

# Making the Right Choices

## Reforming Medicaid to Improve Outcomes for People Who Need Mental Health Care

### INTRODUCTION

Medicaid is the primary payment source for most community-based mental health services and the only health plan that finances a full range of the rehabilitative services needed by people with psychiatric disabilities. Low-income children and adults have nowhere else to turn for mental health care and must rely heavily on Medicaid. Furthermore, many people with mental and emotional disorders have significant overall health care needs; they depend on Medicaid for coverage of medical/surgical benefits as well.<sup>1</sup>

Medicaid also prevents certain cruel outcomes. For example, today thousands of families with modest incomes that are nonetheless too high for Medicaid give up custody of their children to the state in a desperate move to obtain access to mental health services for their children.<sup>2</sup>

This report analyzes recent proposals to change Medicaid from the perspective of adults and children with mental illnesses. These proposals have included plans to reduce the array of services that states must provide and to reduce the number of beneficiaries entitled to services by:

- replacing the current entitlement program with one or more block grants to states;
- giving states greater flexibility to reduce the benefit package for some or all eligible individuals;
- permitting states to create separate programs within Medicaid, with a lower level of coverage, higher co-payments and fewer protections for individuals who fall within optional eligibility populations.

Other suggested reforms would:

- give states a greater role in defining the specific services in the benefit package;
- expand the program to pay for covering low-income uninsured individuals who are not now eligible;
- alter the financing arrangement of Medicaid to give states fiscal relief.

Some of these proposals involve major restructuring of the program, while others represent incremental and modest reforms. Drastic changes that curtail access to mental health care could have the unintended consequences of increasing overall state, local and federal spending while leading to poorer outcomes, wasted lives, even death. Potentially, a major restructuring of Medicaid could have the effect of:

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The Bazelon Center is the leading national legal advocate for adults and children with mental disabilities. Its mission is to protect their rights to exercise meaningful life choices and to enjoy the benefits of community life. The Center uses a coordinated approach of litigation, policy analysis, coalition-building and technical support for local advocates to end the segregation of children and adults with mental disabilities and assure them of the opportunity to access needed services.

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- swelling the number of people with mental illnesses who are homeless and on the streets;
- diagnosing a child’s mental disorder and then denying early treatment; and
- increasing the number of adults and juveniles with serious mental illnesses who languish in jails, juvenile detention centers and prisons for lack of access to community mental health care.

**MEDICAID AND MENTAL HEALTH**

As new Medicaid proposals are discussed, it is important to understand fully their ramifications for individuals with mental illnesses—a large and growing segment of the Medicaid population. Many of the proposals currently on the table could have immediate and devastating consequences for Medicaid recipients with mental illnesses. Furthermore, public mental health systems increasingly rely on Medicaid as a primary source of funds.

- Those who use mental health or substance abuse services represent 10.6% of all Medicaid enrollees (16% of adult enrollees aged 21-64 and 8% of children under 21 years of age).<sup>3</sup>
- Spending on these services ranges from 9-13% of Medicaid costs, (where separately estimated, only 0.5-1.3% of these costs are for substance abuse).<sup>4</sup>
- As a group, people with disabilities (of all types) on Medicaid have the second-highest costs per enrollee<sup>5</sup> and account for the highest total payments (43.6% of all Medicaid payments are for individuals with disabilities).<sup>6</sup>

These significant costs reflect the fact that many users of Medicaid mental health services are adults or children with psychiatric disabilities who need ongoing services due to the severity and chronic nature of their disorders. Individuals disabled by psychiatric disorders make up about a quarter of SSI recipients with disabilities on Medicaid.

Another reason the number of mental health users is so large and the mental health costs so high in Medicaid is that states deliberately seek federal matching funds for mental health services that were once entirely state-funded. The program’s absorption of costs previously assigned to other state budget lines (e.g., mental health, child welfare) contributed significantly to Medicaid’s growth during the 1980s and 1990s. This dependence on Medicaid revenue means that Medicaid is increasingly the only financing source of community services for people with serious mental disorders:

- Medicaid is the single most important source of revenue for state mental health systems.



- From 1987 to 1997, a national study shows Medicaid’s share (federal funds and state match) of state and locally administered mental health program costs increased by 50%, rising from slightly more than one third to 50% of state and local spending.<sup>7</sup>
- Medicaid contributes half of all revenue for community services and thereby supports state initiatives to integrate people with psychiatric disabilities in the community.
- Other state systems also rely on Medicaid to fund mental health services for children. Child welfare and education systems typically bill Medicaid for mental health services.

