

Medicaid and Mental Health Services

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OVERVIEW — *Medicaid is the largest payer of mental health services in the United States, contributing more than any other private or public source of funding. This background paper highlights the variety of services and supports needed by individuals with mental illness and Medicaid's increasing role in mental health coverage. It provides an overview of Medicaid coverage of mental health services and identifies some of the key challenges in providing that coverage.*

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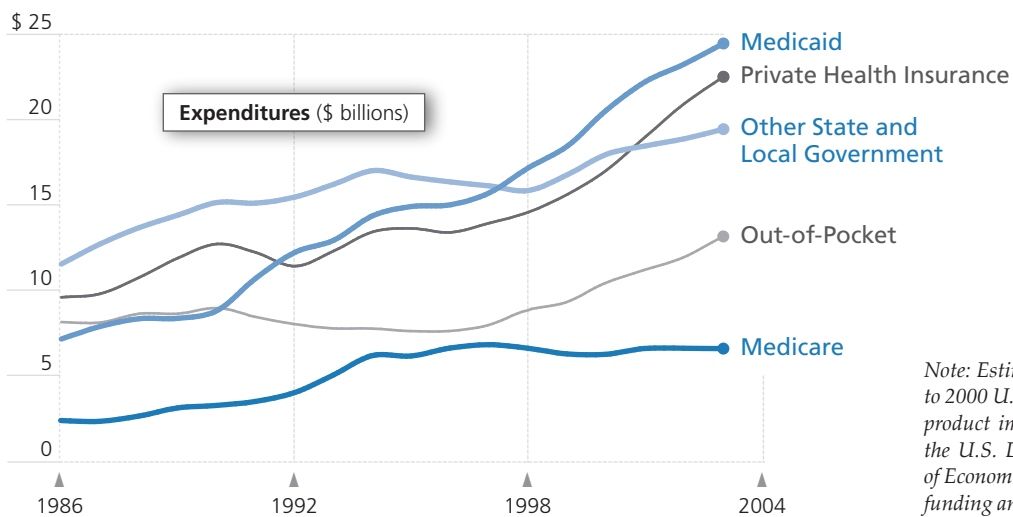
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Medicaid and Mental Health Services

Medicaid is the largest payer of mental health services in the United States, contributing more than any other private or public source of funding (Figure 1). In 2003, Medicaid spent over \$26 billion on mental health services—about 26 percent of total national mental health expenditures.¹ This number has grown from approximately \$7.5 billion (16.1 percent of total spending) in 1986, when Medicaid contributed less than three other payers: state and local governments, private health insurance, and consumers.² The increase in Medicaid spending is primarily the result of the shift in service delivery from public institutions, where (as described later) Medicaid funding is limited, to community-based services, for which Medicaid covers a larger share of the costs and provides greater access. Other factors contributing to the increase in Medicaid costs include eligibility expansions, increased use of services, and state cost shifting.

FIGURE 1
National Mental Health Expenditures, in constant 2000 dollars



Note: Estimates have been inflation-adjusted to 2000 U.S. dollars using the gross domestic product implicit price deflator developed by the U.S. Department of Commerce, Bureau of Economic Analysis. Excludes other private funding and other federal government expenditures, which combined are 7 percent of total mental health expenditures in 2003.

Source: Tami Mark et al., National Expenditures for Mental Health Services and Substance Abuse Treatment, 1993–2003, SAMHSA Publication No. SMA 07-4227 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007); available at www.samhsa.gov/spendingestimates/SAMHSAFINAL9303.pdf.

Despite its large financial commitment, Medicaid has been criticized as not meeting the mental health needs of many individuals. Similar criticisms are often leveled at the Medicaid program in general. They usually stem from the great state variation in Medicaid eligibility levels, services that are covered, limits placed on those services, and coordination and management of services—disparities that leave some people without

coverage or without adequate access to services. Federal statute and regulation also play a role in the extent to which people and services can be covered.

THE NEED FOR MENTAL HEALTH SERVICES

Almost 6 percent of the adult U.S. population has a serious mental illness (SMI), such as schizophrenia, major depression, or bipolar disorder.³ About 10 percent of children have a serious emotional disorder (SED), such as chronic depression, major conduct disorders, and substance abuse problems. Medicaid plays a significant role in providing mental health services to a portion of these populations—those individuals who are able to qualify as Medicaid-eligible, either on the basis of disability or as a member of a low-income family with children.⁴ To qualify as disabled, a person must have a long-standing, severe physical or mental impairment. Approximately 4 percent of Medicaid enrollees gain eligibility because a mental disorder qualifies them as disabled.⁵ However, mental health services are also available to enrollees whose eligibility is based on income rather than disability. Approximately 13 percent of all Medicaid enrollees use mental health services at some time during the year.⁶

Not all low-income people with mental illness are eligible for Medicaid, either because their impairments are not severe enough to qualify them as disabled or because their incomes do not fall within the Medicaid eligibility range. Some groups, such as nondisabled single adults and immigrants, are not eligible for Medicaid coverage at all. Finally, individuals with SMI may be homeless or too impaired to complete the Medicaid enrollment process.

