

Home Health Care Management & Practice

<http://hhc.sagepub.com>

Shifting Focus: The Impact of the Deficit Reduction Act and Medicaid Regulations on National Mental Health Policy

Chris Koyanagi and Laurel Stine

Home Health Care Management Practice 2009; 21; 271 originally published online Apr 20, 2009;

DOI: 10.1177/1084822308329253

The online version of this article can be found at:
<http://hhc.sagepub.com/cgi/content/abstract/21/4/271>

Published by:



<http://www.sagepublications.com>

Additional services and information for *Home Health Care Management & Practice* can be found at:

Email Alerts: <http://hhc.sagepub.com/cgi/alerts>

Subscriptions: <http://hhc.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations <http://hhc.sagepub.com/cgi/content/refs/21/4/271>

Shifting Focus

The Impact of the Deficit Reduction Act and Medicaid Regulations on National Mental Health Policy

Chris Koyanagi, MA, JD

Laurel Stine, MA, JD

Bazelon Center for Mental Health Law

Over the past 20 years, state mental health agencies have shifted the bulk of funding for community mental health services to the federal-state Medicaid program. Over this same period, states adapted their Medicaid programs to more comprehensively address the service needs of people with mental illness. Adopting the financing mechanism that primarily funds other health care for low-income people moves mental health more toward the mainstream. But it is a policy with risks. Changes to Medicaid are now outside the purview of those most concerned with mental health issues. In 2006, Congress radically altered Medicaid, making fundamental changes to the law. These were soon followed by further proposed shifts in federal administrative policy. This article describes these federal policy changes and assesses their impact on individuals and on state mental health policy. (It should be noted that most administrative changes have since been halted by the Obama Administration).

Keywords: *Medicaid; Deficit Reduction Act; mental health; screening; case management; rehabilitation services; home and community services.*

The legislative changes for Medicaid occurred through the enactment of the Deficit Reduction Act (DRA) of 2005, which was signed by President Bush in February 2006. This law amended several federal entitlement programs to reduce federal spending; Medicaid changes were included in Title VI and were numerous. Some focused specifically on reducing spending through increased emphasis on fraud and abuse or by imposing limits on federal reimbursement for certain services, thereby deliberately shifting costs onto other state and local programs. Others were designed to alter the nature of the program, reducing beneficiaries' rights and allowing states greater flexibility to change program eligibility and services. At the same time, the bill included several provisions to allow people with disabilities greater access to home and community-based services and to self-direct their services.

The new options for states were designed to save the federal government money; some also yield savings for states, but most increase state costs. Most will likely have very grave consequences for millions of children and adults with mental disabilities who rely on Medicaid for necessary health and mental health care.¹

The DRA: Altering Medicaid in Fundamental Ways

Medicaid is an insurance program, paying for covered services furnished to covered individuals by Medicaid-qualified providers. Medicaid operates as a joint federal-state program, with shared responsibility for setting policy and financing the program. Until the enactment of the DRA, Medicaid law protected all those enrolled in the program in several important ways. First, the benefits include a broad array of covered services, in recognition of the fact that the program covers people with disabilities, the elderly, and persons with very low incomes. All of these are groups with especially high health care needs, and many of them require long-term services and supports that are rarely needed by persons enrolled in employer-sponsored private health insurance. Thus, the Medicaid benefit package looks generous when compared with private plans.

However, various state policies ensure that service utilization is controlled. Some of these policies are deliberate quality and cost control measures (such as utilization review); others are policies that act by default (low

payment rates result in too few providers taking Medicaid patients). In addition, many of the services are optional and a state does need not include them in its state plan benefit package.

Children have even more protections under the law than adults do. Children are entitled to Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and for their treatment, are entitled to any of the services covered in federal law, regardless of whether the state has included that service in its state plan. The EPSDT mandate is designed to ensure that all children receive early intervention and comprehensive services.

Other beneficiary protections in federal law include requirements that states ensure that services are provided in sufficient amount, duration, and scope to meet their purpose; services are not restricted based solely on a person's diagnosis, type of illness, or condition (comparability); services are available in all geographic areas of the state and not limited to only a few beneficiaries ("statewide-ness"); and services are furnished with reasonable promptness. Before the DRA, federal law also strictly limited the out-of-pocket charges that beneficiaries could be forced to pay, and exempted certain groups, such as children, from being charged any copayments at all.

States that wanted to alter any of these protections were required to file a request with the federal government for a waiver of the applicable rules. There are some consumer protections in the waiver process, including requirements for public notice and comment, strict federal review, and time limits on how long the waiver can run, although in point of fact, most are renewed. Waivers have been used by states primarily to shift beneficiaries into managed care arrangements or to expand the number of uninsured people eligible for the program.

All of these protections were essential to making Medicaid a true safety net program. Individuals on Medicaid have no recourse to other coverage, nor are they in a financial position to pay out of pocket for essential services. If denied by Medicaid, they have nowhere else to go and must fall back on charity care or the very limited services offered in some state programs.

