Potential coverage gaps among Medicaid beneficiaries with serious mental illness: Possible consequences and state options for tailored strategies as Medicaid eligibility redeterminations resume

Commissioned by Karuna Therapeutics

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State Medicaid programs face a great challenge as they work to unwind pandemic-related continuous coverage requirements. Certain populations, including people with serious mental illness, face a greater possibility of healthcare gaps due to losses of coverage during this transition. This paper explores considerations for states as they formulate strategies to maintain appropriate Medicaid coverage for these beneficiaries.

As the nation emerges from the COVID-19 public health emergency (PHE) and state Medicaid programs begin to unwind their pandemic-related continuous coverage requirements this spring, the U.S. Department of Health and Human Services (HHS) anticipates the resulting Medicaid disenrollment will be the largest health coverage transition event since the first open enrollment of the Patient Protection and Affordable Care Act (ACA).[1] Milliman was commissioned by Karuna Therapeutics to evaluate how eligibility redeterminations might impact people living with serious mental illness (SMI) during this coverage transition. This paper focuses on strategies states can take to ensure that individuals with SMI are supported to maintain Medicaid coverage to the extent they continue to meet eligibility requirements. Although this paper is focused on populations with SMI, states may consider the options discussed in this paper to be generally applicable to other groups who are at heightened risk of a care gap due to losing coverage at redetermination (e.g., aging populations, people who speak English as a second language, and individuals with other serious disabilities beyond SMI).

This paper is the first of a two-part series exploring how the unwinding of the pandemic-related Medicaid coverage requirements may impact health benefits coverage for people with SMI. The second paper will discuss options for maintaining access to care for people with SMI who do lose Medicaid eligibility as they transition off that coverage.

Medicaid's role in coverage of individuals with mental illness

The unwinding of Medicaid's continuous eligibility requirement is complicated by the fact that it is taking place at a time when communities across the country are facing unprecedented challenges from the increasing prevalence of mental health and substance use disorders and are seeking solutions to ensure that people have consistent access

[1] Medicaid.gov. Unwinding and Returning to Regular Operations After COVID-19. Retrieved February 17, 2023, from https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.

to the care and services they need.[2,3] The most recent data from the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that over 46 million Americans (age 12+) had a substance use disorder (SUD) in 2021, while 57.8 million people (age 18+)—or approximately one in every five U.S. adults—had a diagnosable mental illness.[4] Of those with a mental illness, 14.1 million had a serious mental illness (approximately 5% of U.S. adults).[5]

The American Psychiatric Association (APA) characterizes SMI as "a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Examples of serious mental illness include major depressive disorder, schizophrenia, and bipolar disorder."[6]

As the largest payer of mental health services in the United States,[7] Medicaid plays a significant role in ensuring that people are able to access needed mental health and substance abuse disorder treatment services. This is especially true for people with SMI. In 2020, 29% of Medicaid nonelderly adult beneficiaries had a mental illness (relative to 21% of those who are privately insured) and 9% had a serious mental illness.[8] Research has indicated that Medicaid covers nearly 70% of noninstitutionalized adults with schizophrenia.[9]

The role of Medicaid in providing health coverage has become even more pronounced during the COVID-19 pandemic, as Medicaid enrollment increased significantly during the PHE and the pandemic exacerbated the challenges faced by Americans living with mental illness.[10,11,12]

Though the options presented in this paper are generally applicable and supportive of everyone with SMI,[13] Karuna Therapeutics requested we place a particular emphasis on schizophrenia and bipolar disorder due to the particularly acute challenges—such as housing insecurity—that these individuals (and other similarly at-risk populations) are likely to face in the context of Medicaid unwinding. As discussed in more depth below, to help ensure continuous coverage and access to care during the pandemic, the federal government effectively suspended Medicaid eligibility renewal processing. As Medicaid agencies resume renewals (also called redeterminations) in the coming months, policy makers may wish to consider tailored assistance strategies for individuals with SMI and other vulnerable

[2] Kaiser Family Foundation (December 13, 2021). Mental Health and Substance Use State Fact Sheets. Retrieved February 19, 2023, from https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/.

[3] Guth, M. (December 9, 2021). State Policies Expanding Access to Behavioral Healthcare in Medicaid. Kaiser Family Foundation. Retrieved February 19, 2023, from https://www.kff.org/medicaid/issue-brief/state-policies-expanding-access-to-behavioral-health-care-in-medicaid/.

[4] Substance Abuse and Mental Health Services Administration (January 4, 2023). 2021 NSDUH Annual National Report. Retrieved February 19, 2023, from https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report.

[5] Ibid.

[6] American Psychiatric Association (November 2022). What Is Mental Illness? Retrieved February 19, 2023, from https://www.psychiatry.org/patients-families/what-is-mental-illness.

[7] Medicaid.gov. Behavioral Health Services. Retrieved February 19, 2023, from https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.

[8] Saunders, H., & Rudowitz, R. (June 6, 2022). Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020. Kaiser Family Foundation. Retrieved February 19, 2023, from https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/#:~:text=Further%2C%20Medicaid%20enrollees%20have%20the,privately%20covered%20and%20uninsured%20people.

[9] Khaykin, E., Eaton, W. W., Ford, D. E., Anthony, C. B., & Daumit, G. L. (August 1, 2010). Health Insurance Coverage Among Persons With Schizophrenia in the United States. *Psychiatric Services* (Washington, D.C.), 61(8), 830–834. Retrieved February 19, 2023, from https://doi.org/10.1176/ps.2010.61.8.830.

[10] Panchal, N. et al. (February 10, 2021). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Retrieved February 19, 2023, from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

[11] Kearney, A., Hamel, L., & Brodie, M. (April 14, 2021). Mental Health Impact of the COVID-19 Pandemic: An Update. Kaiser Family Foundation. Retrieved February 19, 2023, from https://www.kff.org/coronavirus-covid-19/poll-finding/mental-health-impact-of-the-covid-19-pandemic/.

[12] Corallo, B. & Moreno, S. (February 6, 2023). Analysis of Recent National Trends in Medicaid and CHIP Enrollment. Kaiser Family Foundation. Retrieved February 19, 2023, from https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/.

