Medicaid as a Model for Mental Health Service Delivery

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Introduction

Medicaid, the publicly funded insurance provider for low-income individuals, is the "single largest payer for mental health services" in the United States.[1] In 2010, Medicaid financed 28% of all mental health services, spending over $31 billion, but accounted for only 17% of total health care outlays; these statistics demonstrate the program's comparatively significant commitment to funding mental health treatments.[2] Medicaid has expanded rapidly over the past quarter century: in 1986, the program accounted for only 16.1% of mental health service payments, or $7.5 billion.[3] As Medicaid plays an increasingly significant role in financing mental health services, policymakers need to understand its payment mechanisms as well as eligibility requirements, and to address both the efficiencies and inefficiencies in the system.

Jointly administered by the state and federal governments, Medicaid consists of numerous programs and incentive schemes aimed at financing mental health treatments. Three of the most prominent programs include home- and community-based services (HCBS), health homes and targeted case management (TCM). An evaluation of these programs indicates that their efficiency, measured by both cost-effectiveness and patient outcomes, varies significantly across states depending on the specific implementation techniques adopted by state officials. This paper analyzes the methods that states employ to provide insurance through Medicaid, examining the factors that have enabled some administrators to see significant declines in costs and increases in quality of care. Specifically, states that prioritize mental health services, provide for early-onset disease intervention and focus on holistic community-based care see the most efficient outcomes in treatment of mental health patients. This paper also aims to assess mental health pilot programs and promote implementation rationales based on clinical outcomes and cost effectiveness criteria. The analysis in this paper offers evidence that, when applied to the framework of mental health management, programs designed to integrate holistic care models offer greater potential than fragmented care systems to offset long-term spending and improve health outcomes.

Mental Health Services in the United States

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a serious mental illness (SMI) as a "diagnosable mental, behavioral, or emotional disorder…that results in serious functional impairment." According to data gathered by SAMHSA, nearly 11 million adults in the United States (age 18 or older) had some form of SMI in 2009, and approximately one in eight adults received treatment for a mental health-related medical problem during the same year.[4]

The American medical system faces a formidable scope of mental health problems, and many Medicaid programs focus on alleviating the burden of expenses. However, Medicaid primarily funds patients with low income levels as well as those with disabilities, defined as "long-standing, severe physical or mental impairment[s]." These eligibility requirements ensure that Medicaid targets a specific portion of the population, focusing on those who are particularly vulnerable to medical crises (due to their lack of access to preventive care) and those who lack the ability to pay for health services.[3,5]

Medicaid is distinct from private insurance in the way it finances mental health services. First, Medicaid has always offered coverage for preexisting conditions, unlike many private insurers prior to the passage of the Affordable Care Act of 2010. Second, Medicaid focuses its coverage on community-based services, which are offered in a patient's home or workplace rather than in a hospital or other clinical institution. Private insurers often deny coverage for these programs. Finally, Medicaid does not impose the kinds of spending limitations that private insurers frequently implement, such as lifetime caps.[3]

Home and Community-Based Services

Medicaid is structured to promote state-level innovation in the provision of mental health care. Under HCBS, states apply to the federal government for waivers, which enable accessible health care in a patient's home, school or workplace rather than in an institutional setting. The objective is to provide patients with "individualized, person-centered care" while simultaneously reducing costs because community-based care is typically less expensive than care administered in a full-time nursing home or institutional setting.[6,7,8] As originally enacted, the HCBS waiver program included four mechanisms for minimizing costs: (1) it required states to demonstrate that community-based care would be cost-neutral compared to care in an institutional setting; (2) it required states to limit the number of patients eligible for community-based care under each waiver; (3) it allowed states to implement spending caps; and (4) it allowed states to tailor specific eligibility criteria based on income level, medical condition or place of residence.[9] Under the cost neutrality requirements, individuals who were ineligible for institutional care were typically ineligible for community-based care as well because there was no way to develop cost-neutral treatments for patients receiving no state-provided care in the first place. However, the Deficit Reduction Act of 2005 eliminated the waiver requirement, allowing states to provide certain services in community-based settings without demonstrating cost-neutrality. Therefore, some patients could receive care in their home or workplace even if they would not otherwise have been eligible for institutional care.[10]

