NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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Frequently Asked Questions: Health Reform and Medicaid

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The Patient Protection and Affordable Care Act was signed into law March 23, 2010 and its companion, the Health Care and Education Reconciliation Act of 2010, March 30, 2010. Together, the bills are known as the Affordable Care Act (ACA). The ACA includes a significant expansion of Medicaid to an estimated 16 million individuals. This expansion will greatly impact community mental health and substance abuse disorder services. The following provides responses to frequently asked questions about the Medicaid expansion. For more information, access the PowerPoint and recording from the National Council's June 8, 2010 webinar, "Healthcare Reform Implementation: Medicaid Expansion and the Impact on Behavioral Health", which featured Ann Kohler, Executive Director of the National Association of State Medicaid Directors.

Eligibility/Enrollment:

Who is eligible to participate in the Medicaid expansion under the new law authorized by the ACA?
Under the law, all persons who meet the new national income limit of 133% of the federal poverty level (FPL) ($29,326 annual income for a family of four in 2009) based on modified adjusted gross income will be eligible for Medicaid. Prior to this, individuals with mental illness and/or substance use disorders had to be "categorically eligible" for Medicaid; meaning, they had to not only meet income requirements but also be eligible due to their disability status (as recognized by the Social Security Administration). Because of this, it is estimated that there are many individuals with behavioral health problems who are currently ineligible for Medicaid who will be able to benefit from the Medicaid expansion as it's solely based on income status.

When will this go into effect?
States must put this expansion into affect by January 1, 2014. However, they can choose to implement the expansion before then and would receive their current Federal Medicaid Assistance Percentage (FMAP) for the expansion population until 2014, when all states will receive 100% FMAP funding for Medicaid expansion beneficiaries. For example, in June, Connecticut became the first state to have an incremental implementation plan approved and will soon be expanding Medicaid eligibility to approximately 45,000 currently uninsured adults between 56-68% of the FPL. They will receive federal funding retroactive to April 10, 2010. You can read more about Connecticut's plan online. Check with your state Medicaid offices to learn more about the timeline in your state.

Does this include childless adults?
Yes, childless adults up to 133% FPL ($14,404 annual income for a single person in 2009) will now be covered in every state.

Does CHIP eligibility change?
Yes, children between 100-133% FPL currently covered by CHIP will be transitioned to Medicaid.

Is there anything for eligible children that are denied due to federal allotment caps?
Children in those cases will be screened and if determined to no longer be Medicaid eligible, will qualify for tax credits for a plan approved by the Secretary beginning April 2015.

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What about children in foster care?
By the new law, when children in foster care turn 18, they are covered by Medicaid until they are 26 years old.

How many people will the expansion add to Medicaid?
While the estimates are static, the Congressional Budget Office has projected 16 million new people will be covered nationally by Medicaid by 2019, of these, 15 million would not have qualified before the reform. To find out projections for your state, review a study from the Kaiser Family Foundation.

How will people enroll?
Each state will be required to set up a website that allows people to apply for or renew Medicaid as well as CHIP and the future state exchanges. Monitor progress in your state's Medicaid office and find out what processes they expect to put into place.

Services:

What services will be provided to the new enrollees?
For childless adults, states are only required to offer benchmark, or benchmark equivalent plans. Standards for the benchmark plans are found in Section 1937 of the Deficit Reduction Act of 2005 and allow states to provide benchmark benefits based on or equivalents to the Federal Health Benefits Program package, their State Employees Health Benefits Package, the HMO benefits package with the largest non-Medicaid enrollment in their state, or another package approved by the Secretary. The Affordable Care Act of 2010 requires that these Medicaid benefit benchmarks now include prescription drug coverage and mental health benefits and addiction and to do so in accordance with the Mental Health Parity and Addiction Equity Act. Because it is optional whether a state offers any additional services beyond this benchmark, we encourage you to advocate to your state Medicaid or Substance Abuse Disorder and Mental Health Commissions to discuss the importance of mental health and substance abuse treatment to those covered by Medicaid.

What mental health and/or addiction services will be provided as a result of healthcare reform?
Because of the direct reference to the 2008 federal parity law, Medicaid expansion benchmark packages must include services relating to mental health and substance abuse treatment to comply with the Mental Health Parity and Addiction Equity Act. The Centers for Medicare and Medicaid Services will issue new regulations on benchmark plans to comply with the new requirement. However, how these will be interpreted and details of services have not yet been determined. Services beyond the benchmark will be determined by the states. To find out or weigh in on what services your state plans may cover, contact your state Medicaid office.

Will new enrollees get the same services as current enrollees?
Not necessarily, each state will have the option of offering the new enrollees a less comprehensive package than current enrollees. The reference of the bill to the Mental Health Parity and Addiction Equity Act ensures mental health and substance abuse treatment services are included. New research by the Center for Budget and Policy Priorities shows that poor childless adults who will make up a large portion of the newly eligibles may be in the most need for mental health and substance abuse care, and it recommends therefore, that states extend the same Medicaid benefits to this population. The estimated cost of providing full benefits is minimal.

What if my state currently offers more than the benchmark services that will be set? Will they then have to offer the same services for the expansion population?
No, there is no requirement for services to the expansion population to mirror current services. Each state will be making these decisions and we encourage you to be proactive and advocate for the mental health and substance abuse treatment community services. (See previous question above)

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State vs. Federal Responsibility:

How much of the cost of the Medicaid expansion will the federal government cover?
Federal funding will be provided 100% financing, for all new eligibles up to 133% FPL in 2014- 2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% federal financing for 2020 and subsequent years.

What if states want to cover individuals or families with incomes higher than 133% FPL?
States have the option of providing Medicaid coverage above 133% but will only receive 100% FMAP up to that point. For coverage of people at 134% of FPL and above, current FMAP rates will be provided.

Will provider payment rates be affected?
Reimbursement for mental health and substance abuse treatment outside of the primary care setting will be decided by each state. Mental Health Parity and Addiction Equity Act regulations define provider reimbursement on Non-Quantitative Treatment Limitations, and require comparability in rates and with other healthcare providers.

Are states required to expand their Medicaid programs?
The Federal reform law will require each state to not only maintain current Medicaid programs but to expand to cover everyone up to the 133% FPL.

What is the Maintenance of Effort/Eligibility?
States are required to maintain eligibility levels that were in place on March 23, 2010 in order to remain eligible for federal funding. This applies until the Secretary determines that a state's exchange program is fully operational for adult coverage (except for coverage of non-disabled adults with incomes above 133% FPL) and through September 30, 2019 for coverage of children in Medicaid or CHIP.

Miscellaneous:

How do I find out what plans are being made for the expansion?
Check with your state Medicaid or Substance Abuse Disorder and Mental Health Commissioners. Communicate with them the importance of supporting mental health and substance abuse treatment.

When will all of this be implemented?
Many of the provisions affecting Medicaid and CHIP will be implemented by 2014. The Kaiser Family Foundation has put together a timeline of provision implementation.

Given that more people with serious mental illnesses of substance abuse disorders will have insurance either through Medicaid or private expansion, what impact will this have on other funding streams for mental health and substance abuse disorders services?
The National Council continuously supports increased appropriations for Block Grants as they provide the opportunity for prevention and treatment efforts to include a broader array of services to more people than would be offered otherwise. They allow states to have more funding flexibility and be innovative with prevention and treatment options.