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**Review of the Literature  
on Administration and  
Policy Development for  
Medicaid Mental Health  
and Substance Abuse  
Services**

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## I. INTRODUCTION

This review of the literature (and other relevant information) on the administration and policy development of Medicaid mental health and substance abuse (MH/SA) services is part of a larger project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The overall purpose of the project is to gain a better understanding of MH/SA service use and expenditures in state Medicaid programs. It encompasses two separate, but related components. The first component is intended to provide data on service use and expenditures in 1999 for Medicaid beneficiaries with MH/SA diagnoses; 1999 is the most recent year for which complete data are available. The information will be presented in a report and in a set of tables for each state and for the nation as a whole. Service use and cost data will be shown for institutional care and noninstitutional ambulatory care, by age group, sex, MH/SA diagnosis group, and Medicaid eligibility group. These data will be compared for Medicaid beneficiaries with and without MH/SA diagnoses. In addition, service use and cost data will be developed for users of prescription psychoactive drugs.

The second component of the project is intended to go beyond the data and examine in greater depth, the processes and procedures used by states to administer MH/SA services, and develop MH/SA policy in their Medicaid programs. Another important goal of this component of the project is to identify and assess the data on these services that are generated and maintained by state Medicaid programs and state mental health programs. Here, the focus is on publicly available data and reports on service use and/or expenditures, data elements, quality and integrity of the data, and comparability of the data across state agencies.

### A. BACKGROUND

One of the most dramatic trends over the past two decades in public MH/SA services has been the shift in the financing of these services from state general funds to Medicaid sources (Frank, Goldman, and Hogan 2003; Lutterman, Hollen, and Shaw 2003; Coughlin, Zuckerman, and Wallin 1999). In 1997, half of all funds for state- and locally-administered mental health programs came from Medicaid, up from one-third in 1987 (Buck 2001). According to spending estimates extrapolated from these recent trends, Medicaid may account for two-thirds of public MH/SA service spending by 2017 (Buck 2003). With total national spending—including federal, state, and local funding—on MH/SA services in 1997 reaching \$85 billion (Coffey et al. 2000), Medicaid's growing role warrants considerable attention from policymakers and researchers.<sup>1</sup>

In 1999, only Medicaid and the corrections system accounted for a larger share of states' overall budgets than they did at the beginning of the decade (NASBO 2000). The increase partly results from active efforts by states to shift financing of certain health care services that were previously funded solely by state or local dollars to the federal-state Medicaid program.

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<sup>1</sup>The most recent year for which there are comprehensive data available is 1997.

Medicaid funding replaced state and local funding in a variety of areas, but during the 1990s increased Medicaid funding of mental health services was the most common change (Smith, Ellis, and Hogan 1999; Buck 2003). The most comprehensive estimates suggest that Medicaid spending for MH/SA services is between 9 and 13 percent of all Medicaid dollars (Mark et al. 2003).

Despite Medicaid's increasingly prominent role as a funder of MH/SA services, only a relatively small number of studies have looked closely at the intricacies and nuances of Medicaid's relationship to these services. In particular, there are three issues that this study eventually hopes to answer:

1. What are the processes and procedures used to set Medicaid policy for MH/SA services?
2. What utilization and expenditure data are available for Medicaid MH/SA services, and how are they used (or might they be used) to help inform relevant policy discussions and development?
3. What are the key administrative and financial arrangements that states use for Medicaid MH/SA services?

## **B. PURPOSE OF THE LITERATURE REVIEW**

The purpose of the literature review is to better understand what information exists on Medicaid MH/SA services administration and policy development. The review generally focuses on the timeframe of 1991 to the present, although select information prior to this period is also included. Because the literature is so sparse, this review goes beyond the academic press to also look at so-called "fugitive" data sources—information from relevant national organizations and others. Because information on the topics of interest is limited overall, this review documents not only what exists, but also assesses current gaps in the literature.

There are three additional chapters in this review. Chapter II focuses on information pertaining to administration and policy development for Medicaid MH/SA services. Chapter III looks at information on what public reporting and information systems exist to capture data on Medicaid MH/SA service use and expenditures, including their comprehensiveness and reliability. Chapter IV summarizes the gaps in the literature and highlights important next steps necessary for the overall study to help build the body of knowledge on Medicaid MH/SA services.

## **II. ADMINISTRATION AND POLICY DEVELOPMENT FOR MEDICAID MH/SA SERVICES**

States' MH/SA service systems are complex and involve numerous stakeholders. This chapter examines the roles and responsibilities of these stakeholders in the administration of MH/SA services financed by Medicaid. It also explores, to the extent possible given the limited information that is available, the processes and procedures states use to develop policy around Medicaid MH/SA services. Additionally, several Medicaid financing policies of interest are discussed.

### **A. ADMINISTRATION OF MEDICAID MH/SA SERVICES**

States have considerable flexibility in how they set up and operate their Medicaid programs. This results in considerable state-to-state variation in how services, including MH/SA services, are administered and financed. This section examines the roles and responsibilities of key stakeholders that either directly administer these services or indirectly influence them. It also addresses recent trends in states' administration of Medicaid MH/SA services.

#### **1. Key Stakeholders—Roles and Responsibilities**

Several state and federal agencies are active participants in the administration of Medicaid MH/SA services. These efforts are often undertaken with at least the awareness, if not the assistance, of consumer and advocacy groups and other important stakeholders. The extensive variation that exists among states in terms of organization, administration, and financing of MH/SA services in Medicaid makes it difficult to characterize and generalize the specific roles and responsibilities that key stakeholders play. Moreover, existing information that describes these roles and responsibilities is limited. Despite the variation, however, the two largest players in the administration of MH/SA services are relatively consistent in each state—the state Medicaid agency and the state mental health authority (SMHA). These two agencies are most central to the decision making process. Other stakeholders such as consumers and advocates may have an interest in the decisions made, but are more peripheral to the actual process. This section presents information that generally describes key stakeholders' roles and responsibilities.

##### **a. State Medicaid Agency**

Often found under another umbrella agency or department, the state Medicaid agency is charged with the task of administering and operating the state Medicaid program (which usually includes Medicaid managed care programs if they exist in the state).<sup>2</sup> It is also the lead agency

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<sup>2</sup>The State Children's Health Insurance Program (SCHIP) is often part of the state Medicaid agency. In 2002, 16 states (including the District of Columbia) expanded their Medicaid programs to include SCHIP, 16 states created standalone SCHIP programs, and 19 states had a combination standalone and Medicaid-expansion SCHIP program (CMS 2003b).

that is the state's liaison for Medicaid at the federal level. Among its various responsibilities, the Medicaid agency determines eligibility, certifies and/or licenses providers, develops coverage policies, and processes claims (Fox et al. 1993).

Each state Medicaid agency develops and maintains a Medicaid state plan that describes its program's eligibility, benefits, reimbursement, and administrative policies. The plan requires approval by the Centers for Medicare and Medicaid Services (CMS), but can be revised at any time. Requests for amendments to the state plan go to the appropriate CMS regional office, which has 90 days to approve the amendment, reject it, or request additional information. Regional offices do not have the authority to reject a state plan amendment; the CMS central office is responsible for formally rejecting state plan amendments (Fox et al. 1993).

Medicaid does not have a discrete MH/SA benefit per se; rather, it provides generic coverage for medical services that are not linked to specific conditions or diagnoses (Horgan et al. 1994). Federal Medicaid law establishes a variety of requirements that each state must comply with to become eligible for federal matching dollars. States are required to cover a basic level of services, but, with CMS approval, the state may add voluntary options to its state plan. Medicaid regulations require that the following services be covered (CMHS 1998; Fox et al. 1993):

- Physician services and the services of other health care practitioners working under physician supervision, however, greater restrictions are sometimes placed on coverage for psychiatrists' services than on the services of other physicians
- Inpatient hospital services, although states may determine if inpatient hospital settings are reimbursable for certain types of MH/SA services (e.g., substance abuse rehabilitation and detoxification). Inpatient psychiatric hospital services are also subject to the Institutions for Mental Diseases (IMD) exclusion, whereby federal Medicaid law prohibits reimbursement to IMDs for beneficiaries between the ages of 22 and 64<sup>3</sup>
- Outpatient hospital services, but states may limit the types of care appropriate for this setting, such as substance abuse services

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<sup>3</sup>An IMD is 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, including medical attention, nursing care, and related services" (USDHHS 1992, 1994). Further, "[a]n institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases" (USDHHS 1994). When Congress created the Medicaid program in 1965 and subsequently amended it in 1972, it relaxed the IMD rule. The rule allowed funding for inpatient psychiatric care rendered in general hospitals as well as certain services for IMD residents age 65 years and older and persons under age 21 (USDHHS 1992). Medicaid reimbursement for inpatient psychiatric care provided by IMDs is available for individuals under age 21 and for individuals age 65 years and older if the state elects these optional services under its Medicaid state plan.

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children under the age of 21, including follow-up treatment to ameliorate the identified condition if the treatment is medically necessary and is covered by Medicaid

State Medicaid agencies are given considerable flexibility in terms of benefit design and eligibility determination for MH/SA services. State Medicaid agencies frequently make decisions that differentially affect MH/SA care, such as establishing payment and benefit levels/limits, restricting care settings and/or types of providers, and creating utilization review requirements. State Medicaid agencies are allowed to include certain optional MH/SA services in their Medicaid state plan and receive federal Medicaid matching funds for them (CMHS 1998). Examples of these optional services include:

- Inpatient psychiatric hospital services for persons under age 21 and/or age 65 and older
- Substance abuse services in specialty hospital settings
- Clinical services directed by a physician in a non-hospital outpatient setting
- Rehabilitative outpatient-based services that are recommended, but not necessarily directed, by a physician
- Other licensed practitioner services, including those provided by psychologists and social workers

In 2003, 23 states directly reimburse psychological services (HMA 2003). According to a survey conducted in 1996, 17 states directly reimburse clinical social workers, and 13 states directly reimburse professional counselors (ACA 1997).

