HEALTH REFORM ROUNDTABLES: CHARTING A COURSE FORWARD

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON Medicaid and the Uninsured

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MEDICAID POLICY OPTIONS FOR MEETING THE NEEDS OF ADULTS WITH MENTAL ILLNESS UNDER THE AFFORDABLE CARE ACT

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) aims to expand access to affordable health coverage and reduce the number of uninsured Americans. A primary pathway through which many Americans will gain access to healthcare is through the expansion of Medicaid eligibility to all individuals with incomes up to 133% of the federal poverty level ($14,484 for an individual in 2011). The newly eligible Medicaid population includes many people with mental health needs. Approximately one in six currently uninsured low-income adults (those with incomes below 133% of the federal poverty level) has a severe mental health disorder and many others have mental health service needs for less severe mental disorders.[1] Because those with a mental health disorder are more likely to have low incomes, Medicaid will be the primary source of coverage for individuals with mental illness who gain insurance under ACA.[2] Policymakers implementing the ACA face several crucial decisions in effectively designing benefits, service delivery, and outreach and enrollment programs to meet the needs of newly-eligible adults with mental health disorders. To explore these issues, the Kaiser Commission on Medicaid and the Uninsured and the Bazelon Center for Mental Health Law convened a roundtable of national and state policy experts on November 16, 2010. This report summarizes the key issues participants raised in the discussion.

It is important to consider the unique needs of individuals with mild, moderate, and severe mental health disorders, respectively, in making decisions about the scope of benefits available under Medicaid expansions. Under the ACA, states have the option to provide newly-eligible Medicaid beneficiaries with a "benchmark" benefits package—typically more limited than traditional Medicaid benefits—rather than the full Medicaid benefit package. Participants agreed that, although research shows a high rate of mental disorder among the newly eligible group, many newly eligible with mental health service needs will have mild or moderate disorders. The types of mental health services they are likely to need—pharmacy, therapy, inpatient hospital, etc.—are typically included in private health insurance plans. Many believed that benchmark coverage could adequately meet the needs of this group. However, there was also consensus that benchmark coverage is not likely to provide the full scope and intensity of benefits needed by those with more severe illnesses such as schizophrenia or bipolar disorder. Participants felt that the full, traditional Medicaid benefits package was more appropriate for those with severe mental illnesses. The marked difference in service needs between those with mild/moderate and severe mental illness highlighted the key challenges states face in trying to develop benefit packages under reform. Participants noted particular challenges in operating two benefits packages for groups with different levels of mental health impairment and concluded that states will have to assess whether the expected actuarial difference between benchmark coverage and full Medicaid benefits merits the transaction costs of screening and assessment for running parallel programs.

The ACA provides new opportunities to design service delivery to better meet the needs of Medicaid beneficiaries with mental health needs. Participants were enthusiastic about the potential for new service delivery models such as health homes to improve integration of care, a critical component of treating individuals with mental illness. The behavioral health-based health home—wherein the health home is based in a behavioral health setting that integrates physical health—was the model participants felt would best serve individuals with serious mental illness, since their primary point of contact with the health system is likely their

mental health provider. For others, participants were enthusiastic about the potential for primary care-based medical homes to integrate services and promote early identification and effective treatment of mental illness. Participants were also optimistic that the changes the ACA makes to Medicaid home and community-based services will be pivotal to states covering important components of a recovery-focused mental health system and promotion of evidence-based practices.

Effectively serving newly-eligible adults with serious mental health needs calls for building capacity in the current mental health system. The group agreed that there is insufficient capacity and coordination in the current public mental health system to adequately serve the newly-eligible population with mental health needs. Participants also agreed that the future of state-funded mental health systems is unclear given the economy and health system changes under health reform. States will be faced with key decisions about how their mental health programs, as well as other state agencies such as housing and criminal justice, will work in conjunction with Medicaid to meet the needs of newly-insured adults with mental illness.

