



Behavioral Health Care in Health Care Reform Legislation

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Summary

The 111th Congress has been considering various proposals that aim to improve the quality of and access to health care, including aspects of behavioral health care such as treatment for mental illnesses and substance abuse disorders. Behavioral health care-related proposals include requiring behavioral health coverage, expanding the provider workforce, improving behavioral health care coordination, and increasing funding for research on mental illness. Specifically, the proposals include provisions that would expand the scope of behavioral health parity, authorize grants to train behavioral health care providers, and provide for research on postpartum depression. Of these provisions, the one with possibly the most far-reaching effect would be that of expanding the scope of behavioral health parity.

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), signed into law on October 3, 2008 (P.L. 110-343). This law expanded previous federal requirements for behavioral health coverage (which required parity for behavioral health coverage with that for physical illnesses in terms of annual and lifetime treatment benefits). Generally, the provisions of MHPAEA apply at the beginning of the plan year beginning after October 3, 2009. In April 2009, the Departments of Treasury, Labor, and Health and Human Services sought feedback from insurers and behavioral health providers about the costs and benefits of MHPAEA, impact on small employers, additional paperwork burdens, and regulatory concerns with regard to MHPAEA's various provisions. The departments expect to publish final regulations for the implementation of MHPAEA by January 1, 2010. Under H.R. 3962 (Affordable Health Care for America Act), which passed the House on November 7, 2009, qualified health benefits plans (which would be required to provide behavioral health services) would be required to comply with the MHPAEA rules regarding the amount, duration, and scope of mental health and substance abuse benefits. This is also true of the minimum qualifying coverage specified in the Senate amendment (S.Amdt. 2786) in the nature of a substitute to H.R. 3590 (Patient Protection and Affordable Care Act). MHPAEA would also require carve-out programs (which are specialized managed care organizations that administer the behavioral health benefits for an insurance plan) to comply with parity requirements in the same manner that the insurer would have been required.

Four other provisions in the health care reform proposals affect the behavioral health care system. First, there are provisions that aim to address the issue of behavioral health provider shortage by providing for the establishment of grant programs to train and educate such providers. Second, some provisions aim to address the issue of affordability and lack of coordination of behavioral health care through the co-location of primary and specialty care services with behavioral health services. Third, some provisions aim to address research needs in specialty areas of mental health care by authorizing studies on postpartum depression. Fourth, a provision in the House bill would establish federally qualified behavioral health centers.

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Introduction

The 111th Congress has been considering various proposals that aim to improve the quality of and access to physical and behavioral health care.¹ The proposals discussed in this report are contained in two bills that have been approved by committees or passed by a chamber in the 111th Congress. On October 29, 2009, Representative Dingell introduced a health reform bill, the Affordable Health Care for America Act (H.R. 3962). The legislation is based on an earlier measure, the America's Affordable Health Choices Act of 2009 (H.R. 3200), which was jointly developed and reported by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor. H.R. 3962, as amended, was passed by the House on November 7, 2009.² On November 18, 2009, Senate Majority Leader Harry Reid unveiled the Patient Protection and Affordable Care Act, a comprehensive health reform bill that represents an amalgam of separate measures reported by the Committee on Finance and the Committee on Health, Education, Labor, and Pensions (HELP). The Patient Protection and Affordable Care Act is being debated by the full Senate as an amendment (S.Amdt. 2786) in the nature of a substitute to H.R. 3590.³

In the past decade, four federal reports have offered insight into the nation's behavioral health care system and recommended a fundamental transformation of the system.⁴ While the current health reform proposals would not lead to the fundamental transformation recommended by these reports, they could have a significant effect on certain aspects of behavioral health care in the United States. The proposals include provisions that would expand the scope of behavioral health parity⁵, authorize grants to train behavioral health care providers, require co-location of primary and behavioral health care, and provide for certain mental health research needs. Of these provisions, the one with the most far-reaching effect would possibly be that of expanding the scope of behavioral health parity.

A partial federal mental health parity law, which required parity only for annual and lifetime limits in mental health coverage, had been in existence since 1996. The Paul Wellstone and Pete

¹ Behavioral health care includes treatment for mental illnesses and substance abuse disorders.

