

The American Art Therapy Association has been working with various mental health agencies to develop recommendations for inclusion in the merged version of the *Affordable Health Care for America Act* and the *Patient Protection and Affordable Care Act*. It is expected that the final bill will be passed by mid February and then signed into law. Key recommendations included in our letter to government law makers through our joint efforts with mental health care organizations include:

**“Mental Health and Substance Use Coverage. Both the House and the Senate included in the essential benefit package “mental health and substance use disorder services” at parity with medical/surgical services and for including rehabilitation services.** The House specifically requires parity for all people enrolled in Exchange plans. The inclusion of these minimum benefits and parity guarantees, coupled with critical private insurance market reforms such as a prohibition on pre-existing condition exclusions, guaranteed issue and renewal requirements and the elimination of discrimination based on health status and disability, will foster access to needed physical, mental and behavioral health care for millions of Americans.

**Integrated Health Care. Vitaly important integrated health care provisions in both bills appropriately move health care delivery toward an interdisciplinary team-based approach that coordinates traditional diagnostic and therapeutic services, and, if necessary, coordinates care and links individuals to other providers and community services.** We support the furtherance of such integrated interdisciplinary health care systems through Medicaid medical home (or “health home”) efforts outlined in the two bills. Additionally, building on collaboration existing in a number of Medicaid programs between community health centers and behavioral health specialists, we urge you to accept the Senate language allowing community mental health centers to be designated medical homes for their patient population. Furthermore, individuals with a serious mental illness must continue to be expressly included as beneficiaries.

Senate Section 3502 admirably furthers the adoption of integrated health care throughout the private health system by establishing community health teams to support patient-centered medical homes. Including the House Medicare medical home pilot project (Section 1302) will help evaluate how successful this approach to health care delivery will be in reducing health care costs and coordinating health care services, provided that new language clearly covers mental health and substance use disorder services.

We urge that the conferees accept Section 3022 of the Senate bill that promotes shared savings through establishment of accountable care organizations (ACOs) to provide integrated care to Medicare beneficiaries. Under the Senate language, a full range of Medicare providers will be permitted to participate in ACOs to provide needed services to patients. The comparable House provision, Section 1301, unduly limits ACO participation to physician practices only.

**We support the House provision to require the HHS Secretary to establish a program to fund mental health and substance use disorder screening, brief intervention, referral and recovery services in primary care settings.**

**Medicaid, CHIP and Long-Term Services and Supports.** As you well know, Medicaid is an important source of coverage for low-income individuals, including children and adults with a

mental disorder who benefit from a range of services. **We applaud the raising of Federal Poverty Level eligibility in both bills and support the higher coverage level (150% FPL) to maximize extending benefits to millions of Americans who are currently uninsured, among them childless single adults.** We urge you to provide these newly eligible individuals (many with chronic and debilitating conditions) with the benefit of full, traditional Medicaid coverage. We support House Section 1721 to bring Medicaid reimbursement rates for primary care in line with comparable Medicare rates to help ensure access to care for Medicaid beneficiaries.

Additionally, as approved by the House in Sec. 1729 and in the Finance Committee-approved bill, we urge inclusion of language clarifying coverage of therapeutic foster care services under Medicaid. This is a cost effective, evidence-based intervention that helps thousands of children in need of intensive mental health services receive them in less restrictive, out-of-home settings.

We are very pleased that both bills recognize the long term service and support needs of our nation and include the Community Living Assistance Services and Supports Act. **Adding the Senate's Community First Choice Medicaid Option provisions in the merged bill would help address Medicaid's institutional bias and provide individuals with disabilities, including those with a mental illness with the ability to receive essential care at home or in the community.**

We also support the provision in the Senate bill to remove benzodiazepines and barbiturates from the list of excludable medications in Medicaid. These medications can be helpful in the treatment of serious mental health conditions.

We support the House provision that would require states to suspend rather than terminate Medicaid eligibility for youth incarcerated in a public institution, thus avoiding problems of reenrollment upon release (Section 1729).

Low-income children in working families have benefited from the success of the Children's Health Insurance Program in providing needed health and mental health care. This vulnerable population should receive mental health and substance use services and other critical program benefits and not be left worse off in any expansion of health care services.

Workforce Development. **We appreciate your commitment to implementing strategies that will address mental and behavioral health workforce shortages in underserved communities.** The merged bill should include the critical language from both bills expanding workforce development within the primary care and public health arenas, **specifically authorizing mental and behavioral health education and training grants, and loan forgiveness to child mental health professionals included in the Senate bill.**

Capacity to serve newly insured individuals in the public sector with a high demand on mental health services will be greatly assisted by the House language creating a definition of federally qualified behavioral health centers (Section 2513). This establishes national standards of care for community mental health centers applying for federally qualified status.

Prevention and Wellness. The elimination of cost-sharing for preventive care in the essential benefits package in both bills will help to improve health outcomes and may even lower overall health care costs in the long term. **The Senate provisions of particular importance are those that: authorize community transformation grants; direct the Clinical Preventive Services Task Force to consider best practices presented by scientific societies in developing clinical preventive recommendations; and enhance access to preventive services for special populations, including children, women, older adults, ethnic minorities and people with disabilities.** Furthermore, we applaud the recognition of the Substance Abuse and Mental Health Services Administration as a vital agency to be consulted on the development of prevention and wellness strategies pertaining to behavioral health.

