



February 13, 2013

**TO:** CMHDA Membership

**FROM:** Molly Brassil, Associate Director, Public Policy, CMHDA

**SUBJECT:** Implementation of the Patient Protection and Affordable Care Act and Other Health Care Reform Activities – Highlights & Recent Updates Relevant to California's Public Mental Health System

#### MEMORANDUM

On March 23, 2010, President Obama signed into law the comprehensive health care reform legislation promising to extend coverage to 33 million Americans, the Patient Protection and Affordable Care Act (ACA). Key components of the ACA include changes to private insurance, an emphasis on quality improvement and prevention & wellness, the creation of state health insurance exchanges and the expansion of public programs. Please find below several highlights and recent updates related to ACA implementation and other health care reform activities as they pertain to California's public mental health system.

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<http://www.cmhda.org/go/publicpolicy/healthcarereformresources.aspx>

## Federal Guidance

### *Basic Health Program and Expansion FMAP – CMS Q&A – February 6, 2013*

The Centers for Medicare and Medicaid Services (CMS) released on February 6, 2013 a Questions and Answers (Q&A) resource to help inform states in their implementation of the ACA. The Q&A primarily focuses on the Basic Health Program (BHP), Federal Medical Assistance Percentage (FMAP) considerations, and the transition to Modified Adjusted Gross Income (MAGI). Related to the BHP, CMS clarifies that due to the scope of coverage changes that states and the federal government will be implementing on January 1, 2014, the US Department of Health and Human Services (HHS) will not be finalizing guidance on this program until 2014, so that the program will be operational beginning in 2015 for states interested in pursuing this option. The Q&A also provides some important clarity on the increased FMAP for state expenditures for low-income individuals in the new adult group, including how CMS will decide whether the new FMAP applies and how states will qualify. To review the Q&A in its entirety, [click here](#).

### *Application of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit (Benchmark) Plans – CMS State Health Official Letter – January 16, 2013*

In connection with the President's announcement regarding the national response to the Sandy Hook tragedy, CMS released a State Health Official letter on January 16, 2013 on the *Application of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit (Benchmark) Plans*. This letter issues new guidance on application of MHPAEA in Medicaid and expands upon the existing guidance for CHIP. The letter additionally includes some limited discussion of "Prepaid Inpatient Hospital Plans" (PIHPs) and "Prepaid Ambulatory Health Plans" (PAHPs) and their role in providing a more limited set of state plan services, including in some instance through a "carve-out arrangement." Specifically, *CMS urges states with these [carve-out] arrangements to apply the principles of parity across the whole Medicaid managed care delivery system when mental health and substance use disorder services are offered through a carve-out arrangement*. According to the letter, CMS intends to issue additional guidance that will address this issue of "carve-out arrangements" and will continue to consider additional regulatory changes that may be necessary to properly implement MHPAEA. CMS plans to offer technical assistance to states regarding strategies for PIHPs and PAHPs to implement MHPAEA. To review the letter in its entirety, [click here](#).

It is still anticipated that HHS will release further guidance on mental health and addiction parity. Advocates speculate that the forthcoming guidance may simply finalize the interim final rules released in February 2010. However, advocates hope that the final parity guidance will be more substantive than the interim final rule, and go into more detail on some of the questions raised in the essential health benefit defining process, such as service exclusions.

*Medicaid Eligibility Expansion Under the Affordable Care Act of 2010, Part 2 – Notice of Proposed Rulemaking – January 14, 2013*

CMS released on January 14, 2013 in the Federal Register a Notice of Proposed Rulemaking (NPRM) titled “Medicaid Eligibility Expansion Under the Affordable Care Act of 2010, Part 2” (CMS-2334-P). While this notice has not yet been officially “published” in the register, the pre-publication version is now available in PDF format for review. It will be formally published on January 22, 2013. To review the pre-publication version of the NPRM, [click here](#). Specifically, the NPRM proposes new and more streamlined eligibility rules, a structure and processes with state options for Medicaid and Children’s Health Insurance Program (CHIP) eligibility appeals and notices that promote coordination with the Exchanges, provisions related to Medicaid essential health benefits for the new low-income adult population that will become eligible for Medicaid in 2014 and additional eligibility categories authorized in the Children’s Health Insurance Reauthorization Act (CHIPRA) and the ACA, such as former foster care children, deemed newborns (as amended by CHIPRA), family planning coverage through the state plan, and coverage of lawfully residing children and pregnant women. Public comments are due February 13. CMHDA will be reviewing the NPRM closely alongside both state and federal partners and will plan to submit comments as appropriate.

