NAMI State Advocacy
National Alliance on Mental Illness

Public Mental Health Service Funding: An Overview

Public mental health services are shaped by multiple sources of funding. The two primary sources of funding are Medicaid and state general fund dollars, which on average fund 90 percent of the system. However, 10 percent of the system is funded by Medicare, federal mental health services block grant funds and county as well as municipal funds. For youth facing serious mental health conditions, funding for services may also be provided by other sources, including schools and the State Children's Health Insurance Program (S-CHIP).

State mental health services and community mental health programs are suffering deep cuts despite rising demand for mental health services. When funding for public mental health services is inadequate to meet demand, state agencies and community mental health programs must cut services, restrict eligibility for care or both. As a result, many youth and adults are not getting the help they need.

Primary Funding Sources: Medicaid and State General Mental Health Funds

Medicaid Funding

Medicaid is a combined federal and state program that provides funding for health and long-term care services for certain categories of low-income Americans. Medicaid is rapidly becoming the largest source of funding of public mental health services for youth and adults living with mental illness. In fiscal year 2006, the most recent year that data is available, 44 percent of state mental health funding came from Medicaid.[1]

Medicaid is jointly funded with federal and state money. Federal funding is provided at a federal match rate, or Federal Medical Assistance Percentage (FMAP), that ranges from 50-76 percent of overall funding, depending upon the economic status of the state. This means that every dollar a state invests in their Medicaid program brings at least another dollar in federal contributions.

Eligibility rules for Medicaid are complicated and vary from state to state. In most states, individuals who are eligible for federal Supplemental Security Income (SSI) are automatically eligible for Medicaid. Because each state designs its own Medicaid program, services vary from state to state. Thirty-nine states and the District of Columbia either provide Medicaid automatically to SSI recipients or use the same criteria for determining Medicaid eligibility. Eleven states use separate criteria for determining Medicaid eligibility: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia.[2]

Every state dollar cut from a Medicaid budget results in the loss of a dollar or more in federal funds, increasing the total impact of state budget cuts.

States are required by federal law to cover children under age six with family incomes below 133 percent of the federal poverty level, as well as children aged 6-18 with family income below the federal poverty level. Additionally, many states cover "optional" Medicaid populations, including people with disabilities who may not qualify for SSI but whose income falls below the federal poverty level.

However, significant numbers of single adults, parents and children and youth are ineligible for their state Medicaid program because they don't meet stringent disability or income criteria, even though many have serious or chronic mental health needs, are uninsured and/or have exhausted private coverage.

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What Services Does Medicaid Provide?

Federal law requires Medicaid to cover certain mandatory services such as physicians, laboratory and x-ray services, nursing home services and home health care services.[3]

Most mental health services, including prescription drugs, are optional services, meaning that states are not required to cover them. However, all states currently cover prescription drugs and many states cover other vital services for youth and adults living with mental illness, such as case management services, rehabilitation services and other evidence-based services for youth and adults. Some states will also pay for transportation to medical appointments or other appointments with Medicaid. Because each state designs its own Medicaid program, services vary from state to state.[4]

States are generally required to cover inpatient and outpatient hospital services under Medicaid. However, inpatient services in public psychiatric hospitals and similar facilities are not usually reimbursed with federal Medicaid dollars for adults ages 22-64.[5]

States are also required to cover Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for eligible children under age 21, which guarantees that children will have access to medically necessary services, whether or not these services are generally covered in the state's Medicaid program.

What Are Medicaid Waivers?

In general, details about Medicaid eligibility and services covered under Medicaid can be found in state Medicaid plans. Medicaid waivers (exceptions) may be authorized by the federal government to allow states to innovate and try new approaches to covering low income individuals and people with disabilities under Medicaid.

States have used waivers to expand eligibility for uninsured children and adults previously ineligible for Medicaid, implement managed care systems, create home and community-based alternatives to institutionalization, increase cost-sharing and/or use innovative service delivery systems. All Medicaid waivers must be budget-neutral, meaning that federal spending can be no higher under the waiver than it would have been without the waiver.

