Almost one in five children suffers from a mental illness or serious emotional disturbance that, without treatment, may limit school performance, cause great distress for children and families, and increases overall physical health care costs. Nevertheless, approximately 75 percent to 80 percent of children in need of treatment do not receive services. Despite the service gap, a considerable number of states reported scaling back children's mental health services in fiscal years 2002 and 2003, and several states have reported feeling the effects of the tightened belt in 2004.

Since 2000, states have faced a daunting fiscal environment that has necessitated difficult choices. The crisis hit from two directions: less tax revenues and increasing numbers of poor people who depend on public programs for health care and basic needs. States already have enacted substantial cost containment strategies to cope with shortfalls, but they are likely to consider additional cuts or changes to balance budgets that may affect mental health services. Thirty-one states reported budget shortfalls in fiscal year 2005, with a deficit of about $37 billion, and 26 states project a combined budget gap of $24.7 billion in fiscal year 2006.

Although public mental health programs are not among the hardest hit, they have not been spared. All funding streams that provide children's mental health services—in particular, state mental health agencies, Medicaid and State Children's Health Insurance Program (SCHIP) programs—have sustained budget cuts. Although children's health programs are high priorities in many states—and most common cost-saving strategies do not specifically target children—most cuts inevitably affect children's services. At the same time, strained finances have forced state governments to develop creative methods of bringing services to children who need them. Many states have responded with innovative programs to maintain—and, in some cases, improve—public mental health resources. This paper provides an overview of how state budget cuts affected children's mental health care and reviews implications for the current system and potential trade-offs for policymakers to use as they make decisions about services for children.

**Public Managed Behavioral Health Care**

In 2003, 38 states provided children's mental health services through managed care arrangements. These organizations were not immune from budget reductions either. The authors of the Health Care Reform Tracking Project at the University of South Florida's Research and Training Center for Children's Mental Health surveyed public sector managed care systems for children in 37 states to gauge the effects of various approaches on children and adolescents with mental illnesses, and their families. The researchers found that more than three-quarters of managed care systems (78 percent) reported damaging effects from recent budget cuts. The most common effects that made services less accessible to children and adolescents were:

- Reductions in services for uninsured children and adolescents (45 percent of states);
- Elimination of specific populations from the managed care system (34 percent);
- Reducing or eliminating the amount, duration or scope of services (25 percent); and
- Initiating or raising co-payments (25 percent).

States communicated that, due to budget cuts, they had to take measures such as decreasing the capitation or case rates to managed care organizations or implementing more stringent treatment authorization policies, despite the challenges that these measures posed for managed care providers. States also described the negative effects of budget cuts on other child-serving systems, resulting in reduced interagency coordination; less coverage for Medicaid, SCHIP and other high-cost/high-need populations; and a decline in the use of risk-adjusted rates and other risk adjustment mechanisms.
State mental health agencies did not escape the budget ax, which affected all people who access mental health services, not only children. A survey of 42 state mental health agencies found that most (35) had revenue shortfalls in fiscal year 2003 that resulted in budget cuts in 29 states. Thirty-two states anticipated budget cuts in the following fiscal year. The average state mental health agency cut in fiscal year 2003 was 4.4 percent, and ranged from zero to 12.5 percent. The average expected cuts in fiscal year 2004 were at 7.2 percent, but ranged from zero to 26 percent. Table 1 displays how some agencies reported that cuts would affect state residents.

Respondents anticipated more of the same for fiscal year 2003: 67 percent of states planned program changes to reduce or contain costs for children’s mental health services. Many of the cuts were planned for community-based services, such as therapeutic interventions, and after-school and summer programs. The report concluded that, although all children involved in the public mental health system could be affected, the most significant access problems probably would emerge among uninsured children. Federal matching funds allow state governments to expend fewer resources to treat Medicaid and SCHIP-enrolled children, while serving uninsured children can only be accomplished by state-only children’s mental health programs.

