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Reforming Medicaid's Disability Coverage

By Michael Bond, Ph.D.

Medicaid was created almost as an afterthought in 1965. Now it's the nation's largest health plan, providing coverage for more than 51 million Americans.

The vast majority of Medicaid's beneficiaries are in fee-for-service or managed-care plans providing traditional health care. Another 8 million are adults and children with disabilities such as blindness, paralysis, mental illness, retardation, cerebral palsy, Downs Syndrome, and HIV/AIDS. More than 75 percent of the disabled access the Medicaid program on the basis of qualifying for Supplemental Security Income.

Slightly more than half of this group receives acute care involving physicians, hospitals, and prescription drugs. The rest receive long-term care, which can include home health services, nursing facilities, and institutional care facilities.

Although the disabled account for less than 20 percent of beneficiaries, they account for more than over 40 percent of Medicaid's program costs. Per enrollee, the disabled cost six times as much as coverage for non-elderly adults and eight times as much as coverage for children.

Further, the growth rate in the number of disabled beneficiaries as well as the growth rate of the cost of covering them has been faster than the growth rate for the rest of Medicaid. The inescapable conclusion is that any plan for dealing with Medicaid's trillions in unfunded liabilities must involve reforming coverage for the disabled.

Medicaid's traditional fee-for-service arrangement is not well suited for dealing with this population and, indeed, may produce low quality outcomes for the general Medicaid population. Most states have looked at managed care as a possible solution. As of 2003, some 45 States had implemented a managed care system for children's behavioral health services.

Of the 45 States and the District of Columbia that have implemented managed care, more than 80 percent remain involved in managed care. As of 2003, three-quarters of the managed-care systems included substance-abuse treatment. When substance-abuse treatment was not included in managed care, it remained available on a fee-for-service basis in 78 percent of the systems. In the remaining systems, it was either a separate carve out or was included in a physical health managed-care arrangement that does not include mental health.

These trends mirror the reforms over the past two decades in the national health care delivery system. The diverse issues that Medicaid's disabled face may not be adequately addressed by Medicaid networks and HMO plans.

While effective competition among managed-care plans with consumer choice is desirable (and currently underway in Florida's path-breaking reform), the nature of the issues facing some of Medicaid's disabled may require a much more specialized model. For example, those with mental health issues are not likely to be able to make consistently good choices in receiving treatment for their problems.

Some states have used an alternative carve-out design where mental health services are operated separately from physical health services. One study comparing the differential impact of integrated and carve-out designs found that states with carve-out or partial carve-out designs tend to cover a broader array of children's mental health services, offer more home and community-based services, and allow greater flexibility in service delivery than states with integrated designs.

A number of factors contribute to the relative strengths of a carve-out, including protection of the funding for behavioral health services, easier blending of Medicaid with non-Medicaid dollars, a greater likelihood that savings will be reinvested into children's mental-health services, and greater involvement of agencies and individuals with expertise in child behavioral health policy.

One approach to achieving good outcomes for this group is "braided funding." Under this model, developed by the firm Value Options, Medicaid brings together multiple state agencies

and provides oversight for the program as a whole. The program integrates the resources of 18 different state agencies to eliminate redundancy and expand the quantity and quality of care for the mentally ill and substance abuse. The program, in place in New Mexico since 2004, has been widely heralded. In addition to state agencies, Value Options has arranged for 15 regional groups to deliver services to this group.

New Mexico's Gov. Bill Richardson believes the program provides better access for enrollees and savings for taxpayers. He argues that the braided funding model increases possible sources of treatment, increases accountability, and reduces administrative overhead.

The model has received bipartisan recognition. Former U.S. House Speaker Newt Gingrich says that it is an interesting program that keeps beneficiaries from "getting lost in the system." The program has been particularly effective in dealing with issues facing disabled Native Americans in New Mexico.

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