In one study an average of 52% of individuals on Medicaid who used mental health services went to providers who are not part of the public mental health system for some or all of their care, and those providers directly billed the Medicaid agency; and 59% of those who used both mental health and substance abuse services had some or all of their care financed in this manner.<sup>8</sup>

This does not mean, however, that all Medicaid mental health spending is for individuals who are under the care of the public mental health system. Medicaid recipients receive mental health care from other providers, who then bill the Medicaid agency directly. Over half of Medicaid mental health users use services that are not funded through the state mental health authority, but are instead directly billed to the Medicaid agency (see box). Thus Medicaid is important not only for those who seek care in the public mental health system but also for many others who receive specialty mental health care from private providers. Any consideration of changes to Medicaid policy needs to address their needs.

While it is correct that the program could be more responsive to newer approaches in mental health service delivery (see below), drastic and fundamental change is not needed to achieve that goal. Rather, it is critically important not to unravel the safety net for low-income individuals with mental illnesses but instead to maintain what works while modernizing and improving other aspects. Recent proposals to substantially restructure Medicaid would undermine that goal.

**REPLACING THE ENTITLEMENT WITH A BLOCK GRANT**

Medicaid currently operates on principles similar to commercial insurance. States are required to cover a defined set of benefits for a defined group of people. Medicaid programs then must pay for any medically necessary service covered in the state plan provided to any eligible individual. States have the flexibility to expand eligibility, within federal rules, and to expand the array of services to which eligible individuals are entitled, again within federal rules. As a result of this flexibility, state Medicaid programs vary considerably. However, at the same time, federal law ensures that all Medicaid beneficiaries in a particular state have the same benefit package and comparable services,<sup>9</sup> and that all Medicaid recipients receive services in sufficient “amount, duration and



scope” to meet their medical needs. These protections are the reason Medicaid is an effective safety net.

Over the years, there have been discussions about whether Medicaid should be changed from an entitlement program that operates like commercial insurance to one that operates like a government grant program. Creating a block grant in place of the Medicaid entitlement is a major change that would have significant ramifications for low-income individuals with mental illnesses. A block grant fundamentally alters the program’s structure. It would dismantle the uniform federal standards and safeguards that ensure quality and accountability in Medicaid. It would eliminate federal requirements, such as the requirements that recipients receive sufficient services to treat their condition effectively and that all residents of the state have the same coverage regardless of where they live. Instead it would allow for services to be covered in one part of the state but not others, or for services to have arbitrary limits on mental health care, such as 20 visits per year.

A block grant also eliminates the federal match for state spending, replacing the current flexible funding with a capped amount of resources that cannot increase if people need more services or if the state wishes to expand its program. On average, states receive 57 cents from the federal government for every 43 cents they spend on a Medicaid service to a covered person. Over time, if health costs increase but federal matching funds do not because the federal contribution has been capped through a block grant, states would be forced either to pay 100% of the costs or to deny services even to those currently eligible.

Finally, a block grant would undermine one of Medicaid’s most important features—its ability to compensate automatically in times of need. Medicaid is counter-cyclical, in that when unemployment rises and more individuals have low incomes or are uninsured, coverage becomes available to them. Under a block grant, states cannot claim the necessary federal match for such fluctuations but would be given the flexibility to deny coverage during economic downturns, compounding the adverse impact of such events.

States are nearly evenly split between those that place S-CHIP children in Medicaid and those that use a private insurance option. However, in terms of number of children, the great majority of S-CHIP children (75%; 4 million children) have the reduced private option coverage.<sup>10</sup>

### **REDUCING BENEFIT PACKAGES FOR ALL OR SOME RECIPIENTS**

Another frequently discussed proposal for Medicaid reform involves shifting some or all Medicaid-covered individuals into a benefit package modeled on private insurance coverage. The current benefit package in the State Child Health Insurance Program offers a glimpse of how those who need mental health care would be affected if this package replaced Medicaid’s. While some S-CHIP children are enrolled in Medicaid, states have chosen to enroll many more



in a health plan modeled on or comparable to one of several benchmark private plans cited in the federal law (see box). States using this private-plan option have significantly restricted mental health benefits, typically offering a limited number of inpatient days (30 days) and outpatient visits (20-30 visits). Only a few states add case management/care coordination.<sup>11</sup> Moreover, the S-CHIP statute only requires states to provide a mental health benefit that is 75% of the value of the benefit in the benchmark plan, whereas for all of healthcare the S-CHIP plan must have the full actuarial value of the benchmark plan. Thus, S-CHIP mental health benefits can be significantly below even the limited benefit of the private benchmark plan.

