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The Relationship Betweenmedicaid Expansion And The Utilization Of Behavioral Health Care Services By Severely Mentally Ill Patients In Arizona.

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Abstract: ***In the American state of Arizona, medical and behavioral health care services for the economically disadvantaged were expanded in January 2014 to be in compliance with the "Affordable Care Act" (as known as "Obamacare"), a federal law. This expansion increased Medicaidfinancial eligibility to 133% of the Federal Poverty Level. This paper examined the effect that this expansion had on program eligibility and Severe Mental Illness (SMI) service. It was found that by April 2015 the eligibility expansion resulted in more than 270,507newly enrolled SMIadults (a 52% increase in 16 months). By the end of the study period,a mean of 2,641SMI patients received one or more professional behavioral health care encounters per month. There was significant upward trending for eligibility and service encounters while the penetration ratio declined, possibly indicating a service ability saturation point. Individual patients were not tracked. Additionally, it compared growth trends predicted by a 2013 Executive Budget Report to the Office of Governor.***

Keywords: Obamacare, Behavioral Health Care Cost, Medicaid Expansion, Severely Mentally Ill, Title XIX

INTRODUCTION

The goal of this investigation was to measure possible changes in Medicaid (Title XIX of the Social Security Act) eligibility and utilization of behavioral mental health care services by indigent seriously mentally ill persons afterthe "Affordable Care Act" was fully implemented in Arizona. Enrollment and eligibility data from October 2012 through April 2015, obtained from official state sources, was examined [1].The uniqueness of this investigation was that it focused solely on the effect that an expanded Medicaid eligibility had on behavioral health care services to the Seriously Mentally Ill (SMI).An additional goal was to compare the actual results of the eligibility expansion with that which was projected in a 2013 Executive Budget Report to the Office of the Governor [2].

One of the achievements of the Obama Administration in the United States (2008 to 2016) was the creation of the "Affordable Care Act" (ACA), also known as "Obamacare", which radically overhauled the providing of medical care insurance. The primary focus of this federal law was to assure that all citizens had access to medical health care insurance. Historically, individuals and families who had annual household incomes below the Federal Poverty Level (FPL) did not receive the same level of medical care and were typically using hospital emergency rooms for care that would otherwise be given at a physician's office. The FPL in 2013

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was about $32,500 for a family of four and $15,856 for an individual The ACA sought to remedy the social imbalance of access to health care insurance.

This Federal Act remainedextremely controversial due to the partisanship of its enactment and its forecastedsizeableaddition to the already burdened national debt. While all citizens are required to obtain medical insurance whether through their employment or on their own via healthcare insurance providers, those who are financially unable to buy their own insurance can apply for governmental assistance through Medicaid (Title XIX of the Social Security Act). This is funded by both the federal and state governments. As administrated in Arizona, Medicaid originally set its eligibility at 100% of the FPL. However, that level still left up to 57,000 individuals uncovered by health insurance. The ACA, therefore, required an expansion of Medicaid to accommodate individuals up to 133% of the FPL. This expansion was happened at the very time that Arizona found itself financially overwhelmed by 1.3 million Medicaid participants or 20.6% of the state population at the end of Fiscal Year 2013. Enrollment in this program had grownexponentially since its inception in 1985.

The ACA expansion to 133% was initially opposed by the state's governor as an unconstitutional overreach by the federal government. The United States Supreme Court ultimately sided with the federal government and Arizona found that it was in its own best interests to comply. In January of-Fiscal Year 2014 (ending September 30, 2014) the legislature and governor expanded financial eligibility to 133% of the Federal Poverty Level in compliance with the Affordable Care Act.

Medical and mentalhealth care funding for low income individuals within the state of Arizona was administered by the Arizona Health Care Cost Containment System (AHCCCS). Behavioral or mental healthtreatment for both the Title XIX and non-Title XIX (that is, those who were not medically indigent) populations wasadministered by the Division of Behavioral Health Services, a major unit of Arizona's Department of Health Services.There are multiple categories of behavioral health care including, but not limited to, general mental health (GMH), substance abuse (SA), various children programs and inpatient care at the Arizona State Hospital (a mental health institution). In April 2015, 22% of the Medicaid eligible behavioral health care members were classified as SMI(Figure 1).

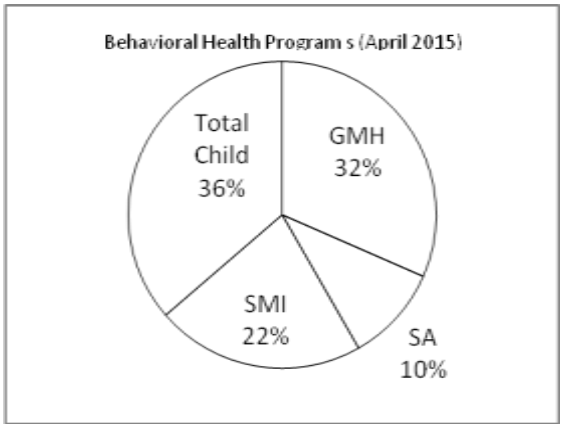

Figure 1. Behavioral health treatment category membership (April 2015)

A critical component of Arizona'sbehavioral health care service delivery system was the effective and efficient identification of persons who had special behavioral health needs due to the severity of their mental disorder or a Serious Mental Illness (SMI). These individuals, without the receipt of appropriate care, would be at a high risk of further deterioration of their physical and mental condition. These risks included increased hospitalizations, potential homelessness and incarceration[3].

