to prescribe certain controlled substances via telehealth. The SUPPORT Act directed the DEA to issue regulations to implement a special registration process by October 24, 2019, which would facilitate a permanent pathway to prescribe controlled substances via telehealth. As of today, DEA has not yet issued a proposed rule to address this provision.

Ensuring equitable access to behavioral health services for Medicaid beneficiaries via telehealth will require addressing barriers to technology for both beneficiaries and providers as well as improving the reach of reliable broadband (MACPAC 2021g). For example, telehealth has the potential to improve access to behavioral health services in rural areas where nearly a quarter of residents under age 65 are covered by Medicaid and where there may be few behavioral health providers (MACPAC 2021b). But, in 2019, only about 63 percent of adults in rural areas had access to home broadband services, and only one-half to one third had a tablet, computer, or smartphone (MACPAC 2021g, Perrin 2019). In addition, 29 percent of



individuals with low income reported not having a smartphone, 44 percent reported not having home broadband, and 46 percent did not have a computer (Anderson and Kumar 2020).

While solutions to these concerns extend beyond Medicaid, state Medicaid programs could help to inform providers and beneficiaries about resources to address certain technological barriers. For example, the Federal Communications Commission administers the Lifeline Program, which provides eligible, low-income individuals with discounted telecommunications and broadband services, and the Rural Health Care Program, which provides funding assistance to eligible rural providers (FCC 2020a, 2020b).

MACPAC has commented on the need for research to understand how telehealth is affecting Medicaid utilization, cost, and quality of services, including for behavioral health (MACPAC 2021h, Jee 2020, Jee et al. 2020, MACPAC 2018c). While the evidence base has grown since we commented on this in our March 2018 report to Congress, information and data gaps remain (MACPAC 2021g). While national data for 2020, when coverage and use of telehealth greatly expanded, are not yet available due to usual data lags, it is notable that early and preliminary data from CMS indicate that use of telehealth for outpatient mental health services for adults and children increased substantially during the pandemic, peaking in April 2020, but did not fully offset the decline in in-person outpatient visits (CMS 2021b, 2021c). MACPAC plans to assess the availability and quality of administrative data on telehealth in the Transformed Medicaid Statistical Information System (T-MSIS) in the coming months. MACPAC also recently began examining state use of telehealth for providing behavioral health services and state approaches for payment for telehealth. We expect findings from this work in spring 2022.

Finally, states pursuing telehealth strategies for behavioral health services would benefit from technical assistance from CMS and structured opportunities to share information with other states on policy design and overcoming barriers (MACPAC 2021g). CMS could build upon its existing infrastructure to facilitate this information sharing. For example, CMS could add to its Medicaid telehealth toolkit, which the agency created and has updated in response to the COVID-19 pandemic. The toolkit, which currently highlights policy considerations for states in implementing broad telehealth expansions including statutory and regulatory changes that may be needed, could be adapted to address SUD-related factors. CMS also could facilitate state-to-state learning through its existing Medicaid and CHIP Learning Collaborative structure. States may be able to draw upon their several months of experience providing expanded coverage for tele-behavioral health services during the COVID-19 pandemic to identify approaches that have worked, as well as challenges they experienced.

## Improving Access for Children and Young People

Behavioral health disorders usually begin in childhood or adolescence and can have long-term implications for an individual's physical and mental health (WHO 2020, CMS 2018, Kessler et al. 2005). In 2018, approximately one in five non-institutionalized youth age 12–17 had experienced an MDE in their lifetime and roughly 4 percent had an SUD in the past year (SHADAC 2020). In 2018, non-institutionalized Black and Hispanic youth age 12–17 were more likely to have had a lifetime MDE (12.3 percent and 18.9 percent,



respectively) compared to their white peers (24.2 percent) (MACPAC 2021c). Having SUD increases the risk of mental health disorders and vice versa, and the majority of youth with SUD have a co-occurring mental health disorder (CMS and SAMHSA 2015).