Every state that covers any level of mental health disorders through a separate S-CHIP plan applies limitations and exclusions that would not be permissible in Medicaid.<sup>12</sup> Many of the services needed by children with special health care needs are “precisely those that are either omitted or subject to limits under SCHIP, including case management... rehabilitative therapies and behavioral health services.”<sup>13</sup> Examples of mental health limitations in S-CHIP plans include a limit on inpatient mental health services of 15 days a year (Florida) and 72 hours per episode (Alabama). Kansas limits inpatient and outpatient mental health services to disorders found to be “biologically based.”<sup>14</sup>

The limited nature of S-CHIP private plans’ mental health coverage constrains appropriate treatment. The limits on outpatient care are particularly inappropriate because, even for children with less disabling mental disorders (such as depression or generalized anxiety disorders), they reduce access to appropriate treatment.

A shift to S-CHIP or a private-insurance model of benefits would also have the effect of eliminating access to many rehabilitative and other optional Medicaid services needed by adults and children with more serious disorders. People with disabilities, including psychiatric disabilities, rely heavily on the Medicaid optional services. Sixty-six percent of all Medicaid expenditures for beneficiaries with disabilities are for these optional services.<sup>15</sup>

Significant home- and community-based mental health services are widely available under Medicaid, in part because they are optional services and do not require a special federal waiver. Included are such services as social and independent living-skills training and assertive community treatment for adults, as well as behavioral aides and therapeutic foster care for children. These and other intensive rehabilitative community services are particularly important to adults and children with serious mental disorders, and Medicaid is the only health plan that funds them. Unlike many other groups of individuals with disabilities, adults and children with serious mental disorders can be eligible for a range of home- and community-based services through the rehabilitation

All 50 states and the District of Columbia include coverage of the optional service of psychiatric rehabilitation for adults in their Medicaid programs.<sup>16</sup> State mental health systems spend the largest percentage (19%) of their Medicaid funds for which a specific service can be identified on the intensive community services funded under the Psychiatric Rehabilitation services category.<sup>17</sup>



In 2000, about 1.4 million individuals, 850,000 of them children, qualified for SSI (and Medicaid) due to a serious mental illness (over 27% of disabled SSI recipients). These individuals are a mandatory eligibility group in most states. States may also opt to cover other individuals who meet federal disability criteria, including those who receive state SSI supplements, those with incomes under the poverty level and working adults with disabilities.<sup>18</sup>

Substantial numbers of people with psychiatric disability qualify for Social Security Disability Insurance (SSDI). In 2001, 1.6 million individuals received SSDI based on psychiatric disability (26.8 % of SSDI recipients).<sup>21</sup> SSDI eligibility is linked to Medicare coverage, but Medicare has very limited mental health coverage. Many individuals whose SSDI benefit is low due to a short work history (typical of persons with major mental illness) qualify for Medicaid because they are disabled and have high medical costs.

option, and states have consequently been able to make these services widely available.

Replacing Medicaid with plans modeled on private insurance (as are many S-CHIP plans) risks leaving many people unable to access evidence-based services in the community that are essential to maintain or improve their functioning.

**SEPARATE PROGRAMS FOR OPTIONAL AND MANDATORY ELIGIBLE GROUPS**

Many of the optional Medicaid-eligibility categories cover a significant number of low-income children and adults with mental disorders. Many have serious mental disorders or histories (such as being in foster care) that put them at risk for psychiatric disabilities. Important social policy goals—such as helping people with disabilities or low-income welfare recipients return to work—will be at risk if these individuals lose their Medicaid coverage or have more limited coverage of a narrow range of mental health services with arbitrary limits.

States already have considerable flexibility in determining who should be eligible for Medicaid. Nearly four million low-income adults, four million children and 1.5 million people with disabilities qualify for Medicaid through the optional Medicaid-eligibility categories. This is 39 percent of all adults who qualify, one-fifth of children, and one-fifth of people with disabilities.<sup>19</sup> Also, 65% of Medicaid expenditures are for groups of people or services that are not mandated by federal law.<sup>20</sup>

The optional eligibility categories most important to individuals with mental health care needs are shown in the chart on the next page.