² For more information on the provisions in H.R. 3962, see (1) CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead; (2) CRS Report R40885, *Private Health Insurance Provisions of H.R. 3962*, by Hinda Chaikind et al.; (3) CRS Report R40898, *Medicare Program Changes in H.R. 3962, Affordable Health Care for America Act*, coordinated by Patricia A. Davis; and (4) CRS Report R40900, *Medicaid and Children's Health Insurance Program (CHIP) Provisions in Affordable Health Care for America Act (H.R. 3962)*, coordinated by Elicia J. Herz.

³ For more information on the provisions in S. 3590, see (1) CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Senate Amendment in the Nature of a Substitute to H.R. 3590*, coordinated by C. Stephen Redhead and Erin D. Williams; and (2) CRS Report R40842, *Community Living Assistance Services and Supports (CLASS) Provisions in H.R. 3962 and Amendment in the Nature of a Substitute to H.R. 3590*, by Janemarie Mulvey.

⁴ The four reports are (1) National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, 2008, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>; (2) United States Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>; (3) Institute of Medicine Committee on Quality of Health Care in America, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, 2005; and (4) The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

⁵ Behavioral health parity refers to the provision of equitable coverage for behavioral health conditions as compared to physical illnesses.

Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was signed into law on October 3, 2008 (P.L. 110-343). This law expanded previous federal parity requirements for mental health coverage to require that the conditions of coverage for behavioral health, both in terms of the limitations placed on treatment (such as number of doctor visits and inpatient days) and the cost-sharing requirements (such as deductibles, co-pays), be no more restrictive than for coverage of medical and surgical benefits.⁶

This report provides an overview of the behavioral health provisions in the House and Senate health care reform proposals (H.R. 3962, S.Amdt. 2786). In this report, H.R. 3962 is referred to as the “House bill” and the S.Amdt. 2786 is referred to as the “Senate Amendment.” Since parity is potentially the most far-reaching provision of those currently being considered, this report focuses in greater depth on health reform issues related to MHPAEA. It provides background on MHPAEA, clarifies the plans that MHPAEA applies to and those exempt from it, and analyzes some of the issues that have arisen or may arise as Congress considers the role of behavioral health parity in health care reform. This report will be updated as necessary to reflect legislative action on health reform.

Behavioral Health Parity

On October 3, 2008, President George W. Bush signed into law P.L. 110-343, which provided authority for the federal government to purchase and insure certain types of troubled assets to provide stability to the economy and financial system. MHPAEA was incorporated in Division C of P.L. 110-343 as Title V, Subtitle B. The MHPAEA amends the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (IRC) to require parity for behavioral health coverage.⁷ This section summarizes the key provisions of MHPAEA and discusses issues that are at the intersection of health care reform and behavioral health parity.

Overview of MHPAEA

MHPAEA’s provisions require group health plans that provide behavioral health coverage to provide it on par with the medical and surgical benefits that they provide, with respect to certain aspects of the coverage. Specifically, MHPAEA requires plans to ensure that

- the financial requirements (including deductibles, copayments, coinsurance, and out-of-pocket expenses) applicable to the behavioral health benefits are no more restrictive than those applied to substantially all of the plan’s medical and surgical benefits;
- there are no separate cost-sharing requirements that are applicable only to behavioral health benefits;

⁶ For more information on federal mental health parity, see CRS Report RS22958, *Mental Health Parity: An Overview*, by Ramya Sundararaman.

⁷ ERISA regulates employee benefit plans, including employer-sponsored group health plans; the PHSA applies to insurance companies and managed care organizations, and to nonfederal government health plans; and the IRC covers group health plans (using a slightly broader definition than ERISA).

