Medicaid & Serious Mental Illness in New York

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Research Interest: Medicaid Coverage for New York Beneficiaries with Serious Mental Illness [1]

Medicaid enrollees commonly experience disruptions in Medicaid coverage due to financial and administrative complications, such as misconceptions about eligibility for Medicaid and unstable sources of income. Further, of those who experience disruptions in Medicaid coverage, the majority become uninsured, rather transition to other sources of insurance, such as private insurance. Disruptions in Medicaid coverage disproportionately impact the mental health outcomes of enrollees with serious mental illness, who require continuous coverage to pay for the treatments necessary to manage their symptoms. However, the New York state government lacks policies that reduce coverage disruptions experienced by or that facilitate transition to private insurance for enrollees with serious mental illness. Thus, residents of New York with serious mental illness who are enrolled in Medicaid remain susceptible to coverage disruptions that may exacerbate their symptoms.

Background on Medicaid in the United States and New York

Medicaid is a healthcare entitlement program for residents of the United States who earn low-incomes (i.e., less than or equal to 200% of the federal poverty line), with the purpose of increasing access to health care coverage and quality health care services for eligible residents.[2, 3, 4] Resident eligibility for Medicaid is established by state government officials, subject to federal guidelines which require Medicaid benefits be provided by state officials to "mandatory populations" in all states. For example, Medicaid benefits must be provided in all states to residents "who are pregnant and earn income below 138 percent of the [federal] poverty line" (FPL).[5] Although states officials may choose to not cover mandatory populations, an "alternative to eligibility and coverage" for Medicaid must be provided to residents who lose Medicaid coverage due to state officials not covering all mandatory populations;

[1] See Section, "Research Design", for definitions.

[2] U.S. Centers for Medicare & Medicaid Services (n.d.). Health coverage. *healthcare.gov*. https://www.healthcare.gov/glossary/health-coverage/

[3] Cornell Law School (n.d.). 42 U.S. Code § 234 - Health care professionals assisting during a public health emergency. 42 USC § 234(d)(2). https://www.law.cornell.edu/uscode/text/42/234#d_2

[4] Kaiser Family Foundation. MEDICAID IN NEW YORK June 2023. https://files.kff.org/attachment/fact-sheet-medicaid-state-NY

[5] Center on Budget and Policy Priorities (2020). Policy Basics: Introduction to Medicaid. *Section: "Who Is Eligible for Medicaid?"* https://www.cbpp.org/research/policy-basics-introduction-to-medicaid

the alternative must be consistent with the purposes of Medicaid. [6, 7] In addition to the mandatory population, state officials have the option to expand Medicaid benefits to cover residents other than those included in the mandatory population.[8]

In New York, eligibility for Medicaid is based on an asset test and/or an individual's annual or monthly modified adjusted gross income (MAGI).[9, 10] MAGI-based eligibility for Medicaid applies to adults under the age of 65, parents and caretakers, 19- and 20-year-olds who live alone or with their parents, children who are between the ages of 1 and 19, infants who are under 1 year-old, and pregnant women.[11] For example, as of January 2024, pregnant women who are residents of New York, live alone, and whose annual MAGI is less than or equal to $33,584 or whose monthly MAGI is less than or equal to $2,799 are eligible to enroll in Medicaid.[12] The resource test for Medicaid eligibility applies to individuals who are ages 65 and over, blind, or disabled, as well as other groups.[11] For example, as of January 2024, residents of New York who are ages 65 and over, who are below 100% of the federal poverty line, whose annual MAGI is less than or equal to $15,060 or whose monthly MAGI is less than or equal to $1,255, and who own resources (i.e., assets) worth less than or equal to $31,175 are eligible to enroll in Medicaid.[13]

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[6] Congressional Research Service (2023). Medicaid: An Overview. *R43357*. *Section: "Summary"*.
https://crsreports.congress.gov/product/pdf/R/R43357

[7] Centers for Medicare and Medicaid Services (2024). 1115 Demonstration Monitoring & Evaluation.
https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/index.html

[8] Center on Budget and Policy Priorities (2020). Policy Basics: Introduction to Medicaid.
https://www.cbpp.org/research/policy-basics-introduction-to-medicaid

[9] Modified Adjusted Gross Income equals household income plus untaxed foreign income, non-taxable Social Security benefits, tax-exempt interest, and any income deductions or adjustments. Sources: (1) irs.gov/e-file-providers/definition-of-adjusted-gross-income; (2) cms.gov/marketplace/eligibility-enrollment-resources/MAGI-rules.pdf.

[10] See "Appendix A: Eligibility for Medicaid in New York Based on Modified Adjusted Gross Income".

[11] New York State Department of Health (n.d.). MAGI and Non-MAGI Eligibility Groups. pp. 1.
https://www.health.ny.gov/health_care/medicaid/publications/docs/adm/04_attac1.pdf

[12] New York State Department of Health (2024). New York State Income and Resource Standards, Effective January 1, 2024, and Revised January 17, 2024. pp. 3-4. Office of Health Insurance Programs.
https://www.health.ny.gov/health_care/medicaid/publications/docs/gis /24ma01_att1.pdf

[13] The City of New York (2024). Preliminary Medicaid Income Eligibility Levels. pp. 1.
https://www.nyc.gov/assets/ochia/downloads/pdf/all_populations_medicaid.pdf

Although the range of benefits received by residents enrolled in Medicaid varies by state, federal law requires that state governments provide "mandatory benefits", such as inpatient and outpatient hospital services, to all enrollees.[14] However, the implementation of mandatory benefits by state officials varies by state.[15, 16] For example, in 2017, residents of New York who were enrolled in Medicaid were required by state officials to pay a fee for inpatient hospital services, while residents of the District of Columbia were not required to pay a fee for inpatient hospital services.[16]

State governments also have discretion in implementing optional Medicaid benefits.[16] The New York State Medicaid Program includes optional benefits including occupational therapy and health homes, which can provide important health benefits to individuals with serious mental illness.[17, 18, 19] However, such benefits may be removed from the New York Medicaid program at the discretion of the New York state government, as the benefits are optional.[16]

[14] Centers for Medicare & Medicaid Services (2024). Mandatory & Optional Medicaid Benefits. https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html

[15] Kaiser Family Foundation (2018). Medicaid Benefits. *State Health Facts.* https://www.kff.org/statedata/collection/medicaid-benefits/

[16] Kaiser Family Foundation (2018). Medicaid Benefits: Inpatient Hospital Services, other than in an Institution for Mental Disease. *State Health Facts.* https://www.kff.org/medicaid/state-indicator/inpatient-hospital-services-other-than-in-an-institution-for-mental-diseases/

[17] Valverde-Bolivar E, Simonelli-Muñoz AJ, Rivera-Caravaca JM, Gallego-Gómez JI, Rodríguez González-Moro MT, García-Arenas JJ. Occupational Therapy in Severe Mental Disorder-A Self-Controlled Quasi-Experimental Study. Healthcare (Basel). 2022 Mar 8;10(3):493. doi: 10.3390/healthcare10030493. PMID: 35326971; PMCID: PMC8954915.

[18] Fortuna KL, DiMilia PR, Lohman MC, Cotton BP, Cummings JR, Bartels SJ, Batsis JA, Pratt SI. Systematic Review of the Impact of Behavioral Health Homes on Cardiometabolic Risk Factors for Adults With Serious Mental Illness. Psychiatr Serv. 2020 Jan 1;71(1):57-74. doi: 10.1176/appi.ps.201800563. Epub 2019 Sep 10. PMID: 31500547; PMCID: PMC6939136.

[19] New York State (2024). Medicaid Health Homes - Comprehensive Care Management. https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Medicaid Funding and Financing

Medicaid is an appropriated entitlement program in that any resident who qualifies for Medicaid coverage in their state has the right, under federal law, to receive Medicaid benefits.[20, 21] Moreover, federal funding for Medicaid is based on the statute governing Medicaid (i.e., Title XIX of the Social Security Act) and the benefits provided to Medicaid enrollees. That is, the level of mandatory federal funding for Medicaid received by the Centers for Medicare and Medicaid Services (CMS) is determined by the legislators who oversee Title XIX of the Social Security Act. Thus, if Members of Congress do not pass the appropriation legislation necessary to fund the CMS, recipients who qualify for Medicaid "may have legal recourse".[22, 23]

The amount of mandatory funding received by state governments from the federal government for Medicaid is based on the federal medical assistance percentage (FMAP) and FMAP multiplier.[24] State governments do not receive federal funding for Medicaid if all mandatory populations are not covered by state Medicaid policies and an alternative to eligibility and coverage for Medicaid is not provided to residents who would otherwise be considered a mandatory population.[25, 26]

The FMAP establishes the percentage of Medicaid expenditures that are eligible for reimbursement by the federal government, and the FMAP multiplier establishes the amount of federal funding that a

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[20] Center on Budget and Policy Priorities (2023). Policy Basics: Non-Defense Discretionary Programs. *Policy Basics. Section: Subtitle.* https://www.cbpp.org/research/federal-budget/non-defense-discretionary-programs

