



House Tri-Committee Bill: Assessing Coverage for Mental Illnesses

On June 19, 2009, the chairmen of the three committees with jurisdiction over health policy in the U.S. House of Representatives unveiled a draft bill for health care reform. The bill, H.R. 3200, was debated and passed by each committee, with votes of 21-28 in the Energy and Commerce Committee, 26-22 in the Education and Labor Committee, and 23-18 in the Ways and Means Committee. The bill, along with the other major proposals under consideration, grapples with a host of coverage and delivery system reforms to promote access to affordable coverage and better value and quality in health care.

Major provisions of the proposal include:

- A Health Insurance Exchange, which would constitute a public brokerage through which uninsured individuals and small employers could purchase a private health plan or a new public insurance option.
- Standardized benefit packages that would make it easier for purchasers to select coverage based on cost and quality information. Exchange plans would be designed to harness the power of group purchasing and would be required to conform to standardized marketing and enrollment procedures, as well as new federal consumer protection standards.
- Insurance reforms, ending discriminatory practices that often occur with mental illnesses, such as exclusions for pre-existing conditions and rates based on health status, gender or occupation.
- Expansion of Medicaid to households with incomes below 133 percent of the federal poverty level.
- Requirements that all plans must have mental health and substance use treatment and that this coverage must be at parity (i.e., equal to the coverage for other conditions).
- Individual affordability credits to help households with incomes up to 400% of the federal poverty level (\$43,000 for individuals or \$88,000 for families of four) for the cost of coverage and cost-sharing (co-payments and deductibles) at the time of service.
- A cap on premiums and out-of-pocket spending, which would help to ease the burden on people who have frequent needs for health care services, drugs and supplies.
- Elimination of co-pays or deductibles for preventive care.
- A requirement that individuals obtain coverage or pay a penalty. Similarly, employers would have to either provide health insurance or pay a fee (eight percent of their payroll).

Benefits

The bill would require all participating health plans to provide mental health and substance use coverage. This mandated coverage, along with the requirement that coverage must be at parity with general medical and surgical coverage, is quite significant. Past proposals to cover the uninsured typically allowed health plans to discriminate by allowing coverage that excluded mental health and substance use services, restricted access to these services by discriminatory limits on annual and lifetime benefits and placed more restrictive terms and conditions on this coverage. Last year's enactment of the Wellstone-Domenici Parity Act, requiring parity in employer-sponsored group plans of 50 or more that offered mental health and substance use coverage, was a milestone for non-discrimination in insurance coverage. It is fitting that H.R. 3200 builds upon this accomplishment and provides protection from discrimination to those obtaining coverage individually or through small group plans.

H.R. 3200 would also require all plans to have an essential benefits package that includes rehabilitative and habilitative services (both of which can be very important for individuals with serious mental disorders), as well as coverage for hospitalization, emergency department services, outpatient services, prescription drugs, maternity benefits, preventive services and vaccines, and for those under 21 years of age, oral health, vision and hearing services, equipment and supplies. Individuals would have a choice of three benefit packages—basic, enhanced and premium. The differences among benefit packages are the levels of cost-sharing, not the benefits covered. An additional option that could be offered is premium plus, which would provide additional benefits such as dental and vision care for adults—benefits which are not considered part of the essential benefits package.

During the bill mark-up process, H.R. 3200, as reported by the Education and Labor Committee, was amended to include within the essential benefits package those services defined by Medicaid's child health component, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, for all children under the age of 21 who receive health care coverage through the Health Insurance Exchange. This amendment was offered by Rep. Scott of Virginia, and passed a roll call vote with 32 ayes and 17 nos. Amending the bill to include EPSDT services is particularly critical in light of the elimination of the State Children's Health Insurance Program (SCHIP) under the House bill. The EPSDT definition mandates the assessment of a child's health needs through initial and periodic examinations and evaluations thus ensuring that health problems, including mental health problems, are identified and treated early, before they become more complex and their treatment more costly. This provision also requires the delivery of all medically necessary treatment so as to "correct or ameliorate defects and physical and mental illness and conditions discovered by the screening process."¹

In addition, the bill specifies that:

¹ 42 U.S.C. §1396d(a).