### Medicaid and SCHIP Funding

Medicaid is the only provider of care for some people with serious mental illness, particularly children, and now funds more than half of public mental health services administered by states. Experts predict that Medicaid will increase to two-thirds of all public mental health expenditures in 10 to 15 years. Depending on the state, between 25 percent to 50 percent of those who receive state mental health services receive them only from Medicaid.

"Between 25 percent to 50 percent of those who receive state mental health services receive them only from Medicaid."
Balancing Budgets and Health Services: Children’s Mental Health in an Era of Budget Cuts

Cost-cutting in Medicaid and SCHIP can affect mental health care for children by making families and children ineligible, tightening services and increasing co-payments. A Kaiser Family Foundation report found that, despite already considerable reductions, in fiscal year 2005, all 50 states are planning at least one new cost-containment action for their Medicaid programs that could restrict access to care. SCHIP programs were affected as well. Another Kaiser report found that, between April 2003 and July 2004, 23 states had to take steps to decrease eligibility for children and families. States use a number of tools to contain costs, including pharmacy cost controls, eligibility restrictions, reduced benefits, increased copayments and frozen or reduced provider payments.

- **Pharmacy cost controls.** Pharmaceuticals—and psychotropic medications in particular—have driven up Medicaid costs, and several states have taken initiatives to curb spending. New psychotropic medications, such as selective serotonin reuptake inhibitors (SSRIs) and new antipsychotic drugs, may work better, but they also cost more. As figure 1 shows, 43 states planned pharmacy cost controls for fiscal year 2005, including limiting access to prescription medicines through preferred drug lists, prior authorization, limits on the number of prescriptions per month, and requiring that patients use older, less expensive drugs before they receive newer ones. Limiting prescription benefits too severely may pose serious difficulties for people with mental illness, which may reverse any cost savings. In a 1998 federally funded study, the Lewin Group found that reductions in Medicaid prescription budgets gained by excluding effective drugs from coverage is more than offset by increases elsewhere in the system, such as increased hospitalization and emergency room visits. The Florida Psychiatric Society found that a year’s worth of psychotropic medication is equivalent to the cost of two visits to a crisis stabilization unit. States might want to evaluate whether a change in pharmaceutical policies might drive up costs elsewhere in the system.

- **Restricted eligibility.** States can reduce the number of groups they cover under Medicaid or tighten income eligibility standards. In order to reduce costs, 25 states took action in 2004, and 14 reported plans to do so in fiscal year 2005. Some states have made enrolling in Medicaid more difficult by increasing administrative requirements. Eight states have reversed previously adopted simplifications that facilitated SCHIP enrollment and restored stricter requirements for reporting and verification. For example, enrollment in SCHIP dropped by 149,000 children in Texas since the beginning of 2004, partly due to a new requirement that families renew their children's coverage more frequently. This increases the chance that children will lose coverage if families are unable to comply within the time limits. Seven states froze SCHIP enrollment between 2003 and 2004 to reduce cost overruns. In Washington, new eligibility verification policies for the Medicaid program caused 20,615 people—primarily children—to lose coverage from April through December 2003. Given the large number of children who rely on Medicaid for mental health care, reducing eligibility often leaves children without access to treatment.

- **Reduced benefits.** Nine states reported plans to reduce or restrict optional Medicaid benefits for fiscal year 2005. Most mental health benefits are optional under Medicaid rules. Children have some protection from benefit cuts in the Medicaid Early Periodic Screening, Diagnosis and Testing (EPSDT) statute, which requires states to screen and provide treatment for any physical or mental disorders detected among all Medicaid-enrolled children. However, a 2003 study revealed that only 23 states had adequate screening tools or resources to detect and treat mental illness in the EPSDT program. Furthermore, state-based children’s mental health care benefits have been cut over the last four years in almost every state despite this protection. Figure 2 provides examples of specific benefit reductions in children’s mental health services. Three states reduced funding for or closed residential facilities and two cut funding for community mental health centers. One state severely reduced funding for crisis services, while another eliminated several children’s mental health services altogether.

