

# Medicaid Handbook: Interface with Behavioral Health Services

## Module 7

### *Recent Federal Legislation and Medicaid and Medicare*

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# Module 7: Recent Federal Legislation and Medicaid and Medicare

## ***Introduction***

This module examines the relationship of two major recent pieces of federal legislation—the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act—to the existing Medicaid and Medicare programs, and the importance of these laws to behavioral health care and the people who have mental and substance use disorders.

## ***The Mental Health Parity and Addiction Equity Act of 2008***

Passage of the Paul Wellstone and Pete Domenici MHPAEA was intended to align insured health care benefits for M/SUDs with those for medical and surgical care. The goal of MHPAEA was to stop inequitable practices that had been undertaken by some health insurers.<sup>1</sup>

## **Requirements of the Act**

MHPAEA requires certain group health plans, which are described more thoroughly below, to ensure that financial requirements (e.g., copays and deductibles) and treatment limitations that are applicable to M/SUD benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits.<sup>2</sup> MHPAEA does not mandate that a plan *must* provide M/SUD benefits. Rather, it requires that *if* a plan provides medical, surgical, and M/SUD benefits, it must provide them in an equitable fashion.<sup>3</sup>

MHPAEA supplements the provisions that were included in the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPA did not, however, apply to SUD benefits; MHPAEA continues the MHPA parity rules for mental health benefits and extends them to benefits for SUDs.<sup>3</sup>

## **Application of the Act**

MHPAEA applies to fully insured and self-insured group health plans covering more than 50 employees, Medicaid managed care plans, Taft-Hartley group health plans, Children's Health Insurance Program (CHIP), and federal employee benefits plans.<sup>1</sup> MHPAEA's requirements apply to Medicaid only insofar as a state's Medicaid agency contracts with managed care organizations (MCOs) or prepaid inpatient health plans (PIHPs) to provide medical, surgical, and M/SUD benefits. In these cases, the MCOs or PIHPs must meet the parity requirements. MHPAEA parity requirements *do not apply* to a state's Medicaid program if it does not use MCOs or PIHPs to provide benefits.<sup>4</sup> MCOs and PIHPs are discussed more fully in Module 5.

Application of the MHPAEA to CHIP is broader than its application to Medicaid. CHIP is a health insurance program for children; it is jointly funded by state and federal governments. States may choose to operate their CHIPs as an expansion of their Medicaid programs, as a separate program, or as a combination of both. Module 2 contains a more detailed discussion of CHIPs.

MHPAEA requirements apply to a state’s entire children’s health insurance plan including, but not limited to, any MCOs that contract with the state. Additionally, §502 of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) requires that CHIPs comply with the MHPAEA requirements “in the same manner” as such requirements apply to a group health plan. Therefore, if a state’s CHIP provides medical, surgical, and M/SUD benefits, then any treatment limitations, lifetime or annual dollar limits, or out-of-pocket costs for M/SUD benefits must comply with the provisions added to the Public Health Service (PHS) Act by MHPAEA. Section 502 of CHIPRA also specifies that CHIPs must satisfy M/SUD parity requirements if they provide coverage for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). This means that any state that operates its CHIP as an expansion of its Medicaid program or provides coverage of EPSDT benefits in a separate or combination CHIP will be in compliance with M/SUD parity requirements.<sup>4</sup> EPSDT is discussed more fully in Module 2.

### **Benefits That Require Parity**

The MHPAEA defines six classifications of benefits that require parity: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. If a plan has no network of providers, all benefits in the classification are characterized as out of network. If a plan provides any M/SUD benefits, it must provide M/SUD benefits in each classification for which any medical or surgical benefits are provided.<sup>5</sup> If a plan or issuer that offers out-of-network medical and surgical benefits also offers M/SUD benefits, it must offer out-of-network M/SUD benefits.<sup>3</sup>

The MHPAEA requires that plans make available certain information about M/SUD benefits. Specifically, the method by which determinations of medical necessity are made with respect to M/SUD benefits and the reason for a denial of payment for services with respect to M/SUD benefits must be made available to the participant or beneficiary.<sup>3</sup>

### **The Relationship of the Affordable Care Act’s Essential Health Benefits to the Mental Health Parity and Addiction Equity Act**

The Affordable Care Act extends application of MHPAEA to qualified health plans sold within states’ Health Insurance Marketplace (also known as the Health Insurance Exchange or Affordable Insurance Exchange). A qualified health plan is an insurance plan that is certified by the Marketplace, provides essential health benefits, and meets other requirements.<sup>6</sup>

The Affordable Care Act requires that by 2014, health plans offered in the individual and small group markets—both inside and outside of the Health Insurance Marketplace—offer a comprehensive package of items and services known as essential health benefits. A small group market has the meaning given under the applicable state’s rate filing laws, except that where state law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act.<sup>7</sup> These benefits must include items and services within at least the following 10 categories.<sup>8</sup>

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care

- Mental and substance use disorder services, including treatment of behavioral disorders
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace.