## Access to care

Despite federal requirements to ensure access to behavioral health services for children and youth with Medicaid and CHIP, their needs often go unmet (MACPAC 2021c, 2018d).<sup>28</sup> Experts have noted that while access to behavioral health services is a challenge across the lifespan, young people often face additional barriers to care, including a shortage of behavioral health providers offering tailored programming for youth willing to provide services to Medicaid and CHIP beneficiaries (Tsai 2020). In 2018, only about half of non-institutionalized youth enrolled in Medicaid or CHIP who experienced an MDE in the past year received some form of mental health treatment, and only 6 percent of adolescent beneficiaries with SUD received treatment. Adolescent beneficiaries were also more likely than their privately insured peers to receive mental health treatment in a hospital or a residential facility (SHADAC 2020). In 2018, among all youth covered by Medicaid or CHIP, Black, Hispanic, American Indian or Alaska Native, and Native Hawaiian or other Pacific Islander youth were less likely to receive any form of mental health services than their white counterparts (MACPAC 2021c). Generally, among Medicaid and CHIP beneficiaries with MDE, treatment rates were similar across racial and ethnic groups (MACPAC 2021c).

Behavioral health services for children and youth may be delivered in a variety of settings, such as schools, offices, and specialty treatment facilities. Schools provide education and related services, including behavioral health services, to support a child's ability to learn and ensure that a child with disabilities receives a free and appropriate public education. Such services may be provided by school-based personnel or community providers offering outpatient services in a school setting. MACPAC found that in 2018, all youth and youth with MDE covered by Medicaid or CHIP were more likely to report receiving mental health services from education sources than those with private coverage or uninsured. All youth with Medicaid or CHIP coverage were also more likely to receive specialty treatment in a school or attend a school program for emotional problems than their privately insured and uninsured peers (MACPAC 2021c).

Many different types of providers, including social workers, psychologists, psychiatric nurse practitioners, psychiatrists, and professional counselors deliver office-based behavioral health services to children and adolescents. However, there is no data source that captures the availability of all of these providers or their willingness to participate in Medicaid. Specialty mental health treatment facilities provide services ranging from outpatient mental health services, to partial hospitalization, to inpatient psychiatric services. In 2018, there were nearly 12,000 specialty mental health treatment facilities in the United States, but many did not accept children or youth or offer tailored programming for adolescents with serious emotional disturbance. Only one-third (32 percent) of these facilities offered such programming and participated in Medicaid (MACPAC 2021c).

Unmet need for behavioral health services among children and adolescents has been exacerbated by the COVID-19 pandemic. Families have been under increased stress, and for many months, school closings





and social distancing measures contributed to social isolation and limited access to services (Brown et al. 2020, Hoffman and Miller 2020). Preliminary data show a 32 percent drop in mental health services among children covered by Medicaid and CHIP from March 2020 to February 2021 compared to the same period in the prior year (CMS 2021 c). Meanwhile, the proportion of mental health-related emergency department visits among children has increased by 24 percent among children age 5–11 and 31 percent among youth age 12–17 from March to October 2020 (Leeb et al. 2020).

Our analysis found that no single federal or state agency is responsible for addressing the needs of children and adolescents with significant mental health conditions (MACPAC 2021c). Thus, designing and implementing Medicaid behavioral health benefits for children and youth requires collaboration with multiple partners, which can be complex and time consuming. For example, CMS, SAMHSA, and the Administration for Children and Families play important roles at the federal level, as do behavioral health, child welfare, and juvenile justice agencies at the state level (MACPAC 2021c, Herman 2020).

