

May 22, 2009

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate  
Washington, D.C. 20510

The Honorable Charles E. Grassley  
Ranking Member  
Committee on Finance  
United States Senate  
Washington, D.C. 20510

Re: Finance Committee Document on Expanding Health Care Coverage

Dear Chairman Baucus and Ranking Member Grassley:

The following comments on the Committee's recommendations regarding policy options for health care coverage are submitted jointly by the Bazelon Center for Mental Health Law, Mental Health America, the National Alliance on Mental Illness and the National Council for Community Behavioral Healthcare.

We appreciate the opportunity to comment on these proposals and hope that our comments and recommendations will be helpful to the Committee as it moves forward with the very important legislation to reform the nation's health care system. Contact information for each organization is presented at the end of this document.

## **Section I: Individual Market Reforms**

We support the Committee's proposals that will reform the insurance market to make health insurance more readily available and affordable.

### **Health Insurance Exchange**

In describing the Health Insurance Exchange proposal, the Senate Finance Committee white paper analogizes to the Massachusetts Connector. As a result, the experience of persons with mental health and addiction disorders in the state's connector program is important to examine. In fact, their experiences indicate that two discrete adjustments are required in the context of national health care reform.

According to the Mental Health and Substance Abuse Corporation of Massachusetts (MHSACM) many low income patients/consumers have an intense service utilization pattern because of the severity of the conditions being treated. "Behavioral healthcare often includes

multiple and regular visits over a period of time or may involve visits with both a psychiatrist and a non-physician if medication is involved.” Additionally, the remaining population of uninsured persons in Massachusetts today is disproportionately composed of persons with mental health and addiction disorders. Again, according to a recent MHSASCM memo, the cognitive impairments that commonly accompany mental illnesses combined with a “burdensome” Connector enrollment process results in a low enrollment rate among this population.

Therefore, first, the premium subsidies discussed in the white paper must be specifically extended to co-payments and deductibles -- at least for individuals with poor overall health status or who have health conditions (including mental health and addiction disorders) that require intense specialty health services utilization. Second, the enrollment program described on page 6 provides insufficient support for persons with cognitive impairments including intellectual disabilities, mental illnesses and addiction disorders. More robust enrollment initiatives are required encompassing: a.) a Part D-like auto-enrollment process, b.) authorization of federal funds that could facilitate one-on-one counseling, and c.) clarification of the Medicaid Targeted Case Management (TCM) option to authorize reimbursement for enrollment assistance provided to non-Medicaid eligible individuals attempting to participate in the Health Insurance Exchange.

## **Section II: Making Coverage Affordable**

### **Benefit Options – Including MH/SUD Benefits/Parity (pp. 8-10)**

Our organizations strongly support the proposed option – outlined on page 9 – of a minimum benefit package for all health insurance plans in the non-group and small group marketplace. We are pleased to see that the Finance Committee proposal would require both mental health and substance services be mandatory components of a package of medical and health benefits and that these plans cannot have lifetime limits on coverage or annual limits on any benefits.

Under this approach, mental health and addiction services are assumed to be integral to overall health. According to *Mental Health: A Report of the Surgeon General*, the burden of mental health disorders on health and productivity in the United States and throughout the world has long been profoundly underestimated. Data developed by the Global Burden of Disease study, conducted by the World Health Organization, the World Bank and Harvard University reveal that mental illness ranks second in the burden of disease in established market economies. As a class, these conditions are more disabling than all malignant diseases (cancer), all respiratory conditions and all infectious diseases. Similarly, in the United States, more than 23 million people are in need of addiction treatment each year, yet only 10% or 2.4 million receive it, often due to lack of health care coverage and inability to pay. Substance abuse and dependence are common disorders, affecting 16% of the adult population in any given year.

In addition, our organizations strongly endorse the application of parity for cost sharing and treatment limitations for all categories of services contained in health insurance plans offered through the exchange. Specifically, it is essential that parity between mental health/substance abuse services and medical/surgical services apply to ALL benefit packages irrespective of tier. In short, this approach entails extending the tenets of the recently enacted Mental Health Parity

and Addiction Equity Act (P.L. 110-343) to insurance coverage offered through the new nationwide Health Insurance Exchange.