States have adopted vastly divergent methods for providing home and community-based services to their patients. Despite the belief that HCBS would improve medical outcomes by providing individualized care, it has proven difficult to systematically gather data about health care quality under HCBS. In 2005, Marek et al. provided limited evidence that HCBS improved health outcomes compared to nursing home care. For example, patients receiving HCBS demonstrated improved cognition, lower rates of depression and greater levels of daily activity than patients treated in full-time nursing home facilities.[11] However, the challenge of monitoring HCBS care and the absence of comparative studies have made it difficult to gather reliable data about patient outcomes.[12] Improving standardization of data sets through innovative collection methods, such as using electronic health records or coordinating care under an integrated health unit, could serve as a potential way to ameliorate existing challenges in data collection.

One of the major justifications for HCBS is that it leads to higher levels of patient satisfaction with their medical care than do patients in institutional settings. Studies of numerous states

have validated this justification. For example, a 2006 study investigated patient satisfaction with HCBS in seven states—Alabama, Indiana, Kentucky, Maryland, Michigan, Washington and Wisconsin. The study found high levels of satisfaction among patients receiving HCBS, noting that physically disabled patients under 65 years old were substantially more satisfied with their medical care when they received services at home rather than in institutional settings. 77% of HCBS patients stated that they were "very happy" with their home- and community-based services, while another 19% described themselves as "somewhat happy." Only 10% of individuals claimed that they had had problems with the provision of HCBS services in the past, and 99% of patients stated that they related "well" or "very well" to their caregivers.[13] Other studies have produced similar findings, indicating that patients may be responding positively to the personalized care provided under HCBS. In particular, individuals are more likely to classify their medical providers as "helpful, well-trained and respectful," and few beneficiaries have serious complaints—such as inefficient, unfriendly or uncommunicative healthcare providers—while receiving HCBS.[14,15]

Despite the abundance of positive feedback about HCBS, states have differed significantly in their ability to provide HCBS for Medicaid beneficiaries. In Minnesota for example, policymakers have shifted large amounts of funding from nursing homes to HCBS. They have also offered home- and community-based services under Medicaid plans overseen by managed care organizations, which allow private insurers to finance medical services in return for capitation payments from the state. Similar spending shifts have occurred in Idaho, which eliminated its waiting list for HCBS. This ensured that beneficiaries did not have to spend any time in nursing homes and could immediately begin receiving care at home. In contrast, Georgia devotes a significant portion of Medicaid funds to nursing homes, which are some of the primary facilities, along with hospitals, that provide institutional care in the United States. In Georgia, approximately 67% of Medicaid beneficiaries requiring long-term care are first treated in nursing homes; the comparable values for Idaho and Minnesota are 33% and 17%, respectively.[16]

These cases suggest that states can promote HCBS by adopting a series of relatively simple reforms, especially by shifting funds to HCBS and eliminating waiting lists. Some states have hesitated to engage in these reforms because they fear the economic consequences of devoting funds to home- and community-based care. Certainly, evidence on the cost-effectiveness of HCBS is ambiguous. Some studies indicate that HCBS increases long-term costs, since state funds devoted to HCBS are not always offset by reductions in financing for nursing homes or other institutional settings.[17,18,12] However, HCBS has generally been associated with greater cost efficiency when states adopt one or more of the following reforms: (1) limiting eligibility for HCBS to those who require nursing home-level care; (2) adopting spending controls or caps; and/or (3) implementing cost-neutral measures that offset any increases in HCBS care with decreases in funding for nursing home facilities.[12]