[21] Wachino, V., Schneider, A., & Rousseau, D. (2004). Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds. *Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured, pp. i.* https://www.kff.org/wp-content/uploads/2013/01/financing -the-medicaid-program-the-many-roles-of-federal-and-state-matching-funds-policy-brief.pdf

[22] Heniff Jr., B. (2012). Entitlements and Appropriated Entitlements in the Federal Budget Process. *Congressional Research Service. RS20129. pp. 1.* https://budgetcounsel.com/cyclopedia-budgetica/cb-appropriated-entitlement/

[23] United States Government Accountability Office (2005). A Glossary of Terms Used in the Federal Budget Process (Supersedes AFMD-2.1.1). *GAO-05-734SP. pp. 13.* https://www.gao.gov/products/gao-05-734sp

[24] Kaiser Family Foundation (2024). Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. *State Health Facts. Section: "Notes".* https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

[25] Congressional Research Service (2023). Medicaid: An Overview. *R43357. Section: "Summary".* https://crsreports.congress.gov/product/pdf/R/R43357

[26] Centers for Medicare and Medicaid Services (2024). 1115 Demonstration Monitoring & Evaluation. https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/index.html

state government receives from the federal government per dollar spent on Medicaid.[27] For New York, the FMAP and Multiplier have been 50% and 1, respectively, since fiscal year 2011, apart from fiscal years 2020 through 2023 – during the COVID-19 public health emergency.[27]

The federal government provides broad guidelines to states regarding allowable funding sources for the state share of Medicaid expenditures. However, states are largely free to determine how to fund their share of Medicaid expenditures. Thus, funding sources vary significantly from state to state. States can use state general funds (i.e., personal income, sales, and corporate income taxes) and other state funds (e.g., provider taxes, local government funds, tobacco settlement funds) to finance the state share of Medicaid. Federal statute (i.e., the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991) allows as much as 60% of the state share to come from local government funding.[28, 29, 30] Federal regulations (i.e., 42 CFR § 433.51) also stipulate that the state share cannot be funded with federal funds (Medicaid or otherwise).[28, 31]

Brief History of Medicaid

In 1965, the legislation for Medicaid was introduced in Congress by Representative Wilbur Mills and Senator Robert S. Kerr. Medicaid was authorized as a federal and state program in the United States (U.S.) through Title XIX of the Social Security Act – the Medical Assistance Program.[32, 33]

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[27] Kaiser Family Foundation (2024). Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. *State Health Facts*. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

[28] Congressional Research Service (2015). Medicaid Financing and Expenditures. *R42640. pp. 4.* https://crsreports.congress.gov/product/pdf/R/R42640/9

[29] Congressional Research Service (2016). Medicaid Provider Taxes. *RS22843. pp. 3.* https://crsreports.congress.gov/product/pdf/RS/RS22843

[30] Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234). Health Care Financ Rev. 1992 Spring;13(3):131-5. PMID: 10120178.

[31] Cornell Law School (n.d.). 42 CFR § 433.51 - Public Funds as the State share of financial participation. Legal Information Institute. https://www.law.cornell.edu/cfr/text/42/433.51

[32] National Library of Medicine (1965). REPORT OF THE COMMITTEE ON WAYS AND MEANS ON H.R. 6675. *pp. 9.* https://www.nlm.nih.gov/exhibition/forallthepeople/img/1703.pdf

[33] Cohen WJ. Reflections on the enactment of Medicare and Medicaid. Health Care Financ Rev. 1985, pp. 10;Suppl(Suppl):3-11. PMID: 10311372; PMCID: PMC4195078. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195078/

Like today, Medicaid was established to provide health insurance to specified groups of low-income individuals and families, aiming to increase access to healthcare for previously uninsured people. The implementation of Medicaid marked a considerable expansion of social welfare services in the United States, indicating a change toward a more comprehensive approach to healthcare for vulnerable populations. It became an important safety net, aiming to ensure that low-income individuals and families receive medical care. The 1965 authorization of Medicaid included several critical elements, including the commitment of the federal government to financing states that chose to participate in the program. Federal funding for state Medicaid programs was intended to help states meet the costs of providing healthcare to individuals and families who qualified to enroll in Medicaid. Title XIX also established uniform Medicaid eligibility requirements across all states, which ensured that individuals and families in need had consistent access to healthcare services, regardless of where they lived.

Wilbur J. Cohen had a major role in creating American social policy, particularly healthcare.[34] He was an important figure in the Kennedy and Johnson administrations when he helped design and pass Medicare and Medicaid legislation in Congress. Medicaid was established to solve a specific challenge raised by Congressman Wilbur Mills, who was concerned that Medicare could evolve into a bigger, compulsory insurance scheme (i.e., insurance that residents who qualify for Medicare are required to buy). Cohen's response was to include coverage for critical groups of impoverished people, which not only addressed Mills' concern but also reflected Cohen's long-standing support for universal health insurance. Cohen developed Medicaid into a program that provided healthcare access to low-income persons and families by considering the opinions of state welfare directors.

Initially, residents eligible for Medicaid benefits included only those who received cash welfare payments from the Aid to Families with Dependent Children (AFDC) Program. This was limited to basic amenities such as inpatient hospital stays, physician visits, and nursing home care for the elderly.[35] However, the specific services provided, as well as eligibility requirements, differed significantly by state. New York's Medicaid program differs from those in other states in key ways. It expands Medicaid eligibility to the non-poor or middle class for long-term care, pays institutional providers such as hospitals, nursing homes, and institutions for the disabled at rates higher than competitive

[34] Cohen W. J. (1985). Reflections on the enactment of Medicare and Medicaid. Health care financing review, Suppl(Suppl), 3–11.

[35] Gornick, M., Greenberg, J. N., Eggers, P. W., & Dobson, A. (1985). Twenty years of Medicare and Medicaid: covered populations, use of benefits, and program expenditures. Health care financing review, Suppl(Suppl), 13–59.

costs, and permits excessive use of certain services, such as personal care and inpatient hospital care. These distinguishing qualities help to set New York's Medicaid program apart from those in other states. Further, the number of residents enrolled in Medicaid was limited, relatively to enrollment in 2024. For example, data from Statista indicates that in 1966, 4 million Americans were enrolled in Medicaid, a number that has since grown to 19 million in 2022 since then.[36] This limited reach and disparity in coverage between states underlined the need for a more comprehensive strategy.

Medicaid's role in funding long-term care (LTC), such as nursing home care and health home services for enrollees with SMI, has also grown dramatically over time, which highlights the increasing role of Medicaid as a primary source of funding for long-term care services. In 1968, Medicaid funded approximately 24% of total nursing home care expenditures in the United States.[37] This share rapidly increased over the next few decades, eventually accounting for over half of total nursing home spending in the United States by 1998. In the 1970s, home health care – a subset of Home and Community-Based Services (HCBS) – became mandatory. Medicaid's expansion to include HBCS has been a key step. This move to community-based care has been motivated by a desire to improve the quality of life for those requiring long-term care and by a recognition of the cost-effectiveness of delivering care in non-institutional settings.

Based on reporting from Kirsten Colello (2022), "the share of Medicaid [long-term services and supports (LTSS)] spending for HCBS has almost quintupled over the past three decades, accounting for 12% of Medicaid LTSS spending in FY1989 and increasing to more than half (59%) of total Medicaid LTSS spending in FY2019".[38] HCBS allows Medicaid enrollees to receive care in their own homes or communities rather than in institutions, such as nursing homes. Further, the Medicaid HCBS program has given beneficiaries additional options for obtaining care and has helped minimize reliance on institutional care, which trend toward person-centered, community-based care models.

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[36] CMS. "Total Medicaid Enrollment from 1966 to 2022 (in Millions)." Statista, Statista Inc., 13 Dec CMS. (December 13, 2023). Total Medicaid enrollment from 1966 to 2022 (in millions) [Graph]. In Statista. Retrieved April 25, 2024, from https://www.statista.com/statistics/245347/total-medicaid-enrollment-since-1966/

[37] Provost, C., & Hughes, P. (2000). Medicaid: 35 years of service. Health Care Financing Review, 22(1), 141–174. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/25372498

[38] Kirsten Colello (2022). Medicaid Coverage of Long-Term Services and Supports. *Congressional Research Service. R43328. pp. "Summary".* https://crsreports.congress.gov/product/pdf/R/R43328

Section 1915(c) waivers were created in 1981, allowing states to provide a greater range of HCBS with federal financing, which was limited to the cost of institutional care for the same persons. This transition was aimed in improving access to care for people with chronic mental illnesses, allowing them to get the help they need while remaining integrated into their communities. Based on reporting by Wiener et. al. (2002), by 1998, HCBS waivers serviced over 467,000 beneficiaries, indicating a major shift toward community-based.[39] This transition was aimed in improving access to care for people with chronic mental illnesses, allowing them to get the help they need while remaining integrated into their communities. Medicaid's HCBS's waiver program has helped to transform the way care is delivered to Medicaid-eligible people, notably those with disabilities, persistent mental illness, and other diseases. This program enables states to develop and implement innovative alternatives to institutional care, including a variety of services given in a person's home or community environment. States can adapt these waiver programs to meet the specific requirements of their populations, ensuring that persons receive the care and support they require to remain in their communities. One of the most important components of the HCBS waiver program is its capacity to meet the different needs of Medicaid enrollees. States can create waiver programs for certain populations, such as those with developmental impairments, mental illnesses, or traumatic brain injuries. These programs can provide a wide range of services, including personal care support, homemaker services, respite care, and adult day care. By adapting these programs to specific demographics, states may ensure that individuals receive the care and assistance they require to live independently in their communities.