Targeted outreach and enrollment may be necessary to reach newly-eligible adults with mental illness and substance use disorders. Under health reform states are responsible for conducting outreach and enrollment to populations potentially eligible for Medicaid. Participants believed that most of the newly eligible with mental illnesses—especially those with serious mental illness—would most likely be reached through their current mental health provider when they access services, rather than through general outreach campaigns. Since many of these providers operate as direct service providers, these efforts will require education about the shift from a service delivery to an insurance model. Participants also noted the challenges individuals are likely to face transitioning between sources of coverage and the need for states to take actions to alleviate problems during coverage transitions.

The homeless population with mental illness presents particular challenges for outreach, enrollment, and service delivery under ACA-related Medicaid expansions. The homeless population has high rates of serious mental illness, and most are uninsured adults who will become eligible for Medicaid under the ACA. Homeless individuals with mental illness have very complex health and social services needs, and participants noted several challenges in enrolling and serving the homeless population in Medicaid. Many people in this population have experienced tenuous or negative interactions with public programs; they often lack a permanent address, which complicates Medicaid enrollment and renewal processes; and they are often in an age cohort (mid 50s) where their health problems are beginning to manifest. This could potentially place large demand on nursing home services which are often the only long-term option for ill individuals without other housing available.

Medicaid expansions under the Affordable Care Act offer the opportunity to improve access to care for millions of Americans with mental health disorders. States will be tasked with making decisions about designing benefits, structuring service delivery, and conducing outreach and enrollment for this population. In this roundtable discussion, participants emphasized the need for careful consideration of the unique health and social service needs of individuals with mental disorders, particularly those with severe disorders, in order to meet the potential of ACA to fully serve this population. Additionally, policymakers face many challenges in effectively serving individuals with mental disorders, but participants are hopeful that the provisions in ACA will help ameliorate longstanding issues of fragmentation, gaps in quality, and under-funding in the mental health system.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, aims to significantly expand access to affordable health coverage and reduce the number of uninsured Americans. A principal pathway for achieving these aims is the expansion of Medicaid eligibility to all individuals with incomes up to 133% of the federal poverty level (FPL— $14,484 for an individual and $29,726 for a family of four in 2011). Prior to reform, eligibility for Medicaid was limited to those who met income eligibility requirements (often set lower than the new threshold) and who fell into specified categories, such as parents or individuals with disabilities; as a result, many low-income individuals, particularly adults, were left out of eligibility. The Medicaid expansion passed as part of the ACA will reach millions of uninsured Americans. Approximately 17.1 million currently uninsured adults have incomes that qualify them for this new eligibility pathway.[3]

The newly-eligible Medicaid population includes many individuals with mental health needs. Approximately one in six currently uninsured low-income (<133% FPL) adults has a severe mental disorder, and many others who do not meet the criteria for severe disorder also have mental health service needs for less severe mental disorders.[4] Because those with a mental health disorder are more likely to have low incomes than those without, Medicaid will be the primary source of coverage for individuals with mental illness who gain insurance under ACA.[5]

Newly-eligible individuals with mental disorders may have a broad range of specialized service needs, such as psychosocial counseling, pharmacotherapy, partial hospitalization, residential services, mobile crisis services, or assertive community treatment. People with serious mental illness often require additional non-medical services, such as income support, vocational training, or housing assistance, to help them manage day-to-day activities. Some people with severe mental illness have functional impairments or face complex problems including homelessness, extreme (below 50% FPL) poverty, or criminal justice system involvement. In addition, individuals with mental disorders are more likely than those without to have physical health problems or substance use disorders. Thus, they also rely on non-mental health services and have a high need for care coordination across sectors of the health system.

Policymakers implementing the ACA Medicaid expansion face several crucial decisions in effectively designing benefits, service delivery, outreach, and enrollment programs to meet the needs of newly-eligible adults with mental health disorders. To explore these policy issues, the Kaiser Commission on Medicaid and the Uninsured and the Bazelon Center for Mental Health Law convened a roundtable of national and state policy experts on November 16, 2010. This was the third roundtable in a series conducted by the Kaiser Commission on Medicaid and the Uninsured focusing on issues related to the implementation of the ACA. This report summarizes the key issues participants raised in the discussion.

KEY ISSUES

1. It is important to carefully consider the unique needs of individuals with mild, moderate, and severe mental disorders, respectively, in making decisions about the scope of benefits available under Medicaid expansions.

