

It is likely that antipsychotic and antidepressant medications are going to be scrutinized and targeted for cost containment and utilization management strategies employed by Medicaid agencies. The implications for mental health care are clear. The devastating consequences of obstructing access to medications cannot be understated. Advocates will need to highlight to policymakers the implications of denying or delaying care to patients and the potential economic results.

Navigating Through the Storm

The presentations at the two conferences clearly highlight the significant challenges ahead for advocates of mental health care. However, there are steps that can be taken now to assure that people with mental illnesses are not cast away in the financing and economic storm within state Medicaid programs and the forces that will be unleashed as a result of that impending crisis.

Some of the steps that should be taken now include:

- Arranging meetings with state Medicaid officials and officials in the executive branch, as well as with state policymakers and their staffs.
- Tracking the state budget process and hearings that may impact access to prescription drugs.
- Establishing short-term broad-based coalitions with interest groups who have similar objectives on access to prescription drugs.
- Contacting the media and health care reporters to discuss the potential implications to impeding access to prescription drugs.

Medicaid Fact Sheets and bulletins developed through NAMI's Policy Research Institute will provide additional assistance on steps that advocates can take to engage state officials.

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**In Harm's Way:
The Imminent Financial Threat to
Mental Health Care Services in Medicaid Programs**

Two conferences on Medicaid held in September 2002 point up the enormous challenges ahead for the program's financial outlook and implications for mental health services. The conferences, sponsored by the Centers for Medicare and Medicaid Services (CMS) and the Council on Health Care Economics and Policy, provide a context for solving several problems in the Medicaid program and assuring access to needed services for people with serious mental illnesses.

Another Perfect Storm

Several forces have collided – economic, political, social and demographic – 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 18 months, the number of people who have become eligible for Medicaid has dramatically increased which has placed more pressure on policymakers to implement short-term solutions to control their spending liabilities.

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 mental illnesses.

The combination of these economic forces 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.

The recent economic storm that has engulfed the Medicaid program comes at a time when the program has been under severe criticism in the way it is financed and administered, and fuels the debate that something must be done immediately to fix the program. However, many analysts argue that the program which serves 44 million people, has been successful in addressing the needs of lower-income Americans who otherwise would have little or no health care coverage. Therefore, any attempt to reform Medicaid either short-term or long-term, should include a discussion on the problems that reforms would solve.

Lifeboats Against the Storm – Proposals for Restructuring Medicaid

Many analysts believe the Medicaid program has become a financing stream rather than a discrete program and that its roots are in social welfare spending and in addressing the health care needs of the states' sick-

est, neediest, and most uninsurable residents.

Trish Riley, Judy Feder with Georgetown University and Michael Doonan with the Council on Health Care Economics, offered several approaches to restructure the Medicaid program but the primary ones fell into the following categories:

Restructuring the Medicaid program into three parts: Core Medicaid — which would retain Medicaid's current benefits to serve lower-income people; Health Care for Chronic Illness and Long-Term Care; and Health Insurance for the Uninsured which would combine Medicaid and SCHIP with state-based programs for the uninsured.

Block granting the Medicaid program: A block grant gives a set budget to states to meet prescribed and general needs set forth by the Congress. Because of the fixed budget nature of block grants, one anticipates that entitlements will be lost and that states would be given considerable flexibility, as they were with the social services block grant, to structure programs to meet their needs. This approach has the potential to do the most harm to existing coverage and benefits to lower-income people with severe mental illness.

An Island in the Storm or a Mirage?

While strategies to fix the Medicaid program are being considered by policymakers and experts, the Administration has implemented a new Medicaid and SCHIP waiver policy to meet specific policy goals.

In 2001, the Administration introduced its Health Insurance Flexibility and Accountability (HIFA) demonstration initiative for Medicaid and SCHIP that is intended to reduce the ranks of the uninsured. The policy provides individual states additional flexibility that would translate into savings that states could use to finance further coverage expansions through Medicaid. However, analysts at the Council seminar believe that the policy invites states to cut critical health benefits and increase cost sharing for millions of lower-income individuals without any requirement that states use the resulting savings to expand coverage.

Mental health advocates will need to think broadly and begin to offer new approaches in order to maintain and expand its gains, as the federal government and the states begin to think of ways of “reimagining” Medicaid.

A Tale of Two Cities (Separated by a Turbulent Financial Ocean) – Medicaid and Mental Health Services

As rising health care costs and declining state revenues collide, and onerous federal public policies threaten the tenets of the Medicaid program and mental health care services, there continues to exist fundamental issues below the surface that fuel the storm. Speakers at the CMS national conference on “Medicaid and Mental Health” said that significant misperceptions persist in the relationship between Medicaid agency representatives and mental health advocates.

The gulf that exists could, if not dramatically closed, threaten the necessary funding that is required to support mental health services. What issues are at the core of these misunderstandings and tensions?

Ann Patla with the University of Illinois at Chicago and Cynthia Wainscott provided a list of misperceptions from the perspectives of Medicaid and mental health.

- One in five Americans will have a mental illness and most people will not receive treatment for their conditions. Medicaid agency representatives think this a threat to their capacity. Mental health representatives also think this is a threat to their capacity unless needed delivery and financing changes occur.
- Over 50 percent of public mental health services are paid for by Medicaid and are growing steadily. Medicaid representatives think of mental health care as a “bottomless pit” – mental health thinks of Medicaid as a “sugar daddy.”
- Perception of mental health is “access to new medications equals recovery”; Medicaid looks at it as a “giant sucking sound.”
- Misperceptions abound within Medicaid agencies that people with mental illness are “dangerous” and “can’t hold a job”.
- Restrictions by Medicaid are hurting people and people who suffer relapses are going back into hospitals and jail. Medicaid does not pay for all of the services – it is not comprehensive. But Medicaid says “we pay for mental health services – what do advocates want from us.”
- Another source of friction is outcomes and quality measurement. Medicaid thinks that mental health is insufficient in this area and mental health thinks that Medicaid doesn’t understand.

Although these misperceptions and views persist and present barriers to understanding between the two interests, an even wider chasm could develop as Medicaid programs struggle to control their costs. In an era of limited financial resources, it is clear based on these presentations that a new dialogue must begin immediately between Medicaid and the mental health community.

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

Due to the Medicaid budget crisis, and the gulf of misunderstanding that exists between Medicaid officials and the mental health community, 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.

States have recently implemented several initiatives to control prescription drug spending in Medicaid. Approaches can be grouped into three general categories:

- Programs designed to change physician prescribing patterns;
- Strategies using formularies to influence utilization and/or pressure manufacturers for price concessions; and
- Efforts to reduce pharmacy payment levels.