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Medicaid Reforms in the One Big Beautiful Bill Act and Mental Health Care

Richard G. Frank, Ph.D.



**Think Bigger
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Policy Series

Dear Reader,

Now is the time to address the growing behavioral health needs across our country by advancing public policies that transform how mental health and substance use disorder services are delivered—and by modernizing outdated funding systems that stand in the way of progress.

This paper is part of *Think Bigger Do Good*, a series launched in 2017 through the leadership and support of the Thomas Scattergood Behavioral Health Foundation and Peg’s Foundation. While the topics have evolved over time, our mission remains constant: to shape a forward-thinking policy agenda that improves health outcomes for all.

In collaboration with national behavioral health experts—including our editors, Howard Goldman and Amanda Mauri—we have identified several critical topics for this series of papers. Each paper defines the problem and offers clear, actionable solutions for policymakers, practitioners, and advocates alike.

We invite you to join us in championing stronger behavioral health policies. Please share this paper with your colleagues, community partners, policymakers at all levels, advocacy organizations, and voters. To explore the full *Think Bigger Do Good* series, visit www.thinkbiggerdogood.org.

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Medicaid Reforms in the One Big Beautiful Bill Act and Mental Health Care

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1 / Introduction

Medicaid is the nation's largest payer for care of mental illnesses and substance use disorders. It covers approximately one-third of all adults with mental health conditions and one-fifth of adults with substance use disorders. That coverage encompasses a wide variety of behavioral health services (1). Because Medicaid uniquely funds both clinical treatments and supportive services, it serves as a cornerstone of the behavioral health safety net. As a result of Medicaid's dominant role in the behavioral health ecosystem, federal policy changes can have far-reaching consequences for people with mental health conditions and substance use disorders. Policies that serve to limit eligibility and access to care through the creation of new administrative hurdles, in addition to direct spending cuts, can be particularly impactful.

The recently enacted One Big Beautiful Bill Act (OBBBA) imposes Medicaid work requirements, increases income-verification frequency, and establishes new cost-sharing practices for many services (2). These changes represent the most sweeping restructuring of Medicaid eligibility in more than 10 years. The Congressional Budget Office (CBO) estimates that OBBBA's Medicaid provisions will cause an increase in the number of uninsured people of approximately 10 million over the next 10 years compared with the 2025 baseline (2, 3). The eligibility changes in the OBBBA, along with other Medicaid provisions, are projected to reduce Medicaid spending by nearly \$1 trillion over that time frame (2).

For adults with a serious mental illness, the potential harms are especially acute. This population experiences higher than average rates of coverage churn, and those with cognitive limitations and low frustration tolerance often have difficulty navigating bureaucratic systems (4, 5). I outline herein the OBBBA provisions and draw on clinical, administrative, and policy-based evidence to assess the likely impacts on individuals with mental health conditions and on the behavioral health system.

2 / OBBBA Medicaid Provisions

Medicaid Work Requirements

OBBBA imposes a work or qualifying-activity requirement of 80 hours per month on adults in the Medicaid expansion population and similar waiver groups. The Medicaid expansion, under the Affordable Care Act, allowed states to cover people with incomes below 138% of the federal poverty line. Forty-one states elected to expand their Medicaid programs. Compliance with this requirement must be verified through semiannual eligibility checks and retrospective look-back periods (6). The CBO projects that 7.8 million people will lose Medicaid as a result, and most losses will likely occur because enrollees cannot consistently navigate the administrative process—not because they fail to work (2, 7).

OBBBA imposes a work or qualifying-activity requirement of 80 hours per month on adults in the Medicaid expansion population and similar waiver groups.

Statutory exemptions for persons with mental health conditions and substance use disorders. The work-requirements statute exempts people who are medically frail, which the statute indicates include the following: those with a disabling mental disorder, a substance use disorder, or a serious or complex medical condition or those actively participating in addiction treatment (6). Short-term hardship exemptions (e.g., psychiatric hospitalization) are permitted.