*Conversion of Net Income Standards to MAGI Equivalent Income Standards – CMS State Health Official/Medicaid Director Letter – December 28, 2012*

On December 28, 2012, CMS released the much anticipated guidance regarding Modified Adjusted Gross Income (MAGI) conversion. The purpose of this guidance is to inform states about the provisions under the ACA for converting current net income eligibility thresholds to equivalent MAGI thresholds in the Medicaid program and CHIP, the conversion methodology and process, and the timeframes for executing the conversions. To access and review the guidance, [click here](#).

*Exchanges, Market Reforms and Medicaid – CMS Frequently Asked Questions – December 10, 2012*

On December 10, CMS released a Frequently Asked Questions (FAQ) resource addressing a number of issues related to Exchanges, market reforms and Medicaid. Of particular interest to many stakeholders was the guidance provided related to the expansion of the Medicaid program. Foremost, the guidance is clear that states choosing to expand must expand coverage to 133% of the federal poverty level (FPL) in order to receive the enhanced federal matching funds (100% support for newly eligible adults in 2014, 2015, and 2016). The FAQ asserts that the law does not provide for a phased-in or partial expansion and, as such, CMS will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. To review the FAQ in its entirety, which includes a number of other key points of clarification on Medicaid, [click here](#).

*Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders – CMCS Informational Bulletin – December 3, 2012*

On December 3, 2012, the Center for Medicaid and CHIP Services (CMCS) released an informational bulletin regarding *Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders*. According to CMCS, the purpose of the bulletin is to provide information regarding services and good practices for individuals with a behavioral health disorder. Citing increasing interest in this issue, CMCS plans to release a series of Informational Bulletins over the next year that will provide additional information regarding services and supports to meet the health, behavioral health and long term services and support needs of individuals with mental health or substance use disorders. To review the CMCS Informational Bulletin, [click here](#).

*Patient Protection and Affordable Care Act Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation – Proposed Rule – November 26, 2012*

CMHDA submitted comments in late December to HHS outlining our concerns and recommendations regarding the proposed regulation related to *Patient Protection and Affordable Care Act Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation* (CMS-9980-P). The proposed federal rule primarily seeks to codify the approach described in the Essential Health Benefits bulletin released by the Center for Consumer Information and Insurance Oversight (CCIIO) December 2011 ([click here](#)), which was followed by an FAQ released in February 2012 ([click here](#)) and an additional bulletin on actuarial value also released in February 2012 ([click here](#)). The outlined approach, and now proposed through regulation, utilizes a reference plan model by which states essentially identify an existing insurance product to set as the benchmark – supplementing as necessary in order to ensure coverage of all ten essential health benefits, including mental health/substance use disorder treatment. The proposed rule provides an explicit recognition of the ACA requirements for essential health benefits to include mental health and substance use disorder services, in a manner consistent with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). While CMHDA and our partners are pleased with this recognition, we do have a number of concerns, as outlined in our comments, related to the lack of detail in a number of key areas, including, among others, compliance enforcement, specific benefits, discrimination standards and benchmark supplementation.

