NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Office of Planning and Policy Support
200 Independence Avenue, S.W.
Room 408-B
Washington D.C. 20201

Attn: Strategic Plan Comments

To Whom It May Concern:

The National Council for Community Behavioral Healthcare (National Council) is pleased to respond to the Department of Health and Human Services' (HHS) **Draft Strategic Plan for Fiscal Years 2010-2015.**

The National Council, a non-profit association representing over 1700 community mental health centers and other community-based mental health and addiction providers, is dedicated to fostering clinical and operational innovation and promoting policies that ensure more than 6 million low-income children, adults, and families our members serve have access to high quality services. We appreciate the opportunity to provide the following comments, and we commend the Department on its willingness to be open and seek comments in the interest of improving the nation's health and wellbeing.

Goal 1: Transforming Healthcare

Objective A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured.
The draft strategic plan states that "this increased oversight of the insurance industry will help insure that individuals are getting what they pay for and will make the health care system more responsive to the needs of patients, health care providers, and other stakeholders."

It took the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act in 2008 to establish once and for all that substance use disorders and mental health benefits need to be treated equally with medical/surgical benefits. The Affordable Care Act goes a long way towards extending this understanding. However, despite the issuance of federal regulations outlining how the MHPAEA must be implemented, there has so far been no appreciable change in insurer behavior. In fact, early evidence indicates that insurers are managing mental health and substance use disorders even more as a result of the law. If the MHPAEA and the Affordable Care Act are to have their intended effect, we must monitor and enforce this new standard.

The strategies outlined for achieving Objective A are good, but they are not enough. It is estimated that 25% of individuals who are currently uninsured have a substance use disorder (SUD) or mental health (MH) disorder, and that large numbers of persons will remain uninsured in 2019. In Massachusetts' early experience with health reform, the state found that while only 2% of the general population remains uninsured, approximately 30% of persons

reporting to the specialty SUD system are uninsured. The introduction to Goal 1 mentions the importance of ensuring access to care for persons with special needs – but there is nothing in this section that describes how the health insurance exchange enrollment process will target vulnerable populations like those with MH and SUD needs, who are likely to make up a disproportionate share of individuals remaining uninsured under health reform. HHS should work to financially support safety net SUD and MH organizations to do education, outreach, and enrollment of these individuals.

Objective B: Improve health care quality and patient safety
Recent studies have consistently shown that persons with serious mental illnesses who are clients of the public mental health system die sooner than other Americans, and have an average age of death at 52 – largely as a result of untreated, chronic medical conditions. A 2007 federal report found that one in fourteen stays in U.S. community hospitals involved substance disorders, accounting for about 2.3 million hospitalizations, average stays of 4.6 days and a cost of $2 billion nationally in 2004. According to a recently released report, *Faces of Medicaid III,* 49% of Medicaid beneficiaries with disabilities have a psychiatric condition (52% of dual eligibles) and psychiatric illness is represented in three of the top five most prevalent dyads among the highest-cost 5% of beneficiaries with disabilities.

We suggest that HHS implement specific quality improvement efforts targeting these populations.

Objective C: Emphasize primary and preventive care linked with community prevention services.
The National Council believes that it is not sufficient for individuals to be "informed of existing community services that support health promotion, such as exercise programs, educational classes, self-management training, and nutrition counseling." The stigma surrounding mental illness, along with cognitive impairments that may occur in individuals with mental illness, hamper these populations from taking full advantage of these resources.

The proposed strategy of "expand[ing] community-based prevention programs to help improve the health and quality of life of individuals with, and at risk for, chronic diseases and conditions, and to build resilience and skills to cope with risk factors for behavioral health disorders" needs to include targeted programs for individuals with SUD and MH disorders.

Additionally, the proposed strategy of "increase[ing]…medical homes for children, youth and adults" needs to include elements to ensure that all medical homes take proactive steps to explicitly identify, and coordinate treatment for SUD and MH conditions. We also encourage HHS to promote the development of specialty medical homes for persons with severe mental illness and chronic addiction disorders.

Objective D: reduce the growth of health care costs while promoting high-value, effective care
The strategies outlined for achieving Objective D are sound, but we would recommend specific attention be paid in the implementation of each strategy to the needs of persons with MH and SUD conditions. Additionally, the introduction to this section mentions the meaningful use of health information technology, but health IT is not mentioned as a component of the strategies. We encourage HHS to work to ensure that SUD and MH providers are included in federal and state efforts to support the adoption and implementation of health IT.

