State Mental Health Service Funding

An Overview

State Medicaid budgets and state mental health agency budgets (community mental health programs and state hospitals) are integral to providing needed treatment for children, youth and adults living with mental illness. Together, these two sources fund 90 percent of our public mental health systems.

Medicaid Funding

Medicaid is a joint federal-state program that generally covers low-income children, seniors, and people living with disabilities, though eligibility varies from state to state.[1] Medicaid is significant because it is one of the largest payers of mental health services in the country and provides coverage for many persons who are severely affected by mental illness.[2]

Federal funding for Medicaid is provided at a match rate that ranges from 50 to 76 percent of overall funding, depending upon the economic status of the state. This means that every dollar a state invests in their Medicaid program brings in *at least* another federal dollar to provide services and fuel state economies.

Eligibility: In most states, individuals who are eligible for Supplemental Security Income (SSI) are automatically eligible for Medicaid. Thirty-nine states and the District of Columbia either provide Medicaid automatically to SSI recipients or use the same criteria for determining Medicaid eligibility, while 11 states use separate criteria to determine eligibility.

Medicaid requires states to cover children under age six with family incomes below 133 percent of the federal poverty level and children and youth aged six to 18 with family income below the federal poverty level. While many states cover "optional" Medicaid populations, most states do not currently cover parents who live in poverty and even fewer cover adults without dependent children, even if they are impoverished.

Services Provided: Because each state develops its own Medicaid program(s), services vary from state to state. All states cover prescription drugs, and many states cover an array of services for children, youth and adults living with mental illnesses, such as care management and crisis services, therapy, peer supports and various intensive treatment and support services that aid in recovery and community integration.

Federal law requires Medicaid to cover certain services, such as physicians, laboratory and x-ray services, nursing home services and home health care services.[3] States are also required to cover certain screening, diagnostic, and treatment services for eligible children under age 21, whether or not these services are covered in the state's Medicaid program. Importantly, federal Medicaid law does not allow Medicaid to pay for state hospital care for adults aged 22-64.[4]

State Public Mental Health Funding

State mental health budgets are primarily funded by state general fund dollars to provide state hospital and inpatient care, crisis services and community mental health services for children, youth and adults. The state mental health budget we refer to here is separate from Medicaid funding of mental health services for Medicaid enrollees.

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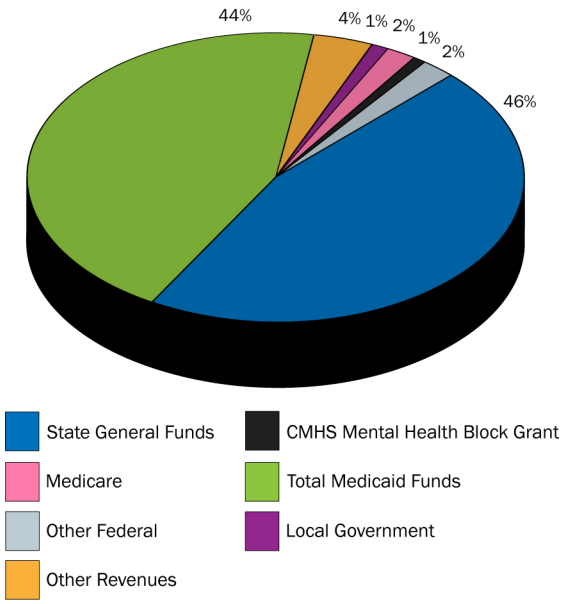
State mental health budgets play a vital role in covering non-Medicaid eligible children, youth and adults. These budgets also provide needed treatment and supports for Medicaid enrollees that are either not covered by Medicaid due to federal rules (such as state hospital care for adults aged 22-64) or because they were not included in a state's Medicaid plan design.

Eligibility: Eligibility for community mental health services varies from state to state and sometimes within a state. Generally, services are prioritized for people in crisis and/or those who are severely impacted by serious mental illnesses.

Eligibility is important because community mental health services serve as a critical "safety net" for the significant number of single adults, parents, children and youth who are ineligible for state Medicaid programs because they do not meet disability or income criteria, even though many have very high mental health needs, are uninsured or have exhausted private coverage or are awaiting eligibility for Medicaid.

Services Provided: Services and supports available for mental health vary from state to state. In some states, services include screening and assessment, effective therapies, peer supports, assertive community treatment (ACT) teams, Supportive Housing and Supported Employment, jail diversion, crisis services and inpatient and longer-term care, among others. In other states, services are extremely limited.

State Mental Health Authority Controlled Revenues FY 2006



Endnotes

[1]Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*, March 2007. Publication #7235-02.
[2]New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003. p. 21.
[3]Center on Budget and Policy Priorities, "Policy Basics: Introduction to Medicaid", (Dec 17, 2008). Accessible on the Web at www.cbpp.org/cms/index.cfm?fa=view&id=2223.
[4]A federal Medicaid law provision called the "Institutions for Mental Diseases" (IMD) exclusion prohibits use of federal Medicaid dollars for services in IMDs, defined as facilities serving individuals between the ages of 22 and 64 with 16 or more beds, at least one-half of which are psychiatric beds. As a result of this exclusion, state hospital care is primarily funded with state general fund dollars.

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