



## **The Role of Federal Programs: Medicaid, SCHIP & Medicare**

This is one of a series of issue briefs by the Bazelon Center on the integration of mental health in healthcare reform. They offer policy recommendations for:

- ◆ integration of mental health in primary care;
- ◆ medical homes;
- ◆ chronic care management;
- ◆ integration of mental health in the public health system;
- ◆ the role of public insurance programs (Medicaid, SCHIP and Medicare); and
- ◆ improving the quality of care.

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Children, low-income families, seniors and individuals with disabilities rely on public health insurance programs for needed care. Medicaid provides an array of services and supports that are fundamental in promoting independence and community integration. The State Children’s Health Insurance Program (SCHIP) provides important coverage to low-income children who are not financially eligible for Medicaid. Medicare provides health and basic mental health care for both seniors and certain people with disabilities.

These federal and state health insurance programs play an important role for individuals with disabilities, including those with mental illnesses. As reforms are made to the health care system, Medicaid, SCHIP and Medicare must remain viable options for the populations they cover. Indeed, they need to be strengthened and expanded to ensure that they continue to protect the health of the most vulnerable. These reforms must include provisions to more fully integrate mental health with healthcare.

### **Background**

Medicaid is an important source of coverage for individuals with low incomes, including those with disabilities—populations that generally have significant healthcare needs and often require very specialized services. Individuals with mental illnesses qualify for Medicaid under various eligibility categories. Particularly important for adults is the eligibility category linked to receipt of Supplemental Security Income (SSI) disability benefits. Thirty five percent of the 3.8 million SSI beneficiaries between the ages of 18 and 64 in 2001 had a mental disorder.<sup>1</sup>

Low-income children rely on both Medicaid and SCHIP. In both programs, enrolled children have higher prevalence rates of mental health problems than other insured children or uninsured children.<sup>2</sup>

Medicare provides coverage for individuals over age 65 and those who are eligible for Social Security Disability Insurance. Both groups have significant mental health care needs, with serious mental illnesses being highly prevalent among Medicare beneficiaries under age 65 who qualify for Medicare because of a disability.<sup>3</sup> Approximately 37 percent of Medicare beneficiaries with a disability have a serious mental illness.<sup>4</sup>

### **Medicaid**

Medicaid is a joint federal-state program that is administered by the states under federal guidance. States must provide coverage to individuals who meet categorical and financial eligibility criteria. Eligible individuals generally must receive a set of mandatory services detailed in federal law. States may opt to cover other services, including clinic, rehabilitation

and case management services that are extremely important for children and adults with mental disorders. For children, states must cover any medically necessary service authorized in federal law as well as regular screening and well-child check-ups (a Medicaid requirement known as Early and Periodic Screening, Diagnosis and Treatment or EPSDT).

Medicaid provides a more appropriate range of services for people with severe mental illnesses and other individuals with disabilities than other public or private insurance programs. Medicaid is also the dominant payer for mental health services for poor children and of community services for adults with serious mental illnesses. Medicaid now contributes over half of all spending on public mental health system community services.<sup>5</sup>

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Over the past few years, the Administration has proposed, and sometimes implemented, changes to Medicaid that weakened its role as the basic insurer of low-income individuals with very serious healthcare needs. Among examples are proposed changes to coverage of community services for children and adults with mental disorders and other disabilities. These changes would have adversely affected rehabilitation services, school-based services and targeted case management. If implemented, they would have reduced states' ability to pay for the most effective, evidence-based services. However, in July 2008, legislation was enacted to impose a moratorium on issuance of these regulations (and others) until April of 2009.

These proposed rules limiting services for people with mental illnesses should be taken off the table. However, clarification of some of the issues raised in them is still needed. Without such clarification, states may be cautious and seek to cut back services that were called in question by these proposals.

The proposed rules also highlighted two policy areas where new legislative authority may be needed because the underlying statute is either unclear or inadequate. One was a policy denying reimbursement for physical health ailments of children placed in psychiatric residential treatment facilities. The other involved denial of coverage for therapeutic foster care. Medicaid law should be amended to authorize payment for physical healthcare for children in residential placements and to specifically cover therapeutic foster care as a Medicaid service.