Under ACA, states have some flexibility to design Medicaid benefits packages for newly-eligible adults. Most notably, states have the option to provide newly-eligible Medicaid beneficiaries a “benchmark” or “benchmark equivalent” benefits package, rather than the traditional, full Medicaid package.[6] Benchmark benefits are typically more limited than traditional Medicaid benefits. Federal law defines

benchmark coverage as that equal to one of three specified commercial insurance products or other coverage approved by the U.S. Secretary of Health and Human Services. Benchmark equivalent coverage includes basic specified services and has an aggregate actuarial value equivalent to one of the benchmark options. ACA requires that benchmark and benchmark equivalent coverage contain certain "essential benefits," including mental health and substance use disorder services and treatment; the specific definition and breadth of essential coverage will be determined through rulemaking by the Secretary of Health and Human Services. Benchmark coverage must also comply with the Mental Health Parity and Addiction Equity Act of 2008, which calls for insurers to use similar financial requirements and treatment limitations for physical and behavioral health services. States may provide additional services to supplement benchmark coverage or design specialized benchmark packages for specific groups of beneficiaries (e.g., those with chronic conditions), but they are not required to do so.

Federal regulations exempt certain populations from mandatory enrollment in benchmark coverage rather than traditional Medicaid coverage. Individuals falling into these groups must be provided the option of receiving traditional, full Medicaid benefits. These groups include (among others) those with "special health needs," including individuals with disabling mental disorders and individuals with mental disabilities that significantly impair their ability to perform one or more activities of daily living.[7] Current federal regulations do not specifically exempt adults with a serious mental illness, instead leaving to the states the decision to include or exclude this population.[8]

Participants agreed that, although research shows a high rate of mental disorder among the newly eligible group, many newly eligible with mental health service needs will have mild or moderate disorders. The types of mental health services they are likely to need—pharmacy, therapy and inpatient hospital—are typically included in private health insurance plans. Many believed that benchmark coverage could adequately meet their health service needs.

However, there was also consensus that benchmark coverage is not likely to provide the full scope and intensity of benefits needed by those with more severe illnesses, such as schizophrenia or bipolar disorder. These individuals will have needs similar to those who currently qualify for Medicaid due to a psychiatric disability and are likely to require many of the unique services covered by traditional Medicaid coverage to meet the needs of low-income individuals with severe mental illness, such as intensive case management, crisis intervention, and psychosocial support services. Participants also noted the importance of the rehabilitative services option available to states under traditional Medicaid (the "rehab option") in providing many services needed by those with severe illnesses. The flexibility allowed under this service category enables states to finance a range of psychosocial services, such as peer specialist counseling, family psycho-education, and supported employment .[9] The group noted that lack of access to the full range of support services for newly eligible individuals with severe mental illness could lead to increased burden on inpatient care units or public mental health systems due to unmet need.

Given the difference in service needs between those with mild/moderate and severe mental illnesses, as well as the requirement that individuals with disabling conditions have the option of full Medicaid benefits, participants noted several challenges in opting to provide benchmark coverage for newly-eligible Medicaid beneficiaries. Operating two different benefit packages for groups with different levels of mental health impairment presents administrative challenges and transaction costs. States opting for this approach have to establish criteria for exemption from benchmark coverage, and beneficiaries need to be individually screened to determine which benefits package they receive. Many participants noted that current approaches for such criteria and screening are quite onerous, noting that the disability

determination process is slow and complex. Participants also noted that operating two benefits packages can be costly. A participant from one state described how that state had determined that the transaction costs of screening and assessment for its expansion population outweighed the small (7%) actuarial difference between benchmark coverage and full, traditional Medicaid benefits.

Many participants agreed that states could be well served by opting to provide full, traditional Medicaid benefits to newly eligible adults. In addition to avoiding transaction and administrative costs described above, states could avoid increased costs in other areas due to unmet needs under benchmark plans. Some noted that the high federal matching rate available under the Medicaid expansion creates an incentive to provide full Medicaid benefits, since costs in other sectors such as the public mental health system would be financed with state only dollars. Further, participants believed that states could rely on medical necessity criteria and other utilization control tools to ensure that individuals receive only appropriate services under full Medicaid benefits.

