

Take Advantage

of New Opportunities to Expand Medicaid Under the Affordable Care Act

*A guide to improving health coverage and
mental health services for low-income
people, following the Supreme Court
ruling on the Affordable Care Act.*

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Introduction

The Affordable Care Act (ACA) represents a watershed in health care policy that could result in 97 percent of Americans having health care coverage. The ACA will expand access to health care and encourage improved quality of care and a reduction in overall health care costs. One of the ACA's most important provisions for children and adults with serious mental disorders is an expansion of eligibility. Under the ACA, all individuals under the age of 65 with incomes below 133 percent of the federal poverty level^a can become eligible for Medicaid. The Supreme Court's ruling on the ACA made the expansion of Medicaid eligibility an option states could accept or decline.

The optional expansion presents states with a significant opportunity to secure federal funding for health care for low-income Americans. Each state will make a number of critical policy decisions regarding the Medicaid expansion over the next several months (or, in some states, potentially over the next several years). These decisions will have a profound impact on public mental health systems and on everyone who uses those systems, including those who meet today's Medicaid eligibility standards.

State policymakers may become so caught up in the multiple pressing issues associated with implementing the ACA that the specific needs of people with mental illness could be overlooked. For this reason, those concerned with state mental health policy, including advocates and providers, will need to be vigilant and active. They can play a key role as states make decisions about the scope of benefits, consumer protections and other policies.

This paper focuses on mental health policy issues related to the Medicaid expansion and provides guidance on best policy options. In addition, the paper also discusses the connection between state Medicaid policy and state options under the ACA's expansion of access to private insurance.

^a \$14,856 for an individual and \$30,657 for a family of four in 2012

Background

Medicaid—the federal-state health care program for children and adults with low incomes—is the nation’s primary funder of public mental health services, and accounts for roughly a quarter of all spending on mental health services in the U.S. each year.¹ Medicaid is particularly important for children and adults with serious mental illness because the program covers a wide array of services, including intensive community services that are critical to improving an individual’s functioning and ability to live in an integrated community setting.

There are many ways to qualify for Medicaid and all states have different combinations of eligibility rules. For children, eligibility is largely based on family income; for adults, the most important factors are disability status and parental status.

As a result of these rules, many childless adults with serious mental illness have not been eligible for the program. Also, in some states, some children in families with incomes under 133 percent of poverty (i.e. the threshold for Medicaid eligibility under the ACA’s Medicaid expansion) have not been eligible because states set stricter income requirements. The Medicaid expansion under the ACA would mean that, for the first time, these adults and children can be eligible for Medicaid. In fact, individuals with mental illness are a significant proportion of those who could gain Medicaid coverage under this expansion.

Relevance of the Medicaid Expansion for Individuals with Mental Illness

- ❖ Approximately one in six currently uninsured adults with incomes below 133 percent of poverty has a severe mental disorder.²
- ❖ Many others have less serious mental health conditions.³
- ❖ Half of the newly eligible individuals have incomes 50 percent of poverty or less. Many of these extremely low-income individuals are homeless, and approximately one quarter of them have a serious mental illness.^{4,5}

Uninsured individuals with mental illness receive at best only very basic, state-funded public mental health services—frequently of limited duration and often only crisis-oriented care. The ACA enables states to replace state and local dollars spent on mental health services with federal Medicaid funds while at the same time providing a more comprehensive array of services to those in need. States can recoup substantial savings under the Medicaid expansion because the federal government will pay nearly all of the costs for the newly eligible group.

State Decisions on Expanding Medicaid Eligibility

Issue

The 2012 Supreme Court ruling confirmed that the expansion of Medicaid under the ACA is constitutional if the federal government does not terminate all Medicaid funds to a state that chooses not to implement this expansion. In part, because the Court considered the Medicaid expansion to be effectively a new and separate program, the Court found the prospect of losing all Medicaid funding to be unduly coercive. As a result, the heavy penalty that would have ensured that all states expanded Medicaid to cover those with incomes at or below 133 percent of poverty is not in force. There is a very strong case to be made in favor of states pursuing the ACA's Medicaid expansion.

Best Policy Option

- ❖ States should expand Medicaid eligibility, beginning January 1, 2014 at the latest, for all individuals with incomes at or below 133 percent of the federal poverty level.