A 2001 study of Florida's HCBS program, known as the Diversion project found considerable cost-per-patient savings. Only beneficiaries who required nursing home-level care could qualify for the program.[19] A 2000 study indicated that Michigan's HCBS program was less "resource intensive" than nursing home programs in neighboring Ohio, since HCBS patients were better able to perform activities of daily life and self-care without medical assistance. The study indicated that Michigan's success may have emerged from its ability to restrict HCBS care to those patients who required nursing-home-level services.[20] Finally, in October 2005, Vermont adopted the Choices for Care (CFC) program, which aimed to expand HCBS while limiting the use of nursing home facilities. The program offered access to HCBS only for individuals with the "highest need," including those who required "extensive or total assistance" with toileting, decision-making and/or eating. The statute did not even extend eligibility to all patients who required nursing home care. In addition, Vermont imposed a total limit on spending for long-term care under Medicaid. The results were staggering: between October 2005 and January 2009, enrollment in nursing care facilities decreased by 9%, while use of HCBS increased by 155%. At the same time, Vermont met the needs of its citizens at less than half of the total projected cost.[21,22] The experiences encountered by the states of Florida, Michigan and Vermont demonstrate the possibility of designing cost-effective Medicaid HCBS programs.

The quality and efficiency of HCBS programs varies significantly across the United States, but certain techniques have enabled states to employ these programs with substantial success. Shifting funds from nursing homes to HCBS programs, eliminating waiting lists and establishing efficient eligibility criteria can offset increases in HCBS costs with decreases in nursing home expenditures. These measures ensure cost effectiveness without sacrificing quality of care. The programs implemented by several states serve as models for these reforms, and they deserve emulation by healthcare administrators across the nation.

However, there are also potential downsides to widespread implementation of HCBS programs. There is little affirmative evidence that HCBS treatments improve patient outcomes, and further research is required to determine whether these treatments possess clinical or medical benefits compared to institutional alternatives.[12,10] In addition, the implementation of HCBS programs would inevitably require tradeoffs. If states were to reallocate funds from institutional care centers to community-based treatment, the quality of care for patients in hospitals and nursing homes might decline. This raises particularly compelling concerns, since patients in institutional settings typically require more care and attention than individuals treated in their homes or workplaces.[12,20] Finally, inequities in HCBS expenditures across states would result in disparate levels of care across the country. Increasing horizontal equity across state lines might necessitate increased federal government intervention, which may face political opposition and result in the expansion of an already bloated federal health care bureaucracy.[10] These potential drawbacks deserve further investigation, and they must be balanced against the possible benefits of expanding HCBS programs in the United States.

The objective is to provide patients with "individualized, person-centered care" while simultaneously reducing costs.

Medicaid Health Homes

In addition to providing quality HCBS, Medicaid is committed to delivering essential mental health services to the elderly and chronically ill. The needs of these population subsets are costly and largely underserved, given the health and demographic profile of these subsets. Three recent studies have shown that only 50% of individuals with chronic mental illness receive adequate community-based mental health treatment; of this group, only 7% receive services derived from evidence-based practices.[23,24,25] In a 2001 study, Kessler et al. investigated instances of mental-health patients whose illnesses went untreated. The authors found that less than 40% of patients with SMI received "stable treatment," and young adults and those living in rural areas were particularly likely to receive inadequate or inconsistent treatment.[24] Moreover, most individuals with chronic mental health conditions suffer from multiple comorbid conditions and are non-compliant on medication. As a result, they demonstrate "emergency room recidivism, high rates of psychiatric hospitalization, homelessness, incarceration and increased health-care costs."[23] For chronically ill patients, access to patient-centered primary care is crucial. For example, prescriptions must be carefully overseen to reduce harmful side effects and interactions, especially when mental health patients are taking additional medications for

other diseases. Moreover, compliance must be monitored to ensure proper adherence to medication. Studies have suggested that improving compliance alone could result in annual savings of $100 million for Medicaid. These savings could be achieved by implementing coordinated care among specialists, replacing fragmented systems that limit accountability and transparency.[23,26]