A substantial number of people within the uninsured population are in need of mental health services. Data from the 2005 and 2006 National Survey on Drug Use and Health show that more than one in four adults who are uninsured have a mental illness, substance use disorder, or co-occurring disorder.⁷ Approximately one-third of people with mental illness, substance use disorders, or both are have incomes under the federal poverty level (FPL) and are uninsured. As states have shifted more of their mental health budgets toward Medicaid, less state funding is available to provide services for these uninsured populations. For example, 32 percent of Oregon's 1995 mental health budget was made up of state general funds for indigent care. By 2000, this number had fallen to 19.5 percent.⁸

Individuals with SMI usually have significant limitations in a variety of life activities. This may include deficits in social interactions, behavior, work-related activities, activities of daily living (eating, bathing dressing, and toileting), instrumental activities of daily living (such as shopping, budgeting, and household chores), and navigating the complex world of social service delivery. In addition, mental health disorders frequently co-occur with other disorders or illnesses, such as substance abuse, developmental disabilities, or

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chronic physical illnesses, that can overshadow mental health issues and create service coordination challenges. Consequently, many individuals with SMI require assistance in a number of areas, including income support, rehabilitation, vocational services, and housing support, in addition to psychiatric and medical services. While Medicaid can address many of the needs presented by people with SMI, it is primarily designed to provide medically related treatment and support services, not to offer every nonmedical support that is required to live successfully in the community. For example, Medicaid does not reimburse for costs related to housing, education, or vocational services.

THE EVOLUTION OF MEDICAID'S ROLE IN MENTAL HEALTH

Mental health services until the mid-1950s were provided mostly in large, state-funded institutions. The few community mental health programs that existed were funded solely with state and local dollars. During the 1950s, the introduction of effective, anti-psychotic drugs such as Thorazine made it possible to serve more individuals with SMI in the community. These medications, in conjunction with litigation challenging the segregation of individuals in mental institutions, spurred a movement toward deinstitutionalization. In 1963, Congress enacted the Mental Retardation Facilities and Community Mental Health Centers Construction Act (P.L. 88-164), to provide localities with funding for the development of community mental health centers and to provide services for the uninsured poor.⁹

Following the enactment of Medicaid in 1965, states began to aggressively pursue available federal matching funds for mental health services that were previously funded with state and local dollars.¹⁰ Because Medicaid funds for institutional services were (and remain) limited, states could maximize federal participation toward their costs by providing services in community settings (see text box, right). In fact, many observers believe that the enactment and implementation of the Medicaid program sped up deinstitutionalization. For the first time, a comprehensive public insurance mechanism was available to pay for health care, including mental health services, opening up new choices

Institutions for Mental Disease (IMDs)

At the time Medicaid was enacted, state and local mental hospitals were viewed as primarily custodial institutions and a state responsibility—a

responsibility that had the potential to significantly increase costs to the federal government. As a result, the Medicaid statute specifically precludes coverage of services for individuals ages 22 to 64 in IMDs—defined as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.”^{*} This “IMD exclusion” means that federal Medicaid matching payments are available for the costs of short-term inpatient care for a Medicaid-eligible individual in a general hospital psychiatric unit but not in a state or local mental hospital. However, the Medicaid statute does permit coverage of services for children under age 21 in psychiatric hospitals and adults age 65 and older in IMDs, as long as those institutions meet special conditions of participation.

One way that states have financed IMDs is by directing federal disproportionate share hospital (DSH) funds to those institutions. Under the DSH program, each state receives an annual capped allotment. Funds from that allotment are intended to reimburse hospitals that serve a disproportionate share of uninsured, low-income patients. Between 2001 and 2006, DSH payments to IMDs averaged approximately \$3.3 billion annually.[†] Some states have also received approval from CMS to cover IMD services under waiver programs; however, CMS has been phasing out this practice in recent years as waivers are renewed.

^{*} Code of Federal Regulations, 42 CFR, section 435.1009.

[†] Brian Burwell, Kate Sredl, and Steve Eiken, “Medicaid Long-term Care Expenditures in FY 2006,” Thomson Reuters, August 10, 2007; available at www.hcbs.org/files/120/5959/2006LTCExpenditures2.xls.

of providers for beneficiaries. Over the years, Medicaid has also become a major source of financing for state mental health agencies. Revenues from Medicaid increased from a fiscal year 1997 level of \$4.7 billion to a fiscal year 2005 total of \$12.4 billion, or approximately 42 percent of state mental health agency revenues.¹¹

Although Medicaid is a major player in providing and paying for mental health services, it is important to recognize that there are many other state and local agencies that also have responsibility for providing mental health services. These agencies may include school systems, disability services administrations, juvenile justice or corrections departments, child welfare departments, and, foremost, state mental health agencies. While states vary widely in the way programs are administered, the mental health agency is usually responsible for operating large public psychiatric hospitals and funding community mental health centers (CMHCs). Because these various agencies receive significant portions of their funds from state and local sources and have differing legislative mandates, they operate under unique rules and often have flexibility to decide what services will be offered and what populations will be targeted. Differing rules and funding sources makes coordination of services for individuals with mental illness difficult (see text box, below). Challenges in service coordination occur throughout the Medicaid program, but they are exacerbated in the case of mental health because so many different agencies provide these services. As states have sought to gain more Medicaid matching funds, differing rules and funding sources have also led to a disconnect between the services provided under existing programs and those that Medicaid will reimburse. State and local programs have often had to change their methods of administration and operation in order to gain Medicaid reimbursement. Further, the state mental health agency (and its mental health expertise) may play a diminished role as the state Medicaid agency assumes more responsibility for program design, regulation, rate setting and contracting with providers.

