Insights and Opportunities: Medicaid Directors Identify Mental Health Issues

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Medicaid has become central to financing public mental health services, and state Medicaid directors are now in a position to wield considerable influence over the direction that mental health policy takes in a state. As state mental health authorities seek to shape state and local mental health systems, they should find it useful, perhaps critical, to understand the perspectives and opinions of Medicaid directors. (*Psychiatric Services* 58:1032–1034, 2007)

In preparing a 2006 Medicaid issues briefing for the Substance Abuse and Mental Health Services Administration (SAMHSA), Health Management Associates informally asked Medicaid directors what they viewed as their most important mental health challenges and what they saw as effective strategies for improving collaboration between Medicaid and the mental health system. Medicaid officials in 35 states responded to our inquiries. Strong common themes emerged across states.

Our research uncovered a keen interest in mental health issues among Medicaid officials. They were aware of the federal call for transformation of the mental health system to promote recovery through consumer-centered and evidence-based care. A significant number of state Medicaid officials reported the need for new or redesigned mental health services, including options for community-based services, improved continuity of service options, and care management and coordination. Others identified concern about inadequate access to mental health professionals for children and in rural areas.

Medicaid directors and their key mental health staff also expressed strong frustration relating to two issues. First, there was a fairly widespread belief that state and local behavioral health systems fail to fully understand the fundamental parameters—and therefore the limitations—of Medicaid as a funding mechanism for public mental health systems. Second, the most frequently raised concern was what Medicaid officials described as conflicting priorities and policy directions between the Centers for Medicare and Medicaid Services (CMS) and SAMHSA.

Local tension and opportunities

CMS describes Medicaid's primary purpose as helping to fund medically necessary services and has issued guidance that state plan services in support of evidence-based practices in mental health treatment must be medical services (1). Several Medicaid directors noted that Medicaid's "medical model" causes much mental health system discontent. The need to build service delivery with licensed providers, the requirement for medical justification and documentation of a patient's progress to support a claim, restrictions on treating family members not covered by Medicaid, and the inability to cover nonmedical support services that may be part of effective treatment were cited as points of frustration for mental health systems. Other basic federal Medicaid tenets that can be in conflict within state and local mental health systems include the requirements that the same benefit package be available statewide (2), that comparable services be available to all Medicaid consumers (3), and that consumers have free choice of providers (4).

Medicaid directors across the country expressed concern over the cost of mental health services (especially pharmacy) as well as over the impact that inadequate treatment of mental health conditions has on other costs borne by Medicaid. Many called for improved accountability for outcomes and predicted that a focus on outcomes would find significant common ground for collaboration between Medicaid and mental health authorities. As one director put it, "accountability and outcomes" was "a language Medicaid could understand." In addition, improved management of pharmacy services and effective integration of behavioral health services with primary care are high on many lists of state Medicaid issues.

Medicaid officials expressed optimism that Medicaid's support for mental health consumers at the state level could be improved by joint planning and collaboration between the state mental health authorities and the Medicaid agency. Directors cited successful collaborations that were accomplished both through the combined administrative direction of an umbrella agency and through cross-department initiatives. Directors stressed that common goals and a shared understanding of Medicaid program opportunities and limitations were key to more successful mental health strategies.

Shared goals may become even more important, because state Medic-

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Editor's Note: This column is the sixth in a series addressing the goals that were established by the President's New Freedom Commission on Mental Health. The commission called for the transformation of the mental health system so that all Americans have access to high-quality services that promote recovery and opportunities to pursue a meaningful life in the community. This column reports on the views of state Medicaid directors about mental health services. As noted in an earlier article in this series, the commission identified Medicaid as a key source for financing services and recommended changes in coverage policies to promote high-quality services. The views of state Medicaid directors are central to the successful implementation of the recommended changes in policy. The series is supported by a contract with the Substance Abuse and Mental Health Services Administration (SAMHSA). Jeffrey A. Buck, Ph.D., and Anita Everett, M.D., developed the project, and Dr. Buck and Kenneth S. Thompson, M.D., are overseeing it for SAMHSA. The series will feature 15 articles on topics such as employment, housing, and leadership, which will be solicited by the journal's editor and peer reviewed. Also planned are case studies from each of the states that received a SAMHSA-funded State Incentive Mental Health Transformation Grant.

aid programs have been given additional flexibility in defining benefit packages for some populations under the Deficit Reduction Act of 2005, including the flexibility to limit mental health care or other coverage for target populations. The Deficit Reduction Act also provides states with opportunities to create community-based service options for mental health populations through Money Follows the Person grants, a demonstration opportunity to create home-based alternatives for children in residential care, and new state plan options to offer home and community care.