- Health care items and services cannot be limited based on considerations other than clinical appropriateness.
- There would be no cost-sharing for preventive services.
- Overall, cost-sharing in the first year will be limited to \$5000 for an individual and \$10,000 per family. These levels will increase each year by the annual percentage increase in the Consumer Price Index for All Urban Consumers.
- A health benefits advisory committee, chaired by the Surgeon General, will make recommendations about benefits.

The elimination of the cost-sharing for preventive services is important for preventing avoidable health disparities and addressing problems early when the effects of diseases and conditions can be better managed. Numerous studies have shown that even when people have insurance coverage, they may not obtain preventive care because of financial costs. Limiting out-of-pocket spending is also critical for people contending with serious illness. For individuals with mental illnesses, as well as for others that have conditions requiring regular care, co-payments mount up quickly and can present significant financial problems. Whether the proposed caps and the other affordability provisions of the bill are sufficient to make care accessible is an open question, but clearly limiting total out-of-pocket spending is vital to ensure that both access to insurance and access to care is affordable. Health care reform must ensure that financial barriers do not deter people from seeking care or prevent them from following the advice of their providers about regular care and treatment.

Insurance Market Reforms

Sections 111 -114 of the bill proposes to:

- Prohibit pre-existing condition exclusions;
- Require plans to sell and renew policies to all who apply (guaranteed issue and renewal);
- Specify that premium rates cannot vary by age by more than a ratio of 2 to 1;
- Only allow premium variation based on geographic area and family size, as permitted by state insurance commissioners and the Health Choices Commissioner, and prohibits other factors from affecting rates; and
- Establish federal authority to set rules prohibiting discriminatory practices.

These insurance reforms would make it easier for people with mental illness to purchase insurance. Currently in states where insurers can refuse to sell or renew policies based on health status, and where coverage can be denied for pre-existing conditions, coverage may be unobtainable, exorbitantly priced or riddled with significant gaps in coverage. Historically, individuals with mental illnesses have been subjected to lifetime and annual limits on their mental health treatment, leaving them saddled with sizable debt if they experienced on-going health and mental problems and on-going needs for treatment. They have not had the financial protection that insurance was intended to provide. Establishing authority to set rules to ensure non-discrimination will help protect consumers should health plans try to subvert the non-discrimination intent of the law.

The bill establishes a new federal entity responsible for oversight, the Health Choices Administration, would set network adequacy standards that plans would be required to meet.

Holding insurers accountable for having an adequate network of providers to serve the number of people enrolled in their plans is a key protection for consumers. It is especially important for consumers with mental illnesses. Currently, even when insured, individuals may face difficulties in obtaining mental health services. Coverage may be more theoretical than actual if, for example, the plan's list of mental health providers is primarily composed of providers who are not accepting new patients, are no longer a participating provider, or can only offer appointments that require a long wait.

Participating health plans would be required to have medical loss ratios of at least 85%. If plans do not meet that requirement, rebates to enrollees are required.

There is no current national standard that insurers must meet for the percentage of premium that must be spent on medical care versus spending on administration, marketing and profits. Setting a minimum medical loss ratio will benefit all consumers by ensuring that 85% or more of a premium dollar is spent on care or returned to the consumer.

Consumer Protections

The bill would establish some consumer protections in federal law including the requirements for health plans to:

- Use non-technical language that is easy to understand in marketing materials, benefit descriptions, cost-sharing differentials between in-network and out-of-network coverage, claims information and other plan documents.
- Meet standards for timely internal grievance and appeals mechanisms and to establish an external review process.
- Be transparent and timely with advance notice about benefit changes and other information for consumers, along with timely notice and payments for providers.
- Contract with essential community providers.
- Provide culturally and linguistically appropriate services and communications.

