



*The Interplay between Medicaid DSH Payment Cuts, the IMD Exclusion and the ACA Medicaid Expansion Program: Impacts on State Public Mental Health Services*

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**EXECUTIVE SUMMARY**

**This bulletin has been prepared to inform State Mental Health Agencies (SMHAs) and other mental health stakeholders on the interplay between Medicaid disproportionate share hospital (DSH) payments, the Medicaid Institutions for Mental Disorders (IMD) exclusion, the new Medicaid expansion program embodied in the Affordable Care Act (ACA), and declining state mental health budgets – and the impact of this “perfect storm” of events on state public mental health systems and people with serious mental illness.**

DSH payments will be significantly reduced beginning in 2014. Through specific provisions in the ACA, the Department of Health and Human Services (HHS) is required to cut supplemental Medicaid payments to hospitals with high a proportion of publicly insured and uninsured patients on the theory that expansions in health insurance coverage under the ACA will lower uncompensated care costs in safety net facilities. However, this process will create an unintended risk to the mental health safety net system. Due to the ACA provisions on DSH payment cuts, safety net hospitals could see reductions close to \$22 billion from 2014 to 2021. NASMHPD has informed policymakers that a number of SMHAs depend on DSH payments as a significant source of Medicaid funding for state psychiatric hospitals.

Overall, DSH dollars represent a sizeable share of the \$37 billion nation-wide under the direction of SMHAs – including community-based care – so losses of this magnitude will further erode resources available to address the needs of individuals in state hospitals and community-based safety net programs. In FY 2010, there were 37 SMHAs that reported receiving a total of \$2.8 billion in DSH funds. This amount represented 27 percent of all state hospital revenues in FY 2010. In those states that use DSH payments to fund home- and community-based waiver programs, there will be larger constraints on the SMHA’s ability to meet Olmstead objectives. These concerns are exacerbated by recent losses sustained in state funding for mental health programs, approaching \$5 billion across the last five fiscal years in 41 states.

Another critically important dynamic of this perfect storm scenario is that the Federal Medicaid matching payments for hospital services are prohibited for institutions for IMDs that includes those levels for the population between the ages of 22 and 64.

NASMHPD also has informed policymakers that on top of the DSH payment reductions, because the ACA does not eliminate Medicaid’s prohibition on reimbursing IMDs or state psychiatric hospitals for care provided to Medicaid recipients, these institutions will not be able to collect Medicaid reimbursement for care to currently eligible or newly eligible Medicaid adult beneficiaries – at the same time DSH payments will erode.

Another major factor in this policy dynamic is that beginning in 2014, the ACA expands Medicaid to include a new mandatory eligibility group: all adults under age 65 with income up to 138 percent of the federal poverty level (FPL).

Originally, it was assumed that all states would implement the ACA Medicaid expansion in 2014 as required by ACA statute because implementing the expansion was required in order for states to receive *any* federal Medicaid funding. However, the Supreme Court ruled in 2012 that the federal government cannot terminate federal Medicaid funding a state receives for its current Medicaid program if a state refuses to implement the new Medicaid expansion initiative. The Supreme Court ruling has unleashed a financial scramble on whether states should take or leave new funds offered through the new Medicaid expansion at a 100 percent match rate between 2014 and 2016 and tapering off to 90 percent in 2020. Regardless of their decision, states will experience DSH payment reductions. Currently 18 states have indicated to HHS that they will not opt in to the new Medicaid expansion program.

It will be the worst of all worlds if some states choose not to participate in the Medicaid expansion at the same time their DSH funds are reduced, the IMD exclusion remains in force and state mental health programs suffer additional budget cuts. States will be caught in a tight payment vise as they provide care to the uninsured, but receive little or no compensation from government agencies to offset costs associated with treating uninsured people.

In states that do not expand Medicaid, there is likely to be a substantial loss of adult psychiatric beds. This oncoming “perfect storm” of budget and DSH cuts coupled with a growing uninsured population with behavioral health conditions and decreasing bed capacity demands serious consideration and a policy solution. It is incumbent for mental health advocates to reach out to all state officials making decisions about the new Medicaid expansion effort to fully inform them about the negative consequences for access to psychiatric inpatient care and community-based programs, if a state chooses to opt out of the Medicaid expansion initiative.