HCBS allows Medicaid enrollees to receive care in their own homes or communities rather than in institutions, such as nursing homes. Further, the Medicaid HCBS program has given beneficiaries additional options for obtaining care and has helped minimize reliance on institutional care, which trend toward person-centered, community-based care models.

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) authorized the replacement of AFDC with the Temporary Assistance for Needy Families (TANF) block grant, which ended welfare-based eligibility for Medicaid and gave state officials increased

[39] Wiener et. al. (2002). Home and Community-Based Services in Seven States. *HEALTH CARE FINANCING REVIEW/Spring 2002/Volume 23, Number 3*. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/Review_02Springpg89_p.pdf

discretion in funding state Medicaid programs.[40] In addition, the TANF block grant established work requirements for Medicaid eligibility, time limits for receiving welfare payments, and changed state eligibility and enrollment processes for Medicaid.[41, 42] The establishment of work requirements had important negative implications for adult residents with serious mental illness, a large percentage of which do not participate in the workforce due to their condition; for example, data from the Census Bureau indicates that, in 1996, 46.2% of Medicaid enrollees not in the labor force reported being unable to work due to a chronic illness or disability, such as serious mental illness.[43] Further, TANF left state officials unable to provide Medicaid benefits through transitional medical assistance (TMA)—a program allowing residents to continue Medicaid enrollment for about 12 months following an increase in income above the Medicaid eligibility threshold in their state.[41]

The Affordable Care Act (ACA), adopted in 2010, aims to expand health care to the estimated 47 million uninsured Americans. It increased insurance coverage and expanded Medicaid eligibility. According to analysis by Christine Eibner and Peter Hussey (n.d.), by April 2015, 22.8 million Americans had received coverage through various sources, bringing the overall number of uninsured down from 42.7 million to 25.8 million.[44] One of the most contentious aspects of the ACA was the individual mandate, which required most individuals to carry insurance or pay a fine to achieve the goals of the ACA in terms of reducing the number of uninsured Americans. According to the analysis, if the mandate did not exist, an estimated 12 million people who would otherwise sign up for coverage would be without insurance.[44] The Affordable Care Act also provided subsidies to assist low-income people and families in obtaining health insurance. Christine Eibner and Peter Hussey calculated that removing subsidies in states with federally administered marketplaces would drop enrollment from

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[40] Center on Budget and Policy Priorities (2022). Policy Basics: Temporary Assistance for Needy Families. *Section: "What is TANF?"* https://www.cbpp.org/research/family-income-support/policy-basics-an-introduction-to-tanf

[41] Moore JD. Welfare Reform and Its Impact on Medicaid: An Update [Internet]. Washington (DC): National Health Policy Forum; 1999 Feb 26. (Issue Brief, No. 732.) *pp. 3*. https://www.ncbi.nlm.nih.gov/books/NBK559488/

[42] Tanner, M. D. (2016). Twenty Years after Welfare Reform: the Welfare System Remains in Place. *CATO Institute. Paragraph 8*. https://www.cato.org/commentary/twenty-years-after-welfare-reform-welfare-system-remains-place

[43] Census Bureau (1996). Reasons People Do Not Work Household Economic Studies. *1996*. https://www2.census.gov/library/publications/2001/demographics/p70-76.pdf

[44] Christine Eibner and Peter Hussey (n.d.). The Affordable Care Act in Depth. *RAND Corp.* https://www.rand.org/health-care/key-topics/health-policy/aca/in-depth.html

13.7 million to 4.1 million, with significant premium increases.[45] Medicaid expansion under the ACA was proven to benefit states by strengthening their economies and increasing access to care for the poorest populations. Despite these improvements, an estimated 19 million uninsured Americans are still ineligible for Medicaid or ACA subsidies.[45]

The End of Continuous Enrollment In New York

In response to the coronavirus disease outbreak in 2019 (COVID-19), Members of Congress declared a public health emergency (PHE) and passed legislation including the Families First Coronavirus Response Act (FFCR Act).[46] The FFCR Act included a law requiring the "maintenance of eligibility and continuous enrollment" in Medicaid, which provided all individuals, enrolled in Medicaid or who enrolled in Medicaid during the PHE, with Medicaid coverage through the end of the month that the PHE ends (i.e., continuous eligibility); that is, individuals enrolled in Medicaid or who enrolled in Medicaid during the PHE could not lose Medicaid coverage until one month after Members of Congress end the PHE.[46, 47, 48]

After Congress ended the PHE on March 31, 2023, the New York state government announced plans to end the policy of Continuous Enrollment and begin the process of unwinding as required through the Consolidated Appropriations Act of 2023. Unwinding refers to the process of redetermining the eligibility of Medicaid enrollees and the unwinding period refers to the time period during which the New York state government will redetermine the eligibility of each Medicaid enrollee. During the unwinding period, those who are determined to be ineligible or who could not finish the renewal process for Medicaid lose coverage (i.e., are disenrolled), representing a fundamental change in the New York State Medicaid Program relative to Medicaid policy during the PHE.

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[45] Christine Eibner and Peter Hussey (n.d.). The Affordable Care Act in Depth. *RAND Corp.* https://www.rand.org/health-care/key-topics/health-policy/aca/in-depth.html

[46] Moss et. al. (2020). The Families First Coronavirus Response Act: Summary of Key Provisions. Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/

[47] Congress (2020). H.R.6201 - Families First Coronavirus Response Act. *Legislation 118th Congress. pp. 134 STAT. 208 - 134 STAT. 209*. https://www.congress.gov/bill/116th-congress/house-bill/6201/text

[48] Tolbert, J., & Ammula, M. (2023). 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/

Reporting from KFF (2024) shows that, as of April 11, 2024, at least 20,104,000 residents of the United States who were enrolled in Medicaid during the PHE have lost Medicaid coverage.[49] The unwinding process has differed by state, with some states commencing the unwinding process faster than others. In New York, the disenrollment process has been complicated, with 31% of those who completed a renewal application for Medicaid being disenrolled and 69% having their coverage renewed.[49] However, due to reporting delays, these data are likely to underestimate the true number residents who have been disenrolled.

Serious Mental Illnesses in the United States

People with SMIs frequently experience considerable difficulties in finding work due to stigma, discrimination, and misconceptions about mental health. Despite attempts to promote workplace diversity and inclusion, many people with SMIs face challenges to employment, such as limited job opportunities, a lack of understanding from employers, and fears about how disclosure may affect their career chances.

According to research conducted by Alison Luciano and Ellen Meara (2014), titled "The employment status of people with mental illness: National survey data from 2009 and 2010", found that employment rates fall as the severity of mental illness grows, demonstrating a significant influence on individuals with SMIs' capacity to find and keep work[50]. 39% of persons with major mental illness had incomes under $10,000, compared to 23% of those without mental illness ($p<0.001$). Adjusted employment rates differed significantly ($p <.001$) between individuals aged 18-25 and those aged 50-64 with serious mental illness. This data also shows a significant difference in employment rates and income levels between people with SMIs and those without mental illnesses. The discovery that more than one-third of people with major mental illnesses had earnings of less than $10,000 emphasizes the economic issues that this community faces. Low income can exacerbate existing financial difficulties and restrict access to critical resources and services. The research conducted also established a job discrepancy between people with major mental illnesses and those without is especially prominent in older age groups. This shows that as people with SMIs age, the obstacles of finding work may grow more difficult, potentially resulting in long-term economic and societal effects.

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[49] Kaiser Family Foundation (2024). Medicaid Enrollment and Unwinding Tracker. *New York*. https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-state-enrollment-and-unwinding-data/

[50] Luciano, A., & Meara, E. (2014). Employment status of people with mental illness: national survey data from 2009 and 2010. *Psychiatric services (Washington, D.C.)*, *65*(10), 1201–1209. https://doi.org/10.1176/appi.ps.201300335

Furthermore, individuals with SMI frequently require intensive and long-term treatment, which may include medication, therapy, and other supportive services. This treatment is critical for managing symptoms, increasing quality of life, and lowering the chance of negative consequences like hospitalization or suicide. Despite attempts to increase access, only 64.5% of adults in the United States with SMI received mental health services in 2020, leaving a sizable proportion without adequate care[51]. Unfortunately, treating SMI incurs significant healthcare costs. Around $280 billion was spent on mental health services in 2020, about a quarter of which came from the U.S. Medicaid program[52].