COVERAGE UNDER MEDICAID

With the exception of coverage for individuals under age 21 in psychiatric hospitals and age 65 and older in IMDs, mental health services or benefits are not specifically defined in the Medicaid statute. The law does, however, spell out certain mandatory benefits that states must offer and optional benefits that states may choose to offer. It is

The President's New Freedom Commission on Mental Health

On April 29, 2002, President Bush announced the creation of the New Freedom Commission on Mental Health. The commission was charged with studying the mental health service delivery system and making recommendations that would enable adults with SMI and children with SED to live, work, learn, and participate fully in their communities. In July 2003, the commission submitted its final report.* It found that the mental health system is fragmented, disconnected, and often inadequate. The report made a number of recommendations for improvement and emphasized the need for collaboration among the various players involved in providing mental health services, including the need for federal guidance on how to use Medicaid funds seamlessly with other private sources.

* The final report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, is available at www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf.

through these generic categories of benefits that mental health services are provided. For example, psychiatrist services are provided through the general coverage category of physician services, and community support services are usually offered through the rehabilitation services option (Table 1).

TABLE 1
Mental Health Services and Medicaid Coverage Categories

SERVICE	Coverage Category	Mandatory	Optional
Psychiatrist	Physician Services	●	
Psychologist	Other Practitioners' Services		●
Clinical Social Work	Other Practitioners' Services		●
Hospitalization*	Inpatient Hospital	●	
Medications	Prescribed Drugs		●
Personal Assistance	Personal Care		●
Diagnosis	Diagnostic, screening, rehabilitative and preventive services		●
Outpatient Mental Health Services	Outpatient hospital service Clinic Services ("Clinic option")		●
Community Support Services	Diagnostic, screening, rehabilitative and preventive services ("Rehab option")		●
Substance Abuse Treatment	Clinic Services Diagnostic, screening, rehabilitative and preventive services		●
Service Coordination/ Case Management	Targeted case management		●

*Under age 65 with specific exceptions

Source: Gary Smith et al., Using Medicaid to Support Working Age Adults with Serious Mental Illness in the Community: A Handbook, U.S. Department of Health and Human Services, January 2005; available at <http://aspe.hhs.gov/daltcp/reports/handbook.pdf>.

Each state describes the services that will be offered in its Medicaid plan, which must be approved by the Centers for Medicare & Medicaid Services (CMS). Once a benefit is included in the state plan, it must be made available to all Medicaid-eligible enrollees. States can define Medicaid benefits to include services that are needed by individuals with mental illness, as long as those definitions comport with federal statute and regulation. Services particularly relevant for states wanting to offer community-based mental health services include the following:

- **Targeted case management (TCM)** — TCM services are designed to help specific populations, such as individuals with SMI, gain access to needed medical, social, educational, and other services. TCM can be used to manage both Medicaid and non-Medicaid services. It can also be used for service and support planning and monitoring the delivery of services. Delaware is the only state that does not cover TCM services. Expenditures for these services have grown by 105 percent over a six-year period, totaling \$2.9 billion in 2005.¹²
- **Rehabilitative services (“rehab option”)** — Rehabilitative services are designed to restore or remediate loss of function.¹³ They can be provided by a wide range of mental health professionals in a variety of settings. This option is used to provide many of the services under evidence-based practices (EBPs), such as assertive community treatment (ACT), that have been shown through research to be effective for people with mental illness. (For a list of six EBPs for which CMS has released guidance, see text box, next page.) Rehabilitative services can also be used to provide case management of Medicaid-covered services. In 2006, 48 states and the District of Columbia covered rehabilitative services. FY 2005 expenditures totaled \$6.4 billion—an increase of more than 76 percent over six years.¹⁴
- **Clinic services** — Clinic services must be directed by a physician in a clinic setting, such as a CMHC. These services are used primarily for individuals with milder impairments who can be treated on an outpatient basis. Services must be provided in accordance with a written plan of care and reviewed every 90 days. This service category is sometimes criticized as being a medical model of treatment—that is, a model focused on diagnosing and treating an illness or disability—that, in the view of some disability rights groups, disempowers individuals and does not place enough emphasis on providing needed home and community supports.
- **Prescription drugs** — Although an optional service under Medicaid, prescription drugs are a vital component of treatment for many people with mental illness and are covered by all states. Expenditures for drugs used for the treatment of mental disorders are among the fastest rising costs for Medicaid, representing an estimated 20 percent of Medicaid’s total payment for pharmaceuticals in 2003.¹⁵

Benefit Limitations

Using Medicaid’s mandatory and optional benefits, states have incorporated a wide array of mental health services into their Medicaid programs. However, states have also used the considerable flexibility permitted under Medicaid rules to set limits on the services they provide. While the statute requires that each Medicaid service category must be “sufficient in amount, duration, and scope to reasonably achieve its purpose,” states

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Evidence-Based Practices

Evidence-based practices (EBPs) are a range of treatments and services with well-documented effectiveness. In response to a recommendation in the final report of the President's New Freedom Commission on Mental Health, CMS released guidance describing six EBPs and discussing how Medicaid could be used to support all or part of the practice. EBPs include (but are not limited to):

Assertive Community Treatment (ACT) — ACT targets individuals with SMI for whom traditional or less-intensive services have been ineffective. ACT is furnished by interdisciplinary teams. Services are available on a 24-hour basis in community settings (rather than offices or clinics) and continue as long as necessary.