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Objective E: ensure access to quality, culturally competent care for vulnerable populations

The proposed strategies for achieving Objective E include: "improve access to quality care through the prevention and correction of discriminatory actions and practices." In accordance with our comments on p. 1 about MH/SUD parity, the National Council urges HHS to assertively monitor and enforce the implementation of this new standard.

In response to the proposed strategy of "support[ing] concentrated approaches to quality improvement in service delivery programs, and build comparable focus on improvement in the quality of behavioral health services," the National Council also encourages HHS to support SAMHSA in taking the lead on development of quality measures and concrete quality improvement initiatives for the field.

Additionally, in response to the proposed strategy of "work[ing] with the Departments of Defense and Veterans Affairs, the National Guard, and states to improve access to needed behavioral health and supportive services for active, guard, reserve, and veteran men and women and their families," the National Council notes that Sec. 306 of the Caregivers and Veterans Omnibus Health Services Act of 2010 allows the VA to contract with community behavioral health organizations to provide care in rural areas. We suggest that HHS work with the other federal agencies to make better use of existing SUD and MH treatment capacity in all communities.

Objective F: Promote the adoption and meaningful use of health information technology

Because SUD and MH agencies are not currently eligible for federal Medicare and Medicaid incentive payments for the adoption and meaningful use of health IT, they are being excluded by many states from health information exchanges and other efforts related to health IT. HHS should encourage the explicit inclusion of SUD and MH agencies in evolving health IT efforts.

Goal 3: Advance the Health, Safety, and Well-Being of Our People

The National Council thanks HHS for recognizing that "substance abuse and mental illness contribute to many of the nation's social and economic problems, as well as other health concerns."

Objective A: Ensure the safety, well-being, and healthy development of children

In response to the proposed strategy of "encourage[ing] healthy behaviors and reduc[ing] risky behaviors among children and youth," the National Council suggests that HHS mention SUD use/misuse prevalence and specifically mention community and clinical prevention for substance use/misuse.

Objective B: Promote economic and social well-being for individuals, families, and communities

The National Council thanks HHS for including MH and SUD in many of the strategies for this section. However, the strategies do not explicitly address the importance of re-entry for incarcerated populations, despite mentioning this issue in the introduction. Populations with mental illness and SUD face particular challenges. For example, regarding restoration of benefits upon release, HHS could encourage states to suspend, rather than terminate, Medicaid eligibility when an individual is incarcerated. Additionally, many policies discriminate against

persons with addictions disorders in public housing and access to benefits. The National Council encourages HHS to address these issues with re-entry in the strategies for achieving Objective B.

Objective C: Improve the accessibility and quality of supportive services for people with disabilities and older adults
Persons with SUD and mental illness are not mentioned at all in this section, nor is there any mention of SAMHSA. The National Council encourages HHS to add behavioral health to Strategies #1 and #4.

Objective D: Promote prevention and wellness
In the first strategy for this section, we encourage HHS to mention the high rate of smoking among persons with mental illness and SUD. We suggest that these individuals be explicitly mentioned in this strategy.

Objective E: Reduce the occurrence of infectious disease
One of the strategies included in this section is to “prevent the spread of HIV infection and increase efforts to make people aware of their status and enable them to access HIV care and treatment.” Given the high correlation between substance use and HIV, this section should mention that SUD prevention and treatment are needed to reduce HIV rates in the population.

Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce

The National Council commends HHS for its plan to “fund scholarships and loan repayment programs to increase the number of primary care physicians, nurses, physician assistants, mental health providers, and dentists in the areas of the country that need them most.” We suggest that addictions treatment providers be added to this list. Addiction specialty providers should have access to loan repayment through federal programs to enhance the capacity of the healthcare workforce.

The National Council for Community Behavioral Healthcare would like to thank the Department of Health and Human Services the opportunity to provide comments on the Draft Strategic Plan for Fiscal Years 2010-2015. We hope the commentary we have provided will be helpful as you evaluate and revise the document. Please let us know if you have any questions.

Sincerely,

Linda Rosenberg, MSW
President and CEO