Another tool at the disposal of state Medicaid agencies is a Medicaid waiver. States have used Medicaid waivers for MH/SA services in several ways. First, state mental health policymakers may blend funding streams from Medicaid and state public mental health under Medicaid waivers, which offer the potential to use Medicaid funds to cover certain beneficiaries who might not otherwise be eligible for Medicaid (USDHHS 1999). Second, Medicaid waivers are often used to authorize managed care or alternative delivery/reimbursement systems. Section 1915(b) and Section 1115 waivers, both of which fall under Title XIX of the Social Security Act, are the two main vehicles states have used to implement Medicaid managed care programs, some of which have also encompassed MH/SA services (Draper et al. 2003).

## **b. State Mental Health Authority**

The SMHA is designated as the state's central authority for public mental health services. It is the entity that administers the Community Mental Health Services Block Grant and is responsible for planning, organizing, and financing community mental health systems (Lutterman, Hollen, and Shaw 2003).<sup>4</sup> The SMHA often has additional responsibilities, such as administering state mental health institutions and substance abuse and mental retardation/developmental disabilities (MR/DD) programs. In many states, however, responsibility for overseeing these programs may be assigned to another agency (NRI 2002a).

In carrying out its functions, the SMHA interacts and coordinates with other state agencies, including Medicaid, the health department, social services, housing, vocational rehabilitation, and corrections (Mechanic and Surles 1992). At the local level, the SMHA also may work with school systems, county boards, and a range of professional and consumer groups (Mechanic and Surles 1992).

Based on information from SMHAs in 47 states that submitted data, the National Association of State Mental Health Program Directors Research Institute (NRI) found in 2001 that the location of the SMHA within state government is highly variable.<sup>5</sup> Where the SMHA is positioned within state government is important, because that positioning may be directly linked to the level of influence that the agency is able to exert in state policy and other decision-making processes. Most often, SMHAs are located within a larger umbrella state human services agency. In 2001, for example, 17 SMHAs were located within departments of human services, 9 were in health departments, and 5 were located in departments that combined health and human services. Sixteen SMHAs were either independent state departments of mental health or joint departments of mental health and mental retardation. Among the 16 independent SMHAs, the SMHA Director is a member of the Governor's Cabinet in nine states (NRI 2002a).

The location of the SMHA within state government has been in flux over the past several years, although information sources do not indicate what the impetus for and/or goals of these organizational changes have been. Nor do these sources convey the extent to which the changes may reflect Medicaid's growing role in MH/SA funding. Between 1998 and 2001, 32 SMHAs were reorganized. This includes duplicate counts of SMHAs that reorganized more than once during this period (NRI 2000, 2002a). During the period 2000 to 2001, three reorganizations involved moving the organizational location of the SMHA within state government. In two states, additional disability services were transferred to the SMHA, and in another two states, disability services were transferred from the SMHA to another agency.

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<sup>4</sup>The Community Mental Health Services Block Grant is authorized by Title XIX of the Public Health Service Act and is the single largest federal contribution dedicated to improving mental health service systems across the country. SAMHSA's Center for Mental Health Services (CMHS) administers the block grant to encourage development of community-based care systems for people with mental disorders (SAMHSA 2003a).

<sup>5</sup>The District of Columbia and the Virgin Islands are included among the 47 states. Five SMHAs did not submit data about the location of their SMHA within the state government.

The breadth of responsibilities of SMHAs also differs substantially among states. In addition to mental health services, the SMHAs in 24 of the 47 states are also responsible for providing substance abuse treatment services.<sup>6</sup> In 16 states, the SMHA is responsible for providing MR/DD services. In 12 states, three disability services—mental health, substance abuse, and MR/DD—are organized together within the SMHA. In 15 states, the SMHA is responsible for providing services to persons with mental illness in prisons or jails (NRI 2002a).

The SMHA is responsible for operating state psychiatric hospitals in all but two states (South Dakota and Wisconsin). In those two states, a different division of state government operates the state psychiatric hospitals and the SMHA is responsible only for community mental health services. These two states, however, have developed agreements to coordinate care between the hospitals and their community care systems (NRI 2002a). Additionally, SMHAs vary widely in the specific services and population groups for which they provide mental health services (Table 1).

TABLE 1  
SMHAS' LEVEL OF RESPONSIBILITY FOR PROVIDING  
MH SERVICES IN 47 STATES

Population Group	Level of Responsibility		
	Primary	Shared	None
Child/adolescent	29	16	2
Adult Forensic	31	13	3
Sexual offenders	5	15	21
Alzheimer's disease or organic brain Syndrome	4	18	22
Brain-impaired persons	5	14	21

SOURCE: RI 2002a

NOTE: Not all 47 SMHAs provided data for each category. Therefore, the sum is different across each category.

SMHAs report often working directly with Medicaid to administer MH/SA services in their states (NRI 2002b). For example:

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<sup>6</sup>Four states did not provide data about the disability responsibilities of SMHAs.

- **Medicaid options.** Forty-one SMHAs have adopted the Medicaid Rehabilitation Option to provide community mental health services, 23 states use the Clinic Option, and, 12 states use the COBRA Case Management Option to cover MH services.<sup>7</sup>
- **Interagency agreements.** Thirty-one states have interagency agreements between the SMHA and state Medicaid agency. The agreement pertains to the provision of services in 18 states, the sharing of fiscal resources in 18 states, joint training in six states, and staffing in six states.
- **Access and use of Medicaid data.** Thirty SMHAs receive Medicaid paid claims data from their state Medicaid agency, and in 26 of these the SMHA reportedly links Medicaid paid claims data with its own patient databases to analyze Medicaid service use and expenditures. Twenty-nine SMHAs receive information other than paid claims data from Medicaid, including 24 SMHAs that get periodic reports on Medicaid expenditures for mental health services.
- **Setting Medicaid rates.** SMHAs are responsible for setting Medicaid rates for mental health services in 13 states.<sup>8</sup>
- **Delegated authority over Medicaid services.** In seven of the above 13 states, the state Medicaid agency has delegated authority to the SMHA for setting both Medicaid rates and options related to mental health.<sup>9</sup>

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<sup>7</sup>The Rehabilitation Option provides states with Medicaid reimbursement for services that are provided in an individual's home, school, or other natural environments. The Clinic Option allows states to reimburse services furnished by MH/SA clinics and school clinics, among others. The COBRA Case Management Option provides Medicaid coverage for certain targeted case management (Fox et al. 1993).

<sup>8</sup>Thirty states reported having no responsibility for setting Medicaid rates for MH services. Eight states did not respond. (These numbers do not include the Virgin Islands.) While some SMHAs report having responsibility for setting rates for Medicaid mental health services, what exactly these responsibilities entail is unclear from the literature. This is an area that will be explored in greater depth as part of the current project.

<sup>9</sup>What exactly a state Medicaid agency may delegate to an SMHA varies substantially from state to state. For example, in Maryland, the Medicaid agency delegates all administrative and financial authority related to MH/SA services to the SMHA. In California, Medicaid and mental health are in a single state agency, and administrative and fiscal responsibility for all mental health services is delegated to the county mental health authority (expert advisory panel meeting, 1/8/04). This cross-state variation has not been well documented in the literature, but is an area that will be further explored in the current project.

**c. Other State Government Agencies**

Other state government agencies, not including the SMHA and state Medicaid agency, have varying levels of responsibility for and/or control over the administration of Medicaid MH/SA services, depending on the way these services are organized and financed within the state. For example, state government agencies that target children and families such as public and child welfare agencies frequently use Medicaid to expand the range of mental health (and physical health) services available to clients since the vast majority of clients served by these agencies qualify for Medicaid assistance. For example, in some states and localities, mental health professionals are co-located in the welfare office to assess welfare recipients for mental health conditions and link them to existing Medicaid-funded mental health providers (Derr et al. 2001, 2000). Child welfare agencies rely heavily on Medicaid to access mental health and substance abuse treatment for children and parents involved with the child welfare system. The primary challenge for families served by these agencies is accessing services in a timely way and accessing specialized treatment (i.e., treatment for co-occurring disorders or residential substance abuse treatment). Other stakeholders within the state government include, but are not limited to, those agencies responsible for vocational rehabilitation, mental retardation/developmental disability (MR/DD) services, housing, education, corrections, and juvenile justice (expert advisory panel meeting, 1/8/04).

**d. County and Local Government**

In some states, responsibility for the administration of MH/SA services is delegated to county or local authorities, although states vary widely in the scope and breadth of control given to local entities. In California, for example, the state has delegated to each of its 58 counties, responsibility for the administration of public mental health services, including services for Medicaid recipients. The counties are at financial risk for mental health services for their residents and control how mental health dollars are spent (Draper et al. 2003).

**e. The Substance Abuse and Mental Health Services Administration (SAMHSA)**

Created in 1992 under Public Law 102-321, SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. It oversees state mental health plans and related reporting requirements. SAMHSA administers formula grant programs, primarily the MH/SA Prevention and Treatment Block Grant Programs. For these programs, SAMHSA supports specific services and assesses and reports on progress, needs, and ongoing activities (SAMHSA 2003a).

**f. The Centers for Medicare and Medicaid Services (CMS)**

CMS is the lead federal agency charged with working with states to administer the Medicaid program. Within broad national guidelines that CMS provides, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and operates its own program (CMS 2003a). CMS also provides oversight of state Medicaid agencies, as well as approving amendments to a Medicaid state plan.