Medication Management — Medication management promotes the systematic selection of medications, measures outcomes, modifies medications based on outcomes, and enhances the individual's adherence to medication regimens. It stresses shared decision making by the individual and practitioner in the selection of medications.

Supported Employment — Supported employment programs aid individuals to secure regular jobs in the community. Employment specialists work with individuals in locating and acquiring a community job and furnish ongoing supports to individuals, usually outside of the work place.

Family Psychoeducation — Family psychoeducation is a method of working with families to help them develop coping skills for handling problems posed by mental illness in the family and skills for supporting the recovery of the family member with a mental illness.

Illness Management and Recovery Program — Practitioners work with people to develop personalized strategies for managing mental illness and achieving personal goals.

Integrated Dual Disorders Treatment — This treatment combines mental health and substance abuse treatments within the same system of care and provides a comprehensive range of integrated services.

It is important to note that Medicaid may not pay for all components of an EBP. In supported employment, for example, vocational training is excluded from Medicaid reimbursement because federal vocational rehabilitation funds are available for such training. However, counseling that may be needed to help an individual maintain employment could be a Medicaid-covered service.

Sources: Gary Smith et al., Using Medicaid to Support Working Age Adults with Serious Mental Illness in the Community: A Handbook, U.S. Department of Health and Human Services, January 2005; available at <http://aspe.hhs.gov/daltcp/reports/handbook.pdf>; Centers for Medicare & Medicaid Services, "Medicaid Support of Evidence-Based Practices in Mental Health Programs," (undated); available at www.cms.hhs.gov/PromisingPractices/Downloads/EBP_Basics.pdf.

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may place restrictions on these requirements. For example, although the law permits states to impose day limits on hospital services, a state would not be permitted to restrict coverage for inpatient hospital care to only one day per year, as that would not be considered sufficient. Limits on amount, duration and scope are potentially problematic for beneficiaries, particularly those with special needs such as SMI. For example, Indiana limits rehabilitation services for mental health and substance abuse to 14 days per year in a psychiatric residential treatment facility.¹⁶ Mississippi limits prescriptions to five prescriptions per month.¹⁷ While generally sufficient for the majority of Medicaid beneficiaries, such restrictions could be insufficient for people with long-term chronic illnesses, including people with SMI. In fact, many states choose to make exceptions to these limitations, particularly when prior authorization is requested.

Children are treated differently than adults with respect to amount, duration, and scope of services under Medicaid rules. The mandatory Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit requires states to furnish all medically necessary services found to be needed through a periodic screening for any Medicaid-eligible child under age 21, regardless of whether those services are included in the Medicaid state plan. For children and youth with mental illness, this means their needs can be identified, evaluated, and treated. However, many states have been criticized for not implementing adequate screening tools to identify mental health issues and for not providing adequate community-based services that would allow children with SED to remain with their families rather than being placed in a residential facility.¹⁸

While Medicaid beneficiaries are entitled to covered services that are medically necessary to meet the person's needs, states have discretion to define medical necessity and, through that discretion, can control the circumstances under which a service is provided. A specific type of treatment may be authorized only for individuals with certain diagnoses, medical histories, or functional limitations. For example ACT service criteria often require that the person have a history of frequent psychiatric emergencies. States may also require prior authorization before some types of services are furnished. So the inclusion of a benefit in a state's plan does not necessarily mean that a beneficiary will receive that service.

These measures help states to ensure that only needed services are delivered and to control the resulting costs of service. Cost controls can be particularly important for home and community-based waiver programs because, as discussed below, waiver programs must meet a federally mandated cost neutrality test. In addition, faced with limited budgets, states must constantly balance the amount of services provided to each individual with the need to cover the maximum possible number of people eligible for them.

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Medicaid versus Private Insurance

Despite limitations that states may place on Medicaid-covered services, Medicaid coverage is often more generous than that offered under private health insurance. First, Medicaid does not exclude coverage of preexisting conditions, as private health insurance sometimes does.¹⁹ Second, Medicaid often covers community-based services and supports that frequently are not covered by private health insurance. For example, the Blue Cross/Blue Shield Preferred Provider health plan for federal employees covers a range of mental health services, including professional services (by psychiatrists, psychologists, clinical social workers, and psychiatric nurses), diagnostic tests, inpatient services, outpatient services, partial hospitalization, and facility-based intensive outpatient treatment. However, these services must all be provided by licensed professionals in a hospital or other professional or facility setting, such as a clinician's office or CMHC.²⁰ In contrast, Medicaid often covers services and supports that are delivered in the person's home, school, or workplace: settings where individuals with SMI and youth with SED often need a great deal of support. For example, Colorado's Medicaid Community Mental Health Services Program covers not only professional services and inpatient and outpatient services similar to those offered under the Blue Cross/Blue Shield plan, but also ACT, case management, clubhouses and drop-in centers, crisis services, home-based services for children and adolescents, intensive case management, mental health rehabilitation and support, psychosocial rehabilitation, prevention programs, recovery services, school-based services, respite care, specialized services for addressing adoption issues, and vocational services.²¹ Finally, most private health insurance plans place lifetime caps on coverage that are often inadequate for individuals with SMI. Lifetime caps are not permitted under Medicaid.

