

# Mental Health Liaison Group

March 17, 2017

The Honorable Paul Ryan  
Speaker  
U.S. House of Representatives  
1233 Longworth House Office Building  
Washington, DC 20515

The Honorable Nancy Pelosi  
House Minority Leader  
U.S. House of Representatives  
233 Cannon House Office Building  
Washington, DC 20515

Dear Speaker Ryan and Democratic Leader Pelosi:

The Mental Health Liaison Group (MHLG) wishes to express our serious concerns about the provisions of the American Health Care Act (AHCA) that would restructure the Medicaid program and end the Medicaid expansion, as well as provisions of that legislation that would significantly reduce the Federal premium assistance that enrollees receive from the Federal government to maintain continuous insurance coverage, and impose a significant penalty for not maintaining continuous coverage. We are also very concerned that the legislation would eliminate required coverage for prevention and treatment of mental illness and substance use disorders under state Medicaid managed care and alternative benefit programs, as Medicaid is the major source of Federal funding in every state for mental health and substance use services.

The MHLG is a coalition of dozens of national organizations representing consumers, family members, mental health and substance use treatment providers, state behavioral health agencies, advocates, payers, and other stakeholders committed to strengthening Americans' access to mental health and substance use services and programs.

The elimination of Medicaid expansion under the AHCA would leave without coverage the 1.3 million childless, non-pregnant adults with serious mental illness who were able, for the first time, to gain coverage under Medicaid expansion. It would also leave uncovered the 2.8 million childless, non-pregnant adults with substance use disorders who also gained coverage under expansion for the first time. These are populations that Congress promised and worked to serve with the passage of 21<sup>st</sup> Century Cures and the Comprehensive Addiction and Recovery Act (CARA) of 2016, respectively. And it is important to remember that untreated mental health and substance use disorders intensify and serve to increase the number of co-morbid medical conditions in those populations, thereby multiplying total Medicaid program costs.

Medicaid is the single largest payer for behavioral health services in the United States, accounting for about 26 percent of behavioral health spending, and is the largest source of funding for the country's public mental health system. The Congressional Budget Office estimates the Medicaid provisions of the AHCA would reduce Medicaid funding over 10 years by \$880 billion, or about 25 percent. With an estimated 14 million people—one in five of Medicaid's 70 million enrollees—living with mental illness or substance use disorders and depending heavily on Medicaid services, allowing states to determine whether those services should be covered could very well leave many low-income Americans without access to medically necessary prevention and treatment services.

National organizations representing consumers, family members, advocates, professionals and providers c/o Laurel Stine, JD, American Psychological Association at [lstine@apa.org](mailto:lstine@apa.org), Jeff Regan, MA, American Psychiatric Association at [jregan@psych.org](mailto:jregan@psych.org), and Debbie Plotnick, MSS, MLSP, Mental Health America at [dplotnick@mentalhealthamerica.net](mailto:dplotnick@mentalhealthamerica.net)

Medicaid covers a broad range of behavioral health services at low or no cost, including but not limited to psychiatric hospital care, case management, day treatment, evaluation and testing, psychosocial rehabilitation, medication management, as well as individual, group and family therapy. In three dozen states, Medicaid covers essential peer support services to help sustain recovery. Additionally, because people with behavioral health disorders experience a higher rate of chronic physical conditions than the general population, Medicaid's coverage of primary care is critical to help this population receive needed treatment for both their behavioral health and physical health conditions.

In states that have expanded Medicaid and which have been particularly hard hit by the opioid crisis, such as Kentucky, Maine, Pennsylvania, Ohio, and West Virginia, Medicaid pays between 35 to 50 percent of medication-assisted treatment for substance use disorders. CARA and 21<sup>st</sup> Century Cures were to increase payment for those services, but the elimination of mandated coverage under Medicaid would likely result in state cost shifting, so that CARA moneys (should they be appropriated) and moneys provided under 21<sup>st</sup> Century Cures for prescription opioid addiction prevention and treatment services would supplant, rather than supplement, the existing Medicaid coverage of services in the states.