## Home- and community-based services

States have faced obstacles in bringing together the various agencies—behavioral health, child welfare, juvenile justice, and others—that play a role in addressing the home and community-based behavioral needs of children in Medicaid and CHIP (Herman 2020). MACPAC’s recent work examining access to behavioral health services for children and youth with Medicaid and CHIP coverage found a lack of available home and community-based behavioral health services for this population (Herman 2020, O’Brien 2020). These services have been shown to improve clinical and functional outcomes, prevent out-of-home placements, and reduce involvement with child welfare and the juvenile justice system (McEnany et al. 2020, O’Brien 2020, MHA 2015, Lee et al. 2014). States generally have the legal authorities needed to design home- and community-based behavioral health benefits for children and adolescents with significant mental health conditions but they often lack the awareness and ability to use the authorities effectively (O’Brien 2020). As noted earlier, in June 2021, MACPAC made recommendations to improve access to these services by issuing federal guidance and providing technical assistance to states on the design and implementation of behavioral health benefits for children and youth with Medicaid and CHIP coverage (MACPAC 2021c).

## Children and youth with juvenile justice involvement

Medicaid and CHIP cover 60.4 percent of children or youth age 12–17 who had stayed overnight in jail or juvenile detention (MACPAC 2021i).<sup>29</sup> Approximately two-thirds of justice-involved youth have a diagnosable mental health or SUD. Even so, fewer than half of juvenile detention facilities provide mental health evaluations to all youth. About half of youth in custody (53 percent) say they have personally met with a counselor at their current facility (MACPAC 2018e). Our recent analysis found that:

- Roughly one-in-five (21.7 percent) youth who stayed in jail or juvenile detention reported experiencing an MDE at some point in their lifetime, and approximately 16.4 percent reported experiencing one in the past year.



- Among Medicaid beneficiaries who stayed in jail or juvenile detention, females were nearly three times as likely to experience a MDE in the past year (25.9 percent) compared to their male peers (9.0 percent). They also reported receipt of specialty mental health treatment at higher rates.
- Few Medicaid beneficiaries (35.3 percent) report receipt of mental health treatment while in jail or juvenile detention. However, two out of three who stayed overnight in jail or juvenile detention received some form of mental health treatment in the past year.
- Roughly one in five beneficiaries (22.0 percent) who stayed in jail or juvenile detention had an SUD in the past 12 months but only 16.9 percent received treatment in the past year (MACPAC 2021i).

## Children and youth in the child welfare system

Medicaid and CHIP cover 63.5 percent of non-institutionalized children and youth age 12–17 in foster care (MACPAC 2021j).<sup>30</sup> Relative to their peers in the general population, children and youth in foster care are more likely to experience behavioral health conditions (MACPAC 2021i). Our recent analyses found that:

- More than a quarter of these youth reported experiencing a MDE at some point in their lifetime and nearly one in five reported having an SUD in the past year.
- Access to non-specialty mental health treatment was high (100 percent) and Medicaid and CHIP beneficiaries generally received mental health services at similar rates as their peers with private coverage.
- There were no significant differences in access to mental health treatment among Medicaid and CHIP beneficiaries when examining rates by sex or race and ethnicity, though our analysis is limited due to the small sample size.
- The majority of all youth who stayed overnight in foster care, including youth covered by Medicaid or CHIP, reported being able to access SUD treatment when needed (MACPAC 2021j).

We hope this information and findings from MACPAC's work examining access to behavioral health services is helpful as you develop a legislative package to address behavioral health challenges. If you have questions about the information in this letter, please reach out to Joanne Jee ([joanne.jee@macpac.gov](mailto:joanne.jee@macpac.gov)) or Anne Schwartz ([anne.schwartz@macpac.gov](mailto:anne.schwartz@macpac.gov)).

Sincerely,



Melanie Bella



## Endnotes

<sup>1</sup> HRSA designates HPSAs, which include geographic areas, populations, and facilities with an inadequate supply of primary care, dental, and mental health providers and services. Geographic HPSAs have a shortage of services for the entire population within an established geographic area. Population HPSAs have a shortage of services for a specific population subset (e.g., low-income individuals) within an established geographic area. Facility HPSAs include facilities experiencing workforce shortages, such as in state mental hospitals, correctional facilities, and other facilities (BHW 2021a). These designations are not specific to Medicaid. To be considered a provider shortage area for mental health, the population-to-provider ratio must be at least 30,000 to 1, or 20,000 to 1 for certain high-need communities.

