Medicaid Expansion & Mental Health Care

NAMI
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NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

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Medicaid Expansion and Mental Health Care

Introduction

The tragic shooting in Newtown, Connecticut and others have stimulated public discussion about the failed mental health system in America. After cuts of nearly $4.35 billion to public mental health programs from 2009-2012[1], mental health services simply are not available to many Americans who need help. With fewer than half of Americans who live with mental illness getting any treatment[2], concern is growing about lack of access to mental health services. People are asking, "Where can I get mental health services if I don't have health insurance and can't afford care?"

As of the date of publication of this report, only 20 states and the District of Columbia have committed to expanding their Medicaid programs. The facts are clear – six out of ten Americans living with serious mental illness have no access to mental health care at all. Glaring gaps in treatment of this kind would not be tolerated for heart disease, cancer or diabetes and they should not be tolerated for mental illness either. States that decline to expand Medicaid will miss as good an opportunity as they may ever have to address this shameful void in access to mental health treatment. See Appendix V to check the status of Medicaid expansion in your state.

Hoping to improve access, some lawmakers are pledging to invest in mental health care. One significant step that states can take is to extend Medicaid to 138 percent of the Federal Poverty Level (FPL), an option available to states as a result of the health reform law, the Patient Protection and Affordable Care Act (ACA).

Medicaid is the most important source of financing for mental health services in America today, offering mental health services that would otherwise be out of reach for low-income people affected by mental illness. Medicaid's role in mental health care has increased, and today the federal/state health financing program pays for nearly half of all publicly-funded mental health services.

Expanding Medicaid will fill critical gaps in access to health and mental health care, reduce uncompensated crisis care and pave the way to recovery and economic self-sufficiency for millions of Americans.

A broad array of vital mental health services and supports are covered by Medicaid. For many, like Sharon's son, Medicaid mental health services are life-changing:

"Three years ago, my son was in a very dark place. He was flunking out of school and living a life of seclusion. He holed up in his room while the rest of the family walked on eggshells. Today, he is a completely different person. It took three years of counseling and finding the right medication for his bipolar disorder, but we did it. If we didn't have Medicaid, I don't know where he would be right now. He not only is doing fantastic in school and life, he has begun to really talk about his illness. He wants other kids to know that there is nothing to be ashamed of." – Sharon

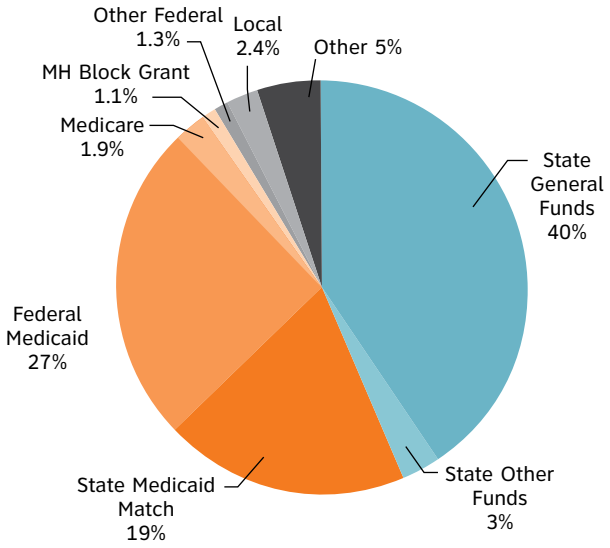
A Snapshot of Medicaid Mental Health Benefits

Medicaid is a life-saving program that provides health and mental health care to low-income children, pregnant women, families, people 65 or older, and certain people with disabilities. Medicaid is particularly important for children and adults with mental illness, offering vital services and supports that are typically not covered by private insurance.

Medicaid is the most important source of funding for mental health services. In 2008, 46 percent of state controlled funds for mental health services came from Medicaid.

[1] Joel E. Miller, et al., November 2012. "The Waterfall Effect: Transforming the Cascading Impact of Medicaid Expansion on States," National Association of State Mental Health Program Directors.

[2] Substance Abuse and Mental Health Services Administration. (2012). Results from the *2010 National Survey on Drug Use and Health: Mental Health Findings*



State Mental Health Agency Controlled Revenues for Mental Health, FY 2008. National Association of States Mental Health Program Directors

Unfortunately, millions of low-income Americans with mental illness are currently shut out of Medicaid, excluded from the care that would help them rebuild their lives. This leaves many people without access to needed mental health services and supports.