Medicaid Programs and Coverage for Serious Mental Illness

The recent trend of state Medicaid programs implementing administrative barriers to enrollment, as highlighted in the article "Medicaid waivers and access to behavioral health services" by Carrie E. Fry, threatens to limit access to mental health care services for individuals with serious mental illnesses[53]. These hurdles, allowed under Section 1115 waivers, can decrease Medicaid enrollment and access to treatment for mental health and substance use disorders. Section 1115 waivers, also known as Medicaid demonstration waivers, are a Social Security Act provision that allows the Secretary of Health and Human Services to waive certain Medicaid requirements for states to conduct experimental, pilot, or demonstration projects that are likely to help promote the Medicaid program's objectives. These waivers allow states to test new Medicaid practices that diverge from federal program standards, to improve care, boost efficiency, and lower costs. States must demonstrate that their waiver ideas are budget-neutral for the federal government for the duration of the waiver and will not limit Medicaid enrollees' access to care. According to previous research on Medicaid contractions and expansions, such changes can impact access to care. For example, a study highlighted in the article discovered that persons with mental illnesses who lost Medicaid coverage had a significantly lower likelihood of receiving any outpatient mental health care than similar adults who did not lose coverage.

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[51] SAMHSA, C. for B. H. S. and Q. (2020). Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health. *Figure 32* https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR102121.htm#fig32

[52] Projections of national expenditures for treatment of ... (n.d.). *pp.15*. https://store.samhsa.gov/sites/default/files/sma14-4883.pdf

[53] Fry C. E. (2021). Medicaid Waivers and Access to Behavioral Health Services: What Is Known and What Can Be Expected. *Psychiatric services (Washington, D.C.)*, *72*(11), 1350–1353. https://doi.org/10.1176/appi.ps.202000865

Mental Health Outcomes of New York Residents Enrolled in Medicaid

Survey data from the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that 4.35% of adult New York residents reported having SMI in 2019.[54] Further, reporting from the New York City DOHMH indicates that 58% of all New York City residents who received psychiatric care in an inpatient setting during the year 2016 used Medicaid to pay for treatment.[55]

Residents of the United States with SMI tend to incur a higher cost of living than residents without SMI. For example, in a study on the medical expenditures incurred by residents of the United States from age 25 through death according to whether they were diagnosed "with SMI by age 25" (i.e., early-onset SMI), Seabury et. al. (2020) find that early-onset SMI is, on average, "associated with … 24% higher medical spending" throughout the life of residents with SMI relative to residents without SMI.[56]

In addition to a higher cost of living, data from the Patient Characteristics Survey for the years 2015, 2017, and 2019 indicates that the employment rate of survey respondents between the ages of 19 and 64 who have SMI and were enrolled in Medicaid during the survey year was between 52% and 56%. Further, of the survey respondents who have SMI, were enrolled in Medicaid, and were employed during the survey year, between 69% and 77% worked one or more part-time jobs in each survey year. Thus, "Medicaid can play a pivotal role in underwriting vital services and supports for low-income individuals with serious mental illnesses".[57]

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[54] Substance Abuse and Mental Health Services Administration (2019). Comparison Of 2017-2018 And 2018-2019 Population Percentages (50 States And The District Of Columbia). *National Survey on Drug Use and Health. pp. 57.* https://www.samhsa.gov/data/report/comparison-2017-2018-and-2018-2019-nsduh-population-percentages-50-states-and-district

[55] New York City Department of Health and Mental Hygiene (2016). Adult Psychiatric Hospitalizations in New York City. *Epi Data Brief, No. 71, pp. 1.* https://www.nyc.gov/assets/doh/downloads/pdf/epi/databrief71.pdf

[56] Seabury SA, Axeen S, Pauley G, Tysinger B, Schlosser D, Hernandez JB, Heun-Johnson H, Zhao H, Goldman DP. Measuring The Lifetime Costs Of Serious Mental Illness And The Mitigating Effects Of Educational Attainment. Health Aff (Millwood). 2019 Apr;38(4):652-659. doi: 10.1377/hlthaff.2018.05246. PMID: 30933598; PMCID: PMC6597007.

[57] Smith et. al. (2005). Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook. *U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. pp. 2.* https://aspe.hhs.gov/reports/using-medicaid-support-working-age-adults-serious-mental-illnesses-community-handbook-0

However, due to complicated administrative processes and strict financial requirements for re-enrollment, Medicaid enrollees commonly experience disruptions in Medicaid coverage and "may or may not regain coverage subsequently".[58]

In terms of financial complications, many adults with SMI who are enrolled in Medicaid "hold [one] or more part-time jobs", which contributes to variable work hours and increases the susceptibility of enrollees with such work arrangements to "coverage interruptions" when their income increases above the asset and/or MAGI-based eligibility threshold for Medicaid. For example, Dynan et. al. (2012) report on "the evolution of household income volatility" (i.e., changes in household income) in the United States between the years 1971 and 2008. [59] In the report, Dynan et. al. (2012) find that the volatility of household income is closely related to volatile work hours, implying that income volatility is, on average, highest among residents who work one or more part-time jobs.[59] Especially for those with "changing family and economic circumstances", income volatility contributes to gaps in healthcare coverage among enrollees with SMI, who tend to earn low-incomes, as disruptions in Medicaid coverage may prevent enrollees with SMI from receiving care if they cannot transition to another insurance provider.[60]

In addition to financial complications, administrative complications such as "misconceptions about eligibility, confusion about recertification, too much paperwork, and complicated lives" commonly cause New York residents who are enrolled in Medicaid to lose coverage.[61] For example, in a survey of New York residents who lost Medicaid coverage in 2008, "former beneficiaries … perceive the recertification process to be unnecessarily burdensome", "some incorrectly assumed that employment or owning a car would automatically disqualify them from coverage", and "many former beneficiaries

[58] Ji X, Wilk AS, Druss BG, Lally C, Cummings JR. Discontinuity of Medicaid Coverage: Impact on Cost and Utilization Among Adult Medicaid Beneficiaries With Major Depression. Med Care. 2017 Aug;55(8):735-743. doi: 10.1097/MLR.0000000000000751. PMID: 28700457; PMCID: PMC6684341.

[59] Dynan, K., et. al. (2013). The Evolution of Household Income Volatility. *The Brookings Institute. pp. 10.* https://www.brookings.edu/articles/the-evolution-of-household-income-volatility-3/

[60] Roberts ET, Pollack CE. Does Churning in Medicaid Affect Health Care Use? Med Care. 2016 May;54(5):483-9. doi: 10.1097/MLR.0000000000000509. PMID: 26908088; PMCID: PMC5548183.

[61] NYS Health Foundation (2009). Reducing Enrollee Churning in Medicaid, Child Health Plus, and Family Health Plus. *Lake Research Partners. pp. 4 – 5.* https://www.issuelab.org/resources/10830/10830.pdf

were unaware they had lost their coverage until they were recruited for the [survey] (i.e., they received no notification from the State)".[62]

In a report on "relationship between Medicaid [disenrollment] and service utilization among adults with major depression" (MDD), Ji et. al. (2017) find that, "the majority" of those with MDD who experience disruptions in or lose entirely Medicaid coverage "become uninsured, rather than transition to private insurance".[63] Further, following a reduction in federal funding for CMS in 2016, survey data from the Commonwealth Fund (2016) indicates that, of the adults who lost Medicaid coverage following the funding decrease, approximately 52% "were still uninsured at the time of the survey"; of the adults who lost Medicaid coverage and became uninsured, 26% were uninsured for over two years and 28% were uninsured for one to two years after losing Medicaid coverage.[64]

Due to the severity and chronic nature of major depressive disorder (MDD or major depression), patients with MDD, including those with SMI, require regular adherence to treatments recommended by physicians in order to manage the symptoms associated with their condition.[62] Disruption in or loss of Medicaid coverage may cause patients with MDD, including those with SMI, to incur out-of-pocket costs to pay for the mental health services required to manage their symptoms.[62] As a result, "patients with MDD – especially low-income patients eligible or nearly-eligible for Medicaid, for whom even a 'minor' health expense can create significant financial strain – may skip visits with mental health specialists and experience disruptions in outpatient treatment".[62]

Thus, disruptions in Medicaid coverage "increases the likelihood that deprived families and individuals only access care when they are in pain or crisis, rather than managing their conditions with support from providers through ongoing visits and consultations", which "undermines the premium necessary to provide critical services that vulnerable patients need".[65] Further, coverage disruptions or loss can

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[62] NYS Health Foundation (2009). Reducing Enrollee Churning in Medicaid, Child Health Plus, and Family Health Plus. *Lake Research Partners. pp. 4 – 5.* https://www.issuelab.org/resources/10830/10830.pdf

[63] Ji et. al. (2017). Discontinuity of Medicaid Coverage: Impact on Cost and Utilization Among Adult Medicaid Beneficiaries With Major Depression. Med Care. pp.2. 55(8):735-743. doi: 10.1097/MLR.0000000000000751. PMID: 28700457; PMCID: PMC6684341.