Advocacy Points for This Policy

- ❖ States stand to gain unprecedented levels of federal funding (100 percent initially, dropping only to 90 percent) by expanding Medicaid eligibility to all individuals with incomes at or below 133 percent of poverty.
- ❖ States already can only offer limited mental health services through their public mental health systems. The opportunity to improve this situation will be lost if the state fails to expand the Medicaid program.
- ❖ This situation is compounded because other provisions in the ACA reduce federal funding for uncompensated care of those who are uninsured and the ACA has no other provision for extending health insurance coverage to those with incomes at or below 133 percent of poverty.

Arguments in Support

The ACA was designed to ensure health care coverage becomes available to all. In its design, individuals with incomes below 133 percent of poverty were to be covered by Medicaid while individuals with higher incomes can be eligible for federal subsidies, depending on income, to purchase private insurance.

Without the Medicaid expansion, states will likely continue to spend significant funds on public mental health services. In 2009, state spending on mental health services was over \$16 billion, representing 42 percent of total costs for those services. Without the Medicaid expansion, states may also face high costs of unnecessary use of emergency rooms and hospitals as well as demands on other systems (such as criminal justice and social services agencies) due to lack of access to mental health services.

In fact, estimates of the Medicaid expansion's value to states show states saving between \$19.9 billion and \$39.7 billion on mental health services by 2019 depending on state-level circumstances.⁶ This is

largely because of the high federal share for nearly all of the costs for the newly eligible group. Under the ACA, the federal government will pay 100 percent of the costs of the Medicaid expansion for the first three years, and while the federal share then reduces in steps, it will remain at 90 percent starting in 2020. In other words, the federal government will assume responsibility for the vast majority of the costs to care for this currently uninsured population—costs now almost entirely borne by the states.

The ACA also reduces some current Medicaid funding. Under the ACA, there will be a significant reduction in federal funds to pay hospitals for services to uninsured individuals. These disproportionate share hospital (DSH) payments will decline, beginning in 2014, on the expectation that between the new Exchange insurance plans and the Medicaid expansion, few individuals will remain uninsured once the ACA is fully implemented. If a state does not utilize the new Medicaid expansion, the loss of DSH funds will be a significant financial blow to hospitals, including psychiatric hospitals.

Medicaid is often cited as being a major drain on state budgets. However, such arguments generally consider the total state and federal spending on the program, and then compare that with other state budget items. In fact, Medicaid state costs are only about 16 percent of total state general fund spending. While this percentage has been increasing slowly over the past 15 years, its share of overall state general fund spending has remained very stable, increasing from 14 percent in 1995 to 16 percent in 2010. Other state costs, such as those for education, have risen faster.⁷ On the other hand, Medicaid spending does rise in times of economic downturn—the program is, in fact, designed to do this, so as to ease the problems of those who become uninsured during recessions.

