AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. MILLER OF CALIFORNIA

Page 30, strike lines 16 through 19 and insert the following:

(which are subject to section 1115), except—

(1) medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is not covered under such section); and

(2) treatment of a substance abuse disorder that is necessary in order to ensure continuity of care for an individual receiving hospital services other than such treatment, where the individual was receiving substance abuse treatment covered under section 1115 prior to receiving such other hospital services.

Page 41, strike line 25 and insert "(c)), including case management.".

Page 42, line 1, strike "nonresidential" and insert "community services for".

Page 42, strike line 3 and insert "(d)), including case management.".

Page 42, line 11, strike "NONRESIDENTIAL, and insert "INTENSIVE COMMUNITY SERVICES,".

Page 42, line 14, strike "nonresidential" and insert "community services for".

Page 42, line 17, strike "management" and insert "management, screening and assessment, crisis services,".

Page 42, line 22, strike "disorder;" and insert "disorder or, in the case of an individual 5 years of age or less than 5 years of age, is at risk for such a mental disorder;

Page 43, strike lines 8 through 19 and insert the following:

(2) CASE MANAGEMENT.—An eligible individual who is receiving an item or service described in this section that does not consist of case management is eligible to receive coverage for case management in addition to coverage for such item or service.

Page 44, line 8, strike "nonresidential" and insert "community services for".

Beginning on page 44, strike line 19 through page 45, line 2, and insert the following:

(A) an inpatient of a hospital or a psychiatric hospital; or

(B) a resident of a residential treatment center, residential detoxification center, crisis residential program, mental illness residential treatment program, therapeutic family home, group treatment home, community residential treatment program, or recovery center for substance abuse.

Beginning on page 45, strike line 21 through page 46, line 5 (and redesignate provisions accordingly).

Beginning on page 46, strike line 15 through page 47, line 5 (and redesignate provisions accordingly).

Page 47, after line 18, insert the following:

(E) ANNUAL AND LIFETIME LIMIT ON HOSPITAL TREATMENT.—Prior to January 1, 2001, such treatment, when furnished to an inpatient of a hospital that is not a psychiatric hospital, is subject to an aggregate annual limit of 90 days. Such treatment, when furnished to an inpatient of a psychiatric hospital, is subject to an aggregate annual limit of 45 days and an aggregate lifetime limit of 190 days per individual.

(F) ANNUAL LIMIT ON RESIDENTIAL TREATMENT.—Prior to January 1, 2001, such treatment, when furnished in a setting other than a hospital or psychiatric hospital, is subject to an aggregate annual limit of 135 days. The number of covered days of inpatient mental illness and substance abuse treatment that are available to an individual under the annual and lifetime limits described in subparagraph (E) shall be reduced by 1 day for each 3 covered days of residential mental illness and substance abuse treatment that are provided to the individual.

Page 47, line 19, strike "NONRESIDENTIAL TREATMENT.—" and insert "COMMUNITY SERVICES.—".

Page 47, line 21, strike "nonresidential" and insert "community services for".

Page 48, line 14, strike "nonresidential" and insert "community services for".

Page 48, strike lines 16 through 22 (and redesignate provisions accordingly).

Beginning on page 49, strike line 16 through page 50, line 14, and insert the following:

(B) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment is subject to an aggregate annual limit of 90 days, except with respect to individuals less than 22 years of age such annual limit shall be 180 days.

Page 50, line 16, strike "nonresidential" and insert "community services for".

Page 50, line 22, strike "nonresidential" and insert "community services for".

Page 51, strike lines 5 through 8 and insert "this subtitle.".

Beginning on page 52, strike line 8 through page 54, line 23 (and redesignate provisions accordingly).

Page 55, after line 12, insert the following (and redesignate provisions accordingly):

(f) UTILIZATION REVIEW REQUIREMENT.—

(1) IN GENERAL.—The mental illness and substance abuse services that are described in this section are not covered for an individual, after each applicable set of visits or set of treatment days described in paragraph (2) has been provided to the individual, unless the health plan in which the individual is enrolled determines, based on a utilization

review, that such services continue to be medically necessary or appropriate.