[64] Collins, S. R., & Gunja, M. Z. (2017). Why Millions Would Lose Coverage Under the Medicaid Expansion Changes in the House Affordable Care Act Repeal Bill. *The Commonwealth Fund.* https://www.commonwealthfund.org/blog/2017/why-millions-would-lose-coverage-under-medicaid-expansion-changes-house-affordable-care

[65] Dapkins I, Blecker SB. Homelessness and Medicaid Churn. Ethn Dis. 2021 Jan 21;31(1):89-96. doi: 10.18865/ed.31.1.89. PMID: 33519159; PMCID: PMC7843054.

exacerbate the symptoms of individuals with MDD and SMI, for example, by increasing "the likelihood of acute episodes" (e.g., "depressive delusion" experienced during episodes of psychosis, also known as acute episodes), which lead to costly and otherwise avoidable "emergency department (ED) and inpatient care" visits.[66, 67, 68]

Without financial assistance for mental health services (e.g., Medicaid), residents of New York who earn low incomes and have one or more mental illness diagnoses are more likely to experience poor social outcomes. For example, network adequacy remains an issue, as evidenced by a 2013 final rule defining the Mental Health Parity and Addiction Equity Act (MHPAEA).[69, 70] This rule expanded consumer rights to include nonquantitative treatment constraints such as geographic location, facility type, and network sufficiency.[68] However, parity regulations do not directly address cash payment to providers, resulting in low reimbursement rates attributed to lack network adequacy.[71] A 2017 analysis of private insurance claims data revealed large payment disparities between psychiatrists and non-psychiatrist medical practitioners for the same treatments, both in-network and out-of-network.[72]

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[66] Better Health Channgel (2019). Psychosis and mental illness.
https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/psychosis

[67] Harman, J. S., Hall, A. G., & Zhang, J. (2007). Changes in health care use and costs after a break in Medicaid coverage among persons with depression. *Psychiatric Services, 58*(1), 49–54. https://doi.org/10.1176/ps.2007.58.1.49

[68] Harman, J. S., Manning, W. G., Lurie, N., & Christianson, J. B. (2003). Association between interruptions in Medicaid coverage and use of inpatient psychiatric services. *Psychiatric Services, 54* (7), 999–1005.
https://doi.org/10.1176/appi.ps.54.7.999

[69] Network adequacy refers to travel times or distances from a beneficiaries' home to a given type of health care provider; the provider-to-patient ratio (i.e., the number of patients that a health care provider has); the waiting time to schedule an appointment from when the patient requests an appointment and the time the patient must wait in office for their appointment; and cultural competency (i.e., providing care to patients with "limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity." Source: *https://www.commonwealthfund.org/medicaid-managed-care-database#/topics/primary-care-access-network-adequacy*

[70] *The Mental Health Parity and Addiction Equity Act (MHPAEA)*. CMS.gov. (n.d.).
https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity

[71] Parity regulations are regulations that make it "makes it easier for Americans with mental health and substance use disorders to get the care they need by prohibiting certain discriminatory practices that limit insurance coverage for behavioral health treatment and services". Source: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html

[72] Rapfogel, N. (2020, March 23). *The Behavioral Health Care Affordability Problem*. Center for American Progress.
https://www.americanprogress.org/article/the-behavioral-health-care-affordability-problem/

These disparities, notably the lower in-network payments to psychiatrists, may deter them from entering networks, so shrinking networks and reducing patient access.

With a heavy reliance on out-of-pocket expenses, mental health care may only be available to individuals with higher earnings. According to a Milliman investigation, specifically, psychiatrists were paid a median of 13 to 20% less than nonpsychiatric medical practitioners for the same in-network evaluation and management services, depending on diagnosis severity[73]. However, for the same treatments provided outside of the network, psychiatrists were paid 28% and 6% more than nonpsychiatric doctors for patients presenting with low to moderate and moderate to severe issues, respectively. Because of this disparity, as well as the mental health workforce deficit, behavioral health professionals participate in the network infrequently. In a 2017 analysis of ACA marketplace networks, just 42.7 percent of psychiatrists and 19.3 percent of nonphysician mental health care providers participated in any network, compared to 58.4 percent of primary care physicians[74]. Furthermore, inconsistencies in provider directories and the volatility of the behavioral health provider business impede access to in-network services, lowering the likelihood that an insurer will cover a beneficiary's care. Overall, the demand for mental health practitioners outstrips the supply, and with low reimbursement rates, many clinicians may maintain a significant client base without accepting insurance, resulting in even lower insurance acceptance rates among psychiatrists than in other specialties.

Research Design

In the following sections, we analyze the extent to which the following Medicaid policies and alternatives, as presented by the New York state government, can improve the mental health outcomes of adult residents of New York with serious mental illness who qualify for or are enrolled in the New York State Medicaid Program:

1. Current Law:
    a. Unwinding Continuous Medicaid Enrollment in New York.

[73] Mark, T. L., Olesiuk, W., Ali, M. M., Sherman, L. J., Mutter, R., & Teich, J. L. (2018). Differential Reimbursement of Psychiatric Services by Psychiatrists and Other Medical Providers. Psychiatric Services, 69(3), 281–285. https://doi.org/10.1176/appi.ps.201700271

[74] Zhu, J. M., Zhang, Y., & Polsky, D. (2017). Networks in ACA marketplaces are narrower for mental health care than for primary care. *Health Affairs*, *36*(9), *pp. 1624–1631*. https://doi.org/10.1377/hlthaff.2017.0325

2. Current Alternatives:
    a. Available State Strategies to Minimize Terminations for Procedural Reasons during the Medicaid Unwinding Period.
    b. Extending 12-Month Continuous Eligibility for Medicaid to Adults with SMI.

To conduct our analysis, we collect research and data on the impact of Medicaid coverage disruptions and coverage loss on residents of New York who have serious mental illness in terms of mental health outcomes. We analyze current policy and current alternatives in terms of the criteria, as we define in the following section, "Selected Criteria".

To measure mental health outcomes, we use the continuity of care as a proxy; as we show in the report, continuity of care is generally considered to have a positive influence on the mental health outcomes of individuals with SMI.[75] Further, we narrow our sample of Medicaid enrollees who have serious mental illness (SMI) to adult residents (i.e., who are of the ages 19 through 64) of New York.

For the purpose of this report, we use the definition of SMI provided by the New York State Office of Mental Health (OMH); that is, as an individual with a designated mental illness (DMI) "according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM)", who is currently enrolled in Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) due to a DMI, who has an "impairment in functioning due to mental illness", and/or who has a "reliance on psychiatric treatment, rehabilitation, and supports".[76, 77] Examples of SMI include psychotic disorders (e.g., schizophrenia), bipolar disorder, and either major depression with psychotic symptoms (i.e., psychosis) or treatment-resistant depression (TRD).[78, 79]

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[75] See "Selected Criteria".

[76] National Institute of Mental Health (2023). Mental Illness. *Mental Health Information. Statistics.* https://www.nimh.nih.gov/health/statistics/mental-illness

[77] New York State Office of Mental Health (n.d.). Serious Mental Illness. https://omh.ny.gov/omhweb/guidance/serious_mental_illness.html

[78] Evans TS, Berkman N, Brown C, et al. Disparities Within Serious Mental Illness [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 May. (Technical Briefs, No. 25.) Background. Available from: https://www.ncbi.nlm.nih.gov/books/NBK368430/

[79] Berger, et. al. (2022). Major depression with psychotic features. Medline Plus. *National Library of* Medicine. https://medlineplus.gov/ency/article/000933.htm

Selected Criteria

To evaluate each alternative, we use the criteria of effectiveness, cost, and administrative feasibility; although other criteria remain important, we restrict our analysis to these criteria for the sake of time. Further, we evaluate each policy alternative using the same criteria to provide a balanced evaluation.

First, effectiveness refers to the extent to which the policy improves the mental health outcomes of adult residents of New York who are enrolled in Medicaid and have SMI. Specifically, we use the continuity of care as a proxy to measure mental health outcomes, as the continuity of care is generally considered to have a positive influence on the mental health outcomes of psychiatric patients, including patients with SMI.[80, 81, 82, 83, 84] For the purpose of this report, we define the continuity of care as an ongoing relationship, established with a team rather than a single provider, between a patient and one or more health care providers, as this definition is "most valued in primary and mental health care".[85]

Second, when assessing Medicaid disenrollment policy and the suspension of continuous enrollment, particularly for people with serious mental illnesses, administrative feasibility is an important factor to examine. This includes reviewing the convenience of enrolling and renewing Medicaid coverage, as well as looking at data like the enrollment rate, disenrollment rate, percentage of ineligible participants, and renewal completion rate. Understanding these criteria is critical for assessing the impact of a given

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[80] Green CA, Polen MR, Janoff SL, Castleton DK, Wisdom JP, Vuckovic N, Perrin NA, Paulson RI, Oken SL. Understanding how clinician-patient relationships and relational continuity of care affect recovery from serious mental illness: STARS study results. Psychiatr Rehabil J. 2008 Summer;32(1):9-22. doi: 10.2975/32.1.2008.9.22. PMID: 18614445; PMCID: PMC2573468.