Proposals to alter Medicaid by permitting lesser benefits and higher co-payments for the optional eligibility groups assume that there is a fundamental difference between the mandatory and optional eligibility groups. Among people with mental illnesses, this is often not the case. Although individuals qualifying through the optional groups have marginally higher incomes, they either have the same level of disability as mandatory eligible individuals, are in similar circumstances (e.g., children in foster care) or are at high risk of mental and physical disorders due to poverty.



People with psychiatric disabilities who receive SSDI benefits are not a mandatory group, although only their prior work history distinguishes them from SSI recipients. They can qualify for Medicaid, with its important community mental health benefits, only through one of the optional categories.

The medically needy option covers people who could qualify for Medicaid except that their incomes or resources are slightly too high. To qualify as medically needy, individuals must “spend down” their income on health care to meet the state’s criteria for the option. In Fiscal Year 2000, about 3.6 million individuals qualified under this option.<sup>22</sup> About 524,000 of them were people with disabilities, including psychiatric disabilities.<sup>23</sup>

There is little difference in need or in ability to pay between those on SSI and those who qualify through this option. Indeed, the income standard for this option is the same as the mandatory income standard for some children.

Other optional eligibility categories cover working disabled persons with incomes above the SSI level of 74% of poverty but still too low to pay for their needed care (see box). Without Medicaid services, it is unlikely that these individuals could continue to work.

In 2003, 22 percent of disabled SSI recipients who work were individuals with mental health disabilities.<sup>24</sup>

Optional eligibility categories that are not specifically geared towards people with disabilities, but rather toward low-income adults and children, are also important for people with mental disorders since these individuals either have no other insurance or are covered by policies with very limited mental health benefits. There is evidence that low-income people on Medicaid need more mental health services than other populations. For example, children and adolescents enrolled in Medicaid are estimated to have more than 1,300 annual outpatient speciality visits per 1,000 children, while the comparable number for children with private insurance is 462.<sup>25</sup> Among adults, low income is often the result of having a mental disorder that precludes employment. For children, the high rate may be related to childhood trauma or abuse, being in foster care, poor nutrition or other factors.

- Moderate to severe psychological problems have been found in children in foster care (35% to 85%)<sup>26</sup> and several studies have confirmed that these children are high users of mental health services. Most children in foster care fall under the mandatory eligibility category, but some qualify through state options (see chart).



**ELIGIBILITY CATEGORIES IMPORTANT TO PEOPLE WITH MENTAL ILLNESSES**

<b>Mandatory Categories</b>	<b>Optional Categories</b>
—Individuals on SSI—27% of recipients in 2000 were disabled by mental illness	—Individuals on SSDI (same standard of disability as SSI recipients) with high medical costs (medically needy); 26.8% of recipients are disabled by mental illness. —Individuals receiving state SSI supplements
—Individuals on SSI who return to work and lose cash benefits but need Medicaid to meet their medical costs (Section 1916(b))	—Individuals with disabilities with incomes under 100% of federal poverty level —Working people with disabilities can be covered under the Ticket to Work Act (33 states) and through a buy-in program also authorized under the Ticket to Work Act (27 states). Working people with disabilities can also be covered if they earn less than 250% of poverty and would qualify but for earnings, or if they have potentially serious disabilities.
—Children 0-6 in families with incomes under 133% of the federal poverty level	—Children 0-6 in families with incomes under 133% but over 185% of the federal poverty level (41 states)
—Children 6-17 in families with incomes under 100% of the federal poverty level	—Children 6-17 in families with incomes over 100% but under 133% of the federal poverty level (30 states) —Children aged 18-19 in families with incomes over 200% but under 300% of poverty (13 states)
—Children in federal foster care program (Title IV-E)	—Children in state adoption assistance programs (check) —Children 18, 19 or 20 who have aged out of foster care. —Children with disabilities who would otherwise be in an institution (TEFRA) (20 states)
—Elderly individuals receiving SSI based on age and income	—Elderly individuals in a psychiatric hospital —Elderly individuals in an IMD or a nursing home —Elderly individuals with incomes under the poverty level
—Other children, adults and elderly persons who meet federal eligibility requirements	—Children, adults and elderly people who would meet state Medicaid eligibility standards but for income/assets and whose high medical costs enable them to spend down to Medicaid eligibility levels (medically needy) (36 states)