<sup>2</sup> Most of these designations are facility HPSAs, while fewer are geographic or population HPSAs (HRSA 2020a).

<sup>3</sup> The percentage of met need was calculated by dividing the number of psychiatrists available to serve an area, group, or facility, by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (KFF 2019).

<sup>4</sup> Preliminary data from Massachusetts indicates high demand for loan repayment from behavioral health providers and robust participation in training programs from peer specialists (PCG 2020). In addition, 94 percent of primary care and behavioral health providers receiving loan repayment awards in 2018 and 2019, and 98 percent of masters-prepared behavioral health providers receiving such awards in 2018, remained employed in community-based settings (MassHealth 2021a). Massachusetts's DSRIP will end in 2022, the state is seeking approval to implement two new student loan repayment programs for behavioral health under its demonstration renewal (MassHealth 2021b).

<sup>5</sup> Specific activities included supporting education, recruitment, and training of a professional, allied health, and peer workforce to provide and coordinate the full continuum of behavioral health services. The provider groups were responsible for developing and implementing their own strategy to address workforce gaps. The strategy was based on a framework established by a statewide behavioral health workforce capacity taskforce (CMS 2016a).

<sup>6</sup> This work occurred from August 2016 through December 2018. While preliminary evaluation findings indicate that the DSRIP helped enhance the behavioral health workforce, provider shortages persist, resulting in fewer treatment options and locations, and long wait times for services. In addition, providers noted ongoing difficulty finding providers to whom they could refer patients with more complex psychiatric needs and co-occurring SUD and behavioral health conditions (CMS 2020a). Strategies such as easing licensing rules made a measurable impact on recruitment and retention of providers.

<sup>7</sup> This analysis only reflects non-facility claims.

<sup>8</sup> This analysis is based on the SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS) survey data.

<sup>9</sup> CMS and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data that EHRs must meet in order to qualify for use in the Promoting Interoperability program, formerly known as Meaningful Use or the Medicare and Medicaid EHR Incentive Program. Structured data allows health care providers to retrieve and transfer patient information easily. EHR technology that meets these requirements is known as certified EHR technology (CEHRT). CEHRT is a specific classification of EHR that has been certified to support certain security and clinical functions such as prescribing, ordering and receiving laboratory and diagnostic imaging results, and making transition plans for care. CEHRT gives assurances to purchasers and others that an EHR system or module offers the necessary technological capability, functionality, and security to help meet the meaningful-use criteria outlined within



the Promoting Interoperability program. Certification can also give providers and patients confidence that the electronic health information technology (IT) is secure, can maintain data confidentially, and can work with other systems to share information (MACPAC 2021d).

<sup>10</sup> Among other things, the statute requires the patient to consent in writing to the disclosure or redisclosure any identifiable information related to their SUD treatment (42 USC 290dd-2). When patients are unable or unwilling to authorize Part 2 providers to disclose SUD treatment information, inadequate or even dangerous care, such as prescribing medications with dangerous or deadly interactions, may occur (MACPAC 2021d).

<sup>11</sup> CEHRT segmentation capabilities enable appropriate controls to share information in accordance with state and federal law (ONC 2015). Data segmentation includes capabilities to tag health care data and allow certain documents, messages, or individual data elements to be marked as sensitive, without restricting access to the entire EHR. This is typically not automated, but it serves as an important technological step to protect patient privacy.

<sup>12</sup> For example, ONC and SAMHSA have developed the Data Segmentation for Privacy (DS4P) standard and the Consent2Share software application to manage patient consent preferences and share Part 2-protected information electronically through EHRs and health information exchanges (HIE). The Health Information Technology Standards Committee advising ONC called into question the maturity of the DS4P standard, suggesting that additional testing and refinements are needed (MACPAC 2018).