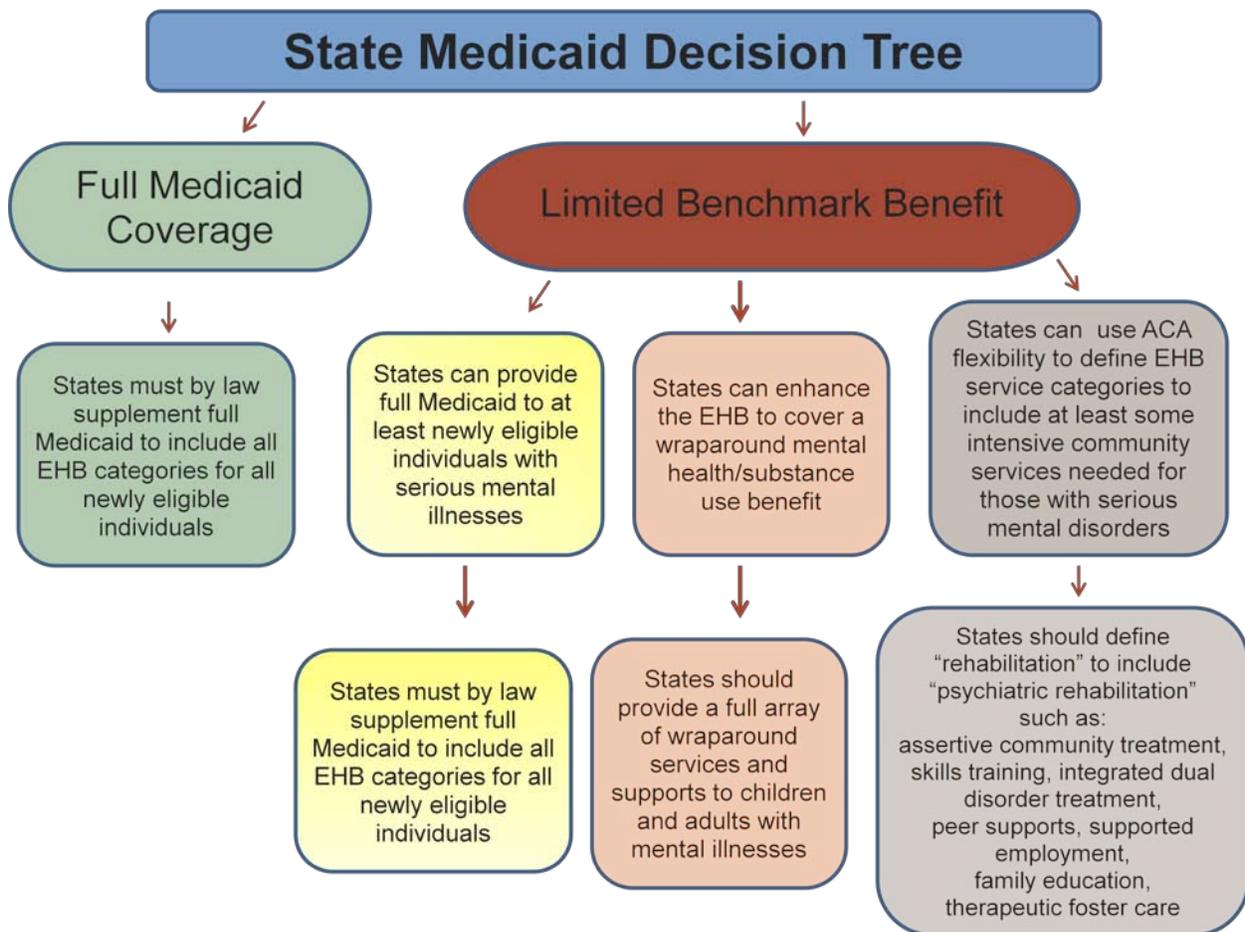
The proposed Medicaid expansion could increase overall spending by states, especially some states, over the next ten years, but by only 2.8 percent over what the states would have otherwise spent on the program. However, this will vary widely from state to state. Moreover, state spending on newly eligible individuals will be a far lower percentage of state Medicaid spending than in the past, given the high rate of federal reimbursement.

Finally, studies show that Medicaid brings significant income to a state and is important for businesses. Medicaid funding supports jobs and generates income within the health care sector and throughout other sectors of the economy due to a multiplier effect. The economic impact is felt in terms of employment, income, state revenue and overall economic output (also referred to as business activity, gross state product or value added). Both state and federal Medicaid spending have a multiplier effect as money is injected into the state's economy. The economic impact of Medicaid spending is intensified by the infusion of new dollars from the federal government that would otherwise not exist in the state.⁸

How Can States Take Full Advantage of the ACA Medicaid Expansion?

Of primary importance is for the state to expand its Medicaid program to cover the newly eligible group for the program under the ACA (see above). After that decision, the state faces other choices.

The following decision tree outlines opportunities for states under the ACA. The state must choose between enrolling all newly eligible individuals into their regular state Medicaid program (the best option) or opting for a limited benefit, which brings additional choices. The best choice for states opting for a limited benefit is to still provide full Medicaid to a defined population, such as those meeting a state definition of serious mental illness. Alternatively, states have great flexibility to improve the ACA Essential Health Benefit (EHB) through wraparound packages or in how they define the details of the EHB service categories. Not shown in the chart is the worst option, which is to provide a basic benefit that parallels the benefits in a private insurance plan (such as only outpatient, inpatient and medications).



The following sections of this document address in more depth the choices shown above that now confront the states.

Will the State Provide Newly Eligible Individuals with the Same Package of Services Available to Others on Medicaid?

Issue

Under the ACA, states are permitted to provide a “benchmark” benefit to adults who are newly eligible for Medicaid. This is a different, and potentially more limited, package of covered services than what is covered for others on the program. The ACA language on benchmark plans is identical to the benchmark plan authority in Medicaid enacted by the Deficit Reduction Act of 2005.⁹ However, for children, states must still offer all services covered in federal Medicaid law, when medically necessary, as required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate.¹⁰ This means children will have access to a range of critical community mental health services, such as intensive in-home services and therapeutic foster care.

Federal parity requirements and anti-discrimination provisions in the law require that states pay attention to the needs of individuals with mental illness when crafting the benefit package of benchmark plans. (The Bazelon Center will write more about these legal obligations in future papers).

Benchmark plans must be based on certain existing private plans in the state, but must also meet the ACA definition of an Essential Health Benefit (EHB).¹¹ The private plans that states can use as models for their benchmark plan are listed by the federal government.^b States may also develop their own plan as long as they have federal approval for it. This is termed “Secretary-Approved Coverage.”