Additionally, CMHDA took the opportunity in our comments to HHS to raise ongoing concerns with the exclusion of non-pregnancy related methadone maintenance treatment in the benchmark plan selected by California to define the essential health benefits for the individual and small group market (*Kaiser Foundation Health Plan Small Group HMO 30 plan – federal product identification number 40513CA035*). CMHDA strongly believes that California's essential health benefit package for the individual and small group market should cover medication-assisted treatment that utilizes methadone. As asserted in our comments to HHS, CMHDA strongly believes that excluding use of methadone from ACA coverage in California violates several provisions of the ACA, including the parity and non-discrimination provisions of the federal law. CMHDA suggests that to be brought into compliance with the requirements of

the law, California's base-benchmark plan must be supplemented to cover medication-assisted treatment that utilizes methadone. The exclusion of methadone not only threatens to violate parity and non-discrimination provisions of the federal law, but also poses a significant threat to our public safety net system in California. If qualified health plans are not required to provide coverage for methadone in the treatment of opioid addiction, the burden of care for this vulnerable population will likely fall to our public system – in California being our "Drug Medi-Cal" system. California counties who manage this program would be in the position of using scarce public dollars to cover the cost of care for individuals who can and should be covered through their qualified health plan.

Finally, the proposed rule makes clear that the essential health benefit applicability to Medicaid will be defined in a separate regulation. Comments on the proposed regulation were invited through a 30-day comment period that closed on December 26. To review the proposed rule, [click here](#). To review CMHDA's comments to HHS, [click here](#). To review the national Coalition for Whole Health's comments, containing significantly more detail on many of the concerns raised in CMHDA's comments, [click here](#).

*Essential Health Benefits in the Medicaid Program – CMCS State Medicaid Director Letter – November 20, 2012*

On November 20, 2012, CMCS released a letter to State Medicaid Directors to provide guidance to states on Medicaid benchmark benefit coverage options (alternative benchmark plans). Essentially, this letter explains how HHS intends for participating states to operationalize the requirement to provide essential health benefits to the Medicaid expansion population. As noted in the letter, alternative benchmark plans were first defined in federal law per the 2005 Deficit Reduction Act (DRA) which amended the Social Security Act (SSA) to provide states with significant flexibility to design Medicaid benefit packages under the state plan. The guidance outlined in the letter closely aligns with the current alternative benchmark plan option, as established in 2005, and continues to provide states with significant flexibility in designing benefit packages. Moreover, the benchmarking process outlined in the letter is very similar to the process outlined in the proposed rule for the commercial sector (including qualified health plans in the Exchanges), however states are required to choose from slightly different plans (for example, the available options do not include small group plans). Also, an important additional option offered to states is "Secretary Approved Coverage" – which includes the Medicaid state plan adult benefit package offered in the state and may be supplemented to ensure coverage of the ten statutorily-specified essential health benefits. The guidance also makes clear that the MHPAEA applies to alternative benefit plans.

State Medicaid Director letters are not open for public comment. To review the November 20, 2012 letter, [click here](#).

**Medi-Cal Expansion**

Beginning January 1, 2014, the ACA establishes a new Medicaid eligibility group of non-pregnant adults between the ages of 19 and 64 with incomes at or below 138% of the federal poverty level based on modified adjusted gross income. This new eligibility group consists of

non-Medicare eligible childless adults and individuals receiving Aid to Families with Dependent Children. Participating states will receive 100% federal medical assistance percentage (FMAP) for the first three years of implementation, gradually declining to 90% in 2020 and thereafter. Participating states are required to provide essential health benefits (benchmark or benchmark equivalent coverage) to Medicaid beneficiaries in the new eligibility group. Following the June 2012 Supreme Court decision, states face a decision about whether to adopt the Medicaid expansion. The recently released NPRM on the Medicaid Eligibility Expansion provides states with further guidance regarding implementation of the optional expansion. Governor Brown's proposed budget makes it clear that California intends to continue toward implementation of federal health reform, and distinguishes between the "mandatory" expansions of Medicaid and the "optional" expansions of Medicaid. Significant discussion is intended to occur between the state and counties in order to determine California's course on the optional areas, and CMHDA will discuss the implications of these options with our members and the California State Association of counties (CSAC) over the coming months. To review a summary of the proposed Health Care Reform provisions in the Governor's FY 13-14 January Budget, [click here](#). To review CMHDA's summary of the Governor's Budget, [click here](#). It is also anticipated that the Legislature will take up legislative initiatives related to the Medicaid expansion this year. CMHDA will continue to work closely with our federal and state partners to monitor this issue and weigh in as appropriate to ensure that any policy development relevant to implementation of the Medicaid expansion aligns with the CMHDA-CADPAAC health care reform principles.