(2) SETS OF VISITS AND TREATMENT DAYS.—

(A) SETS OF VISITS.—The sets of visits referred to in paragraph (1) are—

(i) 1 initial set of 10 consecutive regularly-scheduled outpatient psychotherapy visits provided to an individual during a period that does not exceed 12 months; and

(ii) each subsequent set of 15 consecutive regularly-scheduled outpatient psychotherapy visits provided to the individual that immediately follows the initial set of visits described in clause (i) or another set of visits described in this clause.

(B) SETS OF TREATMENT DAYS.—The sets of treatment days referred to in paragraph (1) are—

(i) 1 initial set of 10 consecutive days of inpatient and residential mental illness and substance abuse treatment; and

(ii) each subsequent set of 15 consecutive days of inpatient and residential mental illness and substance abuse treat-

ment provided to the individual that immediately follows the initial set of treatment days described in clause (i) or another set of treatment days described in this clause.

(3) MODIFICATION OF NUMERICAL SETS BY BOARD.—The National Health Board may by regulation modify the number of visits or days that constitute a set referred to in paragraph (1).

(4) MODIFICATION OF NUMERICAL SETS BY STATES.—With respect to mental illness and substance abuse services that are provided in a State, the State may modify the number of visits or days that constitute a set referred to in paragraph (1), if the modification decreases such number below the number specified in paragraph (2) or specified by the Board under paragraph (3).

Page 86, strike the items relating to intensive nonresidential mental illness and substance abuse treatment, outpatient mental illness and substance abuse treatment, and outpatient psychotherapy and insert the following:

Intensive community services for mental illness and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate

Outpatient mental illness and substance abuse treatment (except psychotherapy for individuals at least 22 years of age, collateral services, and case management)	1115	$10 per visit	20 percent of applicable payment rate
Outpatient psychotherapy for individuals at least 22 years of age and collateral services	1115	$25 per visit until January 1, 2001, and $10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter

Page 97, after line 22, insert the following (and redesignate provisions accordingly):

(7) CONTINUITY OF CARE FOR MENTAL AND SUBSTANCE ABUSE DISORDERS.—Ensuring continuity of care for individuals who require mental illness and substance abuse services described in section 1115, but are not covered for such services because of annual or lifetime limits described in such section, by contracting with providers who provide mental illness and substance abuse services described in such section, unless suitable agreements with such providers cannot be reached.

Page 224, beginning on line 11, strike "Each carrier" through line 17 and insert the following:

(1) IN GENERAL.—Each carrier providing a health plan with an integrated health network (as

defined in section 1902(25)) shall enter into such agreements with health care providers or have such other arrangements as may be necessary to assure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled with the plan through such a network.

(2) SPECIAL REQUIREMENTS FOR MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.—Each carrier providing a health plan with an integrated health network shall enter into such agreements with health care providers or have such other arrangements as may be necessary—

(A) to demonstrate specifically that the carrier has the ability to provide, through such network, to individuals who have severe mental illness, serious emotional disturbance, or a substance abuse disorder, medically necessary or appropriate—

(i) inpatient and residential mental illness and substance abuse treatment (described in section 1115(c)) with respect to a diagnosable substance abuse disorder in a setting that is not a hospital or psychiatric hospital;

(ii) intensive community services for mental illness and substance abuse treatment (described in section 1115(d)); and

(iii) outpatient mental illness and substance abuse treatment consisting of case management (described in section 1115(e)(1)(H);

(B) to ensure that the items and services described in subparagraph (A) are provided to all individuals enrolled under the plan by providers who have a demonstrated ability to identify individuals who require such treatment and to deliver such treatment within a reasonable distance from the residence of an individual;

(C) to ensure continuity of care for individuals who require mental illness and substance abuse services described in section 1115, but are not covered for such services because of annual or lifetime limits described in such section, by developing appropriate plans and linkages with public agencies that may provide such services; and

(D) to ensure that the carrier has established, or is establishing, linkages with existing mental illness and substance abuse service de-

livery programs in the plan service area for services that are required under section 1115(g) to be provided through an organized system of care.