## Introduction

The Affordable Care Act (ACA) commits roughly \$1.2 trillion from 2014-2023 to cover millions of lower- and moderate income Americans who are uninsured. The law provides for expanding Medicaid to all adults making less than 138 percent of the federal poverty level (FPL). It also provides subsidies to help consumers with incomes too high for Medicaid to purchase coverage in state health insurance exchanges. Reduced reimbursements to hospitals help finance these new subsidies, and in return, the ACA's coverage expansion offers hospitals substantial new revenues from newly insured patients.

Over the next 10 years, Medicaid funding for DSH hospitals across all 50 states and the District of Columbia will be reduced by \$21 to \$22 billion (and Medicare DSH funding will fall by \$34 billion, but this report focuses on Medicaid DSH issues only). Conversely, the Medicaid expansion if fully implemented would provide hospitals with an additional \$294 billion in revenues over a 10-year period (a 22 percent increase above what they would have received without the ACA), and hospitals receive additional funds from newly-insured patients covered through subsidies in exchanges. However, revenues from the Medicaid expansion are not guaranteed.

*In those states that do not expand Medicaid through the ACA, hospitals will experience some of the ACA's pain – DSH cuts – but lose out on much of the legislation's promised, offsetting gains through expanding health insurance coverage to lower-income individuals and families.*

The Supreme Court in a major ruling in June 2012 allows individual states to opt out of the Medicaid expansion and will leave hospitals in those states that fail to expand, with the responsibility to provide care for uninsured people but without the offsetting revenues (provided historically through DSH payments) created by newly eligible Medicaid patients under the new expansion effort. In those states that do not expand Medicaid through the ACA, hospitals will experience some of the ACA's pain – DSH cuts – but lose out on much of the legislation's promised, offsetting gains through expanded health insurance coverage to lower-income individuals and families.

This public policy interplay could have major implications for state mental health systems and for people with serious mental illness on several levels which are described in more detail in the following sections.

## Medicaid and Disproportionate Share Hospital (DSH) Payments

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals for treating large numbers of lower-income patients. This provision is intended to recognize the disadvantaged financial situation of those hospitals because lower-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive reimbursements for services rendered to uninsured patients, and Medicaid provider payment rates are generally lower than the rates paid by Medicare and private insurance. The DSH program, which pays out about \$22 billion annually (Medicaid and Medicare together), partially reimburses nearly three-quarters of U.S. hospitals for otherwise uncompensated care provided to

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lower-income individuals.

In large part, *high-DSH* hospitals are either public hospitals (such as psychiatric hospitals), children's hospitals, hospitals located in areas of greatest economic distress, or private non-profit hospitals with a mission of providing access to care regardless of the individual's ability to pay.

As with most Medicaid expenditures, the federal government reimburses states for a portion of their Medicaid DSH expenditures based on each state's federal medical assistance percentage (FMAP). While most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. In FY 2012 alone, federal Medicaid DSH allotments totaled nearly \$11.5 billion.

The health insurance coverage provisions in the Affordable Care Act are expected to reduce the number of uninsured individuals, which means there should be less need for Medicaid DSH payments. As a result, the ACA included a provision directing the Secretary of the Department of Health and Human Services (HHS) to make aggregate reductions in federal Medicaid DSH allotments for each year from FY 2014 to FY 2020 (see chart below).

#### **ACA Annual Aggregate DSH Reductions between 2014 and 2020**

**\$500,000,000 for fiscal year 2014;**  
**\$600,000,000 for fiscal year 2015;**  
**\$600,000,000 for fiscal year 2016;**  
**\$1,800,000,000 for fiscal year 2017;**  
**\$5,000,000,000 for fiscal year 2018;**  
**\$5,600,000,000 for fiscal year 2019; and**  
**\$4,000,000,000 for fiscal year 2020**  
**Total = \$18.1 Billion**

*Source: Select Provisions of the Patient Protection and Affordable Care Act, H.R. 3590 as amended by the H.R. 4872, Health Care and Education Reconciliation Act*

*The Middle Class Tax Relief and Job Creation Act of 2012* extended the DSH reductions to FY 2021 that includes another \$4.1 billion in savings, thereby bringing total DSH cuts between 2014 and 2021 to \$22.2 billion. (The Supreme Court's decision turning the ACA Medicaid expansion program into a voluntary initiative, does not impact these DSH reduction amounts, but states' decisions about implementing the ACA Medicaid expansion could impact the allocation of the DSH reductions across states).

The full force of the DSH reductions will not occur in the initial 10-year period of the ACA

implementation or until the “out years”. However, the disturbing reality is that these cuts to DSH payments will occur, while the projected decrease in uninsured or underinsured patients is not assured in some states. Moreover, the reductions will likely vary drastically from one hospital to another, creating unintended winners and losers.