- **Increased copayments.** Sixteen states implemented or increased required premiums for families enrolled in SCHIP between 2003 and 2004. Many children with serious mental disorders have chronic conditions and need ongoing, frequent care. Imposing co-payments on a low-income population that relies heavily on Medicaid for mental health services could limit families’ ability to obtain needed services. On September 1, 2003, Maryland started collecting a $37 per month premium from the parents of about 6,000 children who formerly received a

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**Figure 1. State Medicaid Changes that Limit Access to Psychotropic Medications in Fiscal Year 2004**
- Implementing Average Wholesale Price (AWP) less greater discount: 17 states
- Including more prescriptions under prior authorization laws: 32 states
- Establishing preferred drug lists: 30 states (2003 and 2004)
- Requiring new or higher copayments: 17 states
- Seeking supplemental rebates: 21 states
- Requiring generics: 5 states
- Limiting number of prescriptions per month: 5 states

comprehensive health care package at no cost. Since July 2004, almost 45,000 Georgia children enrolled in the state’s SCHIP program, PeachCare, have lost program coverage as a result of new regulations and higher premiums (the maximum monthly premium increased from $20 to $70) instituted to help balance the budget. Beneficiaries who pay late now will lose coverage for at least three months.

- **Frozen or reduced provider payments.** Forty-seven states adopted plans to freeze or reduce provider payments in 2005. These changes often frustrate providers, potentially decreasing the number who want to provide Medicaid mental health services and subsequently narrowing beneficiaries’ access to care. In fiscal year 2003, Kentucky, Nevada and Texas froze or reduced mental health provider rates. A shortage of children and adolescent mental health providers already exists; the American Academy of Child and Adolescent Psychiatry reports that there are 7,000 child and adolescent psychiatrists in the United States. However, the estimated need for all children with mental health concerns is 33,000 providers. Low and decreasing reimbursement rates might prolong state staffing shortages and hinder their ability to recruit additional providers.

**Other Stakeholders in the Children’s Mental Health System**

Budget cuts often have a ripple effect; changes in one agency may affect services throughout the system. Because kids are going to other systems to gain access to treatment, focusing on budgets only for mental health or Medicaid systems ignores several other venues for seeking services. For example, Medicaid restrictions also may limit mental health, child welfare, education and juvenile justice programs, curbing children’s access to mental health services in other child-serving agencies. Table 3 shows several state agencies that use Medicaid funds outside the managed care system to provide children’s mental health services.

State child welfare systems have documented the reduced availability of mental health services due to budget cuts. In 2001-2002, the U.S. Department of Health and Human Services conducted the Child and Family Service Reviews to help states improve child welfare services. These reviews cited measures such as narrowing eligibility for services for children with a diagnosis of serious emotional disturbance (or those who are overtly acting out); reducing community contracts; and decreasing support of interagency initiatives. They also identify specific effects on service—longer waiting lists, shorter treatment sessions, limited funds for psychosocial exams, low reimbursement rates for Medicaid providers, and limits on Medicaid-reimbursable services—that continue to pose challenges for the system.

**Promising State Strategies**

Persistent budget constraints have forced states to more critically examine how money is being spent and to become more creative in providing mental health services with fewer resources. “Despite challenging times,” Sheila Pires, partner at the Human Services Collaborative in Washington, D.C.,...
elaborates, “states can use this opportunity as an impetus to restructure their children’s mental health systems, develop more comprehensive systems of care and reduce fragmentation.”

Many states have responded to budgetary pressures with innovative programs to maintain— and, in some cases, improve—public mental health services and to achieve the best use of funds. States are increasingly focusing on treatment outcomes and evidence-based services to ensure that precious taxpayer dollars are spent wisely. Some examples follow.

**California: Proposition 63.** California will tax the richest state residents who earn more than $1 million each year to supplement current mental health funds. The Ballot Initiative that passed by a 53 percent to 47 percent margin in the November 2004 election is expected to raise an additional $275 million in 2004-2005 (partial year) and $750 million in 2005-2006.

**Illinois: Children’s Mental Health Partnership.** Instead of reducing services, Illinois formed a partnership in 2003 to develop a plan of short- and long-term recommendations for comprehensive, coordinated mental health prevention, early intervention and treatment services for children. Mental health stakeholders met to determine how to allocate funds in the most cost-effective and efficient manner to best promote and sustain children’s mental health, development and well-being.