Congress directed HHS to construct the details of the essential health benefits package. HHS, in turn, asked the Institute of Medicine (IOM) to recommend a *process* for defining and updating the package, but not a specific list of benefits. After receiving input from the IOM and many other stakeholders interested in the outcome of the design, HHS announced in December 2011 a policy for implementing this section of the Affordable Care Act.

The announcement proposed that essential health benefits should be defined using a benchmark approach. Essential health benefits will be defined by a benchmark plan selected by each state. The selected benchmark plan will serve as a reference plan. Under this approach, states will have the flexibility to select a benchmark plan that reflects the scope of services offered by a “typical employer plan.” This gives states the flexibility to select a plan that best meets the needs of their citizens. States will choose one of the following benchmark health insurance plans:

- One of the three largest small-group plans in the state by enrollment
- One of the three largest state employee health plans by enrollment
- One of the three largest federal employee health plan options by enrollment
- The largest HMO plan offered in the state’s commercial market by enrollment.<sup>9</sup>

The benefits and services included in the benchmark plan selected by the state will be the essential health benefits package. Plans can modify coverage within a benefit category, as long as they do not reduce the value of coverage. If a state does not select a benchmark plan, HHS intends that the default benchmark will be the small group plan with the largest enrollment in the state.<sup>9</sup>

In addition to these considerations regarding essential health benefits, the Centers for Medicare & Medicaid Services (CMS) has provided guidance for defining essential health benefits for Medicaid benchmark or benchmark-equivalent plans. Note that the term *benchmark* used in this instance does not have the same meaning as the term *benchmark* used above. Since 2006, state Medicaid programs have had the option to provide certain groups of Medicaid enrollees with an alternative benefit package known as *benchmark* or *benchmark-equivalent* coverage, based on one of three commercial insurance products or a fourth, “Secretary-approved” coverage option. Beginning on January 1, 2014, all Medicaid benchmark and benchmark-equivalent plans must include at least the 10 statutory categories of Essential Health Benefits.<sup>10</sup>

## **Mental and/or Substance Use Disorder Benefits as Part of the Essential Health Benefits Package**

As noted above, M/SUD benefits are included in the Affordable Care Act's essential benefits package. Additionally, the Affordable Care Act extends the parity requirements for M/SUD benefits of MHPAEA to plans that provide the essential health benefits package.

In order to craft an essential health benefits package that is focused on the total health and well-being of the individual, there must be comprehensive physical and behavioral health components. This will necessarily mean addressing the historical imbalance between M/SUD benefits and physical health benefits, including significant differences in public and private coverage for M/SUD services and an unacceptably large treatment gap for people with mental and substance use disorder service needs. The inclusion of M/SUD benefits in the essential health benefits package underscores that meeting the needs of an individual's behavioral health is integral to improving and maintaining overall health.<sup>11</sup>

According to the Institute of Medicine (IOM) Committee on Determination of Essential Health Benefits, requirements for a broad and robust M/SUD benefit should include coverage for and access to:

- The full range of quality M/SUD prevention, treatment, rehabilitation, and recovery support
- The clinically appropriate type, level, and amount of care
- All services, interventions, and strategies to help people avoid disease and to help people with these illnesses achieve and maintain long-term wellness
- Ongoing supports to help people manage their disease throughout their lifetimes
- Services for children and families
- Services that are culturally appropriate.<sup>11</sup>

The committee also recommended using the Substance Abuse and Mental Health Service Administration's *Description of a Good and Modern Addictions and Mental Health Service System* to aid in determining which services should comprise the M/SUD benefit.<sup>12</sup>

### ***The Affordable Care Act of 2010***

The Affordable Care Act makes important changes to the U.S. health care system. The goals of health care reform include expanded coverage, controlled health care costs, and an improved health care delivery system. Many of these changes have begun and will continue to impact the Medicaid program and behavioral health services as they are implemented over the next few years.

Many of the Affordable Care Act's provisions are discussed in other modules of this handbook. Those that are not comprehensively addressed elsewhere are discussed below.



## **Provisions Included in the Affordable Care Act That Impact Medicaid**

### **Medicaid Expansion**

The Affordable Care Act establishes a new Medicaid eligibility category for low-income adults between 19–64 years of age and with income at or below 133 percent of the federal poverty level (FPL), which is an annual income of approximately \$15,282 for an individual and \$31,322 for a family of four in 2013.<sup>13</sup>

In states that implement this Medicaid expansion, eligibility will be determined using Modified Adjusted Gross Income (MAGI) based methods. If necessary for establishing income eligibility, an income disregard equal to 5 percentage points of the FPL will be applied. Under the law, the “newly eligible” individuals will be enrolled into a Medicaid Alternative Benefit Plan, which must include coverage of the ten statutory essential health benefit categories and comply with state and federal regulations.