"I was diagnosed with bipolar disorder in 2009. I'm trying to find help but it seems impossible. I called about Medicaid and was told that unless I'm over 65 or have kids, there's no chance of me getting it. That about sums it up." – Jessica

Most importantly, many states cover a broad array of community mental health services and supports in their Medicaid programs that are rarely, if ever, covered by private insurance. Although most Medicaid mental health services are optional, many states cover these services because it is well known that they enhance recovery from mental illness and prevent the horrendous, costly circumstances that occur when people living with mental illness do not receive needed treatment and supportive services. In addition to these "optional" Medicaid services, federal law requires state Medicaid programs to provide physician care, laboratory services, partial hospitalization and, for children under 21, Early and Periodic Screening, Diagnosis and Treatment (EPSDT).[3]

Medicaid programs employ many strategies to address the high rate of chronic medical conditions and early mortality among adults with serious mental illness.[4] Some of the current strategies include health homes, Accountable Care Organizations, co-location of health and mental health clinics, cross-training and credentialing of mental health and primary care providers and electronic medical record sharing.[5]

Impact of Medicaid Expansion on People Living with Mental Illness

For uninsured people living with mental illness, the impact of Medicaid expansion will be significant. If all states proceed with expanding their Medicaid programs, as many as 2.7 million people with mental illness who are currently uninsured could be added to the Medicaid rolls, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).[6] For state-by-state estimates of people living with mental illness who could be added to Medicaid through expansion, see Appendix II.

"My mother was recently diagnosed with schizophrenia. She finally has medication that is working, but this is after a year and a half and four hospital visits. She needs some kind of coverage so badly, but she was turned down for disability. Sad stuff, but I guess you just have to keep fighting." – Tabitha

Expanding Medicaid Keeps People From Falling Through the Cracks

There are currently many Americans living with mental illness who do not have access to health insurance. Many of these individuals go without needed treatment. The consequences can be tragic.

[3] Federal law requires state Medicaid programs to provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This benefit is designed to ensure early assessment of children to identify the existence of illnesses, including mental illness. States are required to provide the treatment necessary for Medicaid eligible children to improve from the illnesses detected in the periodic screening process.

[4] Institute of Medicine. (2006) *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.* Washington, DC. National Academies of Sciences, 2006.

[5] Garfield, R (Sep. 2011) Financing Mental Health Care: A Primer. Kaiser Commission on Medicaid and the Uninsured. Accessed 4/3/13 http://www.kff.org/medicaid/upload/8182.pdf.

[6] Substance Abuse and Mental Health Services Administration. (n.d.) *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in each State.* http://www.samhsa.gov/healthreform/enrollment.aspx.

7.6 million
Emergency department visits were for mental illness in 2007.
1 in 8
were uninsured.

- Over 7 million emergency department visits a year are made by people living with mental illness and more than one in eight is uninsured.[7]
- Mood disorders are the third most common reason children and adults to age 44 are hospitalized.[8]
- There are more than 38,000 suicides every year in America—more than double the number of homicides.[9]
- Over one in five people in jail and prison live with a mental illness. Many of these individuals would not have come into contact with criminal justice systems had they received timely and effective treatment.[10,11]
- 70 percent of young people in juvenile facilities have a diagnosable mental health condition.[12]

Expanding Medicaid will help people get mental health services before their symptoms get worse and they experience debilitating, or even tragic, outcomes.

Expanding Medicaid, a springboard to recovery

Medicaid coverage helps people stay healthy. A recent study of Medicaid expansion in Oregon found that people enrolled in Medicaid see their doctors more often, get more preventive care and report better health and financial stability.[13] A *New England Journal of Medicine* study found that expanding Medicaid reduces the death rate for adults, particularly for minorities and people living in low-income areas.[14]

Expanding Medicaid helps people get back to work and become self-sufficient. Many people living with mental illness want to work, but are afraid of losing their Medicaid coverage. By expanding Medicaid, people can go back to work yet stay in mental health care by transferring to a qualified health plan offered through their state's health insurance marketplace.

"For many of the people in the expansion population, particularly young people with mental illness or substance abuse problems, the new health coverage is expected to rapidly change their earning ability. You'll see many of them rocket out of poverty. If their treatments are interrupted because they lose Medicaid coverage, it could send them back into a downward spiral." - Matt Salo, Director, National Association of Medicaid Directors[15]

In addition, expanding Medicaid will help many people who are reluctant to sign up for disability benefits or who experience challenges with an often daunting disability process. In states that expand Medicaid, it will be easier for people to get and keep coverage for mental health services.