Changes in the law through the enactment of the DRA undermined these previous basic tenets of Medicaid. The DRA sanctioned potentially dangerous changes for vulnerable beneficiaries, including those with significant mental health problems. These changes did the following:

- Allowed states to drastically reduce benefits and furnish private insurance-type coverage for Medicaid beneficiaries, a move especially detrimental to those who need mental health services;

- Allowed states to impose increased cost sharing on people who use Medicaid services, including charging for the use of the emergency room for nonemergency issues, undermining the program's core value to make health care accessible to low-income people;
- Set a precedent for eligibility for basic state plan services to be restricted and available only to a specified number of eligible people or only in a single geographic area, overriding the statewide rule that previously protected access.

Limits on Services

The DRA breached a fundamental principle of Medicaid—that anyone enrolled in the regular program (i.e., anyone not included in a special program through a waiver) has the same benefit package as everyone else. Section 6044(a) of the DRA amended Sec. 1937 of the Social Security Act of 1965 (the Medicaid Title) to adopt policies first used in the State Children's Health Insurance Program, a program for children whose families have incomes too high for Medicaid but are still relatively poor. Under the State Children's Health Insurance Program, and now under Medicaid as well, states can develop new benefit packages modeled on private health insurance plans to replace the comprehensive coverage of Medicaid law. These are termed "benchmark" coverage, because they are similar to certain benchmark plans listed in the statute. Plans that are considered benchmarks to use as models for the new benefit include the Blue Cross or Blue Shield preferred provider plan for federal employees, the state employees' plan, or the HMO plan in the state with the largest non-Medicaid enrollment.

States may also develop "benchmark-equivalent coverage," in which the benefit package has the same actuarial value as one of the specified benchmark plans. Unfortunately, the benchmark-equivalent coverage needs to only include a mental health benefit that is 75% of the actuarial value of the mental health benefit in the benchmark plan. This allows states to reduce a mental health benefit of, say, 30 inpatient days and 20 outpatient sessions to one of 22.5 days and 15 outpatient sessions. The law also allows states to create their own benefit, without specifically modeling it on any existing plan, as long as the Secretary of the U.S. Department of Health and Human Services approves the state's proposal.

If the individual has access to employer-sponsored coverage and that coverage is determined by the state to be benchmark or benchmark-equivalent (a fairly

minimal standard), the state may pay the premium for this employer plan on behalf of the individual. In addition, the state can create a plan by combining the employer insurance with additional wrap-around coverage through Medicaid whereby the premium payments can still be made with Medicaid funds. This option not only changes the benefit package of Medicaid to parallel private insurance coverage but also essentially shifts beneficiaries out of Medicaid and into private insurance. Prior to the DRA, such action required a federal waiver.

Under the DRA changes, services covered under any of these benchmark or other plan options only needed to be basic and didn't need to include the range of community services typically covered by state Medicaid plans for mental health treatment. Although states are allowed to limit Medicaid benefits in this way, they are not permitted to expand them by including other services not normally covered under Medicaid. These options can be used to reduce beneficiaries care options but not to improve them.

As a result, states that opt for benchmark plans could have benefit packages with very restricted coverage of mental health. In fact, they do not need to provide any mental health coverage at all, and this has already occurred. Because these plans are modeled on existing private insurance plans, many will limit inpatient days and outpatient visits, and it is possible that in many states, there will not be coverage of the intensive community services currently offered through Medicaid and public mental health systems.

Special rules in the DRA apply to children under the age of 19. The mandate that children receive any of the services covered under federal law when medically necessary has been retained for children enrolled in benchmark plans. However, states are permitted to separate the benefit into two packages: benchmark benefits and additional Medicaid EPSDT services not covered by the benchmark plan. This bifurcated benefit could easily result in children falling through cracks. Some families may not know that they can obtain the wrap-around benefit; others may find their child inappropriately denied the additional benefit, and even those who manage to access the additional benefits could still encounter discontinuity in providers and treatment plans. Thus, the benchmark plan policy could have a serious impact on children as well as adults.

The DRA specifically permitted certain Medicaid eligibility groups—primarily low-income women and children—to be given no option but an approved new benchmark benefit plan. Other groups, such as people with disabilities, children in foster care, and older adults,

can also be moved into these plans but should be able to opt out again and back into the regular Medicaid program. However, putting the burden on the individual in this way undermines Congressional intent in exempting these groups, as many low-income people will not understand their right to opt out or how to do it. Because these exempt groups include those with disabilities, such as people with serious mental illness, shifting them into the limited coverage of a new benchmark plan will be extremely detrimental. It will also be shortsighted. If individual needs are not met, people will get sicker and go into crisis more often. Eventually, the use of both inpatient and community services will increase over the long term.