(3) SPECIAL REQUIREMENT TO CONTRACT WITH STATE-DESIGNATED PROVIDERS.—In the case of a carrier with respect to which a State has made a finding that the carrier has not satisfied the requirement in subparagraph (A) or (B) of paragraph (2), the carrier, if directed by the State, shall contract with providers designated by the State as having demonstrated experience in providing the services described in paragraph (2)(A).

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. MILLER OF CALIFORNIA

Beginning on page 55, strike "The" on line 16 through page 56, line 10, and insert the following (and redesignate provisions accordingly):

A health plan sponsor shall ensure that mental illness and substance abuse services described in this section are furnished through an organized system of care, as described in paragraph (2), if—

(A) the services are provided to an individual less than 22 years of age;

(B) the individual has a serious emotional disturbance or a substance abuse disorder; and

(C) the individual is, or is at imminent risk of being, subject to the authority of, or in need of the services of—

(i) a public agency that serves the needs of children, such as an agency involved with child welfare or special education;

(ii) the juvenile justice system; or

(iii) the criminal justice system.

(2) REQUIREMENTS FOR SYSTEM OF CARE.—In this subsection, an "organized system of care" is a

community-based service delivery network, which ~~may~~ shall consist of public and private providers, that meets the following requirements:

Page 56, beginning on line 11, after "participation" insert "and coordination".

Page 56, beginning on line 13, strike "area (including" and insert "area, including".

Page 56, line 15, after "justice" insert "criminal justice".

Page 56, line 17, strike "treatment)." and insert "treatment.".

Page 56, line 25, strike "through" and insert "by".

Page 56, line 25, strike "or" and insert "and".

Page 57, line 1, strike "teams that" and insert "teams, which".

Page 57, line 6, strike "children" and insert "individuals".

Page 57, line 7, after "age" insert "who have a serious emotional disturbance or a substance abuse disorder".

AMENDMENT TO COMMITTEE PRINT (H.R. 3600) OFFERED BY MR. MILLER OF CALIFORNIA

Page 564, strike lines 1 through 24 (and conform line 8 on page 560 and the table of contents accordingly).

Page 565, strike line 1 and all that follows through page 567, line 23, and insert the following part (and conform the table of contents accordingly):

PART 3—ASSISTANCE FOR STATE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

SEC. 3531. AVAILABILITY OF ASSISTANCE.

(a) IN GENERAL.—The Secretary may make grants to States for the development and operation of comprehensive managed mental health and substance abuse programs that are integrated with the delivery of items and services covered under the comprehensive benefits package. Such programs shall—

(1) promote the development of integrated delivery systems for the management of the mental health and substance abuse services provided under the comprehensive benefit package;

(2) give priority initially to providing services to low-income adults with serious mental illness or substance abuse disorders and children with serious

emotional disturbance or substance abuse disorders and provide for the phase-in of such services for all eligible persons within 5 years;

(3) ensure that individuals participating in the program have access to all medically necessary mental health and substance abuse services;

(4) promote the linkage of mental health and substance abuse services with primary and preventive health care services; and

(5) meet such other requirements as the Secretary may impose.

(b) EXCEPTION.—Nothing in this part shall be construed as preventing States that have separate administrative entities for mental health and for substance abuse services from establishing separate comprehensive managed care programs for such services and receiving assistance under this part for either or both programs.

SEC. 3532. REQUIREMENTS FOR A PLAN.

In order to receive a grant under this part, a State must have a plan for a comprehensive managed mental health and substance abuse program, which is approved by the Secretary. Such plan shall—

(1) describe the management, access, and referral structure that the State will use to promote and achieve integration of mental health and substance

abuse services with the delivery of items and services covered under the comprehensive benefits package for eligible individuals in the State;

(2) describe how the State will ensure that providers of specialized services will meet appropriate standards and provide assurances that the State has complied with section 1201(a)(7) as it affects mental health and substance abuse services;

(3) describe payment, utilization review, and other mechanisms that the State will use to encourage appropriate service delivery and management of costs;