[81] Puntis, S., et. al. (2014). Associations Between Continuity of Care and Patient Outcomes in Mental Health Care: A Systematic Review. *Psychiatric Services Volume 66, Issue 4*. https://doi.org/10.1176/appi.ps.201400178

[82] Nakic, M., Stefanovics, E.A., Rhee, T.G. *et al.* Lifetime risk and correlates of incarceration in a nationally representative sample of U.S. adults with non-substance-related mental illness. *Soc Psychiatry Psychiatr Epidemiol* 57, 1839–1847 (2022). https://doi.org/10.1007/s00127-021-02158-x

[83] Adair, C. E., et. al. (2005). Continuity of Care and Health Outcomes Among Persons With Severe Mental Illness. *Psychiatric Services Volume 56, Issue 9*. https://doi.org/10.1176/appi.ps.56.9.1061

[84] Lim, C. T., et. al. (2021). Care Management for Serious Mental Illness: A Systematic Review and Meta-Analysis. *Psychiatric Services Volume 73, Issue 2*. https://doi.org/10.1176/appi.ps.202000473

[85] Haggerty J L, Reid R J, Freeman G K, Starfield B H, Adair C E, McKendry R et al. Continuity of care: a multidisciplinary review *BMJ* 2003; 327 :1219 doi:10.1136/bmj.327.7425.1219

Medicaid policy and ensuring that administrative processes do not create hurdles to enrolling in Medicaid or maintaining coverage for enrollees with serious mental illnesses.

Projected Outcomes for Current Unwinding Law

Effectiveness of Unwinding

Using continuity of care as a proxy for effectiveness, disenrolling people with severe mental illnesses from Medicaid could result in a variety of problems, especially given the complicated and chronic nature of SMI.

Individuals with SMI account for 13% of the population receiving Home and Community Based Services (HCBS), demonstrating the high prevalence of this disease in the HCBS community[86]. For these people, the continuous and long-term care provided by HBCS is essential for controlling their diseases and preserving stability. HCBS programs are mostly supported through Medicaid waivers. This implies that if someone loses Medicaid coverage, they risk losing access to the HCBS services they require for daily living and mental health.

Additionally, the timing of the unwinding process being directly after the effects of Covid-19 puts individuals with SMI at even further disadvantage. The results of a study on Key Substance Use and Mental Health Indicators in the United States conducted by SAMHSA found that persons aged 18 and older with SMI in the previous year were more likely than those without mental illness to believe that the pandemic had a negative impact on their mental health "quite a bit or a lot".[87] Almost half of persons aged 18 or older who had SMI in the previous year reported a substantial negative impact on their mental health. In an attempt to alleviate some of these harms, according to the KFF (2022), during the COVID-19 pandemic, New York added 29,000 persons (a 7% increase) to their HBCS waivers, with a large majority of them having developmental disabilities – a type of serious mental

[86] *HCBS population*. AHRQ. (n.d.). https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/findings/find2.html#:~:text=Most%20of%20the%20HCBS%20population,physical%20disability%20at%2024%20percent.

[87] Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Substance Abuse. *pp.66*.
https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf

illness[88]. As a result, disenrollment occurring during the unwinding process will reduce the continuity of care and thus the mental health outcomes of residents with SMI.

This highlights an even greater need for continuity of care and access to mental health services for individuals with SMI, especially after times of crisis such as the COVID-19 pandemic.

Another critical issue affecting the quality of continuity of care for individuals with SMI is rising minimum wage expenditures. Rising minimum wage expenditures may pose a financial barrier for Medicaid providers in sustaining or increasing care for people with SMI. This could lead to decreased access to mental health treatment, longer wait times for services, or cuts to programs that assist those with SMI in managing their illness. Following a significant minimum wage rise in 2016, Congress agreed to reimburse Medicaid providers for additional labor costs. However, implementing a separate, higher minimum wage for home care aides and later statewide increases have added to these costs. As of January 1, 2024, the minimum pay for home health aides increased to $18.55 in downstate areas and $16.20 elsewhere, resulting in a 49 percent increase in Medicaid's minimum wage-related spending between fiscal 2024 and fiscal 2025[89]. These rising expenses, combined with a looser 'global cap' on Medicaid spending imposed by Governor Hochul's administration, may result in policy decisions prioritizing cost containment over the needs of people with SMI. This could include changes to eligibility requirements, decreases in benefits, or restrictions on the sorts of services covered by Medicaid for those with mental illnesses.

Administrative Feasibility of Unwinding

Disenrollment can occur for various reasons, including procedural difficulties such as failing to finish the renewal process or having outdated contact information. According to the Medicaid Enrollment and Unwinding Tracker, as of April 18, 2024, 69% of all individuals disenrolled were terminated for procedural reasons[90]. This figure is significant in New York as well, accounting for 45% of enrollees.

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[88] Molly O'Malley Watts, M. M. (2022, March 4). Medicaid Home & community-based services: People served and spending during COVID-19. *KFF*. https://www.kff.org/medicaid/issue-brief/medicaid-home-community-based-services-people-served-and-spending-during-covid-19/

[89] Hammond, B. (2024, March 7). *New York's post-pandemic Medicaid binge*. Empire Center for Public Policy. https://www.empirecenter.org/publications/new-yorks-post-pandemic-medicaid-binge/

[90] *HCBS population*. AHRQ. (n.d.). https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/findings/find2.html#:~:text=Most%20of%20the%20HCBS%20population,physical%20disability%20at%2024%20percent.

Procedural disenrollment in Medicaid may disproportionately affect people suffering from SMI's. A study conducted by Hall et. al. (2019) looked at issues for enrollees with serious mental illness under Medicaid managed care[91]. The study found that people with complicated health disorders, particularly those with SMI, have difficulty navigating the managed care system. This difficulty frequently results in high procedure disenrollment rates for them. People with SMI frequently have co-occurring physical health issues and complex healthcare needs, making it difficult for them to comprehend and manage their benefits and enrollment requirements. The survey participants stated a need for more regular contact with care coordinators, greater benefit information, and support navigating the system.

Without this added support, they may be more likely to make mistakes throughout the renewal process or miss deadlines, perhaps leading to procedural disenrollment. Furthermore, many participants were unemployed, homeless, or living in insecure conditions, which complicates handling paperwork and appointments and raises the danger of disenrollment. To summarize, individuals with SMI require greater administrative help due to the complexity of their clinical issues. If the managed care system fails to give enough help, they are more likely to be mistakenly disenrolled from Medicaid.

Projected Outcomes for Alternatives Presented to Increase Enrollment

We are analyzing and evaluating the current alternatives to the current Medicaid disenrollment policy, specifically focusing on Available State Strategies to Minimize Terminations for Procedural Reasons During the COVID-19 Unwinding Period and the potential extension of 12-month continuous eligibility for Medicaid to adults with serious mental illness.

Available State Strategies to Minimize Terminations for Procedural Reasons

New York specifically has received approval for waivers targeted at reducing the risk of persons losing Medicaid coverage as a result of the elimination of continuous enrollment requirements during the unwinding process[92]. This is split into 3 strategies (A, B, C).

A. Increasing Ex Parte Renewal Rates entails measures for streamlining the renewal process without needing additional information from subscribers. This includes incorporating financial results from other programs such as SNAP or TANF, introducing Express Lane Eligibility (ELE) for children

[91] Hall, J. P., LaPierre, T. A., & Kurth, N. K. (2019). Medicaid managed care: issues for enrollees with serious mental illness. *The American journal of managed care*, *25*(9), 450–456.

[92] Medicaid. (2023a).

https://www.medicaid.gov/resources-for-states/downloads/state-strategies-to-prevent-procedural-terminations.pdf

based on existing data from other programs, and renewing for people with no income and no data returned. These initiatives are intended to decrease the burden on participants and accelerate the renewal process, maintaining continuity of coverage for those who qualify.

B. Assisting registrants with Renewal Form Submission or Completion focuses on helping registrants' complete renewal forms. This includes allowing managed care plans to assist participants with form completion, allowing authorized representatives to sign forms over the phone, and postponing procedural terminations for one month to provide focused outreach. These techniques seek to provide additional assistance to participants, particularly those with complicated requirements or limited access to resources, so that they can complete the renewal process correctly and on time.

C. Facilitating Reinstatement of Eligible Individuals Disenrolled for Procedural Reasons entails measures for reinstating individuals who were previously disenrolled for procedural reasons but were later found to be eligible. This involves directing the state agency to determine Presumptive Eligibility (PE) for disenrolled persons, appointing pharmacies, and community organizations to make PE determinations, and reinstating eligibility with retroactive coverage for those who were disenrolled.

CMS issued guidance in December 2023 stating that these waivers will be accessible to New York residents who are enrolled in Medicaid until the end of 2024.