Federal constraints

Despite optimism about the potential for local collaboration, Medicaid directors overwhelmingly expressed concern about a growing disconnect between what the mental health system views as "best practice" and what the Medicaid program is able to cover. The U.S. Department of Health and Human Services, through SAMHSA, is encouraging innovation and adoption of evidence-based mental health services, whereas the same federal department, through CMS, is pursing an agenda of tighter compliance with a medical model that in the mental health community might be considered an outdated model of benefit design. Some Medicaid officials described recent experiences where CMS resisted or disallowed implementation of evidenced-based practices endorsed by SAMHSA, observations that are consistent with past research that has examined Medicaid policy challenges to achieving the goals of the President's New Freedom Commission (5).

Another major concern in several states is related to new federal regulations and guidance regarding what costs can be considered in the calculation of managed care capitation rates (6). This issue may influence the ability of Medicaid to support innovative mental health services within capitated arrangements. Directors also remain concerned that, for those with mental health medication needs, coverage for individuals dually eligible for Medicare and Medicaid under Medicare Part D may disrupt continuity of care and effective care management.

Furthermore, many state Medicaid officials are concerned about the direction that federal policy is taking regarding the coverage options most often used by states to support community mental health services. The Deficit Reduction Act tightened the definition of targeted case management (7), and the federal government has announced an intention to issue regulations in 2007 to similarly "clarify" the use of the rehabilitation option. These actions raise questions as to whether federal policy will support continued Medicaid financing of key state and local mental health services.

Recent audit activities by the Office of the Inspector General and increased CMS scrutiny in the review of community mental health–related state plan amendments have spurred further concern about federal intentions.

Medicaid officials generally believe that the increased federal focus on program integrity underscores longstanding compliance expectations regarding documentation and the assurance that Medicaid services are billed only for Medicaid-eligible consumers. However, officials also see new questions being raised about the role of local authorities, the use of certified public expenditures, and definitions of allowable services.

These federal policy challenges, as well as ongoing financial pressures around the larger Medicaid program, led several directors to question the mental health system's dependence on Medicaid as the primary source of new revenue to meet growing demands. Some officials recommended that the mental health systems in their states should broaden their financing strategies for the future to include other public-sector and even private resources. This was an intriguing comment, because mental health system experts predict that Medicaid will grow to pay for two-thirds of state mental health services in the next ten to 20 years (8).

When asked to recommend strategies to improve Medicaid and mental health system collaboration, many state Medicaid officials recommended that SAMHSA and CMS should engage in joint planning to clarify federal direction and to identify effective Medicaid benefit parameters. This federal collaboration was seen as key to achieving the goals of the President's New Freedom Commission on Mental Health.

Conclusions

There is sometimes a concern that state Medicaid officials do not pay sufficient attention to mental health issues. Mental health expenditures tend not to dominate state-level con-

cern the way nursing home or hospital expenditures can.

On the other hand, some in the mental health system are concerned that Medicaid policies are overly influential and create pressures and constraints that skew the system away from critical priorities or more effective treatments. Because the Single State Medicaid Agency is prohibited by federal law from delegating policy making for Medicaid mental health expenditures to the mental health authority, states are presented with a fundamental and potentially difficult dilemma. Although the mental health authority may be best prepared to set effective policy direction for the mental health system, its preferred direction may compromise the availability of much needed federal Medicaid funding. With Medicaid now the largest source of funding for the public mental health system, who, indeed, is to set policy for state mental health systems?

State leaders in the mental health system would be well served to take the initiative to engage and foster partnerships with Medicaid at both the state and national levels. Our review of key issues with Medicaid directors suggests there is real opportunity to forge effective state-level relationships by focusing on goals that are shared by both Medicaid and the mental health system. Overall, Medicaid officials described a relatively high level of engagement on their part in mental health issues in their states. Many expressed a sense of frustration at feeling trapped between evolving mental health system expectations on the one hand and federal Medicaid constraints on the other, but in no case did Medicaid directors indicate the slightest desire to be in charge of their states' mental health systems. Rather, many Medicaid directors indicated a strong willingness to engage with the mental health system to find effective Medicaid program and funding options, especially if accountability for outcomes and cost would be a part of the equation.

In addition, it is clear that longstanding inconsistent and ambiguous federal policy is creating tension at the state and local levels regarding the role of Medicaid in the public mental health system. It can be argued that SAMHSA and CMS, as branches of a single federal department, have the opportunity and even obligation to develop consistent federal policy regarding financing effective mental health services. Recent national association efforts to bring state Medicaid directors and state mental health directors into joint activity could become a springboard toward mutual efforts to achieve consistency in federal mental health policy.

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