Additionally, CMS distributes matching federal Medicaid funds to each state based on the Federal Medical Assistance Percentage (FMAP), a formula used to calculate the federal share of state Medicaid service costs.<sup>10</sup>

#### **g. Consumers/Advocates**

The National Mental Health Association (NMHA) and National Association for the Mentally Ill (NAMI) are two national advocacy organizations for persons with mental illness. NMHA is a large nonprofit organization that addresses various aspects of mental health and mental illness, and works to improve the mental health status of all persons, especially those with mental illness, through advocacy, education, research and service (NMHA 2003). NAMI, which is also nonprofit, is a grassroots, self-help, support and advocacy organization of consumers, families, and friends of persons with severe mental illness (NAMI 2003). In addition to their national presence, each of these organizations has local chapters.

#### **h. State Mental Health Planning Council**

Each state must establish and maintain a state mental health planning council. According to a series of federal laws (Public Law 99-660, Public Law 102-321, and Public Law 106-310), the council must engage in at least three activities to receive Community Mental Health Services Block Grant funds (Ingoglia 2001). These include:

- Monitoring, reviewing, and evaluating the allocation and adequacy of mental health services within the state
- Reviewing the state mental health plan
- Serving as an advocate for adults with serious mental illness (SMI), children with a severe emotional disturbance (SED), and other individuals with mental illness or emotional problems

The regulations require that the council consist of state government representatives and consumer representatives. According to the regulations, states must allow the council to review changes to the state mental health plan, but it is not required to comply with any recommendations made by the council. Similarly, the councils have no authority to review Medicaid policies that affect mental health services (Buck 2001).

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<sup>10</sup>The Federal match applies to qualified State Medicaid expenditure with the current matching rates ranging from 50 percent for the “richest” states up to nearly 80 percent for the “poorest” states (Federal Register 2003).

## **i. Other Key Stakeholders**

While it varies from state-to-state, there are often other key stakeholders that also influence the administration and policy development of states' Medicaid MH/SA services. For example, providers of MH/SA services have an important stake in what decisions states make with regard to these services.

## **2. Recent Trends in the Administration of Public MH/SA Services**

Traditionally, the organization and financing of state mental health services centered on the SMHA under a “community model” (Buck 2003). This approach gave the SMHA primary responsibility for planning, administration, and financial support of public mental health services. Recently, however, the community model has been displaced by another approach—referred to as the “health plan model”—that shifts significant responsibility from the SMHA to the state Medicaid agency. In this more recent model, Medicaid has become more central to the financing of public mental health services. Buck (2003) suggests that important implications of this new “health plan model” may include:

- A waning influence of SMHAs coinciding with rising federal influence through Medicaid
- The organization of SMHAs and state Medicaid agencies to achieve greater integration of SMHA and Medicaid services, such as better data sharing between the two agencies, reflecting the shift away from the community model and toward the health plan model
- The development of data systems that seek to capture information and performance measures for all Medicaid-funded services, not just those under the authority of the SMHA

## **B. POLICY DEVELOPMENT**

The available literature lacks any substantive discussions about the specific processes and procedures used by states to develop policy around MH/SA services in Medicaid. It is also deficient in conveying an understanding of how and what data states may use to carry out this function. There are, however, tangential examples of states' decision making around the administration and financing of MH/SA services that provide important insights. This section examines some of these examples.

### **1. Identifying and Addressing MH/SA Service Issues**

There appears to be a variety of ways states identify and address Medicaid MH/SA service issues—issues that may ultimately lead to new and/or changed policies. One example comes from states' pursuit of strategies to maximize federal Medicaid reimbursement by expanding Medicaid-reimbursable MH/SA services. In these cases, the motivation for addressing MH/SA issues is primarily to increase federal funding by substituting federal dollars for state dollars

(Coughlin and Zuckerman 2002; Coughlin et al. 1999). Such decisions regarding MH/SA issues involve various stakeholders, which has probably added to the diverse array of stakeholders that influence the current public mental health system.

The level of bureaucracy that exists in state government can complicate identifying and addressing MH/SA service issues. In many states, the SMHA resides under a larger umbrella human services agency and the director only has access to key decision points through the parent department. In many instances, the directors are outside the chain of decision making on issues that may affect their areas of responsibility, such as licensing of service providers and rate setting for Medicaid (Mechanic and Surles 1992). To garner influence, state mental health officials and advocates may have to make creative use of organizational and political systems to develop strategies that fit the specific state context and policy-making structure. SMHA directors have varying levels of control over their priorities and departmental budgets, because each state structures and organizes itself in a unique way. Furthermore, state mental health directors often have short tenures and are not in their positions long enough to significantly influence the direction of their agency. Overall, a state mental health director may have limited flexibility and must work within the existing state structure (Mechanic and Surles 1992). Furthermore, budgeting, contracting, and labor agreements occur in the context of general state policy, and accommodation to a single agency is rare (Schinnar, Rothbard, and Yin 1992).

Fragmentation of the public MH/SA system within state governments is an obstacle that states may face when addressing MH/SA issues. Many states struggle with “turf issues”, where agencies “fight” over who has authority or responsibility for certain services or populations. Persons with mental illness often have coexisting disorders, and as a consequence, no individual state agency wants to be held responsible for the full financial costs of treatment. Sometimes turf issues arise when agencies have conflicting goals. In the case of vocational rehabilitation, for example, the outcome standard is closure at 18 months, which is not usually possible for persons with mental illness who tend to have longer-term needs (expert advisory panel meeting, 1/8/04).

## **2. Processes Behind the Development of Mental Health/Substance Abuse Policy**

The complex funding streams and multiplicity of stakeholders factor heavily into the processes and procedures used by states to develop MH/SA policy. State mental health systems have often evolved separately from those for substance abuse services, which means that, in moving to Medicaid managed care for example, states must often coordinate among two or more state agencies (Gold and Mittler 2000). In terms of policy development, how this process actually works is not well documented or understood. The situation is made even more complex because each state employs strategies to respond to its own unique needs and objectives.

Ideally, all stakeholders work together to achieve common objectives. In reality, however, that may not happen. In many states, for example, the dual focus on institutional and community-based care has meant that two, sometimes independent, systems have evolved—one that consists of community care for some populations and another that consists of care, often in state mental institutions, for people with serious mental illness (Gold and Mittler 2000). These diverse systems may have their own, often conflicting, objectives and separate sets of providers

and constituent concerns that complicate the design of the overall components of a state's public mental health system.

To illustrate the diverse set of state agencies that oversee state MH/SA programs, a case study of the structure of Oregon's Medicaid managed care system for MH/SA services as it existed in 1998 provides important insights. Oregon adopted a managed care carve-out for mental health services, while substance abuse services remained under managed care capitation, and psychotropic drugs were a benefit-exclusion with a fee-for-service payment arrangement. Oregon's Office for Medical Assistance Programs is responsible for overseeing all Medicaid managed care in the state. However, the Mental Health and Developmental Disabilities Services Division handles virtually all of the oversight and coordination for mental health, including contract compliance, monitoring, and evaluation. Under this division also falls the responsibility for designing the Medicaid behavioral managed care program. Substance abuse services are included in the regular managed care benefit package, but the Office of Alcohol and Drug Abuse Programs is responsible for educating health plans about the delivery system, developing screening tools for physician use, establishing criteria for inpatient care, and developing specific contract standards. During the design phase, the Senior and Disabled Services Division also was actively consulted on policy for Supplemental Security Income (SSI) eligible persons more generally. In sum, a complex and potentially confusing network of state divisions, agencies, and departments contributed to and designed the Medicaid managed care program for MH/SA services (Gold and Mittler 2000). Gold and Mittler (2000) concluded from their work that state political and organizational considerations strongly influenced program design. They suggest that, in developing mental health policy, states need to anticipate the concerns of the diverse set of state agencies that oversee MH/SA programs, and recognize the importance of cross-agency communication and program coordination.

Program coordination and, more generally, the processes behind the development of MH/SA policy rely to a considerable extent on data. Many states, however, have different program-specific data systems that aren't yet integrated, although Buck (2003) suggests that states may be moving in that direction. Data systems are also constrained by a dearth of encounter data for services that are provided under capitated managed care arrangements (Gold and Mittler 2000). Data issues are discussed in more detail in Chapter III.

### **C. MEDICAID FINANCING POLICIES OF INTEREST**

Looking at all funding sources combined, the state-federal Medicaid program is the largest single public payer of MH/SA services, accounting for 35 percent of all state, local, and federal MH/SA public spending in 1997 (Coffey et al. 2000). State government sources account for the largest share of MH/SA funding. SMHAs received two-thirds of their funding in fiscal year 2001 from state government sources, including general and special funds of over \$12.4 billion, and over \$3.2 billion from the state share of Medicaid. State general funds comprised the largest funding source of SMHA services, and state Medicaid dollars the third largest. The federal government was the second largest funder of SMHA services with FY 2001 dollars totaling almost \$6.5 billion. The bulk of the federal revenues came from the federal share of Medicaid (\$5.2 billion), followed by Medicare (\$456 million), the Community Mental Health Block Grant (\$370 million), and other federal funds (\$461 million). Local and other funds contributed the remaining funds expended by SMHAs (less than 1 percent) (Lutterman, Hollen, and Shaw 2003).

Although state general funds exceeded Medicaid (state and federal) funding in FY 2001, Medicaid was the fastest growing source of revenue for programs operated by the SMHA (Lutterman, Hollen, and Shaw 2003). In addition, Medicaid spending represents most (61 percent) of the growth in expenditures under programs that SMHAs control (Lutterman, Hollen, and Shaw 2003).

The Medicaid program funds a variety of MH/SA services in various care settings. In 2001, for example, Medicaid funds (state and federal) accounted for approximately one-third of the total operating costs for inpatient psychiatric hospitals (Draper et al. 2003). Medicaid also covers large outlays for mental health outpatient services, such as psychotropic drugs (Frank, Goldman, and Hogan 2003; Buck and Miller 2002b; Hennessey et al. 2002) and in outpatient settings more broadly like freestanding outpatient clinics and residential treatment centers for emotionally disturbed children (Witkin et al. 1998).

