

June 2012

Fact Sheet on Harmonizing Funding Streams: The SBHA Role¹

Public behavioral health systems are comprised of multiple funding streams, including direct state appropriations, Medicaid, federal block grants, county, third party insurance, corrections/parole, public benefits and entitlements, housing, vocational rehabilitation and other funds. Often, the SBHA is the agency that brings together separate entities in order to coordinate these complex funding streams into programs that work for people with behavioral health disorders.

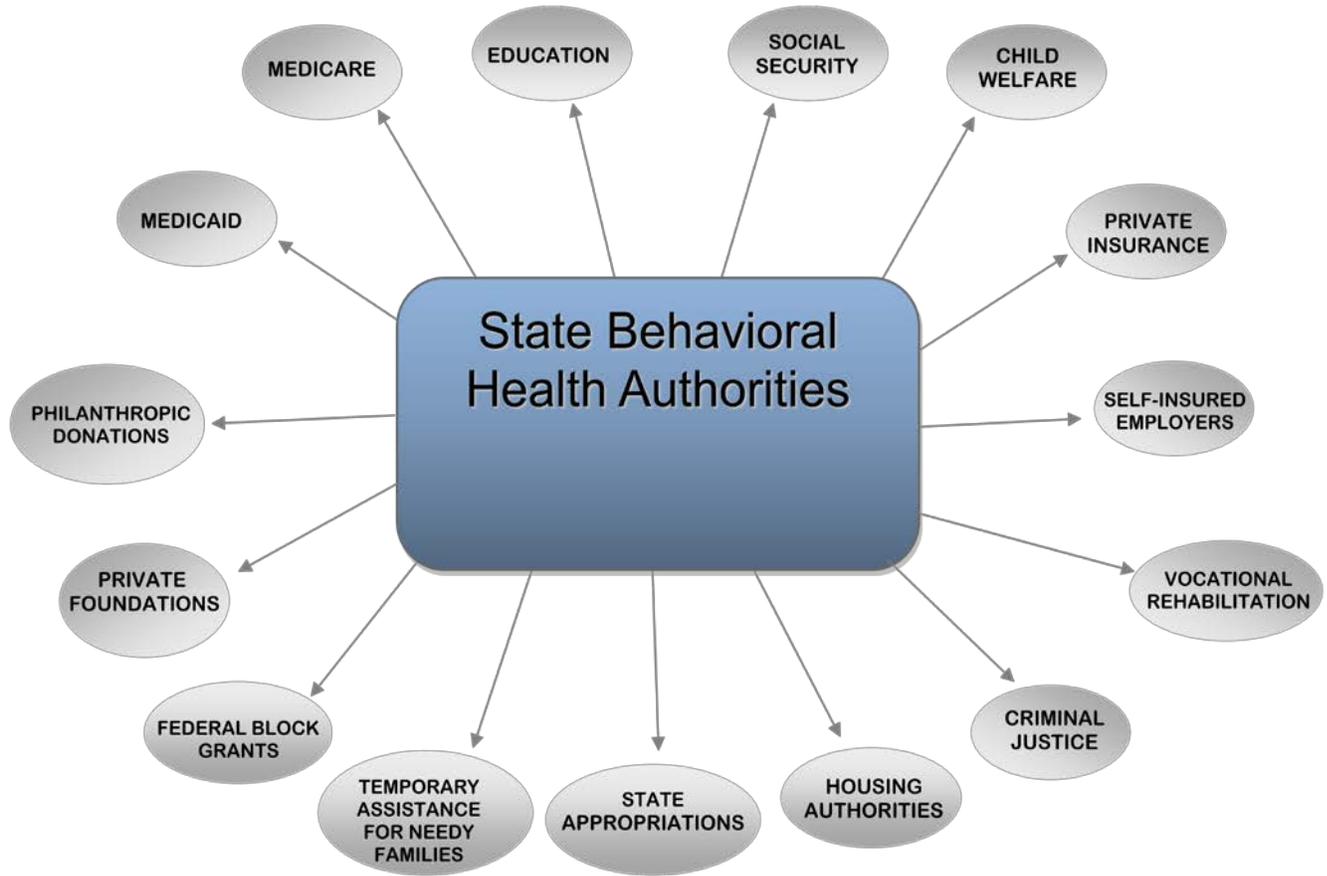
The financing system for behavioral health services differs from that for general medical services. Most notably, public sources play a larger role in financing behavioral health care (representing 61 percent of expenditures) than they do in overall health services (representing 46 percent of expenditures).