Although the Committee paper does not go into detail with respect to these benefits, we urge the committee to include inpatient, outpatient and psychiatric rehabilitation services in the benefit packages of policies in the Exchange.

### **Prescription drug coverage (p. 9)**

The Finance Committee paper states that each plan design offered through the Health Insurance Exchange would have to meet Medicare Part D's class and category of drug coverage requirements. We urge the Committee to clarify that this coverage requirement includes the Part D policy mandating full coverage of medications in six key classes of clinical concern including anti-depressants, anti-psychotics, and anti-convulsants. Comprehensive coverage of medications in these classes is crucial because of the often idiosyncratic responses that individual consumers experience in response to different medications within these classes. Several large comparative effectiveness trials funded by the National Institute of Mental Health (NIMH) reinforce this finding. In the Sequenced Treatment Alternatives to Relieve Depression (STAR\*D) study<sup>1</sup> over 70% of individuals with depression had a full remission of the disorder. However, only about half of these individuals' depression remitted on the initial therapeutic agent employed in the study. Four different strategies involving multiple medication regimens were needed to achieve maximal clinical results for these individuals. Similarly, the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study<sup>2</sup> indicated high medication discontinuation rates for persons with schizophrenia and the need for access to multiple pharmaceutical agents to meet an individual's unique needs. We also support the provision in the Medicare Improvements for Patients and Providers Act (MIPPA) (PL 110-275) requiring that any restriction on access to a medication in one of the protected classes, including through prior authorization or other utilization management, must be approved through the exceptions process that includes a notice-and-comment rulemaking and must be based on scientific evidence and medical standards of practice.

## **Section IV: Role of Public Programs**

### **Medicaid Coverage:**

#### **Eligibility Standards and Methodologies (pp 14-15)**

The Finance Committee document states, page 15, that Medicaid eligibility rules would be amended to require states to raise the income eligibility for pregnant women, children and parents up to 150% of the FPL. There is no similar recommendation for childless single adults or persons with disabilities.

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<sup>1</sup> Rush, A.J. et al., *Acute and Longer-term Outcomes in Depressed Outpatients Who Required One or Several Treatment Steps: A STAR\*D Report*, American Journal of Psychiatry, 163(11), pp. 1905-17 (2006).

<sup>2</sup> Lieberman, J.A. et al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, New England Journal of Medicine, 353 (12), pp. 1209-1223 (2005).

Individuals with mental and physical disabilities are not always eligible for federal disability programs for a variety of reasons. In some cases, individuals may be unaware of disability programs or have not had the assistance that was needed to go through this lengthy and difficult process. In other cases individuals with psychiatric disabilities are denied these benefits despite being significantly impaired by their illnesses. These individuals include single adults who have the same health and mental health care needs as individuals who have qualified for SSI. The Medicaid benefit package is uniquely designed to meet their needs for comprehensive community services, including psychiatric rehabilitation, home and community based services and targeted case management, none of which are typically covered by a private insurance plan.

We strongly urge that this proposed option be amended to include single adults since comprehensive coverage, enabling services and the very limited out of pocket cost features of Medicaid are most critical to people with significant impairments due to serious physical or mental disorders.

We would also point out that the 150% of poverty ceiling for Medicaid coverage eliminates from coverage certain low income children and pregnant women who are now covered up to 185% of poverty. We encourage the committee to create an income level that does not reduce current federal mandates.

We applaud the committee for several important provisions regarding Medicaid including the requirement for states to maintain income eligibility for all previously eligible populations until the Exchange is fully operational. This will be extremely important. However, if the Committee does not accept our recommendation above that single adults under 150% of poverty be covered by the program, then for that group states should continue to maintain previous eligibility categories even after the Exchange is fully operational.