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SMI individuals presented a high level of social dysfunction. There was a strong potential risk of serious harm to others or self with aggressive or assaultive behavior. There was often a history of arrest, incarceration, homelessness, and/or hospitalization.

These individuals had frequent thoughts of death, murder, suicide, and/or self-harm which disrupts normal life, often accompanied with behavioral intent. These actions and ideations were disruptive to social interaction, a successful livelihood and personal care. Schizophrenia was a common diagnosis. Therefore, the identification and treatment of SMI persons was of high social importance as evidenced by the attempted murder of Congresswoman Gabrielle Giffords and the murders of 6 others at a political rally in Tucson, Arizona on January 8, 2011, by an allegedly mentally unstable individual[4].

MATERIALS AND METHODS

Data for this analysis was obtained directly from the Arizona Department of Health, Behavioral Services Division via their publically accessible reports.A key report is within the annual collection of Enrollment Penetration Reports. The most recent, the "Enrollment Penetration Report, Fiscal Years 2013 – 2015" was used in this analysis[5].Information in this file was limited to behavioral health care. The date range for this report was October 2012 (the beginning of Fiscal Year 2013) through April 2015 (seven months into Fiscal Year 2015). The file contained pertinent variables for treatment category, funding entitlement, enrollment, service encounters, and penetration (ratio of service encountered persons to overall category eligibility). These were grouped by month. Additional variables, present in the file, were not germane to the analysis.

The most important variables were eligibility, service encounters and penetration ratio. Eligibility was determined administratively and was determined by financial need. A service encounter (enrollment) was defined as a patient having one or more patient-professional sessions, meetings, or other care events within a given month, counting the individual, not the sum of services. The penetration ratio was the monthly proportion of enrollment divided by eligibility. Only aggregate data was collected; no individual was tracked and no personal identifiers were used. There were no HIPAA or IRB issues due to the unidentified nature of the raw data.

In January 2013, in anticipation of the enrollment and eligibility changes that would result after the ACA expansion, there was a projection of growth for FY2014 and FY2015 of over 200,000 individuals. This was an eligibility, not a usage, projection[2] (Figure 2.).

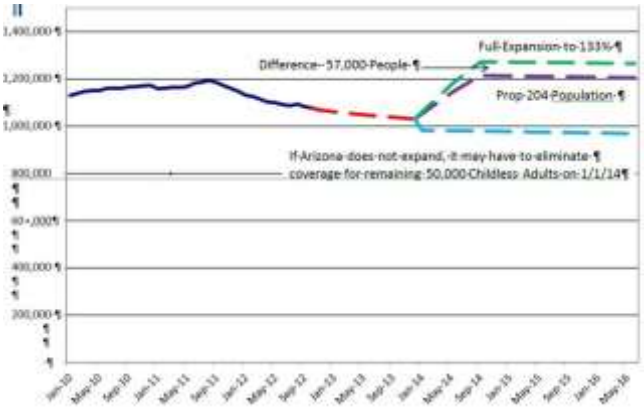

Figure 2: FY2013 projected growth for FY2014 and FY2015 after ACA expansion.

These files, downloaded in PDF format, were converted to Microsoft Excel for examination, cleansing and graphical analysis. The principle statistical routines were time trending, frequency distributions and percent of change growth analysis.

RESULTS

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The SIM eligible population exhibited a slight downward trend of 1.2% overall in the pre-expansion period between October 2012 (n=520,835) and December 2013 (n=514,413)with a loss of 6,422 members. Immediately following the expansion of Medicaid eligibility in January 2014, however, eligibility trended strongly upward, with a gain of 270,507 eligible members by April 2015, a 52% increase over the 16 month period. Total eligible SMI population at the end of the period was 784,920. (Figure 3).

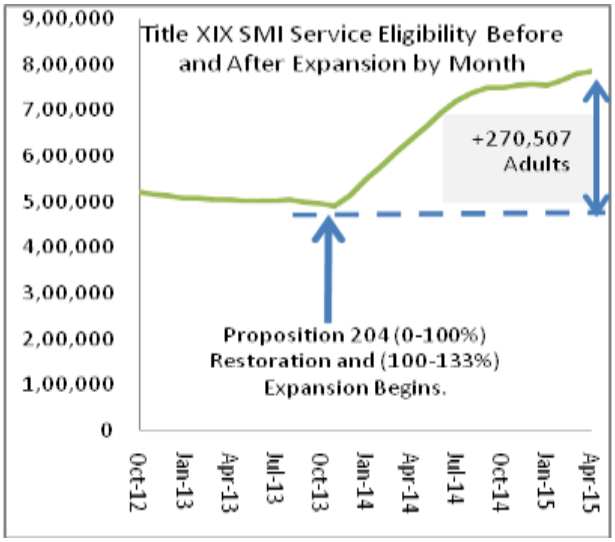

Figure 3.Growth in member eligibility before and after Medicaid expansion in January 2014.