[13] The American Psychiatric Association (APA) characterizes SMI as "a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Examples of serious mental illness include major depressive disorder, schizophrenia, and bipolar disorder." See https://www.psychiatry.org/patients-families/what-is-mental-illness.

populations in order to minimize coverage disruptions and promote continuous access to care, as described in guidance issued by the Centers for Medicare and Medicaid Services (CMS).[14]

Forthcoming Medicaid eligibility changes

Since the passage of the Families First Coronavirus Response Act (FFCRA) at the beginning of the pandemic in 2020, states have received an enhanced Federal Medicaid Assistance Percentage (FMAP) of 6.2% on certain Medicaid spending.[15] In order to receive the enhanced funding rate, states had to meet "maintenance of eligibility" requirements, including that they could not terminate Medicaid coverage for any beneficiary that was "validly enrolled"—with the goal to assure continuous enrollment and access to care for Medicaid recipients throughout the PHE. States choosing to receive the enhanced FMAP were required to stop processing Medicaid eligibility redeterminations for individuals whose renewal date fell during the PHE, creating a temporary status of continuous eligibility for virtually all Medicaid beneficiaries. These provisions ensured ongoing access to care during the PHE, while at the same time resulting in substantial increases in Medicaid enrollment and decreases in uninsured rates of both children and adults.[16]

On January 20, 2023, the Biden administration announced the PHE will formally end on May 11, 2023. Regardless, the impact of the PHE end on Medicaid enrollment is no longer an issue due to the recently enacted Consolidated Appropriations Act of 2023 (CAA).

CONSOLIDATED APPROPRIATIONS ACT OF 2023 (CAA)

On December 29, 2022, President Biden signed the CAA into law.[17] Importantly, this legislation will now *decouple* Medicaid continuous eligibility (as described above under FFCRA) from the PHE end date, providing states and the public with certainty for when Medicaid redeterminations can restart.

Starting on April 1, 2023, the CAA permits states to begin to initiate Medicaid renewals, post-enrollment verifications, and redeterminations. For all individuals enrolled in Medicaid as of that date, states must implement a plan to begin initiating renewals within up to a 12-month period (ending no later than March 31, 2024) and complete the renewals within no more than 14 months (ending no later than May 31, 2024). The activities can occur on a phased basis, using a population-based, a time-based, or a hybrid approach. At the same time, the enhanced FMAP rates paid to states will begin to slowly phase out, resulting in a progressively decreasing transitional rate to be paid through the end of the calendar year ("transitional FMAP").

In order to receive the transitional FMAP rate, states must comply with the provisions laid out in the CAA, specifically that they must:

- Comply with the federal requirements for eligibility redeterminations
- Maintain up-to-date contact information for each individual for whom the state conducts an eligibility redetermination
- Attempt to contact any individual determined ineligible using more than one modality

Regardless of whether or not a state chooses to accept the transitional FMAP, all states must fulfill various data reporting requirements throughout the unwinding period in order to permit federal monitoring of state renewal efforts. For example, states must submit to HHS the number of eligibility renewals initiated and the number of individuals whose coverage was terminated for procedural reasons.

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[14] CMS (March 3, 2022). Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency. Retrieved February 19, 2023, from https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[15] The full text of the Families First Coronavirus Response Act (2020), 116th Congress, is available at https://www.congress.gov/bill/116th-congress/house-bill/6201.

[16] Park, E., Dwyer, A., Brooks, T., Clark, M., & Alker, J. (January 5, 2023). Consolidated Appropriations Act, 2023: Medicaid and CHIP Provisions Explained. Georgetown University Health Policy Institute, Center for Children and Families. Retrieved February 19, 2023, from https://ccf.georgetown.edu/2023/01/05/consolidated-appropriations-act-2023-medicaid-and-chip-provisions-explained/.

[17] The full text of the Consolidated Appropriations Act, 2023, 117th Congress, is available at https://www.congress.gov/bill/117th-congress/house-bill/2617?r=1&s=3.

Potential factors that may contribute to loss of Medicaid Coverage

As states resume the redetermination process this spring, several factors may put Medicaid beneficiaries with SMI (and other similar, vulnerable populations) at greater risk of coverage loss than the general Medicaid population. Factors related to common life circumstances (such as an individual's housing status) as well as challenges associated with their health conditions that can create difficulties with communicating and complying with administrative processes, make this group more likely to be at risk of losing their Medicaid coverage status. A recent 50-state survey of Medicaid agencies revealed concerns that difficulty contacting beneficiaries may be a primary reason they expect disabled and aged individuals to lose coverage at the end of the PHE.[18]

The primary concern around individuals with SMI and other vulnerable populations losing coverage is less about whether their eligibility status will change and has more to do with challenges around communication, outreach, and administration of the redetermination process. These process failures can create the risk of *inadvertent* coverage loss. For particularly vulnerable populations, including individuals with SMI, the risk of these process failures may be exacerbated by other challenges as well.

Homelessness. Most people experiencing homelessness are likely eligible for Medicaid and will remain eligible for Medicaid after the unwinding of the continuous eligibility requirement. However, people who are unhoused—regardless of whether they have SMI—are one of the populations most at risk of inadvertent coverage loss during the unwinding. Though the CAA puts in place basic requirements prioritizing proactive communication with individuals as part of the redetermination process, outreach to individuals experiencing homelessness is typically more challenging due to a lack of established and consistent contact information. People experiencing homelessness might not have a reliable mailing address, access to email, or a phone number, or their contact information might regularly change due to increased transience resulting from housing instability.

Possible impacts for SMI population: This is likely to be a particularly acute problem for people with SMI. Data from the U.S. Department of Housing and Urban Development (HUD) indicates that 21.1% of people experiencing homelessness also have SMI.[19] More specifically, research has shown that there is a disproportionately high incidence of homelessness among individuals with diagnoses such as schizophrenia and bipolar disorder.[20,21,22,23] This high prevalence of homelessness among people with SMI means that they are that much more at risk for inadvertent coverage loss for the reasons described above.