[7] Pamela L. Owens, Ph.D., et al, July 2010. "Mental Health and Substance Abuse-Related Emergency Department Visits among Adults," Agency for Healthcare Research and Quality.
[8] LM Wier (Thompson Reuters), et al, 2011. "HCUP Facts and Figures: Statistics on Hospital-based Care in the United States, 2009," Agency for Healthcare Research and Quality.
[9] J.L. McIntosh, January 2012. "U.S.A. suicide: 2009 official final data," American Association of Suicidology.
[10] Kathleen Skowyra and Joseph J. Cocozza, Ph.D., June 2006. "A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System," National Center for Mental Health and Juvenile Justice.
[11] Doris J. James and Lauren E. Glaze, September 2006. "Mental Health Problems of Prison and Jail Inmates," Bureau of Justice Statistics Special Report.
[12] Teplin, L., Abram, K., McClelland, G., Dulcan,M., and Mericle, A. (2002). "Psychiatric disorders in youth in juvenile detention." *Archives of General Psychiatry,* 59, 1133-1143.
[13] Amy Finkelstein & Sarah Taubman & Bill Wright & Mira Bernstein & Jonathan Gruber & Joseph P. Newhouse & Heidi Allen & Katherine Baicker, 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year," The Quarterly Journal of Economics, Oxford University Press, vol. 127(3), pages 1057-1106. Web. http://www.nber.org/papers/w17190.
[14] Benjamin D. Sommers, M.D., Katherine Baicker, Ph.D. and Arnold M. Epstein, M.D., September 2012. "Mortality and Access to Care among Adults after State Medicaid Expansions, New England Journal of Medicine, vol. 367, pages 1025-1034. http://www.nejm.org/doi/full/10.1056/NEJMsa1202099.
[15] Vestal, C; (Mar. 22, 2013) Ohio, Arkansas May Provide New Model For Insuring Low-Income Residents. Kaiser Health News. Accessed: 4/3/2013: http://www.kaiserhealthnews.org/Stories/2013/March/22/medicaid-expansion-private-insurance-states.aspx.

"After being diagnosed with schizoaffective disorder at the age of 19, I didn't know where to turn. I wasn't aware of mental illness and the impact it could have. I faced a long, uphill battle for years, including hospitalizations, homelessness and jail. I was reluctant to apply for SSI (Supplemental Security Income) because I didn't want to admit that I had a disability, but SSI and Medicaid have allowed me to get treatment and live a dignified life in the community." – Matthew

"I currently get Medicaid for mental health services, but it hasn't been so easy to accomplish. I have had to file for SSI benefits, go for evaluations and repeat every six months just to maintain my meds for bipolar disorder. This is an area that needs to improve." – Walter

Expanding Medicaid, a boost to state and local economies

Expanding Medicaid will bring federal dollars into state economies – dollars that are desperately needed to rebuild mental health services. State and local governments will save millions in reduced costs for uncompensated care as more people get health coverage. Federal dollars will pay 100 percent of the cost through 2016 for people who are eligible for Medicaid under new eligibility rules. Federal support will taper to 90 percent in 2020 and beyond, leaving states with only 10 percent of the cost.

If all states expand Medicaid eligibility they would get an estimated additional $800.2 billion in federal support from 2013 to 2022, over and above normal Medicaid growth.[16] At the same time, states would realize savings of $18.3 billion in reduced uncompensated care costs.[17] The increase in federal funds to states and uncompensated care savings will create jobs, generate economic activity and increase state and local tax revenues. For a chart showing the fiscal impact of Medicaid expansion on a state-by-state basis, see Appendix I.

Medicaid Expansion: Fiscal Impact 2013-2022

States (higest federal dollar increase)	Increase in federal dollars (in millions)	Uncompensated care savings (in millions)
California	$68,750	$1,901
Florida	$66,113	$1,254
Texas	$65,619	$1,712
New York	$56,107	$426
Ohio	$53,341	$876

Medicaid Expansion: Challenges and Opportunities for Advocates

As described above, Medicaid expansion has many potential benefits for people living with mental illness and for society as a whole. However, people living with mental illness, families and advocates will face significant challenges in ensuring that Medicaid expansion will prove to be all that it can be.

- **Medicaid expansion in all states.** After last year's U.S. Supreme Court decision on the ACA, states now have the option of deciding whether or not to expand their Medicaid programs. As discussed above, states that do not expand their Medicaid programs will forfeit millions of dollars in federal subsidies. Despite this, only 20 states and the District of Columbia have committed to expanding their programs as of the date of publication of this report.

- **Coverage of evidence-based mental health services and supports in Medicaid expansion plans.** Although Medicaid will become available for millions of Americans who are currently not covered, there are no guarantees that these expanded Medicaid programs will cover the array of evidence-based mental health treatments and services that are covered in many existing Medicaid programs. The ACA specifies that Medicaid expansion plans must

[16] John Holohan, Matthew Buettgens, Caitlin Carroll and Stan Dorn, Stan, November 2012. ". (November 2012). *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis.* Kaiser Commission on Medicaid and the Uninsured.
[17] *Ibid.*

meet "benchmark" or "benchmark equivalent" standards that are modeled after private insurance plans. Medicaid expansion plans modeled on private insurance may limit coverage to traditional medical services such as inpatient treatment, outpatient counseling and medications. Services such as Assertive Community Treatment (ACT), psychiatric rehabilitation and housing supports, which are covered in many existing Medicaid programs, may not be covered.[18]

NAMI Policy Recommendation

Cover evidence-based mental health services in Medicaid expansion plans. Evidence-based mental health treatment and services have been identified with proven effectiveness in fostering recovery and preventing relapse. These include ACT, cognitive behavioral therapy (CBT), integrated treatment for mental illness and substance use disorders as well as others. These effective interventions are frequently covered by traditional (existing) Medicaid programs and should be covered in Medicaid expansion plans and in policies offered through state health insurance marketplaces.