States' Response

These provisions in the DRA followed several years of pressure from certain governors to limit the benefit package of Medicaid to something that more closely resembled a standard private insurance policy. The Bush Administration also showed a clear interest in such limitations prior to enactment of the DRA when it approved a waiver of federal rules for Florida. That waiver allowed mandatory enrollment of most Medicaid-eligible individuals in managed care organizations that had broad authority to design their own benefit packages. Under this waiver, Florida provides a defined contribution through a risk-adjusted premium that individuals then use to purchase health care from one of these approved plans. If they wish, beneficiaries may opt out of Medicaid altogether and use their premiums to purchase individual or employer-sponsored private coverage.

The benefit rules in this waiver are similar to those in the DRA benchmark provision. Each plan must offer all of the mandatory Medicaid services but has flexibility to determine the amount, duration, and scope of the benefits. The only requirement is that the benefit package of each plan must be actuarially equivalent to Florida's current Medicaid package for the average member of the target population. Florida also sets annual maximum benefit limits for adults. Once adult beneficiaries (except pregnant women) reach this limit, there is no further Medicaid coverage and individuals must cover the costs of their own care.

Evaluations of the Florida waiver have identified problems. Beneficiaries report problems in getting access to medications, and provider participation in Medicaid also appears to be declining (Alker & Hoadley, 2007b). The benefits of HMO plans became less generous in the 2nd

year of the waiver and copayments increased as well. In an attempt to protect themselves from these adverse effects, people with disabilities were found to be more likely to sign up with the provider-sponsored networks that also participate in Florida's system and that are not permitted to limit benefits in the same way as HMOs (Alker & Hoadley, 2007a).

Florida's waiver also breaks new ground by offering "Enhanced Benefit Accounts" for beneficiaries who participate in state-defined healthy activities. These accounts can continue to be used for 3 years after individuals lose their Medicaid eligibility as long as their income remains below 200% of the federal poverty level.

Once the DRA was enacted, other states joined Florida in limiting Medicaid benefit packages. Some of them also adopted policies for penalizing individuals who do not engage in certain "healthy" behaviors.

In the 1st year, eight states implemented limited benefit packages under the DRA, but some of them used this increased flexibility to offer the limited benefits only to individuals who would not normally have qualified for Medicaid. Only Idaho, Kansas, Kentucky, and South Carolina adopted significant changes using benchmark coverage for people who under previous law would have been entitled to traditional benefits (Bazelon Center for Mental Health Law, 2008). However, it is still early days and other states are known to be working on similar plans. The degree to which states will make these fundamental alterations to Medicaid is therefore not yet known.

Idaho, Kentucky, and West Virginia made the most substantial changes to their Medicaid programs. South Carolina created significant change, but this change involved only a pilot operating in a single county. Mental health coverage in these states' benchmark plans is limited, emphasizing basic inpatient and outpatient services with day and visit limits for most populations, although individuals with disabilities generally have broader coverage.

For example, adults in West Virginia's basic plan have access only to mandatory Medicaid services but no inpatient psychiatric care. Children have coverage for limited inpatient and outpatient mental health services. In West Virginia's enhanced plan—intended for eligibility groups with higher needs—adults have limited inpatient and outpatient mental health benefits, whereas children have unlimited inpatient and outpatient coverage. Kentucky's two plans for low-income children and adults offer only inpatient and outpatient services with no limits but with increased copayments; no other mental health services are included.

Kentucky and Idaho automatically enroll individuals who fall into the eligibility categories exempted by law

from mandatory enrollment. In both states, individuals may opt out if they believe it is in their best interest. However, both states appear to have provided insufficient information to their beneficiaries regarding the differences between regular Medicaid and the benchmark packages. Kentucky's approach also penalizes those who choose to opt out by charging them higher copayments.

Idaho, Kentucky, and West Virginia have also all adopted policies that are intended to encourage healthy behavior among Medicaid beneficiaries. West Virginia requires members to meet behavioral expectations set forth in a member agreement; individuals who fail to make and keep these agreements lose their access to the enhanced benefit plan with its more expansive coverage of mental health. Beneficiaries who do not adhere to the agreement will be put back in the basic plan. This agreement includes 12 requirements such as commitments to show up for appointments on time, to take the medication prescribed, and to use the hospital emergency room only for emergencies. To date, very few people with serious mental illness have signed these agreements. Idaho and Kentucky are also using the new benchmark packages to encourage healthy behavior among Medicaid beneficiaries, but on a smaller scale.

Higher Cost Sharing

Another crucial aspect of Medicaid's role as a safety net is the low-cost sharing in the program, designed to enhance financial accessibility. Under the DRA, states have new authority to impose premiums (including an enrollment fee or similar charge), increase the copayments for most services and prescription drugs, and charge beneficiaries for nonemergency use of emergency rooms (Social Security Act of 1965, Sec. 1916A). These cost-sharing amounts are generally subject to a federal ceiling, but this is to increase each year. The secretary of Health and Human Services is required to index allowable amounts by the medical consumer price index. Also, for the first time in the program's history, Medicaid beneficiaries can be denied coverage for failure to pay. Failure to pay their premium within 60 days can lead to their being cut off the program and failure to pay copayments may lead to denial of a service.

