State Budget Cuts, Health Care Reform, and a Crisis in Rural Community Mental Health Agencies

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Between 2009 and 2011, states implemented significant budget cuts to community mental health agencies (CMHAs), which are frequently the sole provider of specialized behavioral health services in rural communities. Starting in 2010, federal policy changes created by health care reform and mental health parity are likely to increase the number of individuals who can afford to seek services for a mental illness. CMHAs under financial stress have begun to eliminate services and reduce staff. These trends could result in a growing gap between available behavioral health services and the number of people who can afford to seek treatment for a mental illness. (*Psychiatric Services* 62:1255–1257, 2011)

Of the estimated one in five adults in the United States who experience a mental illness during their lifetime, approximately one-third receive care (1). Recent changes in public policy created by the Patient Protection and Affordable Care Act (PPACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) were intended to address financial barriers at the patient level that contribute to this disparity. These federal policy changes should substantially increase access to behavioral health services (2,3). Whether providers will be available to meet the demand in rural locales, where 85% of the 1,669 federally designated mental health professional shortage areas are situated, remains a serious question (4).

Federal policy reflects progress in addressing financial barriers to mental health care. However, in 2009, states under economic strain began announcing substantial budget reductions to community mental health agencies (CMHAs) (5–7). State funding has historically played an important role in financing behavioral health services, particularly for people who are uninsured. These reductions mean CMHAs —commonly the only provider of specialized behavioral health services to the uninsured in rural communities— are retracting and dismantling services rather than preparing for more people seeking services. Reconstituting behavioral health services in rural communities may prove difficult, and sometimes impossible, raising concerns about where individuals will go to receive mental health care even as financial barriers are eased by federal policy.

The importance of CMHAs as a system of care for individuals experiencing a mental illness in rural areas is routinely underestimated (8). The types of nonmedical behavioral health services that CMHAs provide, such as individual and group therapy, intensive case management, supported employment, supportive housing, and assertive community treatment, are not typically available from other health care providers, particularly in resource-poor rural areas (8). Evidence suggests that CMHAs can provide cost-effective and clinically appropriate services (9).

State funding cuts

In 2008, state general revenue funds were 40% and Medicaid was 46% of state mental health agencies' budgets (the remaining 14% of funds were from a variety of sources, including Medicare, grants, and county funds) (7). Between 2009 and 2011, general revenue funds to state mental health agencies were reduced by $2.1 billion (7). Examples abound. Arizona reduced its 2010 mental health budget by $36 million, which resulted in a 37% funding decrease to behavioral health services for non–Medicaid-eligible patients (5,6). Mississippi has cut its mental health budget by roughly 8% in each of the last three years and plans to cut more; these cuts have resulted in CMHA closures and consolidations (5,6). California's 2010 mental health budget was re-

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duced by $92 million, limiting access to programs across the continuum of care (6). In New York, programs operated by the Offices of Mental Health, Mental Retardation and Developmental Disabilities, and Alcoholism and Substance Abuse Services were reduced by $151 million (10), and Ohio has discontinued almost all funding to behavioral health services for individuals not eligible for Medicaid (5).

Illinois' experience

For fiscal year 2011 Governor Pat Quinn announced a $90 million (39%) decrease in Illinois general revenue funds for CMHA behavioral health services (11). As in other states, these reductions are part of a three-year trend that has resulted in a total decrease of 56% from 2008 funding levels of $231 million (11). State general revenue funds accounted for approximately 27% of CMHA budgets in 2008.

Recent experiences of CMHAs in southern Illinois show how multiyear cuts to state general revenue funds can affect the availability of behavioral health services in rural areas. Semistructured, journalistic-style telephone interviews were conducted with 12 executive directors from CMHAs serving 24 of the 33 counties in Illinois Region 5. Many of these directors have been mental health professionals for more than 20 years. Region 5 is in the southernmost quarter of Illinois and runs the width of the state. It has a population of approximately 1.2 million, or 15% of Illinois' non–Cook County (Chicago) population. The area consists primarily of depressed agricultural and manufacturing locales that have been hard hit by the economic stagnation and recession between 2000 and 2010.

When asked who was most affected by the 2011 budget cuts, the executive directors universally cited patients who were not Medicaid eligible and who did not have access to private insurance—in other words, people with no tangible means to pay for services. According to the directors, many persons who are uninsured and served by CMHAs have minimum-wage jobs that lack health insurance benefits and do not qualify for Medicaid because of income caps or requirements linking benefits to dependent children. These individuals represent 10%–35% of the population served by Region 5 CMHAs. As a result of state funding reductions, CMHAs can no longer provide treatment planning services, individual or group therapy, case management, or medication administration and monitoring to people without a third-party payer (11,12). Services for uninsured individuals are reduced to two hours of assessment and unlimited access to crisis interventions (12).

The executive directors were asked about the impact of budget cuts on the availability of behavioral health services. They reported that the range of possible services will decrease and the distances that patients travel will increase as CMHAs consolidate or close. When faced with a third year of reductions in state general revenue funds, 100% of the executive directors decided not to accept new patients, 55% reduced services to current patients, 91% plan to reduce services in the future, 87% instituted hiring freezes, 46% laid off staff, 73% used the agency's reserve funds, and 28% borrowed money against future state payments.