- Approximately 18,000 Medicaid-covered children age out of the foster care system each year and normally lose their coverage. Under the Foster Care Independence Act of 1999, states can cover this group of young people, who are unlikely to have any other health insurance options.<sup>27</sup>
- The TEFRA or Katie Beckett Medicaid-eligibility option allows children who need an institutional level of care but who could be cared for at home with the appropriate services to qualify for Medicaid when they live at home.<sup>28</sup>
- Almost 20 percent of people 55 and older experience specific mental disorders that are not part of the normal aging process.<sup>29</sup> These elderly adults qualify for Medicaid under various categories, including several significant optional categories (see chart).

The lack of health insurance coverage for mental health services makes it all the more important that these low-income individuals who qualify for Medicaid through optional categories not lose their access to mental health care. Without Medicaid, even the public mental health system is difficult— often impossible—to access.

#### **COVERING THE UNINSURED**

Federal policy changes to address the needs of the uninsured have taken various forms. For the past decade, states have used the Medicaid Section 1115 waiver authority to add groups of people to the Medicaid program in a cost-neutral manner (using managed care or other cost-saving approaches to ensure budget neutrality). With respect to children, the S-CHIP program targets those in families with incomes generally up to 200-250% of poverty. Recently, the Administration has encouraged states to make sweeping changes to their Medicaid programs through Health Insurance Flexibility and Accountability (HIFA) waivers. Under HIFA, the Administration encourages states to reduce coverage for people who are currently eligible in order to create new basic healthcare coverage for some of the uninsured.

The rationale for both HIFA waivers and for recent proposals to block grant Medicaid is that by reducing benefits and increasing cost-sharing for those currently eligible, savings can be redirected to provide some level of coverage for some people who are uninsured. However, as shown above, significant numbers of children and adults with serious disorders who need mental health services are now on Medicaid and the package of benefits in the program is critical to maintaining them in the community. Covering more of the uninsured by reducing their benefits is neither cost-effective nor humane.



A study of the fiscal impact of reducing coverage by amending current eligibility and benefit rules in the manner recently proposed by the Bush Administration shows that an estimated 3.8 million children and 1.2 million people with disabilities could lose coverage they would otherwise have.<sup>30</sup>

If the policy question at hand is expanding access to health insurance coverage, a combination of Medicaid expansions for very low-income people and access to other health policies for others would address the issue directly, without detriment to the most needy, who depend on the comprehensive array of services Medicaid provides them.

### **STATE RESPONSE TO FISCAL PRESSURES**

Without federal policy change, states are already moving to cut back their Medicaid programs, using the considerable flexibility they already have in federal law. These cost-saving measures will have a dramatic impact on the fragile mental health safety net unless they can be reversed. Given the severity of state budget shortfalls at this time, there is a need for federal intervention. According to the Kaiser Commission on the Future of Medicaid, state actions are widespread:<sup>31</sup>

- 27 states are restricting eligibility to some degree;
- 25 states are reducing benefits (including particularly inpatient and targeted case management);
- 17 states are increasing co-payments;
- 37 states are reducing or freezing already very low provider rates.

Making such cuts in Medicaid, however, overlooks the unique role Medicaid plays in stimulating state economies. Every dollar spent on Medicaid brings new federal dollars into the state through the Medicaid match. Furthermore, these funds pass from one person to another in successive rounds of spending. Medicaid spending has been estimated to generate almost a three-fold return in state economic benefit.<sup>32</sup>

Cuts made to date have already had adverse effects on state mental health budgets. Average cuts to mental health budgets in FY 2003 were 4.4%, ranging from zero to 12.5%. In FY 2004, the average cut is expected to be 7.2%, ranging from zero to 26%. Twenty-nine states have already made cuts in Medicaid that affect mental health services, and some have reduced mental health services funding multiple times in the last year.<sup>33</sup> In the near future, 35 states anticipate further cuts. The National Conference of State Legislatures describes 14 states' cuts as significant reductions or elimination of mental health programs and services.<sup>34</sup>



- Massachusetts reduced community mental health care, excluding some 800 people, including depressed mothers and recently released inmates, from care that they had been receiving. Overall, half of the funding for outpatient counseling services for adults was cut in FY 2002.<sup>35</sup>
- Maine has cut \$14 million from its mental health budget for children’s services.
- Montana has limited Medicaid physician visits to 10 per year for aged and disabled recipients.
- Oregon has cut optional eligibility categories almost entirely and many optional services (Oregon’s Medicaid mental health cuts may amount to 20%). One provider in Oregon now serves 2,500 fewer patients.<sup>36</sup>
- Colorado eliminated Medicaid coverage for legal immigrants.
- Connecticut dropped coverage for parents with incomes over 100% of poverty.