State General Mental Health Funding

Historically, states have used general mental health funds to fund services for adults and youth who do not qualify for Medicaid. However, states are increasingly using general mental health funds for Medicaid enrollees in order to benefit from federal Medicaid matching funds, thus spending less for individuals who live with serious mental illness who do not qualify for Medicaid.[6]

State general mental health funds may be used to pay for an array of community-based services, as well as inpatient treatment in state psychiatric hospitals. In fiscal year 2006, the most recent year for which data is available, an average of 70 percent of state mental health agency expenditures were spent on community-based services, with 28 percent spent on state psychiatric hospital services.[7]

What Is the State Mental Health Budget?

The state mental health budget is typically made up of one or more budgets[8] that are primarily funded by state general fund dollars to provide state hospital and inpatient care, crisis services and community mental health services for children and adults. The state mental health budget is separate from the state Medicaid budget (made up of state Medicaid dollars and federal matching funds), which funds mental health services for Medicaid enrollees.

State mental health budgets are important because they fund needed treatment and supports that are either not covered by Medicaid due to federal rules or because they were not included in the state's Medicaid plan design. In

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addition, state mental health budgets provide critical services for people living with mental illness who are uninsured or underinsured or awaiting eligibility for Medicaid.

Who's Eligible for Community Mental Health Services?

Eligibility for community mental health services varies from state to state and sometimes within a state. Generally, services are prioritized for people in crisis and/or children or adults who are severely impacted by serious mental illness.

During budget crises, non-Medicaid community mental health services often suffer disproportionate cuts because officials want to avoid reductions to Medicaid, where cuts are compounded by the additional loss of significant federal matching funds. As a result, eligibility for services for children and adults who are not enrolled in Medicaid may be severely reduced.

What Services Do Community Mental Health Programs Provide?

Like eligibility, the array of mental health services and support available through community mental health programs varies from state to state. In some states, a wide range of services are available, including screening and assessment, effective therapies, peer support services, respite, medications, case management, family psycho-education, assertive community treatment (ACT) teams, integrated co-occurring disorders treatment, Supportive Housing, Supported Employment, jail diversion and crisis services and inpatient and longer-term care. In other states, services are extremely limited.

Secondary Funding Sources: Medicare, S-CHIP, Local Government and Community Mental Health Block Grants

Medicare

Medicare is another important source of funding for mental health services in the public sector comprising approximately two percent of funding for public mental health systems. Although Medicare is commonly thought of as a program for senior citizens, younger people with disabilities are eligible for Medicare two years after they qualify for federal Social Security Disability Insurance (SSDI) benefits.[9]

Medicare does not cover a broad range of community-based services, unlike most Medicaid programs. Medicare pays for inpatient treatment (up to 190 days during a beneficiary's lifetime) and outpatient office visits with a limited range of professionals, such as psychiatrists, psychologists, clinical nurse specialists and other allied mental health professionals. Medicare also pays for prescription drugs under the Part D program.[10]

Medicare requires co-payments (co-pays) of 50 percent for outpatient mental health treatment. Due to recent federal legislation, these outpatient co-pays will gradually reduce to 20 percent by 2014.

State Children's Health Insurance Program (S-CHIP)

S-CHIP is a program providing federal matching funds to states for health insurance to children whose family incomes are too high to qualify for Medicaid. S-CHIP now includes a mental health parity mandate, but services vary depending on a state's CHIP plan design.[11] In some states, children enrolled in S-CHIP receive the full range of the state's Medicaid mental health services. In other states, the S-CHIP plan's mental health benefits may be less comprehensive than through the state's Medicaid program.

