Policy Debate

THE PERFECT STORM X 50: STATE BUDGET CRISES AND THE IMPACT ON MEDICAID MENTAL HEALTH SERVICES

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The Nation's Voice on Mental Illness

Medicaid represents a major source for financing mental health care. In addition, Medicaid has also encouraged the expansion of innovative community-based treatment modalities for people with serious mental illnesses such as psychiatric rehabilitation, case management, and day treatment/partial hospitalization services. Prescription drugs available through the Medicaid program have been essential to the recovery of many persons with mental illnesses, but overall Medicaid costs are escalating rapidly. State governments are facing budget deficits over the next two years due to declining tax revenues. In response to this difficult economic climate, states are planning to institute Medicaid cost control efforts that are likely to negatively affect lower-income populations with mental illnesses.

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What is Medicaid?

Medicaid is a program financed jointly by federal and state governments, providing medical care and long-term care to many of the nation's most vulnerable lower-income people. Created in 1965, Medicaid pays physician and hospital bills, prescription drug costs, and other health care costs for lower-income mothers and children, frail seniors, and people with disabilities.

Each state decides how to structure benefits, eligibility, service delivery and payment rates with guidelines established by federal law. State spending on Medicaid is "matched" by the federal government (known as FMAP). The federal financing share averages 57% and this federal "match" varies based on per-capita income in the state. Medicaid finances almost 75% of all state health care spending.

States who participate in Medicaid (all states do) must provide all beneficiaries with a basic set of services, including doctor visits, hospital care, lab and x-ray services, family planning services and special health screening for children. States are also required to pay for care in nursing facilities and for home-based services. Medicaid pays for almost 50% of nursing home expenses nationally. Costly long-term institutional care is generally not covered by private health insurance companies or Medicare. States may provide "optional" services, including mental health care, dental care, eyeglasses, speech therapy and prescription drugs (1).

Eligibility rules for people applying for Medicaid are complex, and vary widely from state to state. They are linked to both income and other factors like family or disability status.

Who Does Medicaid Cover?

Major categories of eligible people that the states must cover (known as mandatory populations) include:

- Pregnant women and children under age 6 in families with family incomes under 133% of the federal poverty level ($20,000 for a family of three).
- Children ages 6 to 18 in families with family incomes under 100% of the poverty level ($15,000 for a family of three).
- Parents and 18 year olds whose incomes are below welfare standards as of July 1996.
- Elderly and disabled individuals who are eligible for Supplemental Security Income (SSI) program (2).

States have substantial flexibility to cover "optional populations" who may not have health insurance. These optional populations include:

- Children and adults above the federal minimum income levels;
- Certain working disabled people; and
- People with exceptionally high medical bills also may qualify in the category of being "medically needy."

Spending on optional groups and benefits accounts for two-thirds of all Medicaid spending. The extent to which states cover optional groups varies widely. Massachusetts covers 41 percent of their lower-income non-elderly residents through Medicaid, compared to Virginia, which covers 14 percent of its lower-income non-elderly residents (3).

What is Medicaid's Impact?

Medicaid covered 44 million people in 2000, including 22.6 million lower-income children, 12 million elderly and disabled persons, and 9.2 million lower-income adults.

Over 25% of American children rely on the program for their health coverage. It pays for the care of about two-thirds of nursing home residents. Medicaid finances one-third of the baby deliveries in the country and covers more than half of people with AIDS.

Medicaid spending for 2003 is expected to reach $280 billion, with the federal government share amounting to $159 billion (4).

The State Children's Health Insurance Program (SCHIP)

SCHIP was established in 1997 to provide funds to states to expand coverage to children who were not eligible for Medicaid under state standards in place in 1997. Uninsured children under 200% of the poverty are the target population. States have used their SCHIP funds either to expand Medicaid coverage for children or create a separate SCHIP program. Medicaid program rules apply in SCHIP-funded Medicaid expansions. Nearly 3.5 million children are enrolled in the program as of December 2001 (5).

Medicaid and Mental Health Benefits

Medicaid is the primary payer of *public* mental health services. States have relied heavily on its funding for community mental health services over the past two decades.