Attendees did raise some concerns about the scope of benefits available even under full Medicaid benefits. In particular, questions were raised about how expansive the rehabilitation benefit could be and whether it would include services such as job placement and housing assistance. Participants also mentioned the challenge of having organizations that currently provide such services transition to a Medicaid billing system.

Discussion also highlighted the importance of early federal guidance on the essential health benefits required under benchmark plans in order for states to move forward with key decisions on whether to offer such plans. Analysis of costs and trade-offs of operating two benefits packages requires specific information about what will be included in the essential benefits package, and states face decisions about benefits design well before the 2014 implementation date of the expansion.

While the design of the benefit package, as well as what mental health parity means in practical terms for beneficiaries, are important issues to tackle, many agreed that ensuring individuals are diagnosed and therefore able to access the services they need was a more pressing concern. The behavior within mainstream plans and the general medical health system has led to low detection rates of mental health and substance use disorders, which results in benefits that are currently available not being used effectively.

2. **ACA provides new opportunities to design service delivery to better meet the needs of Medicaid enrollees with mental health needs.**

Health Homes Have the Potential to Improve Integration of Mental Health Care in Medicaid

Much of the discussion of service delivery for newly eligible Medicaid beneficiaries with mental illness focused on the need for better integration of mental health and physical health, given the high rates of comorbidity between mental and physical illnesses. Participants were enthusiastic about the potential for new service delivery models such as health homes to improve integration. Health homes are a patient-centered model of service delivery that includes comprehensive care management, care coordination and health promotion, transitional care from inpatient to other settings, individual and family support, referral to community and social support services as needed, and use of health information technology to link services.[10] ACA establishes a new state option, effective January 1, 2011, that allows states to establish health homes for enrollees with chronic conditions, including mental health conditions. All health homes (regardless of whether they target those with mental illnesses)

must address mental health and substance use disorder issues. States receive enhanced federal matching (90%) for the first two years that the Medicaid health home is in effect. CMS recently released guidance for states seeking to take up this new option.[11]

Participants discussed two potential models of health homes allowed under ACA: (1) a health home based in a physical health setting (e.g., a community health center, clinic, or private practice) that would also provide mental health services and (2) a health home based in a mental health agency or behavioral health specialist office that would also provide physical health services. Both models were viewed as useful additions to mental health service delivery.

The primary-care based health home model was viewed as appropriate for those with milder and more moderate mental health conditions, as their main point of contact with the health system is likely through their physical health provider. The concept of bringing mental health expertise into primary care was seen as having great potential for earlier identification and effective treatment. For example, only half of depression cases are currently identified in primary care visits, and even then frequently the individual often does not receive appropriate, evidence-based treatment. There was some concern among the group as to whether solo practitioners or small group practices would be able to bring mental health professionals on board, as doing so may be too costly or not suited to their style of practice. The group proposed that expanded Medicaid coverage of telemedicine could enable those practices to receive the necessary psychiatric consultation. This approach could be particularly relevant in rural areas.

Participants believed that the behavioral-health based health home model was a better option for individuals with severe mental illnesses, since their primary point of contact with the health system is likely their mental health provider.

Participants suggested that the availability of enhanced matching for health homes provides a window of opportunity for states to establish and develop health homes in their current Medicaid programs. Participants expressed some concern about states sustaining programs at their regular matching rate, but the enhanced federal funding for newly-eligible beneficiaries (starting at 100% and incrementally dropping to 90%) will allow states to continue health homes for this group at a similar matching rate. The law also requires evaluations of the value, quality and cost-effectiveness of health homes, which will help guide state decisions about their future role in Medicaid.

Improvements in Home and Community-Based Services Can Support Development of a Recovery-Based Model of Care

Participants were similarly optimistic about the potential for recent changes to Medicaid home and community-based service (HCBS) to improve service delivery for individuals with mental illness. Originally passed as part of the Deficit Reduction Act of 2005, the 1915(i) state option allows states to provide HCBS as a state option, rather than requiring them to obtain a federal waiver to provide such services (as in the past). ACA made several changes to 1915(i), effective October 1, 2010, that enable states to expand the availability of HCBS. Specifically, ACA expands financial eligibility for 1915(i) services, allows states to target such services to specific populations (such as those with serious mental illness) and expands the services states may cover under this option.[12] Many believe that the changes to HCBS will be pivotal to states covering important components of a recovery-focused mental health service delivery system, such as peer support, supported employment, and supported living services.