Under prior Medicaid law, deductions and copayments were limited to nominal levels, with no more than \$3 to be charged for any service. No cost sharing could be charged for services to children. This policy has served an important purpose. Research has shown that increasing cost sharing can reduce use of services, including appropriate and necessary use. Some studies have focused specifically

on the Medicaid population and found that increasing copayments significantly depresses individuals' use of services (Artiga & O'Malley, 2005; Ku & Wachino, 2005; Newhouse & the Insurance Experiment Group, 1996; Wright et al., 2005).

DRA provisions also depart from the prior Medicaid policy of treating all enrollees in a similar way, by permitting states to set different rules on cost sharing for different groups of Medicaid beneficiaries. States may vary these charges within a group (as "group" is defined by the state), by geographic area, or by type of service. Although some groups are exempt from premiums (primarily children), none is exempted from cost sharing.

There are also some beneficiary protections on the policy of charging people for going to the emergency room. States that permit or require hospitals to charge individuals for nonemergency use of emergency rooms must ensure that hospitals inform individuals of an alternate nonemergency service provider who is available and accessible.

The DRA does include some limits, and it protects people with incomes up to 150% of the poverty level from having to pay premiums. Individuals with incomes under 100% of poverty level are also not subject to these newly authorized higher copayments. States are also not permitted to charge any individuals more than 5% of their family income, although for a family living with a small income, 5% for medical costs could be a very significant burden. Also, no charges can be imposed for certain services, including preventive services.

The impact of these cost-sharing provisions varies by population group, as follows:

- Adults with incomes not exceeding the federal poverty level can be charged for nonemergency use of the emergency room and for nonpreferred drugs;
- Adults with incomes between 100% and 150% of poverty level can be charged up to 10% of the cost of a service and for nonemergency use of the emergency room;
- Children are a little better protected, but those in families with incomes between 100% and 150% of poverty level who are in an optional eligibility group² can be charged up to 10% of the cost of a service as well as for nonemergency use of the emergency room.
- The hardest hit are those with incomes above 150% of poverty who can be charged premiums, cost sharing up to 20% of the cost of the service, 20% of the cost of nonpreferred drugs, and any amount set by the state for nonemergency use of the emergency room.

The combined effect of these provisions—if a state implements them all—is to increase cost sharing on many Medicaid recipients for most or all of their services.

States may condition Medicaid eligibility on prepayment of the premium they impose and can terminate eligibility on the failure of the individual to pay the premium within 60 days of the date it is due. States can also permit providers to require authorized cost sharing before they furnish a covered service. These provisions could impose serious hardship on many low-income families.

To date, only three states (Idaho, Kentucky, and South Carolina) have picked up the option to increase cost-sharing requirements. These states have incorporated these changes into their benchmark plans. Other states have used this increased flexibility to raise cost sharing for groups they plan to cover as expansion populations, who would not normally meet Medicaid eligibility rules in that state.

Connecting People to Other Services

People with serious illnesses, including those with a mental disability, need to access both a range of health care services and other supports in the community. Without access to housing, income support, job training, education, or other social services, many people with mental illness cannot succeed in the community, even if they are receiving extremely good mental health treatment.

Medicaid's case management function was added to the law in the 1980s in recognition of this need. Case management is defined in federal law as services that will assist individuals in gaining access to needed medical, social, educational, or other services. The specific Medicaid category for billing this activity is *targeted case management*, a term that reflects the fact that states are permitted to choose groups of people who will be eligible for this support. Unlike a treatment service, targeted case management has always been specific to a particular population. For example, many states target "adults with serious mental illness" or "children with serious emotional disturbance."

The DRA made several important amendments with respect to the law on targeted case management. Some of them were relatively benign. For example, the legislation defined the term *case management* in a manner that reflected previous federal regulatory policy. Under the DRA, case management consists of assessment, development of a specific plan of care, referral and related activities to help obtain needed services, and monitoring and follow-up activities. It does not include the medical,

educational, social, or other service to which the individual has been referred.

The DRA also attempted to define when Medicaid would pay for case management for individuals who are the responsibility of another system. In this respect, the law focused particularly on foster care systems.

The legislation itself restated existing agency policy with respect to when foster care systems might bill Medicaid for case management. Foster care activities that may not be billed to Medicaid under the DRA as case management include such things as researching and gathering documentation, assessing adoption placements, recruiting foster parents, serving legal papers, investigating homes, and making placement arrangements. These are activities that child welfare agencies conduct for all children in their care, regardless of their health status.

