My Voice My Choice (MVMC): Executive Summary

The MVMC self-directed care (SDC) study was a randomized controlled trial to assess the effectiveness of SDC for adult Medicaid managed care members with serious mental illness (SMI). Self-direction enables members to have authority over a portion of mental health expenditures and greater flexibility over what can be purchased than traditional Medicaid (expanded budget authority). The intervention group participants met with a recovery advisor at least monthly to develop a person-centered recovery plan (PCRP) and managed a budget (up to $1,400 a year) to advance their PCRP goals and objectives. Participants in the control group received services as usual. The MVMC built on a past Texas SDC study conducted in the public mental health system in the Dallas area. MVMC was guided by a stakeholder advisory committee which included people with lived experience, providers, advocates and others.

Primary MVMC study questions

1. Did members assigned to the MVMC intervention have statistically significant different outcomes compared to members assigned to treatment as usual (control) at 12- and 24-months?
2. Did the outcomes of the MVMC intervention group vary?

The sample for analyses included 161 control and 133 intervention participants. Data came from: Baseline, 12-month, and 24-month participant surveys; Medicaid eligibility, claims, and encounter data; Behavioral Health assessment data (i.e., Level of Care); MCO representative interviews; and stakeholder advisory committee interviews. Additional factors analyzed for the intervention group included PCRPs, purchases, advisor visit notes; participant interviews and surveys; and Recovery Advisor interviews.

Key Participant Outcomes

- MVMC made a positive impact on intervention participants' recovery and lives. They reported MVMC helped them attain their self-defined goals and objectives, improved their mental and physical well-being, and increased their confidence, self-esteem, hope, motivation, and sense of purpose.
- Intervention participants demonstrated significant improvement over time and in comparison with the control group on several measures.[1]
- The MVMC intervention increased peoples' active participation in their mental health care which may result in cost savings over time. One study demonstrated a 2% decrease in hospitalization and a 2% increase in medication use for every point increase in active participation.
- MVMC was cost neutral. Intervention participants spent less than the maximum allowed and had no greater Medicaid utilization costs than the control group, consistent with the Dallas study.
- Recovery advisors were a key component in achieving outcomes such as increasing active participation in mental health, increasing social participation and activities, and achieving PCRP goals.
- Social determinants of health such as food insecurity and inadequate housing, which are outside the scope of Medicaid benefits, were associated with poorer study outcomes. Addressing these issues at the state and local level could further promote recovery.

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[1] Including mental health scores (SF-12 MCS), active participation in mental health care (PAM-MH); and, social participation and activities (SSRA).

- There were no statistically significant differences in physical health scores, medical utilization, or expenditures between the intervention and control groups across time.

Process and operational observations

- Expanded budget authority was challenging to implement. Developing an approval process and level of comfort for payors to authorize purchases took time and effort and required intense coordination. This constrained participant self-direction and caused frustration for participants and Recovery Advisors. A well-defined budget and approval process would be essential in an SDC Medicaid benefit.
- The time spent to engage and develop a collaborative relationship between participants and Recovery Advisors allowed for discovery or rediscovery of life goals, development of a PCRP, and purchase of related items.
- Participants and managed care representatives reported network issues in the service delivery area impacting choice. These included the need for more mental health providers (e.g., therapists) and certain physical health practitioners (e.g., pain management, chronic health management).
- Under the study design, participants were not able to use self-directed funds for dental or vision services (e.g. prescription glasses) which were very limited or not included as Medicaid benefits but were important to achieving recovery goals.

Implications and considerations for future implementation of mental health self-direction programs

- HHS Medicaid administrative data was used successfully to identify people with significant mental health conditions for study enrollment. Future SDC implementation could be done using similar population-based data to identify eligible members.
- Participants improved in mental health and engagement most during year two of the study. Future SDC implementation, in which interventions occur over a longer time period, would likely improve these gains and could have a greater impact on a broader array of outcomes.
- MH SDC might be implemented as a Medicaid option in various ways (e.g., under a value-based purchasing model or under a model similar to Consumer-directed Services in STAR+PLUS).
- Each participant's goals were specific to them and differed from those of other participants. Purchases were accordingly diverse as they directly connected to individuals' goals. Classifying purchases into broader categories would present challenges but might help facilitate benefit development.
- This is the first SDC behavioral health study to have a population-based, rather than a targeted approach to enrolling people with SMI in self direction. The MVMC study included people with varying levels of need and service use. Participants across the spectrum (lower to higher need *and* lower to higher service utilization) improved with the intervention. These findings present decision-makers with future implementation options:
    - Targeting people with high need / high service utilizers as a way to increase less intense service utilization and reduce costs; and
    - Targeting people with lower need / lower service utilizers to prevent future need, more intense service utilization, and costs.