Fortunately, some groups cannot be required to enroll in the limited benefit, including people with disabilities, those who are dually eligible for Medicaid and Medicare, medically frail and special needs populations, medically needy individuals, children in foster care, some institutionalized populations, and beneficiaries who qualify for long-term care. States must provide their full state plan benefits to these populations. Individuals with serious mental illness who qualify for Supplemental Security Income (SSI) benefits (or people who qualify under alternative standards in states that do not use receipt of SSI as a criterion) will remain eligible for the full package of Medicaid benefits. State policies to determine who else falls into the category of a person with a disability will be important for other individuals with serious mental illness. Advocates need to be vigilant on how these policies are written and implemented.

While states have the option to create a different, and potentially less comprehensive, Medicaid benefit for the newly eligible individuals, states do not need to. Under federal rules, states can also elect to provide all newly eligible individuals with the services covered under their state Medicaid plan and obtain the very high federal match for those services. To do this, the state would use the option of Secretary-Approved Coverage. Under this approach, the state will also have to ensure that, for the newly

^b The state’s commercial plan options for the Medicaid benchmark are: the state’s largest non-Medicaid HMO, any state employee health plan, or the standard Blue Cross/Blue Shield plan under the federal employees health benefit (FEHBP).

eligible individuals at least, its Medicaid benefit meets the requirements of the ACA Essential Health Benefit. This is because, under the ACA, all newly eligible individuals must have coverage, at a minimum, for the services listed in the EHB.

When states do choose to offer a limited benchmark package to newly eligible individuals, a minimum floor of benefits is required, because the ACA requires all these newly eligible individuals to have coverage for all ten categories of the EHB. While the EHB outlines the required benefit package, states have great latitude to fill in the details and can also develop a unique benefit under the Secretary-Approved Coverage approach.

The EHB in the ACA is generally modeled on private insurance plans, although it is more comprehensive than many of those. The EHB includes mental health and substance use disorder services and requires that these be furnished at parity with medical/surgical care. In this case, “parity” is defined to mean meeting the standards in the federal parity law.¹² As states implement the Medicaid expansion, they must ensure that state rules comply with the federal parity statute for the newly eligible population, including for people who have full Medicaid coverage.

Experience suggests that some health plans do not fully comply with the federal parity statute—sometimes due to confusion in how to compare mental health/substance use disorder services with medical/surgical services, and sometimes due to plans’ attempts to limit costs. Emphasizing the parity requirement in the state’s definition of the EHB is therefore important. In addition, the state will need to monitor implementation of that requirement if the state is to ensure that it is fully effective.

Best Policy Options

- ❖ All newly eligible individuals should have coverage for all of the services covered under the state Medicaid plan.
- ❖ If the state has determined it will not adopt that policy, then at a minimum individuals with serious mental illness should have full state plan coverage. This can be done because states may, under the law, adopt different coverage policies for different groups.

Advocacy Points for These Policies

- ❖ Full Medicaid offers the broadest and most appropriate array of community services for children and adults with serious mental disorders.
- ❖ Public mental health systems rely on Medicaid to fund community services and have limited funds for additional services not covered by Medicaid, leading to inadequate care.
- ❖ States can replace some state dollars with federal Medicaid funds.
- ❖ States can take advantage of the very high federal match rate for services provided to newly eligible individuals so that a state’s fiscal risk is exceedingly small.
- ❖ The administrative burden of operating parallel systems is likely to outweigh any cost advantage of offering a more limited package of services to some.

Arguments in Support

The traditional Medicaid benefit package provides, in virtually all states, a broad array of specialized services and supports. Using a benefit based on private insurance coverage, such as the EHB, will generally result in mental health services being limited to outpatient care, inpatient hospitalization and medications.

Addressing the often-complex needs of individuals with serious mental disorders will be extremely difficult if their Medicaid benefit is limited to the EHB or its equivalent. All states rely heavily on the Medicaid rehabilitation services category to cover various intensive community services, including many evidence-based practices. States must cover rehabilitation services as part of the EHB. Nondiscrimination language in the ACA also means that states must include psychiatric rehabilitation services in this category. However, states will have flexibility in defining the extent of that coverage. It is in the state's interest to cover a robust set of rehabilitation and other services for newly eligible individuals with serious mental illness, particularly since there will be a substantial number of people in the newly eligible group who need these services (see data on page 2).