In addition, however, the DRA added new language that the Centers for Medicare and Medicaid Services (CMS), a federal agency responsible for Medicaid, would later use to take Medicaid policy into a new realm. It denied case management payment to states for any function in which a third party was liable to pay for such services, including as "reimbursement under a medical, social, educational or other program." This language reinforces the fact that other payers must be billed first, but the use of the word "liable" means that such payers must have a legal obligation to pay for a person's care, not that there is a state or local program in existence that could pay.

In December 2007, the CMS issued regulations to implement this section of the DRA (Medicaid Program, 2007b). These regulations and the explanatory material that accompanied them went a great deal further than the law. In background to this rule, CMS stated that no reimbursement would be available for children in foster care for "provision of services to children and families in their own homes, identification of risk factors, referral to services and evaluation (or monitoring) of interventions." This list would appear to overlap with the necessary interventions for children with a serious health condition, such as a mental or an emotional disorder. The agency also categorically stated that it was now federal policy that Medicaid funds cannot be used to pay for services of state child welfare/child protective services workers or juvenile justice workers, including contractors of those systems, regardless of whether the service is provided due to the child's health care condition.

As with other changes in the DRA, these regulatory interpretations make a fundamental alteration to the program. Until now, it was irrelevant whether a child was the responsibility of the child welfare system or the juvenile justice system. Medicaid was deemed to be an insurance program, liable to pay for covered services to

covered individuals when medically necessary. Although Medicaid law has also emphasized that it be last payer with respect to third-party payers (such as private insurance), it has never been interpreted as if its coverage was conditional in the manner proposed by CMS.

In language that appears to acknowledge the insurance nature of Medicaid, CMS stated in the background to its rule that "case management services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home or other community placement . . . when services are identified due to a medical condition" and presumably when the provider has no affiliation with another system, such as child welfare or juvenile justice. Yet it is not at all clear how CMS could differentiate between case management due to a medical condition and case management required for other reasons.

The net result of this rule is that certain Medicaid beneficiaries are excluded from the program because the federal government intends to shift the cost of some services to state or local human services systems. Medicaid then acts, in these situations, more like a federal discretionary grant program than an insurance program.

The case management regulation made other changes beyond the DRA, but these were not fundamental challenges to the way Medicaid has operated in the past. For example, it required that states must pay for case management on a fee-for-service basis, in billable units of 15 minutes or fewer. For mental health care, this new reimbursement methodology threatens certain evidence-based practices that are comprehensive and often paid through case rates or other similar mechanisms. These include assertive community treatment and multisystemic therapy for children. The rule also requires that Medicaid case management services be furnished by only one case manager for each individual, regardless of the complexities of the individual's case. Although problematic and detrimental to many state systems, these provisions are within the agency's authority to regulate.

These regulations became effective on March 3, 2008, but Congress then moved to halt implementation of the sections that went beyond the DRA statute through legislation to impose a moratorium on implementation of the rule until April 2009.³ The moratorium went into effect when President Bush signed this legislation in June 2008.

Limits on Home-Based and Community-Based Services

The DRA includes several provisions that encourage community living for persons with disabilities, including

two new demonstration programs. The demonstrations are to help ensure that children with mental disorders avoid placement in residential treatment facilities and to assist people with disabilities to transition from an institution to the community (DRA, 2005, §6063). The DRA also created a new section in Medicaid law (Social Security Act of 1965, Sec. 1915(i)), authorizing a state plan service for home-based and community-based services for certain people with disabilities.

For several reasons, this last provision also represents an important shift in Medicaid policy that undermines some of the essential entitlements of individuals on the program. State plan services have always been subject to the cited set of rules. That is, once eligible for Medicaid, all individuals are eligible for all services in the state's Medicaid plan (and children for all services detailed in federal law), and states may not limit access to a service by place of residence, level of income, or any other factor. This new home-based and community-based state plan option is the first service to be subjected to limits. First, for this service, there are more restrictive federal financial eligibility criteria than for all other Medicaid state plan services (individuals have to have incomes at or below 150% of poverty). In addition, the DRA allows states to put a limit on the number of people to be served and maintain a waiting list for others. States electing this new option may also choose to provide the services in limited areas of the state without having to meet Medicaid's usual requirement that benefits be available statewide. However, diagnostic group still cannot limit the service, although it can be targeted in such a way that the eligible recipients are effectively limited to a particular diagnostic group.

For no other state plan service are states given the power to make such comprehensive limitations on who is eligible. Although Congress allows states to target case management services to certain populations, case management is a linking function, not a treatment per se. This is not to say that this new state option is unhelpful to people with a disability or the elderly who need these services. It will still benefit many. However, it is a fundamental shift in the entitlement nature of the program.

In its emphasis on home and community services, this new option has important strengths. These strengths make it all the more unfortunate that states can limit service so substantially. For example, services that may be provided include several relevant to persons with mental illness: case management, homemaker or home health aide services, personal care services, psychosocial rehabilitation, and respite care and day treatment.