Therapeutic foster care is an evidence-based practice that has shown significant cost-savings when compared with placement in large treatment centers. It also has better outcomes. It allows children who must be placed out of home to remain in their home communities while receiving services from specially trained adults in a structured setting. For children who would otherwise be in a residential institution, this is a far better option.<sup>6</sup>

The statute's definition of coverage for children placed in residential treatment centers can be interpreted to exclude coverage of their physical healthcare.<sup>7</sup> Congress therefore needs to clarify its intent on this question.

Another Medicaid issue is the categorical nature of adults' eligibility. For children, eligibility is closely linked to income. For adults, low income is insufficient because the person must also fall into one of several other eligibility categories. However, significant

numbers of adults with serious mental illnesses do not meet these standards. Many are single adults without SSI disability benefits and cannot now qualify for Medicaid.

## SCHIP

Like Medicaid, SCHIP is a partnership between the federal and state governments. It provides health insurance coverage to low-income children under age 19 whose families have incomes above the Medicaid limit but are under limits set for SCHIP by each state. The majority of SCHIP children are in families with incomes at or below 200 percent of the federal poverty level.

States have flexibility in the design of their SCHIP programs. They can cover SCHIP children under Medicaid or they can create a new, separate state program. New state programs are either modeled on private insurance plans (benchmark plans detailed in the law) or they can be uniquely designed programs that are approved by the Secretary of Health and Human Services. States using the separate state option can choose not to provide mental health benefits, as these services are not required under SCHIP law. The SCHIP plans that do include mental health services will be subject to a new federal parity law (requiring parity in mental health and substance abuse benefits with medical/surgical benefit in terms of cost-sharing and treatment limitations).<sup>8</sup>

***SCHIP should also be improved as part of health care reform. Mental health and substance abuse benefits should be included in the list of services that must be covered.***

As health reform issues are debated, it is important to continue SCHIP, particularly the option to enroll SCHIP children in Medicaid. However, SCHIP should also be improved as part of healthcare reform and SCHIP children should have coverage for all medically necessary services through inclusion of an EPSDT benefit identical to that in Medicaid. Mental health and substance abuse benefits should be included in the list of services that must be covered. States should also require SCHIP plans to employ strategies that will promote coordination and collaboration between mental and physical health providers.

## Medicare

Medicare provides healthcare coverage not only for seniors but also for other adults who receive federal Social Security Disability Insurance benefits. It covers hospital, nursing home and limited home health care (Part A), outpatient services (Part B) and prescription medications (Part D). Parts B and D are voluntary. Medicare Part C, the Medicare Advantage program, offers managed care options. Part C provides coverage through health maintenance organizations, preferred provider organizations, special needs plans and private fee-for service plans. The federal government pays Medicare Advantage plans a capitated monthly premium to provide all Parts A and B services and Part D, if offered by the plan.

Part D is complicated. There is a \$275 deductible for covered drugs (in 2008) for people with incomes of 150 percent or more of the federal poverty level, a monthly premium and a subsidy for the cost of the drug. Part D is operated through a number of private plans. As a result there are different degrees of cost-sharing, depending on the plan. For most beneficiaries (except those with the lowest incomes) there is a gap in coverage. Coverage ends after the beneficiary has spent generally above \$2,400 in total drug costs and does not resume until out-of-pocket spending reaches \$3,850, at which time Medicare will cover 95 percent or more of medication costs.

**Medicare rules are a significant barrier to effective operation of medical homes and other programs that co-locate mental health with physical health care services.**

Recent Medicare amendments have improved coverage for mental health outpatient services. Legislation enacted in 2008 required parity for Part B outpatient mental health services by 2014. However, this applies only to the limited range of mental health services covered under Part B—therapy and medication management. Additional services, such as psychiatric rehabilitation and case management, which are covered by Medicaid, are critical for individuals with serious mental illnesses and should be added to the Medicare benefit package.

Medicare is also the driver of many health policies in this country. Its reimbursement policies are generally followed by private insurers and often by state Medicaid programs as well. This has been detrimental to achieving better integration of mental health with physical healthcare. As providers seek to co-locate these services, the Medicare rule that no provider entity can bill the program for two services on the same day becomes very problematic. It is a significant barrier to effective operation of medical homes and other programs that co-locate mental health with physical healthcare services.