Medicaid Home and Community-Based Services for People with Mental Illness

Section 1915(c) waiver authority permits states to provide a set of home and community-based services (HCBS) to individuals who would otherwise be institutionalized in hospitals, nursing homes, or intermediate care facilities for persons with mental retardation (ICFs/MR).²² HCBS waivers are attractive to states because they can expand benefits to include services not typically covered in their state plans and can expand coverage to higher-income groups. In addition, the costs of the HCBS provided are generally lower than the costs of services provided in institutions and can be further controlled by capping the number of people for whom waiver services will be provided.

Although states have made extensive use of HCBS waivers to provide services to individuals with disabilities and the elderly, these programs have been used only infrequently for individuals with SMI. In order to gain approval for a section 1915(c) waiver, states must show that the proposed program will be cost neutral, that is, cost no more than would have been

spent if the individual were served in an institution. Because Medicaid does not cover services provided in an IMD to individuals ages 22 to 64, it is virtually impossible to calculate cost neutrality in HCBS for an IMD population the state wants to move into community-based care. Colorado, Montana, and Wisconsin have successfully implemented HCBS waiver programs for adults with SMI on the basis that, as a result of severe cognitive impairment, these individuals meet the criteria for services delivered in a nursing home (a qualified entity for demonstrating cost neutrality). In contrast, all states have one or more waiver programs for the elderly, individuals with physical disabilities, and/or individuals with developmental disabilities and expend a much larger portion of funding for HCBS for these populations.

There are also seven states (Indiana, Kansas, Michigan, New York, Vermont, Wisconsin, and Wyoming) with HCBS waiver programs for children with SED. Because states may cover children and youth under age 21 in psychiatric hospitals, the cost neutrality requirements are easier to meet for this population. However, in recent years, very few children with SED have been served in psychiatric hospitals. Medicaid-eligible children who require residential treatment are usually placed in psychiatric residential treatment facilities (PRTFs)—defined as “any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21.”²³ Because the cost neutrality requirement for HCBS waivers is tied to the cost of psychiatric hospitalization (and not to PRTFs), only a few states have been able to establish cost neutrality for waiver programs serving children with SED.

As a result of these limitations in federal statute, most states use Medicaid state plan benefits rather than HCBS waivers to provide services to adults with SMI and youth with SED in the community. However, the Deficit Reduction Act (DRA) of 2005 established a new option for states to provide HCBS as a part of the Medicaid state plan, without requiring a waiver. This option is advantageous for people with SMI because there is no requirement to show cost neutrality when proposing to provide services through the state plan. In April 2007, Iowa was the first state to receive federal approval of a state plan amendment to operate an HCBS state plan option program that serves persons with a history of psychiatric illness who are undergoing psychiatric treatment. However, it is unclear to what extent other states will adopt this option, because it is limited to optional eligibility groups and to individuals under 150 percent of the FPL rather than to the institutional level of 300 percent of the FPL that many states have adopted.

The DRA also took steps to promote greater use of HCBS for children by authorizing the Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant Program. These grants, designed to provide services to children who would otherwise be served in a PRTE,

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permit states to use PRTF costs in calculating cost neutrality for their projects. In December 2006, CMS awarded \$21 million in demonstration grants to 10 states for these projects; a total of \$218 million will be awarded over the five-year demonstration period.

MANAGED CARE AND MENTAL HEALTH SERVICES

In the mid-1990s, many states began to move toward providing Medicaid services through managed care delivery systems as a way to better coordinate care and control costs. Although the Medicaid statute guarantees enrollees freedom of choice of providers in order to ensure access to services, states sought to mandatorily enroll beneficiaries in managed care networks to maximize cost savings through the use of section 1915(b) Freedom of Choice waivers and section 1115 research and demonstration projects.²⁴

More than 65 percent of the total Medicaid population today is served through some type of managed care arrangement.²⁵ States that have implemented mandatory managed care for their Medicaid beneficiaries have taken two basic approaches for people with mental illness. In the first approach, behavioral health care is “carved out” from managed care arrangements for physical health, and individuals with mental health needs continue to receive mental health services either on a fee-for-service basis or through a separate managed care organization (MCO) that specializes in behavioral health. As of June 2006, 18 states had one or more separate contracts for managed behavioral health services.²⁶ In the second approach, the same MCO that provides general medical care also provides mental health services, either through its own provider network or by subcontracting with a behavioral health organization. As of July 2003, a total of 34 states and the District of Columbia reported delivering some or all mental health services through managed care arrangements, including both carve outs and comprehensive MCOs.²⁷

Most of the advantages and disadvantages that apply to managed care in general also apply to managed care for people with mental illness. Managed care has the potential to improve service coordination, provide greater flexibility in the types of services that are provided, and help to control costs through reduced reliance on hospitalization and residential placement. However, the capitation payments that are used to pay MCOs may also create incentives to inappropriately deny or reduce services in order to improve the MCO’s bottom line. A particular concern for individuals with mental illness is that, when mental health services are provided through a comprehensive MCO, the provider network may be inadequate or lack expertise in serving people with special needs. When behavioral health services are carved out, coordination between the MCO providing medical services and the contractor providing behavioral health services may be more challenging.