NAMI calls upon the U.S. Department of Health and Human Services (HHS) to define a single comprehensive Essential Health Benefit in 2016 that ensures that an appropriate range of specific services are covered in every plan.

- **Exemptions for "medically frail" individuals, including adults with serious mental illness and children with serious emotional disturbances.** The ACA specifies that individuals who are "medically frail" or have "special medical needs" are exempt from mandatory enrollment in more limited Medicaid expansion plans. This includes "adults with serious mental illness" and "children with serious emotional disturbances."

Medically frail individuals, including those with mental illnesses, must be provided with the full benefits available in traditional Medicaid programs at the enhanced federal Medicaid matching rates designated in the Affordable Care Act.

- **The "welcome mat" effect.** When the ACA goes into effect in the states in 2014, it is expected that significant numbers of people will be identified who are already eligible for Medicaid but have never enrolled. Some states have raised concerns about this "welcome mat effect" (also referred to as the "woodwork effect") for fear that they will incur higher financial burdens. In fact, enrolling these individuals in Medicaid will have long term benefits associated with timely treatment and reduced medical or psychiatric emergencies.

- **Outreach and enrollment.** In states that expand their Medicaid programs, millions of uninsured individuals, including many living with mental illness, could be added to the Medicaid rolls. Enrolling all who are potentially eligible will present a formidable challenge, particularly for populations that are traditionally hard to reach. These populations include persons living with mental illness who are homeless, hospitalized, incarcerated or otherwise limited in access to information and services.

NAMI Policy Recommendation

Implement strategies to enroll hard to reach individuals living with mental illness in Medicaid expansion plans. The Centers for Medicare and Medicaid Services (CMS) recently announced the availability of $56 million to support navigators to help provide information to health care consumers about options available through state health insurance marketplaces, Medicaid and Children's Health Insurance (CHIP) programs. NAMI urges CMS to award navigator contracts to mental health agencies or advocacy organizations to conduct education, outreach and enrollment of hard to reach children, youth and adults with mental illness, including those who are in hospitals, homeless or involved with criminal justice systems.

- **State compliance with the EPSDT mandate.** States are required under Medicaid law to provide Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) for all children and youth enrolled in the Medicaid program. The EPSDT

[18] For a list of services that NAMI regards as essential for adults living with serious mental illness, see Array http://www.nami.org/Content/ContentGroups/Policy/Adult_Array.pdf. For a list of services that NAMI regards as essential for children and youth living with mental illness, see Array http://www.nami.org/Content/ContentGroups/Policy/C&A_Array.pdf.

mandate requires mental health screening for all Medicaid enrolled children and youth. If the screening shows signs of emerging mental illness, a further assessment must be provided along with all medically necessary mental health services and supports needed to effectively treat the mental illness. The early detection of mental illness and substance use disorders is important in the overall health of a child and helps to reduce and eliminate the long-term effects of these conditions. However, only a small number of states fully comply with the EPSDT mandate.

NAMI Policy Recommendation

Monitor states and provide guidance to ensure full compliance with the EPSDT mandate. Significant national attention has focused on the need for the early identification of emerging mental illness and early intervention. Guidance and technical assistance are needed from CMS to help states understand the scope of the EPSDT mandate, especially when it comes to mental health screening and the broad array of mental health services and supports that must be provided. CMS has issued some guidance to states, but far more is needed to help states understand how to create effective mental health screening programs. CMS should also monitor states to ensure that they are in full compliance with the broad EPSDT mandate.

- **Mental health and addictions parity.** The Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act of 2008 requires insurance plans that offer coverage for mental illness and substance use disorders to provide these benefits in a no more restrictive way than all other medical and surgical benefits. The ACA extended these requirements to all individuals and small employer health insurance plans offered through state health insurance exchanges as well as non-managed care Medicaid expansion plans. Final regulations defining the specific scope of mental health and addictions parity requirements have not yet been issued but are expected to be released before the end of 2013.