Public mental health systems also rely on Medicaid to sustain their systems, and Medicaid is the largest single payer of public mental health services in the country. Since states will receive a very high federal contribution to the cost of services provided to newly eligible individuals, this is an opportunity for states to initiate coverage and services for a very needy population and have the federal government pay all or most of the costs. By providing the newly eligible group coverage for their full Medicaid program, states can significantly strengthen the public mental health system.

Data from the few states that have already expanded their Medicaid programs and have analyzed the cost suggest that it is more efficient for states to cover newly eligible individuals under the regular state plan than to provide a limited benefit. For example, data from one state that has already created a similar expansion in eligibility shows that administrative costs of having a limited benchmark benefit exceeded the additional cost of providing full Medicaid benefits to newly eligible individuals.¹³ This is because administrative costs and challenges of operating two separate benefit packages under Medicaid are high. That option requires states to have complicated systems to screen each applicant to determine which benefit they will receive.

Providing full Medicaid coverage to all prevents the need for these complicated and costly eligibility determinations.

How Will States Ensure That the Benchmark Package Meets the ACA Requirements?

Issue

Despite the best efforts of advocates, some states may still opt for a limited benchmark plan, using the Essential Health Benefit (EHB) of the ACA as its basis. The ACA EHB has ten benefit categories.¹⁴ These include “mental health and substance use disorder services,” which must be covered at parity with other medical/surgical care. In states that opt for a more limited benchmark plan, this provision provides some protection from arbitrary limits on mental health and substance use disorder services.

However, since the benchmark plan can be modeled on private insurance coverage, the mental health and substance use disorder services covered may well only include outpatient physician and mental health professional services, inpatient hospital care and prescribed medications. In addition, it will be important to monitor the parity requirement to ensure it is followed (see page 6).

The package must include other services that could, if defined appropriately, include important mental health services. For example, “rehabilitation services” should include psychiatric rehabilitation, chronic disease management should include management of serious mental illness, and prevention should include screening for various mental health and substance use disorders. Under the ACA, states also have the option to expand the EHB and provide additional “wraparound” benefits to people in benchmark plans.

States have had flexibility to create limited benchmark plan benefits for some individuals on Medicaid since the enactment of the Deficit Reduction Act in 2005. Although few states have used that flexibility, it is interesting to see that some have excluded children and adults with serious mental disorders from these limited packages and some states have used the option to cover a broader array of services for those individuals than under traditional Medicaid.

Best Policy Options

- ❖ States adopting a limited benchmark plan should incorporate services for people with serious mental illness in the definitions of relevant benefits, such as rehabilitation, chronic care management and prevention.
- ❖ States adopting a minimal benchmark plan should create a wraparound benefit package—that is, one with additional benefits—specifically for individuals with serious mental disorders.
- ❖ This wraparound benefit should include the most critical community services allowed under Medicaid (particularly those that are evidence based) to avoid hospitalizations and institutional placements, and to meet the needs of those with extremely low incomes, many of whom are homeless.

- ❖ States should ensure that health plans—particularly managed care plans providing Medicaid services in the state—adhere to and effectively implement the requirement for parity between mental health/substance use disorder services and medical/surgical services.

Advocacy Points for These Policies

- ❖ Individuals with serious mental illness will need intensive community services not explicitly stipulated in the Essential Health Benefit. Without such access, many will continue to be hospitalized, perhaps repeatedly, or at risk of institutionalization.
- ❖ Given that 50 percent of newly eligible individuals have incomes at 50 percent of poverty or less, homelessness will be a problem for a significant proportion of this group. Outreach and engagement as well as mobile crisis services and integrated mental health/substance use treatment will be especially critical for this group.
- ❖ Without state requirements and monitoring, private managed care plans may not provide benefits at parity.

Arguments in Support

The benefit in any benchmark plan should include, at a minimum, case management services for individuals with serious mental disorders. In addition, the following services, all of which states already cover under Medicaid for other populations, could be required as part of a wraparound benefit:¹⁵

- ❖ Skills training to address functional impairments resulting from a serious mental disorder and furnished in any appropriate setting, including in the home or on the job (this should include social, daily living, communication, personal care and other skills);
- ❖ Assertive Community Treatment (an evidence-based practice);
- ❖ Peer Support Services;
- ❖ Family education, such as Family Psychoeducation (an evidence-based practice);
- ❖ Integrated treatment for individuals with co-occurring mental illness and substance use disorders, such as Integrated Dual Disorder Treatment (an evidence-based practice);
- ❖ Intensive in-home services for children;
- ❖ Crisis residential services for adults;
- ❖ Therapeutic foster care for children; and
- ❖ Outreach, engagement and mobile crisis services for people who are homeless.