Access to care and treatment nonadherence. CMS has expressed its objective to minimize beneficiary burden and promote continuity of coverage for all eligible individuals upon conclusion of the PHE, regardless of particular health conditions.[24] It is especially relevant in the context of SMI, where treatment adherence is recognized as a common challenge and the consequences of treatment nonadherence can be significant.[25]

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[18] Musumeci, MB., O'Malley Watts, M., Ammula, M., & Burns, A. (July 11, 2022). Medicaid Public Health Emergency Unwinding Policies Affecting Seniors and People With Disabilities: Findings From a 50-State Survey. Kaiser Family Foundation. Retrieved February 19, 2023, from https://www.kff.org/report-section/medicaid-public-health-emergency-unwinding-policies-affecting-seniors-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/.

[19] U.S. Department of Housing and Urban Development (2022). Continuum of Care (CoC) Homeless Populations and Subpopulations Reports. Retrieved February 19, 2023, from https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/.

[20] Substance Abuse and Mental Health Services Administration. Behavioral Health Services for People Who Are Homeless. Retrieved February 19, 2023, from https://store.samhsa.gov/sites/default/files/pep20-06-04-003.pdf.

[21] Ayano, G., Shumet, S., Tesfaw, G. et al. (June 9, 2020). A systematic review and meta-analysis of the prevalence of bipolar disorder among homeless people. BMC Public Health 20, 731 (2020). Retrieved February 19, 2023, from https://doi.org/10.1186/s12889-020-08819-x.

[22] Folsom, D., & Jeste, D. V. (June 2002). Schizophrenia in homeless persons: A systematic review of the literature. *Acta Psychiatrica Scandinavica* 105(6), 404–413. Retrieved February 19, 2023, from https://doi.org/10.1034/j.1600-0447.2002.02209.x.

[23] White House Council of Economic Advisors (May 31, 2022). Reducing the Economic Burden of Unmet Mental Health Needs. Retrieved February 19, 2023, from https://www.whitehouse.gov/cea/written-materials/2022/05/31/reducing-the-economic-burden-of-unmet-mental-health-needs/.

[24] CMS (March 3, 2022), op cit.

[25] SMI Adviser. What are some factors that lead to medication nonadherence for people with serious mental illness? Retrieved February 19, 2023, from https://smiadviser.org/knowledge_post/what-are-some-factors-that-lead-to-medication-non-adherence-for-people-with-serious-mental-illness.

Possible impacts for SMI population: People with SMI often face barriers accessing the care and treatment they need. In 2021, over 50% of people with SMI felt they did not receive the care that they needed and, of those people, approximately 40% did not receive any mental health services at all in the previous year.[26] Nearly 55% of those not receiving treatment cited affordability as a reason for not receiving services.[27] Relatedly, a more specific dilemma providers confront when caring for patients with SMI is treatment nonadherence—specifically medication nonadherence. The causes of nonadherence can vary, but patients from lower socioeconomic backgrounds who are particularly vulnerable and who experience higher barriers to care are at heightened risk for nonadherence.[28]

Whether due to a general lack of access or irregular adherence to treatment, people with SMI often do not receive the treatment, care, and services they need. When people do not receive the healthcare they need, it can negatively impact their ability to perform daily living activities—and this is particularly true in the case of individuals with SMI.[29] To the extent that daily functioning is impacted, this can have negative implications for the redetermination process (i.e., even when successful contact is made with these individuals, their conditions can serve as a barrier to completing the renewal).

Eligibility factors. Most individuals qualify for Medicaid based on income level. However, a significant portion of the population gains eligibility on the basis of disability status. Though the pathway to Medicaid for many people with SMI is likely to be based on income, 41% of adults with SMI gain eligibility on the basis of their disability status.[30]

However, even if a person's disability status is unlikely to change, it is possible their income will change. The previously mentioned survey from the Kaiser Family Foundation indicated that a median of 10% of beneficiaries who gain eligibility based on disability and age are expected to lose coverage at the end of the PHE.[31] As cited above, states expressed concern around communication and administrative issues, but still frequently cited change in income as a primary reason they are concerned these individuals will lose coverage.[32] Again, this coverage loss could be inadvertent if they are eligible due to their disability status but are erroneously deemed ineligible due to a change in income.

Possible impacts for SMI population: A little more than half of people with SMI diagnoses who are eligible for Medicaid gain that eligibility through their low incomes.[33] However, there are also many individuals who are eligible due to their disability status irrespective of income. Nearly half of adults and children who are eligible for Medicaid based on having a disability have a mental health diagnosis.[34] Given the chronic nature of diagnoses like bipolar disorder and schizophrenia, it is unlikely that their disability status will change.

Even if the Medicaid renewal process works perfectly, it is a reality that many people currently enrolled in Medicaid will be found to be no longer eligible for benefits. We next turn to an analysis of the impacts of losing coverage for the SMI population.

Implications of coverage loss

Regardless of the reason an individual loses Medicaid coverage, the implications of coverage loss for someone with SMI can be significant, as described below.

[26] Substance Abuse and Mental Health Services Administration (December 2022). Key Substance Use and Mental Health Indicators in the United States: Results From the 2021 National Survey Drug Use and Health, p. A-31. Retrieved February 19, 2023, from https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf.
[27] Ibid., p. A-33.
[28] García, Saínza MSc; Martínez-Cengotitabengoa, Mónica PhD; López-Zurbano, Saioa MD; Zorrilla, Iñaki PhD, MD; López, Purificación PhD, MD; Vieta, Eduard PhD, MDǁ; & González-Pinto, Ana PhD, MD (August 2016). Adherence to Antipsychotic Medication in Bipolar Disorder and Schizophrenic Patients: A Systematic Review. *Journal of Clinical Psychopharmacology* 36(4):p 355-371. DOI: 10.1097/JCP.0000000000000523.
[29] SMI Adviser., op cit.
[30] Zur, J., Musumeci, MB., & Garfield, R. (June 29, 2017). Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals. Kaiser Family Foundation. Retrieved February 19, 2023, from https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/.
[31] Musumeci, MB., O'Malley Watts, M., Ammula, M., & Burns, A., op cit.
[32] Ibid.
[33] Zur, J., Musumeci, MB., & Garfield, R., op cit.
[34] Ibid.