- the treatment limitations (including limits on the frequency of treatment, number of visits, days of coverage, or the scope or duration of treatment) applicable to behavioral health benefits are no more restrictive than those applied to substantially all of the plan's medical and surgical benefits; and
- there are no separate treatment limitations that are applicable only to behavioral health benefits.⁸

In April 2009, the Departments of Treasury, Labor, and Health and Human Services (HHS) published a notice in the *Federal Register* requesting responses from insurance companies and behavioral health providers.⁹ The Departments sought feedback about the costs and benefits of MHPAEA, its impact on small employers, additional paperwork burdens, and regulatory concerns with regard to MHPAEA's various provisions. As of December 7, 2009, the departments have not published final regulations for the implementation of MHPAEA. Kathleen Sebelius, Secretary of HHS, wrote to congressional leaders on October 2 to inform them that a final rule for the 2008 mental health parity law would be delayed until January 2010.¹⁰

Plans Covered by MHPAEA

MHPAEA does not mandate that plans cover behavioral health. The provisions of MHPAEA apply only to group plans that choose to offer behavioral health coverage. In addition, MHPAEA allows insurers to cover only some behavioral health conditions of their choosing. By amending three federal statutes (i.e., ERISA, the PHSA, and the IRC), the MHPAEA standards apply to a range of group health plans, as well as state-licensed health insurance organizations. The ERISA provisions apply to most group plans sponsored by private-sector employers and unions. The IRC provisions, which cover ERISA plans plus church-sponsored plans, permit the Internal Revenue Service to assess tax penalties on employers that do not comply with the MHPAEA requirements. The PHSA provisions apply to group health insurance issuers and some public-sector group health plans. Although states have taken on primary responsibility for the enforcement of many of the mandates as they apply to health insurers, other enforcement actions are available to the Secretaries of Treasury, Labor, and HHS.

MHPAEA exempts small group plans, which are group health plans sponsored by employers with 50 or fewer employees. The law also allows health plans that experience a cost increase of at least 1% (2% in the first year of MHPAEA being in effect) as a result of complying with this Act to be exempt from parity requirements for one year. Self-insured state and local government health plans may elect exemption from the MHPAEA.¹¹

⁸ For more information on MHPAEA, see CRS Report RS22958, *Mental Health Parity: An Overview*, by Ramya Sundararaman.

⁹ Department of Treasury, Department of Labor, Department of Health and Human Services, "Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008," *74 Federal Register*, April 28, 2009.

¹⁰ Daly R., "Parity to Become Federal Law Despite Rule-Making Delay," *Psychiatry News*, November 2009.

¹¹ Self-insured state and local government plans are those that take on some or all of the functions of an insurance company, such as bearing risk and paying the claims of its employees.

Issues for Consideration

The House bill and Senate Amendment include behavioral health parity provisions, which raise questions about the following issues: (1) the effective date for MHPAEA and how that affects or is affected by the health reform bills, (2) the effect of the provisions of MHPAEA on those of the health reform bills, and (3) the use of behavioral health carve-outs. This section analyzes and provides clarification on these issues.

MHPAEA and Plans in H.R. 3962 and S.Amdt. 2786

Neither H.R. 3962 nor S.Amdt. 2786 would directly amend the MHPAEA. However, MHPAEA provisions would affect the scope of certain provisions in the health reform bills. There are two aspects to consider in this potential interaction between MHPAEA and the health reform bills. First, The House bill and the Senate Amendment would require that “qualified”¹² plans include behavioral health benefits and that these plans comply with the requirements of MHPAEA. This would result in plans being mandated to provide behavioral health benefits on par with medical and surgical benefits. Second, while the health reform bills would apply to individual and group plans, the provisions of MHPAEA apply specifically to group plans. This would raise the issue of whether only the qualified group insurance plans would be required to provide parity behavioral health benefits, or whether the requirement would also extend to individual plans.

The House bill would require qualified health benefits plans (including the public health insurance option) to comply with the existing parity statutes in the PHSA regarding the amount, duration, and scope of mental health and substance abuse benefits, as outlined earlier in this report.¹³ Similarly, the Senate Amendment would require qualified health benefits plans (including the public health insurance option) to comply with existing mental health parity rules in the PHSA, in the same manner and to the same extent as health insurance issuers and group health plans.¹⁴

The existing parity rules in the PHSA do not mandate that plans provide behavioral health coverage. However, the essential benefits package outlined in the health care reform bills is required to include behavioral health services. Thus, in general, plans that comply with the qualifying standards set forth in the health care reform bills, and hence include services required in the essential benefits package, would be required to offer full parity for mental health and substance abuse treatment benefits.