- **The Medicaid IMD exclusion.** When the Medicaid program was first created in 1965, the federal law contained a provision excluding coverage of treatment in freestanding psychiatric hospitals known as Institutions for Mental Diseases (IMDs). The policy was driven both by ideology, specifically the desire to incentivize community mental health treatment, and economics. Today, the IMD exclusion in Medicaid remains in effect and is one factor contributing to lack of inpatient beds for acute or emergency psychiatric treatment. The ACA authorized funding for Medicaid Emergency Psychiatric Demonstrations, a pilot project evaluating whether Medicaid "can support higher quality care at a lower cost" by reimbursing private psychiatric hospitals for acute psychiatric inpatient services. Grants have been awarded to 11 states and the District of Columbia to implement the demonstration projects.[19]

NAMI Policy Recommendation

Abolish the IMD exclusion. Preventing Medicaid reimbursement for psychiatric treatment of individuals between the ages of 22 and 64 in IMDs is outmoded and discriminates against people who require inpatient psychiatric care. It is time for Congress to eliminate the IMD exclusion and allow Medicaid dollars to be used for a range of effective mental health services, including inpatient treatment when needed.

- **Medicaid Health Homes**. The ACA created an option for states to establish Health Homes to better coordinate care for people with chronic conditions, including serious mental illness. Health Homes are not physical structures but are rather mechanisms for integrating primary and specialty care in a coordinated fashion for people with chronic illnesses. States are afforded flexibility in how they design these systems and receive an enhanced 90 percent

[19] Center for Medicare and Medicaid Innovation, "Medicaid Emergency Psychiatric Demonstration," http://innovation.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/.

federal Medicaid match for the first two years of implementation.[20] A number of states have implemented or are considering implementing Health Homes, with particular focus on serving individuals with serious mental illness.[21]

- **A new wave of privatization in Medicaid** Privatization of Medicaid is not a new concept. It dates back to the 1990s with the trend toward Medicaid managed care, but several states are considering new privatization arrangements as a way to implement Medicaid expansion. Specifically, some states are considering an approach called premium assistance, in which Medicaid funds are used to purchase private health insurance. To qualify, these plans must offer a set of benefits equivalent to the benchmark Medicaid expansion plan established in the state and must not cost beneficiaries any more in copays than they would owe under a more traditional Medicaid approach.

Conclusion

Medicaid is fundamental to mental health care in America. Medicaid coverage allows mental illness to be treated early, before symptoms worsen. Services available through Medicaid, and sometimes nowhere else, enable people who have been disabled by mental illness to rebuild their lives. When untreated, the human and fiscal impact of mental illness is felt. It is felt not only in uncompensated care costs for emergency room visits and psychiatric hospitalization, but also in school failure, reduced productivity, increased incarceration, homelessness and lost lives. By contrast, Medicaid coverage helps people with mental illness get services, stay healthy and contribute to the vitality of their communities.

In the aftermath of Newtown, many politicians and policy makers have promised to take steps to fix America's broken mental health system. Expanding Medicaid in all states would represent a significant step towards keeping those promises. For people living with mental illness, Medicaid expansion, including adequate coverage and aggressive enrollment strategies, can make the difference between dependency and independence, between misery and dignity. Now is the time to deliver on these promises.

"I have severe mental illness which requires ongoing therapy and medication. Without Medicaid, I would not be able to come close to affording my monthly cost of these much needed services. I am thankful for Medicaid and hope others have access to quality mental health services as well." – Nikkol

[20] Medicaid.gov, "Health Homes," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html.

[21] For an example of one such model, see Missouri Department of Mental Health, "Health Care Home," http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm.

Appendix I

Medicaid Expansion: Fiscal Impact 2013-2022

State	Increase in federal dollars (in millions)[1]	Uncompensated care savings (in millions)[2]
Alabama	$14,371	$512
Alaska	$1,458	$38
Arizona	$10,701	$50
Arkansas	$12,465	$257
California	$68,750	$1,901
Colorado	$10,308	$277
Connecticut	$8,159	$222
Delaware	$1,927	$18
District of Columbia	$852	$18
Florida	$66,113	$1,254
Georgia	$33,711	$726
Hawaii	$3,294	$101
Idaho	$3,280	$97
Illinois	$21,756	$953
Indiana	$17,322	$562
Iowa	$3,909	$13
Kansas	$5,270	$149
Kentucky	$17,832	$451
Louisiana	$15,786	$267
Maine	$3,124	$120
Maryland	$12,253	$178
Massachusetts	$7,270	–$1
Michigan	$17,512	$351
Minnesota	$5,597	$49
Mississippi	$14,499	$400
Missouri	$17,795	$385
Montana	$2,088	$56
Nebraska	$3,063	$97
Nevada	$5,620	$210
New Hampshire	$2,417	$62
New Jersey	$15,366	$296
New Mexico	$4,926	$104
New York	$56,107	$426
North Carolina	$39,638	$1,350
North Dakota	$2,357	$52
Ohio	$53,341	$876
Oklahoma	$8,561	$205
Oregon	$12,842	$280
Pennsylvania	$37,842	$878
Rhode Island	$2,935	$51
South Carolina	$15,827	$543
South Dakota	$2,110	$62
Tennessee	$22,541	$494
Texas	$65,619	$1,712
Utah	$5,274	$101
Vermont	$1,026	$5
Virginia	$14,665	$424
Washington	$8,406	$119
West Virginia	$8,744	$281
Wisconsin	$12,263	$247
Wyoming	$1,353	$28
United States	**$800,245**	**$18,308**