Participants indicated that the ability to provide these services will allow Medicaid programs to provide evidence-based practices for recovery.

Payment and Coverage Decisions Can Promote Quality Improvement in Medicaid Mental Health Care

The group repeatedly mentioned the importance of designing the Medicaid expansion in a way that promotes high quality behavioral health services. Participants believed that the Medicaid expansion provides a window of opportunity to revisit coverage and payment policies and to implement strategies to promote high quality mental health care.

A primary approach to achieving this goal is promotion of evidence-based practices (EBPs), an issue to which the discussion repeatedly returned. Many noted a shortage of EBPs in mental health service delivery, despite the research establishing many EBPs that produce good health outcomes and reduce costs. Participants agreed that strict standards of care, along with reimbursement policies consistent with these standards, could improve access to evidence-based services.

Notably, some participants were skeptical about the use of coverage decisions to promote EBPs (that is, use of a policy that only EBPs are included within the scope of covered benefits), since many practices in mental health are still being established or have effectiveness that varies greatly across individuals. However, participants were optimistic about the potential for payment policy to promote EBPs, which would encourage their use without cutting off access to other services. A participant from one state described a recent rate reform in that state that created a tiered payment system to pay significantly more for services known to be effective. Though the rate change is recently new and thus not evaluated, providers have responded well to it and state officials believe it holds great promise. Similar "pay for performance" payment policies also were seen as useful for promotion of health homes and other service delivery models.

The group also discussed the potential for managed care arrangements to address quality concerns in Medicaid mental health services. Currently, individuals in Medicaid with serious mental illness typically receive their mental health services "carved out" from their general medical managed care plans, either on a fee-for-service basis or through specialty managed behavioral health organizations. Participants anticipate that many states will look to similar arrangements for their newly-eligible populations, and they stressed the importance of some specialty plan capacity to manage mental health services for this population. Many view state contracts with managed care plans as a crucial locus point for developing quality initiatives and hope that states use these contracts to incorporate quality improvement initiatives for mental health.

Integration of Substance Use Disorder Services Into Insurance Coverage Can Improve Access and Coordination

The inclusion of substance abuse coverage in services available to newly eligible Medicaid beneficiaries was viewed as an important step toward integrating such services into both physical health and mental health delivery systems. While some providers have been moving toward integration of these services, the fact that they are currently funded through different sources is viewed as hindering integration. Many providers of substance use disorder services operate under a direct services model, relying on contracts with states and other payers, rather than through an insurance model. Participants were hopeful that health reform would provide an opportunity to incorporate treatment for substance use disorders into health insurance. Because most substance abuse providers are not linked to the Medicaid

program but work on a contract basis, it will be important for Medicaid programs to help these providers with this transition.

3. Effectively serving newly-eligible adults with serious mental health needs calls for building capacity in the current mental health system.

Throughout the discussion, participants raised concerns about the current state of the public mental health system and its ability to meet growing need. The group was unified in its belief that there is insufficient capacity and coordination in the current system to adequately serve the newly-eligible population with mental health needs.

A major area of concern is having enough providers to ensure access to behavioral health services. Participants noted a shortage of providers to meet even the needs of those currently receiving services. Additionally, there is concern about provider participation rates in Medicaid expansions, particularly for behavioral health providers who currently operate outside the Medicaid program and would need to be enrolled in state programs or managed care plans. There has been some resistance to participating in Medicaid from both mental health and physical health specialty providers out of fear that they will be inundated with referrals because of a lack of other specialists in the program. Participants discussed approaches to addressing potential provider shortages, such as relying on primary care providers to deliver some behavioral health services. However, participants believe that doing so requires making mental health support available to primary care providers, either through a licensed mental health provider on the floor or available for consults within a health plan. In more rural locations, where specialists are less concentrated, one possible solution is to use telemedicine services to provide some assistance.