#### **Essential Health Benefits for the Individual and Small Group Markets**

Governor Brown recently signed complementary Senate ([SB 951 – Hernandez](#)) and Assembly ([AB 1453 – Monning](#)) bills related to the essential health benefits to be offered in the individual and small group market. With the signing of these bills, any individual or small group health care service plan contract or health insurance policy that is issued, amended or renewed in California on or after January 1, 2014 shall at a minimum include coverage for essential health benefits, including mental health and substance use disorder treatment (exceptions apply). Furthermore, this coverage requirement applies to individual and small group plans/policies offered to consumers and small businesses both inside *and outside* of California's Health Benefit Exchange. The legislation selects a Kaiser small group product as California's reference ("benchmark") plan. According to the Evidence of Coverage (EOC) for the identified benchmark plan, coverage should include services and benefits for a broad range of mental health conditions, utilizing the mental disorder definition as supplied by the DSM-IV-TR. To review the EOC for the identified benchmark product, [click here](#). CMHDA successfully advocated that language be added to the legislation to clarify that any individual or small group health care service plan or insurance policy issued, amended, or renewed on or after January 1, 2014 must comply with the MHPAEA of 2008 and all corresponding rules, regulations and guidance. CMHDA, and our partners with the California Coalition for Whole Health (CCWH), felt that the inclusion of this reference to federal parity law was particularly important in order to ensure plan/policy compliance with both quantitative and *non-quantitative* limitations – the latter of which may not be easily discernible in the benchmark EOC. Some questions still remain regarding coverage of certain substance use disorder treatments, such as methadone maintenance treatment which is excluded from coverage in the benchmark EOC. The next step

will be for HHS to review California's definition of essential health benefits and ensure appropriate inclusion of all ten statutorily required categories.

## **Covered California – California's Health Benefit Exchange**

### Qualified Health Plan Contracting and Benefit Design

Covered California (California's Health Benefit Exchange) is making steady progress towards its October 1, 2013 open enrollment launch. Covered California has been actively working with interested private health care plans to offer health benefit products online for individuals and small businesses. According to Covered California, consumers can begin using the web portal on October 1, 2013 to select the health plan that best meets their needs and determine if they qualify for federal subsidies to offset the cost of their premiums, or if they are eligible for other public insurance programs. The Covered California Board continues to meet monthly to tackle a host issues in preparation for a 2014 marketplace launch, including qualified health plan contracting and benefit design. In November 2012, Covered California filed emergency regulations to codify the qualified health plan solicitation. Covered California will hold a public hearing and 45-day comment period within the 180 day certification period following the effective date of the emergency regulations. CMHDA, alongside our partners with CCWH, was able to submit comments on the draft solicitation to primarily encourage stronger mention of mental health and substance use disorders as a reminder to qualified health plans that they must not only offer these benefits, but also that they must be offered at parity – meaning that networks must be adequate, grievance processes appropriate, health assessments inclusive, etc. To review those coalition comments submitted in October 2012, [click here](#). CMHDA will plan to reiterate these comments through the forthcoming public regulatory process. The board also spent considerable time at their December 2012 meeting discussing the standardized benefit plan options, which includes making adjustments to co-pays and deductibles for each metal tier to meet federal actuarial value requirements. According to the board, the top priority in benefit design is ensuring that the plan designs sell well and that consumers can make informed choices about options. To review materials from the December 2012 meeting, [click here](#).

### California Conditionally Approved by HHS to Operate State-Based Exchange

On January 3, 2013, HHS Secretary Kathleen Sebelius announced that California, along with six other states, has been conditionally approved to operate a State-based Exchange. The approval is conditional on Covered California continuing to meet its regulatory and start-up benchmarks. To date, 20 states, including DC, have been conditionally approved to partially or fully run their marketplaces – with the remaining states having until February 15, 2013 to apply for a State Partnership Exchange. Beginning in 2014, consumers in every state will be able to buy insurance from qualified health plans directly through these marketplaces and may be eligible for tax credits to help pay for their health insurance. To review the press release shared by Covered California following the notice of approval, [click here](#).