We also strongly support the proposals for the federal government to fully finance the new Medicaid costs of individuals who are newly eligible due to the changes in income eligibility made by health care reform. However, we would urge that there be a longer period of time to phase in the state costs. State governments are facing significant budget deficits that are expected to exceed \$100 billion in the 2009-10 fiscal year and could potentially, by some estimates, exceed \$350 billion over the 2.5-year period through the end of the 2010-11 State fiscal year.<sup>3</sup>

### **Medicaid program Payments (pp 15-16)**

The provision that would ensure that Medicaid providers are more adequately paid by tying Medicaid reimbursement to Medicare payment rates will be a critical part of reform if Medicaid is to play the significant role envisioned in the Committee draft. Extremely low payment rates is one of the major barriers to provider participation in the program. In the mental health arena, community agencies often report they actually lose money on every Medicaid individual they

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<sup>3</sup> See Elizabeth McNichol and Iris J. Lav, "State Budget Troubles Worsen," Center on Budget and Policy Priorities, Washington, DC, January 29, 2009. A comparison of budget-gap concepts can be found in Elizabeth McNichol and Iris J. Lav, "Current and Projected State Budget Deficits: NCSL, NASBO and CBPP," Center on Budget and Policy Priorities, Washington, DC, February 4, 2009.

serve. For this reason we urge the committee to include the percentage of the Medicare rate that is to be required, and that this rate be 80 percent of the Medicare rate (the example given in the Committee document).

### **Options for Medicaid Coverage (pp 16-18)**

The committee offers three possible options for increasing coverage through the current Medicaid structure. None of these options provides the protections for persons with psychiatric disabilities that is needed.

Under approach 2, the disabled, dual eligibles and other special needs populations continue to receive Medicaid coverage. Special needs populations must be defined to include people with serious mental health conditions who may not be receiving disability benefits but who do need access to community-based rehabilitative services generally covered by Medicaid, but not private insurance. Children and childless adults would be covered through insurance plans in the Exchange, with Medicaid benefits furnished as a wrap-around. Experience with current arrangements that operate in a similar manner, such as managed care plans, has shown that there are significant issues with this bifurcated coverage. Often individuals must change providers when they move from the insurance coverage to Medicaid. Since the insurance (or managed care plan) is perceived as the primary coverage, individuals frequently do not know or do not understand that they have the option of seeking more appropriate services from Medicaid (services not covered by their insurance plan). This population is low socio-economic status with limited education and lacking the luxury of time to figure out this complicated arrangement.

People with disabilities (including people with chronic mental health conditions who may not be receiving disability benefits) and childless low-income adults should all be provided coverage under Medicaid. Although approach 2 would give states the option of keeping this population in existing Medicaid, this is not sufficient. Medicaid coverage is needed for all low-income adults and children, in all states. To provide individuals with a choice, those who choose to opt-out in order to use the Exchange should be permitted to do so. However, since the great majority of these individuals will have their needs more appropriately met by Medicaid, this should be the first coverage option provided.

Approach 3 is particularly complicated and potentially harmful to low-income childless adults. Under this approach, these individuals would be enrolled in the Exchange but would be able to use the tax credit as voucher to buy into Medicaid, with the same benefits and cost protections as other Medicaid beneficiaries. Rather than create this complicated pathway for childless adults to be covered by Medicaid, the committee should simply include them in the proposal to cover children, pregnant women and parents.

### **The Children's Health Insurance Program (pp 19-22)**

The Committee proposed to build on the recent reauthorization of the Children's Health Insurance Program (CHIPRA) in health reform, making several improvements that would impact individuals with mental health and addiction disorders. The annual cost of mental, emotional and behavioral disorders among children and youth was estimated in 2007 to be \$247 billion.

One in four pediatric primary care visits are used to address behavioral issues. Mental, emotional and behavioral disorders interfere with children's ability to succeed in school, maintain healthy interpersonal relationships, and transition to independent living and work. When a child or young person has a mental, emotional or behavioral disorder, the whole family is affected. Parents and other caregivers report that their children's condition has resulted in absences at work, un- or underemployment, problems with health care coverage, and financial hardship, including foreclosure and bankruptcy.