To effectively coordinate care for the chronically ill, Medicaid health homes were introduced as an optional state benefit in Section 2703 of the Affordable Care Act of 2010 (ACA), to integrate all "primary, acute, behavioral health, and long-term services and supports to treat the whole person."[27] To effectively address these overarching goals, the program aims to ensure care coordination, health promotion, comprehensive translational care, patient and family support as well as referral to community and social support services. Individuals are eligible for home health services if they have two or more chronic conditions, including asthma, diabetes, heart disease, mental health problems, substance abuse and obesity; have one chronic condition and are at risk for a second; or have one "serious and persistent mental health condition."[27]

To provide integrated, primary-centered care management, this innovative delivery model relies on unique "health home provider arrangements" to deliver care. Beneficiaries can enroll in flexible provider arrangements. Under these arrangements, patients can receive continued medical support from a general practitioner or they can be assigned a "health team" of interdisciplinary medical specialists, social workers, licensed complementary and alternative medicine practitioners, behavioral health providers and pharmacists. In this model, patients are granted freedom to elect team personnel while the primary care physician coordinates care and ensures that a given patient's needs are met in an integrated manner.[6] This holistic, patient-centered model combines medical and behavioral health care for individuals with chronic illnesses and ultimately seeks to improve "clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care."[28]

If it were not enough that patients prefer health homes to existing treatment methods and that health homes frequently produce superior clinical outcomes, the program also holds the potential to provide immense savings for state Medicaid budgets. It is designed to cost far less—in both the short term and the long term—than alternative care models. Strategies aimed at containing Medicaid costs typically focus on offsetting long-term per patient cost (unlike many strategies employed by commercial insurers). Medicaid policy makers adopt this mindset largely due to Medicaid's patient demographic. A disproportionate amount of Medicaid funds is spent on the top 10% of beneficiaries, who have the greatest health and long-term care needs. These individuals, typically covered by both Medicare and Medicaid and known as "dual eligibles," are often elderly and highly disabled. As a result, they frequently require long-term and chronic care support services. In 2008, dual eligibles constituted 15% of Medicaid enrollees and incurred 39% of total Medicaid expenditures. The vast majority of Medicaid expenditures on dual eligibles—over $89.1 billion—was spent on long-term care services, while acute care accounted for less than 5% of total spending, and prescription drugs less than 1.5%. These figures highlight the nature of per-patient spending in Medicaid, which is highly skewed toward consumers requiring chronic support. Unsurprisingly, spending within the dual eligible channel follows overall cost patterns, since patients in the top 10% of dual eligible spending accounted for more than 60% of total dual eligible spending.[29]

Studies have suggested that average health spending for people with mental illnesses is as much as 32% higher than spending for non-mental health patients. The vast majority of total mental health spending—over 75%—is not for treatment of mental complications, but rather for management of comorbidities such as substance abuse, dementia and delirium that arise as a result of mental illness.[30] Additionally, results of a 2011 report demonstrate that the seven-day hospital readmission rate of mental health beneficiaries is markedly higher than that for non-mental health beneficiaries.[31,30] Efforts targeting prevention and early-stage disease management are therefore highly prioritized by Medicaid programs, which seek to reduce spending for emergency visits and chronic long-term care services.

For state Medicaid programs, implementing health homes could result in significant health care savings in the short term, especially if states take advantage of the low-barrier financing options made possible by the federal government. The ACA authorizes a temporary 90% federal medical assistance package for health home services and gives states the flexibility to design their payment methodologies and propose alternatives.[27] Several states with expanding Medicaid populations have initiated efforts to implement health home pilot programs and to improve clinical outcomes and contain costs.[32] As a result of loosened Medicaid eligibility requirements stipulated by the ACA, the Centers for Medicare and Medicare Services (CMS) project that by 2014 Medicaid enrollment will increase by 19.5 million people, and spending will grow 20.3%. These expansions will mandate development of more effective management practices for a burgeoning behavioral health population.[33]

