Perspectives on Systems of Care

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Storm clouds over the public mental health safety net

For over a decade, mental health policy experts have warned about the expanding role of Medicaid in the financing of care for persons with serious mental illness. Not that the expanding role is a bad thing—indeed, many of the innovations in care for consumers with serious mental illness in the areas of case management, new treatment approaches, and medications have been disproportionately borne by state Medicaid programs. With the federal match, states have learned to leverage state dollars—often very creatively—to grow their mental health programs. In many cases one dollar spent for state services such as public psychiatric hospitals, which have been excluded from Medicaid reimbursement for adult patients, can grow into two or three dollars of Medicaid-eligible services—for example, for general hospital psychiatric beds or assertive community treatment programs. But what these experts have warned is that maximizing Medicaid reimbursement—and its attendant privatization of service providers—has shifted funding away from the public safety net for persons not eligible for Medicaid, shifted the policy balance away from state mental health authorities with expertise in and commitment to these consumers, eliminated public hospital beds, and neglected the public mental health workforce—the last item to the point of a national crisis. With many states confronting sizeable budget shortfalls, Medicaid, even with its allure of leveraging for states, has become a seductive target for cuts in eligibility, optional services, or provider reimbursement, pitching the burden of care back to the now frayed public mental health safety net.

Two articles in this issue post sobering reminders about these real-world policy strains. McFarland and coauthors convincingly demonstrate that massive reductions in eligibility for persons with serious mental illness in Oregon's Medicaid program drove substantial new demand for historically reduced state psychiatric hospital beds. This "deleveraging" means the state bears the full cost of services previously cost-shared with the federal government and renews stiff competition for public mental health resources. Elsewhere in the issue, Dodds and coauthors offer a troubling longitudinal analysis of insurance coverage for consumers with early psychosis, finding two-thirds lacked continuous insurance coverage in the first year of follow-up—this coming at a critical time in their illness trajectories. Will expanded federal eligibility for Medicaid in 2014 remedy these worrisome coverage gaps? Possibly for those within 133% of the federal poverty level, but under health care reform newly eligible consumers are guaranteed mental health coverage equivalent to only basic health plans, not the array of optional Medicaid services that have massively raised the bar for recovery-oriented community-based care. Protecting Medicaid and non-Medicaid state mental health funding will require enormous vigilance and advocacy.