**Missouri: Mental Health Medicaid Pharmacy Partnership Program.** The pharmacy utilization management program educates and engages providers in a dialogue about practice standards in prescribing psychiatric medications. The program identifies providers with practices that deviate from best practices (such as more than three psychiatric medications for a child) and sends them mailed alerts and information about current best practices instead of imposing penalties. The changes in both practice and cost have been substantial. The state has saved more than $7.7 million in 2004.

**New Mexico: Interagency Behavioral Health Purchasing Collaborative.** To fully maximize funding and address concerns of all stakeholders in the mental health system, New Mexico created a new collaborative group across all state agencies involved in mental health to reduce fragmentation in financing and service delivery and to pool funds from all groups. The group has selected ValueOptions to manage the collective finances and services for all groups, and interagency work groups participate in program planning.

**Vermont: Home and Community-Based Waiver.** Vermont is one of four states that has a home and community-based Medicaid waiver for children who have a mental illness serious enough to require inpatient care but who can be more effectively served in the community. A 2004 evaluation showed that not only do families and providers prefer the services provided under the waiver, but the program is cost-effective as well: the cost per child per day under the waiver was $156, compared to $1,200 for inpatient services.

**Wisconsin: Tax Equity and Financial Responsibility Act (TEFRA) Option.** Wisconsin uses the TEFRA Option, also known as the Katie Beckett Option, to expand Medicaid eligibility to children whose mental illness meets requirements for institutional Medicaid but who would rather remain at home, regardless of income level. Of the 21 states with TEFRA options, only eight serve children with a serious emotional disturbances.

### Lessons for State Lawmakers

**Make the Best Use of Existing Funds**

As policymakers develop budgets and assess program changes, they may wish to determine if they are making adequate use of their current funding. According to Pires, “States should look to see when kids could be diverted into less expensive and more clinically beneficial community programs.”

Do not let increases in demand thwart investment in services that work, Pires warns. “Unfortunately, as demand for successful, community-based services increases, states may grow nervous and want to reduce expenses, which may have the contrary result of requiring more deep-end, expensive services for those kids down the road.” A report by the Massachusetts Association of Behavioral Health Systems confirms that Medicaid spent $19.5 million to continue hospitalization for hundreds of children with mental illness who no longer needed acute care and most likely would have recovered more quickly in less restrictive and less costly settings. The report concluded that providing appropriate care for these children in home- and community-based programs would have saved the state at least $7 million. The children remained “stuck” in expensive, locked wards because other programs were full. Other studies have shown that providing appropriate psychotropic medications may avert costly hospitalization.

One caveat to cutting institutional programs, however, is that adequate community-based programs need to be in place. A January 2005 study revealed that more than half of California’s juvenile detention facilities house youth who are awaiting mental health treatment. The state cut funding to mental health agencies and, with diminished access to treatment, some youth who have serious mental disorders ended up in detention centers even without criminal charges. California detention centers spend more than $10 million annually to
house children who need mental health treatment. Youth who are awaiting mental health services stay an average 34 days longer than other detainees.\textsuperscript{35}

**Avoid Duplication of Services**

Within states, children’s mental health programs are decentralized and spread across various agencies. Counties often work with different reporting systems, technologies and delivery programs, which makes communication and coordination difficult. The mental health, Medicaid, child welfare, juvenile justice and the education system provide services for children, and it is not unusual for children to be involved in multiple systems that do not communicate or coordinate. It is difficult to evaluate the effects of budget cuts upon children’s health because states must look across programs with discrete budgets and review data from a variety of systems. Legislators should have a complete understanding of how their state agencies finance and deliver children’s mental health services. For example, does one agency provide most of the services, or are mental health services provided by several agencies? Increased interagency collaboration could streamline service delivery, reduce fragmentation for consumers and improve the continuity of care. In addition, collaboration may improve funding efficiency, since services would be less likely to be duplicated in other systems.