The next meeting of Covered California will be February 26 in Sacramento.

## **Section 1115(a) Waiver – California’s Bridge to Reform**

### Behavioral Health Service Plan

As part of the Special Terms and Conditions (STCs) of the 1115 Bridge to Reform Waiver, CMS has required the Department of Health Care Services (DHCS) to develop a behavioral health needs assessment and service plan to prepare for the 2014 Medicaid expansion. As outlined in the STCs, the state must submit a detailed plan to CMS outlining the steps and infrastructure necessary to meet requirements of a benchmark plan and ensure strong availability of behavioral health services statewide no later than 2014. This plan was originally due to CMS by October 1, 2012. However, DHCS requested a six-month extension from CMS in order to provide sufficient time to draft the proposal and ensure continued meaningful public input and transparency in the decision making process.

Per agreement between DHCS and CMS, DHCS submitted a plan outline to CMS on October 1, 2012, to satisfy the due date listed in the STCs. To review the outline, [click here](#). DHCS will plan to submit a revised Services Plan by April 1, 2013.

The finalized Services Plan will describe California’s recommendations for serving the Medi-Cal expansion population and demonstrate the State’s readiness to meet the mental health and substance use disorder needs of this population. According to DHCS, adjustments to the plan may be necessary depending on forthcoming federal guidance and/or state legislative action to implement components of the ACA. DHCS has indicated that they plan to convene stakeholders to inform the development of the final plan. CMHDA plans to participate in this process.

### Low Income Health Program

The Low Income Health Program (LIHP) is scheduled to end December 31, 2013 with the transition of eligible LIHP enrollees to Medi-Cal or a coverage option available under Covered California, effective January 1, 2014. DHCS has begun planning for the upcoming transition of LIHP enrollees to the new coverage options available in 2014 under the ACA. For more information on the transition, including the state’s initial transition plan and Frequently Asked Questions, [click here](#). To review CMHDA’s comments to DHCS on the draft transition plan, [click here](#).

## **Coordinated Care Initiative – California’s Demonstration to Integrate Care for Dual Eligible Beneficiaries**

CMHDA’s priority areas for further consideration in regard to implementation of the eight county demonstration to integrate care for dual eligible beneficiaries include risk and cost shifting concerns, information exchange barriers and opportunities, health plan payment and financial incentives, network coordination, performance measures and shared savings opportunities, among others. Pursuant to the Governor’s FY 13-14 January Budget, the demonstration is now slated to begin in September 2013. In addition to participating as a co-lead in the state’s Behavioral Health Workgroup to further vet and define demonstration policies relevant to mental health and substance use disorders ([click here](#) for more information on the state’s workgroup),

CMHDA has also been hosting monthly calls for our members in the eight participating counties in order to provide an opportunity for county-to-county exchange and share local implementation opportunities and challenges. For more information on California's proposed Duals Demonstration, [click here](#).

#### Governor's Proposed Timeline and Enrollment Phase-In

The Governor's Proposed FY 13-14 Budget includes key changes to the demonstration's timeline and enrollment process. Foremost, the proposed budget calls for implementing both parts of the CCI, the duals demonstration and transition to managed care for Long Term Supports and Services, in September 2013 (the authorizing legislation from 2012 stated that the demonstration should begin no earlier than March 2013). This means that the first notices that any beneficiaries would receive about these transitions would come no earlier than June 2013. Additionally, according to the Governor's proposal, enrollment in the program will take place as follows: in Los Angeles County, enrollment will phase in over 18 months; in San Mateo County, enrollment will occur all at once in September 2013; for all other counties, enrollment will phase-in over 12 months. To review the changes as described in the proposed budget, [click here](#) (see page 62).