Individuals purchasing health plans for themselves or for an employer group now have difficulty comparing plans because of the lack of standardization, inadequate performance reports for consumers to gauge premium value among the plan offered and insufficient standards that govern plan behavior. (This varies, however, from state to state, depending on a number of factors including state law and enforcement of regulations.) The creation of standardized plan options, along with some of the proposed federal consumer protections, would make it easier to comparison shop. The effectiveness of mechanisms to help people understand what they are

buying and how to enforce their rights, however, will require diligence in regulation and enforcement.

Historically, some plans have effectively restricted access to services through indirect means. Access to mental health services can be constrained, for example, if plans have restrictive panels of providers that do not include essential community providers. Another problem that consumers face is the technical language of insurance policies. Because beneficiaries have not had materials that are easy to understand, there are instances of coverage denials because the plan's rules and procedures were not followed and consumers have not had or not understood their appeal rights. The requirement that plans contract with essential community providers, along with support mechanisms that will be provided for consumers (like the requirements for appeals processes, network adequacy and access to Ombudsman services—as discussed in the next section) will make plans more accountable for ensuring true access to services.

Accountability and Oversight

Sections 141-144 of the House Tri-Committee health care bill would establish the Health Choices Administration, an independent agency in the executive branch with oversight and enforcement authority that would be responsible for setting standards for qualified health benefits plans establishing and operating the Health Insurance Exchange, administering affordability credits, and conducting outreach and facilitating enrollment. To promote accountability and responsiveness to consumers, the office of Qualified Health Benefits Ombudsman would be established within the agency to receive complaints, grievances, and requests for information by individuals, as well as report to Congress annually. To address the differences in state laws around benefit requirements without nullifying state authority to do so, language is added to make it clear that states can impose state benefit mandates, but those beyond the essential benefit package will require these states to enter into an agreement with the Health Choices Administration to cover the costs for any net increase in affordability premium credits as a result of the application of the mandates.

This part of the bill addresses infrastructure needs to create and support internal and external review processes. The Commissioner of the new agency, The Health Choices Administration would appoint an Ombudsman responsible for oversight of the review processes and ensure that consumers would have access to appeals to reviewers who are independent and not financially tied to the plans. The Health Choices Administration and the Ombudsman's office are designed to ensure that the consumer protections envisioned in this bill are followed. Like other parts of the bill that pertain to creating accountable health care, the guarantee of fair processes to appeal health plan decisions and the building of the government infrastructure necessary for protecting the public interest are designed to ensure that consumers can rely on the coverage that they pay for and that is promised.

Medicaid

Eligibility: The bill has provisions that would strengthen Medicaid, through changes to eligibility, including:

- Effective 2013, individuals with family incomes at or below 133% of poverty (\$14,400 for an individual in 2009) would be eligible for Medicaid. The cost of care for those newly enrolled in Medicaid as a result of this policy would be paid by the federal government with no state contribution.
- Individuals with incomes at or below 133% of poverty who lose health insurance coverage within the previous 6 months would have the choice of enrolling in Medicaid or enrolling in the Health Insurance Exchange with assistance for their premiums.
- After the Exchange has been in operation for 4 years, all individuals eligible for Medicaid could choose to enroll in a Health Insurance Exchange plan or continue in the regular Medicaid plan.
- Maintenance of effort requirements that prohibit states from imposing eligibility standards, methodologies, or procedures that are more restrictive than those that are currently in place (on June 16, 2009).

While some states have already extended coverage to low-income adults through Medicaid waiver mechanisms, low-income adults, as a rule, are not entitled to Medicaid unless they qualify on the basis of disability or because they have dependent children in their household. Many low income adults, including those with serious mental illness, have been unable to qualify for Medicaid. Allowing adults to qualify solely on economic factors is a long over-due change that will significantly improve access among low-income individuals. Without coverage, the uninsured are much more likely to forego needed care and preventive services, resulting in health and mental health emergencies that take their toll on health and finances.