<sup>13</sup> Among other things, it requires providers to obtain general consent for disclosure of SUD treatment records and allows disclosure of SUD information for treatment, payment, and health care operations. However, providers subject to Part 2 must still obtain consent to disclose information, and information may be shared only with other Part 2 regulated providers and HIPAA-covered entities and business associates. The CARES Act also allows recipients of Part 2-protected information to make redisclosures in accordance with HIPAA. Individuals have the right to request a restriction on the use of SUD records for treatment, payment, and health care operations, and covered entities are required to make every reasonable effort to comply with a patient's request (MACPAC 2021d).

<sup>14</sup> Moreover, in addition to being subject to HIPAA, certain other sensitive health data (e.g., related to HIV/AIDS, mental health, reproductive health, and domestic violence) may also be subject to state laws mandating heightened protections for disclosure or redisclosure.

<sup>15</sup> In 2018, MACPAC found that most states had gaps in their SUD coverage, covering six out of nine levels of care described by ASAM. Nearly half of states (24) provided four to seven levels of care (MACPAC 2021f, MACPAC 2018a).

<sup>16</sup> These 12 services include: case management or care coordination; mental health screening and assessment services; outpatient mental health care; partial hospitalization or day treatment services; assertive community treatment; psychosocial rehabilitation services; residential services; inpatient psychiatric treatment; peer support; supported employment; skills training and development; emergency crisis services; mobile crisis services; and residential crisis services (MACPAC 2021f).

<sup>17</sup> Federal statute defines an IMD as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (§ 1905(i) of the Social Security Act).

<sup>18</sup> Thirty states and the District of Columbia have approved Section 1115 demonstration waivers to provide residential SUD treatment in IMDs (MACPAC 2020d).



<sup>19</sup> Our work on IMDs also focused on oversight and patient protections, noting that federal oversight and guidance varies based on whether the IMDs are Medicare providers and the type of facility. State Medicaid agencies must at a minimum, use Medicare certification standards for providers recognized by Medicare. However, there are no federally mandated standards for SUD treatment in freestanding facilities or residential mental health treatment programs because they are not Medicare providers. State oversight of IMDs is fragmented for several reasons. For example, because states do not have specific IMD licensing criteria; the licensing process may vary for inpatient and residential treatment facilities and for facilities providing SUD treatment or mental health care. We also found that oversight functions are sometimes spread across multiple state agencies (MACPAC 2020b). Finally, we found that while quality of care in IMDs has improved, concerns about living conditions, quality of care, and the rights of patients persist. While protections for individuals with mental health conditions are well defined, their applicability to individuals with SUD are less clear. For example, the Americans with Disabilities Act of 1990 (ADA, P.L. 101-336) treats mental health conditions and SUDs differently. The ADA extends protections to individuals with a mental health condition that “substantially limits” one or more major life activities (e.g., bipolar disorder, schizophrenia, major depression). SUDs are considered a disability under the ADA only when they substantially limit a major life activity. Individuals with an SUD who use illegal drugs are not afforded ADA protections, because these do not extend to individuals “currently engaging in the illegal use of drugs”. The point at which an individual transitions from currently using illegal drugs to having used drugs in the past is sometimes unclear under the law. Although use of medications for opioid use disorder (MOUD) is not considered the illegal use of drugs under the ADA, the determination of whether an individual receiving MOUD is entitled to federal disability rights protections depends on individual circumstances (MACPAC 2020a).

<sup>20</sup> MOUD is defined as a service combining any drug approved by the U.S. Food and Drug Administration, including methadone, or any biological product licensed under the Public Health Service Act, to treat opioid use disorders and counseling services or behavioral therapy. States can be exempted from this requirement if before October 1, 2020, they demonstrate that covering all eligible individuals in the state is not feasible due to a shortage of qualified MOUD providers or treatment facilities willing to provide services under contract either with the state or with a managed care organization working with the state under Section 1903(m) or Section 1905(t)(3) of the Social Security Act.

