National MLTSS Health Plan Association

Why Include Long-Term Services and Supports in Behavioral and Mental Health Reform

The current US health care system provides fragmented care for primary health, behavioral health, and long-term services and supports (LTSS). Stakeholders often discuss the need for care integration between one or more of these categories of services. While the MLTSS Association has advocated for the necessary integration of Medicare and Medicaid services, consideration also needs to be made for behavioral health needs and processes that further integrate care and improve access to care for LTSS beneficiaries. The MLTSS Association is well-positioned to be an ally for efforts that progress thoughtful care delivery for behavioral and mental health.

BACKGROUND: Defining BH, SMI, and LTSS

In a landscape research report, the Senate Finance Committee defines behavioral health (BH) conditions to include both mental health and substance use disorders (SUD).[1] In the context of this brief, we thus define BH to include the broad spectrum of behavioral disorders (i.e. gambling, eating disorders), mental illnesses (such as anxiety, depression, mood and personality disorders) as well as SUD. In 2020, 16% of all U.S. adults had a mental illness and 8% experienced SUD.[2] Medicaid plays a key role in financing BH care due to the correlation between BH condition prevalence and low income.[3] **21% of Medicaid beneficiaries has a BH diagnosis**, associated with a 4-fold increase in spending per beneficiary. These beneficiaries often have an array of physical health needs such as asthma, and chronic liver disease as well as social needs including homelessness and unemployment.[4]

In 2019, **51.5 million** U.S. adults had a diagnosable mental health condition

19.3 million had a substance use disorder

Individuals with BH needs often require assistance with activities of daily living (ADLs) such as eating and bathing or instrumental activities of daily living (IADLs) like housekeeping and finances over an extended period of time.[5] Thus, BH needs often overlap with LTSS needs. LTSS are delivered in a variety of settings, including institutions and home and community-based services (HCBS). A significant subpopulation of LTSS beneficiaries with BH disorders is those with serious mental illness (SMI), defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.[2]

Medicaid is the primary payer for LTSS, providing over half of all LTSS spending.[6] **Three-quarters of LTSS users are individuals who are dually eligible** for both Medicare and Medicaid ("dually eligible beneficiaries").[7] Thus, it follows that dually eligible individuals also have a high prevalence of behavioral health conditions. **41% of dually eligible beneficiaries have at least one mental health diagnosis** (double the rate of Medicaid-only beneficiaries), and 60% have multiple chronic conditions.[8,a] The dually eligible population is particularly high-risk and high-cost due to the complex intersection of medical and socioeconomic factors as well as the convoluted patchwork between the two programs.

[a] CMS in this context defines mental health conditions to include depression, anxiety, bipolar disorder, major depressive disorder, personality disorders, PTSD, schizophrenia, and other psychotic disorders.

In March 2022, the Senate Finance Committee released a landscape research report that outlines key BH challenges and potential solutions, as a result of a robust public fact-finding effort through hearings and over 500 responses to a request for information. Notably, the report highlights the importance of integrating care for dually eligible beneficiaries.[1] Given the overlap of BH and LTSS needs, there is a significant opportunity to consider LTSS and Medicare-Medicaid integration in any legislative proposals to reform behavioral health.

ISSUE: BH needs are predictive of LTSS need

While there is empirical clinical evidence of correlation between BH and LTSS needs, it is difficult to find publicly available data on the national prevalence of BH needs in LTSS users due to varying definitions and unlinked and outdated datasets. However, there is evidence of co-occurrence in the following subpopulations:

- *Washington State (unpublished data):* Washington State found that 18% of LTSS recipients 18+ in 2018 were diagnosed with schizophrenia and psychotic disorders, compared to less than 1% in the national population.[9,b] Among Medicare beneficiaries greater than 65 years of age, entry into Medicaid LTSS recipiency was significantly correlated with depression, schizophrenic/psychotic disorders, and alcohol use disorder.
- *Dually eligible beneficiaries:* Nearly 50% of dually-eligible adults aged 18-64 have a BH condition, compared to 14% of Medicaid-only beneficiaries aged 18-64.[10] **Nearly 1 out of 3 dually eligible beneficiaries have an SMI diagnosis** (triple the rate of Medicaid-only beneficiaries).[11]
- *Youth with SMI (unpublished data):* One of our member plans, a regional health plan providing Medicaid services across multiple states, reports that 18% of their total member population has at least one SMI diagnosis and represents 56% of total medical expenditures. **Of this population, one-third are under the age of 18 but reflect over 15% of total medical expenditures for the health care plan**.
- *Nursing home residents:* BH needs are a strong predictive factor of nursing home (NH) use. 1 in 3 individuals who need assistance with two or more ADLs will become long-term NH residents.[12] Nearly **40% of long-term NH residents on Medicaid under 65 have SMI**.[13,14] New NH admits are more likely to become long-term residents if they have SMI.[15]
- *PACE participants:* BH needs have also been increasing in the Program of All-Inclusive Care for the Elderly (PACE). Over 40% of PACE participants have SMI diagnoses. Many PACE organizations have an increasing proportion of **55-64 year olds, who have higher rates of mental illness (77.6%)** compared to those over age 65 (53.8%).[16,c]

SOLUTION: Incorporate LTSS in BH integration proposals

The vast majority (70%) of all Medicaid beneficiaries are enrolled in comprehensive managed care, making Medicaid managed care organizations (MCOs) an ideal structure for integrated care.[17] Over the last decade, states have been moving to integrate BH with other managed benefits—with the

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[b] The Washington State 18% estimate uses CMS' definition for schizophrenia and psychotic disorders. The <1% prevalence estimate is derived from several studies. NIH notes that precise prevalence estimates of schizophrenia are difficult due to the complexity of the diagnosis, its overlap with other disorders, and varying methods for determining diagnoses. As such, schizophrenia and other psychotic disorders are often combined in prevalence estimation.

[c] Common mental health diagnoses in this context include psychotic disorder, bipolar disorder, major depressive disorder, anxiety disorder, personality disorders, developmental disorders, and substance use.

number of states providing integrated programs growing from only a handful to 16 states by 2016 and 29 states by 2018.[4,18]

States have seen a wide range of success with integration including provider-level data sharing, accountability for quality, and aligned incentives for care coordination. Integrated care products offer opportunities for shared savings, improvements in clinical outcomes, and reduced health disparities.[17,19] Many BH integration policy proposals - including establishing core service and quality standards, incentivizing integration through new and existing payment models, and expanding and training the workforce for integrated teams - are applicable to broader integration goals.[17] Additionally, reducing the reliance on institutional models of care (including in-patient psychiatric treatment and residential treatment facilities) is critical to systems transformation, but requires significant investments in building the capacity of community mental health systems to assure access to high-quality evidence-based home and community-based services that support individuals living with SMI and BH conditions and their families. Such practices include but are not limited to Active Community Treatment (ACT), permanent supported housing, and Individual Placement Support (IPS)-Supported Employment.

Inclusion of LTSS in BH integration has significant implications for improved quality and outcomes and whole-person care. Further, supporting stronger investments in robust health information technology interoperability across public data systems (including Medicaid, Medicare, mental health, child welfare, education, housing, employment, and Older Americans Act programs) and centralized care coordination via integrated models (that bridges clinical, pharmacy, LTSS and social determinants of health) is critical to assuring optimal individual and systems-level outcomes.

Given that the vast majority of LTSS users are also dually eligible beneficiaries with complex health care needs, Medicare-Medicaid integration policies also have implications for improved BH care. FIDE-SNPs offer the highest level of integration for these high-risk, high-need beneficiaries, particularly with the higher degree of integration required for FIDE-SNPs under the CY2023 CMS Final Rule.[20]

CONCLUSION

BH and LTSS needs are inextricably linked. States are seeking opportunities to integrate their LTSS delivery and Medicare and Medicaid services through managed care contracts due to the efficacy of these products. As Congress continues to explore ideas on integrating BH, it is important to acknowledge that the driving force for this initiative also has implications for the value and urgency of LTSS integration as well as integrated care products for dually eligible beneficiaries.