Many states have embraced comprehensive services for children by using Medicaid as the basis for their CHIP plan. It is critical that health reform protect the options that states now have to provide children with access to needed services through Medicaid. The Committee is also to be commended for recommending that all SCHIP plans must include the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This will result in inclusion of mental health and substance abuse services in all SCHIP plans (although we are not aware of any state that excludes those services from SCHIP).

However, we are concerned about the administrative complexity and adverse impact on access to services that could result from having SCHIP enrollees obtain their primary coverage through the Exchange with SCHIP as a secondary payer for services not provided by the Exchange coverage.

We would encourage the newly established Medicaid and SCHIP Payment and Access Commission (MACPAC) to carefully monitor the implementation of the new mental health parity requirements contained in CHIPRA. While that law does not mandate behavioral health coverage, it does ensure that when it is included financial requirements and treatment limitations for mental health and substance use disorders benefits are the same as medical and surgical benefits. It will be important to know how states as well as the marketplace respond to the new parity requirements and to evaluate the impact including behavioral health benefits in SCHIP plans on overall health outcomes.

### **Quality of Care in Medicaid and CHIP (p 22)**

It is important that the child health measures developed address mental health. As emphasized recently by the Institute of Medicine in a report on "Preventing Mental, Emotional, and Behavioral Disorders among Young People," these conditions generally surface early in life -- half of all mental disorders are diagnosed by age 14 and three-fourths by age 24.<sup>4</sup> And unfortunately, there is generally a ten year delay between the time an individual first experiences a mental health condition and the point at which they receive treatment.<sup>5</sup> As a result of this early onset and common delay in treatment, these conditions can significantly interfere with a young person's ability to succeed in school and effectively engage in the workforce. Thus, it is critical that mental health conditions be recognized and treated early to prevent these disabling effects.

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<sup>4</sup> National Research Council and Institute of Medicine, Board on Children, Youth, and Families, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, Mary Ellen O'Connell, Thomas, Boat, and Kenneth E. Warner, Editors, Washington, DC, 2009.

<sup>5</sup> Kessler R.C., Berglund P., Demler O., et al., Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, *Arch Gen Psychiatry*, 2005; 62:593-602.

## **Enrollment and Retention Simplification (p 23)**

The provisions that would require states to implement 12-months of continuous eligibility as well as enroll and redetermine eligibility at various sites are also to be commended. These are positive changes to the program that will significantly affect beneficiaries.

## **Treatment of Selected Optional Benefits (24)**

In addition to the benefits cited in the paper, it should be noted that Clinic Services and Rehabilitation services are covered in all states. The Department of Health and Human Services has described the coverage of rehab services as the most important Medicaid option for working age adults with serious mental health conditions, providing community-based crisis services, medication management, skills training and other support services to reduce hospitalization and enable individuals to live in the community and engage in education or work as productive members of society.

Case management services should likewise be a mandatory benefit. Mental illnesses are often intertwined with other co-occurring conditions including substance use conditions, heart disease, cancer, and diabetes, but systems for delivering mental health care are routinely disconnected from general healthcare. In fact, individuals with serious mental illness who receive care through the public mental health system die on average 25 years earlier than the general population due to these co-occurring conditions.<sup>6</sup> Intensive case management services are needed to improve access to mental health services and particularly to increase care coordination regarding co-occurring illnesses and conditions. Case management services are also essential to helping individuals with mental illnesses obtain other non-medical services they need to lead healthy, productive lives in their communities, including housing, education, employment, and other social services.

We recommend including policy language that would expand provider status to include clinical psychologists (covered in the vast majority of states). We would further urge the addition of a service category for qualified community mental health program providers. (See above for more details regarding this proposal and payment for such entities.) The definition of a qualified community mental health program should set a floor for quality care. We have submitted language for this definition to the Committee, and it is also attached.

The expansion of coverage for mental health services as a result of health reform will tax the existing provider system greatly. We need to expand the capacity of the community mental health system to respond to increased demand and we need to improve access to high quality services. This proposed policy would address both these needs by creating federally-qualified safety net mental health provider system that parallels the community health center programs. The services offered by these community mental health providers are clinic and rehabilitation services which are, as mentioned above, already covered in all states.

