

New Kaiser Resources Address Behavioral Health Financing and Access Options Under Health Reform

Recognizing that “reform” will be the watchword in the coming decade for all participants in the U.S. behavioral health system, the Kaiser Commission on Medicaid and the Uninsured has issued a primer that provides an overview of behavioral health care and how it is funded. It has also released an issue brief that examines concerns raised about how people with serious mental illness will fare under reform.

Funds for mental health and substance abuse treatment in the United States come from numerous sources. This patchwork of public and private programs collectively forms the nation’s behavioral health system, and the complexity of the system is a major challenge to policy makers as they undertake reform.

Of the \$1.9 trillion spent for all health services in the United States in 2005, behavioral health services accounted for \$135 billion. Even at this level of spending, about 60% of adults with a diagnosable disorder and 70% of children in need of treatment do not receive services, according to research cited in the 31-page primer. Many factors contribute to these gaps, including lack of insurance coverage. The current financing system for behavioral health services differs from that for general medical services. Most notably, public sources play a larger role, accounting for 61% of behavioral health expenditures, compared with 46% of expenditures for general health care. Whereas Medicaid and Medicare account for roughly equal shares of general health care financing (17% and 18%, respectively), Medicaid’s role in financing behavioral health services is more than three times larger than Medicare’s (26% and 7%, respectively).

In addition, a substantial portion of behavioral health spending (21%) is accounted for by non-Medicaid state and local dollars, compared with only 6% of general medical care. These state and local funds pay for a range of services, including acute or extended inpatient care, case management, out-

patient services, residential care, supported employment, and housing. State funding is also important to mental health care for the prison population. States set their own criteria about how to deliver these services (for example, through contracted local providers or state employees) and who may receive them (for example, only those with specific illnesses). Typically, state and locally financed services are targeted to individuals with serious mental illnesses who lack other sources of coverage. The state and local dollars are usually from state general funds rather than from a dedicated revenue source, which makes the services they cover particularly sensitive to budget conditions in the state.

Private insurance covers the majority of Americans but accounts for only 27% of behavioral health spending, compared with 41% of expenditures for all health care. The primer describes how federal and state regulations and insurance industry responses to them have led to the passage of federal parity legislation—most recently, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The 2010 health reform law, the Patient Protection and Affordable Care Act (ACA), will further change the role of private insurance in financing behavioral health care. Under the law, certain private insurance plans—“qualified health plans”—that will cover many newly insured individuals must provide an “essential benefits package” that includes behavioral health services.

The public and private programs that pay for behavioral health care interact closely, which has led to the patchwork system. The primer includes a detailed section on these interactions—between public and private payers and between various public programs. In the latter category, one of the most notable relationships is between Medicaid and state funding sources. The availability of Medicaid created incentives for states to shift programs traditionally financed with

state dollars to services reimbursable with federally matched Medicaid dollars. This practice of “Medicaid maximization” has realigned the roles of states and the federal government in the mental health system, greatly increasing federal investment in mental health care. Medicaid is now a crucial component of state mental health systems, and in many states the two are jointly budgeted, with states attributing their Medicaid matching funds to the budget of state mental health agencies (SMHAs). Medicaid funds accounted for 44% of payments for SMHA-administered services in 2006.

Although the infusion of Medicaid financing into SMHAs has had many beneficial effects, it also has posed some challenges, according to the Kaiser primer. Medicaid and SMHAs have different approaches to service delivery and cannot be wholly incorporated. In addition, federal requirements govern which services are Medicaid reimbursable, which has played a role in states’ decisions about the types of services to offer. In fact, according to the primer, “Some believe that the focus on drawing down federal funds has distorted state decisions in mental health policy by shifting focus away from those who don’t meet Medicaid eligibility rules, in particular the uninsured (often highest risk) individuals and services they need.” The dynamics between state funding and Medicaid are expected to continue with the implementation of ACA, because under reform Medicaid will play an even larger role in behavioral health care.

ACA provisions will expand Medicaid eligibility in 2014 to persons with incomes up to 133% of the federal poverty level (\$14,484 for an individual in 2011). Many newly eligible individuals will have mental health needs. Approximately one in six currently uninsured adults with low incomes—below 133% of the poverty level—has a severe mental disorder, and many others have less severe disorders. Policy makers implementing ACA face several important decisions in designing benefits, service delivery, and outreach and enrollment programs to meet the needs of newly eligible adults with mental disorders.

