

TESTIMONY OF
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SENATE SPECIAL COMMITTEE ON AGING
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Chairman Smith, Senator Kohl, and distinguished members of the Committee, my name is Pamela Hyde, and I am Secretary of the New Mexico Human Services Department (HSD). HSD is responsible for New Mexico's Medicaid program and also administers other federal and state programs such as TANF, Food Stamps, Child Support Enforcement, and LIHEAP. As Secretary, I work with my colleagues in other departments across the state on health insurance and service delivery issues for children, families, seniors, and persons with disabilities, including persons with behavioral health needs. In other times of my life, I served as Ohio's Mental Health Director, Seattle's Housing and Human Services Director, and the CEO of Maricopa County's (in Arizona) Regional Behavioral Health Authority or RBHA. Over the years, I have had the privilege of consulting with many jurisdictions about behavioral health and services for persons with disabilities, including the use of Medicaid as a fund source for such services. I was the consultant assisting the President's New Freedom Commission on Mental Health's Subcommittee on Medicaid until I was appointed by Governor Richardson as Secretary of HSD in New Mexico.

In this role, since 2003, I have had the privilege to lead our state's innovative approach to behavioral health services financing and service delivery. New Mexico's Interagency Behavioral Health Purchasing Collaborative brings together 15 agencies to jointly purchase services for persons with mental health and substance abuse service needs, using multiple fund sources (including Medicaid, federal block grants, state general funds, child welfare funding, and other state and local funds). This joint purchase will be through one vendor to create a single and consistent statewide behavioral health delivery system throughout New Mexico. We are in the process of transitioning to that vendor multiple types of funds from six of those state agencies beginning July 1, 2005.

With Congress and the Administration engaged in the process of considering reductions of billions of dollars in Medicaid, it is important to try to understand how this enormously complex program works, what services it provides, and who the people are that it serves. I am grateful to the Chairman and to this Committee for conducting this careful scrutiny and honored to have the opportunity to assist. I am especially grateful to Chairman Smith for his leadership in trying to find compromise in this process and for resisting massive federal budget cuts to this critical program. I am also grateful for New Mexico's Senate leaders – Senator Bingaman who is a champion for the Medicaid program and for the low-income people and children it serves; and Senator Domenici who has been a spokesperson for persons with mental illness and their families.

Today, I would like to make three points about the role of the Medicaid program in serving persons with mental illness and/or substance abuse/addictions, and make three recommendations.

First, Medicaid is a critical source of funding for the services upon which persons with mental illness and/or substance abuse/addictions rely, and reducing that funding will not make these needs go away. Rather, individuals served through Medicaid are often severely disabled by mental illness or substance abuse, and without services designed to assure their ability to live and work in the community, they end up in other systems where their services will be significantly more costly (for example, emergency rooms or inpatient facilities) or will be inappropriately addressed (for example, jails/prisons or homeless shelters). The costs to society, to these other systems, and to the individuals themselves and their families are significantly higher than serving them appropriately through the Medicaid program where state and federal governments share the cost of community-based rehabilitative and supportive services that allow them to live and succeed in jobs, schools and communities.

According to data published in 2002 by the US Department of Health and Human Services, 16 percent of adult Medicaid beneficiaries and 8 percent of children use mental health services. Medicaid recipients of mental health services are generally adults or children with psychiatric disabilities who need on-going services due to the severity and chronic nature of their disorders. About 1.2 million adults receive Supplemental Security Income (SSI) and therefore Medicaid benefits due to a psychiatric disability; 260,000 children receive SSI and Medicaid due to a psychiatric disability. However, some of the adults most in need of mental health and addiction services are not quite disabled enough to receive a disability designation.

In most states, for example in New Mexico, if adults do not have children or are not disabled enough to be on SSI/SSDI, they are not eligible for Medicaid. As a result, they rely on paltry amounts of state general fund dollars from the General Assistance program for their food, housing and health care. Many states have eliminated similar programs so that such individuals have nowhere to turn. The irony is that in many states, a member of a “mandatory” population (for example, a low income TANF family) with a less critical clinical need may be entitled to a “mandatory” service such as a physician visit while an “optional” high need, high risk adult or child cannot get an “optional” service such as ACT, MST or medications.