In many ways, the new service is better for people with mental illness than the authority for federal home and community based waivers that has been in Medicaid for many years. Those waivers enable people at risk of

institutionalization, but not psychiatric hospital care, to receive home-based and community-based services, provided that those services do not cost the federal government more than it would have spent on institutional care (Social Security Act of 1965, Sec. 1915(c)). Federal waiver rules have made it very difficult to use the waiver for adults aged 22 to 64 with mental illness.⁴ The DRA provision gives states the option to provide home-based and community-based services to individuals with disabilities based on an assessment of their needs; they do not need to be in or at risk of placement in a Medicaid-covered institution, and there is no requirement for cost neutrality to the federal government. Thus, adults aged 22 to 64 with mental illness can be included.

States have been slow to implement this provision, in part because federal regulations did not come out until April 2008. However, Iowa applied fairly quickly, using the option for people who need certain psychiatric services. Iowa did not limit services geographically, but it did set enrollment caps, which could result in a waiting list. The state plans to serve 3,700 people in the 1st year, with the number of participants increasing to nearly 4,500 in the 5th year. Iowa further targeted this service by setting needs-based criteria that effectively limited services to those with histories of serious mental illness.

States that choose to limit the covered services to mental health interventions, as Iowa has done, can address the specific needs of individuals who have mental illnesses. On the other hand, because the state can have only one home-based and community-based services benefit, other states may choose to limit services to those benefiting another population group, which may result in people with mental illnesses not having access. Or a state may cover all people with disabilities, in which case, to control its costs, the state may strictly limit covered services or impose a stringent cap on the number of people to be served. Any of these policies undermine the statewideness rule of Medicaid, and state practices could have the effect of overriding comparability as well.

Self-Direction

Another way in which the DRA broke new ground was to include several provisions to allow Medicaid recipients (or their families) to have control over certain service providers and even to manage their own budget of Medicaid funds.

The DRA amends Medicaid to allow states to permit individuals eligible for Medicaid personal care services or home-based and community-based care waiver or state plan option services to self-direct their care and have control over an individual budget. Under the new

Sec. 1915(j) of the Social Security Act, individuals found to require these services and who choose to self-direct can be given certain supports to enable them to manage a budget. Individuals may hire (and fire) their own personal care aides, use family members and friends as aides, and buy items or make home modifications that help them live independently.

Although advocates for beneficiaries generally applaud this shift in policy, it also alters the program from an insurance entitlement to a capped allowance (the individual budget) and places the responsibility to manage that budget on the individual or his or her family. A good principle (self-control of service providers and meaningful choice of services) has been melded with a financing mechanism that could place unfair burdens on low-income persons, especially if it were extended to other sections of Medicaid.

Rehabilitation

Legislation has not been the only vehicle for federal policy makers to make changes to Medicaid's role. On August 13, 2007, CMS published proposed new regulations on rehabilitation services that changed the philosophical approach of Medicaid as a safety net program in some important ways (Medicaid Program, 2007a).

The rehabilitative services option funds most community mental health services provided through the public mental health system to children and adults with serious mental disorders, as well as services for people with physical or developmental disabilities. Changes to this service create a ripple effect across human service systems in the states.

No changes had been made to the law through the DRA or any other legislation for rehabilitation services, but this administrative action followed several requests by the Bush Administration to Congress for cuts in these services (U.S. House Committee on Oversight and Government Reform, Majority Staff, 2008). Federal savings from the proposed regulation were estimated at \$180 million in the 1st year and \$2.2 billion over a 5-year period. Those savings would not accrue to states and localities, which would have to either reduce services or pick up the slack for the lost federal revenue.

As with some of the DRA provisions, the rule was a mixed bag. A number of provisions were quite progressive. For example, each individual was required to have a rehabilitation plan, and for people with mental illnesses or substance abuse disorders, the plan was expected to include recovery goals. Consumers were to be active participants in service planning, plans were to outline anticipated outcomes

and be re-evaluated and changed if there was no progress, and consumers were to have a choice of services and providers.

The regulation also restated the well-accepted policy that rehabilitation is not custodial care and that the goal of a service is the determinant as to whether it is covered (this meant, for example, that recreational or social activities could be covered if therapeutic and written into the person's plan of care).

The rule emphasized that rehabilitation services were to focus on the ability to perform a function, regardless of whether the individual performed that function in the past. This is an important provision for children who may have had (and lost) the ability to function at an age-appropriate level but would not have previously been expected to perform certain specific tasks because of their age.

The philosophical shift in this rule was similar to the one in the targeted case of management regulation. Under this rule, Medicaid would not pay for services furnished through a nonmedical program as a benefit or administrative activity. The list of programs included under this term was long and included foster care, child welfare, education, child care, vocational and prevocational training programs, housing, parole and probation, juvenile justice, and public guardianship.⁵ CMS estimated that this part of the rule would save the federal government \$180 million in 2008 and \$2.2 billion over a 5-year period.