[1] Source: Holohan, John, Buettgens, Matthew, Carroll, Caitlin and Dorn, Stan. Kaiser Commission on Medicaid and the Uninsured. (November 2012). The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. (Table 6).

[2] Source: Holohan, John, Buettgens, Matthew, Carroll, Caitlin and Dorn, Stan. Kaiser Commission on Medicaid and the Uninsured. (November 2012). The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. (Table 14).

Appendix II

Medicaid Expansion Eligibility: Any Mental Illness*

State	Medicaid eligibility: 2013 Childless adults (% of Federal Poverty Level)[1]	Medicaid expansion: % of uninsured adults with any mental illness[2]	Medicaid expansion # of uninsured adults with any mental illness
Alabama	Not eligible	22.6%	78,691
Alaska	Not eligible	16.8%	5,722
Arizona	100% FPL (closed)	11.7%	49,318
Arkansas	Not eligible[3]	23.2%	54,997
California	Not eligible[4]	10.4%	256,202
Colorado	10% FPL (closed)	12.2%	34,027
Connecticut	55% FPL	19.3%	18,216
Delaware	100% FPL	24.2%	6,795
District of Columbia	200% FPL	10.8%	1,536
Florida	Not eligible	15.9%	244,272
Georgia	Not eligible	10.2%	86,058
Hawaii	133% FPL	10.5%	3,229
Idaho	Not eligible[5]	20.9%	22,806
Illinois	Not eligible	12.1%	82,467
Indiana	Not eligible**	22.3%	86,574
Iowa	Not eligible[6]	21.0%	25,286
Kansas	Not eligible	13.2%	21,293
Kentucky	Not eligible	20.0%	64,608
Louisiana	Not eligible	17.0%	59,320
Maine	Not eligible**	21.4%	8,805
Maryland	Not eligible[7]	8.4%	16,425
Massachusetts	Not eligible[8]	6.3%	5,753
Michigan	Not eligible**	19.9%	105,352
Minnesota	75% FPL[9]	30.1%	42,918
Mississippi	Not eligible	16.2%	42,312
Missouri	Not eligible	15.5%	53,637
Montana	Not eligible	16.7%	9,886
Nebraska	Not eligible	30.1%	24,309
Nevada	Not eligible	13.2%	26,489
New Hampshire	Not eligible	15.0%	6,470
New Jersey	Not eligible[10]	10.0%	33,340
New Mexico	Not eligible**	11.2%	19,093
New York	100% FPL[11]	13.2%	96,825
North Carolina	Not eligible	12.8%	87,624
North Dakota	Not eligible	11.1%	2,850
Ohio	Not eligible	24.1%	136,765
Oklahoma	Not eligible[12]	20.1%	59,043
Oregon	Not eligible**	18.9%	50,231
Pennsylvania	Not eligible	14.2%	68,544
Rhode Island	Not eligible	20.0%	8,881
South Carolina	Not eligible	21.2%	72,038
South Dakota	Not eligible	21.3%	8,490
Tennessee	Not eligible	20.4%	83,312
Texas	Not eligible	11.2%	255,086
Utah	Not eligible**	20.3%	28,033
Vermont	150% FPL[13]	23.3%	2,934
Virginia	Not eligible	22.3%	76,974
Washington	Not eligible**	10.4%	36,427
West Virginia	Not eligible	22.1%	27,713
Wisconsin	Not eligible**	20.0%	42,287
Wyoming	Not eligible	17.9%	4,321
United States			**2,744,582**