Research indicates that individuals diagnosed with mental health disorders who receive treatment have lower subsequent medical costs. One state looked at the state costs for disabled Medicaid beneficiaries who received outpatient care and found that they decreased over \$100 per person per month.² Extending Medicaid coverage to individuals at 133% of the population and to individuals who do not qualify based upon disability or dependent status will increase access to mental health treatment, thus increasing potential cost-savings. Additionally, people with serious mental illnesses need the full Medicaid service array that includes benefits that are not covered in typical insurance plans (such as psychiatric rehabilitation services) but are covered in Medicaid.

Adolescents transitioning to adulthood would be greatly helped since young adults have high rates of uninsurance. Previously covered by their parents' insurance, or public programs like the Children's Health Insurance Program (CHIP), young adults often do not have access to insurance through employers and are financially unable to buy a policy. If they have emotional problems and mental health needs, they are likely to have significant gaps in their care. The lack of coverage and limited access to care is not only a problem for the individual, but is a societal concern, as well, since individuals with untreated mental illnesses are at increased risk of winding up in a public institution—sometimes a psychiatric facility but also jails and prisons—or

² Washington State Mental Health Services, "Cost Offsets and Client Outcomes Fact Sheet," December 2003.

struggling to keep maintain daily functioning in the community. Extending Medicaid coverage up to 133% of the federal poverty level is also key to helping prisoners with mental illnesses make a successful transition to the community.

Enrollment: The bill also attempts to improve access to and enrollment in Medicaid for eligible individuals by requiring state Medicaid programs to allow adults to apply for coverage at disproportionate share hospitals (DSH), or hospitals that treat a disproportionate share of disadvantaged individuals, Federally Qualified Health Centers, and locations other than welfare offices.

The enrollment process for Medicaid coverage is protracted and complex, which often deters eligible individuals from applying. This process is particularly difficult for individuals with serious mental illness whose symptoms may impair thought and functioning. Allowing individuals to apply for Medicaid in familiar, frequented locations will decrease barriers to enrollment and effectively encourage individuals with mental illness to apply.

Prevention: The bill would require state Medicaid programs to cover preventive services not otherwise covered that are recommended by the U.S. Preventive Services Task Force and that are appropriate for Medicaid beneficiaries. This section also prohibits states from imposing cost-sharing on these services and provides an enhanced federal matching rate for the cost of such services.

Recent research indicates that co-payments deter people from seeking preventive care. Copayments are a particular problem for people with little discretionary income, including those with mental illnesses. Removing the cost-sharing barrier would help divert people from emergency rooms and crisis services if they can access more cost-effective prevention and early intervention services. People with serious mental illnesses receive little or substandard care for their physical health and die, on average, 25 years sooner than the general population. A regular source of primary care and preventive services is vitally important.

Tobacco cessation: The bill prohibits the exclusion of tobacco cessation programs, including those that fall under the definition of mandated pregnancy-related services, from coverage provided by State Medicaid.

Individuals who have suffered from a mental health disorder smoke at rates two times higher than individuals without and have high mortality rates from lung cancer and vascular disease. Because of this, smoking and tobacco cessation programs are vital services to those with mental health disorders in order to reduce mortality and promote overall physical health.

Home visitation: The bill enables state Medicaid programs to cover home visitation by trained nurses to families during a first pregnancy or with a child under 2 and increases the federal matching rate for the cost of such services.

This provision encourages one of the most promising areas of mental health prevention and intervention: improving the social and emotional development of very young children and identifying early mental health problems in infants and toddlers. Approximately 20 percent of

children will develop a mental health disorder that leads to functional impairments, and abused and neglected infants demonstrate a number of disturbing symptoms such as post-traumatic stress, cognitive dysfunction, greater aggressiveness and more fear in response to angry interactions between adults. Mental disorders are increasingly being identified in younger and younger children as our understanding improves.³ Home visiting programs have demonstrated positive results by mitigating the effects of maternal depression and child maltreatment, by effectively improving the mother-infant relationships and by increasing infant scores on cognitive tests and measures of social functioning.⁴

Medical homes: The bill creates a 5-year pilot program to test the medical home concept with high-need Medicaid beneficiaries. The federal government would match costs of community care workers at 90% for the first two years and 75% for the next 3 years, up to a total of \$1.235 billion

