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USE MEDICAID FOR GROWTH, NOT JUST TO AVOID CUTS

By Michael B. Friedman

In recent years most mental health advocates in New York State, including me, have become realists. We've been buffeted by bad times and have come to believe that not losing ground and getting a few minor gains are successes worth crowing about. It wasn't always that way. We used to expect, and get, major growth in community mental health services while also getting cost of living adjustments to protect current services. That was a long time ago, I admit, but with a better economy on the horizon, it may be worthwhile to revisit the past to encourage us to raise expectations for the future.

Given the general drift to rely on Medicaid to finance mental health services, it is particularly important to understand that in the early 1990's New York State's policy regarding the use of Medicaid to support mental health services underwent a major change.

In the late 1970's and the 1980's Medicaid supported a significant increase in outpatient mental health services at the same time that the State invested its own funding in the development of housing and community support initiatives. Medicaid was used to increase mental health services, not to stabilize them at current levels.

Towards the end of the 1980's the first major change took place. The State decided to control the establishment of new programs using Medicaid by introducing the "Medicaid neutrality cap." This regulatory provision released NYS from the prior regulatory requirement to approve needed, fiscally viable, new program development even if it relied on Medicaid to be fiscally viable. Under the new provision the State could block new program development if the provider could not show a source of the state share of Medicaid funding for the program other than increased state spending. In some cases local governments adopted the same approach.

The Medicaid neutrality cap did not stop outpatient program development using Medicaid, but it slowed it considerably.

In the early 90's an even more profound change took place. New York State discovered that it could replace state and local funding with federal funding by using Medicaid more extensively for existing programs. First, the State introduced Comprehensive Outpatient Program Services (COPS), a supplemental Medicaid rate for mental health clinics so as to replace some State, local, and philanthropic financing with federal funds. Later, the State extended COPS to other outpatient programs. It also moved to use Medicaid to fund some community residences—again making it possible for state and local governments to cut their expenditures while maintaining services at current levels. Soon, a new form of Medicaid licensure will be introduced—Personal Recovery Oriented Services (PROS)—

which will make it possible to once again supplant state funds with federal funds, this time for rehabilitation programs.

The critical point is that in the early 90's New York State, and its local governments, made a vast change in their fundamental policy regarding the use of Medicaid—from a policy of program growth in response to unmet need to a policy of holding the line by substituting federal funds for state and local funds.

Because mental health spending has grown over the past decade, some people will probably take issue with this analysis. But let's take a look at the big picture. According to OMH planning documents, gross spending in the public mental health system has increased in New York State from approximately $4 billion in 1993 to $4.8 billion in 2002 and perhaps something over $5 billion today. However, due to inflation, $4 billion in 1993 is equivalent to $4.98 billion in 2002, suggesting that public spending on mental health in New York State has not kept pace with inflation over the past dozen years or more.

This may seem mysterious. After all the State provided additional funding of $200 million when Kendra's Law passed; there are 9000 more housing units now than in 1993; and there have also been increases in case management, assertive community treatment, peer support, and other community services.

But in fact new program development has been funded in two ways other than overall growth of funding: (1) via redistribution and (2) by failing to provide adequate cost of living adjustments to existing programs, many of which are now on the verge of crisis.

Redistribution makes sense. The shift from an institution-based mental health system to a community-based mental health system should result in substantial redistribution, and I have been a strong proponent of the Reinvestment Act, through which savings from reductions in state hospitals have funded new community services.

But the goal of the original Reinvestment Act was to fund **new** programs with savings from state hospitals, while state and local governments maintained funding for current services, including funding to cover inflation. Sadly that is not what happened. Funding for existing services has consistently eroded when the costs of inflation are taken into account, despite the use of federal Medicaid funds to replace state and local funds.

Over the past decade New York's state and local governments have, in essence, rejected the obligation they previously accepted to provide funds for the service system to grow while also providing adequate funding to sustain existing programs.

> But isn't it clear that we need funding for both stability and growth? And, as the economy improves, shouldn't we advocates call for state and local governments to once again accept their responsibilities to people with mental illnesses?

To do so, New York's funding policy needs to change in four ways.

1. Medicaid should be used to support program growth as it was in the 70's and 80's.

2. When Medicaid can be used to replace state and local funds, freed funds should be used to support new mental health program development.
3. State, local, and Medicaid funding should keep pace with inflation, preferably by instituting an automatic annual cost of living adjustment ("trend factor") like that used in the health system.
4. The Medicaid neutrality cap should be eliminated.

I know I sound wildly unrealistic. But I am old enough to remember when it was the basic policy in New York State to provide stability ***and*** growth. And I am optimistic enough to believe that it can be done again.

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