POTENTIAL IMPACTS TO THE INDIVIDUAL

Individual health and access to care. The most direct and immediate impact of coverage loss is the potential inability of individuals to pay for and therefore have access to medically necessary care and services. Analysis of primary care and specialist visits for Medicaid-enrolled individuals with schizophrenia or bipolar disorder using Milliman's healthcare claims research database illustrates that many beneficiaries have frequent touch points with healthcare providers (see the methodology underlying this analysis in the appendix), meaning that access to these provider touch points may be impaired without health benefits coverage.

Figures 1 and 2 illustrate the distribution of the percentage of months for which a Medicaid-enrolled person with bipolar disorder or schizophrenia had at least one professional visit and pharmacy script, respectively, relative to the Medicaid nonelderly adult population without these conditions during calendar year 2021.

Each identified unique beneficiary was assigned to one of three cohorts based on utilization of professional services (Figure 1) and prescription drug (Figure 2) incurred during calendar year 2021:

- Low utilization: Less than 50% of eligibility months were associated with at least one professional visit (Figure 1) or at least one dispensed prescription drug (Figure 2).
- Medium utilization: Between 51% and 75% of eligibility months were associated with at least one professional visit (Figure 1) or at least one dispensed prescription drug (Figure 2).
- High utilization: More than 75% of eligibility months were associated with at least one professional visit (Figure 1) or at least one prescription drug (Figure 2).

As shown in Figure 1, 27% of beneficiaries with schizophrenia or bipolar disorder had high professional visit utilization, relative to only 8% of beneficiaries without these conditions.

FIGURE 1: PROFESSIONAL VISITS COMPARISON

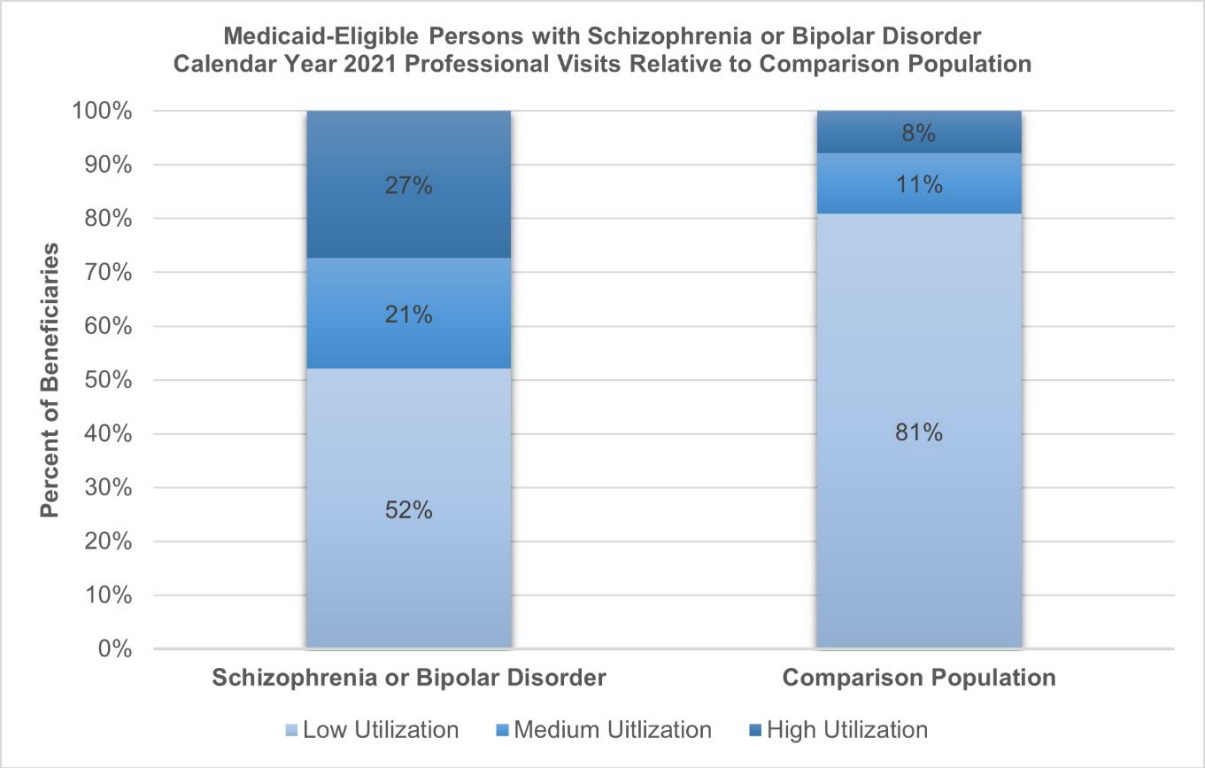
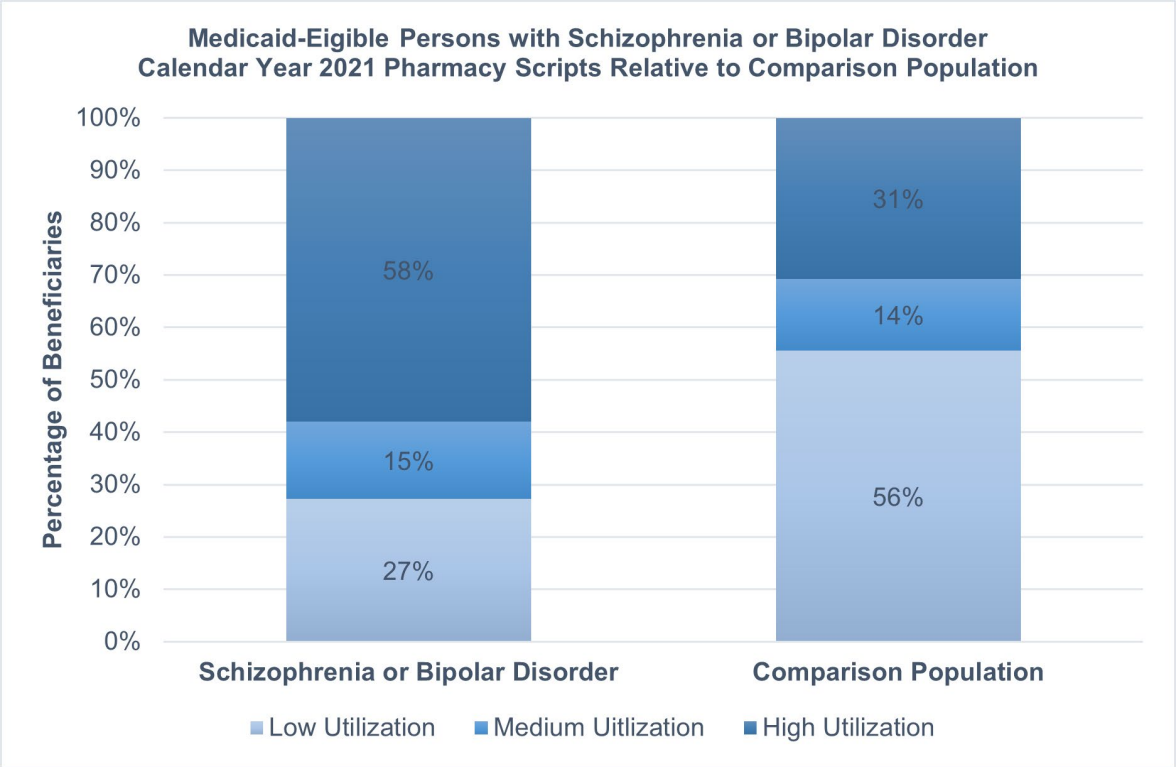