As we discuss below, Strategy A has the most implications in terms of effectiveness, and Strategies B and C have the most implications in terms of administrative feasibility. Thus, we limit our discussion on Strategy A to effectiveness and on Strategies B and C to administrative feasibility.

Effectiveness

The first strategy aimed at increasing Ex Parte Renewal Rates requires that persons be enrolled in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or other means-tested benefit programs. This technique enables states to redetermine financial eligibility for Medicaid for individuals whose SNAP or TANF gross income and assets, as applicable, fall below the appropriate Medicaid restrictions, notwithstanding changes in family structure and income-counting regulations between programs. This technique may not specifically target SMI patients unless they are already enrolled in SNAP or TANF.

Additionally, ex parte renewals renew eligibility based on existing data rather than needing more information from the recipient. This strategy may not be useful for SMI patients whose medical or financial circumstances have changed dramatically since their last enrollment. Additionally, Express

Lane Eligibility (ELE) is a program created exclusively for children. While some people with SMI may have children who are eligible, this program does not specifically target the needs of adults with SMI.

However, based on our findings that individuals with SMI, on average, have lower income levels as well as higher unemployment rates, they may be more likely to be in a means tested benefit program such as SNAP or TANF. Thus, the "ex parte renewals" policy is likely to "promote continuity of care for beneficiaries" with SMI by reducing the number of enrollees who have SMI and who are disenrolled for procedural reasons.[93]

In New York, reporting by Brooks et. al. (2024) indicates that the New York state government has been successful in implementing the ex parte renewal strategy, as the number of ex parte renewals in New York a percentage of total renewals increased by 12 percentage points (i.e., from 24% to 36%) between June 2023 and November 2023.[94] Further, based on reporting from KFF, approximately 52% of all renewals processed by the New York state government have been processed on an ex parte basis.[95] However, this is below the national average of approximately 65.3%.[93] Further, of the beneficiaries who reside in New York and have been terminated from Medicaid coverage since the beginning of the unwinding period, approximately 45.2% have been terminated for procedural reasons.[96]

Many states, such as Alabama, report data on the number former beneficiaries who have been transitioned to other sources of insurance following a procedural termination from Medicaid. Although New York does not report such data, we project that, if the New York state government has not assisted former enrollees transition to other insurance providers, people who become uninsured following a procedural termination from Medicaid may not be able to receive care, which

[93] Medicaid and CHIP Payment and Access Commission (2023). Increasing the Rate of Ex Parte Renewals. pp. 3. https://www.macpac.gov/wp-content/uploads/2023/09/Increasing-the-Rate-of-Ex-Parte-Renewals-Brief.pdf

[94] Brooks et. al. (2024). Most States Show Improvement in Automated (Ex Parte) Medicaid Renewal Rates. *Georgetown University McCourt School of Public Policy. Centers for Children and Families.* https://ccf.georgetown.edu/2024/01/26/most-states-show-improvement-in-automated-ex-parte-medicaid-renewal-rates/

[95] Kaiser Family Foundation (2024). Medicaid Enrollment and Unwinding Tracker. *New York.* https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-state-enrollment-and-unwinding-data/

[96] Kaiser Family Foundation (2024). Medicaid Enrollment and Unwinding Tracker. *Federal Unwinding and Enrollment Data.* https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-national-federal-unwinding-and-enrollment-data/

would likely reduce the mental health outcomes of enrollees who are terminated for procedural reasons.

Administrative Feasibility

It is projected that the second strategy, using information from managed care plans to aid with renewal papers could be beneficial for those with SMI who find paperwork difficult due to their condition. This assistance may result in higher renewal rates by ensuring that required paperwork is filed correctly and on time, lowering the danger of procedural terminations. Furthermore, permitting the selection of authorized representatives for telephone applications may make it easier for beneficiaries with SMI to complete the renewal process, thereby raising renewal rates.

In terms of the third strategy, delaying procedural terminations for beneficiaries by one month while doing targeted outreach may also benefit individuals with SMI by giving them more opportunity to reply to renewal notices. This technique could result in higher renewal rates because beneficiaries with SMI may need more time or assistance to complete the renewal process. Informing all beneficiaries, including those with SMI, of their scheduled renewal dates may help them anticipate and prepare for the renewal procedure, potentially increasing enrollment rates.

However, those with SMI experience additional obstacles during the renewal process that these waivers do not alleviate. Cognitive impairment, which is frequently associated with SMI, might hamper a person's ability to understand complex paperwork or meet deadlines, even when the processes are streamlined.

Additionally, relying on these strategies to streamline form completion may cause concerns, especially since these waivers are temporary solutions to simplify the unwinding process. While these plans might be beneficial, there is a risk that recipients will become unduly reliant on this support. Beneficiaries may face difficulties when these waivers expire, or plans are unable to provide the same amount of assistance in the future. This could result in delays or difficulties in completing renewal paperwork, affecting renewal rates and Medicaid eligibility.

Extending 12-Month Continuous Eligibility to Adults with Serious Mental Illness

Effectiveness

In terms of effectiveness, reporting from Liu et. al. (2021) indicates that extending 12-month continuous eligibility to adults with SMI may be effective in improving mental health outcomes. Specifically, Liu et. al. analyzed whether 12-month continuous eligibility policy in New York,

implemented in 2014, limited "gaps in Medicaid eligibility due to fluctuations in [the] income" among adult Medicaid enrollees who enrolled through the New York State of Health insurance network or Welfare Management System. Using data from the New York State Department of Health (NYS DOH) and Medicaid Data Warehouse, Liu et. al. find that, following the implementation of 12-month continuous eligibility policy:

- The percentage of enrollees with at least 12 months of Medicaid coverage increased by 11 percentage points for NYSOH and WMS enrollees between the years 2012 and 2017.
- The percentage of enrollees with at least 24 months of Medicaid coverage increased by 9 percentage points for NYSOH and WMS enrollees between the years 2012 and 2016.

Further, reporting from the U.S. Health and Human Services Department indicates that, "compared to individuals with consistent Medicaid coverage", unstable Medicaid coverage increases the likelihood that individuals are "unable to afford required prescription medications" which can to a costly and otherwise avoidable inpatient or emergency room visit.[97] Further, Salam Abdus (2014) conducted a multivariate logistic regression analysis on the relation between insurance status and access to health care services among respondents to the Medical Expenditure Panel Survey for the years 2005 through 2010.[98] Based on the analysis, Salam Abdus (2014) finds that, on average, those who are insured for 12 months without interruptions in coverage, relative to those who are uninsured for 12 months, were 26% more likely to receive care right away when needed and 32% more likely to see a specialist when needed; table 1 summarizes results from the study:

[97] Sugar et. al. (2021). Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. *Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. pp. 3.* https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[98] Abdus, S. (2014). Part-year Coverage and Access to Care for Nonelderly Adults. *Medical Care, 52* (8), 709-714. doi: 10.1097/MLR.0000000000000167.

	Insured for 12 months without interruption	Uninsured for 1 to 5 months	Uninsured for 6 to 11 months	Uninsured for 12 Months
Has usual source of care.	80.3% *	67.9% *	65.3% *	55.0% *
Among those who needed care right away, percent who always got care right away.	60.9% *	56.2% *	47.1% *	48.3% *
Among those who needed to see a specialist, percent who were always able to see one as soon as they wanted.	61.2% *	59.4% *	49.4% *	46.3% *

Table 1: Predicted Access to Care of Adults Aged 19–64 by Insurance Status, 2005 to 2010 [99, 96]

Thus, 12-month continuous eligibility may be moderately effective in terms of improving mental health outcomes for residents with serious mental illness, as 12-month continuous eligibility would reduce disruptions in health care coverage among and improve the continuity of care for Medicaid enrollees with SMI.

Administrative Feasibility

Without continuous enrollment, Medicaid eligibility criteria requires individuals to reapply for coverage anytime their income changed, even if they remained qualified for the program. This method was inconvenient for both people and Medicaid agencies. Individuals had to navigate complex paperwork and time-consuming eligibility assessments, which frequently resulted in coverage gaps and delays in receiving care. For Medicaid agencies, it meant processing a large number of reapplications, which diverted resources away from other critical responsibilities.

Continuous eligibility simplifies the re-enrollment process by letting people keep their coverage for the whole year, regardless of changes in income or other factors. This consistency in coverage is critical for ensuring that people have regular access to vital medical treatment, especially those with serious mental illnesses who may have ongoing healthcare demands. For example, without continuous eligibility, individuals with SMI enrolled in Medicaid remain susceptible to gaps in Medicaid coverage as their income fluctuates, compromising their capacity to manage their health issues successfully. For example, someone with diabetes who relies on Medicaid for insulin and regular check-ups may face major health consequences if they lose coverage and are unable to pay for their medicine or routinely monitor their blood sugar levels.

[99] An asterisk (*) indicates that the estimate is statistically significant at the 5% significance level.

Furthermore, continuous access to healthcare services is critical for preventative care and early intervention, which can help identify and address health problems before they worsen and become more expensive to cure. For example, regular screenings and check-ups can aid in detecting illnesses such as high blood pressure or cancer, when they are more treatable.