As state budgets tighten, many policymakers have eyed Medicaid as one of the primary targets for cutbacks. Because MH/SA services are becoming a larger portion of the overall Medicaid budget, there is considerable interest in better understanding this trend. Consequently, recent studies have aimed to detail the size of Medicaid's role in MH/SA services and how it is changing; in particular, SAMHSA has sponsored an ongoing project that generates national spending estimates (Coffey et al. 2000).<sup>11</sup>

Understanding Medicaid's financing mechanisms is crucial to appreciating why it has grown into an ever larger funder of public MH/SA services. Over time, the Medicaid program has become increasingly complex, as policymakers have turned to it to address particular gaps in insurance eligibility and coverage. Policymakers have attempted to use Medicaid's financing to stretch state funds by obtaining a federal Medicaid match for services previously covered solely with state dollars (Coughlin et al. 1999). Medicaid rate-setting processes, the state match for Medicaid MH/SA expenditures, and Medicaid's impact on MH/SA services, all discussed below, are three components of financing policy that underscore Medicaid's role in MH/SA services.

## **1. Rate Setting Processes**

The rapid growth in Medicaid managed care since the early 1990s emphasizes the importance of better understanding the various methods for calculating capitation rates for health care providers. The overarching goal of Medicaid programs is to set rates as low as possible to save money, yet high enough to attract a sufficient number of participating providers and/or health plans (Holahan, Rangarajan, and Schirmer 1999). States also want to set rates at a level that provides plans with specific incentives, such as managing care efficiently and improving care quality. Funding and care delivery may be fragmented between Medicaid and state programs, making costs and utilization difficult to predict and setting rates even more difficult (Hoag, Wooldridge, and Thornton 2000).

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<sup>11</sup>See additional details in Chapter III.

Hoag, Wooldridge, and Thornton (2000) reviewed Tennessee's experiences in setting, monitoring, and updating capitation rates for Medicaid managed care for MH/SA services. Their work is instructive in understanding some important subtleties, particularly current costs, savings expectations, and updating of the rate-setting process. To set rates, states need estimates of current costs, which can be constructed from individual-level claims or encounter data about service use and the costs of services, although these data may not be current and complete enough to be reliable. Another approach is to use more aggregated financial data from health plans. The quality and reliability of Medicaid claims and financial data varies considerably from state to state. Savings expectations are based on projected utilization and cost patterns, so states need to have utilization figures for services in all Medicaid-covered settings. The inherent uncertainty about savings and utilization trends requires states to monitor, assess, and update rates over time, rather than viewing rate setting as a one-time event. The potential consequences of not monitoring and updating rates include jeopardizing quality of care through underpayment or creating political problems by overpayment (Hoag, Wooldridge, and Thornton 2000).

At a minimum, rates require adjustment for inflation. States may also need to update rates to account for new technologies (such as new drugs), medical advances, situation changes (such as case-mix changes), or unintended consequences of existing rates (such as service under- or overuse or cost shifting) (Hoag, Wooldridge, and Thornton 2000).

Medicaid provider reimbursement rates are often set below private market levels (Frank, Goldman, and Hogan 2003). State Medicaid programs have tended to control spending by setting low rates, which may limit the number of physicians willing to participate in Medicaid and may have the unintended consequence of impeding access to care (Frank, Goldman, and Hogan 2003). Until its repeal by the Balanced Budget Act of 1997, the Boren Amendment in the Omnibus Reconciliation Act of 1980 constrained states' ability to set low inpatient hospital and nursing home prices, though low prices on outpatient care did result in low utilization of office-based psychiatrists and other mental health practitioners (Wiener and Stevenson 1998; Frank, Goldman, and Hogan 2003).

## **2. Special Financial Arrangements for Medicaid MH/SA Services**

States vary in the financial arrangements they adopt to pay for MH/SA services. Typically, the provider furnishes covered services using its own employees, and federal law requires that the state Medicaid agency make payment directly to the provider (Social Security Act, section 1902[a][32]). Some state Medicaid agencies, however, have implemented special financial arrangements for submitting MH/SA service claims—outside of the typical fee-for-service (FFS) reimbursement—although little is known about how pervasively these have been used or exactly how they have been crafted.

A state can employ the concept of an organized health care delivery system (OHCDS) to circumvent federally-mandated limitations on direct payments to providers (42 CFR 447.10). An OHCDS is a system in which at least one component is organized for the purpose of delivering health care. There may be other components with other missions, such as education or food distribution, but there must be an identifiable component devoted to the delivery of health care. The OHCDS must furnish at least one Medicaid-covered service itself (i.e. using its own employees, rather than through contractors), and may contract with other qualified providers to

furnish other services (CMS 1994). The OHCDs can have a capitated or fee-for-service arrangement with the state Medicaid agency. If the OHCDs is capitated or at risk, it must also meet all current Medicaid managed care rules (communication between J. Buck at SAMHSA and B. Jackson at CMS, 9/2/2003).

The OHCDs provision allows providers to reassign their rights to Medicaid payment to a state or local governmental agency, although the reassignment must be voluntary (CMS 1994). The state of New York, for example, is considering applying this provision to designate the SMHA as an OHCDs (expert advisory panel meeting, 1/8/04). Reportedly, this arrangement would give the state added flexibility in organizing MH/SA services within its state agencies.

### **3. Establishment of the State Match for Medicaid MH/SA Expenditures**

Medicaid funding for service costs includes a federal and state share of dollars. The federal share of Medicaid spending is determined according to a formula—called the Federal Medicaid Assistance Percentage (FMAP).<sup>12</sup> The method used to calculate the state match varies widely across states. In some states, the SMHA is responsible for coming up with the state match; in other states such as New York, responsibility for the state match lies with the counties (conversation between J. Buck at SAMHSA and MPR staff, 12/22/03). The literature on the processes and procedures used to come up with the state match is sparse, especially around special arrangements that may exist for MH/SA spending.

States have used Medicaid funds both to replace state general funds and to expand programs (Smith, Ellis, and Hogan 1999; Coughlin et al. 1999; Coughlin and Zuckerman 2002). This strategy grew in popularity among states during the 1990s, when they pursued various financing mechanisms to maximize the federal Medicaid matching contributions, most commonly focusing on mental health services (Coughlin et al. 1999; GAO 1998). A major catalyst for this trend has been the continued push towards the deinstitutionalization of persons with severe mental illness, which shifted individuals—most prominently, those aged 22 to 64—from state-run institutions (where they were not eligible for Medicaid for any services) to the community, where they were eligible for Medicaid (Smith, Ellis, and Hogan 1999; Draper et al. 2003; Frank, Goldman, and Hogan 2003).

The public mental health system has been one of the primary beneficiaries of state's Medicaid financing expansions. States have increasingly moved persons out of psychiatric hospitals into the community, where a range of mental health services are reimbursable by Medicaid (Frank et al. 2003; Coughlin et al. 1999). States have also added optional services to their list of covered Medicaid benefits, such as mental health rehabilitative services, enabling them to bill Medicaid for mental health services that fall into these categories. Many states have used the Medicaid DSH program to increase payments to state psychiatric hospitals (GAO 1998),

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<sup>12</sup>The FMAP is based on a state's per capita income (Coughlin and Zuckerman 2002; Fox et al. 1993). Of the roughly \$206 billion spent on Medicaid in 2000, almost 57 percent was from the federal government, with the remainder from states and localities. The federal government also pays 50 percent of administrative costs for state Medicaid services (Fox et al. 1993).

which for many states has become a significant source of revenues for their mental health systems (Draper et al. 2003, Coughlin et al. 1999).<sup>13</sup> It is not always clear, however, how much of this Medicaid DSH funding actually remains in the mental health system, since states sometimes use these funds for other health or non-health purposes.

Although federal law prohibits reimbursement for Medicaid services provided at institutions for mental diseases (IMDs) for beneficiaries between (and including) the ages of 22 and 64, it is estimated that Medicaid funds nearly a third of total operating costs of public psychiatric hospitals (Draper et al. 2003). The funding streams for IMDs arise from several sources, such as IMD optional services and Medicaid managed care waivers; however, the majority of these Medicaid expenditures are DSH payments available to facilities serving a disproportionate number of low-income patients (Draper et al. 2003).

#### **4. Medicaid's Influence on Public MH/SA Services Policy**

Medicaid's generous financing of MH/SA services has given the program added leverage and increased its ability to influence the public MH/SA system. Several broad trends have emerged that are indicative of Medicaid's current financial clout.

1. Medicaid has continuously expanded insurance coverage for low-income people with mental conditions. For instance, data from the National Medical Care Expenditure Survey (NMCES) and the Medical Expenditure Panel Survey (MEPS) show that in 1977 Medicare and Medicaid paid for the care of about 19 percent of people with schizophrenia and 11 percent of people with a substance abuse disorder. By 1996, these programs served 63 percent of people with schizophrenia and 22 percent of those with substance abuse disorders (Glied et al. 2001; Frank, Goldman, and Hogan 2003).
2. Over the past 25 years or so, Medicaid has led to an increased use of MH/SA services. Data from NMCES and MEPS indicate that the percentage of the adult population receiving treatment for a mental disorder rose from 5.2 percent in 1977 to 7.7 percent in 1996, and during that time utilization increased from 10.5 percent to 17.7 percent (Glied et al. 2001; Frank, Goldman, and Hogan 2003).
3. Medicaid's reimbursement policies (e.g., the IMD exclusion) have sped up states' move toward deinstitutionalization and a community-based approach to care for mental disorders (Draper et al. 2003; Frank, Goldman, and Hogan 2003). The IMD exclusion provided a strong fiscal incentive to provide care outside state hospitals and acted as a fundamental motivation for deinstitutionalization (Geller 2000).