For Illinois, which estimates 700,000 new Medicaid enrollments by 2014, expanding health homes among the Medicaid population is advantageous from both clinical and health economics perspectives. The state, which is deeply entrenched in budget deficits, is facing a $74 million (31%) decrease in community mental health grants.[34] Despite requirements to make upfront investments in the implementation of health homes, state experts are aggressively expanding the program. A comparison of price benchmarks indicates that the program has the potential to offset its costs; where average cost to provide health home care was $150 per day, the same services applied in a nursing home or hospital would average $209 per day or $1500 per day, respectively. Studies further demonstrate that states that invested in health homes saw decreases in long-term care services by 7.9% and institutional spending by 16.3%. In contrast, states that did not invest in health homes saw long-term care services rise by 8.8%, which suggests that the increased state spending on home care is associated with decreased spending on more costly long-term care and hospitalization.[35]

Medicaid aims to aggressively target mental health intervention among individuals before they become critical, potentially leading to aversion of health crises and hospitalization.

Among patients with chronic mental illnesses, the community-based health home model offers the potential to provide integrated, cost-effective, longitudinal services and support to bridge the physical and behavioral health gap. This unique service delivery model, which aims to improve overall care by reducing emergency room visits, hospital admissions and reliance on long-term care facilities, may serve as a critical support system for the chronically ill to achieve enhanced clinical outcomes. As most states have begun early stage implementation of health homes, proper evaluation of these programs is crucial to measure the ability of these programs to meet their intended goals. Currently, CMS mandates a core set of guidelines, which includes quality measures that "assess individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes."[6] States instituting health home pilot plans have drafted assessment criteria to evaluate clinical outcomes and program cost-effectiveness. Thus far, evaluation guidelines include: obtaining and holding annual evaluations of baseline measures for annual cost of

care per patient; monitoring hospital admissions; tracking longitudinal patient admission data; and developing qualitative and quantitative tools to measure patient satisfaction.[3,5,6] These evaluation tools must be implemented, standardized and analyzed to provide concrete economic evidence for the effectiveness of Medicaid programs.

The shift towards primary care-centered management highlights Medicaid's commitment to providing coordinated, patient-centered options for effective disease management, a practice considered key to ensuring the long-term well-being of individuals with chronic mental illnesses. Implementation of the health home model, if successful, should simultaneously satisfy the CMS's three goals to improve healthcare: "improving the experience of care; improving the health of populations; and reducing per capita costs of health care without any harm whatsoever to individuals, families, or communities."[6]

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Targeted Case Management

HCBS has proven particularly effective at treating children and those in the early stages of mental illness, while Medicaid health homes focus on the elderly and chronically ill.[36,27] Targeted case management (TCM) is a program that yields benefits for individuals at all stages of life and at all points in the disease management process. Case management aims to direct patients to the health care providers best suited to their needs. Its objective is not to provide services directly to patients, but simply to help them access efficient health care providers. Targeted case management applies these services to specific segments of the population. For example, TCM services might focus on populations with a particular disease, such as tuberculosis, or groups in a particular geographic area.[37] Many state governments have employed TCM as a tool to target mental health patients, connecting them with medical services that can effectively treat their conditions. For example, South Carolina offers TCM services for all "non-institutionalized patients with mental retardation and related disabilities."[38]

Studies of TCM are mixed in their assessments of the program's cost effectiveness and patient outcomes. Between 1999 and 2005, total TCM expenditures grew from $1.41 billion to $2.90 billion—a 105.7% increase. In contrast, total Medicaid expenditures grew by 87%. In addition, per person TCM costs rose by 26.9% from $834 to $1,058.37 A 2001 study indicated that the cost effectiveness of TCM programs varies widely depending on the specific implementation models adopted by states. Nonetheless, the author suggested that certain techniques could ensure cost savings or improvements in patient outcomes.[39] Grandinetti and Slomski found similar results in a 1998 article, arguing that TCM could ensure cost reductions and improve efficiency.[40]

