

The Deficit Reduction Act: Should We Love It or Hate It?

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Some new options created for state Medicaid programs under Title VI of the Deficit Reduction Act (DRA) could have grave consequences for people with mental illness. Some provisions allow states to limit coverage, increase copayments, impose new premiums, and cap benefits. More positive DRA provisions would make it easier for states to provide home- and community-based services. A ten-state demonstration program will expand coverage for children. The author concludes that a state's adoption of the DRA's mental health-friendly provisions may not offset the damage done by its other provisions. (*Psychiatric Services* 57:1711-1712, 2006)

Recently enacted federal legislation makes possible radical changes to Medicaid state programs. The changes are contained in Title VI of the Deficit Reduction Act (DRA), Public Law 109-171, signed by the President on February 8, 2006. Some changes will directly affect Medicaid-funded mental health services, and others have a broader impact on Medicaid eligibility and access.

This law creates new options for states. Very few of the changes are mandated by the federal government, which means that it is highly likely that the DRA will increase the disparities between state Medicaid programs.

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Overall, the amendments are estimated by the Congressional Budget Office to save the federal government \$6.9 billion. Although some amendments may also yield savings for states, some may increase state costs.

Many of the changes could have very grave consequences for children and adults with mental illness if they are implemented by a state. However, the DRA also includes provisions that can improve services, including greater flexibility to furnish community-based services. This column examines positive and negative aspects of DRA provisions.

Coverage and access limitations

Some DRA amendments have the potential to make the most significant change to Medicaid since it was enacted in 1965. In place of a guarantee of coverage for a broad range of health and mental health services, the DRA could result in states' altering Medicaid so that it takes on the appearance of a private insurance plan, with limited covered services, higher cost-sharing, and capped benefits. Such changes are possible because of the new flexibility granted to states to shift some of the Medicaid population into plans that resemble private plans, following rules modeled on the State Child Health Insurance Program (S-CHIP).

S-CHIP is for children in families whose income is higher than the Medicaid-eligibility level and who, generally, do not have serious mental disorders and do not require all the services covered by Medicaid. With enactment of the DRA, some adults and children with incomes well under the Medicaid-eligibility level may find themselves with coverage that limits mental health care to 30 days of inpatient care and 20 outpatient visits per year, with no access

to the more intensive community services offered through the public mental health system and currently funded by Medicaid, such as assertive community treatment, psychosocial rehabilitation, and intensive in-home services for children. The ability of states to set up plans that resemble private plans creates a fundamental shift in the program.

The DRA limits the groups of individuals for whom states can take this option. Children and adults on Supplemental Security Income and other specific groups must remain in the basic Medicaid program. Indeed, there are so many restrictions on the number of people who can be placed in these private plans that states are complaining that the DRA provides them with far less flexibility than advertised. Only some states have taken this route, although more may do so once the Centers for Medicare and Medicaid Services (CMS) writes the regulations. But regardless of whether states take advantage of this option, the language represents a historic shift in Medicaid.

Other changes in the DRA may also significantly affect access. The law permits states to impose higher copayments and to institute copayments for groups for whom they were previously prohibited. Also, for the first time states can charge certain groups a premium to participate in Medicaid. New fees may also be accompanied by state policies that force compliance. Under the DRA, states are permitted to refuse Medicaid coverage to individuals who do not pay their premium within a certain time and to authorize providers to deny services to those who do not meet copayment requirements. Additional provisions to charge for nonemergency use of emergency departments could add further hardships for low-income people.

A further potentially troubling provision would limit federal reimbursement for targeted case management to services for which no other entity is "liable" to pay, including a medical, social, educational, or other program. Depending upon how CMS interprets this language, it might severely restrict access to case management for people with serious mental illness, because all states fund case management through various federal and state programs.