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<sup>6</sup> Parks, J., Svendsen, D., Singer, P., Foti, M., Mauer, B., Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, 2006.

A further change to the benefit package is needed for children with serious mental disorders. The evidence-based practice of therapeutic foster care has been found to be an extremely cost-effective alternative to residential placement. However, recently the Centers for Medicare and Medicaid Services proposed elimination of this service from state programs (states had used the rehabilitation option to cover therapeutic foster care). At this time, many states have cancelled this benefit and are unwilling to reinstate it, even though the CMS regulation has been withdrawn, due to concern that the federal government may in the future deny coverage. It is therefore important to create coverage for therapeutic foster care, which is best done by creating a new service under Section 1905(a). The service should be limited to children who meet the level of care standard for residential placement but who can be served in a specialized therapeutic family-like setting.

### **Mandatory Coverage for Prescription Drugs (pp 25-27)**

We strongly support the proposal to make prescription drug coverage a mandatory benefit within Medicaid. This change is long overdue as prescription medications have become, over the years, some of the most efficacious and widely used treatments for many illnesses and conditions, including mental health conditions.

Benzodiazepines and barbiturates are important treatment options for certain mental health conditions and thus we also strongly support the proposal to remove those medications from Medicaid's excluded drug list. These medications can be critical in the treatment of serious mental illnesses, including anxiety disorders and often help avert serious exacerbation of symptoms and hospitalization.

### **Transparency in Medicaid and Waivers (pp 27-29)**

We strongly support greater transparency in the process of state plan amendments and approval by CMS of state waiver requests. Generally speaking, we favor the committee's proposals.

### **Medicare Coverage:**

#### **Waiver Authority for Dual Eligible Demonstrations (pp 24-37)**

We applaud efforts to improve coordination of services between Medicare and Medicaid for dually eligible individuals. An estimated 59 percent of all duals with disabilities have some type of mental disorder, compared to 21 percent of aged beneficiaries. Moreover, individuals who receive care through the public mental health system (who are often dual-eligibles) die on average 25 years earlier than the general population due to lack of adequate care coordination and preventative measures for co-occurring disorders including diabetes, heart disease, cancer, and asthma. <sup>7</sup> The high rate of mental disorders in the Medicare population with disabilities is primarily driven by the large proportion of beneficiaries with disabilities who qualify for Medicare because of a long-lasting and disabling mental illness. Since 1987, both the number and proportion of disability awards due to mental illness have increased dramatically, and they

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<sup>7</sup> Parks, J., Svendsen, D., Singer, P., Foti, M., Mauer, B., Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, 2006.

have been the leading reason workers with disabilities received Social Security Disability Insurance (SSDI) since 2004. People who qualify for Medicare based on a physical disability are also more likely to have comorbid, potentially severe, mental disorders. It is also worth noting that, although aged beneficiaries in the general Medicare program are less likely to exhibit mental disorders than beneficiaries with disabilities, most of the Medicare beneficiaries with mental disorders are over the age of 65 due to the size of the aged population relative to the population of people with disabilities.

It is also important to note that in all of the MMA demonstrations to date, no disease management effort has focused on a mental disorder to date and few have incorporated mental health screening and care coordination to address the impact of mental co-morbidities on physical conditions like diabetes. Given the prevalence of mental disorders in the Medicare population and the association of mental disorders with higher health care spending, a strengthened emphasis on mental health could prove useful.

Medicare Advantage Special Needs Plans (SNPs), authorized by the MMA, offer a potential avenue to better manage care for Medicare beneficiaries with mental disorders, but a SNP focused on this population has not yet been developed. SNPs provide an opportunity to integrate acute and long-term care services and increase coordination of Medicare and Medicaid financing and benefit structures. These plans are subject to the same rules and requirements as other MA plans but they are able to provide products focused exclusively on high cost populations such as the dual eligibles, the institutionalized, and other chronically ill populations. SNPs may limit enrollment to one of the special needs populations, tailoring benefits and provider networks to best meet the needs of these vulnerable groups. Concerns have been raised that SNPs are not required to coordinate with state Medicaid programs and may do little to integrate care for vulnerable populations.