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<sup>13</sup>The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) required states to make disproportionate share hospital (DSH) payments to hospitals serving a disproportionate share of Medicaid and low-income patients (Geller 2000).

4. States' efforts to maximize Medicaid funds have shifted substantial costs for MH/SA services from the state to the federal government (Coughlin, Zuckerman, and Wallin 1999; Lutterman, Hollen, and Shaw 2003).
5. Medicaid's trend toward managed care for MH/SA services has shifted the public mental health system to a market-based approach and privatization of functions that were historically the responsibility of SMHAs (Frank, Goldman, Hogan 2003). In 2002, enrollees in some form of managed care accounted for 58 percent of the total Medicaid population (CMS 2002; Buck 2003).
6. Medicaid's expanded role has led to a less influential role for SMHAs, at least in terms of purchasing power and managerial responsibility. Many states have started to shift from the "community model" to the "health plan model" (Buck 2003).

#### **D. GAPS IN THE LITERATURE ON ADMINISTRATION AND POLICY DEVELOPMENT**

As the preceding discussion highlights, there are major gaps in the literature on how states administer Medicaid MH/SA services and set related policy. This section briefly summarizes what additional information is needed and would be useful to help inform the discussion.

To date, there has been no comprehensive information collected that systematically documents the infrastructure and processes around the administration of Medicaid MH/SA services and policy development. A state-by-state analysis is needed to fully understand the extent of Medicaid's role; without this information, assessing the impact of existing policy and any changes is difficult, if not impossible. An assessment of Medicaid's role is important to inform policymakers about how to more adeptly manage aspects of their state's MH/SA program, such as program spending, services provided, populations served, and care settings. Additionally, there needs to be a better understanding of the various roles and relationships of the key stakeholders in states' MH/SA systems and how they interact.

Some of the important unanswered questions include:

- How does the MH/SA program structure affect policy development? How does the allocation of authority over state MH/SA resources affect who sets policy within a state and how it is actually set?
- What, if any, unique local circumstances most influence program infrastructure and policy development?
- Are there certain infrastructures and processes that seem to be more effective than others, for instance, in categories such as inter-agency integration, data collection efforts, and financing of the MH/SA system?
- How much do states rely on and learn from each other about what strategies to use for things such as administration, financing, and data compilation and reporting related to their Medicaid MH/SA services?

- To what extent is SMHA staff involved in identifying MH/SA issues in Medicaid and setting policy? What other stakeholders play a role?
- How influential are federal agencies (e.g., SAMHSA and CMS) in state public MH/SA policy development?
- How important is the relationship between SMHAs and state Medicaid agencies in determining Medicaid's role in public MH/SA services?
- What special administrative and financing arrangements have states adopted for Medicaid MH/SA services?
- With the extensive turnover in state Medicaid and mental health director positions, who, if anyone, has the institutional knowledge in states to help inform the policy discussion, and how does this affect Medicaid policy development?

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### **III. MEDICAID MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES DATA AND REPORTING**

As Medicaid becomes an increasingly important financing component of public MH/SA services, states' need for accurate, comprehensive, and timely data is critically important to assist them in making informed decisions around these services. This is especially important when resources are constrained, a situation that almost all states currently face. This chapter broadly describes existing data and information deficits. It also assesses data sources that currently exist that capture information on Medicaid MH/SA service use and expenditures. The chapter also looks briefly at promising developments in the area of data sources.

#### **A. DATA AND INFORMATION DEFICITS**

Only limited data are available on Medicaid MH/SA service use and expenditures. There are two key factors that contribute to this information deficit. First, Medicaid is a heterogeneous program in which the federal government grants states broad flexibility in determining eligibility and covered benefits. This heterogeneity creates challenges for states in designing and maintaining administrative databases, resulting in significant variability in services for which there are not standard procedure codes. Many MH/SA services lack such standard codes (Mark et al. 2003). Second, because neither state Medicaid programs nor CMS generally report program statistics by diagnosis, data specific to MH/SA services are often limited and incomplete (Mark et al. 2003; Buck and Miller 2002a).

The lack of routine program reporting on Medicaid MH/SA services means that available information largely comes from studies that rely on surveys of providers and consumers or analyses of administrative data for a small subset of states. However, each of these sources has its limitations. Consumer surveys are hindered by inaccuracy in recall of details of service use and by difficulty in reaching and/or surveying certain populations (Mark et al. 2003). Provider surveys may overlook non-specialty sources of care, such as non-specialty units of general hospitals and nursing homes. Mark et al. (2003) found that estimates derived from consumer and provider surveys were less comprehensive and reliable than other sources of data, such as administrative data sources. Nevertheless, several studies have analyzed data from these surveys (Coffey et al. 2000; McKusick et al. 1998; Witkin et al. 1998; Zuvekas 2001). The large size and complexity of Medicaid administrative data sets mean that their analysis is expensive resulting in few such studies being conducted. Until recently, Medicaid research files maintained by CMS for all services were limited to four states. Information derived from these four states may not generalize to other states given the significant state-to-state variability that exists in Medicaid programs (Mark et al. 2003).

Finally, regardless of data source, most Medicaid MH/SA studies have applied different methodologies and definitions of what constitutes MH/SA services. Depending on the type and site of service, researchers can characterize a service as being or not being related to mental health or substance abuse. These methodological variations can have major effects on spending and service use estimates. For example, Mechanic, Angel, and Davies (1992) reported that the proportion of private health plan enrollees classified as MH/SA users varied from 10 to 27

percent in one study depending on the comprehensiveness of the definition. Spending on MH/SA services under Medicaid has been examined in the context of specific populations (such as children), for particular states, or under particular programs (such as behavioral health carve-out programs), but research that looks at total Medicaid spending on MH/SA services has been limited.

## **B. EXISTING DATA SOURCES**

This section discusses data sources that currently exist on Medicaid MH/SA services, including a description of the data source, key highlights, and important limitations. The focus in this section is primarily on data that are available at the national level, rather than on data that states themselves may be using for program monitoring, reporting, and policy development purposes. As previously noted, the latter would require a state-by-state assessment as there is no comprehensive dataset or central location where this information is currently housed or maintained.

### **1. Medicaid Statistical Information System (MSIS) and Medicaid Analytic Extract (MAX) Files**

#### **a. Description**

States submit Medicaid claims and eligibility data to CMS in an electronic, standardized database called MSIS. MAX files are research-ready files built from the claims and eligibility records in MSIS. Since the start of fiscal year 1999, CMS requires states to submit Medicaid service and eligibility data for MSIS, which includes individual-level data of all Medicaid submitted claims and eligibility information on each Medicaid recipient.

#### **b. Highlights**

MSIS pulls data from databases housed in the state-administered, highly individualized Medicaid Management Information Systems (MMISs) and organizes them in a standard way. Since claims are not always paid immediately after services are provided, and since payments can be adjusted numerous times after the original payment determination, it is necessary to put together many quarters of MSIS claims data to create a complete set of claims that reflect beneficiaries' annual service experience. Similarly, although to a lesser degree, eligibility information submitted in one quarter can apply to, or adjust information from, a previous quarter.

For many years, CMS has worked to create annual research-ready files from the MSIS data. In the past, these files were known as State Medicaid Research Files (SMRF). Starting with calendar-year 1999 data, CMS has improved the SMRF concept; MAX is more fully documented, has an expanded set of data elements, and includes prescription drug categorization and Medicare enrollment information merged from other sources.

Using state procedure and service codes that MPR has collected from states, it is possible to identify MH/SA populations and services from MAX. This allows a researcher to understand what kinds of care were provided in unique state programs. MPR has already identified a

general group of state service/procedure codes for MH/SA services. The MH/SA group includes all care identified as specifically targeted to the MH/SA population except for pharmaceuticals.

**c. Limitations of MSIS and MAX**

- Incomplete, faulty, or nonexistent encounter records for services provided to enrollees in capitated managed care plans
- Inaccurate or incomplete information on behavioral health plans in many states
- Missing information on dual eligibles, including diagnostic information on “cross-over” claims paid by Medicare, and data on services paid by Medicare, such as inpatient hospital, physician, home health, and lab and x-ray services

**2. Medicaid MH/SA Program Statistics<sup>14</sup>**

**a. Description**

SAMHSA’s Center for Mental Health Services (CMHS) has supported a series of studies that produced a basic set of annual Medicaid MH/SA program statistics for the years 1986, 1988, 1990, and 1992-1995 (Buck, Miller, and Bae, 2000a, 2000b, 2000c, 2000d; Buck and Miller, 2002a). Buck and Miller (2002b) also presented findings from a study that focused on Medicaid reimbursement of psychoactive drugs. Using 1995 Medicaid claims data, the investigators reported statistics on psychoactive drug use for the same 10 states as their 2002(a) MH/SA services study.

**b. Highlights**

- The study used Medicaid claims to report MH/SA service utilization, expenditures, and user characteristics for three states in 1986, 1988, and 1990; twelve states in 1992; and ten states for 1993-1995.
- MH/SA services were identified through a primary MH/SA diagnosis or category of service indicating MH/SA specialty care.
- From 1986 to 1995, MH/SA services constituted between 10 to 11 percent of total Medicaid expenditures.

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<sup>14</sup>A key component of the current project is based on this work and is intended to expand and update what was previously done.

### **c. Limitations**

- Excluded populations were persons over the age of 64 years, Medicare-Medicaid dual eligibles, enrollees in capitated programs, recipients for whom there was no eligibility information, and recipients with claims that did not report diagnostic information. In the 10 study states (1993-1995), about 22 percent of the Medicaid population were excluded (Mark et al. 2003, Buck and Miller 2002a), even though the states chosen had limited capitated managed care penetration.
- Excluded services include prescription drug expenditures (except for the psychoactive drug expenditures reported in the separate drug study) and administrative expenditures (Mark et al. 2003, Buck and Miller 2002a)
- The study was based on data states submitted to CMS, which were not validated in any way (Buck and Miller 2002a).