[1] Source: http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4&print=1.
[2] Source: Substance Abuse and Mental Health Services Administration. (n.d.) *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in each State*. http://www.samhsa.gov/healthreform/enrollment.aspx.
[3] Arkansas offers limited subsidized coverage for individuals below 200% FPL who work for a qualifying, participating employer.
[4] California extends limited Medicaid coverage to adults up to 133% FPL.
[5] Idaho offers premium assistance to adults up to 185% FPL who work for a qualified small employer.
[6] Iowa extends limited coverage to adults up to 200% FPL.
[7] Maryland offers primary care services to childless adults.
[8] Massachusetts extends limited Medicaid coverage to certain childless adults to 100% FPL; adults up to 300% FPL are eligible for more limited subsidized coverage.
[9] Minnesota extends limited Medicaid coverage to adults to 200% FPL.
[10] New Jersey offers coverage to childless adults; the limit is $140 per individual or $210 for individuals who are unemployable.
[11] New York extends Medicaid coverage to childless adults to 78% FPL.
[12] Oklahoma offers limited subsidized coverage to adults meeting certain conditions up to 200% FPL.
[13] Vermont extends coverage to childless adults to 150% FPL; limited subsidized coverage is offered to adults up to 300% FPL.
* The term a*ny mental illness (AMI)* is defined by SAMHSA as "currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994). Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having AMI."
** State offers limited coverage or subsidies to higher incomes, but enrollment is closed to adults with no children.

Appendix III

Medicaid Expansion Eligibility: Serious Mental Illness*

State	Medicaid eligibility: 2013 Childless adults (% of Federal Poverty Level)[1]	Medicaid expansion: % of uninsured adults with serious mental illness[2]	Medicaid expansion # of uninsured adults with serious mental illness
Alabama	Not eligible	13.5%	47,006
Alaska	Not eligible	2.7%	920
Arizona	100% FPL (closed)	4.1%	17,282
Arkansas	Not eligible[3]	10.8%	25,602
California	Not eligible[4]	4.4%	108,393
Colorado	10% FPL (closed)	5.0%	13,945
Connecticut	55% FPL	10.2%	9,627
Delaware	100% FPL	15.0%	4,212
District of Columbia	200% FPL	5.3%	754
Florida	Not eligible	7.8%	119,832
Georgia	Not eligible	3.2%	26,998
Hawaii	133% FPL	4.4%	1,353
Idaho	Not eligible[5]	11.4%	12,440
Illinois	Not eligible	4.9%	33,396
Indiana	Not eligible**	15.2%	59,010
Iowa	Not eligible[6]	11.3%	13,606
Kansas	Not eligible	3.9%	6,291
Kentucky	Not eligible	10.0%	32,304
Louisiana	Not eligible	8.5%	29,660
Maine	Not eligible**	9.1%	3,744
Maryland	Not eligible[7]	2.1%	4,106
Massachusetts	Not eligible[8]	N/A[14]	N/A[14]
Michigan	Not eligible**	9.5%	50,294
Minnesota	75% FPL[9]	18.9%	26,948
Mississippi	Not eligible	7.8%	20,373
Missouri	Not eligible	7.5%	25,954
Montana	Not eligible	8.9%	5,269
Nebraska	Not eligible	11.4%	9,207
Nevada	Not eligible	4.2%	8,428
New Hampshire	Not eligible	7.7%	3,321
New Jersey	Not eligible[10]	5.9%	19,670
New Mexico	Not eligible**	4.3%	7,330
New York	100% FPL[11]	4.3%	31,541
North Carolina	Not eligible	3.8%	26,013
North Dakota	Not eligible	4.7%	1,207
Ohio	Not eligible	12.4%	70,369
Oklahoma	Not eligible[12]	8.3%	24,381
Oregon	Not eligible**	10.2%	27,109
Pennsylvania	Not eligible	6.4%	30,893
Rhode Island	Not eligible	11.2%	4,973
South Carolina	Not eligible	12.7%	43,155
South Dakota	Not eligible	5.4%	2,152
Tennessee	Not eligible	7.9%	32,263
Texas	Not eligible	5.7%	129,820
Utah	Not eligible**	8.5%	11,738
Vermont	150% FPL[13]	15.9%	2,002
Virginia	Not eligible	11.5%	39,695
Washington	Not eligible**	5.1%	17,863
West Virginia	Not eligible	10.8%	13,543
Wisconsin	Not eligible**	12.2%	25,795
Wyoming	Not eligible	14.6%	3,525
United States			**1,285,313**

[1] Source: http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4&print=1.
[2] Source: Substance Abuse and Mental Health Services Administration. (n.d.) *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in each State.* http://www.samhsa.gov/healthreform/enrollment.aspx.
[3] Arkansas offers limited subsidized coverage for individuals below 200% FPL who work for a qualifying, participating employer.
[4] California extends limited Medicaid coverage to adults up to 133% FPL.
[5] Idaho offers premium assistance to adults up to 185% FPL who work for a qualified small employer.
[6] Iowa extends limited coverage to adults up to 200% FPL.
[7] Maryland offers primary care services to childless adults.
[8] Massachusetts extends limited Medicaid coverage to certain childless adults to 100% FPL; adults up to 300% FPL are eligible for more limited subsidized coverage.
[9] Minnesota extends limited Medicaid coverage to adults to 200% FPL.
[10] New Jersey offers coverage to childless adults; the limit is $140 per individual or $210 for individuals who are unemployable.
[11] New York extends Medicaid coverage to childless adults to 78% FPL.
[12] Oklahoma offers limited subsidized coverage to adults meeting certain conditions up to 200% FPL.
[13] Vermont extends coverage to childless adults to 150% FPL; limited subsidized coverage is offered to adults up to 300% FPL.
[14] Data suppressed due to imprecision.
* The term *serious mental illness (SMI)* is defined by SAMHSA as "a designated term for persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities."
** State offers limited coverage or subsidies to higher incomes, but enrollment is closed to adults with no children.