While there are some federal requirements that states must follow in defining DSH hospitals and calculating DSH payments, for the most part, states have been provided significant flexibility.

One way the federal government restricts states’ DSH payments is that the federal statute limits the amount of DSH payments for Institutions for Mental Disease and other mental health facilities.

*DSH payments will occur, while the projected decrease in uninsured or underinsured patients is not assured in some states. Moreover, the reductions will likely vary drastically from one hospital to another, creating unintended winners and losers.*

Since Medicaid DSH allotments were implemented in FY1993, total Medicaid DSH expenditures (i.e., including federal and state expenditures) have remained relatively stable. Over this same period of time, total Medicaid DSH expenditures as a percentage of total Medicaid medical assistance expenditures (i.e., including both federal and state expenditures but excluding expenditures for administrative activities) dropped from 13 percent to 4 percent.

#### **DSH Reductions and the ACA New Medicaid Expansion Program**

Without guidance from the Secretary of HHS, it is unclear exactly how the DSH reductions will be distributed among the states beginning in 2014. However, it is feasible that states’ decisions whether or not to implement the ACA Medicaid expansion could impact the magnitude of states’ DSH reductions.

In 2014, the ACA expands Medicaid to include a new mandatory eligibility group: all adults under age 65 with income up to 138 percent of the federal poverty level (FPL).

Originally, it was assumed that all states would implement the ACA Medicaid expansion in 2014 as required by statute because implementing the ACA Medicaid expansion was required in order for states to receive *any* federal Medicaid funding. However, on June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business (NFIB) v. Sebelius*, finding that the federal government cannot terminate the federal Medicaid funding a state receives for its current Medicaid program if a state refuses to implement the ACA Medicaid expansion. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules. However, based on the Court’s opinion, a state can refuse to participate in the ACA Medicaid expansion without losing any of its current federal Medicaid matching funds.

The Supreme Court’s decision only impacts the ACA Medicaid expansion, so the provision reducing Medicaid DSH allotments remains unchanged. This means the Supreme Court ruling does not affect the ACA Medicaid DSH reduction amounts or the statutory criteria the HHS

Secretary must use to determine a methodology for distributing the DSH reductions among states between 2014 and 2021.

However, the fact that some states may not implement the ACA Medicaid expansion could impact how the DSH reductions are distributed among the states. Specifically, states' decisions whether or not to implement the ACA Medicaid expansion could impact the percentage of uninsured individuals in their state, which is one of the criteria the Secretary must use to determine how to distribute the Medicaid DSH reductions among states.

The percentage of uninsured individuals in all states is expected to decrease through a series of ACA health insurance coverage provisions that increase access to health insurance coverage (most of which will be effective starting in 2014). The ACA increases access to health insurance by establishing state health insurance exchanges, which are structured marketplaces for the sale of health insurance products, and the modified adjusted gross income (MAGI) which is a new income definition used for determining Medicaid income eligibility beginning in 2014.

After the Supreme Court decision, the health insurance exchanges and the premium cost-sharing subsidies are still expected to reduce the percent of uninsured individuals in all states. However, the new Medicaid expansion program is expected to reduce the number of uninsured individuals by less than previously estimated because some states are expected to decide *not* to implement the ACA Medicaid expansion.

Regardless of whether a state decides to implement the ACA Medicaid expansion or not, all states will experience an increase in Medicaid enrollment, due to the "woodwork" effect. This is the name for uninsured individuals who are currently eligible but not enrolled in Medicaid, but due to increased media attention and outreach efforts in other states will obtain coverage.

The magnitude of states' Medicaid DSH reductions depends on a number of factors. The statute provides the HHS Secretary with criteria to use in determining the allocation of DSH reductions. The ACA instructs the HHS Secretary to make the biggest reductions to states with the lowest percentage of uninsured individuals, or to states that do not target their DSH payments to hospitals with high Medicaid caseloads and high levels of uncompensated care.

Since the Supreme Court ruling, some states have stated their intention to implement the ACA Medicaid expansion, other states have asserted that they will not implement the expansion, and other states remain uncommitted. However, it should be noted that states are not locked into their intentions regarding the implementation of the ACA Medicaid expansion. CMS has stated that states face no deadline. However, the federal government will reimburse states 100 percent for all costs in the expansion effort between 2014 and 2016, gradually tapering off to 90 percent in 2020 and remaining at that allocation level. The longer states that opt out of the expansion remain on the sidelines, the less they will receive in matching dollars compared to states that opt in by January 1, 2014 when the 100 percent match kicks in.