Definitional and enforcement gaps. Although “disabling mental disorder” clearly implies that people with a mental illness that qualifies them for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) will be exempted from work requirements, none of the exemption categories is fully defined in the law, leaving states at least partly responsible for developing criteria (subject to federal guidance) and documentation requirements and for establishing data systems. No mechanism for oversight and enforcement of federal policy is authorized in the legislation, suggesting that the states likely will be assigned that role. Furthermore, SSI already qualifies beneficiaries for Medicaid. Without accurate identification systems, individuals with serious mental illnesses or substance use disorders could be inappropriately subjected to work reporting or have their coverage terminated because of noncompliance (6).

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Administrative implementation requirements.

Implementation of the work requirements requires substantial new administrative systems. Those include the following: real-time tracking of work hours, cross-agency data matching with labor departments, expanded reporting portals, large-scale information technology (IT) upgrades, appeals and exemption-review processes, and intensified outreach to beneficiaries. The responsibilities that these administrative layers put on state Medicaid programs are likely to heighten the risk of erroneous disenrollment.

New Eligibility Verification Policies

In addition to its imposed work requirements, OBBA mandates more frequent income checks, shorter reporting windows, and additional documentation. Such policies increase touch points between enrollees and state agencies, dramatically raising the likelihood of administration-based loss of coverage—particularly among individuals with unstable housing, fluctuating earnings, or cognitive limitations (5, 8).

Cost-Sharing

The legislation expands states’ authority to impose cost-sharing on Medicaid beneficiaries. Although behavioral health services are exempt from cost-sharing, people with serious mental illnesses and substance use disorders are relatively heavy users of a variety of general medical services that will carry new, higher levels of cost-sharing. Research has shown that even small copayments can reduce access to health care services, especially among adults with low incomes and chronic mental health conditions (9). Cost-sharing thus compounds the barriers created by coverage reductions.

3 / Implementation Challenges

Defining Medical Frailty

The federal government has proposed guidelines on how medical frailty is defined; nevertheless, there is considerable discretion in implementation of the proposed guidelines for the OBBA's work requirements. Behavioral health conditions often involve fluctuating symptom severity and variable engagement in care, and the systems that treat these conditions are often plagued by inconsistent diagnostic coding and insufficient documentation in administrative datasets (6, 10). Addressing these issues will pose important implementation challenges; specifically, these factors make the types of classifications demanded by OBBA difficult to operationalize.

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State Administrative Capacity

To implement work requirements while avoiding wrongful disenrollment of exempt individuals, states must make extensive investments in technology (IT modernization), data management, clinical assessment arrangements, and communication and eligibility adjudication infrastructures. Many states lack the administrative capacity to carry out these functions effectively. The experiences in Arkansas and Georgia—the only states to fully implement Medicaid work requirements—support these concerns. Failure to put into place systems that shift administrative burden from individuals to the state increases the risk that enrollees with serious mental illnesses or substance use disorders will be misclassified (7, 11).

4 / Coverage and Care Impacts for People with Mental Illness

Administrative-burden theory distinguishes between the deliberate use of administrative processes, which policymakers are reputed to use in order to target access, and unintended frictions, which arise from poorly designed processes (8). Work requirements may generate both. For people with mental illness—many of whom face significant cognitive, motivational, and social challenges—these burdens interact with symptoms in ways that can magnify coverage loss and harm eligible individuals who are not the target of efforts to reduce the eligible population (5, 10).

Why Administrative Burdens Fall Hardest on People with Mental Illness

Many common mental illnesses are associated with significant cognitive deficits, including those related to attention, working memory, executive function, processing speed, and social cognition (10). These impairments can disrupt everyday skills that are essential for navigating administrative systems, such as organizing necessary documents for establishing eligibility, meeting deadlines, understanding notices and other official communications, completing forms, and using online portals. Affective symptoms, such as low motivation, anxiety, or social withdrawal, also can diminish a person's capacity to comply with complicated administrative rules and arrangements (6).

