

What "deficit reduction" means for people with mental disabilities

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The Deficit Reduction Act (DRA), P.L. 109-171, was narrowly passed by Congress (216-214 in the House on January 31) and signed by the President on February 8, 2006. It makes substantial changes to vital federal programs such as Medicaid, Medicare and TANF to reduce federal spending by \$40 billion over five years.

The law creates new options for states under the Medicaid program. These changes could fundamentally alter the way Medicaid operates, with particularly detrimental effects on people who need a wide range of intensive mental health services. The changes are designed to save the federal government money; some also yield savings for states and some will increase state costs. All 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.

In addition to its negative impact, however, the DRA includes some provisions that could improve Medicaid for adults and children with mental disorders, including greater flexibility to furnish community-based services.

Changes to Medicaid

The DRA continues the trend for Congress and the Administration to give states increased flexibility under Medicaid. Most of it comes at beneficiaries' expense. Unlike the bill that originally passed the Senate, which saved money by reducing payments to Medicare managed care plans and to pharmaceutical companies for Medicaid drugs, the law as enacted hits hard at people who depend on Medicaid.

Moreover, the law creates a fundamental shift in the program. The approach used by the State Children's Health Insurance Program (SCHIP) of furnishing private insurance-type (benchmark) coverage is now being extended to Medicaid. This ignores the history of Medicaid policy, which has deliberately included services that meet the extensive needs of disabled, elderly and poor people, and ensures that all children in America (including those in low-income families) have access to early intervention, hearing, vision and mental health services that will help them succeed in life.

States that opt for a benchmark plan for some Medicaid beneficiaries will have benefit packages with very restricted mental health coverage (limits on inpatient and outpatient stays). These packages lack any coverage of the intensive community services offered through public mental health systems.

Furthermore, the imposition of cost-sharing on people who use Medicaid services undermines the program's core value, to make health care accessible to low-income people.

In sum, the DRA opens the door to the unraveling of the Medicaid program. It is important, however, to note that all of these disastrous changes are authorized and 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. Moreover, the law gives states some new options for covering children under Medicaid and expanding community-based services for some children and adults.

Overall, the DRA is plagued with ambiguous legislative language. If Congress doesn't clarify it through passage of a technical corrections bill, and if the language is interpreted adversely by the Centers for Medicare and Medicaid Services (CMS), which administers Medicaid, this law could create even more problems.

Increased cost-sharing and new premiums

States now have significant new authority, effective as of January 1, 2007, to impose premiums (including an enrollment fee or similar charge), deductions and co-payments for groups of Medicaid-eligible individuals and for services. Prior law limits cost sharing to a co-payment of no more than \$3 for any service.

For the first time Medicaid beneficiaries can be denied coverage for failure to pay their premium within 60 days and denied a service if they fail to pay co-payments.

Allowable levels for state-imposed premiums and co-payments vary by family income, and some groups are exempted from premiums. States need not treat all people in a group the same way, but may set different rules on cost-sharing for different subgroups of Medicaid beneficiaries.

No charges can be imposed for preventive services, services to children in foster care or receiving adoption assistance, or services to terminally ill or institutionalized individuals who receive only a personal needs allowance.

Although some groups are exempt from premiums, none are exempted from cost-sharing.

Children in the lowest income groups (up to 133% of poverty for those under age 6 and up to 100% of poverty for those between 6 and 17) can only be charged \$3 for non-preferred drugs or non-emergency use of the Emergency Room. No other cost-sharing can be imposed on

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this group.

Adults with incomes between 100% and 150% of poverty cannot be charged premiums, but cost sharing can be up to 10% of the cost of the service, \$3 for non-preferred drugs and \$6 for non-emergency use of the Emergency Room. Total cost-sharing is capped at 5% of income.

Adults with incomes above 150% of poverty can be charged premiums, cost-sharing up to 20% of the cost of the service, and 20% of the cost of non-preferred drugs. Total cost-sharing is capped at 5% of income.

Case management

Section 6052 of the DRA changes Medicaid's targeted case management option and redefines the term 'case management.' (Case management is often billed under other state services, such as Clinic or Rehabilitation services, as well as under the Medicaid option of Targeted Case Management. The new definition applies in all cases).

The DRA clarifies that to be eligible for targeted case management an individual must be:

- ▶ eligible for Medicaid, and
- ▶ part of the target population for targeted case management specified in the state plan.

It is critical for mental health programs to be able to continue billing Medicaid for covered targeted case management for an eligible individual who is in the state's target population for this service, whether or not the individual is in the child welfare system or served by other programs. The DRA does not deny this coverage, but does leave open the interpretation of just how this will work in practice.

The law also specifies that Medicaid will not pay for certain services that have traditionally been furnished by child welfare system case managers. And it requires states to bill other funding sources that are 'legally obligated' to pay for targeted case management services first, before billing Medicaid.

Under Medicaid law, case management services are services that will assist individuals in gaining access to needed medical, social, educational or other services.

The DRA emphasizes that federal reimbursement is available for case management or targeted case management services only if no third party is liable to pay for such services. This standard appears to restate Medicaid's prohibition on payment for services for which another party is liable. However, the DRA then states that this includes reimbursement under a medical, social, educational or other program. This statement raises concern. Many medical, social and educational programs pay for similar services, but they are underfunded and often targeted (legally or in

practice) to individuals who are not Medicaid eligible. The question is, which of these programs (if any) will be determined 'liable' to pay for services by CMS when it interprets the meaning of this statement.

Stay tuned

Meanwhile, the reduction trend continues. In its Fiscal Year 2007 budget request, which Congress is now considering, the Administration requests further cuts in Medicaid and Medicare, including a 50% reduction in the reimbursement rate for targeted case management. It also serves notice that it will act administratively to redefine rehabilitation services and to restrict federal payment for certain school-based services and administrative costs.