## **3. Integrated Data Base (IDB)**

### **a. Description**

SAMHSA's Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS) sponsored the development of the Integrated Data Base (IDB). The IDB, built from 1996 data, assembled information from state mental health, substance abuse, and Medicaid agencies and aimed to demonstrate the feasibility and difficulties in linking data across agencies (Coffey et al. 2001; SAMHSA 2003b; Whalen et al. 2001).

### **b. Highlights**

The IDB for years 1997 and 1998 are currently in progress (Coffey et al. 2001). By the end of the project, the IDB is expected to be a longitudinal database, containing data from 1996 to 1998. The database was developed for three states—Delaware, Oklahoma, and Washington—and required more than 40 data files from the three states, including nine different Medicaid claims/encounter formats, and MH/SA data from five agencies. The IDB is assembled separately for the three participating states and links person-level and service-level information across the multiple organizations in each state into one uniform database. Using the IDB, states are analyzed separately because of the variation in key dimensions among the states that can greatly influence the results by state. Examples of these highly variable dimensions include: organization of the delivery system, administration of funding, range of services covered, payment methods, and state-specific epidemiology. Taken together, the three state databases account for almost half a million unique MH/SA clients, linked to more than 16 million service-level records.

For the IDB, mental and substance abuse disorders were defined broadly and include those persons who have clinical conditions that may or may not be indicative of a current mental or substance abuse disorder, such as diagnosis of alcoholic cirrhosis. For state mental health or substance abuse authorities, the IDB includes all persons who received clinical treatment

services under their auspices. For Medicaid data, several criteria are used to define the relevant population:

- Persons with a primary or secondary mental illness or substance abuse diagnosis or with a related medical diagnosis, based on the International Classification of Diseases 9<sup>th</sup> Revision (ICD-9-CM);
- Persons with procedures related to specific MH/SA services, based on codes that are either state-specific or from the manual of Common Procedural Terminology, 4<sup>th</sup> Edition (CPT-4);
- Those who receive Medicaid services in settings that may indicate mental or substance abuse disorders, such as community mental health center services or inpatient psychiatric facility services; or
- Those with records with appropriate revenue billing codes (for example, claims with psychiatric room charges, codes for intensive psychiatric therapy, or alcohol rehabilitation charges).

As a result of applying such broad criteria, the IDB includes not only persons with an explicit mental or substance abuse disorder but also those with an “implied” disorder. People with dementia were excluded from the IDB except when they had a co-existing mental health or substance abuse condition (Coffey et al. 2001).

Development of the database involved applying sophisticated linking routines to the data, which produced relatively high linking rates compared to traditional linking methods. These routines allowed SAMHSA to link records for persons who might have been concluded to represent different individuals using less sophisticated techniques. Nevertheless, the linking methodology, although better than some other methods, was not as accurate as having unique identifiers within and across systems of record keeping (Whalen et al. 2001). States rarely have unique identifiers for clients across programs, and none had them across all systems of care. As a result, the process of matching individuals across organizations likely missed some clients who received services from multiple sources. Clarifying these methodological issues can have a direct bearing on the accuracy of estimates of per capita spending and utilization (Whalen et al. 2001; SAMHSA 2003b).

For everyone in the IDB, all medical services provided by Medicaid to the defined MH/SA population are included, which is likely to aid future research on these clients by providing a more comprehensive picture of their service use and expenditures.

### **c. Limitations**

- The IDB data only include three states, which may not be representative of other states.

- It takes considerable time to accumulate and link the data, with 1996 being the most recent year for which complete data are available.
- While diagnoses from Medicaid claims were generally available for analysis, diagnoses on state mental health or substance abuse agency data were sometimes not available for entire service-producing organizations. When such organizations treated one type of client (mental health or substance abuse), all clients under that organization were assigned to the appropriate category of either mental health or substance abuse. The highly variable rate of missing diagnoses across states, organizations supporting treatment, and types of clients could lead to biased conclusions (Coffey et al. 2001).
- The counts of residential treatment are not comparable across states because of differences in labeling and classification of these services/providers.

#### **4. National Spending Estimates**

##### **a. Description**

SAMHSA sponsors a study developing ongoing Spending Estimates (SE) that are comparable to those produced routinely by the National Health Accounts (NHA), sponsored by CMS (Coffey et al. 2000; McKusick et al. 1998).

##### **b. Highlights**

- Spending estimates separate MH/SA spending by payer and service categories, and describe the longitudinal growth of MH/SA spending, including a comparison of MH/SA expenditures to national health care expenditures for all types of conditions.
- The study relies on diagnoses classified in the ICD-9-CM as “mental disorders,” but with some notable exclusions, including cerebral degenerations, organic psychotic conditions (senile and presenile, transient, and other), tobacco abuse, developmental mental delays, mild mental retardation, and other retardation. Two additional diagnoses were also included in the definition of MH/SA services: drug dependence and mental disorders during pregnancy.
- Coffey et al. (2000), in the most recent iteration of the Spending Estimates, used the Uniform Facility Data Set (UFDS) and Inventory of Mental Health Organizations (IMHO) surveys to report total revenues by provider, payer source, and diagnosis.<sup>15</sup> Then spending on MH/SA treatment was carved out from the NHA. Finally, the two methods were integrated after accounting for duplication (Mark et al. 2000).

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<sup>15</sup>McKusick et al (1998) and Mark et al. (1999) were the first two reports submitted under this SAMHSA contract.

- In 1997, mental health services made up about 10 percent of total Medicaid expenditures (Coffey et al. 2000).
- Substance abuse spending was an estimated 1.4 percent of Medicaid expenditures in 1992 (Mark et al. 2003).

**c. Limitations**

- The underlying data sets are limited. At the time for example, IMHO data was only available until 1994 and expenditures in 1995 through 1997 had to be extrapolated using other information. The claims data are also limited. For example, hospital claims may not capture all spending on non-specialty care in general hospitals, particularly when limits on inpatient services cause the cost of a hospitalization to be borne partly or entirely by the client (Coffey et al. 2000).
- The NHA includes expenditures for all health services, but excludes MH/SA-related social services (Coffey et al. 2000).

**5. Inventory of Mental Health Organizations (IMHO)**

**a. Description**

Conducted by SAMHSA’s Center for Mental Health Services, the IMHO is a biennial survey of specialty mental health organizations – including psychiatric hospitals, specialty psychiatric units of general hospitals, mental health clinics, and residential treatment centers (Witkin 1998). The latest available data were collected in 2001 (Draper et al. 2003).

**b. Highlights**

- The IMHO reports Medicaid revenues in specialty mental health facilities.
- The expenditure percentages were between 5 percent and 6 percent of total Medicaid spending in 1990, 1992, and 1994 (Mark et al., 2003; Witkin 1998).

**c. Limitations**

- The IMHO does not capture Medicaid revenues received by independent practitioners (e.g., psychiatrists and social workers), expenditures on care delivered in non-specialty settings, drug spending, or spending on substance abuse treatment (except that provided in psychiatric facilities) (Mark et al. 2003). Consequently, total expenditures reported by this survey are underestimated.
- The 2001 IMHO data provide a sample of mental health organizations, not a complete inventory. Representativeness may be a concern.

## **6. Decision Support 2000+**

### **a. Description**

Decision Support 2000+ (DS2000+) is an integrated set of mental health data standards supported by SAMHSA's CMHS in collaboration with the Mental Health Statistics Improvement Program (MHSIP), Abt Associates, and NRI. Decision Support 2000+ proceeded from the 1989 report, *Data Standards for Mental Health Decision Support Systems*, commonly called the FN10, which recommended standards and presented minimum data sets for patient/client, event, human resources, financial, and organizational data (Leginski et al. 1989).

### **b. Highlights**

The new system builds on these efforts by including the health status of the population, enrollment, encounter, and outcome data as well as system description and performance information (Henderson, Minden, and Manderscheid 2001). The key information modules incorporated into the system are: population-based data and plan enrollment data for persons enrolled in health and behavioral health plans; encounter data and related financial data, organizational data, and human resources data (e.g., characteristics of providers and support staff); data for clinical and system guidelines that reflect adherence to best practices; and data on results, including consumer outcome data, a report card (including surveys of consumers, providers, and others), and performance measure data (MHSIP 2003).

The aim of the DS2000+ system is to make use of existing data at the population and individual level. DS2000+ does not yet exist in operational form; it is currently a proposed framework for an information infrastructure. To date, the operators have completed a requirements analysis for the system, and now are preparing for implementation. Some examples of proposed data elements include: person-level data on third-party payment (e.g., Medicaid) and date of payment, type of service provided, date of service, location of service, and principal and primary diagnoses.

### **c. Limitations**

- The system has not been implemented, so its final form and utility are uncertain.
- The comprehensiveness and quality of the Medicaid service data may be questionable. The sources of these data have not been made public.

## **7. Children's Mental Health Benchmarking Project**

### **a. Description**

The Children's Mental Health Benchmarking Project, conducted by Dougherty Management Associates, Inc. (DMA 2003) with funding from the Annie E. Casey Foundation and the Center for Health Care Strategies, collects administrative data on children's mental health services.

DMA gathers data on indicators in four areas: access, utilization, expenditures, and intersystem involvement.

**b. Highlights**

- In 2002, the project's third year, data were received from state and county mental health authorities in 41 jurisdictions (36 states, 4 counties, and the District of Columbia) and Medicaid agencies in 23 jurisdictions. No data were reported from such other agencies as education and juvenile justice.
- By collecting data from the state and county mental health authorities and state Medicaid agencies, the study was able to compare data reported by each agency (e.g., inpatient expenditures per day reported by the mental health agency versus that reported by the State Medicaid Agency).