Currently, many uninsured individuals with mental illness are served by state-funded public mental health systems. State mental health agencies are struggling from weak provider infrastructure, the loss of state general fund dollars and continued provider reimbursement rate cuts. This situation is likely to only get worse, given the economic and state budget outlook. The future role of state mental health programs under health reform is unclear. Some state legislators are looking to further cut public mental health programs in light of the Medicaid expansion and inclusion of mental health services. However, participants agreed that state mental health agencies will continue to serve an important role in the delivery of mental health services, particularly for the remaining uninsured or for services that fall outside the scope of Medicaid benefits.

As more of their patient population becomes eligible for Medicaid coverage, states will be faced with key decisions about how their mental health programs will work in conjunction with Medicaid to serve individuals with serious mental disorders. Currently, many states appropriate the Medicaid match for behavioral health services to the state mental health agency for Medicaid patients treated by such programs. This arrangement creates confusion as to which agency is responsible for the Medicaid beneficiary, particularly when that Medicaid recipient is under a Medicaid managed care plan, as the plans are paid on a per-member per-month basis rather than a fee-for-service basis. Additionally, keeping track of what services are being provided under which system and by which providers has proven difficult. Tracking such data would help the two systems to work together and identify gaps in mental health coverage. Participants discussed the importance of extending the electronic health record incentive payment program to mental health providers to help address these challenges in coordinating across mental health providers.

Discussion also highlighted the related issue of coordination across other state agencies, particularly housing and criminal justice. Individuals with serious mental illnesses have complex needs and typically rely on services from many sectors for support. Lack of coordination between sectors fragments service delivery and can lead to increased costs for states. Shifting currently uninsured individuals with mental illness into Medicaid coverage will restructure interactions between state agencies. Further, the 2010 election resulted in almost half the states having new agency directors. While this turnover will be challenging, participants believe it could also provide an opportunity to build relationships that promote interagency coordination.

4. **Targeted outreach and enrollment may be necessary to reach newly-eligible adults with mental illness and substance use disorders.**

Under health reform, states are responsible for conducting outreach and enrollment for vulnerable and underserved populations eligible for Medicaid. States are also required to adopt simplified enrollment procedures and to coordinate Medicaid enrollment with that for other coverage options, such as enrollment through Health Insurance Exchanges or CHIP. Many challenges facing states in outreach and enrollment for those with mental illness are similar to those they face for other populations. For example, states are likely to face language and geographic barriers, must educate those with limited familiarity or experience with Medicaid, and will likely partner with community-based organizations to reach newly-eligible adults.[13] However, participants also identified several issues particularly relevant to outreach and enrollment for the population with mental illness.

For example, many people with mental health disorders—particularly severe disorders—are already connected to service delivery systems or state services in some way. Thus, participants believe that most of the newly eligible population with mental illness will be enrolled through providers when they access services rather than learn about their eligibility through general outreach campaigns. Since many of these providers operate as direct service providers, rather than through insurance models, these efforts will require education about the shift from a service delivery to insurance model. Reaching the population with mental illness may also require restructuring the relationships between Medicaid and community mental health centers, substance abuse providers, and criminal justice systems, which may have limited experience with Medicaid eligibility and enrollment systems. The development of information technology systems to facilitate data sharing between Medicaid, mental health and substance abuse providers, criminal justice, and other relevant systems was viewed as essential to reaching individuals with mental illnesses.

Participants also noted several challenges in transitions between sources of coverage for the population with mental illness. The low-income population is likely to experience fluctuations in income that will make a person's eligibility for Medicaid or Health Insurance Exchange insurance subsidies change over time. In Massachusetts, for example, the state found that 9,000 people (out of 1.3 million who participate in both programs) move between their Commonwealth Care program and the Connector each month. Individuals with mental illnesses might have a particularly difficult time with transitions between coverage sources, given the critical nature of the therapeutic alliance between patient and provider. Further, differences in the scope of mental health benefits available under Medicaid and private plans means individuals transitioning will gain and lose access to several essential mental health services. Of particular concern were differences in drug formularies, as disruptions in psychiatric medications can have serious health consequences and potentially undermine functional improvements. Participants also expressed concern over whether those who end up obtaining an income that would

transition them out of Medicaid eligibility with the help of supportive services such as job training and housing supports would ironically lose those services and not be able to maintain progress. Some individuals with mental illnesses will also have difficulty with the stress of changing plans or be unable to complete the necessary administrative tasks due to cognitive deficits.