The federal-state Medicaid program is currently the largest source of financing for behavioral health services in the nation, covering over a quarter of all expenditures. Medicaid plays a large role in financing behavioral health services because its eligibility rules reach many individuals with significant need; it covers a broad range of benefits; and its financing structure allows states to expand services with federal financial assistance. Medicaid coverage of behavioral health benefits has been pivotal to deinstitutionalization and adoption of new treatment modalities. Medicare's role in financing behavioral health care (covering 7 percent of spending) is much smaller than its overall role in the health system, where it finances nearly a fifth of spending.

As Medicaid becomes a larger payer for both persons with behavioral health disorders, it is important to understand that Medicaid is primarily a health insurer, thereby requiring other funding sources to support critical services. In several states, the SBHA directly manages Medicaid and other funding in order to align payments with multiple programs, services, and practices to the extent possible.

SBHAs try to align several funding sources to address the needs of individuals with behavioral health conditions including:

¹ SBHAs are state substance abuse and mental health authorities, and the term *behavioral health* refers to substance abuse and mental health.



Many disabled Medicare beneficiaries qualify for coverage on the basis of a mental illness, but other beneficiaries have behavioral health needs as well. Beneficiaries who are dually eligible for Medicare and Medicaid report the highest rates of behavioral health conditions (59 and 20 percent of disabled and aged, respectively).

Medicare’s behavioral health benefits were initially modeled after private coverage and included many coverage limitations. Some limits on Medicare coverage of behavioral health services have been eased over time, but the program’s behavioral health benefits still retain some of their historical limits on psychosocial and support services, inpatient psychiatric hospital care, and certain providers. A large number of other federal, state, and local public programs finance services to support individuals with behavioral health needs. Many of these programs are not targeted to individuals with behavioral health problems, yet they provide key ancillary support services such as housing, income support, and vocational training.

The largest federal program dedicated to financing behavioral health services is the Community Mental Health Services Block Grant (MHBG), which allocates grants to states to support and enhance community behavioral health systems for individuals with serious mental illness. Stemming from a long history of financing and delivering behavioral health services, other state

and local funds finance a range of services and account for nearly a quarter of financing for behavioral health services in the nation.

Private insurance coverage covers the majority of Americans but finances only about a quarter of spending on behavioral health care. While nearly all (98%) of those with employer-sponsored coverage have mental health benefits included in their health plan, most have limits on these services.

Though they have a long history of funding mental health in the United States, charitable and philanthropic sources account for a small share (4%) of current financing for behavioral health services. Most of these funds are strategically targeted to pilot innovative programs or provide incentives for systems change.

SBHAs directly contract with private local community-based behavioral health providers. SBHAs may also fund local government services (city, county, or multi-county) and managed care entities, which in turn, operate and contract for community behavioral health services. SBHAs are actively involved, often in partnership with the courts, in keeping persons with severe mental illness and addictions out of prisons and jails through criminal justice diversion and reentry programs, drug courts, and outpatient commitment statutes.

States blend or “braid” their state or block grant funds with Medicaid dollars. Pooled financing of Medicaid, state general funds, block grants, and other categorical funds can promote flexibility and the optimum continuum of services for patients. Braided funds can lead to uniform benefits for insured and uninsured populations, and can also reduce the clinical and administrative barriers between programs in some state behavioral health service systems. SBHAs work closely with other major state payers (e.g. criminal justice, child welfare, education) to determine what populations and services are covered by other sources within the state. Such an assessment will help SBHAs target their funding and programs to fill gaps in care.

Given the array of payers with different funding objectives, reporting demands, and administrative mandates, it can be difficult to link consumers (sometimes with multiple eligibilities and conflicting payer requirements) with appropriate funding sources even when the clinical need is great. This hampers access to care and impedes the development of broad evidence-based clinical pathway, as programs are often developed to align primarily with payer specifications, which may not always align with evidence-based care or consumer needs and preferences.