Utilization data elements:

- Inpatient days per 1,000 enrollees
- Inpatient average length of stay, 30- and 90-day readmission rates
- Seven- and thirty-day follow-up care after discharge
- Non-hospital 24-hour care days per 1,000

Expenditure indicators:

- Total expenditures per child served
- Inpatient expenditures per day and per child hospitalized
- Inpatient expenditures as a percentage of total MH expenditures
- Non-hospital 24-hour expenditures per day and per child served

**c. Limitations**

- The study only includes SMHA data from three-quarters of all states and Medicaid data from less than 50 percent of states.
- The study did not report directly on the comparability of data between the two agencies, but states where the SMHA and the Medicaid agency had overlapping responsibilities found it especially challenging to eliminate duplication in their utilization and expenditure data, partly because they had never done so before (DMA 2003).

## **8. The Treatment/Recovery Information and Advocacy Database (TRIAD)**

### **a. Description**

The National Alliance for the Mentally Ill (NAMI), in collaboration with other stakeholders, has initiated and funded the Treatment/Recovery Information and Advocacy Database (TRIAD) to inform advocacy efforts about the treatment available and accessed by persons with mental illness (NAMI 2003). TRIAD will collect a variety of data that characterize the services and settings that are necessary for recovery from mental illness.

### **b. Highlights**

TRIAD is organized around 12 standards of care that reflect the core services, supports, and environmental requirements for a system to promote recovery among adults with mental illness. These standards of care include: access to appropriate information, inpatient care, assertive community treatment (ACT) programs, general medical care, integrated services for dual diagnosis, family psychoeducation and support, peer provided services and supports, supported employment services, affordable housing and supports, jail diversion programs, non-stigmatizing and non-discriminating environment. Current TRIAD efforts include: reports on the implementation of evidence-based treatments and outcomes for severe mental illness in adults and a national survey of NAMI members. The national consumer survey has included information on the primary form of health insurance (including Medicaid) among NAMI members (NAMI 2003). Much of the remaining TRIAD effort is in the database construction and data collection phase.

### **c. Limitations**

- A significant proportion of total MH/SA use and spending may be excluded, including stays in long-term psychiatric facilities, residential treatment facilities, and nursing homes.
- TRIAD may not reach certain populations that have unstable housing, including persons with mental illness.
- Currently, TRIAD contains no Medicaid expenditure data and limited data on service use, only detailing the percentage of those persons with mental illness who are enrolled in Medicaid.
- Data for acute care MH/SA services for institutionalized populations, including jails and prisons, are probably excluded.

## **9. NASMHPD Research Institute Activities**

### **a. Description**

As part of the State Mental Health Agency Revenues and Expenditures Study, the NRI compiles the only national database on mental health expenditures and revenues of SMHAs (NRI

2003). The NRI project, funded by SAMHSA's CMHS, has compiled mental health expenditure data for the fiscal years 1981, 1983, 1985, 1987, 1990, 1993, 1997, and 2001.

The NRI also operates the SMHA Profiling System, a centrally maintained, computer-based compilation of descriptive information about the organization, funding, operation, services, policies, statutes, and clientele of SMHAs (NRI 2003). The related databases, which run from 1996 to the present, include both quantitative and qualitative information. The content of the Profiling System was developed with funding from SAMHSA's CMHS and the assistance of a technical advisory group (TAG) of state mental health directors and other senior managers. During each cycle of the Profiling System, the TAG meets to review previously gathered information, reports generated from the data, and the types and volume of requests made into the Profiling System.

## **b. Highlights**

For the SMHA Revenues and Expenditures Study, state-controlled mental health expenditures are depicted by various settings of services, such as state psychiatric hospitals, community-based programs, and central office. Individual-level service expenditures within these settings are also compiled. Revenue sources are categorized broadly, such as state, federal, local, and other, as well as by detailed funding categories (including federal Medicaid, Medicare, block grants, and other federal funds). Each year's data compilation effort is consolidated into a report that includes descriptive information and tables as well as a focus on emerging issues of public mental health funding (Lutterman, Hollen, and Shaw 2003).

The Profiling System is comprised of 11 components that describe each of the SMHAs, including SMHA organization and structure; policies/statutes/regulations; clients; services; workforce; financial; managed care; forensics; research and evaluation; information management; consumer issues; and state demographic data. Data from 2001 from every state, the District of Columbia, and Guam have been entered into the system and are accessible for public use on the NRI website.

## **c. Limitations**

- The chief limitation of the Revenues and Expenditures Study and the Profiling System are their scope; they only report SMHA data, which represent a fraction of all Medicaid MH/SA service data. Because data from other state agencies, including the Medicaid agency, are excluded from the study and the data system, they cannot provide national estimates on MH/SA service use and expenditures.
- The data is only as good as those reported by state agencies, whose data are not systematically examined for accuracy and validity.

## **10. Medical Expenditure Panel Survey (MEPS)**

### **a. Description**

The MEPS is a nationally representative household survey of the civilian, noninstitutionalized population (Zuvekas 2001).

### **b. Highlights**

- The survey is conducted by questioning family members about their health care expenditures.
- The data are weighted to produce national estimates.
- The 1996 MEPS estimated that Medicaid MH/SA service expenditures equaled \$528 billion or 3.3 percent of total Medicaid spending (Mark et al. 2003)

### **c. Limitations**

- Because the MEPS is a household survey, a significant proportion of total MH/SA service use and spending is excluded, including stays in long-term psychiatric facilities, residential treatment facilities, and nursing homes.
- Data for acute care MH/SA services for institutionalized populations, including jails and prisons, are excluded (Zuvekas 2001).
- It may not reach certain populations that have unstable housing, including persons with mental illness (Zuvekas 2001; Mark et al. 2003).
- Health services delivered in non-health settings (e.g. schools or at home) are also excluded from these data (Mark et al. 2003).

## **11. Uniform Facility Data Set (UFDS)**

### **a. Description**

Conducted by the Office of Applied Statistics (OAS), an office under the SAMHSA umbrella, the Uniform Facility Data Set (UFDS) is an annual survey of specialty facilities providing substance abuse treatment (SAMHSA 2001).<sup>16</sup>

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<sup>16</sup>UFDS is one component of SAMHSA's Drug and Alcohol Services Information System (DASIS). DASIS links UFDS facility-level information to individual-level information on user characteristics found in the Treatment Episode Data Set (TEDS) (SAMHSA 2001). TEDS is a client-level database of persons admitted to substance abuse treatment. A unique identification

## **b. Highlights**

- The UFDS collects data on location, characteristics, and use of substance abuse treatment facilities and services in all 50 states, the District of Columbia, and other U.S. jurisdictions.
- Medicaid spending is assessed by asking providers to report total revenues and to indicate proportions attributable to various payers (SAMHSA 2001).
- In 1999, Medicaid spending on substance abuse treatment represents about 1 percent of total Medicaid spending (Mark et al. 2003).

## **c. Limitations**

- The survey included a limited number of substance abuse services and providers (Mark et al. 2003).
- Because no adjustments were made for non-response, the reported Medicaid expenditures slightly understate the true magnitude of Medicaid funding, due to a 5 percent non-response rate in 2001 (Mark et al. 2003).

## **12. Other Administrative Data Efforts**

Several studies estimate MH/SA service use and expenditures based on Medicaid administrative data sources. These include:

- Larson et al. (1994) used 1993 Medicaid claims data to estimate Medicaid spending on MH/SA services in Michigan, New Jersey, and Washington. The authors included all age groups as well as patients with dementia, but excluded persons enrolled in capitated plans, pharmaceutical spending, and administrative expenses.
- Wright, Smolkin, and Bencio (1995) examined Medicaid MH/SA spending in Michigan and California for 1992, using tape-to-tape claims files that are maintained by the Health Care Financing Administration (HCFA, now called CMS). All age groups and pharmaceutical spending were included, while persons enrolled in capitated plans and administrative expenses were excluded.
- Wright and Buck (1991) conducted a precursor to the above study, looking at 1984 claims data in Michigan and California.

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*(continued)*

number is assigned to each facility, so that TEDS and UFDS data can be linked (SAMHSA 2001).

- Rosenbach and Huber (1994) used 1990 Medicaid claims data from CMS's MSIS for Washington State to examine substance abuse services. All types of services were included in the analysis, including long-term care institutions, pharmaceutical expenditures, laboratory services, and physician services. Managed care enrollees were excluded.
- Larson et al. (1998) analyzed 1993 State Medicaid Research Files (SMRF) claims data from Michigan, New Jersey, and Washington to generate Medicaid MH/SA service estimates. The study included all those with a primary MH/SA diagnosis, a MH/SA procedure (regardless of diagnosis), or a specialty MH/SA provider (regardless of diagnosis or procedure).

Existing evidence suggests that administrative data analyses may offer higher levels of data completeness and reliability than surveys. Nevertheless, due to the complexity of Medicaid claims files maintained at the state and federal level, data quality issues are sometimes problematic. There may also be questions about the completeness of administrative data. These systems may also miss large portions of the population, depending on the structure of the system. Typically administrative data sources do not capture data for enrollees in capitated plans (except in the rare cases when good encounter data are available). In 2002, more than half of the total Medicaid population was enrolled in some form of managed care (CMS 2002; Buck 2003).

### **C. PROMISING DEVELOPMENTS**

No state Medicaid agency provides regular comprehensive reports on its financing of MH/SA services, and federal policy does not require such reporting (Buck 2001). Although most states lack the capabilities to integrate MH/SA data from many sources, evidence suggests that there has been progress on this front. MHSIP, a voluntary collaboration between the federal government and states, helped to attract the attention of state officials to the importance of common data elements, quality of information, and the need to link several kinds of data (Mazade, Wurster, and Lutterman 1992). Similarly, states are moving toward improving mental health data capabilities through the integration of various sources, although the contents of state data systems have not been systematically examined (Buck 2003).