#### Template Language for MOU between Duals Demonstration Health Plans and County Behavioral Health Departments

On January 4, 2013 CMHDA submitted comments to DHCS on the draft Template Language for the Memorandum of Understanding (MOU) between Duals Demonstration Health Plans and county Mental Health Plans (MHPs). CMHDA strongly supports the need to develop formal mechanisms to coordinate emergency and outpatient behavioral health coverage with the selected demonstration health plans, to assure that beneficiary risk and services costs are efficiently managed by both sectors. According to the state's proposal, many of the coordination activities are to be facilitated through the MOU between the demonstration health plans and MHPs. Given the strong emphasis on the MOU, demonstration health plans and MHPs will need to work closely together at the local level to ensure that current MOUs are appropriately redesigned and strengthened in order to achieve the desired coordination goals. To review the draft template language proposed by DHCS, as revised December 18, 2012, [click here](#) (see "Behavioral Health Coordination Documents Posted for Public Comment"). To review CMHDA's comments to DHCS, submitted January 4, 2013, [click here](#).

#### CMHDA Submits Comments to DHCS on Draft Care Coordination Standards for the Duals Demonstration

On December 10, 2012, CMHDA submitted comments to DHCS on the Draft Care Coordination Standards for California's Coordinated Care Initiative. The document made available by the Department for public comment proposes key care coordination standards to be followed by the demonstration health plans, which include the initial assessment process, the Health Risk Assessment, Individual Care Plans, ongoing care coordination, qualifications for care coordinators, and the role of Interdisciplinary Care Teams. To review the draft as released for comment on November 20, 2012, [click here](#). To review CMHDA's comments to DHCS,

submitted December 10, 2012, [click here](#). To review the revised draft care coordination standards, which incorporate the majority of CMHDA proposed edits, [click here](#).

### **Let's Get Healthy California Task Force**

On December 18, 2012, CMHDA submitted comments to the Let's Get Healthy California Task Force to provide feedback on the Final Report released in December 2012. Per the Governor's Executive Order, the California Health and Human Services Agency (CHHS) Secretary, Diana S. Dooley announced in June the creation of the "Let's Get Healthy California Task Force." The Task Force, made up of 25 appointed members and 20 appointed expert advisors, is charged with developing a 10-year plan to make Californians healthier by improving quality, controlling costs, promoting personal responsibility for individual health, and advancing health equity. The Task Force is co-chaired by Secretary Dooley and Don Berwick, MD MPP, who is a senior fellow at the Center for American Progress. To review the roster of task force members and advisors, [click here](#). The final report released in December establishes baselines for key health indicators, identifies obstacles and best practices, and provides recommendations and a framework for measuring improvements in key areas. CHHS has held calls and webinars throughout the summer and fall to gather stakeholder input and begin to outline a framework for improving the health of the population. CMHDA was able to take the opportunity to weigh in to support the inclusion of screening for and treating depression as one of the leading indicators identified in the framework. The majority of the discussion has focused on issues related to healthy communities, such as safe and clean neighborhoods, access to nutritious foods and promotion of physical activity. In response to comments raised by CMHDA, Task Force staff subsequently reached out to CMHDA in the fall to invite additional feedback on the depression indicator proposed in the framework to inform the work of the Task Force. With the help of our System of Care Committee members, CMHDA was able to pass along a number of informative depression screening and treatment resources to the Task Force. Additionally, CMHDA took the opportunity to make several recommendations for how mental health issues might be better included throughout the framework. CMHDA was pleased to note the inclusion of mental health and well-being as one of the key priorities outlined in the final report. To review the final report, [click here](#). To review CMHDA's comments on the final report, [click here](#). CMHDA hopes these comments might assist in the implementation of the goals outlined in the report, including the priority related to mental health and well-being. CMHDA plans to work with partner mental health organizations to continue to monitor the work of the Task Force to ensure ongoing recognition and inclusion of mental health in the discussion. For more information on the Task Force, [click here](#).

### **Policy Briefs and Reports**

#### [UC Berkeley-UCLA Report on Medi-Cal Expansion Under the ACA](#)

The UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research released in January 2013 a report on the Medi-Cal Expansion under the ACA – asserting "significant increase in coverage with minimal cost to the state." The report estimates growth in Medi-Cal enrollment among both the newly and already eligible using the UC

Berkeley/UCLA California Simulation of Insurance Markets (CalSIM) model. The report estimates the federal and state spending on increased Medi-Cal enrollment, along with the state tax revenues generated by new federal Medi-Cal spending and potential savings in other areas of the budget. Additionally, the report discusses the broader impact of the Medi-Cal Expansion in terms of health outcomes, providers and the economy. To access and review the report, [click here](#).