¹² A plan is considered “qualified” in the health reform proposals when they meet certain requirements, one of which is provision of behavioral health services.

¹³ Under H.R. 3962, qualified health benefits plans are individual plans available in 2013 (and after) and group plans available in 2018 (and after) that meet certain requirements, including those affecting behavioral health discussed in this report. Some plans may be deemed “acceptable” while not being “qualified” (such as, grandfathered plans). For more information, see CRS Report R40885, *Private Health Insurance Provisions of H.R. 3962*, by Hinda Chaikind et al..

¹⁴ Under H.R. 3590, qualified health benefits plans refers to private health insurance that is “qualifying coverage” because it “meets or exceeds the criteria for minimum qualifying coverage,” per Sec.1302(a). For more information, see CRS Report R40942, *Private Health Insurance Provisions in the Senate Amendment in the Nature of a Substitute to H.R. 3590, The Patient Protection and Affordable Care Act*, by Hinda Chaikind et al.

Effective Date for MHPAEA

As mentioned above, certain plans would be required to comply with MHPAEA once the health care reform provisions are enacted. This section addresses the issue of *when* these plans would be required to comply with MHPAEA.

Generally, the provisions of MHPAEA apply at the start of the plan year which begins after October 3, 2009. In the case of most health insurance plans, which are based on the calendar year, the effective date will be January 1, 2010. There is an exemption to the general effective date mentioned above. For group health plans that fall under collective bargaining agreements that were ratified before October 3, 2008, there is a special effective date rule. For such plans, MHPAEA's requirements will apply to plan years beginning on the later of the following two dates: (1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008) or (2) January 1, 2010.

The provisions in the House bill and Senate Amendment may expand the scope of MHPAEA to include more plans, as described below. Generally, the newly included plans would be required to comply with MHPAEA at the beginning of their next plan year. In addition to the special exceptions noted above, the effective date for these newly included plans to comply with MHPAEA would vary depending on the date that the parity provisions in health reform legislation are enacted.

Parity and Behavioral Health Carve-Outs

“Carve-out” programs are frequently used by insurers to manage behavioral health benefits. These programs have been criticized by some, as detailed below. MHPAEA allows the use of carve-out programs; the health reform proposals are silent on whether plans may use them.

Medicaid and many private insurers contract with specialized managed care organizations to provide behavioral health benefits. These “carve-out” programs, which transfer the responsibility for behavioral health services to specialty behavioral health organizations, have become increasingly attractive as a cost-containment strategy.¹⁵ They also transfer the risk associated with the cost of providing behavioral health care to these behavioral health organizations. While carve-outs may be an attractive option for insurers, the provider community is opposed to them for a number of reasons. For example, carve-outs may make coordination between physical and mental health services difficult; carve-outs may also reinforce the stigmatization of behavioral health conditions by separating them out.¹⁶

MHPAEA requires carve-out programs to comply with the parity requirements in the same manner that the insurer would have been required. However, MHPAEA does not prohibit medical management of benefits. Hence, the carve-out programs could impose additional requirements, such as referrals or pre-approvals, in order to contain costs associated with providing behavioral health treatment.

¹⁵ Wayne R., Daughtery J., and Meador K., “Effect of a Mental Health “Carve-Out” Program on the Continuity of Antipsychotic Therapy,” *New England Journal of Medicine*, vol. 348 (2003).

¹⁶ AMA House of Delegates, *Elimination of Mental Health and Chemical Dependency Carve-Outs*, American Medical Association, Resolution 702, October 2000.

The House bill and Senate Amendment would require all qualified plans to provide behavioral health coverage and provide such coverage on par with coverage for physical health.¹⁷ When insurers who have not offered behavioral health coverage in the past are required to provide parity behavioral health coverage, they may use carve-out programs in an attempt to shift the risk associated with the cost of providing such care.¹⁸ The health care reform proposals do not directly address the use of behavioral health carve-outs by health insurers.