Continuous eligibility also supports the continuity of care by allowing individuals to form connections with healthcare providers and create tailored care plans. This can lead to improved health outcomes since doctors can better track changes in health status and adapt treatment regimens accordingly.

In terms of administrative feasibility, extending 12-month continuous eligibility to adults with SMI will likely simplify the enrollment process for individuals while also reducing the administrative burden on Medicaid agencies in various ways. First, continuous enrollment eliminates the need for individuals to submit multiple applications and reduces the amount of paperwork required to keep Medicaid coverage, which allows enrollees to stay registered without interruption until the end of the year.

As a result, Medicaid agencies can better manage their resources, focusing on early applications and more complex eligibility assessments. For example, continuous eligibility alleviates the administrative burden on Medicaid agencies by streamlining the eligibility determination process. Without continuous enrollment, Medicaid offices were required to perform frequent eligibility determinations whenever an individual submitted a new application. This frequently entailed confirming income, household composition, and other eligibility requirements, which could be time-consuming and labor-intensive. With continuous eligibility, Medicaid agencies only need to conduct eligibility determinations once a year, when the individual's coverage is due for renewal. This decreases the administrative burden on Medicaid agencies, allowing them to process applications more swiftly and efficiently.

Limitations and Opportunities for Further Analysis

Limitation 1: Data Availability

Data availability was a primary limitation of our research report, as the New York state government does not readily publish survey data on measures of mental health or the mental health outcomes of New Yorkers. Further, when such data is published, the sample size across each insurance category is not large enough to make conclusions about the effect of a given policy on mental health outcomes.

For example, the New York City Department of Health publishes each year a survey named the Patient Characteristics Survey (PCS). In 2014, this survey asked respondents whether they had a serious

mental illness, whether they were unable to access mental health care services when needed, and which type of insurance the respondents had. Without removing any observations, the survey included 8,562 respondents. However, only 239 respondents had SMI. Of the respondents with SMI, only 15 were uninsured, making it difficult to compare the impact of having Medicaid insurance, relative to being uninsured, on access to mental health services. In addition to small samples, the PCS in the years following 2014 does not include questions on whether respondents have SMI and the majority the questions in the mental health section of the survey are different every year.

However, the issue of data availability and consistency is not unique to our report and has been noted by others who have researched this topic, which leads into our next limitation.

Limitation 2: Limited Research

In addition to data availability, little reseach has been done on this topic, as highlighted by Engström et. al. (2023) in a literature review on the relation between the continuity of care and clinical outcomes for patients with serious mental illness.[100] Such a limitation made it difficult to find direct information on this topic. For example, we had to use proxies to measure mental health outcomes (i.e., the continuity of care) rather than using direct measures of mental health outcomes, such as inpatient admissions. Although the continuity of care is generally demonstrated to have a positive influence on mental health outcomes, more research regarding the effect of Medicaid programs on the mental health outcomes of New York residents with SMI using direct measures of mental health outcomes would ultimately improve policy analyses and research memos on this topic. In addition,

Limitation 3: Cost and Budget Analysis

Our research report did not include a cost and budget analysis, as we do not have the experience, resources, or information necessary to conduct such analyses. However, cost and budget analyses are essential when considering Medicaid policy alternatives. Medicaid accounts for a large percentage of the federal budget of the U.S. and the state budget of New York. If implemented, the New York state government would receive federal funding to cover a given amount of the costs associated with the alternatives we analyzed and would have to raise state and local revenues to pay for the remainder of the expenditures not covered by federal funding.

[100] Engström I, Hansson L, Ali L, Berg J, Ekstedt M, Engström S, Fredriksson MK, Liliemark J, Lytsy P. Relational continuity may give better clinical outcomes in patients with serious mental illness - a systematic review. BMC Psychiatry. 2023 Dec 18;23(1):952. doi: 10.1186/s12888-023-05440-1. PMID: 38110889; PMCID: PMC10729558.

Opportunities for Further Research

Based on the limitations of our analysis, opportunities for further research include the creation of surveys that assess characteristics important for the formation and implementation of policies that aim to improve the mental health outcomes of New York residents with serious mental illness. In creating such surveys, future researchers may find the Community Health Needs Assessment (CHNA) and Prevention Agenda helpful, as the surveys include data and information the following focus areas:

1. Promoting "Mental, Emotional and Behavioral Well-Being" in New York Communities".
2. Preventing "Substance Abuse and other Mental Emotional Behavioral Disorders".

The creation and publication of such surveys would address limitation 1 of our analysis, "Data Availability", as publicly available data on the mental health outcomes of Medicaid enrollees with SMI would circumvent the need to use proxies, such as the continuity of care, and would allow for further research in the area of Medicaid Programs for residents with serious mental illness.

In addition to surveys on patient characteristics, an opportunity for further research has to do with the analysis of provider perspectives. That is, investigating the perspectives of healthcare providers involved in delivering mental health services to New York residents with serious mental illness. Understanding provider perspectives can offer valuable insights into the challenges associated with the delivery of care. This research could involve interviews or focus groups with mental health professionals. By examining provider perspectives, researchers can gain a comprehensive understanding of the factors influencing the delivery of mental health services and inform the development of targeted interventions to enhance the quality of care and improve outcomes for Medicaid enrollees with serious mental illness in New York.

Conclusion

Based on our research report, disenrolling individuals with severe mental illness (SMI) from Medicaid due to the unwinding process has the potential to further impact their mental health outcomes negatively. This is due to the complex and chronic nature of SMI, which requires continuous and long-term care provided by Medicaid-funded services like HCBS. Disruptions in coverage can lead to gaps in care, missed medications, and difficulty managing symptoms. The administrative challenges of unwinding Medicaid, particularly for individuals with SMI, further complicate the issue. Procedural errors and difficulty navigating the renewal process can lead to disenrollment even for eligible individuals. While alternative strategies have been proposed to minimize these negative consequences,

it's important to remember that these strategies are temporary. They are currently set to expire by the end of 2024, along with the federal public health emergency that necessitated the unwinding process. This raises concerns about the long-term sustainability of these supports. Ex parte renewals, for example, may not capture changes in an individual's circumstances, and strategies to assist with form completion may not address the underlying cognitive challenges associated with SMI. These limitations are even more concerning given the temporary nature of these programs. Once they expire, individuals with SMI may face even greater difficulty navigating the renewal process and maintaining their Medicaid coverage.

Extending 12-month continuous eligibility specifically for adults with SMI appears to be a more promising solution. Research suggests it can improve mental health outcomes by reducing disruptions in coverage and fostering continuity of care. Additionally, it simplifies the enrollment process for individuals and reduces the administrative burden on Medicaid agencies. However, the feasibility of implementing such a program permanently requires further exploration.

In conclusion, careful consideration should be given to the potential negative impacts of unwinding Medicaid on individuals with SMI. While the current alternative strategies offer some temporary relief, their expiration at the end of 2024 raises concerns about long-term sustainability. More permanent solutions, particularly extending 12-month continuous eligibility to adults with SMI, should be explored to mitigate these risks and ensure they have continued access to the care they need.

Appendix A: Eligibility for Medicaid in New York Based on Modified Adjusted Gross Income and Resources

	Adults under 65; parents/caretakers; and 19- & 20-year-olds living alone ≤138% FPL	Children age 1 - 18 ≤ 154% FPL	19- & 20-year-olds living with parents ≤155% FPL	Infants under 1 year old; Pregnant women; & Family Planning Benefit Program < 223%FPL	Individuals who are Age 65 or older, Blind or Disabled
Household Size	**Annual Household Modified Adjusted Gross Income (MAGI)**				
1	-	$23.19	$23,343	$33,584	$20,784
2	$28,207	$31.478	$31,682	$45.581	$28,212
3	$35,639	$39,763	$40,021	$57,579	-
4	$43,056	$48,048	$48,360	$69,576	-
5	$50,480	$56,333	$66,699	$81,573	-
6	$57,905	$64,618	$65,038	$93,571	-
7	$65,329	$72,904	$73,377	$105,568	-
8	$72 754	$81,189	$81,716	$117,566	-
each additional person	$7,424	$8,286	$8,339	$11,997	-

Source: https://www.nyc.gov/assets/ochia/downloads/pdf/all_populations_medicaid.pdf

Appendix B: Serios Mental Illness in the Past Year: Among Adults Aged 18 or Older; 2008 – 2020

Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
18 or Older	3.7	3.7	4.1	3.9	4.1	4.2	4.1	4.0	4.2	4.5	4.6	5.2	5.6
18 to 25	3.8	3.3	3.9	3.8	4.1	4.2	4.8	5.0	5.9	7.5	7.7	8.6	9.7
26 to 49	4.8	4.9	5.2	5.0	5.2	5.3	4.9	5.0	5.3	5.6	5.9	6.8	6.9
50 or Older	2.5	2.5	3.0	2.8	3.0	3.2	3.1	2.8	2.7	2.7	2.5	2.9	3.4

Source: https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR102121.htm#smi