These reductions are not fiscally responsible. Several states are already experiencing increases in emergency and crisis services as a result of recent cuts in their mental health expenditures.<sup>37</sup> For example, a mental health commissioner in Oklahoma told legislators that prior cuts cost the state several billion dollars a year in more expensive crisis center services. Colorado has experienced increases in emergency room use after mental health programs lost \$20 million, and cuts of \$23 million in South Carolina left individuals waiting for days in emergency rooms or jails for more appropriate placements.<sup>38</sup>

States are not unaware of these consequences or of the fragile state of their mental health systems. Analyses of the first round of Medicaid cuts in FY 2002 show only minimal reductions in services or eligibility, with states choosing to tap other resources (rainy day funds, tobacco funds, etc.) before cutting Medicaid. These decisions reflect understanding among state officials of Medicaid’s critical role as a safety net program. In FY 2003, however, states’ fiscal situations had worsened and real cuts in Medicaid were made.

Current Administration proposals will make states’ problems worse. Over a 10-year period states would lose \$492.1 billion if they all opted for the Bush block grant plan.<sup>39</sup>

In times of economic downturn, it is critically important to protect both the population in need of Medicaid mental health services and the states’ mental health systems. Individuals with serious mental illnesses will use some form of services—whether early and effective community services or high-cost institutional placements. Medicaid provides a strong mechanism for states to secure federal support for their community mental health systems. Once these funds are capped or cut (or eligibility and benefits are reduced), cost-shifting occurs. The shifts are almost entirely into state- and local-funded systems, such



as state psychiatric hospitals, jails and prisons. While such reductions save the federal government money, they save the states' resources only in theory. Medicaid expenditures may fall, but other costs rise at even higher rates. A better mechanism is needed to aid both states and low-income individuals.

### **MAKING THE RIGHT POLICY CHOICES**

The blunt policy instruments of Medicaid block grants and/or cuts in eligibility and services are misguided and will, both immediately and over the long run, have significant repercussions for public mental health policy and for individuals who do not receive appropriate services. While drastic changes that strike at the heart of the program are neither necessary nor wise, some improvements to Medicaid can be made that would assist both states and beneficiaries. Such improvements should include:

- giving states greater flexibility in service definitions;
- covering the uninsured with the lowest incomes directly, without reducing benefits to Medicaid recipients; and
- providing fiscal relief for states.

#### **Flexible Service Definitions**

Although the S-CHIP or private-plan benefits are inappropriate for the Medicaid population, certain changes to Medicaid benefit rules would assist individuals with mental disorders. Some of the current federal rules impede states' delivery of the most effective, evidence-based mental health services. For example, Medicaid's service categories arbitrarily divide related mental health and/or substance abuse services, creating administrative difficulties for provider agencies that offer comprehensive approaches. Also, Medicaid treats each individual as an eligible person, instead of providing family coverage that would enable family-focused care that is more appropriate and effective for children, especially very young children.

Too often, the federal Centers for Medicare and Medicaid Services (CMS) fails to update its approach and is overly concerned with federal outlays to the point that cost-effective approaches cannot be included in state plans. These policies may save federal resources, but they increase state and local costs through cost-shifts into other systems—as when individuals with severe mental illnesses who lack access to treatment become entangled with the law.

What is needed is greater flexibility regarding states' service definitions, in order to keep the program current with modern research and approaches in the mental health field. However, this should be done within the context of a broad



benefit package that does not include arbitrary limits on care. Federal rules should allow states to:

- create a single community mental health services category to incorporate Clinic, Rehabilitation and Targeted Case Management services. This would allow states to fund integrated programs that encourage recovery and facilitate redirection of funds from institutional to community-based care;
- cover home- and community-based services without a waiver. This would allow the provision of support services to families caring for a child with serious mental or emotional disorder at home;
- expand consumer-directed services to include initiatives focused on individuals with mental disorders;
- ensure that very young children, whose problems are not yet diagnosable using standard instruments, receive services when they show significant developmental, social and behavioral delay.