Other Behavioral Health Provisions in H.R. 3962 and S.Amdt. 2786

National reports on the U.S. behavioral health care system have identified a number of issues, including provider shortage, lack of coordination between behavioral health and other care, and lack of research in certain areas of behavioral health.¹⁹ This section outlines these three issues and analyzes how the health reform proposals may address those issues.

Behavioral Health Provider Shortage

According to experts who served on the President's New Freedom Commission on Mental Health, there is a shortage of behavioral health care providers, and this shortage is notably severe in rural areas.²⁰ Some provisions in the health reform proposals would address this shortage by providing for increased education and training resources. The grant programs established by these provisions could lead to an increase in the number of behavioral health care providers in rural and other areas that are experiencing a shortage of such providers.

The Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services (HHS), designates geographical areas with less than one behavioral health provider per 10,000 population as Health Professional Shortage Areas (HPSA) for behavioral health. In 2008, 66% of HPSAs for behavioral health were in rural areas. Also that year, there were 3,059 HPSAs for behavioral health, with a total of 77 million people living in these areas. According to HRSA, it would take 5,145 practitioners to meet the need for behavioral health providers.²¹ Due to the lack of specialty behavioral health providers in rural areas, primary care providers who practice in nonmetropolitan areas play a large role in behavioral health care.

¹⁷ Sec. 114 and 122 of H.R. 3200 and Sec. 142 of S. 1679.

¹⁸ Zuvekas S. et al., "The Impacts Of Mental Health Parity And Managed Care In One Large Employer Group," *Health Affairs*, vol. 21, no. 3, (2002).

¹⁹ The reports include (1) National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, 2008, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>; (2) United States Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>; (3) Institute of Medicine Committee on Quality of Health Care in America, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, 2005; and (4) The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.)

²⁰ The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

²¹ Health Resources and Services Administration, <http://bhpr.hrsa.gov/shortage/index.htm>.

Provisions in the H.R. 3962 and S.Amdt. 2786

Provisions in both bills would authorize grant programs to train behavioral health providers and give preference to grant applicants who would increase the supply of behavioral health providers in rural areas and other areas with a shortage of such providers. While the health reform proposals would authorize certain funding amounts for these grants, the relevant appropriations committees would determine the level of funds that these grant programs receive.

A provision in the House bill would amend PHSA Title VII, Part E, by adding at the end a new Section 3, PHSA Sec. 775, requiring HRSA, in consultation with SAHMSA, to establish a grant program to support interdisciplinary mental and behavioral health training programs. Eligible entities would include (1) accredited schools or programs of psychology, psychiatry, social work, and other disciplines, as specified; (2) an accredited public or nonprofit private hospital; (3) a public or private nonprofit entity; or (4) a consortium of two or more such entities. The Secretary would give preference to applicants who have a demonstrated record of (1) training health professionals who serve in underserved communities; (2) supporting teaching programs that address the health care needs of vulnerable populations; (3) training individuals who are from underserved areas, minority groups, or disadvantaged backgrounds; (4) training individuals who serve geriatric populations; and (5) training individuals who serve pediatric populations. The Secretary would be required to submit an annual report to Congress on this program. For each of FY2011 through FY2015, there would be authorized to be appropriated for this program \$60 million. Of the amounts appropriated for each fiscal year, at least 15% would be required to be used for psychology training programs.²²

A provision in the Senate Amendment would amend PHSA Title VII, Part D, by deleting Sec. 757 (authorizing appropriation for Part D through FY2002), redesignating Sec. 756 (as amended by Sec. 413 of this bill) as Sec. 757, and adding a new PHSA Sec. 756, Mental and Behavioral Health Education and Training Grants. In addition to the eligible entities specified in the House bill, this provision would also authorize the Secretary to award grants to state licensed mental health organizations to train paraprofessional child and adolescent mental health workers. The provision specifies different criteria for giving preference to applicants. The Secretary would give preference to (1) applicants that are certain accredited organizations for grants for education and training in social work; (2) institutions that focus on the needs of specified vulnerable groups for grants in graduate psychology; and (3) applicants that, among other things, are familiar with evidence-based methods for grants to train child and adolescent mental health professionals, and paraprofessional child and adolescent mental health workers. For FY2010 through FY2013, the provision would authorize to be appropriated \$8 million for training in social work, \$12 million for training in graduate psychology, \$10 million for training in professional child and adolescent mental health, and \$5 million for training in paraprofessional child and adolescent programs.²³

Lack of Coordination of Behavioral Health Care

Experts report that there is often lack of coordination of behavioral health care with other health care that is provided in various settings.²⁴ In addition, individuals with behavioral health

²² Sec. 2522 of H.R. 3962.