Few analyses have engaged in extensive case studies to identify the techniques that lead to the successful utilization of TCMTCS in some states but not in others. Additionally, legislative and administrative changes in federal TCM guidelines over the years have resulted in corresponding changes in the states, requiring state legislatures to develop new programs for assessing quality of care, improving clinical outcomes and reducing costs. These changes have made it difficult to study implementation techniques over an extended period of time. Nonetheless, several states have developed innovative approaches that hold significant potential for cost effectiveness and improved patient outcomes. New Jersey's Real Life Choices program, for example, has seen high levels of consumer satisfaction by empowering patients to make crucial health financing decisions. The program provides patients with a sum of money and offers guidance to help them allocate the money efficiently. Wyoming and Wisconsin have implemented similar programs aimed at providing consumers with a greater level of discretion in allocating their health care funds. At the same time, New Jersey has kept costs under control by implementing a tiered TCM system for patients with developmental disabilities. After a comprehensive review of the program, state officials recognized that some individuals did not need the extensive services offered under TCM. Instead, these patients simply required "information, education, referral, and a source of connection to the system when there were problems." To serve these patients' needs, New Jersey created a more limited TCM system known as "Resource Case Management" or "Connections." Officials maintain phone contact with beneficiaries of this system at least once a year, providing the services they need at minimal cost.[41]

The United States' experience with targeted care management demonstrates the states' potential for innovation in providing mental health services through Medicaid. New Jersey's adoption of consumer-oriented programs and tiered service systems demonstrates a possible means of guaranteeing patient satisfaction while reducing costs. In light of growing expenditures on TCM over the past decade, these reforms represent a way forward for states struggling to balance their constituents' needs with overburdened budgets. Nonetheless, New Jersey's approach also illustrates the limitations of the TCM model. Targeted care management can be a potentially costly mechanism for providing care. Although New Jersey was able to overcome cost concerns by developing a tiered-system, this system might become more complicated by requiring administrators to apply different levels of assistance to various groups. Other states have had less success in developing cost effective means of implementing TCM.[39] In addition, although TCM can be used as a tool to empower patients, its emphasis on their independence might also jeopardize the quality of care. Unless TCM administrators provide efficient and effective guidance, patients will be unable to locate the health services that are best equipped to serve them. As a result, agencies might have to adopt a more active role to ensure that the benefits of patient empowerment are balanced against the risks of allowing patients to make their own medical choices. TCM is still an untested system with varying results from state to state, and the effectiveness of its implementation over the next several decades will determine its ultimate staying power.

Final Conclusions and Recommendations

Politicians and administrators often present Medicaid as an example of waste, fraud and inefficiency in the healthcare system. A June 2012 article in the Washington Post declared that growing Medicaid costs have left "most [state] governments in dire fiscal straits," and the federal government spent $208 million identifying fraudulent payments in 2011.[42,43] Yet Medicaid's approach to managing mental health is unique since it seeks to improve health care delivery through its simultaneous pursuit of three goals: prioritization of mental health as a key budget item, emphasis on community-based mental health care and targeted promotion of preventative, early-stage disease intervention. As a result, Medicaid coverage of services for the behavioral health population is often deemed more generous than alternatives offered by private health insurance plans. By providing community-based services across a continuum of care, Medicaid is committed to serving beneficiaries of diverse backgrounds and health needs, especially among the traditionally underserved behavioral health population. Medicaid's commitment to provide comprehensive mental health services is evidenced by the range and quality of programs offered. Through HCBS and targeted case management, Medicaid aggressively targets mental health intervention among individuals before they become critical, potentially averting health crises and hospitalization. For the chronically ill, Medicaid seeks to provide innovative models of patient-centered

care through the provision of health homes designed to integrate physical and behavioral models of disease management.

Mental health stands at a unique, integrated forefront of social, behavioral and physical care—a distinct intersection that raises unique questions and presents significant opportunities for innovation. As a result, developing solutions for treatment requires reassessing key assumptions as well as adopting interdisciplinary management framework models. The approaches Medicaid applies to tackling mental health challenges, while initially costly, have delivered superior clinical outcomes and continue to promise cost-effective, holistic models of care. By prioritizing mental health, relying on community-based care and adopting early-onset disease management tactics, Medicaid policy makers can fulfill this promise in the coming decades.

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