#### Kaiser Report on the Cost and Coverage Implications of the ACA Medicaid Expansion

The Kaiser Family Foundation, Commission on Medicaid and the Uninsured, recently released a report on the cost and coverage implications of the ACA's Medicaid expansion. The report, dated November 2012, includes both national and state-by-state cost estimates. A central goal of the ACA is to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and new Health Insurance Exchanges. Following the June 2012 Supreme Court decision, states face a decision about whether to adopt the Medicaid expansion. These decisions will have enormous consequences for health coverage for the low-income population. The analysis shows that the impact of the ACA Medicaid expansion will vary across states based on current coverage levels and the number of uninsured. The analysis asserts that by implementing the Medicaid expansion with other provisions of the ACA, states could significantly reduce the number of uninsured. According to the report, overall state costs of implementing the Medicaid expansion would be modest compared to increases in federal funds, and some states are likely to see small net budget savings. To access and review the report in its entirety, [click here](#).

#### Kaiser Brief on Role of Medicaid for People with Behavioral Health Conditions

The Kaiser Commission on Medicaid and the Uninsured recently issued a publication, *The Role of Medicaid for People with Behavioral Health Conditions*, dated November 2012, that examines Medicaid's role in providing care for adults with mental illness and substance use disorders and the program's potential to expand access for those who will be newly eligible for Medicaid coverage in 2014 under the ACA. The document also provides a statistical overview of the characteristics of the current Medicaid population versus their uninsured counterparts. To review the report, [click here](#).

#### UCLA Health Policy Fact Sheet on ACA Coverage Expansion and Mental Health Treatment

The UCLA Center for Health Policy Research released in late November a new study asserting that half a million uninsured adults in California who need mental health treatment could gain access to those services through health care reform. Of note, the study calls attention to the fact that in addition to providing new or improved health insurance coverage to as many as 4.6 million Californians, ACA will also implement the MHPAEA of 2008. The study also calls attention to the fact that mental health services will be part of the essential benefits package. According to the study, an estimated 1.6 million California adults reported symptoms that were consistent with severe psychological distress and experienced difficulty with their day-to-day functioning, and about a third of those adults – or half a million – were uninsured all or part of the year. According to the study, nearly 70 percent of uninsured adults with mental health needs

did not receive the mental health treatment they needed in the past year compared with 40 percent of adults with public insurance coverage and 46 percent with private insurance. The report also notes that with almost half of adults with both mental health needs and health insurance coverage also reporting no treatment, other barriers such as stigma may be keeping adults from receiving the mental health services they need. According to the study's principal author, the full implementation of health care reform in 2014 is an opportunity to improve anti-stigma programs and to tailor mental health services that are culturally and linguistically appropriate to reach ethnically diverse populations. To review the report, [click here](#).

#### **CMHDA-CADPAAC Joint Health Care Reform Principles**

CMHDA and the County Drug and Alcohol Administrators Association of California (CADPAAC) have jointly developed and adopted Health Care Reform Principles. The ten principles were reviewed and approved by both associations on December 13, 2012. CMHDA and CADPAAC believe that California's implementation of the ACA should be grounded in these outlined principles to ensure access to the highest quality mental health and substance use disorder services for those in need, and achieve health care reform objectives. The principles have been shared with key partners and policy makers. To review the adopted principles, [click here](#).

#### **CMHDA Resources and Contact Information**

CMHDA has created a new webpage under our "Public Policy" tab to focus on health care reform implementation activities impacting California's public mental health system. CMHDA hopes this will serve as a helpful resource for members in navigating the complex myriad of health care reform activities currently taking place in our state. Foremost, this webpage includes links to key state and federal resources, as well as recent comments developed and submitted by CMHDA to raise concerns with various policy proposals. To access and review the new webpage, [click here](#).

For any other health care reform inquiries or to learn more about CMHDA's new Health Care Reform Committee, please contact Molly Brassil at [mbrassil@cmhda.org](mailto:mbrassil@cmhda.org) or (916) 556-3477, ext. 152.