### **Recommendations**

Medicaid and SCHIP must continue to operate as part of a total national system of healthcare coverage. Both programs play a unique role in the financing of healthcare for low-income people and address critical needs of individuals who are often poor insurance risks. Medicare is also a vital program for seniors and people with a disability.

However, these programs can be strengthened in several ways:

- **Medicaid:** Federal law should be amended to allow payment for physical healthcare, as well as mental health care, for children in residential placements.
- **Medicaid:** Federal law should be amended to include therapeutic foster care as a reimbursable service for children who would otherwise be placed in a Medicaid-covered psychiatric residential treatment facility.
- **Medicaid:** Federal rules should facilitate, and not impede, provision of the most cost-effective services. This requires a flexible payment structure, such as bundled rates and case rates, to reimburse for services that involve several specific interventions.
- **Medicaid:** Federal law should be amended to create eligibility for all adults with incomes at or below the federal poverty line.
- **SCHIP:** Benefits should be comprehensive and modeled on the EPSDT benefit in Medicaid, which covers all medically necessary services for children with a diagnosed health or mental health condition.
- **SCHIP:** Mental health services should be required in all SCHIP plans.
- **SCHIP:** Incentives to improve integration of mental health and physical healthcare for children should be in place. Strategies could include medical homes, co-locating mental health specialists in pediatric offices, specialized units offering clinical case management services and establishing integration work groups that monitor the quality of mental health services for children and make recommendations for improvement.
- **Medicare:** Federal rules should be amended to clarify that reimbursement is

available for more than one visit to a provider entity in any one day, particularly when the purpose of each visit is to treat a different disorder.

- **Medicare:** Medicare law should be amended in order to cover basic psychiatric rehabilitation services, such as skills-training, for individuals with disabilities who are covered by the program.
- **Medicare:** Federal law should be amended to end the 24-month waiting period for Americans with disabilities receiving Social Security Disability Insurance (SSDI). Such individuals should be allowed to receive immediate coverage, as do other eligible individuals, including those with end-stage renal disease and amyotrophic lateral sclerosis—life-threatening illnesses that currently fall under the waiting period exception.

1 Gary Smith, Cille Kennedy, Sarah Knipper, John O'Brien and Janet O'Keeffe. "Using Medicaid to Support Working Adults with Serious Mental Illnesses in the Community: A Handbook." Research Triangle Institute. January 2005, U.S. Department of Health and Human Services. Available at <http://aspe.hhs.gov/daltcp/reports/handbook.htm>

2 Howell, E. "Access to Children's Mental Health Services Under Medicaid and SCHIP". Urban Institute, Series B, No. B-60, August 2004, p 1-7. Available at [http://www.urban.org/UploadedPDF/311053\\_B-60.pdf](http://www.urban.org/UploadedPDF/311053_B-60.pdf)

3 Christopher Loftis and Eileen Salinsky, "Medicare and Mental Health: The Fundamentals". National Health Policy Forum. November 27, 2006. Available at [http://www.nhpf.org/pdfs\\_bp/BP\\_Mcare&MentalHlth\\_11-27-06.pdf](http://www.nhpf.org/pdfs_bp/BP_Mcare&MentalHlth_11-27-06.pdf)

4 Sandra M. Foote and Christopher Hogan, "Disability Profile and Health Care Costs of Medicare Beneficiaries Under Age Sixty Five, *Health Affairs*, 20 no 6 (November/December, 2001), pp. 242-253, available at <http://content.healthaffairs.org/cgi/reprint/20/6/242.pdf>.

5 Sarah Steverman, "Mental Health". National Conference of State Legislatures, June 2007. Available at [http://www.ncsl.org/programs/health/forum/mental\\_health\\_FAQ.htm](http://www.ncsl.org/programs/health/forum/mental_health_FAQ.htm)

6 The 1999 Mental Health Report of the Surgeon General. Available at <http://www.surgeongeneral.gov/library/mentalhealth/home.htm>

7 The Centers for Medicare and Medicaid Services (CMS) maintains that these centers are "Institutions for Mental Diseases" under the law. When individuals are placed in IMDs the state is not eligible for federal Medicaid matching funds. Specific legislative language allows provision of psychiatric services to children in these settings, but there is no specific authority for federal payment for their physical health care.

8 Public Law 110-343



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