**Early Treatment Cuts Costs**

Focusing on early intervention services is another key strategy. As Darcy Gruttadaro, director of the Child Adolescent Action Center, National Alliance for the Mentally Ill, explains, “Early intervention can lessen long-term severity of mental illness. Cutting services will mean that states have to pay for kids down the road—and probably at a significantly higher price because they are on the deeper end of the spectrum.”\textsuperscript{34} From an investment standpoint, funding early intervention services is wise; it avoids increasing the intensity of treatment because complex or costly conditions are managed before they become more severe. Serious episodes may result in immediate short-term costs to health budgets through increased visits to emergency departments, rehospitalizations and crisis management services, as well as long-term costs if conditions worsen. Gruttadaro concludes, “It does not make good fiscal sense to wait, delay or reduce services.”

**Be Aware of Trade-offs**

Using Medicaid waivers to expand access to insurance means that states must severely limit the amount and scope of services offered. For example, some states have pursued Medicaid Health Insurance Flexibility and Accountability (HIFA) Section 1115 waivers to expand Medicaid eligibility for the uninsured. HIFA waivers allow states not only to expand Medicaid coverage but also to cap enrollment, reduce benefits and increase cost-sharing for “optional” Medicaid beneficiaries. To afford expansions, states may have to reduce services and impose high cost-sharing. Utah, for example, expanded Medicaid coverage to a much broader population, but had to eliminate most mental health and substance abuse benefits in order to pay for the expansion.\textsuperscript{35} Oregon adopted a Section 1115 waiver in February 2003; most of the savings resulted from eligibility restrictions and enrollment reductions due to increased premiums. About half of those remaining in the program reported an unmet mental health need. An early survey of people who disenrolled from the Oregon plan reported that 80 percent had an unmet mental need.\textsuperscript{36} Jennifer Bright, the vice president of state health policy at the National Mental Health Association, comments that, although attempts to increase coverage are worthy endeavors, states should be wary of severely ratcheting down services, especially for children.\textsuperscript{37} Children’s mental health disorders are most effectively—and least expensively—treated when addressed before the problems become severe. Holding down services in one program also may result in diffusion of costs to other systems, such as education, child welfare and juvenile justice.

**Use Evidence to Prove Effectiveness**

Finally, Pires recommends that legislators consider which services are most effective before they make changes. Do the services used have evidence-based support or have they been shown to be effective in a target community?\textsuperscript{38} Various psychosocial and psychopharmacological treatments, community and prevention services and school-based approaches are available that consistently have been shown to help kids. The mental health research community has made great strides in understanding how to treat childhood mental health disorders and have recognized specific treatment programs as evidence-based or as promising practices. Legislators may want to focus on treatment outcomes achieved by existing programs to determine if programs achieve positive outcomes and are appropriate for children and families. A detailed analysis may reveal that kids could be treated more effectively and at a lower cost in the community. Investing in services that have been shown to be effective can reduce long-term symptoms and costs.

**Conclusion**

In recent years, policymakers have had to cope with rising health care costs and substantial unmet need for children’s mental health services. These conditions have necessitated service cuts, eligibility reductions, shrinking provider payments and new copayments for recipients. They also have spurred a host of creative responses from states and providers, including interagency collaboratives, pharmaceutical reviews.
that focus on evidence-based treatment and provider training, group purchasing and early intervention. State legislators have an increasing array of options that they can use to exercise control over their states’ budgets while maintaining quality mental health services for children and families.

**NOTES**

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6. National Association of State Mental Health Program Directors Research Institute Inc. (NRI), *“State Mental Health Budget Shortages”: FY ’03 ’04, “State Profile Highlights no. 03-01 (January 2003).*
19. William Kanapaux, “Budget Cuts Threaten State Medicaid Programs.”


34. Darcy Gruttadaro, director of the Child Adolescent Action Center, National Alliance for the Mentally Ill, phone conversation with author, January 18, 2005.

35. Jennifer Bright, vice president of state health policy at the National Mental Health Association, phone conversation with author, January 12, 2005.


37. Jennifer Bright, vice president of state health policy at the National Mental Health Association, phone conversation with author, January 12, 2005.