²³ Sec. 5306 of Senate Amendment to H.R. 3590.

²⁴ The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

conditions are faced with problems of affordability of care and differences between payment systems.²⁵ Provisions in the health reform proposals would enable the provision of coordinated and affordable behavioral health care at federally qualified behavioral health centers, or by co-locating primary and specialty care services with behavioral health services.

According to the Office of the Surgeon General, effective functioning of the behavioral health care system requires connections and coordination among public and private sectors, various specialty services, and a range of institutions in housing, criminal justice, and education.²⁶ Individuals with mental illnesses may receive social services and general health care services from various agencies or providers. Lack of effective communication between these service providers could result in missed opportunities to ensure that individuals with behavioral health conditions, who may come in contact with any of these systems, get routed to appropriate care. The Surgeon General's report on mental health asserts that such coordination at the systems level, or with financial mechanisms, is necessary to ensure that an individual, whose cognitive ability may be diminished as a result of his or her mental illness, is able to navigate the system's bureaucracy and receive the mental health care he or she needs.

Individuals often pay for the behavioral health care they receive with more than one funding source, and different payers may require different processes for seeking and paying for care. Some providers may not accept public and private mechanisms for financing behavioral health care. The situation is further complicated because the mental functioning of an individual needing this care is often reduced. Hence, without coordination, care can soon become fragmented, creating barriers to access.

Provisions in the H.R. 3962 and S.Amdt. 2786

Provisions in both bills aim to provide coordinated and affordable behavioral health care. While both bills would fund demonstration grants to assess the effectiveness of co-locating specialty and mental health care in community-based centers, the House bill would also authorize the establishment of federally qualified behavioral health centers (FQBHCs) nationwide to provide coordinated and affordable care.

Behavioral Health Services in Primary Care Settings

A provision in the House bill (Sec. 2538) would add a new PHSA Sec. 544, requiring the Secretary to establish a program to fund mental health and substance abuse screening, brief intervention, referral, and recovery services in primary care settings. Eligible entities would include those that (1) provide primary care services, (2) seek to integrate behavioral health into their services, (3) have working relationships with behavioral health providers, (4) demonstrate the need to integrate behavioral health into their services, and (5) agree to certain reporting requirements. The Secretary would give preference to applicants who provide services in rural or frontier settings; school, college, or university-based settings; or those who provide services to certain special needs populations. The funding period would not exceed five years. The Secretary

²⁵ Different payment systems for behavioral health care may have different managed care requirements, such as pre-approvals and co-payments. Payers may also differ in the process they use to process claims and reimburse for behavioral health care.

²⁶ United States Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

would be required to submit an annual report to Congress on evaluation results and performance measures of this program within four years of when funds are first appropriated for it. There would be authorized to be appropriated for this program \$30 million for FY2011 and such sums as necessary for FY2012 through FY2015. Of the amounts appropriated for each fiscal year, no more than 5% would be used for program management.²⁷

A provision in the Senate Amendment (Sec. 5604) would create a new PHSA Sec. 520K, Grants for Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings, requiring the Secretary to fund demonstration projects for providing coordinated care to individuals with mental illness and co-occurring primary care conditions and chronic diseases. Primary and specialty care services would be co-located in community-based mental health settings. The provision in the Senate Amendment does not specify who the eligible entities would be, or which applicants would receive preference. It specifies that grantees would be required to use the grant funds for providing primary care services, certain referrals for specialty care, providing for information technology needs, and certain facility modifications. It would also disallow more than 15% of the funds from being used for information technology or facility improvements or modifications. The provision in the Senate Amendment would require a different reporting period from that in the House bill. Specifically, within 90 days of expiry of the grant, grantees would have to submit to the Secretary an evaluation of the effectiveness of the activities carried out under the grant. There would be authorized to be appropriated \$50 million for FY2010 and such sums as necessary for each of FY2011 through FY2014 to carry out Sec. 5604 of the Senate Amendment.²⁸

The provisions in the House bill would establish a program, while the Senate Amendment would establish a demonstration grant.