There are limitations to journalistic-style telephone interviews with CMHA executive directors in one region of Illinois, but findings from the National Association of State Mental Health Program Directors Research Institute (NRI) show that other states are responding similarly to budget shortfalls (7). NRI reported that in 2010, 53% of state mental health agencies reduced funds to community providers, 40% reduced community mental health services, 35% reduced the number of persons served in the community, 78% instituted hiring freezes, and 53% laid off staff. Community-level services eliminated include clinic services (individual and group therapy), peer support programs, targeted case management, supportive housing, and workforce development programs (7). The survey also found that 56% of state mental health agencies reported an increased demand for community-based services in the same period (7).

Health care reform and mental health parity

Although flaws in patient coverage for behavioral health services remain, policy changes enacted by PPACA and MHPAEA work in concert to address patient-level financial barriers that have traditionally limited access to mental health care (2,3). PPACA expands the number of individuals covered by private insurance or Medicaid from 83% to 94% of the U.S. population—or 32 million individuals who will have better access to health care. Estimates indicate that 25% of uninsured adults have either serious psychological distress or substance abuse issues, and over 6% have a serious mental illness (2). As individuals gain access to private insurance or Medicaid, MHPAEA should guarantee, for the most part, that mental health coverage is available and not cost prohibitive. The institutionalizing of parity in health insurance when coupled with PPACA suggests that more individuals will be able to afford behavioral health services (2,3).

Most increases in coverage created by PPACA for individuals with a mental illness are realized in two phases. First, as of 2010, those with preexisting conditions can enroll in low-cost, high-risk pools, and insurance companies cannot deny coverage because of these conditions. This phase should help persons who can afford to enroll in individual and small-group market plans and have been denied coverage because of prior mental illness. As of March 2011, enrollment in high-risk insurance pools was approximately 18,000, well below the Chief Actuary of Medicare and Medicaid's prediction of 375,000 (13). Two reasons have been cited for lower-than-expected enrollment: high premiums and limited public knowledge about the program (13). The high-risk pools could provide a third-party payer for some of the patients now served by CMHAs and supported by state general revenue funds if premiums are adjusted to better fit the resources of the working poor in rural communities.

Second, effective in 2014 Medicaid eligibility will expand to individuals with income up to 133% of the federal poverty line and will include adults without dependent children. As well,

individuals without insurance and employers who do not provide insurance and have more than 50 employees will be encouraged through financial incentives and penalties to acquire health care coverage (2). The 2014 provisions of PPACA are likely to provide the greatest expansion of access to behavioral health services at CMHAs because the provisions are directed at individuals with demographic profiles similar to those of patients supported by state general revenue funds.

Community health centers (CHCs)

In addition to provisions aimed at decreasing barriers to insurance, PPACA included $9.5 billion in funding for CHCs to build capacity in areas such as mental health care (14). These funds could have directly benefited CMHAs under a provision that would have provided a mechanism for them to become "federally qualified," similar to CHCs, but the provision was not included in the final law (15). The capacity-building funds when coupled with PPACA Sections 5403 and 5603, which promote interdisciplinary community-based linkages and colocation of mental health care and general health care, may encourage CHCs to build on their growing expertise in behavioral health services (14). Unfortunately, federal budget difficulties related to a slow economic recovery have jeopardized much of the expanded funding to CHCs. In mid-2010, $600 million was rescinded from CHCs' budget. The National Association of CHCs warned its members to expect more reductions in 2011 and 2012 (16). These reductions are likely to have the greatest impact on CHCs' noncore services, such as those associated with mental health care.

Workforce development

PPACA also has provisions directed at increasing the number of mental health professionals, which may lessen the workforce erosion created by state budget reductions. Section 5306, Mental and Behavioral Health Education and Training Grants, provides $35 million between 2010 and 2013 to fund social work and psychology programs for training graduate students to work in behavioral health settings (14). Workforce provisions created under the Public Health Service Act that are focused on increasing the number of primary care providers in underserved areas are reaffirmed by PPACA with moderate increases in funding (14). Some of these primary care providers may have expertise in behavioral health services. The overall impact of PPACA workforce provisions on replacing rural mental health professionals lost because of state budget reductions is difficult to gauge. However, neither the CHCs nor workforce development provisions of PPACA are apt to offset entirely what is projected by 2012 to be more than a $2.2 billion decrease in state funding for behavioral health services.

Conclusions

Because of multiyear reductions in state funding, the system of behavioral health services that CMHAs provide in rural communities is diminishing, and patients are losing access to care. If PPACA and MHPAEA are fully implemented and uninsured patients gain access to either Medicaid or private insurance, the policies should lessen CMHAs' need for state general revenue funds. Unfortunately, the bulk of increases in patient access to insurance may not occur soon enough, and there is little evidence that other health care providers will assume the services provided by CMHAs. The result could be a diverging supply and demand that is difficult to correct in resource-poor rural areas.

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