MENTAL HEALTH FIRST AID
NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
Healthy Minds. Strong Communities.

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August 18, 2018

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Kentucky HEALTH Demonstration Project under Section 1115 of the Social Security Act

Dear Secretary Azar:

On behalf of the National Council for Behavioral Health (National Council), thank you for the opportunity to comment on Kentucky's proposal for Kentucky HEALTH, a demonstration project under section 1115 of the Social Security Act. The National Council is the unifying voice of America's health care organizations that deliver mental health and SUDs treatment and services. Together with our 14 Kentucky-based community mental health center members serving over 18,000 adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council, in total, represents 2,900 member organizations serving over 10 million Americans across the country.

Millions of Americans rely on Medicaid for access to lifesaving mental illness and substance use disorder (SUD) treatment services, providing health coverage to more than one in four adults with a mental illness and one in five adults with SUD.[1,2] The program plays a vital role in ensuring beneficiaries receive high quality services when and where they need them. Delays or barriers in accessing this care can lead to poorer outcomes for consumers and unnecessary costs to the an already burdened health care system. Federal oversight, therefore, is needed to ensure that Medicaid remains a strong, accessible program serving our nation's most vulnerable citizens. Inability to access necessary care for these disorders results in high levels of homelessness, unnecessary interaction with law enforcement, death by overdose and suicide.

Kentucky's proposal to take Medicaid coverage away from people who do not meet work requirements, pay premiums, renew their coverage on time, or report minor changes in income **will cause a significant loss of coverage — resulting in a corresponding increase in the number of uninsured Kentuckians**.

Medicaid's primary objective is to provide coverage to people who otherwise would not have it. Approving policies that lead to a loss of coverage and an increase in the number of uninsured people therefore cannot be justified as a proper use of section 1115 waiver authority. While taking away coverage for failure to meet a work requirement will be harmful for many Medicaid enrollees across demographic groups, these policies will be particularly harmful for people with mental illness and SUD. Medicaid expansion has significantly increased coverage rates for people with SUD and reduced the share

[1] Medicaid and CHIP Payment and Access Commission, "Behavioral Health in the Medicaid Program—People, Use, and Expenditures," June 2015, https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/
[2] Rebecca Ahrnsbrak, Jonaki Bose, Sarra Hedden, Rachel N. Lipari, and Eunice Park-Lee, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2017, https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

of uninsured hospitalizations for SUD in expansion states from 20 percent in 2013 to 5 percent in 2015.[3] Medicaid is a lifeline for many people with these conditions and losing covering could be detrimental to their health.

Medicaid provides an important lifeline for people with mental illness and SUD as they face barriers to work and need additional supports. While most people with these conditions can and want to work, many face significant barriers to sustained employment. In 2012, less than 18 percent of adults with a serious mental illness were able to work.[4] Several states, including Iowa, Mississippi, Wisconsin, and Washington have implemented supported employment programs for people with mental illnesses.[5] Each state uses evidence-based approaches that have helped participants find and maintain employment through an array of services such as skills assessment, assistance with job search and job applications, and job development and placement. But none of these supported employment programs require work as a condition for eligibility for health coverage.

The impact of mental illness and SUD on the ability to carry out normal routines like attending work often fluctuates, which can lead to inconsistent attendance at work or sudden job loss. These obstacles can be minimized if the person has access to services designed to overcome barriers to employment such as individualized job search assistance, job coaching, and counseling.[6] Despite this research, the guidance on work requirements explicitly states that federal Medicaid funding cannot help pay for these additional supports. It is estimated that 87 percent of adults with serious mental illness are unable to work as a result of their illness.

Medicaid provides treatment for both behavioral and physical health conditions that, if threatened, could make it harder for them to work. It is well documented that Americans living with behavioral health conditions have an average life expectancy 25 years shorter than the general population.[7] This is due to a large percentage of individuals having both a persistent mental health condition or SUD in conjunction with a chronic physical illness like hypertension, diabetes, or asthma.[8] These illness can and must be treated together in order to ensure high quality care for all Americans.

Under the guidance as written, many Kentuckians will not qualify for an exemption or be unable to prove that they do. Guidance from the Centers for Medicare and Medicaid Services on imposing work requirements mandates states exempt people from the requirement if they are deemed "medically frail," but the definition of that term is strict and will leave out many people with behavioral health conditions.[9]

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[3] U.S. Department of Health and Human Services, "Continuing Progress on the Opioid Epidemic: The Role of the Affordable Care Act," January 11, 2017, https://aspe.hhs.gov/system/files/pdf/255456/ACAOpioid.pdf

[4] National Alliance on Mental Illness, "Road to Recovery: Employment and Mental Illness," July 2014, https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/RoadtoRecovery.pdf

[5] Jessica Schubel, "No Need for Work Requirements in Medicaid," Center on Budget and Policy Priorities, May 1, 2015, https://www.cbpp.org/blog/no-need-for-work-requirements-in-medicaid

[6] Scott Holladay, "Evidence-Based Supported Employment and Medicaid," National Academy for State Health Policy, March 2013, https://nashp.org/evidence-based-supported-employment-and-medicaid/

[7] Joe Parks, Dale Svendsen, Patricia Singer, Mary Ellen Foti, and Barbara Mauer, "Morbidity and Mortality in People with Serious Mental Illness," National Association of State Mental Health Program Directors Medical Directors Council, October 2006, https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

[8] The Henry J. Kaiser Foundation, "Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured," June 2017, http://files.kff.org/attachment/Fact-Sheet-Facilitating-Access-to-Mental-Health-Services-A-Look-at-Medicaid-Private-Insurance-and-the-Uninsured

[9] 42 C.F.R. §440.315, Accessed at: https://www.ecfr.gov/cgi-bin/text-idx?SID=7becf6352680464a4659264a26d0eebf&mc=true&node=se42.4.440_1315&rgn=div8

For mental health, the definition only explicitly includes individuals with "disabling mental disorders." Kentucky estimates that ten percent of its Medicaid population will be designated medically frail and be exempted from work requirements under this definition. But data from other states show that many more people have mental health conditions that may affect their ability to work on a consistent basis. Nearly 18 percent of Ohio[10] expansion enrollees and 20 percent of Michigan[11] expansion enrollees reported that they had a mental health condition that impaired their ability to function.