THE ROCKY ROAD TO IMPROVED COVERAGE AND COORDINATION

Over the years, the mental health community has consistently pressured state Medicaid programs to better meet the needs of people with mental illness and to serve more people in community settings. At the same time, states have been eager to maximize federal reimbursement for services that were previously funded solely with state and local dollars. As a result, many states have expanded and improved mental health services for eligible beneficiaries. However, the road to increased Medicaid coverage and improved service coordination with the mental health system has not been smooth.

Lost in Translation?

As discussed earlier, the mental health system is composed of organizations and providers who receive different sources of funding and operate under differing rules. Mental health organizations with expertise in providing services often lack knowledge and expertise in Medicaid, its complex eligibility and coverage rules, and the processes that states must go through to gain approval from CMS for particular types of services. Even though Medicaid offers a great deal of flexibility in defining services, the perception often exists that certain EBPs can not be covered. To gain federal reimbursement for these services, mental health agencies must learn to speak in terms that Medicaid understands—by working closely with the state and federal Medicaid agencies to define services in a manner that complies with federal rules and to determine what services can and can not be covered. Mental health organizations often need to develop new processes to adequately meet federal requirements, such as identifying Medicaid-eligible clients separately from non-Medicaid clients (for whom services can not be reimbursed), showing data to establish reimbursement rates, and documenting receipt of covered services. To address these issues, the National Association of State Medicaid Directors, with sponsorship from the Substance Abuse and Mental Health Services Administration, has formed a technical advisory group to encourage dialogue between Medicaid and mental health directors and find common strategies for improving services.

Navigating the System

Individuals with SMI often need access to a number of social services beyond the scope of Medicaid, if their needs are to be addressed in a comprehensive manner. The variety of organizations that must be involved in providing supports for individuals with SMI leads to a system that is extremely complex for a consumer, or even a mental health professional, to navigate. Funding is often described as occurring in “silos,” with a lack of coordination among the organizations and funding sources that must be involved. Medicaid can assist consumers in gaining access to and coordinating with other social

service programs, for example, through the use of the TCM benefit described earlier. Some state programs have also taken unique approaches to integrating funding streams to better serve beneficiaries. (For a description of one such approach, see text box, below.) The President's New Freedom Commission on Mental Health has recommended that states develop and implement comprehensive mental health plans to promote a unified approach to system planning and management at the state level.

Access

An ongoing concern in providing mental health services has been a lack of both institutional and community-based mental health providers. For example, one study found broad agreement that gaps in service exist for people with SMI and that those gaps have grown larger in recent years due to budget pressures.²⁸ In fact, the rate of inpatient mental health beds per 100,000 civilian population declined by 45 percent between 1990 and 2004.²⁹ Communities also report shortages of key outpatient staff, especially psychiatrists.³⁰ Medicaid reimbursement rates, which tend to be lower than both Medicare and private market levels, can affect the number of providers who are willing to participate in the program. Recognizing these barriers, some states have made serious commitments to improving access to mental health services. For example, in the early 2000s, New Jersey made mental health services a priority and, over a five-year period, invested \$20 million into the community mental health system, provided \$15 million in grants for housing, and expanded its ACT program.³¹

Tightening Federal Rules

In 2007, CMS proposed a number of regulations designed to implement provisions of the DRA, reduce federal budget costs, and eliminate perceived abuses of the Medicaid program. As proposed, two of these regulations would have particular impact on access to mental health services because they affect the TCM and rehab option benefits that are widely used for individuals with mental illness (as well as other Medicaid populations).

- **TCM** — The DRA enacted changes to the TCM benefit to address inappropriate claiming of Medicaid matching payments that occurred when some states used this benefit to provide case management

Wraparound Milwaukee

Wraparound Milwaukee integrates services and funding for children with SED and their families. It provides a coordinated system of care through a single public agency that coordinates a crisis team, provider network, family advocacy, and access to 80 different medical and support services. The program's \$30 million budget is funded by pooling child welfare and juvenile justice funds (previously spent on institutional care) and by a set monthly fee for each Medicaid-eligible child. (The fee is derived from historical Medicaid costs for psychiatric hospitalization or related services.) Outcomes include a reduced rate of juvenile delinquency, higher school attendance, better clinical outcomes, lower use of hospitalization, and reduced costs of care. The program costs \$4,350 per month per child, a considerable savings over the \$7,000 cost of residential treatment or juvenile detention.

Source: President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America, final report, DHHS Pub. No. SMA-03-3832, July 2003; available at www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf.

services that could be paid for by third parties or other federal programs, such as child welfare or foster care programs. In December 2007, CMS published an interim final rule, which took effect March 3, 2008, implementing the provisions of the DRA.³² Of particular concern to states and advocates, the regulation limits individuals to one case manager. While attempting to prevent duplicative services, this provision seemingly ignores the fact that co-occurring disorders may require more than one case manager under some circumstances. For example, an individual with both SMI and a developmental disability may have case managers in each system who work together to coordinate services. The regulation also shortens previously allowed time frames for providing case management services to people transitioning from institutional settings. Other provisions eliminate the ability of case managers to authorize services and require that case management be billed in 15-minute increments: provisions that run counter to the way many states have established their programs and are not specified in the DRA legislation.