If states reject a full wraparound benefit for individuals with serious mental illness, then at a minimum each of the relevant benefit categories of the ACA Essential Health Benefit should reflect coverage of the appropriate mental health services, not only coverage of appropriate medical/surgical care. For example:

- ❖ *Rehabilitation services* should include skills training for people with severe mental illness, among other services.

- ❖ *Chronic care management* should include intensive case management (or Assertive Community Treatment) for individuals with severe mental illness, as well as family education and illness/disability self-care.
- ❖ *Mental health and substance use disorder services* should include integrated treatment for individuals with co-occurring mental illness and substance use disorders, and intensive outpatient treatment for substance use disorders.
- ❖ *Prevention services* should include:
 - ❖ screening of both children and adolescents for behavioral health and developmental problems;
 - ❖ depression screening, especially for new mothers; home visitation for newborns and infants;
 - ❖ obesity screening for individuals taking anti-psychotics known to put them at risk of weight gain; and
 - ❖ tobacco use screening and tobacco cessation interventions for individuals with serious mental illness.

How Will the State's Benefit Package for Newly Eligible Individuals Ensure Nondiscrimination for People with Mental Disabilities?

Issue

Under the ACA, the Essential Health Benefit (EHB) for Medicaid and Exchange plans may not discriminate in the design of their service package with respect to people with mental and physical disabilities. People with mental and physical disabilities must have equal access to the benefits of the ACA.

Best Policy Options

- ❖ States should ensure that services to *maintain* functioning or prevent deterioration of a mental or physical condition are covered as well as services to *restore* functioning.
- ❖ Payments to providers must take into account the additional time needed to manage care for individuals with one or more chronic conditions, including serious mental illness.
- ❖ Reimbursement rates and service packages must ensure that individuals with disabilities are not needlessly served in segregated and institutional settings.

Advocacy Points for These Policies

- ❖ Individuals with disabilities need access to ongoing services that enable them to function well and live in the community.
- ❖ Providers require more time to address fully the often-complex health conditions of individuals with disabilities.
- ❖ Service packages should include coverage of services that are specifically designed to ensure that people with disabilities are not unnecessarily institutionalized, usually at state expense.

Arguments in Support

Some private health plans—but not Medicaid—limit coverage to only services that can *improve* a person's condition. States should ensure that all plans follow the Medicaid practice of paying for services that maintain a person's current level of functioning and that prevent deterioration of skills.

Service packages focused on acute care discriminate against people with disabilities. A broader array of services is necessary to ensure that a person with a disability can avoid unnecessary institutionalization. (See the list of potential wraparound services in the above section on benchmark packages.) Reimbursement policies and rates are also often based on the assumption that all cases require the same amount of a provider's time. Tiered rates, based on the complexity of the case, should be used.

Can States Improve Services for People with Mental Disorders as Part of Their Implementation Policies Under the ACA?

Issue

This time of policy review presents a broader opportunity to review Medicaid policy. The ACA has made improvements to the relatively new state plan option under Section 1915(i), which can cover home and community-based support services for individuals with serious mental disorders. Section 1915(i) was first authorized under the Deficit Reduction Act and was designed to fund those services previously only covered through a Medicaid waiver under Section 1915(c). Section 1915(i) allows states to cover these same services through a state plan amendment, eliminating the need for states to request a waiver from the U.S. Department of Health and Human Services.

As originally enacted, there were some limitations on Section 1915(i). The ACA has made a number of important changes to the statute, including expanding the range of services, loosening the financial eligibility rules, and clarifying that states may target 1915(i) to specific populations and then provide specific services just to those populations. Finally, services must now be statewide—and unlike the waiver, there can be no waiting lists or limited number of slots.

A number of services particularly appropriate for individuals with serious mental illness can be covered under Section 1915(i), such as:

- ❖ Supported employment (all program costs including job coach);
- ❖ Supported housing (excluding ongoing room and board, but including start-up costs, such as security deposits, first month's utilities and rent deposits);
- ❖ Peer support services;
- ❖ Supported education; and
- ❖ Respite care.

Best Policy Option

- ❖ As states redesign their Medicaid program in order to cover the newly eligible population, this is an excellent time to press for improved coverage of home and community-based services for children and adults with serious mental disorders.

Advocacy Points for These Policies

- ❖ Home and community-based services are extremely cost-effective services for a state to cover, and the ACA now presents an opportunity for people with mental illness to fully benefit from these services.
- ❖ States can target a 1915(i) option as narrowly as they wish, limiting both eligibility and services covered and thus reducing their exposure to costs.
- ❖ Some states have used this option exclusively to cover services previously funded only through state dollars. This strategy is a win-win—for the state that saves resources, and for the individual who receives needed services.