#### **Covering More of the Uninsured**

Federal policy could be amended to improve the eligibility criteria of Medicaid so as to cover at least some of the uninsured. Such eligibility, however, should ensure access to the Medicaid package of benefits, including its important array of community mental health services. Minimal benefit packages that offer only primary care or have little or no mental health coverage will not help these individuals.

The current Medicaid eligibility rules exclude from coverage many people with significant needs. For example, single adults with serious mental illnesses who have for one reason or another no federal disability benefits under SSI or SSDI generally cannot qualify for Medicaid. Some may be covered through medically needy options, but most are without coverage. Other individuals with serious mental illnesses lose benefits and/or eligibility from time to time due to life circumstances—such as becoming homeless, decompensating or being arrested—that make it difficult or impossible for them to handle the requirements for maintaining their SSI eligibility. These individuals need easier access to healthcare coverage that includes a comprehensive mental health benefit.

- Single adults would be better served through an optional eligibility category tied directly to income instead of requiring them to fit into one of the myriad small eligibility groups now permitted under federal law. Federal law should create an optional eligibility category to cover all single adults below some percentage of the poverty level.



- Access to coverage should be improved through programs that assist individuals who are homeless or in public institutions, including hospitals, jails and prisons, in applying (or re-applying if they have previously been on the program) for Medicaid.

These and other changes to eligibility could ensure that Medicaid more evenly covers individuals based on income, disability and age. It would thus serve as a more effective safety net for the most needy.

#### **Fiscal Relief for States**

While states currently face significant budget shortfalls and concerns about the cost of Medicaid, there are ways to give states fiscal relief without reducing benefits to Medicaid beneficiaries or drastically cutting the resources on which public mental health and other state agencies now depend. Policies that should be considered include:

- immediate fiscal relief, such as that now provided through the new tax law (that provides \$10 billion, or a 2.95%, increase in federal match rates through September, 2004 if states maintain or reinstate the eligibility levels in place on September 2, 2003);
- improved coverage under Medicare of community mental health services, including prescription medications, outpatient counseling, psychiatric rehabilitation and case management, so that the federal government picks up costs for SSDI recipients and the elderly;
- increased federal support for state and local mental health programs through increases to the federal community mental health block grant.

#### **CONCLUSION**

Medicaid is a complex program meeting the needs of multiple populations, all of whom have low income. Most of those relying on Medicaid today have no other source of healthcare coverage; others rely on it at times of significant poverty but do not remain with the program for long. Medicaid is thus the critical safety net program providing healthcare to a significant proportion of the uninsured and responding in a counter-cyclical way to economic downturns. Reducing Medicaid coverage to ineffectual levels for some or all of those now relying on it is a poor policy choice.

People with mental illnesses are particularly vulnerable if major policy shifts are made in Medicaid. The absence of parity between physical and mental health and the low levels of coverage for mental illnesses in private health insurance combine to make Medicaid the critical program in the safety net for those who cannot support themselves due to serious mental illness.



Policies that would cap funding for optional populations and/or reduce the benefit package for mandatory populations will be counterproductive. Failure to treat serious mental and emotional disorders with the appropriate array of services leads to poor outcomes. Lack of access to services will likely lead to an exacerbation of existing health problems and disability and, for some, inappropriate institutionalization, homelessness or incarceration.

Block grants and other drastic changes to eligibility and coverage are therefore likely not only to harm people with mental illnesses but also to threaten the viability of the fragile public mental health system. This is not the time to pull the financial rug of Medicaid out from under public mental health systems. According to the President’s New Freedom Commission on Mental Health, these systems are already “in shambles.”<sup>40</sup>

The goal of public mental health system services, reinforced in the President’s Commission report, is recovery. All benefit when individuals with mental illnesses are able to improve their functioning and live, work, learn and participate fully in their communities. Medicaid is a critical element in achieving such a goal. Significant cutbacks in Medicaid coverage for this population will make it unattainable.

Medicaid can, and should, undergo some reform. That reform, however, needs to be based on a serious review of the impact of any changes on mental health care and on people with mental illnesses. Unless the right choices are made, these individuals could suffer dire consequences and states would find themselves on the front line to respond without adequate federal financial support.

**NOTES**

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