Figure 2 illustrates the even higher likelihood of an individual with schizophrenia or bipolar disorder interacting monthly with the healthcare delivery system for a prescription medication. Nearly 60% of persons with schizophrenia

or bipolar disorder were categorized with ”high utilization” for prescription drugs. Medication protocols for persons with SMI are complex. Based on an analysis of Milliman’s Consolidated Healthcare Service Database (CHSD—further information regarding the CHSD is provided in the appendix of this report), Medicaid beneficiaries with bipolar disorder and schizophrenia were dispensed 5.3 prescriptions per eligibility month during calendar year 2021 compared to 3.6 prescriptions per eligibility month for the comparison group. The range of monthly prescriptions for beneficiaries with bipolar disorder and schizophrenia was one (10th percentile) to 11 (90th percentile).

FIGURE 2: PHARMACY PRESCRIPTION COMPARISON



As illustrated by Figures 1 and 2, many Medicaid-enrolled persons with schizophrenia or bipolar disorder have much more frequent touch points with the healthcare system (high to medium utilization), due to the ongoing nature of treatment for their conditions, meaning that a loss of health benefits coverage (even if temporary) is more likely to result in the inability to access needed services and prescription drugs.

Analysis has demonstrated that, when people with Medicaid lose coverage, the majority will experience a period of uninsurance, approximately 33% will reenroll in Medicaid after a period of uninsurance, and 9% will reenroll after enrolling in another source of coverage.[35] Such gaps in coverage that result in loss of access to care—even if temporary—can contribute to deteriorations of symptoms and exacerbation of illness, relapse, increased emergency department utilization, and increased morbidity.[36]

Quality of life and daily functioning. It is not just people’s health that is impacted when they are unable to access treatment for their serious mental illness. The consequences extend into other parts of life and daily living activities. Experiencing symptoms of schizophrenia or bipolar disorder can negatively impact an individual’s ability to function

[35] Corallo, B., Burns, A., Tolbert, J., & Claxton, G. (January 25, 2023). What Happens After People Lose Medicaid Coverage? Kaiser Family Foundation. Retrieved February 19, 2023, from https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage/.

[36] SMI Adviser, op cit.

and make it difficult to perform daily activities relating to employment, education, and interpersonal relationships—ultimately leading to generally poorer quality of life and worse life outcomes.[37,38]

For example, in the context of employment, research has shown that the challenges of living with bipolar disorder or schizophrenia can impact productivity at work, absenteeism, lost wages, and an increased likelihood of job loss.[39] Individuals with SMI have lower educational attainment over the course of their lives relative to those without SMI, but early interventions can increase educational attainment.[40] Such early interventions are at risk of being lost if individuals lose Medicaid coverage.

Risk of homelessness. As discussed above, homelessness and housing insecurity are strongly connected to people receiving insufficient treatment for their mental illness. Someone with SMI becomes homeless due to reasons associated with their illness, or is already experiencing homelessness, which makes access to needed treatment difficult. This lack of treatment then makes it even more challenging to achieve housing security. It is a cycle that results in large economic costs for society.[41]

Risk of incarceration. Untreated mental illness has also been shown to be associated with higher rates of incarceration.[42,43] It is estimated that approximately 40% of people who are incarcerated have a history of mental illness—twice the rate of the general population—and over 60% of incarcerated individuals with mental illness do not receive needed care and treatment when incarcerated.[44,45] Again, just like in the case of homelessness, this can often be a cycle and result in millions of dollars in direct and indirect costs to society.[46]

IMPACTS ON MENTAL HEALTH/SUD REFORM EFFORTS

In recent years policy makers have given significant attention and increased state investment to shoring up the mental health and SUD care and service delivery systems. For example, as of February 2023, 10 states have received and seven are awaiting approval for waivers for mental health reform efforts that would allow new federal expenditures and add new services to the behavioral continuum of care, with the broader goal of increasing access to care.[47] States have also been more generally expanding their arrays of Medicaid behavioral health services, such as coverage of opioid treatment programs, enhanced care management, and behavioral health services and care coordination targeted toward youths with complex behavioral health needs.[48] During the COVID-19 pandemic, states have drastically increased access to behavioral healthcare through coverage of services delivered via telehealth.[49] Additionally, more than half of states have said they intend to pursue a new option made available by the 2021 American Rescue Plan Act (ARPA) to provide crisis intervention services.[50] At the federal level, the recently passed CAA and Bipartisan Safer Communities Act (BSCA) are two recent examples of laws passed by Congress that made investments in the mental health system, and many states have likewise undertaken significant behavioral health

