



**National
Mental
Health
Association**

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Cynthia Wainscott, Chair of the Board • Michael M. Faenza, President and CEO

August 23, 2005

The Honorable Joe Barton
Chairman, Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable John Dingell
Ranking Member, Energy and Commerce Committee
2322 Rayburn House Office Building
Washington, DC 20515

The Honorable Nathan Deal
Chairman, Health Subcommittee
Energy and Commerce Committee
2133 Rayburn House Office Building
Washington, DC 20515

The Honorable Sherrod Brown
Ranking Member, Health Subcommittee
Energy and Commerce Committee
2332 Rayburn House Office Building
Washington, DC 20515

Dear Representatives:

On behalf of the National Mental Health Association (NMHA) and our over 340 state and local Mental Health Association affiliates nationwide, I am writing to express **grave concerns regarding several of the Medicaid proposals recently sent to Congress by the U.S. Department of Health and Human Services (DHHS). We are particularly alarmed by the proposals to narrow the definition of services that can qualify for Medicaid funding through the rehabilitation services and targeted case management optional funding categories.** These changes would significantly reduce access to community-based mental health services.

The Medicaid program provides a lifeline of support for millions of low-income Americans who need mental health care. Medicaid enables these individuals to access critical mental health services ranging from inpatient hospital care to psychologist and psychiatrist services, rehabilitation, and prescription drug coverage. Importantly, many of these services and benefits that Medicaid covers enable individuals to remain in their homes and communities instead of costly institutions. Without Medicaid, these individuals would have nowhere else to turn in light of the paltry levels of support available through other programs, including the mental health block grant.

Rehabilitation Services

The rehabilitation services option (rehab option) in the Medicaid program is a primary source of funding for community-based mental health services. In fact, this option is most commonly used to

underwrite mental health services, and nearly every state uses it to provide services and supports for individuals with mental illness.¹ This option enables states to offer a wide range of services in community-based settings that foster an individual's rehabilitation and recovery far more effectively than clinical facility settings. The rehab option was intended to be flexible, in contrast to a funding category like the *clinic option*, in which services must be provided in a medical setting to receive Medicaid reimbursement.

The rehab option currently authorizes Medicaid reimbursement for "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."² Examples of community-based services funded through the rehab option include supported employment services, consumer-run services, and day treatment, which enable individuals with mental illness to maintain jobs and live in their communities.

The Administration is proposing to eliminate Medicaid payment for services through the rehab option if such services could be funded through other Federal, State or local programs. This dramatic shift in policy would greatly reduce access to community-based mental health services because, as stated earlier, the alternative sources of support are completely inadequate. This proposal would also undermine one of the most helpful features of the rehab option with regard to mental health treatment – i.e., the capacity it offers states to cover a range of comprehensive community-based services in a more coordinated fashion. This coordination would be lost if states are required to piece together what little alternative funding is available for needed services from different programs, resulting in fragmentation of services. The President's New Freedom Commission on Mental Health singled out fragmentation of mental health services as one of the principle barriers to effective mental health service delivery and as a primary cause of so many people with mental illness "falling through the cracks."³ To adopt this proposed change would be to disregard the findings of this important Commission.

Equally alarming is the Administration's proposal to prohibit Medicaid payment for services that a state also provides to non-Medicaid-eligible individuals free of charge. This provision has the potential to wipe out Medicaid funding for all community-based mental health services, for example, in states that use other, non-Medicaid funds to cover the cost of community-based mental health services for other indigent individuals, including homeless individuals.

The Administration also proposes to require that rehab services be "prescribed by a physician or other licensed practitioner of the healing arts" while the current law only requires that services be "recommended by a physician or other licensed practitioner." In addition, the Administration specifies that these services must be "provided by, or under the direction of, a physician or other licensed practitioner of the healing arts." Both of these changes would have the effect of limiting Medicaid

¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, January 2005, p. 56.

² Social Security Act, Sec. 1905(a)(13)

³ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003 (available at www.mentalhealthcommission.gov), p. 27.

reimbursement to rehabilitative services that employ more of a medical model than the community-based recovery model that the rehab option was designed to promote.

The proposal to require that services be provided by or under the direction of a physician or other licensed practitioner would add a new requirement of more direct involvement of physicians or other medical professionals in all rehabilitative services. According to HHS, under current law “neither the statute nor the regulations mandate that a psychiatrist or psychologist directly furnish or oversee the day-to-day provision of rehabilitative services” in contrast with the clinic option that requires a medical professional to directly furnish or closely supervise the service in order to qualify for Medicaid reimbursement.⁴

This shift in policy runs counter to the current consensus on best practices in mental health services that establish recovery as the goal and emphasize the importance of community-based, consumer-centered services. As noted by the U.S. Department of Health and Human Services in a recent report regarding Medicaid coverage of mental health services, the rehab option is “well suited to implementing the community support services concept where the emphasis is on bringing services to individuals in their homes and elsewhere in the community” because the Medicaid statute provides that rehab services may be provided in a variety of locations, not just clinics or other medical settings.⁵ The proposed changes would undermine these critically important features of the rehab option.