Most states that have indicated they will *not* implement the ACA Medicaid expansion currently have relatively high percentages of uninsured individuals and relatively lower Medicaid eligibility levels for non-disabled adults under age 65.

It appears at this time, that potential Medicaid DSH reductions are not a significant factor in states' decisions whether or not to implement the ACA Medicaid expansion because the impact of the Medicaid DSH reductions pales in comparison to other potential impacts. For instance, while the aggregate Medicaid DSH reductions from FY 2014 to FY 2021 total \$22 billion, if all states implement the ACA Medicaid expansion it is estimated that all the ACA health insurance coverage provisions could reduce uncompensated care up to \$183 billion.

*The “boarding” of mental health patients in emergency departments is a widespread problem that is on the rise, in part because of cutbacks in inpatient hospital beds and the long-standing IMD exclusion.*

### **Current Medicaid Law and the IMD Exclusion**

Institutions for Mental Disease (known as IMD) are inpatient facilities of more than 16 beds whose inpatient roster is more than 51 percent of people with severe mental illness. Federal Medicaid matching payments for hospital services are

**prohibited** for IMDs that includes those levels for the population between the ages of 22 and 64. IMDs for persons under age 22 or over age 64 are permitted, at the state option, to draw federal Medicaid matching funds.

The IMD policy has been in place since 1965 when Medicaid was enacted. State and local psychiatric hospitals housed large numbers of persons with severe mental illness at (non-federal) public expense. Congress made clear that the new Medicaid dollars were not to supplant this public effort that was already going on with resources from state and local governments. Later, exemptions for children and the elderly were added by amendment. The exclusion for adults was upheld in a Supreme Court case. In the 1980s, the 16-bed exemption was legislated as a response to the Court's decision. It made a moderate concession to the realities of deinstitutionalization, and re-stated opposition to financing "warehousing" in state mental health hospitals.

Because Medicaid beneficiaries ages 22 to 64 may not receive coverage for IMD services, many of them visit general hospitals when they experience a psychiatric episode that requires emergency care. This can place a strain on a general hospital, which may already be struggling with demand in its emergency department and is also frequently not equipped to treat patients with acute psychiatric needs.

For the Medicaid beneficiary, this may result first in a delay in treatment, and then when treatment is provided, inadequate care. Many individuals end up waiting in hospitals hallways or other emergency room areas for inpatient beds. The “boarding” of mental health patients in emergency departments is a widespread problem that is on the rise, in part because of cutbacks in inpatient hospital beds and the long-standing IMD exclusion.

*If all states implement the ACA Medicaid expansion it is estimated that all the ACA health insurance coverage provisions could reduce uncompensated care up to \$183 billion. However, several states that do not opt in to the Medicaid Expansion could be in for a rude awakening: Less DSH funds and more uncompensated care costs.*

An unacceptable consequence of the present situation is that not only is an IMD facility precluded from being reimbursed by Medicaid, but individual patients' eligibility for Medicaid is excluded while they are inpatients in an IMD. Consequently, to receive treatment for medical disorders not related to their severe mental illness, they must be discharged from the IMD setting, have their Medicaid eligibility reinstated, be treated in a medical/surgical setting, and then be readmitted to the IMD.

NASMHPD projects that the IMD exclusion coupled with the DSH payments cuts will leave many people with a mental illness unable to access needed care due to fewer available services as hospitals cut back on inpatient beds. Furthermore, although the ACA's Essential Health Benefit package includes hospital services, the reality could be that Medicaid expansion enrollees could find it difficult to access needed acute care due to a lack of hospital beds. The hospital benefit in the ACA could be a weak benefit for many individuals trying to access acute care.

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### **Where the Rubber Hits the Road: DSH Cuts, the IMD Exclusion and ACA Implementation**

While the ACA may see the expansion of Medicaid and subsidized health insurance through the exchanges as reducing the need for DSH payments, due to the IMD rule state hospitals are probably not going to be able to bill Medicaid for these services to make up for the decline of DSH funds. Instead, the expanded

Medicaid and subsidized insurance may be going into community mental health and other services not constrained by the IMD rule (thus potentially increasing over mental health funding for programs that are SMHA funded, but leaving a potential significant, harmful cut in SMHA-operated state hospital financing.