Collaborative care models, such as medical homes, have been found in over 35 randomized controlled trials to be effective in treating mental illness.⁵ It is therefore essential that behavioral health specialists be included in any medical home effort. Public mental health policies have long endorsed organized systems of care, which are critical to improving the quality of care. Such systems offer an opportunity for prevention and early intervention and can form a basis for improving quality and making care more affordable. In an ideal medical home model, primary care and behavioral health professionals can be co-located and offer enhanced services, such as easy access to mental health treatment for those with other serious or chronic illnesses whose recovery is impaired by a co-occurring mental health disorder and, for more complex cases, improved referral and linkage with community mental health specialty care. Thus, community behavioral health centers, which often serve as the only source of care for individuals with severe mental illnesses, provide ideal medical homes for individuals with mental health disorders, allowing individuals to receive coordinated primary care services in familiar locations

Therapeutic Foster Care: The House Energy and Commerce Committee passed by voice vote an amendment introduced by Rep. Baldwin of Wisconsin that ensures that the health reform legislation being amended does not preclude states from covering therapeutic foster care services under Medicaid. Therapeutic foster care (TFC), a cost-effective and evidence based practice, provides an intensive therapeutic living environment for a child with a behavior disorder who requires out-of-home care. TFC offers a structure and supervision by a specially trained family for one or two children at a time, and is a vital service for children who would otherwise be placed in restrictive hospital or residential treatment programs.

³ Department of Health and Human Services (1999). Mental health: A report of the Surgeon General. Rockville, MD: Department of Health and Human Services.

⁴ Cicchetti, D. & Toth, S. (2004). Child maltreatment. *Annual Review of Clinical Psychology*, 1, 409-438; Cummings, E.M. & Davies, P.T. (1999). Depressed parents and family functioning: Interpersonal effects and children's functioning and development. In T. Joiner & J.C. Coyne (Eds.), *The interactional nature of depression* (p 299-327). Washington, DC: American Psychological Association.

⁵ Thielke, S., Vannoy, S. & Unützer, J. (2007). Integrating mental health and primary care. *Primary Care: Clinics in Office Practice*, 34, 571-592.

Preservation of Medicaid Benefits for Youth: The House Energy and Commerce Committee also passed by voice vote an amendment introduced by Rep. Tim Murphy of Connecticut and Rep. Bart Stupak of Michigan instructing states to suspend, not terminate, Medicaid benefits for incarcerated youth, thus ensuring that youth and young adults who are transitioning from secure detention back into their communities are able to access services necessary to engender successful reintegration. The amendment also directs states to enroll incarcerated youth who are eligible but not currently enrolled in Medicaid.

Medicare

The bill includes provisions that would assist Medicare beneficiaries through the elimination of cost-sharing for preventive services, improvements to the Part D drug program and the expansion of low-income subsidies. In addition, the bill envisions two types of demonstration programs—the Accountable Care Organization Pilot Program, which would test different payment mechanisms that provide incentives for quality services and innovations in practice that lead to improved outcomes; and the Medical Home Pilot Program, which would test different models of care coordination and integration of mental health and primary care. The bill improves the Part D prescription drug program by eliminating the “donut hole,” or the gap in coverage that occurs when an individual has reached an initial prescription drug coverage limit, thus requiring them to pay 100% of the cost of prescription drugs until reaching the qualifying out-of-pocket limit upon which catastrophic coverage kicks in. The elimination of the gap begins with a \$500 reduction in 2011, and is completely phased-out by 2023. The funds needed to close the donut hole will be raised by requiring drug manufacturers to provide Medicaid rebates for drugs used by individuals who are fully dual eligible (i.e. those who are entitled to Medicare Part A and/or Part B and are also eligible for some form of Medicaid benefit). The bill also increases reimbursement for primary care, and adds coverage for services provided by mental health counselors and marriage and family therapists.