Recasting the rehab option to fund more of a medical model of treatment instead of community-based, recovery-oriented services also contravenes the goals of the President’s New Freedom Initiative and the findings of the President’s New Freedom Commission on Mental Health. In its final report, the Mental Health Commission concluded that in order to improve mental health care delivery, services and treatments must be consumer and family centered, giving consumers real and meaningful choices about treatment options and care must focus on facilitating recovery and enabling people to cope with life’s challenges instead of just managing symptoms.⁶ Just last month DHHS embraced those principles formally, in releasing a federal action agenda, *Transforming Mental Health Care in America*. To illustrate, the report emphasizes the importance that Americans “understand that mental illnesses and emotional disturbances are treatable and that recovery should be the expectation. In a transformed mental health system, services and treatments must be geared to give consumers and families real and meaningful choices about treatment options and providers, and care must focus on increasing individuals’ abilities to cope successfully with life’s challenges, on building resilience, and on facilitating recovery.”⁷ Rather than realizing that policy goal, adoption of this proposal would shrink people’s options and their prospect for recovery.

Moreover, we are concerned that requiring increased physician involvement in rehab services could limit access to consumer-providers and consumer-run services. The flexibility inherent in the rehab option has enabled certain states to develop well-established peer support programs, as exemplified in Georgia where certified peer specialists are involved in many of the services funded through the rehab option and where the rehab services option also covers peer supports as a distinct consumer-driven and consumer-led

⁴ U.S. Department of Health and Human Services, *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, January 2005, p. 57

⁵ Ibid.

⁶ New Freedom Commission on Mental Health, p. 5.

⁷ U.S. Department of Health and Human Services, *Transforming Mental Health Care in America. The Federal Action Agenda: First Steps*. DHHS Pub. No SMA-05-4060. Rockville, MD: 2005, pp 4 – 5.

service. The President's New Freedom Commission on Mental Health recommended consumer-run services as important sources of community-based care:

“Consumers who work as providers help expand the range and availability of services that professionals offer. Studies show that consumer-run services and consumer-providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis. Because of their experiences, consumer-providers bring different attitudes, motivations, insights, and behavioral qualities to the treatment encounter.”⁸

While we support some oversight of consumer-providers and consumer-run services by physicians and other licensed practitioners, extensive oversight would cause the cost of these programs to become prohibitive. In addition, in some rural areas, physicians and licensed providers are in scarce supply and will likely not be available to provide day-to-day oversight which could further limit access to these important services in areas that desperately need alternative sources of care.

The Administration also proposes to limit reimbursement to rehabilitation services that “are necessary for the achievement of specific, measurable outcomes” related to the reduction of physical or mental disability or the restoration of an individual to the best possible functional level. Further clarification of what is intended by this proposal is needed. We are concerned that this new requirement could result in reduced funding for services if a state could only show that a beneficiary *maintained* progress toward established goals or outcomes. We are also concerned that DHHS intends to require states to produce clinical research data in support of their programs which may not be available for some of the newer treatment models.

Targeted Case Management

The Administration is proposing very similar restrictions on use of the targeted case management (TCM) option in Medicaid.

The targeted case management (TCM) option is used by many states to link beneficiaries to mental health and other services. TCM services are defined in current law as “services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.”⁹ Thus, a key distinction between TCM and other types of case management that may be funded through Medicaid is that TCM services may be used to help Medicaid beneficiaries gain access to non-Medicaid services and supports including food stamps, energy assistance, emergency housing, and legal services. **In a recent report, DHHS underscored the importance of the TCM option in stating that “successfully supporting working age adults with serious mental illnesses in the community often involves not only addressing their treatment needs but also assisting them in other areas (e.g., finding affordable housing or securing employment).”¹⁰**

⁸ New Freedom Commission on Mental Health, p. 37.

⁹ Social Security Act, Sec. 1915(g).

¹⁰ U.S. Department of Health and Human Services, *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, January 2005, p. 64.

The Administration's proposal to eliminate coverage through the TCM option for case management services that could be provided through any other programs or services negates the unique and valuable features of this option which like the rehab option enables states to better coordinate services for beneficiaries. **Dismantling these key features of the TCM option would reject a fundamental tenet of the President's New Freedom Commission on Mental Health – the need to achieve integrated service-delivery. It would also institutionalize the fragmentation of services that the Commission identified as one of the primary barriers to effective mental health treatment.**

The National Mental Health Association appreciates your consideration of our concerns and we **urge you to reject the Administration's proposed changes to the rehabilitation services and targeted case management options in Medicaid.** Please contact Kirsten Beronio at 202-675-8413 or kberonio@nmha.org if you have any questions regarding our views.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael M Faenza". The signature is fluid and cursive, with a large loop at the end.

Michael M Faenza, MSSW
President and CEO