Medicaid agencies have greatly influenced the development of public mental health care, especially related to organization, financing, services covered, and access.

Some key facts about Medicaid and mental health services:

- Medicaid now pays for more than 50% of the public mental services that states administer.
- It is expected that Medicaid financing of mental health services will reach 60% by 2007. The beneficiaries of these services represent 30% of the "high cost" enrollees.
- Depending on the state, between 25% and 50% of persons receiving state mental health services only receive them from Medicaid**.**
- Among 6-14 year olds, about 25% of Medicaid spending is for mental health services; in some states it is as high as 40% (6).

Medicaid has relatively generous coverage for mental health benefits, compared with private insurance plans. Substance abuse services are covered less often.

Medicaid provides coverage for inpatient and outpatient mental health services and physician services, although the number of days or visits per year may be limited.

Other key services in a mental health continuum such as rehabilitation and case management services are optional under Medicaid, although the majority of states cover them for children.

Several states provide Programs for Assertive Community Treatment (PACT) services under the "Rehabilitation Option". PACT programs deliver comprehensive community treatment, rehabilitation and support services to consumers in their homes, at work, and in community settings.

Many states cover partial hospitalization/day treatment under outpatient care with a higher reimbursement rate.

The Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit of Medicaid is mandatory. The Medicaid EPSDT mandate requires states to provide the following services to Medicaid eligible children and adolescents:

- **Screening** – states must provide children with early, periodic and comprehensive assessments of both physical and mental health development;

- **Diagnosis** – when a screening examination indicates the need for further evaluation, states must ensure that referrals to treatment and service providers are made without delay and follow-up must be done to ensure that a child receives a complete diagnostic evaluation; and

- **Treatment** – states must ensure that children receive the health care and treatment necessary to treat their physical or mental condition discovered by the screening services.

Medicaid also plays a fundamental role in the provision of outpatient pharmacy services to lower-income populations. Prescription drug coverage is one of the most widely utilized benefits in Medicaid programs (second only to physician services) and it is the fastest growing area of Medicaid spending.

Medicaid's drug benefit is particularly vital to those enrollees who depend most upon drugs to maintain or improve their health and functioning, including those with severe mental illnesses.

Caught in Between the Waves – Medicaid Spending Increases and State Budget Deficits

Several economic forces are in play that are likely to impact the financing and delivery of needed services for people with serious mental illnesses. The acceleration of Medicaid spending growth, fueled by rapidly escalating health care costs, has attracted the close attention of both federal and state federal policymakers. At the core of this tension are deteriorating economic outlooks and declining revenue which have strained state budgets, and the

federal budget also is in deficit. Due to the sputtering economy over the last two years, the number of people who have become eligible for Medicaid has dramatically increased which has placed more pressure on state policymakers to implement short-term solutions to control Medicaid costs. In essence, 50 perfect economic storms are being churned up in the states threatening basic health care services for the most vulnerable populations, including people with severe mental illness.

We know the indirect economic costs and social and medical consequences that come from inadequate and denied treatments for people with serious mental illness are staggering:

- Over $100 billion in lost productivity (e.g., absenteeism from work and school and disability), including $11 billion in Social Security Disability Insurance benefits to 1.3 million persons and $11 billion in Supplemental Security Income benefits to 2.0 million persons (7).

- Mental illness ranks first in terms of causing disability in the United States, Canada and Western Europe. Mental illness accounts for 25% of all disability across all industrialized countries. Heart disease and cancer account for 5% and 3% respectively (8).

- $12 billion in lost productivity due to premature death, including suicide (9). Up to 90 percent of all persons who commit suicide suffer from a treatable severe mental illness (10).

- $6 billion to incarcerate more than 283,000 persons with mental illnesses in jails and prisons (11). This is four times the number of people with these illnesses being cared for in hospitals.

- 50-75% of youth in juvenile justice facilities have a diagnosable and most often untreated mental illness (12).