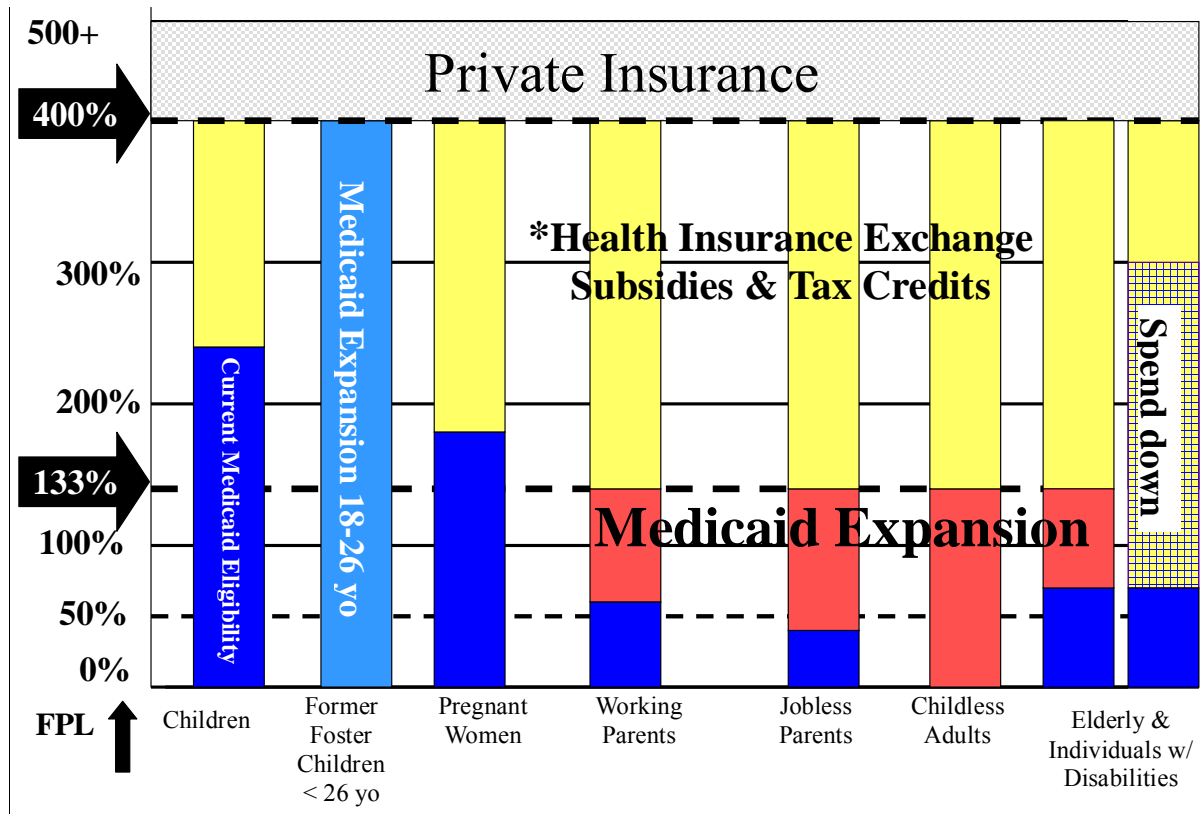
Individuals earning more than their state’s Medicaid eligibility threshold but less than 400 percent of the federal poverty guidelines have access to federal premium tax credits and/or cost sharing reductions to help pay for private health insurance—specifically qualified health plans—through the Health Insurance Marketplace. The Health Insurance Marketplace is intended to provide a central location where predictable and transparent insurance products can be purchased.

Individuals earning more than 400 percent of the federal poverty guidelines will not receive tax credits or subsidies to purchase insurance. However, these individuals will have the opportunity to purchase coverage in the Health Insurance Marketplace. The Health Insurance Marketplace is designed to make health insurance coverage in the individual and small group market easier to buy and more affordable. These Marketplaces will provide a “one-stop shop” for individuals to compare qualified health plan options, get answers to health coverage questions, find out if they are eligible for affordability programs like Medicaid and CHIP or premium tax credits to purchase private insurance, and enroll in a qualified health plan that meets their individual needs.

Although there is significant variation among state eligibility categories and associated requirements, the Figure 7-1 provides an overview of eligibility changes related to the Medicaid expansion using median Medicaid eligibility data from the states.

Current Medicaid eligibility is shown in bright blue and reflects the national median eligibility threshold. For example, in a list of eligibility thresholds from lowest to highest, the median eligibility for children is 250 percent of the federal poverty guideline. The yellow bars reflect the income categories that will be eligible for subsidies and tax credits associated with the Health Insurance Marketplace. The eligibility category associated with individuals who are elderly and/or individuals with disabilities is not directly impacted by the Affordable Care Act. The bars with the blue and yellow pattern represent the impact of spending down, which some states use to determine eligibility. For those states without spenddown provisions for the elderly and disabled, these individuals may qualify for the expansion, up to 133 percent of the federal poverty level, if they are not eligible for Medicare. The Medicaid expansion option is shown in red.