According to federal SAMHSA and CMS officials, Medicaid programs spend nine to 17 percent of their overall expenditures on mental health and addiction services. In the early part of this decade, Medicaid became the single biggest source of funding for public mental health services administered by states (not including in-prison services for inmates of correctional facilities), accounting for over 50 percent of public mental health expenditures and more than a third of the mental health expenditures managed by state mental health agencies. In New Mexico, Medicaid accounts for over 60 percent of those expenditures and will account for almost 75 percent of the expenditures purchased through the Interagency Behavioral Health Purchasing Collaborative.

According to one study,¹ states spend four percent of its substance abuse expenditures for the treatment and prevention of substance abuse and addiction and ninety-six percent of its expenditures for the impacts on families, children, and other systems of not treating those substance abuse needs. States need federal assistance to increase their expenditures on mental health and substance abuse services, not decrease them by reducing federal funding or forcing states to reduce the single most important source of funding for behavioral health treatment and supportive services.

Second, many of the populations, and most of the services considered to be optional in the Medicaid program are simply not optional for persons with mental illness and/or addictions. Persons with mental illness are treated differently – one could say even in a discriminatory manner – compared to persons with other disabilities or medical needs in the Medicaid and Medicare programs.

“Optional” but critical services for persons with mental illness are available to states largely through what is called the Rehabilitation or Rehab Option. Mandatory services include outpatient, inpatient and physician services. However, they do NOT include medication monitoring or prescription medications, clinical services of psychologists and social workers, or personal assistance services. Mandatory services do NOT include those community based services that are particularly helpful for the management of symptoms and life with mental illness. They also do NOT include those now widely accepted evidence-based practices such as assertive community treatment (ACT), family psychoeducation (FPE), multi-systemic therapy (MST) or targeted case management (TCM). These are all services that are not optional by any means for adults with serious mental illness or children with severe emotional disturbances.

As states are forced to reduce the costs or the growth in costs of their Medicaid programs, they have no choice but to reduce access to services for those populations that are considered optional or to reduce optional services. Since some populations in need of behavioral health services and almost all the services needed by seriously mentally ill adults and severely emotionally disturbed children are optional, these artificial distinctions have a disproportionate impact on such individuals.

In waiver processes, CMS sometimes allows states to exclude optional mental health benefits from limited benefit package approaches to controlling Medicaid costs. Coupled with the disparate treatment of mental illness and substance abuse in the Medicare program, persons with mental illness are often treated differently and unfairly. Their physical health costs increase; their costs to other state/federal programs grow.

Third, Medicaid rules and regulations stifle creativity in the treatment of persons with mental illness and addictions, and prevent the utilization of evidence-based practices for such individuals. Some of the most appropriate supportive services for adults and children with mental illness or emotional disturbances such as supported

¹ National Center on Addiction and Substance Abuse at Columbia University. (2001). Shoveling up: the impact of substance abuse on state budgets. New York, NY: Author, 13.

employment or housing arrangements for adults, integrated treatment approaches for persons with co-occurring disorders, and after school therapeutic programs for children are difficult if not impossible to obtain approval for – even through waivers as they are for other disabled populations. Because the Medicaid program for mentally ill individuals is medically rather than rehabilitatively oriented and because of the historical unwillingness of the federal program to pay for institutional care for adults with mental illness that had previously been paid for by states, a so-called IMD (Institutions for Mental Disease) exclusion is enforced for adults between the ages of 18 and 64. The IMD exclusion prevents states from making the case they are required to make about the financing of home and community based services in order to obtain waivers to fund these appropriate supportive services for adults with mental illness. Such waiver services are available for persons with developmental disabilities and other disabling conditions.

Again, states find themselves in the awkward situation of being required to fund medically oriented services for populations that would best be served by a rehabilitative or supportive therapies approach. The mandatory and optional categories do not work well for persons with behavioral health needs.

There are a number of recommendations that were made by the consultants who finished the background paper for the Medicaid Subcommittee of the President's New Freedom Commission on Mental Health. However, I want to highlight only three recommendations as you consider Medicaid reform and how it will impact persons with behavioral health needs.