[37] Seabury, S.A., Axeen, S., Pauley, G., Tysinger, B., Schlosser, D., Hernandez, J.B., Heun-Johnson, H., Zhao, H., & Goldman, D.P. (April 2019). Measuring the Lifetime Costs of Serious Mental Illness and the Mitigating Effects of Educational Attainment. Health Affairs. *38*(4), 652-659. Retrieved February 19, 2023, from https://doi.org/10.1377/hlthaff.2018.05246.
[38] Hofer, A., Mizuno, Y., Wartelsteiner, F., Wolfgang Fleischhacker, W., Frajo-Apor, B., Kemmler, G., Mimura, M., Pardeller, S., Sondermann, C., Suzuki, T., Welte, A., & Uchida, H. (October 2017). Quality of Life in Schizophrenia and Bipolar Disorder: The Impact of Symptomatic Remission and Resilience. *Eur Psychiatry*;46:42-47. doi: 10.1016/j.eurpsy.2017.08.005. Epub 2017 Sep 1. PMID: 28992535.
[39] Elliott, M., Reuter, J.C. (July 9, 2021). The Benefits and Challenges of Employment for Working Professionals Diagnosed With Mental Illness. *Community Ment Health J* 58, 645–656. Retrieved February 19, 2023, from https://doi.org/10.1007/s10597-021-00866-x.
[40] Seabury, S. A. et al., op cit.
[41] White House Council of Economic Advisors, op cit.
[42] Ibid.
[43] Bronson, J. & Berzofsky, M. (June 2017). Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. U.S. Department of Justice. Retrieved February 19, 2023, from https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf.
[44] National Alliance on Mental Illness. Mental Health Treatment While Incarcerated. Retrieved February 19, 2023, from https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Treatment-While-Incarcerated.
[45] Bronson, J. & Berzofsky, M., op cit.
[46] White House Council of Economic Advisors, op cit.
[47] Kaiser Family Foundation. (February 2, 2023). Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State, Table 4. Retrieved February 19, 2023, from https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table4.
[48] Guth, M., State Policies Expanding Access to Behavioral Health Care, op cit.
[49] Ibid.
[50] Ibid.

reforms aimed at reinforcing and developing the safety net for these services.[51,52] At both the state and federal level, most of these efforts seek to provide access to services as a component of Medicaid coverage, meaning that a loss of that coverage would prevent individuals from obtaining the very services states are intending to make available to them.

State options to address these challenges

HHS acknowledges the expiration of the continuous coverage requirement authorized by the FFCRA as the single largest health coverage transition event since the first open enrollment period of the ACA.[53] The exact number of Medicaid beneficiaries who will lose Medicaid coverage is unknown; however, in August 2022 HHS projected that 17.4% of Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, or approximately 15 million individuals, will lose coverage. As states resume renewals and redeterminations, there are strategies they can implement that will help promote continuity of coverage and reduce administrative churning (disenrolling and reenrolling in short time periods).

TAILORING MEDICAID REDETERMINATION STRATEGIES FOR SPECIFIC AT-RISK POPULATIONS

HHS has published extensive unwinding guidance, policies, and resources to support states to initiate and complete enrollment actions while preventing inappropriate terminations. While these strategies support coverage continuity for all Medicaid populations, applying a "one size fits all" approach could cause unintended churn. Differentiated redetermination policies attuned to the needs of individuals with SMI, such as those described below, may be more likely to help maintain coverage and access to treatment.

Focus teams and reporting. Specialized units to process redeterminations for beneficiaries with SMI or other complex/time-consuming redeterminations, e.g., individuals experiencing homelessness or housing instability may help create focus within state agencies and assist with resource allocation. States could leverage analytics to identify the prevalence of SMI in their renewal populations, employ monitoring strategies to review periodic reporting by population cohorts, examine termination data closely, and make course corrections to minimize the burden and adverse impacts to populations with SMI.

De-prioritize renewals. States can postpone renewals for populations with SMI (i.e., conduct renewals for this group later within the 12-month unwinding period), to minimize beneficiary churn and provide additional time to ensure eligible individuals retain coverage.[54] States could prioritize eligibility and enrollment actions for individuals in groups who are most likely to be no longer eligible and delay renewals for other at-risk population groups to permit additional time for outreach and securing accurate contact information.

Target communication and outreach strategies. Designing specific communication and outreach campaigns for beneficiaries with SMI will support having accurate and current contact information, while also increasing the likelihood of the individual successfully completing and returning the determination form. Before beginning actual direct outreach, a pragmatic first step for states might consider conducting an inventory of who they *currently* are unable to reach—i.e., where possible, identify existing gaps in beneficiary contact information. As states prepare to educate Medicaid beneficiaries about the upcoming changes, developing broad and targeted communication strategies that build on previously successful COVID-19 public health campaigns can create awareness of renewal activities. Employing multiple engagement modalities including social media platforms and internet search advertisements to disseminate simple, direct, and informative messages may reach more individuals.

States could also prioritize engagement with community partners and those health and social services systems that already have established trust, confidence, and acceptance with people with SMI. Many individuals will have varying levels of ability and capacity to understand and act on information they receive—sometimes due to their illness and

[51] The full text of the Bipartisan Safer Communities Act is available at https://www.congress.gov/bill/117th-congress/senate-bill/2938/text.
[52] Guth, M., State Policies Expanding Access to Behavioral Health Care, op cit.
[53] Medicaid.gov, Unwinding and Returning, op cit.
[54] CMS (April 2022). Medicaid and CHIP Unwinding Planning Efforts: Summary of Best and Promising State Practices from CMS/State Discussions. Retrieved February 19, 2023, from https://www.medicaid.gov/resources-for-states/downloads/state-unwinding-best-practices.pdf.

sometimes due to other challenges in their lives. Meeting these individuals where they are and building on these existing trusted relationships may increase the chance that the person will complete the required renewal processes on time. Examples may include collaborating with community-based organizations and coalitions, tribal organizations, food banks, legal aid networks, faith organizations, community centers, disability partners, and other resources, as well as other systems like schools, social services, and health departments. Community providers, including federally qualified health centers (FQHCs), community mental health centers (CMHCs), certified community behavioral health clinics (CCBHCs), provider associations, pharmacies, and other groups that have deep-rooted relationships with people with SMI can be more useful tools for states to effectively reach this group.