### **Cost Effectiveness Test (pp 35-36)**

With regard to any waivers proposed to establish contracting with managed care organizations (e.g., carve-outs, Special Needs Plans), it will be important to require these entities to ensure access to broad array of community mental health services and providers. Although parity provisions of the Medicare Improvement for Patients and Providers Act will improve access to mental health services, it is critical to remember that Medicare's benefit structure is not optimally designed to support the kinds of mental health services demonstrated to be most effective for individuals with disabilities and older Americans. As a result, Medicare spending on mental health has not traditionally matched that of other payers. Before the introduction of Part D, Medicare spending on mental health accounted for a relatively small proportion of total mental health expenditures and an even smaller proportion of total Medicare spending.<sup>8</sup> Part D will likely accelerate the growth of mental health spending under Medicare significantly; however, while psychotropic drugs are an important dimension of mental health treatment, providing appropriate psychosocial services to Medicare's disabled and aged beneficiaries is a broader challenge than simply ensuring access to medications.

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<sup>8</sup> Tami L. Mark et al., "U.S. Spending For Mental Health And Substance Abuse Treatment, 1991-2001," Health Affairs Web Exclusive (March 29 2005), p. W5-137.

### **Office of Coordination for Dually Eligible Beneficiaries (pp 36-37)**

We strongly support the Committee's proposed option and request that community based mental health services be included in the OCDEB report. Regardless of whether standard outpatient mental health benefits are expanded as a result of the reduced cost sharing requirements that will be phased in through 2014, operational policies now being implemented by carriers are believed to unfairly restrict access to mental health care because they are unclear and inconsistently applied. Clinical failures and inefficiencies are perhaps more closely tied to disconnects across services and providers, rather than poor performance within service type or provider class. Both beneficiaries and providers appear confused regarding the circumstances under which a mental health service is covered.

The OIG has recommended that carriers improve providers' awareness of coverage rules and documentation requirements and federal guidance has been issued to give carriers a template for making local coverage decisions. A recent Medicare Payment Advisory Commission (MEDPAC) report<sup>9</sup> on dual eligibles identified a number of conflicts, inconsistencies, or unclear policies that have the potential to hinder care delivery for this population. To the extent that these efforts have failed to achieve an adequate level of consistency and equity across regions, a national coverage policy on outpatient mental health services may be needed. Although such a national coverage determination would be complicated by variations in state laws governing the scope of practice for different mental health providers, opportunities could exist to clarify medical necessity standards and documentation requirements. Consideration may be given to these issues as CMS pursues broader reform of its contracting mechanisms.

### **Reduce or Phase-Out the Medicare Disability Waiting Period (pp 37-38)**

We comment the Committee for the commitment to move towards elimination of the two-year waiting period for Medicare coverage for individuals receiving SSDI benefits. We have long advocated the total elimination of the waiting period. Data reported in a recent study by the Commonwealth Fund indicates that SSDI beneficiaries are much more likely to be uninsured than other working-age adults and are twice as likely to live in families whose income is below the federal poverty level.<sup>10</sup> Additionally, although 12 percent of individuals report being in poor health two years prior to SSDI entry, this figure more than doubles in the year immediately prior to SSDI entry and significantly increases for those in the first year after disability.<sup>11</sup> Given that the individual has just been found to have a disability which severely impairs their functioning, it simply makes no sense to leave them without health care coverage.

The Committee has proposed three alternatives to phase out the waiting period and a fourth option that would be combined with the phase-in of one of the first three alternatives.

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9 MEDPAC Report to the Congress: New Approaches in Medicare, "Chapter 3: Dual eligible beneficiaries," (June 2004).  
[http://www.medpac.gov/publications/congressional\\_reports/June04\\_Entire\\_Report.pdf](http://www.medpac.gov/publications/congressional_reports/June04_Entire_Report.pdf)

<sup>10</sup> Livermore, G., Stapleton, D. & Claypool, H. Health Insurance and Health Care Access Before and After SSDI Entry, The Commonwealth Fund, May 2009.

<sup>11</sup> Livermore, et al.