Medicare already has relatively high-cost sharing requirements and no overall limits on out-of-pocket spending, so provisions in this bill that lessen the financial burdens, like addressing the coverage gap in Part D and increasing low-income subsidies, are important to ensure that beneficiaries are not forced to choose between filling vital prescriptions, seeing the doctor and paying for other necessities. Roughly 25% of people on Medicare have mental health disorders and more than a third have three or more chronic conditions. Co-pays, deductibles and premiums mount up quickly. The prioritization of preventive services through the elimination of cost-sharing is critical to promoting regular preventive care and improving health outcomes, without adding to the financial burden of those who are struggling with high-cost conditions.

As more people with mental health conditions receive health care coverage, it will be important to ensure the availability of behavioral health service providers. The steps that this bill would take, including providing Medicare reimbursement to behavioral health professionals not previously eligible, should help lessen the effects of current workforce shortages.

Quality

The bill seeks to enhance the nation's ability to evaluate and track quality and best practices in the delivery of health care. It does so by establishing a Center for Quality Improvement to prioritize the identification of existing and development of new best health care practices, and oversee their implementation, assessment and dissemination at the state and regional levels. Additionally, the bill creates a Bureau of Health Information to oversee comprehensive data collection and surveillance efforts for key national health indicators.

Comparative Effectiveness Research: The bill seeks to ensure the quality of health care by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support and synthesize research relevant to the quality, appropriateness and effectiveness of health care services.

A recent report issued by the Institute of Medicine (IOM) listed a number of behavioral health disorders and treatments among its top 100 priorities for a new national investment in comparative effectiveness research. Although many evidence-based, effective treatments exist for mental health and substance use disorders, therapies that are less or not effective continue to be used in a variety of treatment settings; fewer than 25% of individuals with serious mental illness receive appropriate care (Health Affairs, May/June 2009). Outdated practices persist and specific evidence-based practices are slow to be adopted, despite their proven superiority to some traditional service modalities. Systematic review of data regarding mental health and substance use disorder treatments will inform and encourage improvements in practice and prevention efforts.

Quality Measurements: The bill would establish national priorities for improving health care, with precedence given to chronic diseases, health disparities, and strategies to make care more cost-effective and patient-centered. To monitor the effects of these efforts, quality measures would be established to assess patient outcomes, safety, treatment effectiveness and access to care.

Increased focus on the quality and delivery of health services is an essential part of health reform; one that has the potential to substantially impact individuals with mental illness. Mental health disorders affect one in four American adults, or nearly 58 million Americans, and are the leading cause of disability in the U.S. and Canada for ages 15-44 (NIMH). Although mental health and substance use disorders are not explicitly mentioned in this section, the bill requires consideration of those conditions that contribute to the largest burden of disease, suggesting that mental health will be among those considered.

Public Health and Workforce Development

Public Health: The bill would establish a Public Health Investment Fund to pay for federal public health initiatives and would also increase funding for community health centers.

Investing in public health (meaning the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention) offers many opportunities to impact the mental health of the American people. The public health system has a broad agenda, offering opportunities to incorporate behavioral health in various ways, through education, surveillance/data collection, screening, and prevention and early intervention strategies.

Workforce: The bill seeks to strengthen and expand the health care workforce, including mental health care providers, through a variety of provisions that include loan repayment programs, increased funding for the National Health Services Corps, public health training grants for public health professionals, cultural and linguistic competence training, and workforce incentives to promote diversity in the workforce.

Mental and Behavioral Health Training: The House Energy and Commerce Committee adopted by voice vote an amendment introduced by Rep. Green of Texas, Rep Murphy of Pennsylvania, Rep Baldwin of Wisconsin and Rep. Bono Mack of California that addresses workforce development by establishing an interdisciplinary mental and behavioral health training program to award grants and contracts that will develop and support training programs for mental and behavioral health professionals. Entities eligible to receive such support include accredited health professions schools that house mental and behavioral health programs and accredited public or private hospitals or nonprofit entities.