- **Rehab option** — In August 2007, CMS issued a notice of proposed rulemaking to clarify the definition of rehabilitative services.³³ A major concern of this rule is that the tightened definition of rehabilitation services would prevent individuals from receiving services because some services would be considered “habilitation” rather than rehabilitation. The rule would also eliminate Medicaid coverage of some services that are viewed as an intrinsic part of another agency’s responsibilities, such as foster care, child welfare, education, child care, vocational and pre-vocational training, housing, parole and probation, juvenile justice, and public guardianship.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 includes a moratorium on both these rules until April 1, 2009.

Fiscal Realities

Their complex needs make individuals with SMI and children with SED among the costliest populations to serve. Improving the coordination of services and raising the quality of services (for example, through the use of EBPs) have the potential to help control rising Medicaid costs. However, state budget realities mean that not all needs can be met for all populations. State funding for Medicaid tends to run in cycles: eligibility and services are expanded when state revenues are good and are contracted when revenues decline. For example, in 2007 and 2008, 34 states proposed coverage expansions for the uninsured; however, some states have already scaled back those proposals as a result of falling revenues, and other states are anticipating cuts in 2009.³⁴ As budgets contract and states attempt to rein in their Medicaid budgets, they can take a number of measures that may disproportionately affect people with mental health needs. During the last economic downturn, those measures included reducing eligibility levels, freezing or reducing

provider payment rates, reducing or eliminating certain optional services, and increasing cost sharing for beneficiaries. Because many of the services provided to people with SMI are optional and costly, those services are likely targets for reductions as state revenues decrease.

CONCLUSION

Medicaid is a vital source of funding for mental health services. It is often the only source of health care coverage available for low-income individuals with mental illness. However, Medicaid alone can not fund the full range of needs presented by those requiring mental health services, nor was it designed to do so. Close collaboration among the numerous agencies that serve beneficiaries is critical to creating a cohesive, consumer-friendly system. In this regard, Medicaid, along with the state mental health agency, can play an important role—not only in helping to coordinate services for beneficiaries but also in providing the leadership necessary to assure that collaboration occurs. While states vary in the extent to which mental health services are covered, state budget realities often interfere with even the most comprehensive programs. Given the current fiscal outlook in most states, it appears likely that gaps in services will persist into the near future.

ENDNOTES

1. Tami Mark *et al.*, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1993–2003*, SAMHSA Publication No. SMA 07-4227 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007); available at www.samhsa.gov/spendingestimates/SAMHSAFINAL9303.pdf.
2. The distribution of funding sources for substance abuse treatment differs significantly from that for mental health services. Other state and local government funds account for the largest share (40 percent) of substance abuse expenditures.
3. National Alliance on Mental Illness, “Mental Illness: Facts and Numbers,” October 2007; available at www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53155.
4. There are nearly 60 Medicaid eligibility categories established in statute, some that states are required to cover (mandatory groups) and some that states may choose to cover (optional groups). To qualify for one of these groups, an individual must have income and resources that are at or below levels specified by the state. Some individuals may also “spend down” to Medicaid income eligibility levels if they have high medical expenses that can be deducted from income. There is no eligibility group exclusively for people with mental illness.
5. Jeff Crowley and Molly O’Malley, “Profiles of Medicaid’s High Cost Populations,” Kaiser Commission on Medicaid and the Uninsured, December 2006, p. 27; available at www.kff.org/medicaid/upload/7565ES.pdf.
6. Crowley and O’Malley, “Profiles.”
7. Mary Giliberti *et al.*, *Coverage for All: Inclusion of Mental Health and Substance Use Disorders in State Healthcare Reform Initiatives*, National Alliance on Mental Illness and National Council for Community Behavioral Healthcare, June 2008; available at <http://healthcareforuninsured.org/wp-content/uploads/Full.pdf>.