We oppose approach 1, which retains the waiting period albeit for a shorter period of time (12 months). We would favor phasing out the waiting period in a manner that provides the greatest advantage to the most significant number of people, which we believe is approach 3. While this option retains the waiting period for people who are now, or will shortly be, on disability benefits, all other beneficiaries will benefit from this approach which phases out the waiting period entirely by 2011.

## **Section VI: Options to Improve Access to Preventive Services and Encourage Healthy Lifestyles (pp 43-49)**

In March 2009, the Institute of Medicine (IOM) issued a report on “Preventing Mental, Emotional, and Behavioral Disorders among Young People” illustrating the dramatic impact that these conditions have on this population but also the tremendous opportunity there is to prevent mental health and substance use conditions.<sup>12</sup>

In recent decades there has been an explosion in research on prevention of mental health and substance use conditions and studies have shown that many interventions can result in long term reductions in behavioral health disorders as well as other positive outcomes such as improved academic achievement. A number of these successful interventions focus on improving parenting skills and mitigating disruptive family influences such as divorce and maternal depression, as well as school-based programs and comprehensive early education programs.

We appreciate and support the emphasis in this set of proposals from the Committee that would improve access to preventive services. Although mental health is a critical component of overall wellness, it is often not included in programs promoting preventive services.

Thus, we urge the Committee to include specific reference to mental health in the various prevention programs proposed in this document.

We also urge the Committee to provide incentives in public and private plans for certain well tested preventive interventions for children. The IOM report on “Preventing Mental, Emotional, and Behavioral Disorders among Young People” asserts that the greatest prevention opportunity is among children and youth. These conditions are so devastating in part because they have such an early age of onset (half of all mental disorders are diagnosed by age 14 and three-fourths by age 24) with lifelong effects of interfering with a young person’s ability to succeed in school and effectively engage in the workforce. The IOM also found that there is a window of opportunity in the gap of two to four years from the point at which a symptom first appears to development of a diagnosable disorder.

Thus, we urge the Committee to provide incentives for covering the following interventions:

- home visiting by public health nurses for low income first time mothers;
- coaching of caretakers of children regarding children’s social/emotional development needs as a component of pediatric care;

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<sup>12</sup> National Research Council and Institute of Medicine, Board on Children, Youth, and Families, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, Mary Ellen O’Connell, Thomas, Boat, and Kenneth E. Warner, Editors, Washington, DC, 2009.

- screening for depression and substance use in pregnant and perinatal women;
- behavioral health screenings as part of every well-child check-up from early childhood through adolescence; and
- screening and early intervention (for both physical and mental health) services provided by school-based and child-care-based health programs.

We also support the recommendation in this IOM report for a cross-agency coordinating body to prioritize prevention of behavioral health disorders across programs particularly those overseen by the Department of Health and Human Services, the Department of Justice, and the Department of Education.

**Promotion of Prevention and Wellness in Medicare:  
Personalized Prevention Plan and Routine Wellness Visit**

For example, we strongly support the proposal to establish a personal prevention plan for Medicare beneficiaries to be renewed every five years, but urge the Committee to specify that development of the plan include screening for mental health and substance use conditions.

**Incentives to Utilize Preventive Services and Engage in Health Behaviors**

We also strongly support eliminating cost-sharing in Medicare (and Medicaid) for preventive services rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF). Depression screening for adults and adolescents have both received “B” ratings from the USPSTF. We encourage the Committee to consider also eliminating cost-sharing for other preventive services assessed by other expert panels, including the IOM. The USPSTF has a limited capacity and the process of assigning grades to services is arduous and time-consuming.

**Promotion of Prevention and Wellness in Medicaid:  
Access to Preventive Services for Eligible Adults**

We also support the proposal to provide incentives to states to cover all USPSTF-endorsed preventive services but urge the Committee to clarify that Medicaid reimbursement is not restricted to only covering USPSTF-endorsed services and urge that preventive services assessed by other well-respected entities, including the IOM, be included. We are concerned that basing all coverage decisions on USPSTF endorsement will be overly restrictive and not effective at improving access to a wide range of preventive services.