### **States with Large Amounts of DSH Dollars (numbers in millions)**

- \$578.2 M New York
- \$285.0 M Texas
- \$252.7 M Pennsylvania
- \$247.3 M New Jersey
- \$205.5 M Missouri
- \$130.4 M North Carolina
- \$126.2 M Washington (state)
- \$100.5 M Louisiana
- \$100.4 M Florida
- \$93.4 M Ohio
- \$92.9 M Michigan
- \$90.7 M Indiana
- \$89.4 M Illinois

### **States with a Large Share of Their State Hospital Revenues from DSH**

- 85.2% Maine
- 73.2% Texas
- 63.9% Pennsylvania
- 57.6% Louisiana
- 57.6% Washington
- 50.2% New Jersey
- 48.3% Missouri
- 46.7% Ohio
- 44.2% Alaska
- 43.8% Indiana
- 42.6% Arizona
- 39.7% North Carolina
- 36.2% West Virginia
- 35.7% Connecticut
- 35.5% Michigan
- 32.6% South Carolina
- 32.0% Illinois
- 30.6% Florida
- 31.9% New York

*Source: NASMHPD Research Institute, Fiscal Year 2010 SMHA-Controlled Revenues and Expenditures*

In FY 2010, there were 37 SMHAs that reported receiving a total of \$2.8 billion in DSH funds. This represents 27 percent of all state hospital revenues in FY 2010. States varied widely in how much DSH funds they received, and how large a percentage of their budget it represents.

At the same time we have this developing financial storm, the economic downturn has forced state budgets to cut nearly \$5 billion in public mental health spending over the 2009-2013 period, the largest combined reduction since de-institutionalization. Based on new data coming from the states, it appears that this trend will likely continue for several years. Meanwhile, during the same 5 year period, the state public health system has seen a nearly 10 percent increase in utilization in publicly financed inpatient and outpatient behavioral health treatment services – even as we have witnessed substantial cuts in behavioral health funding.

### **A Case Study: Key Findings from Missouri on Medicaid Expansion and the Potential Loss of DSH Funds**

In a new report – *The Impact of Strengthening Medicaid on Missouri's Mental Health System* -- four hospitals in Missouri were used as a case example of the impact of DSH cuts – which will be similar in most states – that choose **not** to expand Medicaid.

Basically the main takeaways from the Missouri report were:

- 1) The federal funding to hospitals for the uninsured (i.e., the disproportionate share payments) will be reduced by 50 percent after January 1, 2014 once the Medicaid expansion becomes available to states.
- 2) The percentage of uninsured persons on adult psychiatric units is 2 to 3 times higher than for a General Hospital as a whole.
- 3) In states that do not expand Medicaid, hospitals will lose DSH funds and still have the same portion of uninsured people and will grow in this income group. This will be a substantial loss of funding.
- 4) In order to make up for the loss, hospitals will reduce psychiatric beds preferentially or initially, because those units have a substantially higher portion of uninsured patients than other hospital units.
- 5) The loss of psychiatric beds will increase the number of people backed up in emergency rooms waiting to get an inpatient bed, and in the amount of time that ambulances and law enforcement spend driving long distances to get people to an available bed in an emergency situation.

On this latter point, the Missouri study highlights that the closure of psychiatric inpatient beds will significantly impact the Missouri Department of Corrections. More than 16 percent of inmates in the Missouri prison system have a mental illness such as schizophrenia, major depression, or bipolar disorder.

A crisis in mental health adult inpatient beds, and the resulting additional pressures on Missouri’s county and city jails, will likely to push this number higher. Missouri corrections officials have expressed deep concern about an increase in the inmate population of individuals who would normally be served through the mental health system in the community, but now will be entering the criminal justice system in large numbers and ultimately prisons.

Missouri officials have indicated that the inevitable growth in the population needing mental health services will require the state to pay the increasingly high costs of incarceration for these individuals instead of cost-effective community-based services.

**The Medicaid Emergency Psychiatric Demonstration Project**

The Medicaid Emergency Psychiatric Demonstration was created under Section 2707 of the ACA to test whether partially eliminating the prohibition against payments to IMDs for services rendered to Medicaid recipients aged 22 to 64, improves psychiatric care for people with mental illness and reduces state Medicaid program costs. HHS will oversee this demonstration initiative.