(4) describe uniform patient placement criteria that the State will use to ensure placement in appropriate substance abuse treatment;

(5) describe the process the State will use to ensure that individuals will continue to have access to treatment through referrals from nonhealth public entities, such as the juvenile or criminal justice systems, or social service systems;

(6) specify the methods the State will use to ensure that individuals receiving services under the program have access to all medically necessary and appropriate mental health and substance abuse services;

(7) define terms that will be used by the State in determining the eligibility of individuals for services under the program;

(8) describe how health plans will use services under the comprehensive managed mental health and substance abuse programs established under this part;

(9) describe the sources of funding, including the medicaid program and the block grants authorized by title XIX of the Public Health Service Act, that will be used by the State, other than the grant received under this part, to operate the program, and provide the status of any request for a medicaid waiver relating to the delivery of mental health and substance abuse services submitted by the State to the Secretary;

(10) describe how the State provided for broad-based public input in the development of the plan, and the mechanism that will be used for ongoing public comment on and review of amendments to the plan; and

(11) describe grievance procedures that will be available for individuals dissatisfied with their health plan's participation in the comprehensive managed mental health and substance abuse program, and

mechanisms that will be available to review the performance of health plans and fee-for-service arrangements to ensure against undertreatment.

SEC. 3533. MAINTENANCE OF EFFORT.

States receiving assistance under this part shall maintain expenditures of non-Federal funds, including State medicaid expenditures and State substance abuse treatment expenditures required by title XIX of the Public Health Services Act, for all covered services for covered persons provided under the comprehensive managed mental health and substance abuse program at the level of such expenditures for the fiscal year preceding the first fiscal year for which the State receives such a grant. Such level must be adjusted annually for inflation in accordance with the general health care inflation factor (as defined in section 6001(a)(3)), but may be reduced in proportion to reductions in the State population.

SEC. 3534. ADDITIONAL FEDERAL RESPONSIBILITIES.

The Secretary shall, upon the submission of a State's plan—

(1) ensure the timely consideration of any request for a medicaid waiver relating to the delivery of mental health and substance abuse services submitted by the State to the Secretary,

(2) affirm that the State has met the responsibilities required under section 1201(a)(7), and

(3) affirm that carriers providing health plans in the State meet the requirements of paragraphs (2) and (3) of section 1407(a).

SEC. 3535. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under this part $100,000,000 for each of the fiscal years 1996 through 2000.

Amendment To Committee Print (H.R. 3600)

Offered By Mr. Green of Texas

Page 10, line 13, before the period insert "or making payment on the individual's own behalf (or on behalf of a relative or other individual) for such services directly to a health care provider that is legally authorized to provide the services, subject to the balance billing requirements of this Act".

Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, Virginia 22003

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(703) 941-7400
FAX (703) 941-3951

Date: 5/13/94

----------*Please Deliver Immediately*----------

To: Jennifer Klein

From: Gordon Trapnell

Re:

Memo: Revised estimates of Miller Dental Amendment
2.20% premium (17.6 billion over 5 years)
(around $7.3 billion in 1994 dollars for Plans)

We are transmitting ___ pages (including this transmittal sheet).

a:\dental.wq1
05/12/94
rgm

MILLER DENTAL AMENDMENT

NO ANNUAL LIMIT

Contract Type	GRT Increment	CBO Premium	HCFA Counts (Millions)	Aggregates GRT Increment (Millions)	Aggregates CBO Premium (Millions)	% Increase
Single	$65.84	$2,100	41.9	$2,758.70	$87,990	3.14%
Couple	132.82	4,200	17.5	2,324.35	73,500	3.16%
One Adult	83.56	4,095	6.9	576.56	28,256	2.04%
Two Adults	151.78	5,560	25.8	3,915.92	143,448	2.73%
Total			92.1	$9,575.53	$333,194	2.87%