Federally Qualified Behavioral Health Centers (FQBHC)

A provision in the House bill (Sec. 2513) would amend PHSA Sec. 1913 to establish FQBHC as part of SAMHSA's Community Mental Health Services block grant.²⁹ It would establish criteria for FQBHC, including a description of services to be offered, replacing the current criteria for community mental health centers. Specifically, FQBHC services would be required to include screening, assessment, diagnosis, risk assessment, person-centered treatment planning, outpatient mental health services, outpatient primary care services, crisis mental health services, case management, psychiatric rehabilitation and peer and family support. By replacing the term "community mental health centers" with "federally qualified behavioral health centers," this section would require that services funded by the block grant be provided through appropriate, qualified community programs. This section also would require an entity to be certified as a FQBHC by the SAMHSA Administrator at least every five years, based on the specified criteria. The Administrator would be required to issue regulations for certifying these centers within 18 months of enactment.³⁰

There is no comparable provision in the Senate Amendment.

²⁷ Sec. 2538 of H.R. 3962.

²⁸ Sec. 5604 of Senate Amendment to H.R. 3590.

²⁹ PHSA, Title XIX, Part B, Subpart I, Sec. 1911-1920.

³⁰ Sec. 2513 of H.R. 3962.

Research on Postpartum Depression

Significant advances have been made in the general understanding and treatment of mental illness. Despite these advances, experts believe that many Americans are not benefiting from improved mental health care.³¹ According to experts, one of the reasons for this is a shortage of research in a number of specialty areas of mental health care.³² One specialty area of mental health care—postpartum depression—is addressed in the House bill and the Senate Amendment.

Provisions in the H.R. 3962 and S.Amdt. 2786

A provision in the House bill (Sec. 2529) would encourage the Secretary to expand and intensify research on the causes of, and diagnostic techniques and treatments for, postpartum depression and other conditions, and information and education programs for health professionals and the public. The Secretary would be required to study and, within two years of enactment, report to Congress on the benefits of screening for postpartum conditions. It would include a Sense of Congress statement that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study, between FY2011 and FY2020, on the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways. There would be authorized to be appropriated to carry out this section, in addition to any other amounts authorized to be appropriated for such purpose, such sums as necessary for FY2011 through FY2013.³³

The Senate Amendment provision is the same as that of the House bill, with the following differences. Under the Senate Amendment (Sec. 2952), the nationally representative longitudinal study would be conducted between FY2010 and FY2019. The Senate Amendment has an additional provision stating that subject to the completion of the longitudinal study, beginning within five years of enactment and periodically thereafter for the duration of the study, the NIMH Director could submit to Congress reports on the study's findings. It would create a new SSA Sec. 512, Services to Individuals with a Postpartum Condition and their Families. This provision would authorize the Secretary to award grants, in addition to any other funds that would be provided to states under Title V, to eligible entities to establish, operate, and coordinate effective and cost-efficient systems for the delivery of essential services and support services to individuals with postpartum conditions and their families. The Secretary could integrate this program with other grant programs within PHSA Sec. 330.³⁴ There would be authorized to be appropriated \$3 million for FY2010, and such sums as necessary for FY2011 and FY2012 to carry out Sec. 2952 of the Senate Amendment.³⁵

³¹ Wang, P. S., Demler, O., and Kessler, R. C., "Adequacy of treatment for serious mental illness in the United States," *American Journal of Public Health*, vol. 92 (2002).

³² The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

³³ Sec. 2529 of H.R. 3962.

³⁴ PHSA Sec. 330 establishes health centers and authorizes funding for a number of grant programs to address issues such as infant mortality and health concerns of homeless populations and migratory and seasonal workers.

³⁵ Sec. 2952 of Senate Amendment to H.R. 3590.

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