<sup>21</sup> Other barriers included the limited pool of providers certified to prescribe buprenorphine, and limited provider participation in Medicaid.

<sup>22</sup> When used for OUD treatment, methadone may be ordered and dispensed only through an OTP that has been certified by SAMHSA and registered as a narcotic treatment program with the DEA. OTPs provide the patient with a structured environment and daily interaction with treatment providers.

<sup>23</sup> For those in their first 90 days in treatment, take-home doses are limited to one per week. During the second 90 days, two take-home doses per week may be provided. In the third 90-day period, a three-day take-home supply may be given to each patient. After two years, up to a one-month take-home supply may be given (42 CFR 8.12).

<sup>24</sup> For instance, absent the PHE, patients must be in treatment for two continuous years before they may receive a one-month supply of take-home medication (42 CFR 8.12).

<sup>25</sup> Under typical conditions, in which patients visit the OTP daily, the entity receives a payment for each day. Providing take-home doses would reduce the number of visits and potentially OTP revenue. Insufficient revenue could threaten the viability of OTP and the availability of treatment services.

<sup>26</sup> The Narcotic Treatment Act of 1974 restricts methadone prescribing to clinicians working in federally regulated OTPs. Physicians working in other settings cannot prescribe methadone for OUD, even if a patient has been stable on methadone for years (Madras et al. 2020). Some advocates have called for making methadone available in primary care settings and pharmacies (Madras et al. 2020, McBournie et al. 2020, Priest 2020).



<sup>27</sup> About 28 percent of specialty mental health facilities reported offering telehealth services and accepting Medicaid in 2018. The availability of such services varies widely across states, ranging from 3 percent of facilities in Connecticut to 71 percent of facilities in North Dakota. While use of telehealth for behavioral health has increased during the COVID-19 pandemic, we do not know if the number of specialty mental health facilities offering telehealth services also grew. Given their high Medicaid participation, and the fact that all states and the District of Columbia expanded use of telehealth during the pandemic, it is likely the percentage of facilities has increased (MACPAC 2021a).

<sup>28</sup> These include the ADA under which Medicaid beneficiaries with serious mental illness are entitled to receive necessary mental health treatment in the most integrated setting possible. In addition, the Supreme Court’s ruling in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), required states to provide treatment for individuals with disabilities, including serious mental illness, in community-based settings, if the individuals are not opposed to such services, and such placement is appropriate and can be reasonably accommodated by the state. However, Medicaid beneficiaries with mental illness still have difficulty accessing services in the community (MACPAC 2021c). In addition, under Medicaid’s mandatory early and periodic screening, diagnostic, and treatment (EPSDT) benefit, Medicaid-eligible individuals under age 21 are entitled to all medically necessary services, including behavioral health services. In separate CHIP, behavioral health services are a required benefit.

<sup>29</sup> This analysis uses five years (2015 – 2019) of data from the National Survey on Drug Use and Health to analyze the experience of children age 12–17 who reported that they stayed overnight in jail or juvenile detention in the past 12 months. Medicaid and the juvenile justice system share responsibility for providing health care to justice-involved youth. With few exceptions, Medicaid is the payer of health care services for eligible and enrolled individuals living in the community, while correctional institutions must pay for health care costs while youth are confined to these facilities. Although inmates of public institutions can remain eligible for Medicaid in many states, federal law prohibits use of federal Medicaid funds for most health care services for inmates of public institutions except in cases of inpatient care lasting 24 hours or more.

<sup>30</sup> This analysis uses five years (2015 – 2019) of data from the National Survey on Drug Use and Health to analyze the experience of children age 12–17 who reported that they stayed overnight in foster care in the past 12 months. Low-income children and adolescents who have been removed from their homes are automatically eligible for Medicaid on the basis of their eligibility for child welfare assistance under Title IV-E of the Social Security Act. Those who are not receiving Title IV-E assistance may be eligible for Medicaid on another basis, such as having low income or a disability.

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