the importance of the competitive bid proposal and the importance of New York focusing more attention on surveillance, monitoring and enforcement of contract provisions related to the carve-in of behavioral health services into Medicaid managed care. •

GAO points to populations at high risk of BH effects of COVID

Americans have reported feeling more isolated and stressed, and many have experienced economic hardship as a result of COVID-19, causing an increase in demand for behavioral health services, including those from mental health and substance use, according to a new Government Accountability Office (GAO) report. People most at risk of the effects of the pandemic include health care workers, children and adolescents, and people with preexisting behavioral health conditions, the GAO report stated.

Released in December, the report, Behavioral Health and COVID-19: Higher-Risk Populations and Related Federal Relief Funding (GAO-22-1044377), is required by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The GAO report noted that the federal government has provided more than $8 billion to help individuals experiencing mental health or substance use issues related to the pandemic.

Most of the $8 billion in funding support has been used for grant programs, and that money has gone to states and community-based providers to provide behavioral health services directly to people in need, Alyssa M. Hundrup, a director in the GAO’s health care team, stated during the GAO’s Watchdog Report podcast.

Hundrup noted that, for example, more than $5 billion went to the Substance Abuse and Mental Health Services Administration’s Community Mental Health Services block grant and Substance Abuse Prevention and Treatment block grant. “And those funds are distributed directly to local governments and nonprofits to provide mental health services and substance use disorder treatment services or recovery programs,” she said.

Compilation of the GAO report involved a review of selected research on COVID-19 and behavioral health, and relevant federal funding opportunity and awards documents. The GAO also interviewed stakeholders, such as federal officials, researchers and grantees. Grantees included state officials and providers in four states and Washington, D.C., selected based on state behavioral health metrics and CARES Act-funded grants received, among other factors.

Six impacted populations

According to the GAO, the six populations most frequently identified by stakeholders that may be at higher risk of behavioral health effects related to the COVID-19 pandemic are: (1) people from certain racial and ethnic groups, (2) health care workers, (3) children and adolescents, (4) people with preexisting behavioral health conditions, (5) young adults and (6) people facing financial distress.

The six populations were cited “time and time again,” Hundrup said. Black, Hispanic and Native American populations have suffered a disparate impact from COVID across the board, she said.

Hundrup added, “Experts are also deeply worried about children and teens, especially when they didn’t have access to or connections with their peers or their schools. Health care workers have been particularly affected given the added risks and stress they’ve experienced. People facing financial stress have also been vulnerable, as not having jobs or concerns about food can certainly take a toll. And, of course, people with preexisting behavioral health conditions, such as those with severe mental illness or substance use disorder.”

As demand for behavioral health treatment services was expected to increase as a result of the COVID-19 pandemic, access to treatment was also expected to worsen, the GAO report stated. Concerns about the availability of behavioral health treatment, particularly for low-income individuals, have been longstanding, as have been concerns about shortages of qualified behavioral health professionals, particularly in rural areas. The pandemic has exacerbated these concerns.

According to SAMHSA, contributing factors include layoffs of behavioral health staff and the loss of providers without the financial reserves to survive in the long term.

Young adults have also been impacted, Hundrup noted. “Leading up to the pandemic, there were concerns about higher rates of mental illness and loneliness in this group and I think the pandemic certainly exacerbated those issues,” she said. “And of course, it’s important to mention that these groups are not mutually exclusive. And so you can have one individual who is represented in multiple populations. And then, of course, not everyone in those groups will necessarily develop any symptoms.”

Research

Research has indicated a number of more reports of anxiety and depression across U.S. adults. Before 2019, about 11% of adults were reporting symptoms of depression or anxiety, said Hundrup. “Fast forward to April 2020 to September 2021, across that timeframe, up to 43% were reporting those symptoms. So quite a difference. We’re also seeing an increase in alcohol

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and drug use. And unfortunately, drug overdose deaths have increased — I think provisional data recently came out from April 2020 to April 2021, so over a one-year time frame, there was a 29% increase in overdose deaths, and that is predicted to be a record high, with over 100,000 lives lost.

The effects of the COVID-19 pandemic and related economic crisis — such as increased social isolation, stress and unemployment — have intensified concerns about the number of people in the United States affected by behavioral health conditions: mental health and substance use disorders, according to the GAO report.

“But looking ahead, it’s still so early it’s not possible to yet determine the full impact on the behavioral health or the impacts that COVID has had,” said Hundrup. “It will take time to determine both impacts and then how that money is being used and how effective it is in terms of reaching those populations,” she said.

To view the GAO report, visit https://www.gao.gov/products/gao-22-104437.

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hospitalizations among Whole Person Care enrollees did not increase during the time when overall service utilization began to rise again in the latter part of 2020.

“We’re interested in why hospitalization rates remained lower — it sounds like good news,” lead author Nadereh Pourat, Ph.D., associate director of the UCLA center and professor of health policy and management at the university’s Fielding School of Public Health, told MHW.

Pourat believes it will be important to retain flexibility in service delivery (including care delivered remotely) and a disease management orientation as the state moves into a CalAIM phase that will be managed by health plans. The transition to the new program took effect at the start of this year.

Findings of report

Whole Person Care was part of a Section 1115 Medicaid waiver and was designed to improve coordination of health, behavioral health and social services for high users of multiple service systems. Because of disruptions caused by COVID-19, the federal Centers for Medicare & Medicaid Services granted a one-year extension to the five-year Whole Person Care program, which had been scheduled to expire at the end of 2020. Twenty-five entities in 26 California counties provided Whole Person Care services, with care coordination and housing support common to all of the pilots.

The UCLA report examined the impact of pandemic-associated restrictions that began with a statewide shelter-in-place order that took effect in California on March 20, 2020. Twenty of the 25 pilot program entities reported that pandemic-related requirements limited their ability to deliver Whole Person Care services in person.

While many programs were able to transition to telehealth for core services, “pilots explained that it was difficult to make meaningful progress toward care management goals when enrollees frequently had inadequate access to cell phones, computers, the internet, or electricity,” the report states.

“In some cases, there is one computer for the entire household, and all are trying to use it to work or go to school.”

Nadereh Pourat, Ph.D.

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