Service encounters also increased after the expansion with a very sharp rise of 6.2% in the first month. Over the 16 month period following the initiation of the expansion, there was an overall increase of SIM enrollment of 9.4%, representing 2,641 more member care events per month(Figure4).

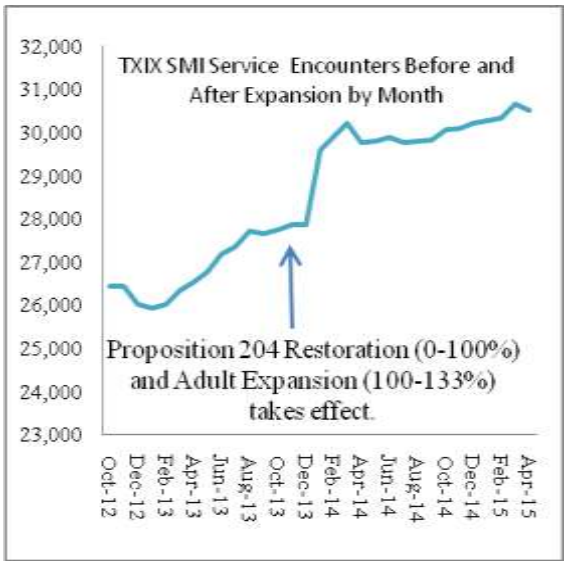

Figure 4. Growth of SMI service encounters before and after the Medicaid expansion in January 2014.

Towards the end of the data period in early FY2015, the encounter trend began to stabilize somewhat, while eligibility continued to trend upward. This could indicate a possible saturation of service availability.

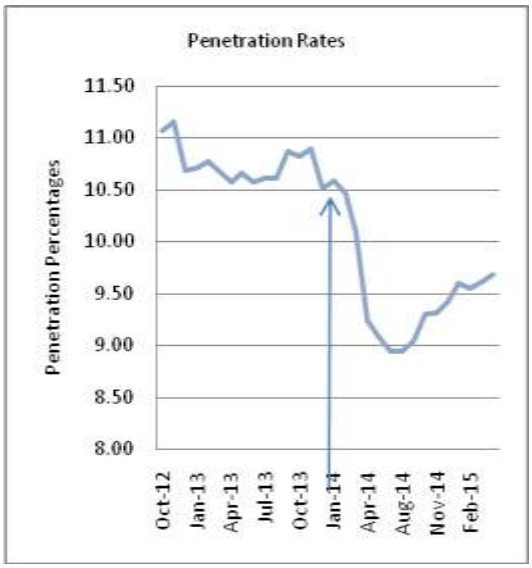

Figure 5.Penetration rates for SMI members before and after the Medicaid expansion in January 2014

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The penetration metric reflected these delivery differences. Because eligibility was increasing at a higher rate than the service encounters (52% and 9.4% respectively), the corresponding penetration ratio of encounter to membership declined.This ratio reached its low point six months following the Medicaid expansion. After that, there has been a positive trend as care began to catch up with the membership growth.

DISCUSSION

The Medicaid expansion covering those with a minimum household income to up to 133% of the Federal Poverty Level that began in January 2014, while still politically controversial, had resulted in the addition of over 270,000 seriously mentally ill individuals,newly made eligible for Medicaid funded behavioral health care. As of April 2015, the monthly behavioral health care service encounters had increased to 30,487persons per month. The per capita cost, as reported at the end of FY 2014, was $7,975[6,7].

The downward trend of the penetration ratio is believed to be due to the sizeable differences between encounter growth and eligibility growth rates. It is likely that the care delivery system was approaching saturation in the latter months of this study.

The Medicaid population is studied extensively by many entities, including the AHCCCS, the Arizona Department of Health and the Division of Behavioral Services. But as a caveat,various reports and analyses are subject to unique date range and program inclusions and exclusions making inter-report comparisons difficult.

The Episode of Care - Penetration Report yielded important raw data for analysis[5]. This study uniquely focused on just the severely mentally ill and the ACA program expansion of January 2014.

The ACA expansion, especially with regard to mental health care, can arguably show an important societal benefit in as much as the identification and treatment of the severely mentally ill within the community is of benefit to all. Historically, it is the untreated individual who hurt himself and others but it is impossible to quantify this benefit in as much SMI care results in socially unacceptable activities not having happened and, therefore, not recordable.

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