Mental health care is experiencing a workforce crisis that must be addressed to ensure continued access to vital treatment and rehabilitative services. The Health Resources and Services Administration Shortage Designation Branch reports that as of March 31, 2009, there are more than 3,000 communities or areas experiencing shortages in mental health practitioners; shortages that affect over 80 million individuals.

Community Living Assistance and Supports: The House Energy and Commerce Committee also passed by voice vote an amendment introduced by Rep. Pallone of New Jersey that establishes a national voluntary insurance program known as the CLASS (Community Living Assistance Service and Supports) Independence Benefit Plan, to pay for long-term care, including home-based services. For many individuals with mental illness, long term services and supports are a vitally important and often unmet care need. The amendment aims to provide individuals with functional limitation, such as those with psychiatric disabilities, with means to maintain independence in their communities through financing strategies and infrastructure development. The program will be implemented and eligibility criteria and benefit levels will be determined by the Secretary of Health and Human Services.

Prevention and Wellness

A Prevention and Wellness Trust would be established to fund prevention related activities, and develop a national prevention and wellness strategy. Additionally, the bill would modify and expand the capacity of two autonomous, advisory task forces — the U.S. Preventive Services Task Force (USPSTF) and the Task Force on Community Preventive Services (TFCPS) — that will undertake rigorous, systematic reviews of existing science to recommend the adoption of proven and effective services at the clinical (individual) and community levels. The legislation

would also establish grant programs and require increased coordination of prevention and wellness research activities by the CDC and NIH.

Research on successful prevention strategies is critical to determine how to best prevent and intervene upon the course of mental health disorders and chronic illnesses, and funding effective prevention practices is currently much needed. Data on disabilities, including mental health-related disability, is rarely collected in national health studies, preventing accurate assessment of the health disparities of these individuals.

Community-based prevention strategies and wellness promotion programs that aim to prevent and intervene early are important to those with serious mental health disorders, who are also more likely than others to have chronic disorders, such as heart disease and diabetes. Individuals with serious mental illness die, on average, 25 years earlier than the general population. This may be the result of gaps in services and treatments, as well as inadequate attention to and assistance for modifying health habits that contribute to chronic disorders. As health reform moves forward, it is critical to ensure that mental health is included in activities funded by community-based prevention and wellness grants.

To ensure that a mental health perspective is represented throughout the development of prevention and wellness activities, the House Energy and Commerce Committee passed by voice vote an amendment introduced by Rep. Sutton of Ohio that adds the Substance Abuse and Mental Health Services Administration (SAMHSA) to the list of agencies and organizations that the Secretary is instructed to consult with when developing a national prevention and wellness strategy.

School-Based Health Clinics: The bill would provide prevention and wellness grants to school-based health clinics, with preference given to areas that have shortages of primary care and mental health services for children and adolescents.

The core services of these school-based clinics include comprehensive primary health services as well as behavioral health services, including mental health assessments, crisis intervention, counseling, treatment, and referral to a continuum of services. Children spend a significant portion of their day at school, making schools ideal places to locate necessary mental health services, allow for collaboration between schools and local mental health agencies, and link children with appropriate services.

Federally Qualified Behavioral Health Centers: The Energy and Commerce Committee adopted by voice vote an amendment offered, under the leadership of Rep. Matsui of California and Rep. Engel of New York, by Rep. Pallone of New Jersey that clearly defines and establishing criteria for Federally Qualified Behavioral Health Centers. Recent data suggests that more than one in four uninsured American adults have a mental illness, substance use disorder or a co-occurring disorder; many of whom will gain access to health care coverage as health reform proceeds. In order to respond to the increased demand for mental health services that will undoubtedly accompany increased access to health insurance with quality, effective services, the legislation establishes national standards of care for community behavioral health centers that wish to apply for Federally Qualified status. Community mental health centers and other community programs wishing to be certified as FQBHCs must provide person-

centered, multi-disciplinary, evidence-based mental health and primary care screening, assessment, diagnostic, treatment, prevention and wellness services as well as connect patients to other necessary community health and social services. Peer support and counselor services as well as family supports must also be facilitated by these Centers.