Arguments in Support

Home and community-based services have been covered under Medicaid through waivers of federal rules for many years. However, few states have such waivers for people with mental illness. This is due to the waiver rule that the community services may not be more expensive than Medicaid-covered institutional services that would have been used absent the waiver.

Because services in an Institution for Mental Diseases (IMD)^c are not covered under Medicaid for individuals aged 22-64, home and community-based waivers for adults with mental illness have been very difficult to obtain. For children, placement in a psychiatric residential treatment facility is a covered Medicaid service, but this type of facility is not considered an “institution” for purposes of the waiver. As a result, there have been very few waivers for children with mental health disorders.

Section 1915(i) changes the rules, because there is no requirement that home and community-based services must be cost neutral to Medicaid by offsetting institutional costs.

The law also gives states great flexibility to target Section 1915(i), both by how the state defines the population to be eligible and by the service array it covers. Several states, such as Iowa, Wisconsin and Oregon, have chosen to target individuals with serious mental illness, providing access to various psychosocial rehabilitation and behavioral services.

The types of services that can be covered under Section 1915(i) include a number of inexpensive, but effective, options, such as respite care and peer support. Other services can fill in the service array—such as paying the full cost of supported employment, including a job coach, or helping establish someone in independent housing. Currently, these costs are frequently borne by mental health systems.

^c IMDs are primarily psychiatric hospitals and nursing homes whose resident population has a significant percentage of people with mental illness. Other facilities that meet a federal regulatory definition are also IMDs.

What Happens When a Person's Income Rises and the Person Is No Longer Eligible for Medicaid?

Issue

Some individuals' income will change over time, fluctuating between less than 133 percent of the federal poverty level and more than that level. This will cause “churning” between Medicaid coverage and a subsidized Exchange plan. Income volatility is common among individuals whose income falls around 133 percent of poverty and more than 50 percent of adults with family incomes below 200 percent of poverty are projected to experience a change in eligibility within any one year.¹⁶ Such instability could seriously disrupt care.

Interruptions in care are especially detrimental to individuals with serious mental illnesses, given the critical and unique nature of therapeutic relationships. Moreover, there is generally a vast difference in the coverage of community mental health services under Medicaid and private plans.

Best Policy Options

States can take the following steps to alleviate these problems:

- ❖ Guarantee a specific period of continuous eligibility for Medicaid (a year, for example), which could reduce churning between Medicaid and a private plan.
- ❖ Require that at least one health plan be available through both Medicaid and the Exchange.
- ❖ Work to align provider networks between the Exchanges and Medicaid, or require access to previous providers when individuals transition between Medicaid and plans sold through the Exchange.
- ❖ Require plans to allow individuals who are transitioning to a new plan to access non-formulary prescription medications. Alternatively, Exchange plans could be required to cover all psychiatric medications covered under the state Medicaid plan.

Advocacy Points for These Policies

- ❖ Gaps in care resulting from churning will undermine continuity of care and likely lead to a person's deterioration in function.
- ❖ This deterioration will ultimately result in additional future costs of care and in some cases result in the need for institutional care.
- ❖ Switching providers is especially detrimental in the case of mental illness where one's relationship with the therapist is so crucial.
- ❖ Serious health consequences may result from discontinuation or disruption of psychiatric medications mid-episode due to differences in prescription drug formularies between plans.

Arguments in Support

Creating a transition period for individuals moving off Medicaid would enable people who have benefited from Medicaid's comprehensive services to gradually move towards greater independence; for example, by moving off a supported employment program. It will also allow them to gradually switch their providers to those covered by their Exchange plan.

This can be accomplished in various ways, from continued Medicaid eligibility to requirements on plans and Medicaid to avoid a complete and sudden break in health care access and providers. For instance, continuity of care can be improved by allowing access to providers who served a person in their previous plan for a year following a switch. Alternatively, the plan the person is leaving could be required to provide this coverage.

States can also improve the alignment of Exchange plans and Medicaid. For example, states can encourage providers that participate in one or more Exchange plans to take Medicaid patients as well. States can also require at least one health plan that participates in Medicaid to also be sold through the Exchange.

Specific medications can be critical for a person with serious mental illness and any disruption or switch to another medication in the same class can have significant consequences. States should require all health plans that participate in Medicaid and the Exchange to allow individuals who have transitioned from Medicaid to access non-formulary prescription medications for a period of time.