*State officials making decisions about the Medicaid expansion effort should be informed about the potential problems that people will face trying to access needed psychiatric inpatient care and community services, if a state chooses to opt out of the new Medicaid expansion initiative.*

The demonstration provides states with federal Medicaid matching funds to reimburse private psychiatric hospitals for emergency inpatient psychiatric care provided to Medicaid recipients aged 22 to 64 who are experiencing a psychiatric emergency.

This demonstration is designed to test whether providing Medicaid reimbursement for IMDs results in faster, more appropriate care for Medicaid beneficiaries with psychiatric needs and provides relief to general hospitals.

Applications for the demonstration program were limited to State Medicaid programs. Inpatient services necessary to stabilize a psychiatric emergency medical condition represent the scope of coverage under this demonstration. The specific services necessary will be determined by the beneficiary’s medical or psychiatric diagnosis and the physician's treatment orders.

Each state selects which private psychiatric hospitals with 17 or more beds can participate in the demonstration. States will contact the hospitals they wish to include in the demonstration and make arrangements to provide Medicaid payment for emergency psychiatric admissions under the demonstration.

This project will provide up to \$75 million in federal Medicaid matching funds over three years to 11 states – Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia and the District of Columbia.

Participating states will submit claims data quarterly. CMS will review data for accuracy and completeness and make the federal matching payment if data is correctly submitted and accurate.

## Conclusion

While several states are still considering whether to opt in to the new Medicaid expansion program, state policymakers and other officials need to consider the ramifications on the safety net systems in their states if they do not participate in the new expansion effort. The combination of DSH cuts and a growing uninsured population will likely have severe financial impacts on public and private hospitals and vulnerable populations like people with serious mental illness.

- If Medicaid eligibility is extended, a large number of newly eligible citizens would receive mental health services through SMHA-funded community treatment and support programs. Many of these people will be young adults, between the ages of 18-30, with developing mental illness such as schizophrenia or bipolar disorder. The state's public mental health system due to major budget cuts does not currently serve them as well as we like because they are generally uninsured and have no means to pay for their treatment.
- Through the new Medicaid expansion, community mental health centers (CMHCs) and other SMHA-contracted community behavioral health providers will engage individuals earlier in the onset of their mental illness or substance abuse. It has been proven that early intervention and treatment result in better health outcomes at lower costs especially through programs that focus on high-cost Medicaid recipients with co-occurring mental illness and chronic medical conditions.
- State hospitals, that deliver inpatient services to uninsured and indigent patients, receive millions annually through DSH payments. Under the ACA, all hospitals receiving DSH reimbursements will ultimately lose approximately 50 percent of this funding. Hospitals will lose millions in federal reimbursements for the charity care they provide, whether or not the state chooses to extend eligibility.
- The number of our acute psychiatric community hospital beds are low for adults between the ages of 18 and 65, even though the onset of serious mental illness usually occurs during the early and mid-adult years. While child and geriatric inpatient beds have lower percentages of indigent patients and have other funding streams, such as Medicare, to cover their costs, adult psychiatric inpatient beds do not.
- If Medicaid eligibility levels remain the same, many hospitals will likely be forced to reduce services to indigent patients. While the overall percentage of a hospital's indigent patients may be small, the percentage of indigent patients served in its acute psychiatric units is much higher.

*Individuals who have serious mental illness and in crisis are often involuntarily committed to acute inpatient care for diagnosis and treatment by our courts. The additional loss of acute psychiatric beds will create even greater problems for county sheriffs and city law enforcement departments that must transport these individuals, often for long distances, in search of a psychiatric inpatient bed. Local law enforcement officers already stay at the hospital emergency rooms and inpatient units for many hours as these patients are admitted to care. This situation will worsen.*

It is incumbent upon SMHAs to make sure that all state officials making decisions about the Medicaid expansion effort are fully informed about the potential problems that people will face trying to access needed psychiatric inpatient care and community services, if a state chooses to opt out of the new Medicaid expansion initiative. This potential perfect storm of budget and DSH cuts coupled with a growing uninsured population with mental health conditions with decreasing bed capacity demands serious consideration.

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To access this report, *The Interplay between Medicaid DSH Payment Cuts, the IMD Exclusion and the ACA Medicaid Expansion Program: Impacts on State Public Mental Health Services*, please visit: [www.nasmhpd.org](http://www.nasmhpd.org)

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The National Association of State Mental Health Program Directors (NASMHPD) represents the \$37 billion public mental health service delivery system, serving nearly 7 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association and is the only national association to represent state mental health commissioners/directors and their agencies.

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