Part of the focus was to deny payment for the evidence-based practice of therapeutic foster care—a service primarily offered to children in foster care but in some states available to other children with severe mental illness. The proposed rule described therapeutic foster care as a model of care, not a separate service, and disallowed it as a specific rehabilitation service.

These rules on rehabilitative services have not been put into effect. They, along with the case management rule, were delayed by the moratorium legislation until April 1, 2009 (Supplemental Appropriations Act, 2008). The moratorium would essentially prohibit CMS from implementing or otherwise taking further action on the regulations through guidance, policy, practice, or any other related actions.

Implications for Public Mental Health Systems

Although it is not the first time the integrity of the Medicaid program has been under attack, the DRA and the rules that CMS recently issued have heightened the

threats to Medicaid's role as a critical safety net. For mental health, the direction of these changes conflicts with the Bush Administration's own New Freedom Commission on Mental Health. The DRA continued a trend that started in 2001 for Congress and the Bush Administration to give states increased flexibility under Medicaid. Most of it comes at beneficiaries' expense.

Public mental health systems—now so dependent on Medicaid—could find themselves facing change after change, all leading to fewer people on the program, fewer mental health services covered, and higher costs for both beneficiaries and for mental health systems. Public mental health will likely have to pick up some of the out-of-pocket costs for public sector clients and fill the gaps in services not now covered, due to these various changes.

States that decide to adopt several of the various new options available to them could make it especially hard for people with mental illness to get the services they require. For example, the benchmark plans represent a huge step backward for the beneficiaries with mental health needs who may find themselves in limited plans and with higher cost sharing. States that focus on using Medicaid funds to purchase private employer-based health insurance and/or to set up health savings accounts will also likely hamper access to mental health services, again leaving states to pick up the tab or individuals to go without care.

Even the DRA changes that are largely positive, such as the new home-based and community-based services option, will not benefit all individuals who may be eligible for Medicaid in a particular state, due to the tighter income requirements and the ability of states to cap enrollment. These provisions may limit its potential for furthering the goals of public mental health systems.

In addition, adoption of several of these new policies in any one state could combine to undermine the program's core mission of making health care accessible and affordable to low-income people.

The DRA can certainly be viewed as a mixed bag for people with mental illness on Medicaid. Some of its provisions may reduce access and coverage, but others expand opportunities for community services and community living for some persons with disabilities. But the provisions in the DRA that are of benefit to people with mental illness are generally small. There are two demonstration programs that encourage community services in place of institutional care and there is a new eligibility option for states to allow families of children with disabilities to buy into the program if their income is less than 250% of poverty level. These changes, however, pale in comparison to the damage that might be done if states wholeheartedly adopt policies that change

Medicaid into a plan parallel to private insurance, restrict access to some of the most beneficial state plan services, and raise cost-sharing requirements.

Conclusion

Medicaid was first enacted in 1965. One might expect that changes would be needed to a program that has been in place more than 40 years to update it and bring it more in line with today's health policy. This is, in fact, not the first time that fundamental changes have been made to Medicaid that are reflective of broader policies adopted in the private insurance market. In the 1990s, many states shifted the program's beneficiaries into managed care arrangements through new federal authority to waive Medicaid's requirement that individuals have freedom of choice with respect to their providers. Since 2000, the Centers for Medicare and Medicaid Services have also encouraged states to make changes to the program that removed certain beneficiary protections, but these could only be made through a federal waiver.

So the question arises: Why do some advocates for low-income people think that the DRA and the recent policies promoted by CMS are so devastating to Medicaid? The answer perhaps lies in the extent and scope of these changes, the fact that most of them were made by amending the statute and because really fundamental aspects of the program could be threatened if states were to take advantage of the opportunities afforded by the DRA to eviscerate key entitlements currently afforded to Medicaid beneficiaries.

However, although the DRA opens the door to unraveling many of the beneficiary protections of the Medicaid program, it is important to note that most of these changes are permitted but not mandated. States—not the federal government—will decide whether the DRA adds to the number of people who are uninsured and underinsured or whether the Medicaid program will continue to protect the health and mental health of low-income people. Adverse changes proposed in regulation have been put on hold by the Congress, and it is possible that under a new Administration, they may never be put into effect.

The DRA may nonetheless have changed the way Medicaid is viewed by some policy makers, and the various changes both made and proposed indicate some grave misconceptions about the role and purpose of a safety net program. Given the importance of Medicaid to public mental health systems, these changes will be a challenge in states that opt to implement them. State mental health systems could be faced with the problem of how to pay for

significant levels of service for a Medicaid population that is now underinsured for mental health.