Health Disparities. With respect to addressing health disparities, we strongly support the retention of the provisions in both bills that provide for data collection and analysis to ensure collection and reporting of data on race, ethnicity, gender, geographic location, socioeconomic status, primary language and disability status (especially for subpopulation groups), as well as the development of quality measures to evaluate the data collection process. We also request that the House language reauthorizing the Indian Health Care Improvement Act be included in the final bill.

Comparative Effectiveness Research. We commend the sustained investment in comparative effectiveness research in both bills, as this will greatly enhance the research and clinical evidence used by patients and clinicians to make informed health decisions. The House bill draws directly upon the existing and substantial federal infrastructure of the National Institutes of Health and the Agency for Healthcare Research and Quality. This reliance will help speed the translation of discoveries supported by these and other federal agencies into practical application in local communities. Should you decide to accept the Senate's establishing the CER Institute as a private nonprofit, please retain the requirement to include patients and patient representatives on the board and advisory panels of the CER Institute as well as the provision to ensure that these patient representatives receive support and resources to help them effectively participate in technical discussions regarding complex research topics. Adding a mental health expert to any CER advisory body would ensure that this perspective is brought to bear on the broad range of health conditions modified by psychosocial factors and human behavior.

We favor the provision in the Senate bill that supports postpartum depression research and services for women with this condition. Though the causes of postpartum disorders are still unclear, research has shown that they are treatable. However, a great number of cases go undetected. This initiative would improve understanding of postpartum conditions as well as increase awareness and treatment opportunities. We also support the Senate language establishing National Centers for Excellence in Depression.

Medicare. We appreciate the mental health policy changes in both bills that will help maintain the viability of the outpatient mental health benefit, including an extension restoring reimbursement cuts for psychotherapy services. Though separate legislation has temporarily postponed Draconian payment cuts to health professionals under the Medicare Sustainable Growth Rate, we urge you to find a permanent solution.

We are glad that the House did not include a new Independent Medicare Advisory Board, as creation of this new powerful entity would increase pressure on Medicare reimbursement rates outside of the congressional process. **Your including House Section 1308 that expands Medicare's coverage of state-licensed mental health professionals would enhance beneficiary choice of provider and access while not broadening existing outpatient services.** The program's limited coverage of mental health services for nursing home residents would be significantly expanded with the inclusion of House Section 1307, which covers clinical social work services to nursing home resident stays covered under Medicare Part A.

We thank you for the attention to Medicare beneficiaries enrolled in Part D who must pay out of pocket entirely for the cost of prescriptions due to the coverage gap (also known as the doughnut hole). We urge your support for the House provision that moves to eliminate this financial barrier in accessing needed medicines.

We support the Senate language to strengthen the requirement that Medicare Part D plans provide full coverage of six classes of clinically sensitive medications, including anti-depressants, anti-psychotics and anti-convulsants. We recommend that the final bill ensure coverage of the current protected classes through at least 2015 and maintain the MIPAA requirement that any restriction on access to medication must be approved through the exceptions process and be based on scientific evidence and medical standards of practice.

Effect on State Laws. **The MHLG has a longstanding interest in ensuring that state mental health and substance use mandated benefits and parity laws are preserved for consumers during consideration of federal health care legislation.** States have enacted these laws over many years to ensure that mental and substance use coverage adequately protects their citizens. Though Senate Section 1334 creating new "multi-state" plans has lessened the danger from the "nationwide" plans language it replaced, we still prefer that it be deleted because these plans could provide coverage to consumers without having to comply with these mandated benefits and parity laws. We have a similar objection to the Health Care Choice Compacts in Senate Section 1333 and House Section 309. Should you choose to retain multi-state plans and compacts, please require that the benefit laws of the state most protective of consumer rights prevail.

**To ensure access to highly sensitive health care, we recommend that it be made clear, as in the HITECH Act and the Medicare statute, that nothing in the bill is intended to eliminate the patient's right to pay out of pocket for health care to protect his or her privacy.**

Thank you again for your tireless efforts and leadership in ensuring that our nation has access to quality mental and behavioral health services. We look forward to working with you to enact in the coming weeks comprehensive health care reform legislation that gives affordable coverage to the greatest possible number of families and individuals.

Sincerely,

*[Cosigners as of Jan. 11, 2:05 PM: 32 + 4 ]*

Alliance for Children and Families  
American Academy of Child and Adolescent Psychiatry  
American Art Therapy Association  
American Association for Geriatric Psychiatry  
American Association for Marriage and Family Therapy  
American Association of Pastoral Counselors  
American Counseling Association  
American Foundation for Suicide Prevention/SPAN USA.  
American Group Psychotherapy Association  
American Mental Health Counselors Association  
American Nurses Association  
American Psychiatric Nurses Association  
American Psychoanalytic Association  
American Psychological Association  
Anxiety Disorders Association of America  
Association for the Advancement of Psychology  
Association for Ambulatory Behavioral Healthcare  
Bazelon Center for Mental Health Law  
Center for Integrated Behavioral Health Policy \*  
Children and Adults with Attention-Deficit/Hyperactivity Disorder  
Clinical Social Work Association  
Clinical Social Work Guild 49, OPEIU  
Corporation for Supportive Housing \*  
Jewish Federations of North America \*  
Mental Health America  
National Alliance on Mental Illness  
National Association for Behavioral Health \*  
National Association for Children's Behavioral Health  
National Association for Rural Mental Health  
National Association of Anorexia Nervosa and Associated Disorders -- ANAD  
National Association of Psychiatric Health Systems  
National Association of Social Workers  
National Council for Community Behavioral Healthcare  
National Federation of Families for Children's Mental Health  
National Foundation for Mental Health  
Therapeutic Communities of America  
Witness Justice