First, Medicaid reform cannot be disconnected from Medicare. Many adults with serious mental illness are dually eligible for both programs. Until the Medicare Part D program begins, these adults receive their prescription drug services from Medicaid, and some of their physician or inpatient services through Medicare. Once Medicare Part D begins, many of these individuals will find themselves dealing with multiple formularies and having to receive some of their medications through Medicare, some through Medicaid, and some not through either (that is, they will have to self-pay for medications Medicare will not cover and that a state elects not to continue covering). Medicare does not cover all of the needs of persons with mental illness, especially not the Medicaid optional rehabilitative services, so coordination of benefits is necessary and is always difficult for the individual, their families and their providers.

Additionally, dually eligible individuals have to wait two years to become Medicare eligible. They may receive Medicaid services during that two years, then they must switch to those services that Medicare will cover once the waiting period is through.

At the least, the two year waiting period should be eliminated so that these dually eligible individuals can be covered by Medicare upon receipt of their disability determination. Better yet, Medicare should pick up all the medication costs for this population from the day they are determined to be disabled, and should assure that the

formularies cover all the drugs they need, including the newest anti-psychotic medications that have less side effects and therefore higher compliance rates.

Best, Congress should seriously consider having the federal government take over the whole care of persons who are dually eligible, perhaps starting with those who are eligible due to mental illness and/or substance abuse. The savings to systems, to providers, and to states in not having to deal with coordination of benefits and the associated administrative burdens would be enormous. The simplification of process and better coordination of care for such individuals would be equally significant.

Second, make it simple to allow states to put evidence-based practices into their state plans or into waiver programs. States have to wait long periods of time for approvals of state plan amendments and waiver requests even if they are changes other states have been doing for years. New Mexico is waiting for approval of the addition of ACT teams to its state plan. Anything another state has been allowed to do, especially if it helps to implement an evidence-based practice for adults or children with behavioral health needs should be allowed on a fast track approach through forms and technical assistance from CMS regional offices charged with helping states do so. Rehab Option services should not only be allowed but be encouraged for all states. And, CMS needs to work with states to come up with creative ways to deal with the IMD exclusion so that housing supports and supported employment can be available to persons with mental illness and addictions just as they are for DD and other populations taking part in home and community based services waivers.

Third, as Congress considers reforms, do not make those reforms different for optional and mandatory populations or services without considering what may not be optional in the lives of those with serious behavioral health needs. Every state is now seeking to constrain the growth in health care costs. To the extent Medicaid is experiencing that growth because of increased pharmaceutical costs and increased eligibility of older and higher cost individuals, states are seeking the same kind of ability to control these rising costs as the federal government. CMS should work with states to find ways to do so without hurting those most reliant on the Medicaid and Medicare programs. The attitude seems to be that the federal government wants to control its costs and leave the states to figure the rest out on their own. The assumption is that states are going to behave inappropriately in order to gain more of the federal government's money instead of realizing that we are in this together; it's a partnership; and we share common goals

Congress has given CMS more funding to implement Medicare Part D, and put auditors into every state regularly and constantly. The Administration has proposed funding for the federal government to do additional outreach to get more eligible people enrolled, especially children. States want to do all these things, too. However, no one has given the states more money to implement all the administrative changes that are being put on their plates to implement Part D. No one has given me more staff to answer all the questions and produce all the reports demanded of us by the CMS

auditors. No one has given me any money to do the additional outreach we'd like to do but cannot afford because we do not have the state match to serve additional people who might enroll.

If we get more people on the program (and we'd like to do so) I will simply have to do additional cost containment strategies to stay within my Medicaid budget. This in a state with high uninsurance rates, high poverty, and significant mental illness and substance abuse needs. This in a state that has been penalized from the beginning of the SCHIP program because we took a step before the federal government did to increase eligibility for children. That means we lose SCHIP dollars every year when other states get to use them for the very same population.

States are not the enemy. We have less flexibility than the federal government does. We do not want to be in the situation where we have to reduce services or eligibility that will hurt the most vulnerable individuals with mental illness because the federal government wants to preserve services to "mandatory populations" and reduce its own spending on so-called "optional" ones. The states and the federal government have a common goal to contain costs while providing critical services to those most in need. We should work together to do so. Thank You.