Similarly, converting Medicaid into a per capita cap block grant program or a simple block grant program will shift significant costs to states over time. Ultimately, states will be forced to reduce their Medicaid rolls, benefits, and already low payment rates to an already scarce workforce of behavioral health providers. Mental health and substance use disorder treatments and programs will be at high risk because, even though they are cost-effective, they are intensive and expensive. Furthermore, the elimination of the ACA's required Medicaid managed care coverage of mental health and substance use disorder services and the long-term reduction of real funding dollars will leave states and managed care plans no alternative but to reduce or eliminate services in order to balance state Medicaid budgets and operate within managed care organizations' capitated rates.

In addition, these cuts will hit children with serious emotional disorders, as well as adults with mental illness. Fifty percent of Medicaid beneficiaries are children. Seventy-five percent of mental conditions emerge by late adolescence. The loss of Medicaid-covered mental and substance use disorder services for adults would result in more family disruption and out-of-home placements for children, significant trauma which has its own long-term health effects, and a further burden on a child welfare system that is struggling to meet the current demand for foster home capacity. In addition, we estimate \$4 to \$5 billion in Medicaid assistance will be lost by schools for specialized instructional support services, including mental and behavioral health services.

More directly, the rollback of the maximum eligibility level for children ages 6 to 19 from 133 percent of the Federal Poverty Level to 100 percent FPL will undoubtedly have the result of reducing access to mental health and substance use disorder services, and critical Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, for those older children. This is a particularly problematic change since 5 percent (1.2 million) of adolescents between the ages of 12 and 17 had substance use disorders in 2015 and EPSDT screening is the most effective early identifier for emergent mental health issues.

## **AHCA Changes to Private Insurance Coverage**

If Medicaid is not to provide the avenue for recovery for individuals with mental illness or substance use disorders, then the private insurance market may have to serve as an alternative, but the \$2,000 to \$4,000 refundable tax credits provided under the AHCA to subsidize insurance premiums constitute a significant reduction in the advance premium tax credits paid under the ACA, which averaged 72 percent of gross premiums. Further, the 30 percent premium surcharge required under AHCA to be imposed for a failure to maintain continuous coverage will likely hit hardest the lowest-income enrollees who will be struggling to maintain premium payments for coverage. It will be particularly destructive for those enrollees whose serious mental illness or substance use disorders may render them cognitively impaired and thus unable to maintain premium payment schedules until they recover, when the sizeable surcharge will leave them unable to pick up coverage. For the foregoing reasons, these provisions of the AHCA leave us very concerned for the continued well-being of the individuals with serious mental illness and substance use disorders we have been better able to serve since the implementation of the ACA's expanded coverage.

We urge you to continue to protect these vulnerable Americans' access to and coverage of vital mental health and substance use disorder care and services, and to not reverse the recent progress made with the enactment of key mental health and substance use disorder prevention and treatment reforms under the 21<sup>st</sup> Century Cures Act and CARA.

Sincerely,

American Art Therapy Association  
American Association of Child & Adolescent Psychiatry  
American Association for Marriage and Family Therapy  
American Association for Geriatric Psychiatry  
American Association on Health and Disability  
American Dance Therapy Association  
American Foundation for Suicide Prevention  
American Nurses Association  
American Psychiatric Association  
American Psychoanalytic Association (APsaA)  
American Psychological Association  
American Society of Addiction Medicine  
Anxiety and Depression Association of America  
Association for Ambulatory Behavioral Healthcare  
Association for Behavioral Health and Wellness  
Bazelon Center for Mental Health Law  
Campaign for Trauma-Informed Policy and Practice  
Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD)  
Clinical Social Work Association  
Clinical Social Work Guild 49-OPEIU  
Depression and Bi-Polar Support Alliance  
Eating Disorders Coalition  
EMDR International Association  
Global Alliance for Behavioral Health and Social Justice  
International Certification & Reciprocity Consortium (IC&RC)

The Jewish Federations of North America  
Mental Health America  
National Association for Children's Behavioral Health  
The National Association of County Behavioral Health and Developmental Disability Directors  
(NACBHDD)  
The National Association for Rural Mental Health (NARMH)  
National Association of Social Workers  
National Association of State Mental Health Program Directors (NASMHPD)  
National Alliance on the Mental Illness (NAMI)  
National Council for Behavioral Health  
National Disability Rights Network  
National Federation of Families for Children's Mental Health  
National Health Care for the Homeless Council  
National Register of Health Service Psychologists  
No Health Without Mental Health (NHMH)  
School Social Work Association of America  
Trinity Health of Livonia, Michigan  
Young Invincibles