**Figure 7-1** *Current Median Medicaid/CHIP Eligibility Thresholds as a Percentage of the Federal Poverty Guideline and Eligibility Under the Affordable Care Act*



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**Understanding the Opportunities for Expansions in Medicaid Coverage and Associated Affordable Care Act Provisions**

According to a 2009 report, because almost half (46 percent) of uninsured Americans, or 21 million people, live in households with incomes under 133 percent of the federal poverty guidelines, the Medicaid expansion was projected to do more to increase the number of people with health insurance than any other provision in the law.<sup>15</sup> As originally intended, between 15 and 17 million Americans were projected to become insured through Medicaid, either because they were newly eligible or because of increased awareness of the Medicaid program as a result of the expansion.

***Childless Adults and Others Earning Up to 133 Percent of the Federal Poverty Guidelines***

The Medicaid expansion will most significantly impact the childless adult population. Most states do not cover childless adults, regardless of their income. As of January 2010, adults with low income and without dependent children could not qualify for Medicaid in 43 states.<sup>16</sup> Module 2 contains additional information on Medicaid eligibility. In states that choose to implement the Medicaid expansion, childless adults—and all other nonelderly individuals—earning up to 133 percent of the federal poverty guidelines will gain coverage.

### ***Individuals Not Covered by Their State's Medicaid Program and Earning Between 100 Percent and 400 Percent of the Federal Poverty Guideline***

As noted above, individuals earning between 100 percent and 400 percent of the federal poverty guidelines will have access to federal premium tax credits and/or cost sharing reductions to help pay for private health insurance—specifically qualified health plans—through the Health Insurance Marketplace. Therefore, even in states that choose not to implement the Medicaid expansion, individuals earning at least 100 percent of the federal poverty guidelines will have access to affordable insurance. In states that choose not to implement the Medicaid expansion, there will likely be a gap for childless adults earning less than 100 percent of the federal poverty guidelines.

There also could be a gap in access to affordable health care for parents with low income. Medicaid eligibility for parents varies by state. For example, as of December 2012—

- In Arizona, parents earning up to 106 percent of the federal poverty guidelines are eligible for Medicaid
- In New York, parents earning up to 150 percent of the federal poverty guidelines are eligible for Medicaid
- In Ohio, parents earning up to 90 percent of the federal poverty guidelines are eligible for Medicaid
- In Arkansas—the state that covers parents at the lowest income threshold—parents earning up to 17 percent of the federal poverty guidelines are eligible for Medicaid<sup>17</sup>

These examples illustrate the various ways in which individuals may be impacted by a state's decision to not implement the Medicaid expansion. Using the information above, if Arizona or New York chooses not to implement the expansion, there will be no gap in access to affordable insurance coverage because Medicaid eligibility for parents begins at greater than 100 percent of the federal poverty guidelines—the threshold for subsidies in the Health Insurance Marketplace. However, if Ohio or Arkansas chooses not to implement the expansion, the portion of the parent population earning more than the income threshold for Medicaid eligibility—90 percent and 17 percent, respectively—and less than 100 percent of the federal poverty guidelines will not have access to affordable insurance.

### ***Implications for States that Implement the Medicaid Expansion***

For many of the states that choose to implement the expansion, the implications are significant. For example:

- Under the terms of the expansion, children in families with income between 100 percent and 133 percent of the federal poverty guidelines who are covered by a CHIP at the time that the Medicaid expansion takes effect will be transitioned to Medicaid. This means that all children in families earning between 0 and 133 percent of the federal poverty guidelines will be in Medicaid beginning in 2014.<sup>18</sup>
- Medicaid eligibility for this expansion group will be based on income only, with no asset or resource test. This is a significant departure from the way most states currently determine eligibility.
- Using available tax return information, states will apply the modified adjusted gross income (MAGI) standard for determining financial eligibility for most Medicaid and

- CHIP enrollees. This includes a special income adjustment of 5 percentage points, so 133 percent of the federal poverty guideline becomes 138 percent. This is also a departure from the way that states currently determine eligibility. The transition to MAGI will require considerable systems and process changes by states, plus a significant increase in state or local capacity to process millions of applications.
- States will be responsible for up to 10 percent of the cost of the expansion population. The federal government will pay for 100 percent of the cost of the expansion for the first 2 years, decreasing to 90 percent in 2020 and beyond. According to the Congressional Budget Office, over the next 10 years the federal government will pay \$434 billion of the cost of the expansion and states will pay about \$20 billion.<sup>19</sup>
  - States must extend Medicaid coverage to individuals younger than 26 years who were in foster care at age 18. This includes access to the federal EPSDT benefit. EPSDT is discussed more fully in Module 2.
  - Starting in 2014, considerable interface will be required between Medicaid, CHIP, and the new state Health Insurance Marketplace. Specifically, states must:
    - Allow individuals to apply for Medicaid, CHIP, and Marketplace plan coverage through a single state-run website
    - Allow Medicaid applications and renewals online, with electronic signatures
    - Conduct outreach to uninsured and underinsured persons
    - Decide if the Marketplace may determine eligibility for premium subsidies.<sup>18</sup>

The Affordable Care Act gave states the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010. For states that chose this option, they will continue to receive their regular FMAP until 2014 even if they implement the expansion before that year. Beginning on January 1, 2014, if these states choose to implement the Medicaid expansion, they will then begin to receive 100 percent FMAP.