While many state Medicaid agencies and SMHAs reportedly share data on service use and expenditures, the specifics of these exchanges—types of data, elements, frequency, format—are sketchy at best. According to information reported by 47 SMHAs, more than two-thirds, or 30, say that they receive Medicaid paid claims data from their state Medicaid agency, and in 26 of these, the SMHA links Medicaid paid claims data with its own patient databases to analyze the use of Medicaid-covered services (NRI 2002b). Twenty-nine SMHAs receive information other than paid claims data from Medicaid, including 24 SMHAs that get reports on Medicaid expenditures for mental health services.

Several data systems have been developed to fill in gaps in data reporting and to enhance current data capabilities. Each of these systems was built to address a different set of research, policy, and management questions, which affects the structure and application of the database. The types of data collected by different sources also reflect their variety of purposes. For example, mental health and substance abuse agency data generally provide more patient

information than do Medicaid data. Medicaid data, however, include more service use information, including charge and payment data (Whalen et al. 2001). How policymakers, managers, and researchers intend to use the data will affect how data systems are designed and how the data are collected and entered into the system. Once these decisions are made, using the systems and data for other purposes may prove difficult. One of the challenges for many of the data systems described in the preceding section is that they primarily use administrative claims payment data, so the data were not necessarily collected for purposes relevant to a particular research or policy question. One possible solution to this limitation is to link data from different sources (Buck 2003; Whalen et al. 2001), but this process may be complicated, especially in the absence of a unique identifier for each person across each data source (Whalen et al. 2001).

#### **D. GAPS IN DATA ON MH/SA SERVICE USE AND EXPENDITURES**

This section briefly summarizes the gaps in what is available, and the steps that are needed to fill these gaps.

Several approaches to reporting MH/SA service use and expenditures data (including Medicaid data) have been attempted. Many recent efforts show promise, but all are limited in some respect. Studies based on surveys miss a large proportion of respondents. Even studies that use multiple data sets, such as Coffey et al. (2000), do not provide individual-level data that can help answer important policy questions. For instance, how has the intensity of use by persons in treatment changed (Mark et al. 2000)? Policymakers need this data to develop more effective ways to target MH/SA spending. Longitudinal person-level data would be necessary to answer such questions, but to date, comprehensive person-level service use and expenditure data have not been available for all MH/SA users. In the cases where the data have been available, they have been limited to a small subset of states (e.g., Miller and Buck 2002a) and for discrete time periods.

Comprehensive data for all 50 states and the District of Columbia are needed to be able to compile national statistics on MH/SA service use and expenditures. This information needs to be detailed enough (by diagnosis, treatment settings, and other individual-level characteristics) to analyze specific components of the MH/SA care delivery system, and analyze specific subpopulations. Such data can provide insight into the state-to-state variability that exists and the factors that may contribute to this variation.

Researchers and policymakers currently do not have a data warehouse where they can access comprehensive information on Medicaid MH/SA service data. Although some of the data systems mentioned in this chapter are moving toward that goal, all are still in development. A user-friendly nationwide data system does not yet exist. Once it exists, data from the system also needs to be publicly available at the aggregate level, if not at the person level. As a result, stakeholders continue to be limited in their knowledge of Medicaid's role in delivering and financing MH/SA services. Also, without a comprehensive effort that can be maintained over time, the costs of building such a database will become increasingly prohibitive.

One useful tool would be a resource that describes in detail the data elements maintained within relevant state agencies' systems. The data systems currently under construction either do not rely on state data or fail to incorporate data from multiple agencies (and for all states, in the

case of the IDB). In order to create a database that pulls together comparable data, researchers first need to understand the level of comparability of the data that exist in current state data files. This knowledge would presumably also assist with identifying data limitations in state systems.

## **IV. CLOSING THE GAPS**

### **A. IMPORTANT TAKEAWAYS**

One main purpose of this review has been to outline the current state of knowledge about Medicaid MH/SA services administration and policy development. Upon review, some information about Medicaid's function is known but much is not. Various state agencies and other stakeholders have an important stake in how Medicaid MH/SA services are organized, financed, and delivered. There are no known efforts that have explicitly studied the decision-making processes that control the administration and policy development of MH/SA services. In addition, information is lacking on how issues relating to MH/SA services are identified by state government, such as how they develop budgets, set priorities, and allocate resources.

Beyond the infrastructure and policy domains, data on MH/SA service use and expenditures in Medicaid are also limited. Several studies have provided national estimates of service use and expenditures, but the methods used have had significant limitations. The most accurate national estimates partly rely on consumer surveys that miss sizeable portions of the MH/SA population. In addition, when studies have employed administrative data sets, they have typically focused on a small subset of states, precluding the compilation of national statistics. Several organizations are working to create a one-stop data system for stakeholders to access, but these are currently works in progress and not yet publicly available.

The current body of research also leaves other information gaps. For instance, what role does the State Children's Health Insurance Program (SCHIP) play in the public MH/SA system? SCHIP is still a relatively new program, so its role and effect on MH/SA service use and expenditures has not been systematically explored. Also, to what extent are mental health services and substance abuse services treated separately as discrete entities on the state and federal level? Future research needs to address these questions as well as many others.

### **B. NEXT STEPS**

In 2001, President Bush announced the New Freedom Initiative to promote increased access to educational and employment opportunities for people with disabilities. As part of this effort, the President launched the New Freedom Commission on Mental Health to address the problems in the current mental health system. One of the Commission's 19 recommendations for the improvement of the mental health system was to align federal programs to improve access and accountability for mental health services. Part of this recommendation seeks to align federal financing for health care. According to the statement of the Commission's goals, "All too often, the interplay of existing policies, waivers, and exemptions can cause the collaboration between the State mental health authorities and State Medicaid programs directors to be inconsistent" (sic) (New Freedom Commission on Mental Health 2003).

Additionally, the Commission recommends that states create a comprehensive state mental health plan to better coordinate services. The recommendation suggests that the Office of the Governor lead this effort to reach beyond the traditional SMHA and address the full range of

treatment and support service programs that consumers and families need. It further suggests that state and local levels of government be more responsible for results, not solely to federal funding agencies (e.g. CMS), but to consumers and families as well (New Freedom Commission on Mental Health 2003).

SAMHSA recently awarded a contract to Mathematica Policy Research, Inc. (MPR) to study the role of Medicaid in the administration of public MH/SA services. The scope of this project fits well into the framework created by the Commission. As recognized by the President's New Freedom Commission, aligning federal financing for mental health care and piecing together the fragmentation in the mental health system is essential. MPR's project is intended to provide a piece of the foundation by informing the discussion on Medicaid's role—the largest federal funder of MH/SA services—in the mental health system. MPR's project aims to (1) provide consistent and comparable state-level data on the extent to which mental health and substance abuse services are provided and paid for by Medicaid, and (2) expand the level of understanding and knowledge around the policy development and other decision making around the administration of Medicaid MH/SA services. MPR will undertake a series of activities that include: convening an expert advisory panel, conducting a survey of state officials, and performing an analysis of Medicaid claims data for 1999 in all states.<sup>17</sup>

## **1. Expert Advisory Panel**

MPR has invited 15 experts in the field to serve on an advisory panel. The panel will provide important insights and perspectives to help guide the project, including the development and administration of a survey of state officials. The panel members represent a range of perspectives including representatives from state mental health authorities, state Medicaid agencies, mental health services research, relevant national organizations, advocacy organizations, and CMS. The panel also represents a range of states that vary in terms of geographic location and size, organization of state MH/SA services, and experiences with Medicaid program types (fee-for service, managed care, and primary care case management).

## **2. Survey of State Officials**

This project directly addresses the Commission's goal to understand the relationship between the state mental health authority and state Medicaid agency through a survey of state officials. The methodology, including instrumentation, will draw heavily from the recommendations of the expert advisory panel. MPR will target respondents working in various state agencies and with various job descriptions who play an important role in the administration of MH/SA services in their states' Medicaid programs as well as assisting with related policy development. Respondents will likely include key informants from each state's mental health

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<sup>17</sup>Although our study will analyze data for all states, it may not be possible to report data for Medicaid-funded MH/SA services on all states. A small number of states may be omitted because their data do not meet standards for quality and completeness. Other states may be omitted because they have a large percentage of the Medicaid population in capitated plans that generally do not report complete and reliable encounter or claims data.

authority, Medicaid agency, SCHIP program, and other relevant agencies. The results of the survey aim to shed light on the processes behind the administration and development of policy in each state's mental health system.

### **3. Analysis of Medicaid Data**

As discussed earlier, there is a strong need for more comprehensive data on Medicaid MH/SA service use and expenditures. MPR will respond to this need by conducting an analysis that updates and expands previous work with Medicaid claims data conducted by Buck and Miller (2002a, 2002b). The goal is to provide consistent and comparable state-level data on the extent to which MH/SA services are provided and paid for by Medicaid. Buck and Miller generated a set of tables for 10 states, using 1995 data. MPR will use 1999 data to create descriptive tables for all states, to the extent possible based on the quality and completeness of each state's data.

This project will use the Medicaid Analytic Extract (MAX) files. MAX files are research-ready files built from the claims and eligibility records in the Medicaid Statistical Information System (MSIS). These files are a greatly improved version of the State Medicaid Research Files (SMRF). MAX is more fully documented than SMRF, has an expanded set of data elements, and includes prescription drug categorization and Medicare enrollment information merged from other sources.

This is a two-year project. It is expected to run through September 2005. Several deliverables will result from the project including: a report and set of tables for all 50 states and the District of Columbia on service use and expenditures; a report on mental health services administration and policy development in Medicaid programs; a report on mental health data and reporting; and up to four briefings and presentations for SAMHSA officials and others on the study's findings.

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