For SUD, the "medically frail"[12] exemption only includes people with "chronic" SUDs, suggesting individuals must have had multiple episodes of substance use or that their illness has persisted for a long time. While many people with SUD will not meet this standard, Kentucky's waiver does allow for people with substance use disorders to count the hours of qualifying treatment received toward the state's requirement that beneficiaries document that they worked, searched for a job, or volunteered for at least 80 hours each month. However, this accommodation falls short because people with Medicaid coverage may not be in active treatment or may not be in treatment for an average of 80 hours per month. Moreover, it is not clear in the guidance what is considered qualifying treatment.

The National Survey on Drug Use and Health estimates that in 2016, about 15 percent of all unemployed U.S. adults needed SUD treatment (defined as services in an inpatient hospital, rehabilitation facility, or mental health center) but only 2.5 percent got care.[13] It is likely that a narrow range of treatment options, such as inpatient care or care at a mental health clinic, will qualify as "medical treatment," and that several evidence-based behavioral health services delivered in the home or other informal setting may not.

The bureaucratic obstacles and paperwork requirements have been shown to reduce enrollment in Medicaid across the board.[14] To prove exempt status, individuals with a mental health condition or substance use disorder will need to obtain letters from their health care providers, medical records, or whatever documentation a state deems necessary. This will be particularly difficult for people who need to obtain paperwork but do not have health coverage and cannot pay for a doctor's visit. Additionally, these conditions can interfere with clear thinking and executive function, skills needed to meet documentation and reporting requirements. Some individuals with a mental health condition or SUD will have significant privacy concerns about disclosing their condition to Medicaid eligibility staff.

For persons with SUD, there will be significant privacy concerns about disclosing the details of their diseases to Medicaid eligibility staff. Individuals who do not wish to disclose the use or history of use of illegal substances may opt to forego coverage, putting their treatment and stability at risk. While Kentucky's waiver says that the state must provide reasonable ADA accommodations, it offers little detail about what the accommodations should be or who is entitled to them, whether the state must identify beneficiaries entitled to accommodations, or how beneficiaries themselves would request them. Leading up to the planned July 1st implementation of Kentucky's work requirement, the state failed to give

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[10] The Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf

[11] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian, "Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan," *Journal of the American Medical Association*, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2664514

[12] 42 C.F.R. §440.315, Accessed at: https://www.ecfr.gov/cgi-bin/text-idx?SID=7becf6352680464a4659264a26d0eebf&mc=true&node=se42.4.440_1315&rgn=div8

[13] Rebecca Ahrnsbrak, Jonaki Bose, Sarra Hedden, Rachel N. Lipari, and Eunice Park-Lee, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2017, https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

[14] Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning in It," *The New York Times,* January 18, 2018, https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html

beneficiaries adequate notice of their rights under the ADA and procedures for getting a reasonable accommodation.

Premiums have been shown to confuse beneficiaries and have likely prompted fewer people to enroll in and maintain coverage. Kentucky's waiver would require all Medicaid enrollees except pregnant women, children, and those found to be medically frail would have to pay monthly premiums as high as four percent of monthly income. This amount is higher than premiums ever before approved for Medicaid beneficiaries, and higher than the maximum amount people in this income range would pay for silver benchmark coverage in the marketplace. Extensive research shows that premiums significantly reduce low-income people's participation in health coverage programs.[15] These studies show that the lower a person's income, the less likely they are to enroll and the more likely they are to drop coverage due to premium obligations. People who lose coverage most often end up uninsured and are unable to obtain needed health care services.

For example, under Indiana's waiver, fifty-five percent of people eligible to make a premium payment during their enrollment did not do so at some point during their enrollment. Three-quarters of those below the poverty line who did not make premium payments said they missed the payment because it was unaffordable, they were confused about how to pay, or they did not know a premium was required.[16] A focus group conducted by the Kaiser Family Foundation found similar confusion.[17] Beneficiaries at all income levels said they did not know whether they owed a premium and thought they would be disenrolled from coverage if they missed a payment.

The National Council appreciates the opportunity to provide comments. We welcome any questions or further discussion about the recommendations described here. Please contact Chuck Ingoglia at chucki@thenationalcouncil.org or 202-684-7457 ext. 249. Thank you for your time and consideration.

Sincerely,

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[15] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings," The Kaiser Family Foundation, June 2017, http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations.

[16] The Lewin Group, "Healthy Indiana Plan 2.0: POWER Account Contribution Assessment," March 31, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf

[17] MaryBeth Musumeci, Robin Rudowitz, Petry Ubri, and Elizabeth Hinton, "An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana," The Henry J. Kaiser Family Foundation, January 2017, http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Medicaid-Expansion-Waiver-Implementation-in-Michigan-and-Indiana