States that have already expanded eligibility to adults with incomes up to 100 percent of the federal poverty guideline will receive a phased-in increase in the FMAP for nonpregnant childless adults, so that by 2019 they will receive the same financing as other states. The Affordable Care Act requires that states maintain current Medicaid and CHIP eligibility levels for children until 2019 and current Medicaid eligibility levels for adults until a Marketplace is implemented.<sup>18</sup>

In deciding whether to implement the Medicaid expansion, states will need to evaluate the effects of insuring individuals who currently do not have access to health care and the cost of providing services. Following the Court's ruling on the Medicaid expansion, some states inquired as to whether they could expand Medicaid coverage to an income level less than 133 percent of the federal poverty guidelines and still receive enhanced federal financing. HHS responded that Congress directed that the enhanced matching rate be used to expand coverage to 133 percent and the law does not provide for a phased-in or partial expansion. As such, HHS will not consider partial expansions for populations eligible for the 100 percent federal matching rate in 2014 through 2016.

One additional impact of the expansion should be noted. There is widespread concern that adding this many people to the Medicaid program will result in a shortage of primary care providers—especially those most likely to work with Medicaid patients, such as pediatricians

and family practitioners. The shortage is exacerbated by current Medicaid reimbursement rates that often are criticized as being too low to encourage doctors to treat Medicaid consumers. This problem also needs to be considered in the context of the shortage in behavioral health service providers that already exists, in large part because of state budgetary pressures.

## **Provisions in the Affordable Care Act That Impact Medicaid and/or Medicare**

### **Establishment of the Center for Medicare & Medicaid Innovation**

The Affordable Care Act established the Center for Medicare & Medicaid Innovation (CMMI) within CMS. CMMI is charged with designing innovative payment and service delivery models for implementation in the Medicare and Medicaid programs. CMMI has already funded, and will continue to fund, a variety of projects nationwide that are focused on improving health care quality and efficiency while reducing costs.<sup>20</sup>

The Center's mission is:

- Better health care by improving all aspects of patient care, including safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity (the domains of quality in patient care as defined by IOM).
- Better health by encouraging healthier lifestyles in the entire population, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventative care.
- Lower national cost of health care and lower out-of-pocket expenses for all Medicare, Medicaid, and CHIP beneficiaries, through preventive medicine, coordination of health care services, and reduction of waste and inefficiencies.<sup>21</sup>

The Center is committed to discovering existing—and encouraging development of new—care delivery and payment models that result in better health care and better health at reduced costs. These models should:

- Have the ability to improve how care is delivered nationally and the greatest potential impact on Medicare, Medicaid, and CHIP beneficiaries.
- Focus on health conditions that offer the greatest opportunity to improve care and reduce costs.
- Address the priority areas in the National Quality Strategy.
- Meet the needs of the most vulnerable populations and address disparities in care.
- Improve existing Medicare, Medicaid, and CHIP payments to promote patient centeredness and better health outcomes.
- Be relevant across diverse geographic areas and states.
- Involve major provider types.
- Engage broad segments of the delivery system.
- Balance short-term and long-term investments.
- Be structured at a scale and scope consistent with the evidence.
- Be consistent with CMMI and CMS capacities.<sup>22</sup>

## **Prevention and Wellness**

### ***Improved Access to Preventive Services***

The Affordable Care Act expands the current Medicaid State Plan rehab option to include: (1) any clinical preventive service recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and (2) with respect to adults, immunizations recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices. Included in USPSTF's grade of A or B is alcohol misuse counseling, depression screening, and tobacco use counseling.<sup>23</sup> States that cover and prohibit cost sharing for these additional services and vaccines will receive a one percentage point increase in the FMAP effective January 1, 2013.<sup>24</sup>

### ***Annual Medicare Wellness Visit***

For preventive services provided on or after January 1, 2011, Medicare enrollees will have access to an annual wellness visit, a comprehensive risk assessment, and a personalized prevention plan. Medicare enrollees are eligible for an initial preventive physical exam during their first year of Medicare coverage and for personalized prevention services thereafter.<sup>20</sup>

## **Improving Reimbursement for Primary Care**

### ***Increased Medicare Reimbursement for Primary Care***

Primary care physicians and general surgeons will receive a 10 percent reimbursement increase for services rendered on or after January 1, 2011. The rate increase is to be effective for 5 years.<sup>20</sup>

### ***Increased Reimbursement to Medicaid Primary Care Providers***

The Affordable Care Act requires states to make Medicaid reimbursement at least equal to Medicare payment rates—which are typically higher than Medicaid reimbursement—for primary care services provided between January 1, 2013 and December 31, 2014. Primary care services eligible for this payment increase include: (1) evaluation and management services—the billing codes that most frequently correspond to new and establish patient office visits, and (2) services related to immunizations that are provided by a physician that primarily specializes in family medicine, general internal medicine, or pediatric medicine. Medicaid managed care plans are also subject to this requirement. The federal government will be responsible for paying 100 percent of the cost of the increase.