LEVERAGING MANAGED CARE STRATEGIES

States with managed care delivery systems, especially those with specialty behavioral health plans, have an additional lever to maximize continuity of care for individuals with SMI. HHS guidance to states on engaging managed care plans to prepare for return-to-normal operations includes four key strategies, two of which are applicable to promoting Medicaid coverage continuity.[55]

Partner with health plans to obtain and update beneficiary contact information. States can require managed care plans to request updated contact information (addresses, emails, phone numbers, authorizations for text messaging) during every interaction with beneficiaries who are members of their plan. Managed care plans can also aid members to update their contact information directly with the state agency, for example by a warm transfer to state call center or help with an online portal.[56]

Additionally, states can require their managed care plans to share updated contact information for their plan members back to the state. States may treat this information as reliable and update the individual's beneficiary record with the new information received from the health plan if the information was received directly from the beneficiary and the state sends a notice to the individual's original address on file with the agency (using the beneficiary's preferred mode of communication) and provides the individual with a reasonable period of time to dispute the accuracy of the new contact information. If the beneficiary does not respond, states can treat the information from the health plan as verified. States may also apply for Section 1902(e)(14)(A) waiver authority to temporarily accept updated beneficiary contact information from managed care plans without the additional confirmation from the individual. Under this authority, the state can treat contact information from the managed care plan as reliable and update the record without any further verification.[57]

As states consider partnership strategies to assist with the redetermination process, they can require managed care plans to develop targeted outreach plans that are broader than obtaining accurate beneficiary contact information for particular at-risk populations.

Partner with health plans to support renewals. States can share renewal files with health plans and require them to conduct outreach and provide support to individuals during their renewal periods. This support could be in the form of requiring health plans to contact their members directly to remind them to complete their renewal form and to provide completion assistance, given that it follows all state and federal laws and regulations and complies with the managed care contract related to enrollment outreach and marketing.[58] Outreach could occur at two phases of the renewal process. First, states could provide monthly files with the beneficiary information to managed care plans and require them to conduct outreach and provide assistance with the renewal process. Second, states could use a similar approach at a later phase of the renewal process and require managed care plans to reach out to their members who are at risk of losing coverage because they have not yet submitted their renewal form or required information.

[55] CMS (January 2023). Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations. Retrieved February 19, 2023, from https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf.
[56] Ibid.
[57] CMS (March 3, 2022), op cit.
[58] CMS (January 2023), Strategic Approaches, op cit.

STREAMLINING ELIGIBILITY AND ENROLLMENT ADMINISTRATIVE PROCESSES

Reducing beneficiary burden to complete a renewal form and submit other needed documentation will help eligible individuals with SMI maintain coverage and mitigate procedural denials based on the absence of information. States can utilize an option called the "ex parte renewal process" and complete renewals based on available information that is unlikely to change.[59]

The "ex parte renewal process" allows states to use other sources of information or data—e.g., Supplemental Nutrition Assistance Program (SNAP) eligibility—to process renewals, as opposed to requiring the individual to submit documentation. This option may be especially helpful for vulnerable populations for whom completing paperwork is more of a challenge.

As part of this strategy, states may expand the number and type of data sources used to complete an ex parte renewal. When unable to confirm eligibility on an ex parte basis, states can send pre-populated renewal forms to minimize the amount of information required. Other solutions to streamline the enrollment process include increasing reliance on electronic data sources, decreasing reliance on paper documentation, offering multiple channels for submitting required information (i.e., phone and online submissions in addition to mail and in-person), and permitting self-attestation to verify income and/or assets.[60] Removing the requirement for in-person interviews as part of the Medicaid application process is another strategy that can promote continuity of coverage, in particular for individuals with SMI who may experience unique barriers to attending in-person meetings or might struggle with in-person interactions due to their illness or condition.

PROVIDING CONTINUOUS ELIGIBILITY TO ALLOW MAINTENANCE OF COVERAGE

As states begin to process renewals of Medicaid eligibility, they must also start processing redeterminations of Medicaid eligibility based on changes in beneficiary circumstances. This potentially means states may take action on a beneficiary's case more than once during the unwinding period. To relieve states of this burden and reduce the opportunity for churn, states can adopt continuous eligibility for some or all populations. Under this option, a beneficiary retains Medicaid eligibility for the duration of a period determined by the state even when their eligibility circumstances change.[61] Starting January 1, 2024, the CAA grants anyone under the age of 19 one year of continuous eligibility from their enrollment date.[62] In the interim, states can provide up to 12 months of continuous eligibility for children under age 19 through a state plan amendment (SPA). As of January 2022, 24 states have adopted this option to guarantee full-year coverage to children.[63]

Currently there is no SPA option to provide continuous eligibility to adults or more than one year of continuous coverage to children and, as such, these policies require Section 1115 demonstration authority. Oregon recently received HHS 1115 waiver approval to provide continuous eligibility for children ages 0 through 5 until the end of the month of their 6th birthday and 24 months of continuous eligibility for individuals ages 6 and above.[64] States could consider applying for 1115 waiver approval to provide continuous eligibility to all populations, similar to Oregon, or they could take a more narrow, risk-based approach to provide continuous eligibility to the disabled population, or specifically for people with SMI for whom redeterminations could create greater risks for coverage continuity and treatment adherence.

[59] CMS (December 22, 2020). Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency. Retrieved February 19, 2023, from https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf.
[60] Musumeci, MB., O'Malley Watts, M., Ammula, M., & Burns, A., op cit.
[61] CMS (March 3, 2022), op cit.
[62] The full text of the Consolidated Appropriations Act, 2023, is available at https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.
[63] Kaiser Family Foundation (January 1, 2022). State Adoption of 12-Month Continuous Eligibility for Children's Medicaid and CHIP. Retrieved February 21, 2023, from https://www.kff.org/health-reform/state-indicator/state-adoption-of-12-month-continuous-eligibility-for-childrens-medicaid-and-chip/?currentTimeframe=0.
[64] HHS (September 28, 2022). Letter to Dana Hittle, Oregon Health Authority. Retrieved February 21, 2023, from https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-1115-Demonstration-Approval.pdf.