What Benefits Will Individuals with Serious Mental Disorders Have Under an Exchange plan?

Issue

This paper is focused on the needs of individuals on Medicaid; however, as some individuals will “churn” between Medicaid and the subsidized Exchange plans, the benefits in Exchange plans are also relevant for public mental health policy.

As with the Medicaid benchmark plan, states may select from a list of plans as they define the benefit package to be sold through the Exchange. Some of those plans are the same as those to be used as benchmarks for Medicaid. In states where full Medicaid is not available to newly eligible individuals, people whose incomes fluctuate would be better off if the state selects the same health plan as its model for both the Exchange and the Medicaid benchmark. In that case, there would not be a sudden change in benefits for these individuals who move between the Exchange and the Medicaid benchmark. However, if this results in an inadequate benefit for people with mental illness, then clearly it is not a good option and a broader benefit would be preferable.

The benefits in the Exchange plans are likely to be inadequate for people with serious mental illness. As a result, these individuals will be forced to turn to the public mental health system for additional community services. Or, if those services are not available, an individual’s condition may deteriorate such that they need hospital care and/or lose income and return to Medicaid. In either event, the state is at risk for additional costs.

It is therefore important for states to address at least some of the service needs of individuals with serious mental illness in the required state Exchange plan benefit package. Exchange plans must include at least the ACA Essential Health Benefits and also any mandated benefits in state law in effect in December 2011. (If state mandated benefits are not included, the state must defray the cost of those services; such costs will not be the responsibility of the health plans. More federal guidance on how this will work is expected to be forthcoming in the next several months).

Additional rules could strengthen Exchange plans, such as requiring plans to: encourage co-location of primary care and mental health and substance use disorder service providers through reimbursement policies that allow billing for two separate services on the same day; set up health home systems that address the needs of people with serious mental illness; and pay for consultation and collaboration between providers serving children and adults with mental illness.

Best Policy Options

- ❖ States should choose a benchmark package that includes all state mandated mental health and substance use disorder services.
- ❖ States should include in the Essential Health Benefit an array of effective mental health community services for individuals with serious mental illness.

- ❖ States should ensure that individuals with serious mental illness have access to services—such as chronic care management and rehabilitation—that are tailored to their needs particularly since parallel services are to be covered for those with other disorders.
- ❖ Health policies that are being considered for medical/surgical care (health homes, accountable care organizations, etc.) should also focus on the needs of people with serious mental illness.
- ❖ Best practices, such as co-located services and improved collaboration across providers, should be encouraged.

Advocacy Points for These Policies

- ❖ Most states have mandated certain minimum mental health and substance use disorder coverage in health plans in the state. There is no rationale for having different or less comprehensive standards in the Exchange Essential Health Benefits.
- ❖ Effective intensive community service options exist for ensuring that individuals with serious mental illness avoid hospital and institutional placement. Unless some of these services are covered in Exchange plans, people’s functioning will deteriorate and they will either fall back into Medicaid or need public mental health system services. This will cost the state more.
- ❖ Best practices in health care delivery should be required of Exchange plans. In the long run, these practices will improve quality and reduce overall costs to the state.

Arguments in Support

Much work has gone into the development and enactment of state statutes that relate to the coverage and delivery of mental health and substance use disorder services in private health plans. The policies in those state mandates should be made to apply to Exchange plans.

It would be good fiscal policy for the state to select as its benchmark plan one that includes strong benefits. States should ensure that the benefit package is broad enough to reduce the burden of uncompensated care on the state. Critical categories of the Essential Health Benefit that should include appropriate reference to the needs of people with mental illness are: Mental Health and Substance Use Disorder Services, Rehabilitation Services, Chronic Care Management and Prevention (see page 10).

Finally, many innovations in the care of individuals with serious mental illness are being implemented in Medicaid and the public mental health systems. These include health homes, co-located primary care and mental health services, and payment for time of providers to collaborate or work as part of a team in the care of people with serious mental illness. These innovations should be encouraged in Exchange plans.

Conclusion

States will play a central role in implementing the provisions of the ACA that expand access to coverage—particularly with respect to the Medicaid coverage for individuals not previously covered by the program. This newly eligible group includes significant numbers of individuals with serious mental illness, many of whom are the neediest in our communities due to extremely low incomes and even homelessness.

States are well aware of their important role in implementing the ACA and most are working either openly or behind the scenes to make the policy decisions that will lead to Medicaid reforms by 2014. Now is the time for those concerned with public mental health policy to act at the state level to ensure that these policies support the needs of children and adults with mental illness.

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