## **Shared Savings and Innovative Care Models**

### ***Medicare Shared Savings Program***

Beginning in January 2012, providers became eligible to organize as accountable care organizations (ACOs). An ACO is an organization of providers such as hospitals, physicians, and others involved in patient care that shares responsibility for coordinating and providing care to patients and is accountable for the care of consumers assigned to it. ACOs are responsible for the overall health care of a certain group of people for a fixed amount of money. ACOs are more thoroughly defined in Module 6.

The goal of the ACOs under the Shared Savings Program is to coordinate care for beneficiaries under Medicare Parts A and B. Providers organized as ACOs that meet quality-of-care targets and reduce costs are eligible to share in the savings they generate for Medicare.<sup>20</sup>

### ***Pediatric Accountable Care Organizations***

As discussed in Module 7, the Affordable Care Act contains two provisions that recognize the existence of ACOs—one for providers of services to Medicare consumers under the Medicare Shared Savings Program and one for pediatric providers, including those reimbursed by Medicaid. The Affordable Care Act establishes a demonstration project that allows states to implement pediatric ACOs. Under the demonstration, pediatric medical providers can organize as ACOs and are eligible to receive incentive payments from Medicaid. States will work with HHS to establish a minimal level of savings that must be reached for an organization to qualify for an incentive payment.

The pediatric ACOs must meet quality standards ensuring that care provided under the ACO is of no less quality than care that would otherwise be delivered by Medicaid and CHIP outside of the ACO. The federal law gives states considerable authority to define parameters for pediatric ACOs, unlike ACOs established under the Medicare Shared Savings Program.<sup>20</sup>

### **Payment Innovations**

#### ***National Pilot Program on Medicare Payment Bundling***

The Affordable Care Act established a pilot program aimed at encouraging hospitals and physicians to improve patient care and achieve savings for Medicare by implementing bundled payment models. Under the program, CMS will link payments for multiple services that patients receive during an episode of care and will evaluate how services surrounding an episode of acute care can be integrated to improve the coordination, quality, and efficiency of Medicare services.

<sup>20</sup> Bundled payments are discussed more thoroughly in Module 5.

### **Pharmaceuticals**

#### ***Discounts to Medicare Part D Enrollees***

Beginning in January 2011, a new Medicare coverage gap discount program began to provide a 50 percent discount on brand-name drugs to Medicare Part D enrollees who spend enough money on prescription drugs to enter the *doughnut hole*. Medicare enrollees enter the doughnut hole when they reach Medicare Part D's initial coverage limit for prescription drugs and become responsible for 100 percent of their drug costs until they become eligible for catastrophic coverage. Under the Affordable Care Act, additional discounts on brand-name and generic drugs will be phased in to completely close the doughnut hole by 2020.<sup>20</sup>

### **Hospital and Other Quality Initiatives**

#### ***Medicaid Payment for Health Care Acquired Conditions***

The HHS Secretary was charged with developing, by July 1, 2011, regulations prohibiting Medicaid from paying for costs associated with treating certain health care acquired conditions. To develop a list of health care acquired conditions for use in the Medicaid program, the Secretary identified current state practices that prohibit payment for health care acquired conditions.<sup>20</sup>

#### ***Reducing Avoidable Hospital Readmissions in Medicare***

For discharges from hospitals occurring on or after October 1, 2012, there will be a reduction in inpatient hospital reimbursement for hospitals with excess hospital readmissions for certain

conditions. The HHS Secretary named the first three conditions—heart attacks, congestive heart failure, and pneumonia—and will incorporate additional conditions by 2015.<sup>20</sup>

#### ***Medicare Hospital Value-Based Purchasing Program***

For hospital discharges occurring on or after October 1, 2012, a percentage of hospital reimbursement will be tied to hospital performance on quality measures related to common and high-cost conditions. This provision requires the HHS Secretary to select measures, other than measures of readmissions, and requires that quality measures chosen for fiscal year 2013 cover at least the following—

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Surgeries
- Health care-associated infections.<sup>20</sup>

#### ***Medicare Payment Adjustment for Conditions Acquired in Hospitals***

Beginning October 2014, hospitals in the top 25<sup>th</sup> percentile for rates of hospital-acquired conditions will be subject to a 1 percent payment penalty under Medicare.<sup>20</sup>

### **Disproportionate Share Hospital Payments**

#### ***Reductions in Medicaid Disproportionate Share Hospital Payments to States***

Because the original goal of the Affordable Care Act was to expand coverage to millions of currently uninsured Americans, Congress targeted Medicaid disproportionate share hospital (DSH) payments for a reduction. The DSH program is discussed in detail in Module 5. Congress reasoned that the DSH program will not need to be funded at its current level because hospitals now receiving DSH payments to cushion the blow of providing uncompensated care will instead receive reimbursement from Medicaid or other insurance plans once the Affordable Care Act is in effect.