Discussion highlighted several possible actions to alleviate problems during coverage transitions. One option is for states to ensure that managed care organizations participating in the Exchanges also are included in Medicaid managed care programs. Alternatively, mental health providers serving the Medicaid population could become credentialed to participate in Exchange plan networks. States also have the flexibility to require Exchange plans to cover essential mental health provider agencies in their networks. Last, states could look to optional eligibility categories (such as buy-in programs for people with disabilities) to provide a transition period of extended Medicaid coverage.

5. The homeless population with mental health disorders presents particular challenges for outreach, enrollment, and service delivery under ACA-related Medicaid expansions.

The homeless population, which has high rates of serious mental illness,[14] was of particular concern to the group of experts. The majority of the homeless are single adults,[15] and most are uninsured and will be newly-eligible for coverage under ACA Medicaid expansions.[16] Homeless individuals with mental illness have very complex health and social support needs, as they experience high rates of substance use disorders, are in poorer physical health, have more barriers to employment, and are more likely to have contact with the criminal justice system than homeless individuals without mental disorders.[17] Compared to other individuals with mental illness, homeless individuals with mental illness face additional barriers to treatment due to their housing instability. Despite high levels of need, many lack access to mental health services: Over one in five homeless adults has an unmet need for mental health care.[18]

Participants noted several challenges in enrolling and serving the homeless population in Medicaid. This population's connection to public programs was described as tenuous or substandard and not always positive. Further, the lack of a permanent address presents challenges for Medicaid managed care plans and for Medicaid renewal processes. Last, experts described the homeless adult population as a specific age cohort, now in their mid-50s, that is reaching the age at which many of their health problems will manifest. This cohort effect will potentially place a large demand on nursing home services, which are often the only long-term option for ill individuals without other housing available.

Participants were in agreement that effectively serving the homeless population requires not only financing health services but also coordinating with community-based organizations that provide a wide array of social services such as housing and job training. With housing slots in public programs full and community-based organizations stretched thin from the economic downturn, participants discussed the potential to use the 1915(i) HCBS option to cover services for the homeless population and free up resources in other funding streams to focus on housing assistance. Another policy option mentioned is targeting Money Follows the Person demonstration initiatives to the homeless, since this long-term care program allows funding for transition coordinators to help recipients find suitable housing. Discussion also explored the potential of using "shallow subsidies" rather than Section 8 vouchers to assist the homeless with housing needs, since such subsidies allow for more flexibility in housing arrangements.

CONCLUSION

Medicaid expansions under the Affordable Care Act offer the opportunity to improve access to care for millions of Americans with mental health disorders. In implementing these expansions, states face several decisions about designing benefits, structuring service delivery, and conducing outreach and enrollment for this population. Throughout the roundtable discussion, participants emphasized the need for careful consideration of the unique health and social service needs of individuals with mental disorders, particularly those with severe disorders, in order to meet the potential of ACA to fully serve this population. Discussion also highlighted the need for coordinated activity, both between the federal government and states and between different state agencies, to address the comprehensive needs of individuals with mental disorders. Policymakers face many challenges in effectively serving individuals with mental disorders, but participants are hopeful that the provisions in ACA will help ameliorate longstanding issues of fragmentation, gaps in quality, and under-funding in the mental health system.

This brief was prepared by Chris Koyanagi of the Bazelon Center for Mental Health Law and Rachel Garfield, Jhamirah Howard, and Barbara Lyons of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The Commission extends its deep appreciation to the officials and experts who generously shared their valuable expertise, experience, and insights.

This was the third roundtable in a series conducted by the Kaiser Commission on Medicaid and the Uninsured focusing on issues related to the implementation of the ACA. For reports on other roundtables, see: http://www.kff.org/healthreform/health-reform-round-tables.cfm.

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This publication (#8181) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.