- Suicide is the third leading cause of youth in the 15 to 24 year-old age group, preceded only be homicide and accidents, and as many as 90% of children and adolescents who commit suicide have a mental disorder (13).

- Approximately one-third of the nation's 600,000 homeless persons suffer from severe mental illnesses (14).

- Many people with severe mental illness die prematurely or experience disproportionately high rates of medical illnesses because of neglect or disregard by health care systems of their medical symptoms. A recent report issued by the Massachusetts Department of Mental Health (DMH) showed a seven-fold increase in the number of deaths from cardiac events among DMH clients in the 25 to 44 year-old group in 1998 and 1999 (15).

The indirect costs and consequences of not supporting mental illness recovery are clear and must be considered even in times of state fiscal pressures. The costs of not treating consumers with serious mental illnesses will make it even more difficult for states to control costs due to increased hospitalizations, more physician visits and higher prescription drug costs.

The costs associated with the Medicaid program have skyrocketed in recent years, with projected program growth of 9.5% between fiscal years 2002 and 2003. This growth in total spending follows on the heels of 11% growth between FY 2001 and FY 2002. Long term, under current law, program growth is projected 8.5% annually over the next ten years (16).

States fiscal conditions have been hit hard over the last 12 months, with revenue losses not seen in at least two decades. In response, states have been forced to implement numerous cuts to public services, slashing growth in spending to levels far below historic norms and implementing a range of reductions in services such as Medicaid health care programs, public education and child care.

The outlook for state finances in the next couple of years is bleak. State revenues are unlikely to rebound quickly, and many of the reserve funds and one-time measures used to balance last year's budgets will no longer be available to fill budgetary shortfalls. When state legislatures meet in early 2003, they will likely be faced with fiscal problems as unfavorable (or in some cases worse) as those they encountered last year. The difficult choices of significant additional program cuts and/or tax increases may be unavoidable.

A sign of the times: Governor Warner of Virginia announced recently 11% to 15% reductions for each state agency for fiscal year 2003. And state support for community mental health, mental retardation, and substance abuse services will be reduced by 10%. Warner said that more targeted reductions, which could further affect mental health services, will be necessary in order to balance the budget (17).

As states contemplate cuts in Medicaid, state lawmakers are faced with the reality that every dollar of state appropriations cut for Medicaid forfeits anywhere from $1 to $2 of federal funds through the Federal Medical Assistance Percentage (FMAP).

The federal government reimburses states for a substantial portion of their Medicaid costs. The Medicaid budget problems that states are experiencing are being exacerbated by reductions in federal Medicaid matching payments to many states, which are based on the "Federal Medical Assistance Percentage" or FMAP. The FMAP is based on historical economic data. Unfortunately, the rates for 2002 are based on economic data from the late 1990s, when economies were booming. Even though the economy has weakened greatly since then, the federal Medicaid matching rates for 29 states declined in 2002, and matching rates for 17 states will be lower in 2003 than in 2002. Since current matching rates are based on data from years prior to the economic downturn, several states are in the position of having to fund their Medicaid programs with fewer federal dollars in a budget-challenging period (18).

Realizing the service and economic development impact of the loss of federal funds, state governors are aggressively supporting congressional attempts to increase the federal match rates. Proponents of an FMAP increase contend that increased federal support will temper the need for drastic cuts in Medicaid programs.

The Medicaid program is based on a federal-state partnership. During this difficult economic period, the federal government should increase its role in this partnership and provide some needed fiscal relief to states. A temporary increase in the FMAP could help to ensure that lower-income children, families, elderly people, and persons with disabilities continue to receive the medical care they need. It would also help to ensure that there are sufficient financial resources for hospitals, clinics, nursing homes, physicians, and other health care providers to continue to offer health care services to lower-income people.

But as the debate on the FMAP continues in Washington, state leaders are faced with the reality of budget cost containment at home. With many one-time measures unavailable (e.g., tobacco settlement funds) and assistance from the federal government apparently on hold, states that continue to experience ongoing budget deficits will likely be forced to choose between raising new revenues (raising taxes) and/or reducing access to health care under their Medicaid programs and other vital public health services. It appears that state policymakers will follow the latter path because raising taxes in the current economic environment is not politically popular.