DSH payments will decrease by \$14.1 billion between 2014 and 2020, with the reduction per year more heavily weighted toward the end of the decade. DSH cuts will be split among states based on the overall size of DSH participation per state. When making DSH allocation decisions, the HHS Secretary is instructed to look at the percentage of a state's reduction in the uninsured and whether a state targets DSH funds to hospitals with high Medicaid volumes or uncompensated care.<sup>25</sup>

#### ***Medicare Disproportionate Share Hospital Payment Reductions***

Beginning in October 2013, Medicare DSH payments—payments made to hospitals that provide a large amount of care to patients with low income—will be reduced by 75 percent. The Medicaid DSH program is discussed more fully in Module 5.<sup>20</sup>

### **Examples**

The Medicaid program and the Affordable Care Act provide tools to improve care and services for individuals with behavioral health needs and to undertake system reform. Development, enactment, and implementation of MHPAEA and the Affordable Care Act provide a strong public policy platform to remedy the historic disparity between: (1) the *benefits* provided in the



physical and behavioral health systems (e.g., absence of the provision of needed behavioral health treatments), and (2) the *system requirements* (e.g., limitations on behavioral health services, dissimilarities between behavioral and physical health benefits). However, it is imperative that policymakers, stakeholders, and advocates remain engaged and vocal in keeping the importance of these issues at the forefront of policy discussions. The significance of a state's decision to implement the Medicaid expansion to those served in our nation's behavioral health system cannot be overstated. Extending Medicaid to individuals earning up to 133 percent of the federal poverty guideline will provide access to behavioral health coverage for millions of individuals who previously did not have access to services or had access to services paid only with state funds.

For example, in Missouri, expanding Medicaid would provide coverage to an additional 300,000 Missourians; an estimated 50,000 of these previously uninsured Missourians would seek mental health services, including treatment for SMI.<sup>26</sup> Likewise, Michigan estimates that its mental health program would save approximately \$175 million in general fund/general purpose dollars by expanding Medicaid. Over 10 years, that would lead to about \$2 billion in savings to the state.<sup>27</sup> These are not small numbers. It is incumbent upon behavioral health stakeholders to ensure that state Medicaid officials understand the benefits of Medicaid expansion to the Medicaid and behavioral health programs and to their state and local economies.

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<sup>1</sup> Milliman. Mental Health Parity and Addiction Equity Act. *Basics*. Retrieved July 9, 2013 from <http://www.milliman.com/expertise/healthcare/services/mhpaea/basics/>.

<sup>2</sup> Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. SEC. 512. MENTAL HEALTH PARITY.(a)(1)(A)(i). [PDF version.] Retrieved July 9, 2013 from <https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/MHPAEA.pdf>.

<sup>3</sup> United States Department of Labor. (January 29, 2010.) Employee Benefits Security Administration. Fact Sheet. *The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Retrieved July 9, 2013 from <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

<sup>4</sup> Centers for Medicare and Medicaid Services. (November 4, 2009.) *Center for Medicaid and State Operations*. [PDF version.] SHO 09-014. CHIPRA #9. Retrieved July 9, 2013 from <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf>.

<sup>5</sup> *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*. Federal Register / Vol. 75, No. 21 / Tuesday, February 2, 2010 / Rules and Regulations. [PDF version.] Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf>.

<sup>6</sup> HealthCare.gov. *Glossary*. Retrieved from <http://www.healthcare.gov/glossary/q/qhp.html>. Accessed July 9, 2013.

<sup>7</sup> 45 CFR 154.102. Retrieved July 9, 2013 from <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+45+percent2FSubtitle+A+percent2FSubchapter+B&oldPath=Title+45+percent2FSubtitle+A&isCollapsed=true&selectedYearFrom=2011&ycord=1558>.

<sup>8</sup> HealthCare.gov. *Glossary*. Retrieved from <http://www.healthcare.gov/glossary/e/essential.html>. Accessed July 9, 2013.

<sup>9</sup> HealthCare.gov. *Essential Health Benefits: HHS Informational Bulletin*. Retrieved July 9, 2013 from <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

<sup>10</sup> Centers for Medicare & Medicaid Services. Center for Medicaid and CHIP Services. (May 22, 2012.) *Medicaid/CHIP Affordable Care Act Implementation. Answers to Frequently Asked Questions*. Benefits and

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Delivery Systems. [PDF version.] Retrieved July 9, 2013 from <http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/Benefits-FAQs.pdf>.

<sup>11</sup> Samuels P. (January 13, 2011.) *Addressing Mental Health and Substance Use Disorder Needs: Priorities for AFFORDABLE CARE ACT Implementation*. Institute of Medicine, Meeting of the Committee on Determination of Essential Health Benefits. [PDF version.] Retrieved July 9, 2013 from [http://www.iom.edu/~media/Files/Activity/percent20Files/HealthServices/EssentialHealthBenefits/2011-JAN-12/350 percent20Samuels.pdf](http://www.iom.edu/~media/Files/Activity/percent20Files/HealthServices/EssentialHealthBenefits/2011-JAN-12/350%20percent20Samuels.pdf).

