

Additionally, numerous private players are involved in state Medicaid programs, notes Ms. Hermer. If states no longer have control over Medicaid, then states might lose the ability to determine funding for providers of all the goods and services that are necessary to provide and administer

health and long-term care to their Medicaid populations, she explains.

Ms. Hermer notes that Wyoming, Texas and Indiana studied what would happen if they withdrew from the Medicaid program, shortly after the PPACA was enacted.

“The bottom line for most of

them turned on the effect such a withdrawal and concordant loss of federal funds would have on their respective health care economies,” she says.

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Access, integration top priorities for adults with mental illness

Medicaid beneficiaries who receive care for mental health or substance abuse have greater physical health needs and higher overall costs than other beneficiaries, indicating the need for better integration of physical and behavioral health care under Medicaid, according to *Providing Care to Medicaid Beneficiaries with Behavioral Health Conditions: Challenges for New York*, a February 2011 report from the Medicaid Institute at United Hospital Fund in New York City.¹

Barriers for adults with serious and persistent mental illness who are on Medicaid include shortages of housing and community supports and inadequate outreach and engagement efforts, says **Michael B. Friedman**, adjunct associate professor at Columbia University School of Social Work and former director of the Center for Policy, Advocacy, and Education of The Mental Health Association, both in New York City.

Most adults with mental illness who are covered by Medicaid don't have a long-term psychiatric disability, notes Mr. Friedman. “Integrated treatment for them can probably be provided in the context of primary health care,” he says.

However, for people with long-term psychiatric disabilities, integrated services often need to be provided in the context of behav-

ioral health programs, says Mr. Friedman, at least for those who have access to services and use them.

“Others either cannot get services they might benefit from, or reject them,” he says. “For them, expansion of service capacity — especially housing and outreach — is critical.”

Goal of increased access

There is disproportionate physical morbidity and premature death among individuals served in the public mental health system, says **Charles Ingoglia**, MSW, vice president of public policy at the National Council for Community Behavioral Healthcare in Washington, DC, primarily due to preventable medical conditions such as cardiovascular, pulmonary and infectious disease.

“Increasing access to primary healthcare for this population is one of the most important policy priorities,” says Mr. Ingoglia.

The Patient Protection and Affordable Care Act (PPACA) solidifies federal support for the Substance Abuse and Mental Health Services Administration's primary care/behavioral health integration program, notes Mr. Ingoglia, and includes dedicated funding for the expansion of community health centers and the ser-

vices that they provide, including behavioral health services.

The PPACA also contains a number of delivery system redesign projects, Mr. Ingoglia adds, including healthcare homes and Accountable Care Organizations, and behavioral health conditions are explicitly mentioned in both cases.

“Persons with serious mental illness are mandatory populations for the Medicaid health home state plan option,” he says. “Community mental health organizations are listed as eligible medical home providers.”

These models will test the ability of healthcare providers to work together to manage the overall healthcare expenditures for a defined population, says Mr. Ingoglia. “The prevalence data related to behavioral health conditions suggests that these efforts will fail, if they do not adequately involve the treatment of underlying behavioral health conditions,” he adds.

The most costly Medicaid cases involve individuals with co-occurring serious physical and behavioral disorders, including both mental and substance use disorders, notes Mr. Friedman, and this population is often not connected with the mental health system.

“Almost everyone agrees that managed care for the high-cost

cases, who are generally people with serious co-morbid conditions, is the way to go,” he says. “This includes managing medication, as well as managing other forms of treatment.”

The PPACA emphasizes integration of physical and behavioral health services via “medical homes” and “health homes,” notes Mr. Friedman, but he is doubtful that medical homes will do much to improve service for people with serious and persistent mental disorders.

“They are fundamentally primary health care practices that will provide modest coordination with behavioral health care,” he explains. “On the other hand, health homes

are designed to be comprehensive managed care organizations. If New York is any example, they can and will be used specifically for the population of highest cost Medicaid cases.”

For a couple of years, states will be able to establish health homes and get a substantial increase in the federal share of Medicaid, adds Mr. Friedman. “If it proves possible to engage those people who are the highest cost Medicaid cases *before* they develop acute disorders that require long inpatient stays, substantial cost savings should be possible,” he says.

The big question, according to Mr. Friedman, is whether health homes will be successful in engaging the

high-cost cases, which will require extensive outreach efforts rather than waiting for these individuals to come in for care on their own.

“Assertive community treatment teams have been effective in doing this, as have some case management programs,” he says. “Whether a managed care entity will be able to do this remains to be seen.”

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REFERENCE

1. Patchias EM, Birnbaum M. *Providing care to Medicaid beneficiaries with behavioral health conditions: Challenges for New York*. February 2011: Medicaid Institute at United Hospital Fund, New York, NY. ■

Participant-directed program saves \$18 million

The foundation that was laid for the operation of Arkansas’ Cash and Counseling demonstration and the Independent Choices program was “unique from the very start,” says **Deborah Ellis**, a program administrator with the Arkansas Department of Human Services’ Division of Aging and Adult Services. “It truly was a spirit of teamwork on all levels to implement this new program.”

There was “tremendous enthusiasm on a national level,” she says, from the Centers for Medicare & Medicaid Services (CMS), the Robert Wood Johnson Foundation, and the Cash and Counseling National Program Office.

“What made it most unique was the focus on the people that would enroll in this program, and not on the providers who would provide the service to the people,” she says. The big question, says Ms. Ellis, was whether people would act responsibly if given an opportunity to be in control of meeting their health care needs, or if they would be worse off.

While much flexibility is given to participants, she says, much is expected in return. “It is the people that I have encountered that have taught me my best lessons in state government,” she says. “People can teach us a lot about the right things to do. Our policies have a direct impact on a person’s quality of life.”

For instance, the program helps family caregivers who provide the majority of in-home care, Ms. Ellis says, which in turn decreases high institutional costs. The Independent Choices program offered some people the ability to leave the nursing home and return home, she adds, and allowed others to avoid institutional care altogether.

“Offering a participant-directed program goes much further than the policies that mold the program,” she says. “To me, it puts the ‘human’ in human services.”

Participant-directed programs require the same continuous quality improvement plans as any other program, Ms. Ellis notes. “We are continuously seeking ways to improve the program,” she says.

“Participant-directed programs do not function well without a lot of human interaction in the operation of the program.”

In fiscal year 2005, 15,309 adults received agency personal care services, and 1,433 persons had their personal care services met through the Independent Choices program, while in 2011 personal care agencies met the needs of 14,122 adults and Independent Choices provided personal care services to 3,368 participants.

One of the earliest trends that was first identified by the Cash and Counseling demonstration evaluator, Mathematica Policy Research, was that savings in long-term care costs was helping to off-set higher personal care cost, Ms. Ellis reports. A longer-term follow-up study showed that savings in long-term care would continue through the third post-enrollment year, with nursing facility use reduced by 18% over the entire three-year study.

In 2010, an Independent Choices staff person, Mr. Daniel Clark, repli-