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Responses to Questions for the Record

**House Committee on Energy and Commerce Subcommittee on
Oversight and Investigations**

**“Mental Health: HHS Leadership Needed to Coordinate Federal Efforts
Related to Serious Mental Illness”**

February 11, 2015

The Honorable Tim Murphy

- 1. Please share with the Committee the status of the ASPE study on mental illness, violence and criminal justice referenced during the hearing and provide to us the final report when it is available.**

Answer: We are in the process of developing a request for proposals to hire an independent contractor to assist us with carrying out this study. We would be happy to share the final report for this study when it is finished.

- 2. Please share with the Committee whether HHS has seen evidence of high deductibles under the Affordable Care Act discouraging individuals from seeking treatment for mental illness.**

Answer: It is too soon to assess the impact of the pricing structure of Marketplace plans on enrollees' behavior.

- 3. The Protecting Access to Medicare Act (Public Law 113-93) creates a demo project for new Certified Community Behavioral Health Clinics. One of the requirements for these new outpatient mental health clinics is that they "improve availability of, access to, and participation in assisted outpatient mental health treatment in the State" (Section 223(d)(4)(A)).**

Assisted outpatient mental health treatment, or AOT, allows judges, after full due process, to require certain mentally ill individuals with a history of violence, arrest, and medically unnecessary hospitalizations, to be placed in six months of monitored treatment as a condition for living in the community. AOT reduces institutionalization and provides an off ramp before prison.

Nearly every state has an AOT law, but they are not uniformly applied or constructed. Does HHS (SAMHSA and CMS) plan to ensure state applicants meet the AOT requirement under Section 223(d)(4)(A)?

Answer: The Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) are working collaboratively to implement this demonstration program. The Department of Health and Human Services (HHS) is implementing the program in accordance with section 223 of the Protecting Access to Medicare Act of 2014.

- 4. What has HHS done, and what is it currently doing, to coordinate with states on implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and specifically what meetings have occurred and what resources have been shared with state insurance commissioners, state mental health agencies and state attorneys general (and when) to ensure that the Act is fully implemented and enforced at all levels of jurisdiction?**

Answer: HHS has taken a number of steps to coordinate implementation of MHPAEA with states, including several calls organized by the National Association of Insurance Commissioners to review the provisions of the MHPAEA statute and regulations. CMS in particular regularly works with individual state regulators to address specific issues and provide technical assistance. SAMHSA has organized several meetings through its Regional Offices to bring together state regulators and state behavioral health agencies with CMS, ASPE, and SAMHSA staffs to brief state officials on MHPAEA regulations and respond to questions. The Department has worked extensively with regulators from New York, Illinois, Iowa, Ohio, West Virginia, Massachusetts, Connecticut, Colorado, and California, among others, on specific MHPAEA implementation issues. We also provide assistance to state regulators in analyzing how their state mental health parity laws intersect with MHPAEA. Finally, CMS is developing a qualified health plan tool to assist states and issuers in identifying areas for further review for MHPAEA compliance issues.

- 5. What has HHS done, and what is it currently doing to ensure that physicians have access to the full range of mental health medications that they deem medically necessary to prescribe, without going through burdensome prior authorization or other utilization limits due to restrictive Medicaid state formularies? In specific, there are a number of currently pending state proposals to restrict the ability of Medicaid beneficiaries, and the doctors that treat them, from access to the full range of mental health medications available.**

Answer: Timely access to mental health services and medications is often a critical step in treating individuals with mental health issues. HHS, acting through CMS, has taken several steps to strengthen coverage and access to these services and we are committed to working with the Congress to continue to improve outcomes for individuals who need mental health services.

As you know, state Medicaid programs that choose to offer prescription drug coverage as a benefit (currently all state and territory Medicaid programs) must meet certain minimum coverage and benefit requirements that are generally found in section 1927 of the Social Security Act. Among these is the requirement that once a drug manufacturer enters into a rebate agreement with the Secretary, states generally must include coverage for all of that manufacturer's drugs. States may elect to impose certain prior authorization requirements or establish preferred drug lists (PDLs), but the effect of these programs cannot be to deny coverage for medically-appropriate treatment.

In addition to the Medicaid prescription drug coverage requirements, in 2008, MHPAEA was enacted, supplementing and expanding upon the protections for mental health services that were enacted in the Mental Health Parity Act of 1996. MHPAEA included a number of financial and coverage requirements to ensure that mental health and substance use disorder treatments are no more restrictive than medical or surgical treatment. As you know, MHPAEA does not apply to all Medicaid plans, but its protections do extend to Medicaid managed care organizations (MCOs), the Children's Health Insurance Program, and Medicaid alternative benefit plans (ABPs).

On January 16, 2013, CMS sent a letter to state health officials and state Medicaid directors that provided additional guidance to states on the applicability of MHPAEA to Medicaid.¹ In addition, on April 6, 2015, CMS released a notice of proposed rulemaking on MHPAEA's application to Medicaid MCOs, ABPs, and CHIP. We are committed to working with stakeholders and states to ensure that Medicaid beneficiaries have access to the full range of mental health and addiction services benefits they are entitled to under the law and their state plan.

- 6. Was ASPE specifically consulted by the Centers for Medicare and Medicaid Services (CMS) before CMS, in January 2014, proposed to eliminate Part D “protected class” status for medications used to treat serious mental illness? What interagency coordination occurred with respect to the CMS proposal since the January 2014 proposal?**

Answer: HHS has an extensive internal review and consultation process that is applied to all regulatory, policy, funding, and program documents as well as correspondence. This proposal was thoroughly reviewed and discussed by all relevant HHS components.