We also urge the Committee to include as minimum requirements, screening for depression and substance use in pregnant and perinatal women, home visiting by public health nurses for low income first time mothers, and behavioral health screenings as part of every well-child check-up from early childhood through adolescence.

**Incentives to Utilize Preventive Services and Encourage Healthy Behaviors**

We strongly support eliminating cost-sharing in Medicare (and Medicaid) for preventive services rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF), see comments above.

### **Options to Prevent Chronic Disease and Encourage Healthy Lifestyles (pp 47)**

We urge the Committee to specify that the RightChoices program, to provide short-term coverage of preventive services for the uninsured, includes coverage of depression screening in addition to the other preventive services specified in the Committee document including hypertension screening, tobacco use screening and obesity screening.

### **Prevention and Wellness Innovation Grants (pp 47-48)**

The prevention and wellness innovation grants to promote health and human services integration, improve care coordination, and access to preventive services should also support comprehensive care management at community mental health centers instead of only focusing on primary care practices. We appreciate that the description of the integrated delivery systems that would be funded through this grant are described as including behavioral services. Nonetheless, individuals with serious mental health conditions often receive most of their services through the community mental health centers. These consumers have recently been discovered to be at risk of dying 25 years younger than the general population due to other physical co-occurring disorders. These individuals are in dire need of improved care coordination and access to preventive services and thus should be specified as a priority population to be served by this program.

### **Employer Wellness Credits (pp 48-49)**

We support tax credits to encourage development of employer-sponsored prevention and wellness programs. This proposal should also incorporate opportunities for community-based organizations to provide technical assistance for employers in evaluating and implementing wellness programs.

## **Section VII: Long Term Care Services and Supports**

### **Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid HCBS State Plan Option (pp 49-52)**

There are several positive amendments to these Medicaid programs in the paper. First, we applaud the Committee for the proposed amendment to the state plan option that would permit states to provide a wider range of services. This flexibility is already available to states through the 1915(c) waivers, and it would permit states to add to the HCBS package under the state plan option various supportive services for persons with mental illness.

The Committee's proposal would also eliminate the institutional level-of-care requirement for waiver services and require states to replace it with less stringent criteria. This would allow the waiver services to be made available to individuals without requiring that their condition deteriorate to the point where institutional care is a viable option. Instead, home and community based services could be furnished so as to maintain a higher level of functioning.

There is a further change needed with respect to the waiver program. Currently, states cannot use the HCBS waiver for children who would otherwise be in a psychiatric residential treatment facility (PRTF). PRTFs are not included in the list of institutions used to assess budget neutrality. CMS is currently operating a demonstration program that permits ten states to do this. Although that demonstration is not finished, it is clear from the participating states (and the great interest in other states in following this approach) that a more sound policy would be to change the underlying statute and permit all states to use PRTFs as offsets for HCBS. Since these waivers remain budget neutral, there should be no cost to the federal government for such a change, but there would be great benefit to the children who could remain with their families as a result.

We also support the amendments proposed to the eligibility criteria for the state plan option for home and community based services – that is, eliminating the prohibition against providing these services to individuals with income above 150% of poverty, but giving states the option to cover individuals up to 300 percent of the maximum SSI payment.

We are also pleased to see the Committee address the issue of reducing waiting lists for both waiver and state plan services, but urge adoption of approach 2, which would eliminate waiting lists. We also support increasing the federal match for home and community based services by one percent. This would encourage states to offer community services in place of institutional care.

Finally, we support the proposal to increase the federal match for HCBS by one percent. This change would provide encouragement to states to offer community services in place of institutional care.

## **Section VIII: Options to Address Health Disparities**

### **Standardized Categories for Data (pp 58-59)**

The Committee's proposal requires collection of access and treatment data for people with disabilities. It is important that the language in the legislation make clear that this includes all persons with disabilities by using phrasing that includes mental impairments as well as physical, sensory and other impairments. While we assume that this is the Committee's intent, we have too often seen people with mental disabilities omitted from important projects by federal agencies when they are not specifically included.

Thank you for considering our comments. If there are questions about any statements in this document, please contact any of the following individuals:

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