The second new resource from the Kaiser Commission, *Medicaid Policy Options for Meeting the Needs of Adults With Mental Illness Under the Affordable Care Act*, summarizes key issues addressed by national and state policy experts at a roundtable convened in November 2010 by the Kaiser Commission and the Bazelon Center for Mental Health Law.

Many of these issues were covered in a special section on health reform and mental illness in the November 2010 issue of *Psychiatric Services* (ps.psychiatryonline.org/cgi/content/full/61/11/1073). Briefly, the 12-page Kaiser document explains that the “benchmark” coverage that states can offer newly eligible Medicaid enrollees is not likely to meet the needs of persons with severe mental illnesses; however, operating two different benefit packages for groups with different levels of mental impairment will present particular challenges. Also described are new opportunities available under reform to improve service delivery for people with mental health needs, in particular the state option, effective in January 2011, to establish “health homes” to integrate care for Medicaid enrollees with chronic conditions. In addition, ACA includes changes to Medicaid waiver provisions that allow states to expand home and community-based services, which many believe will be pivotal in allowing states to cover critical components of a recovery-focused system, such as peer support and supported employment.

Other issues covered in the Kaiser brief include designing targeted outreach and enrollment procedures for newly Medicaid-eligible persons, meeting special challenges in covering the homeless population, and building the capacity of state systems to meet growing need. This issue brief and *Mental Health Financing in the United States: A Primer* are available on the Kaiser Web site at www.kff.org.

NEWS BRIEFS

What families want when their child has a mental illness: Primary care doctors are critical to detecting

mental illness among children. Yet in a nationwide survey of families conducted by the National Alliance on Mental Illness (NAMI) in 2009, only 34% of the 554 respondents said their primary care doctors were knowledgeable about mental illness; 59% indicated that their doctors were not knowledgeable about its treatment. To correct this knowledge gap, NAMI has released the results and analysis of the survey in a 15-page report, as well as a brochure for primary care physicians on how to communicate with families and provide the support and resources they seek. According to the respondents, whose children were diagnosed as having mental illness before age 18, the “top five” most helpful things for a doctor to say are that there is hope, the family is not alone, their child’s illness is not their fault, “I understand,” and their child has many strengths. The report outlines steps for primary care physicians to take when a family raises concerns about a child’s mental health. Physicians are urged to listen, ask questions, screen and evaluate, refer families to mental health professionals, follow up and collaborate with mental health providers, provide treatment if specialists are not available, and provide encouragement. Families in crisis welcome information, and physicians are urged to make handouts, reading lists, and information on local support groups and workshops available to their clients. The Family Experience With Primary Care Physicians and Staff report and the brochure “What Families Want From Primary Care” are available at www.nami.org.

Recommendations from the Commission to End Health Care Disparities: Racial and ethnic disparities in health care in the United States are long-standing and well documented, with complex origins. For more than a decade, providers have been urged to undertake “step 1” in eliminating disparities: systematic collection of basic demographic data from their patients. But research shows that most do not do so or do so in nonsystematic ways. To address this problem, the American Medical Association’s (AMA’s) Com-

mission to End Health Care Disparities has issued a report that provides recommendations for collecting and using patient demographic data in the ambulatory setting. The recommendations are intended not only for health professionals but also for vendors of electronic health record (EHR) systems, policy makers, hospitals, health plans, and insurers. Along with detailed guidance on when and how to collect demographic data and what data to collect, the 26-page report describes uses for such data (for example, for quality improvement and ensuring equity), barriers to collection (for example, perceived legal barriers and staff discomfort about race), and barriers to data use (for example, small sample sizes and lack of statistical expertise). *Collecting and Using Race, Ethnicity and Language Data in Ambulatory Settings* is available on the AMA Web site at www.ama-assn.org/ama.

New framework proposed for DSM-5. The American Psychiatric Association (APA) has released the organizational framework proposed for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The chapters and categories of disorders have been restructured to reflect current scientific thinking about how various conditions relate to each other and how these relationships may influence care. APA is inviting comments from the public and mental health and other professionals who use the manual for both diagnostic and research purposes. Currently, the 16 chapters in DSM-IV-TR are organized on the basis of underlying vulnerabilities and symptom characteristics, and this has led to many patients’ receiving multiple diagnoses within and across disorder groups. The new framework arranges chapters by general categories, such as neurodevelopmental, emotional, and somatic, to reflect the potential commonalities in etiology within larger disorder groups. Public comment is invited through June 15 on the draft framework and the latest proposed revisions to diagnostic criteria, both available on www.dsm5.org.