Local Government: County and Municipal Mental Health Funding

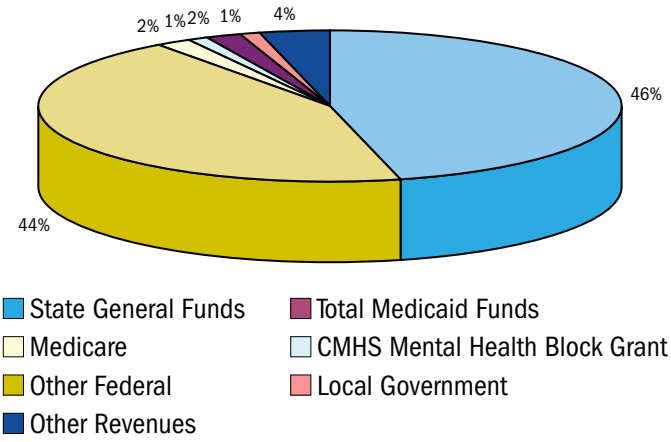
Mental health services may be administered and partially funded at county or municipal levels. In a number of states, counties set priorities and oversee mental health services at the local level. In FY 2006, an average of one percent of state

controlled mental health revenues came from local funding sources,[12] but the actual amount contributed by county and municipal governments for public mental health services is believed to be considerably higher.

Community Mental Health Services Block Grant

The Community Mental Health Services Block Grant is a federal program administered by the Center for Mental Health Services (CMHS) to foster innovation and improvements in community-based services for youth and adults living with mental illness. Grants are awarded to states based on a funding formula. In FY 2006, the Block Grant constituted an average of one percent of state mental health funding.[13]

State Mental Health Authority Controlled Revenues FY 2006



Endnotes

[1] NASMHPD Research Institute, "Table 24: SMHA-Controlled Mental Health Revenues, By Revenue Source and by State, FY 2006," www.nri-inc.org/projects/Profiles/RevExp2006/T24.pdf.
[2] Social Security Online, www.socialsecurity.gov.
[3] Center on Budget and Policy Priorities, "Policy Basics: Introduction to Medicaid," (Dec 17, 2008). www.cbpp.org/cms/index.cfm?fa=view&id=2223.
[4] For a copy of your state plan amendment, contact your state Medicaid agency or visit www.cms.hhs.gov/MedicaidGenInfo/StatePlan/list.asp#TopOfPage.
[5] A federal Medicaid law provision called the Institutions for Mental Diseases (IMD) exclusion prohibits use of federal Medicaid dollars for services in IMDs, defined as facilities serving individuals between the ages of 22-64 with 16 or more beds, at least half of which are psychiatric beds. As a result of this exclusion, state hospital care is primarily funded with state general fund dollars.
[6] Frank, R, Goldman, HH, Hogan, M: "Medicaid and Mental Health: Be Careful What You Ask For," Health Affairs 22(1): 101-113, (2003).
[7] NASMHPD Research Institute, "Table 8: SMHA Mental Health Controlled Per Capita Expenditures For State Mental Hospital Inpatient Services, Community Services (State Hospital and Other Community-Based), Research, Training and Administration, FY 2006," www.nri-inc.org/projects/Profiles/RevExp2006/T8.pdf.
[8] In some states, there may be several mental health budgets. For example, if the state hospital system is in a separate department or agency from the state mental health authority, it will have a separate budget. For ease of reading, "state mental health budget" is used in this fact sheet to refer to any non-Medicaid budgets for mental health services.
[9] In contrast to SSI, which provides income assistance to aged, blind or disabled individuals with low incomes and limited resources, SSDI is intended to replace a portion of a worker's income if illness or disability prevents him or her from working.
[10] For more information about Medicare mental health benefits, see Centers for Medicare and Medicaid Services, "Medicare and Your Mental Health Benefits," www.medicare.gov/publications/pubs/pdf/10184.pdf.
[11] For more information about the S-CHIP program, see Kaiser Commission on Medicaid and the Uninsured, "Health Coverage of Children: The Role of Medicaid and CHIP, (October 2009). www.kff.org/uninsured/upload/7698-03.pdf
[12] NASMHPD Research Institute, "Table 24: SMHA-Controlled Mental Health Revenues, By Revenue Source and by State, FY 2006," www.nri-inc.org/projects/Profiles/RevExp2006/T24.pdf.
[13] *Ibid.*

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