Summary

State Medicaid agencies will soon be faced with the largest volume of eligibility transactions they may have faced since the implementation of the ACA. At the same time, certain populations may be more likely to lose coverage at renewal based on challenges with communication or completing administrative paperwork than due to determinations that they no longer meet eligibility criteria. Because Medicaid is the safety net for low-income and disabled populations who lack access to other coverage options, and because certain beneficiary groups—such as those with SMI—may be more likely to experience a care gap if their Medicaid coverage is interrupted, states may wish to develop tailored supports to assist these populations through the process. State investments in specific added supports to help keep this group enrolled would be well-aligned with current state and federal behavioral health reform efforts as well as Medicaid's core program goals of ensuring access to healthcare for vulnerable and low-income communities.

Recognizing that not all individuals should stay enrolled post-unwinding (e.g., those who rightly no longer meet eligibility requirements), states may also wish to consider ways to support these beneficiaries to avoid adverse healthcare results, uncompensated care, and other impacts like increased incarceration and homelessness that may occur due to gaps in care when losing coverage. For individuals who are no longer Medicaid-eligible, states may wish to provide information and connection to different health coverage options (e.g., ACA marketplace plans), or consider other types of supports to meet their ongoing care needs. These topics will be further discussed in the second paper in our series.

Caveats and limitations

This paper was commissioned by Karuna Therapeutics. The discussion and/or analysis in this paper does not constitute legal advice. We recommend that users of this material consult with their own legal counsel regarding interpretation of applicable laws, regulations, and requirements.

Milliman has developed certain models to calculate values included in this paper. The intent of the models was to summarize professional and prescription drug utilization for Medicaid beneficiaries with schizophrenia or bipolar disorder. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Paul Houchens is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this paper.

In performing this analysis, we relied on publicly available data and other information found in research. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Appendix

Milliman's proprietary Consolidated Healthcare Service Database (CHSD) was used to summarize historical utilization and cost for Medicaid-enrolled individuals identified within a subset of the SMI population. The SMI subset was limited to Medicaid beneficiaries with a schizophrenia or bipolar disorder ICD-10 primary or secondary diagnosis code. The diagnosis codes for each condition were identified using Milliman's proprietary classification software and limited to the list below after clinical review. The SMI cohorts are not mutually exclusive.

FIGURE 3: ICD-10 DIAGNOSIS CODES

ICD-10	DIAGNOSIS CODE DESCRIPTION
	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
	Bipolar Disorder
F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disord, crnt episode manic w/o psych features, unsp
F3111	Bipolar disord, crnt episode manic w/o psych features, mild
F3112	Bipolar disord, crnt episode manic w/o psych features, mod
F3113	Bipolar disord, crnt epsd manic w/o psych features, severe
F312	Bipolar disord, crnt episode manic severe w psych features
F3130	Bipolar disord, crnt epsd depress, mild or mod severt, unsp
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disord, crnt epsd depress, sev, w/o psych features
F315	Bipolar disord, crnt epsd depress, severe, w psych features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disord, crnt epsd mixed, severe, w/o psych features
F3164	Bipolar disord, crnt episode mixed, severe, w psych features
F3171	Bipolar disord, in partial remis, most recent epsd hypomanic
F3173	Bipolar disord, in partial remis, most recent episode manic
F3175	Bipolar disord, in partial remis, most recent epsd depress
F3177	Bipolar disord, in partial remis, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified

We reviewed enrollment and incurred claims experience for calendar years 2019 through 2021. Prevalence rates for SMI cohorts did not vary materially among the three calendar years. Calendar year 2021 results have been summarized in this report, as we believe this experience period is most reflective of the enrolled Medicaid population at the time of the publication of this report.

We have reviewed the SMI prevalence rates contained in the CHSD for the analysis cohort, approximately 4% for calendar year 2021, and believe it is reasonable in relation to published national statistics for the Medicaid 18-to-64 population when considering that our analysis was limited to a subset of the SMI population.[65] Additionally, utilization and prevalence rates within an individual state may vary materially relative to the national values presented in this report.

The SMI analysis cohort was limited to Medicaid beneficiaries ages 18 through 64. As a proxy for dual-eligible beneficiaries and other beneficiaries with third-party coverage under age 65, we excluded beneficiaries with more than $100 in identified cost sharing or coordination of benefits during a calendar year from our analysis. After applying the above limitations to the SMI analysis cohort, we identified approximately 119,000 unique beneficiaries meeting the analysis criteria for calendar year 2021. The data set reflects approximately 1.3 million member months across more than 20 states.

The comparison population was identified as other nonelderly adults meeting the same criteria as the SMI analysis cohort, but who did not have a claim incurred containing a schizophrenia or bipolar disorder ICD-10 primary or secondary diagnosis code. For calendar year 2021, 2.6 million unique beneficiaries and 27.6 million member months were identified in the comparison population.

The CHSD is a multi-year, multi-line-of-business, longitudinal claims and enrollment data structure assembled by Milliman for its use in its product production, internal research, and client engagements. National and regional health plans contribute their annual enrollment and claims detail. The CHSD is not a fully representative sample of the nationwide Medicaid population. The results shared in this report will vary to an unknown extent based on population differences between the CHSD and the nationwide Medicaid population.

Professional visits were based on utilization in the following service categories (defined by Milliman's Health Cost Guidelines™ – Grouper): Preventive Physical Exams, Outpatient Psychiatric, Office/Home Visits – Primary Care Physician, Office/Home Visits – Specialist, Outpatient Substance Abuse Disorders. The counting of professional visits was not limited to services with an SMI-associated ICD-10 code. The counting of prescription drugs was not limited to SMI-related medications.

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[65] Saunders, H. & Rudowitz, R. (June 6, 2022). Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020. Kaiser Family Foundation. Retrieved February 21, 2023, from https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/.