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Mental Health and Medicaid Costs: Why Ignoring Mental Health Is Expensive

Cost containment is one of the major goals of health policy reform in the United States. Because spending on mental health and substance abuse services (commonly called "behavioral health services" when referring to both) is less than 8 percent of all health spending, behavioral health seems an unlikely candidate for substantial savings. But that perception is wrong!

People with behavioral health conditions are at higher risk than others for physical illness and disability, and the cost of medical care for them is, on average, much higher than the cost of medical care for people without behavioral health conditions. Better behavioral health services for this population would be likely to reduce the costs of their physical health care and produce significant overall savings in health spending.

This view received fresh support this week from a very important report from the United Hospital Fund in New York City. Entitled "Providing Care to Medicaid Beneficiaries with Behavioral Health Challenges," the report reveals that Medicaid recipients with mental health conditions are 30 percent to 60 percent more likely to have hypertension, heart disease, pulmonary disorders, diabetes, and dementia. People with substance abuse conditions are 50 percent to 300 percent more likely to have heart disease, pulmonary disorders, and HIV/AIDS.

The United Hospital Fund report also documents far higher spending for Medicaid beneficiaries with behavioral health conditions than beneficiaries without behavioral health conditions. According to the report, average health spending for people with mental health conditions in 2003, (the year studied), was $28,451; for those without mental health conditions it was $15,964. Only 25 percent of the spending for this population was for treatment of mental disorders. "Mental health beneficiaries spending on physical health services ($21,002) was 32 percent higher than comparable spending for non-mental health beneficiaries."

For people with substance abuse conditions, average Medicaid spending was $27,839; for those without substance abuse disorders it was $18,051. Only 24 percent of the spending was for substance abuse treatment. "Substance abuse beneficiaries mean Medicaid spending on physical health services ($21,053) was 17 percent higher than comparable spending for non-substance abuse beneficiaries."

The difference in spending for inpatient services for people with behavioral health conditions and those without is particularly striking. "Average annual expenditure for inpatient treatment [for people with mental illness] was $7017 compared to $3629 for others." For those with substance abuse disorders, inpatient costs averaged $11,738 compared to $3,301 for others. Also striking is the fact that, "the seven-day hospital readmission rate of mental health beneficiaries was 50 percent higher than non-mental health beneficiaries. Substance abuse beneficiaries' rate was 150 percent higher than [others.]"

Prior work supported by the United Hospital Fund and the New York Community Trust sheds additional light on the link between Medicaid spending and the co-occurrence of severe behavioral and physical health conditions. A study led by John Billings showed that nearly 60 percent of all Medicaid spending in New York is for 10 percent of the beneficiaries. Two-thirds of these "high cost cases" had severe behavioral health conditions as well as physical health conditions. Most did not get adequate care until their physical conditions became critic and resulted in long stays in hospitals.

Is it possible to improve treatment for people with behavioral health conditions before they become critical and thus bring down overall spending?

Although there are disputes about how to structure a system to improve care for people with both physical and behavioral disorders, there is consensus that earlier interventions with this population could avert health crises and thus reduce health spending. And the fundamental elements of an effective system seem clear enough. Those at highest risk need to be identified before they are in crisis; history of payments by Medicaid makes this possible. Aggressive outreach is needed to locate and engage people at high risk before they are in critical need. Those not identified until they come to emergency rooms, as they frequently do, need to be linked to community-based services immediately. Physical and behavioral health services for them in the community need to be integrated. And fundamental life needs must be addressed -- particularly the need for stable housing, without which little else can be accomplished.

None of this is easy to do; but if it is not done, people with both serious behavioral health conditions and serious physical health conditions will continue to be the high cost Medicaid cases. And most Medicaid spending will continue to be for the 10 percent of Medicaid beneficiaries who have the greatest needs.

Our health care system can continue to largely neglect mental illness and substance use disorders, but at great avoidable cost. Bottom line: forget about mental health, forget about savings.