The combination of the economic forces facing states and the solutions being contemplated has the potential to severely undermine the basic tenet of the Medicaid program, which is to provide comprehensive and affordable health coverage, services and benefits to eligible lower-income populations. The implications for people with mental illnesses who are served by Medicaid could be devastating as coverage and benefits for mental health services are curtailed in order to control government bottom line costs.

Controlling the Storm Surge – State Efforts to Limit Medicaid Spending on Prescription Drugs

The threat to mental health services is beginning to play itself out at the state level with a tidal wave of initiatives to limit Medicaid expenditures for prescribed drugs. The raw numbers that are staring down at Medicaid officials are likely to cause knee-jerk and systematic reactions to escalating drug costs and utilization:

- It is estimated that total spending for outpatient prescription drugs in Medicaid was $21 billion in 2000. This figure represents roughly 10% of total Medicaid expenditures in 2000 (19).

- Medicaid spending for outpatient prescribed drugs increased by 6.5 billion dollars from 1997 to 2000, or 16% of the $40.2 billion increase in total Medicaid spending over that period.

- Medicaid spending for outpatient prescription drugs increased by an average of 18.1% per year from 1997 to 2000, compared to 7.7% for total expenditures.

- It is estimated that nearly 12% of total Medicaid prescription drug expenditures are attributable to the use of psychoactive prescription drugs (20).

The current double-digit growth rates of Medicaid spending have serious implications for states and the federal government as they face deteriorating economic outlooks and declining revenue growth. As drug expenditures continue to climb and budgetary pressures mount, states are becoming more aggressive in trying to limit utilization of prescription drugs and regulate pharmaceutical prices.

It is likely that medications for people with severe mental illness are going to be scrutinized and targeted for cost containment and utilization control strategies employed by Medicaid agencies.

The implications of the current budget environment for mental health are clear. Unlike FY 2002 when many state mental health budgets avoided the budget knife, upcoming fiscal years promise to not be as kind to persons with mental illness.

Access to quality care is at risk when states implement cost containment strategies. Decisions regarding specific medications prescribed to persons with mental illnesses should be based on physician judgments of treatments, not on economic factors. Studies show that limiting needed medications can result in interruptions in recovery and increases in costs to the system through higher hospitalizations, more physician visits and higher medication costs. Further, shifting costs away from the health care system into other systems (e.g., homelessness), has been documented earlier in this article.

The Medicaid program is a critically important safety net for lower-income people with severe mental illnesses. NAMI and other mental health advocates are communicating to state officials and Medicaid representatives that:

- The state must not balance the budget on the backs of its most vulnerable citizens.

- Adequate funding of the state's mental health care system is critical to ensuring the health of the state's citizens and communities. People with severe mental illness are the most vulnerable consumers – removing access to treatment is life threatening.

- We must adequately fund and support a strong mental health system and Medicaid program in the state. It is well documented that our nation's failure to provide adequate services for children and adults with mental illnesses has resulted in a crisis for schools, families, communities, and the state.

- Cutting Medicaid expenditures will have a profound and rippling effect. Not only will affect the health of the citizens of the state, but it will also impact the health care industry and the economy in the state.

- Rising pharmacy costs should be understood as part of

the larger picture: Dramatic reductions in hospitalizations and criminalization result from access to effective medication and outpatient care for people with serious mental illnesses.

- Medicaid health care services to people with mental illness are especially important in the state's rural areas, where a system of hospitals and community clinics and centers meet not only the critical health care needs of citizens of the state, but also provide a backbone to the rural economies.

Conclusion

The cataclysmic consequences of failing to provide children and adults with mental illnesses with necessary services will result increased deaths, homelessness, incarceration in jails, prisons and juvenile justice systems and immeasurable suffering. The devastating consequences of obstructing access to medications and services for people with serious mental illnesses cannot be understated. We must assure that people with mental illnesses are not cast away in the financing and economic storm that states and Medicaid programs are experiencing.

Notes

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