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The early onset of many mental illnesses disrupts education and human-capital accumulation. Individuals with adolescent-onset mental illness have lower probabilities of high school graduation and college enrollment (12). Having less education can create further difficulties in the navigation of complicated administrative systems.

Research has found that deficits in mental health predict difficulty complying with public program requirements and that administrative frictions can produce large drops in program participation among individuals with cognitive limitations (5). This finding implies that people with mental illnesses and substance use disorders—especially individuals with a serious mental illness—are at risk of experiencing disproportionately high disenrollment under OBBBA.

Lessons from Arkansas

Evidence from the Arkansas Medicaid work requirement program shows that most of the reduced coverage stemmed from administrative failures, not failure to work. Enrollees with chronic conditions (including mental illnesses) faced higher loss rates of Medicaid coverage even when they were technically exempt. The same pattern is expected to be observed among adults with mental illness with widespread implementation of the OBBBA work requirements. Simulations that have applied Arkansas' loss rates of coverage to broader Medicaid populations likely have underestimated the impact for adults with mental illness, whose cognitive vulnerabilities can be greater than those in the general population with chronic illness (7, 11).

Enrollees with chronic conditions (including mental illnesses) faced higher loss rates of Medicaid coverage even when they were technically exempt.

Projected Coverage Impacts for People with Mental Illness

Coverage loss resulting from administrative processes.

Most loss of Medicaid coverage among people with mental illness is likely to result from process failures, not true ineligibility. Work requirements and intensified income verification will create multiple points of interaction with administrative requirements that may result in alleged failures to comply (7, 11).

At-risk populations: persons with serious mental illness and those with less serious conditions not receiving SSI.

Because SSI beneficiaries (34% of people with a mental illness) are almost certainly exempt from work requirements, the impacts will fall primarily on two groups: an estimated 1.38 million adult Medicaid recipients with a serious mental illness who are not enrolled in SSI or SSDI and 3.06 million adults in the expansion population with a less serious mental illness and who do not receive SSI (6). These are the populations at risk of being especially vulnerable to the new administrative hurdles in Medicaid in general. Adults with conditions related to mental health and substance use have long displayed coverage patterns that are consistent with a vulnerability to administrative burdens posed by public programs; for example, they have been shown to exhibit higher coverage churn (4).

State policy makers and behavioral health providers anticipate that the reductions in coverage by Medicaid will further increase levels of uncompensated care and emergency department utilization, raising the likelihood of closures of clinics and hospitals, especially those located in rural and underserved areas.

Systemwide Effects on the Behavioral Health System

State policy makers and behavioral health providers anticipate that the reductions in coverage by Medicaid will further increase levels of uncompensated care and emergency department utilization, raising the likelihood of closures of clinics and hospitals, especially those located in rural and underserved areas (3, 6). Because Medicaid finances crisis care, workforce pipelines, and community supports, reductions in its funding threaten the stability of many state behavioral health systems.

5 / Conclusion

Medicaid is the cornerstone of coverage for Americans with mental illnesses, especially for those with low incomes and serious mental illnesses. The OBBBA has established work requirements and a variety of new administrative steps for establishing program eligibility. This legislation recognizes that some people enrolled in Medicaid are not capable of working at the levels required by the law; however, the exemptions for work requirements are not well defined and, in practice, are accompanied by a variety of complicated administrative hurdles. Although such hurdles are sometimes seen as tools for discouraging the least needy from seeking benefits, the evidence for people with mental illnesses suggests exactly the opposite; that is, the people who have the most significant impairments will be least likely to navigate the new administrative requirements for eligibility and exemption from work requirements. That suggests that work requirements and other administrative systems for public programs, in particular those that disadvantage people with impairments that affect cognitive skills, are likely to harm the people with the most significant mental health conditions and leave a growing number of people with considerable treatment needs with few, if any, resources for obtaining care.

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