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8. Richard G. Frank, Howard H. Goldman, and Michael Hogan, “Medicaid And Mental Health: Be Careful What You Ask For,” *Health Affairs*, 22, no. 1 (January/February 2003): pp. 101–113; available at <http://content.healthaffairs.org/cgi/reprint/22/1/101>.
9. This program was later repealed under the Reagan administration and turned into the Community Mental Health Services (CMHS) Block Grant program, which continues to function today and is administered by the Substance Abuse and Mental Health Services Administration. The CMHS Block Grant program provides states with flexible formula grant funding to develop new services and provide services to targeted populations. It provides less than 2 percent of annual funding for CMHCs. For more information, see Gary Smith *et al.*, *Using Medicaid to Support Working Age Adults with Serious Mental Illness in the Community: A Handbook*, U.S. Department of Health and Human Services (HHS), January 2005; available at <http://aspe.hhs.gov/daltcp/reports/handbook.pdf>.
10. For more information on growth of mental health services following the introduction of Medicaid, see Frank, Goldman, and Hogan, “Medicaid And Mental Health.”
11. Theodore Lutterman, Vera Hollen, and Robert Shaw, *Funding Sources and Expenditures of State Mental Health Agencies: Fiscal Year 2001*, National Association of State Mental Health Program Directors (NASMHPD), May 2003, available at www.nri-inc.org/reports_pubs/2001/RevExpenReprts2001.pdf; NASMHPD Research Institute, “Table 24: SMHA-Controlled Mental Health Revenues, By Revenue Source and by State, FY 2005,” available at www.nri-inc.org/projects/Profiles/RevExp2005/T24.pdf.
12. Cliff Binder, “Report for Congress: Medicaid Targeted Case Management (TCM) Benefits,” order code RL34426, Congressional Research Service, March 27, 2008; available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/medicaid%20regs/crs%20medicaid%20targeted%20case%20management.pdf>.
13. Rehabilitation services are distinct from “habilitation” services which are used to teach a new skill—for example, teaching a person with mental retardation to dress himself—and are often provided through Medicaid home and community-based services programs. The rehabilitation option also may not be used solely to provide assistance—for example, helping a person with a physical disability to dress—for which the Medicaid personal assistance benefit is the appropriate option.
14. Cliff Binder, “Report for Congress: Medicaid Rehabilitation Services,” order code RL34432, Congressional Research Service, April 2, 2008; available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy%2Fmedicaid+regs%2Fcrs+medicaid+rehabilitation+services.pdf>.
15. Office of the Inspector General, “Medicaid’s Mental Health Drug Expenditures,” HHS, OEI-05-02-00080, August 2003; available at <http://oig.hhs.gov/oei/reports/oei-05-02-00080.pdf>.
16. Kaiser Family Foundation, “Medicaid Benefits: Online Database, Benefits by State: Indiana (October 2006)”; available at www.kff.org/medicaid/benefits/state.jsp?st=15&cat=0&yr=3&nt=on.
17. Kaiser Family Foundation, “Medicaid Benefits: Online Database, Benefits by State: Mississippi (October 2006)”; available at www.kff.org/medicaid/benefits/state.jsp?st=25&cat=0&yr=3&nt=on.
18. Henry Ireys, Sheila Pires, and Meredith Lee, *Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbances: Selected State Strategies*, HHS, January 2006; available at <http://aspe.hhs.gov/daltcp/reports/2006/youthSED.pdf>.
19. Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) places limitations on preexisting condition exclusions for group health insurance (that is, insurance offered through an employer), it does not entirely eliminate these exclusions and does not apply to insurance that is offered to individuals outside the group market.

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20. The Blue Cross/Blue Shield Preferred Provider option is offered through the Federal Employees Health Benefits Program, U.S. Office of Personnel Management, “2008 Blue Cross and Blue Shield Service Benefit Plan,” (RI 71-005); available at www.fepblue.org.
21. These services are offered through Colorado’s section 1915(b) Freedom of Choice waiver. Centers for Medicare & Medicaid Services (CMS), *2006 National Summary of State Medicaid Managed Care Programs: Program Descriptions as of June 30, 2006*, June 2006; available at www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/nationalsummreport06.pdf.
22. For more information on home and community-based services (HCBS) waivers, see Cynthia Shirk, “Rebalancing Long-Term Care: The Role of the Medicaid HCBS Waiver Program,” National Health Policy Forum, Background Paper, March 3, 2006; available at www.nhpf.org/pdfs_bp/BP_HCBS.Waivers_03-03-06.pdf.
23. CMS, “What is a PRTF”; available at www.cms.hhs.gov/CertificationandCompliance/downloads/WhatisaPRTF.pdf.
24. For more information on Freedom of Choice waivers and section 1115 research and demonstration projects, see Cynthia Shirk, “Shaping Medicaid and SCHIP Through Waivers: The Fundamentals,” National Health Policy Forum, Background Paper 64, July 22, 2008; available at www.nhpf.org/pdfs_bp/BP64_MedicaidSCHIP.Waivers_07-22-08.pdf.
25. CMS, “2006 Medicaid Managed Care Enrollment Report: Summary of Statistics as of June 30, 2006”; available at www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer06.pdf.
26. Author’s analysis of information contained in CMS, “2006 Medicaid Managed Care Enrollment Report.”
27. Gail Robinson *et al.*, *State Profiles of Mental Health and Substance Abuse Services in Medicaid*, HHS, (undated); available at http://mentalhealth.samhsa.gov/Publications/allpubs/State_Med/StateProfiles.pdf.
28. Peter Cunningham, Kelly McKenzie, and Erin Taylor, “The Struggle to Provide Community-Based Care to Low-Income People with Serious Mental Illnesses,” *Health Affairs*, 25, no. 3 (May/June 2006): pp. 694–705; available with subscription at <http://content.healthaffairs.org/cgi/reprint/25/3/694>.
29. National Center for Health Statistics, *Health, United States, 2007: With Chartbook on Trends in the Health of American*, (Hyattsville, MD: National Center for Health Statistics, 2007), p. 12; available at www.cdc.gov/nchs/data/hus/07.pdf#fig07. For more information on declining inpatient capacity, see Eileen Salinsky and Christopher Loftis, “Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?” National Health Policy Forum, Issue Brief 823, August 1, 2007; available at www.nhpf.org/pdfs_ib/IB823_InpatientPsych_08-01-07.pdf.
30. Cunningham, McKenzie, and Taylor, “The Struggle to Provide Community-Based Care.”
31. Cunningham, McKenzie, and Taylor, “The Struggle to Provide Community-Based Care.”
32. For more information on the TCM proposed rule, see Binder, “CRS Report for Congress: Medicaid Targeted Case Management (TCM) Benefits.”
33. For more on the rehabilitation option proposed rule, see Binder, “CRS Report for Congress: Medicaid Rehabilitation Services.”
34. Vernon K. Smith, Health Management Associates, presentation at National Health Policy Forum meeting, “State Budget Cuts: How Will Health Care Fare in FY 2009?” July 11, 2008.



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