Notes

1. The Deficit Reduction Act was not the first federal policy to promote fundamental changes to Medicaid; in 2001, the Bush administration initiated a special kind of Medicaid waiver program (Health Insurance and Flexibility Accountability waivers) that allowed states to reduce benefits for Medicaid recipients to save money that would then be used to provide coverage to some of the uninsured by either purchasing private insurance or developing new programs that offered less than Medicaid in the way of benefits.

2. The optional eligibility group refers to a child younger than 6 years old whose family income is between 133% and 150% of the poverty level and children aged 6 to 17 whose family's income is between 100% and 150% of the poverty level.

3. The moratorium was part of legislation making Supplemental Appropriations Act for 2008.

4. An important aspect of the state plan option compared with a home-based and community-based waiver is that states do not have to demonstrate budget neutrality. It has been nearly impossible for states to secure home and community-based services waivers for adults age 22 to 64 with mental illnesses due to the Medicaid rule that prohibits federal financial participation for services provided in Institutions for Mental Diseases (IMDs). States could not show that community care would be budget neutral, because IMD expenditures were disallowed.

5. Under Sec. 1903(c) of the Social Security Act of 1965, services in a child's Individualized Education Program under the Individuals with Disabilities Education Act are payable by Medicaid. Those services would not be included in this new prohibition on federal financial participation.

References

- Alker, J., & Hoadley, J. (2007a, December). *Medicaid pilots at one year: How is the new Medicaid marketplace faring?* (Briefing #4). Retrieved December 10, 2007, from www.dupontfund.org/learning/pdfs.brief4_final.pdf
- Alker, J., & Hoadley, J. (2007b, May). *Waving cautionary flags: Initial reactions from doctors and patients to Florida's Medicaid changes* (Briefing #2). Retrieved December 10, 2007, from www.dupontfund.org/learning/pdfs/waving.flags.pdf
- Artiga, S., & O'Malley, M. (2005, May). *Increasing premiums and cost sharing in Medicaid and SCHIP: Recent state experiences*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Retrieved October 27, 2008, <http://www.kff.org/medicaid/upload/Increasing-Premiums-and-Cost-Sharing-in-Medicaid-and-SCHIP-Recent-State-Experiences-IssuePaper.pdf>
- Bazon Center for Mental Health Law. (2008, January). *State Medicaid policy choices under the Deficit Reduction Act provisions*. Retrieved October 23, 2008, from <http://www.bazon.org/pdf/3-08DRAreport.pdf>
- Deficit Reduction Act of 2005, §6063, codified at 42 USC §1396a note.
- Ku, L., & Wachino, V. (2005, July 5). *The effect of increased cost-sharing in Medicaid: A summary of research findings*. Washington, DC: Center on Budget and Policy Priorities. Retrieved October 27, 2008, from <http://www.cbpp.org/5-31-05health2.htm>
- Medicaid Program. (2007a). Coverage for rehabilitative services. 72 Fed. Reg. 45201 (to be codified at 42 C.F.R. pts 440 and 441).
- Medicaid Program. (2007b). Optional state plan case management services. 72 Fed. Reg. 68077 (to be codified at 42 C.F.R. pts 431, 440 and 441).
- Newhouse, J., & the Insurance Experiment Group. (1996). *Free for all? Lessons from the RAND health insurance experiment*. Cambridge, MA: Harvard University Press.
- Social Security Act of 1965, Section 1903, codified at 42 USA §1396b.
- Social Security Act of 1965, Section 1915(c), codified at 42 USC §1396n(c).
- Social Security Act of 1965, Section 1915(i), codified at 42 USC §1396n(i).
- Social Security Act of 1965, Section 1916A, codified at 42 USC §13960-1.
- Social Security Act of 1965, Section 1937, codified at 42 USC §301 et seq.
- Supplemental Appropriations Act. (2008). Pub. Law No 110-252 (2008) Section 7002(a)(2)-(a)(3).
- U.S. House Committee on Oversight and Government Reform, Majority Staff. (2008, March). *The Administration's Medicaid regulations: State-by-state impacts*. Retrieved October 27, 2008, from <http://oversight.house.gov/features/medicaid08/state%20Medicaid%20Impact%20Report.pdf>
- Wright, B. J., Carlson, M. J., Edlund, T., DeVoe, J., Gallia, C., & Smith, J. (2005). The impact of increased cost sharing on Medicaid enrollees, *Health Affairs*, 24(4), 1106-1116.

Chris Koyanagi is responsible for the advocacy agenda of the Bazelon Center for Mental Health Law. She has more than 30 years of experience in Washington, DC; serves on several mental health policy advisory committees; and has authored numerous articles and publications on mental health policy, particularly financing policy.

Laurel Stine is the Bazelon Center's principal lobbyist on mental health policy issues before the U.S. Congress and the federal government. For over 10 years she has advanced and helped shape the advocacy agenda of the Bazelon Center on a range of issues, including health care, juvenile and criminal justice, and education. Ms. Stine has also represented the interests of several other national disability and health care organizations before the U.S. Congress.