<sup>12</sup> Substance Abuse and Mental Health Services Administration (SAMHSA) (April 18, 2011). *Description of a Good and Modern Addictions and Mental Health Service System, draft*. [PDF version.] Retrieved July 9, 2013 from [http://www.samhsa.gov/healthreform/docs/good\\_and\\_modern\\_4\\_18\\_2011\\_508.pdf](http://www.samhsa.gov/healthreform/docs/good_and_modern_4_18_2011_508.pdf).

<sup>13</sup> ASPE.HHS.gov. *2013 HHS Poverty Guidelines*. Retrieved July 9, 2013 from <http://aspe.hhs.gov/poverty/13poverty.cfm>.

<sup>14</sup> Based on Figure 4, Median Medicaid/CHIP Eligibility Thresholds, January 2012. Kaiser Commission on Medicaid and the Uninsured. *Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012*. Retrieved July 9, 2013 from <http://www.kff.org/medicaid/8272.cfm>.

<sup>15</sup> Collins S. (July 13, 2010.) The Commonwealth Fund Blog. *How the Affordable Care Act of 2010 Will Help Low- and Moderate-Income Families*. Retrieved July 9, 2013 from <http://www.commonwealthfund.org/Blog/How-the-Affordable-Care-Act-of-2010.aspx>.

<sup>16</sup> Cancer Action Network. American Cancer Society. (April 2010). *Affordable Care Act: Medicaid Expansion*. [PDF version.] Retrieved July 9, 2013 from <http://www.acscan.org/pdf/healthcare/implementation/factsheets/hcr-medicaid-expansion.pdf>.

<sup>17</sup> Statehealthfacts.org. Adult Income Eligibility Limits At Application as a Percent of the Federal Poverty Level (FPL), January 2013. Retrieved July 9, 2013 from <http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4>.

<sup>18</sup> Piper K. (June 15, 2010.) Sellers Dorsey. Medicaid Expansion. *Briefing for Medicaid Health Plans of America*. Webinar. [PDF version.] Retrieved July 9, 2013 from [http://www.mhpa.org/\\_upload/SDwebinarJune2010.pdf](http://www.mhpa.org/_upload/SDwebinarJune2010.pdf).

<sup>19</sup> Drum, K. (April 20, 2010.) Mother Jones. *The Cost of Medicaid Expansion*. Retrieved July 9, 2013 from <http://motherjones.com/kevin-drum/2010/04/cost-medicaid-expansion>.

<sup>20</sup> The Commonwealth Fund. *Health Reform Resource Center*. Retrieved July 9, 2013 from <http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx>.

<sup>21</sup> Centers for Medicare & Medicaid Services. Center for Medicare and Medicaid Innovation. Retrieved July 9, 2013 from <http://innovations.cms.gov/>.

<sup>22</sup> Centers for Medicare & Medicaid Services. Center for Medicare and Medicaid Innovation. *Our Portfolio Criteria* Retrieved July 9, 2013 from <http://innovations.cms.gov/About/Our-Portfolio-Criteria/index.html>.

<sup>23</sup> U.S. Preventive Services Task Force. (August 2010). *USPSTF A and B Recommendations*. Retrieved July 9, 2013 from <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.

<sup>24</sup> Affordable Care Act §4106. Retrieved July 9, 2013 from <http://www.healthcare.gov/law/full/index.html>.

<sup>25</sup> Affordable Care Act §2551. Retrieved July 9, 2013 from <http://www.healthcare.gov/law/full/index.html>.

<sup>26</sup> Office of Missouri Governor Jay Nixon. Missouri Governor Jay Nixon's News Release. *Accepting federal dollars for Medicaid expansion will help families and communities by strengthening Missouri's mental health system, Gov. Nixon says*. (February 14, 2013.) Retrieved July 9, 2013 from [http://governor.mo.gov/newsroom/2013/Gov\\_Nixon\\_discusses\\_how\\_Medicaid\\_expansion\\_will\\_improve\\_mental\\_health\\_strengthen\\_communities](http://governor.mo.gov/newsroom/2013/Gov_Nixon_discusses_how_Medicaid_expansion_will_improve_mental_health_strengthen_communities).

<sup>27</sup> House Fiscal Agency Memorandum. Re: Medicaid Expansion: Affordable Care Act. (July 17, 2012.) [PDF version.] Retrieved July 9, 2013 from [http://house.michigan.gov/hfa/PDFs/Medicaid\\_Expansion\\_Memo\\_Jul17.pdf](http://house.michigan.gov/hfa/PDFs/Medicaid_Expansion_Memo_Jul17.pdf).

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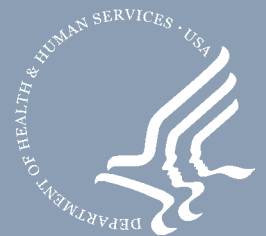
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