- 7. What consultation is HHS doing, and with whom, to address workforce shortages of psychiatrists, particularly in rural and underserved areas, and with minority populations?**

Answer: HHS is committed to addressing workforce shortages. Components across HHS also are working to create a data capacity to improve documentation of the extent of workforce needs and address shortages.

¹ SHO #13-001, available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

SAMHSA is working with HRSA to expand the quality and availability of behavioral health care providers, including psychiatrists, with a particular focus on underserved communities through the National Health Service Corps (NHSC). Mental and behavioral health disciplines in the NHSC have increased significantly since 2008, from approximately 700 to 2,600 in FY 2014. Roughly one of every three clinicians in the NHSC provides mental or behavioral health services.

The NHSC provides scholarships and repays educational loans to over 9,200 clinicians providing care to approximately 9.7 million people who live in rural, urban, and frontier communities. Mental and behavioral programs eligible for the NHSC include health service psychologists, clinical social workers, professional counselors, marriage and family therapists, and psychiatric nurse specialists. HRSA also supports the Graduate Psychology Education program that trains psychologists to address access to behavioral health care for vulnerable and underserved populations.

As part of the President's *Now is the Time* initiative, both SAMHSA and HRSA are working together to expand the behavioral health workforce by supporting clinical training for behavioral health professionals through the Behavioral Health Workforce Education and Training (BHWET) Grant Program. In addition to the \$35 million that was awarded in FY 2015 for this initiative, the FY 2016 President's Budget includes \$56 million to support the clinical training of approximately 2,850 additional behavioral health professionals and approximately 2,750 additional paraprofessionals, including those in the areas of community health, outreach, social services, mental health, substance-use disorder, and youth.

Additionally, SAMHSA augments the workforce programs by providing workforce-development resources, technical assistance, grant programs, such as the Minority Fellowship Program, and subject matter expertise regarding mental and substance use disorder prevention, treatment and recovery settings and practice. SAMHSA also has increased its focus in this area through its new workforce strategic initiative described in its current strategic plan – *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018*.²

SAMHSA supports the Minority Fellowship Program (MFP), which helps address the shortage of psychiatrists in underserved populations. The MFP awards grant funds and provide technical assistance to seven professional organizations identified by the Congress to support educational scholarships and training opportunities for MFP fellows. SAMHSA's National Network to Eliminate Disparities in Behavioral Health (NNED) provides a workforce development component that trains providers, including psychiatrists, serving racially and ethnically diverse underserved populations across the country. NNED includes a focus on tribes, and thus provides training for Tribal practitioners, particularly on reservations and in rural areas.

SAMHSA and HRSA also ensure collaboration between HRSA telehealth resource

² Available at <http://store.samhsa.gov/shin/content/PEP14-LEADCHANGE2/PEP14-LEADCHANGE2.pdf>.

centers and the National Frontier and Rural Addiction and Treatment Transfer Centers to expand access to behavioral health expertise, including psychiatrists, in rural and frontier communities.

Together, SAMHSA and HRSA provided a comprehensive review of programs that support workforce development in its January 2013 Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues. SAMHSA and HRSA have continued to expand efforts on behavioral health workforce. Expansion of some of these initiatives, along with new proposals, can be found in the President's FY 2016 Budget.³

- 8. Did HHS have any interagency consultation with respect to the recent proposal to exclude psychiatry from Step 2 beneficiary assignment in the Medicare Shared Savings Program? Were any analyses conducted on this proposal's impact on the health of individuals with mental illness and substance use disorders or an ACO's ability to manage risk?**

Answer: HHS has an extensive internal review and consultation process that is applied to all regulatory, policy, funding and program documents as well as correspondence. This proposal was thoroughly reviewed and discussed within and across all relevant HHS components.

The Honorable Michael Burgess

- 1. HHS, in its comments on the GAO report, holds that the recommendation that it should establish a mechanism to facilitate interagency coordination “is not supported by a specific need identified by the agencies, stakeholders or individuals with SMI.”**
 - a. Did HHS perform an exhaustive survey of federal agencies, stakeholders, or individuals with SMI before forming this opinion?**

Answer: HHS formed its opinion based on ongoing work and engagement with the relevant agencies, stakeholders, and individuals with SMI. However, HHS is strongly committed to promoting care coordination for people with serious mental illnesses. We believe more can be done at all levels to coordinate care for this vulnerable population.

HHS is building upon and expanding intra- and inter-agency Federal coordination efforts related to individuals with SMI. In so doing, HHS is leveraging existing Federal coordination methods including the Behavioral Health Coordinating Council (BHCC) Subcommittee on SMI, the Interagency Task Force on Military and Veterans Mental Health, the National Action Alliance for Suicide Prevention, the U.S. Interagency

³ Department of Health and Human Services FY 2016 Congressional Budget Justification for the Substance Abuse and Mental Health Services Administration, 9, available at http://www.samhsa.gov/sites/default/files/samhsa-fy2016-congressional-justification_1.pdf.

Council on Homelessness, the Re-entry Policy Council, and senior-level communication.

These efforts will occur in conjunction with the BHCC SMI Subcommittee and reflect current work of other Federal departments. HHS also will seek to engage other departments in these efforts, specifically to identify additional programmatic and policy approaches to address critical, unmet needs for this population.

The Honorable David McKinley

1. Does HHS fund organizations that oppose the use of vaccines?

Answer: We do not track the views of HHS grantees. HHS requires grantees to follow the anti-lobbying rules that prohibit utilization of HHS appropriated funds for lobbying purposes as defined by the Labor, HHS, and Education Appropriations Act. The Federal Government cannot legally require organizations that seek or receive Federal funding to advocate or promote or refrain from advocating or promoting any particular position on policy or health related issues outside of the Federally-funded program.⁴

⁴ See *Agency for Int'l Dev. v. Alliance for Open Soc'y Int'l*, 133 S. Ct. 2321 (2013).