The DRA thus continues the trend for Congress and the Bush Administration to give states increased flexibility that can be used to reduce Medicaid access to services. These changes ignore the history of Medicaid, which has been specifically designed to include the services necessary to meet the extensive needs of people with disabilities, elderly persons, and persons in poverty and to ensure that all low-income children have access to early intervention and comprehensive services, including hearing, vision, and mental health services—the services that can be specifically limited under the DRA. Under the DRA this concept is at risk.

Expanded eligibility and services

The DRA has also made some progressive shifts in Medicaid. Of particular interest to those concerned with mental health are expansions in home- and community-based services for people with disabilities.

Advocates for children with disabilities have for many years urged passage of legislation that would have enabled children with disabilities from families with incomes higher than the Medicaid level to access the comprehensive services in the program. Known as the Family Opportunity Act, that proposed legislation was intended to give states the option to allow certain families to buy into Medicaid through a sliding-scale premium. For children with significant mental health care needs, such an approach might obviate the need for these families to give up custody of their child to the state child welfare system or juvenile justice system solely to secure mental health services.

A scaled-down version of the Family Opportunity Act is included in the DRA. It would be phased in by age group, and by 2010 all children under

18 who meet eligibility requirements regarding disability and income could be covered. States may offer this opportunity to families with incomes up to 300 percent of poverty—or, currently, up to \$58,500 for a family of four. Family premiums would be capped on the basis of income.

Two other DRA provisions deal with a long-standing problem in Medicaid mental health policy: the inability to provide home- and community-based services because of a federal requirement that such services be offered only through a Medicaid waiver that is budget neutral. Budget neutrality has been ensured by requiring home- and community-based services to be no more costly than the Medicaid-covered institutional services the individual would otherwise access. Medicaid does not cover services in an "institution for mental disease" (IMD) for adults aged 22 to 64. Therefore, states have been prevented from implementing home- and community-based waivers for these adults because there are no institutional costs to offset the costs of community care.

The DRA authorizes states to provide home- and community-based services as part of their basic state plans, instead of requiring them to apply for a federal waiver. States can now expand the array of community services for people with disabilities, including persons with mental illness. Because there is no budget neutrality requirement for this new service, the IMD rule is irrelevant.

Of interest to mental health advocates is that states may not restrict access to home- and community-based services in the new state plan on the basis of diagnosis or disability. Thus any such service would be open to any individual with a medical need for it. A challenge to states, however, will be to create services for people with the full range of disabilities, including those with mental retardation and developmental disabilities, those with physical disabilities, elderly persons, and persons with mental illness. Although certain home- and community-based services are needed by only one disability group, any service with broad benefit across populations, such as respite care or supported employment, cannot be limited by group.

Thus home and community service options that are limited to persons with mental illness may be rare. But when this option is chosen for other populations, people with mental illness should also be able to benefit.

However, new restrictions are permitted for these home- and community-based services. States need not offer the services statewide but can limit participation by geographic area. They can also cap the number of participants and create waiting lists. These restrictions are the same as those permitted under a waiver, but this is the first time that services offered in a basic state Medicaid plan could be so limited.

The DRA also authorizes a demonstration program to allow ten states to obtain home- and community-based waivers for services to children with serious mental disorders who are in a residential treatment center or are at risk of placement in such a facility. Before the DRA, federal law required that in order for children to be eligible for home- and community-based waivers, they must be in a hospital, an intermediate care facility for people with mental retardation, or a nursing home or at risk of placement in one of these facilities. Under the demonstration program, states may provide a range of community services, such as respite care and other family supports to children who would otherwise be in residential treatment. However, states with these waivers may limit the number of children who can participate and may create waiting lists.

Conclusions

The DRA is a mixed bag for mental health advocates. There are helpful provisions to move the Medicaid program toward home- and community-based services. At the same time, states have options that may lead, in time, to undercutting the basic and critical premise of Medicaid: that low-income populations, people with disabilities, and elderly persons must have the protection of access to a broad range of services that working people will rarely need. In some states, the Medicaid safety net may soon be shredded. If that occurs, adoption in those states of the DRA's mental health-friendly provisions will hardly offset the damage done by its other provisions.