Appendix IV

Race/Ethnicity
Medicaid Expansion Eligible
Uninsured Adults with Serious Mental Illness

State	Non-Hispanic White	Non-Hispanic Black	Other	Hispanic
Alabama	72%	23%	1%	4%
Alaska	65%	2%	30%	3%
Arizona	59%	3%	10%	28%
Arkansas	78%	14%	2%	6%
California	45%	6%	11%	38%
Colorado	73%	4%	4%	19%
Connecticut	67%	12%	7%	14%
Delaware	64%	25%	2%	10%
District of Columbia	43%	42%	4%	12%
Florida	62%	18%	3%	18%
Georgia	59%	28%	3%	10%
Hawaii	49%	2%	46%	4%
Idaho	88%	1%	3%	8%
Illinois	60%	19%	5%	16%
Indiana	85%	9%	1%	5%
Iowa	87%	4%	3%	7%
Kansas	81%	6%	4%	9%
Kentucky	89%	7%	2%	3%
Louisiana	60%	34%	2%	3%
Maine	95%	1%	4%	0%
Maryland	54%	30%	5%	11%
Massachusetts	72%	9%	7%	13%
Michigan	81%	13%	2%	4%
Minnesota	75%	11%	7%	7%
Mississippi	61%	36%	1%	3%
Missouri	83%	12%	2%	3%
Montana	90%	0%	8%	1%
Nebraska	82%	5%	3%	10%
Nevada	65%	8%	7%	21%
New Hampshire	95%	1%	3%	1%
New Jersey	53%	14%	9%	23%
New Mexico	40%	2%	22%	36%
New York	55%	15%	10%	19%
North Carolina	66%	19%	3%	11%
North Dakota	77%	3%	19%	2%
Ohio	85%	12%	1%	3%
Oklahoma	77%	6%	9%	8%
Oregon	85%	2%	4%	10%
Pennsylvania	78%	14%	3%	5%
Rhode Island	74%	9%	3%	13%
South Carolina	65%	28%	1%	7%
South Dakota	70%	2%	26%	2%
Tennessee	80%	13%	1%	6%
Texas	47%	12%	4%	37%
Utah	79%	1%	5%	14%
Vermont	98%	0%	2%	0%
Virginia	70%	18%	4%	7%
Washington	77%	3%	8%	13%
West Virginia	95%	3%	1%	1%
Wisconsin	81%	8%	4%	7%
Wyoming	87%	0%	7%	6%

[1] Source: http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4&print=1.
[2] Source: Substance Abuse and Mental Health Services Administration. (n.d.) *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in each State.* http://www.samhsa.gov/healthreform/enrollment.aspx.
[3] Data from Massachusetts is suppressed due to imprecision.

Appendix V

State Medicaid Expansion*
May 20, 2013

State	Medicaid Expansion
Alabama	No
Alaska	No
Arizona	Pending
Arkansas	Yes
California	Yes
Colorado	Yes
Connecticut	Yes
Delaware	Yes
District of Columbia	Yes
Florida	No
Georgia	No
Hawaii	Yes
Idaho	No
Illinois	Yes
Indiana	Pending
Iowa	Pending
Kansas	Pending
Kentucky	Yes
Louisiana	Pending
Maine	Pending
Maryland	Yes
Massachusetts	Yes
Michigan	Pending
Minnesota	Yes
Mississippi	No
Missouri	No
Montana	Pending
Nebraska	No
Nevada	Yes
New Hampshire	Pending
New Jersey	Yes
New Mexico	Yes
New York	Yes
North Carolina	No
North Dakota	Yes
Ohio	Pending
Oklahoma	No
Oregon	Yes
Pennsylvania	No
Rhode Island	Yes
South Carolina	Pending
South Dakota	No
Tennessee	Pending
Texas	Pending
Utah	Pending
Vermont	Yes
Virginia	Pending
Washington	Yes
West Virginia	Pending
Wisconsin	No
Wyoming	No

* Data derived from Vestal, C. (2013, May 20). *Medicaid Expansion by the Numbers.* Stateline. http://info.pewtrusts.org/site/R?i=H-gJtTalArWoXJqCQmzK9Q