ANNUAL LIMIT

Contract Type	GRT Increment	CBO Premium	HCFA Counts (Millions)	Aggregates GRT Increment (Millions)	Aggregates CBO Premium (Millions)	% Increase
Single	$59.85	$2,100	41.9	$2,507.91	$87,990	2.85%
Couple	120.75	4,200	17.5	2,113.05	73,500	2.87%
One Adult	75.96	4,095	6.9	524.15	28,256	1.86%
Two Adults	137.98	5,560	25.8	3,559.93	143,448	2.48%
Total			92.1	$8,705.03	$333,194	2.61%

Cost Estimates Relate to 1994

Adult	66.41
Child	9.03

[redacted]ization - High Cost Sharing (Miller)

DENTAL SERVICES

(ADULT) pop = 158,732,000	Chief Dental Officer - PHS						Large Employers						Merge						High CS Plan			
	Freq	Part	Unit Cost	Per Capita	% Cov	CSM	Freq	Unit Cost	Per Capita	% Cov	CSM	Freq	Part	Unit Cost	Per Capita	% Cov	CSM	Copay	Ded	Coins	Base
A. Prevention and Diagnosis				$42.09		$0.00			$44.43		$0.00				$68.41		$68.41				$68.41
1. Assessments				$26.27		$0.00			$21.65		$0.00				$41.45		$41.45				$41.45
Clinical oral examinations	1.021	70%	$20.03	$14.32	0%	$0.00	0.528	$16.27	$8.64	0%	$0.00	1.612	70%	$20.09	$22.60	100%	$22.60	$0	1.00	1.00	$22.60
Radiographs	0.958	70%	$17.81	$11.94	0%	$0.00	0.580	$20.41	$12.04	0%	$0.00	1.512	70%	$17.81	$18.84	100%	$18.84	$0	1.00	1.00	$18.84
2. Dental sealants																		$0	1.00	1.00	$0.00
3. Fluoride				$2.39		$0.00			$0.00		$0.00				$3.77		$3.77				$3.77
Professionally applied	0.192	70%	$17.81	$2.39	0%	$0.00				0%	$0.00	0.302	70%	$17.81	$3.77	100%	$3.77	$0	1.00	1.00	$3.77
Supplements					0%	$0.00				0%	$0.00					0%	$0.00	$0	1.00	1.00	$0.00
4. Dental prophylaxis	0.491	70%	$44.52	$13.43	0%	$0.00	0.587	$38.76	$22.75	0%	$0.00	0.480	70%	$44.52	$21.20	100%	$21.20	$0	1.00	1.00	$21.20
B. TREATMENT				$90.62		$7.87			$246.84		$1.26				$208.27		$5.01				$3.45
1. Emergencies				$3.62		$0.62			$0.63		$0.63				$3.92		$3.92				$1.80
Emergency exams	0.150	100%	$26.71	$4.01	100%	$4.01				100%	$0.00	0.105	100%	$26.71	$2.80	100%	$2.80	$0	0.51	0.80	$1.18
Sedative filling	0.020	100%	$35.82	$0.71	100%	$0.71				100%	$0.00	0.014	100%	$35.82	$0.50	100%	$0.50	$0	0.51	0.80	$0.20
Palliative	0.085	100%	$38.96	$0.58	100%	$0.58	0.018	$35.50	$0.63	100%	$0.63	0.011	100%	$38.96	$0.41	100%	$0.41	$0	0.51	0.80	$0.17
Traumatic wounds	0.005	100%	$61.22	$0.31	100%	$0.31				100%	$0.00	0.003	100%	$61.22	$0.21	100%	$0.21	$0	0.61	0.80	$0.10
2. Routine Fillings	1.256	70%	$51.20	$45.01	0%	$0.00	0.911	$58.16	$53.00	0%	$0.00	0.977	70%	$57.00	$53.17	0%	$0.00	$0	0.34	0.80	$0.00
3. Prosthodontics				$1.58		$1.58			$132.52		$0.63				$107.15		$1.09				$0.85
Dentures					0%	$0.00	0.001	$647.53	$0.59	0%	$0.00	0.001	70%	$647.53	$1.10	0%	$0.00	$0	1.00	0.80	$0.00
Crowns					0%	$0.00	0.185	$474.72	$87.67	0%	$0.00	0.184	70%	$474.72	$61.18	0%	$0.00	$0	1.00	0.80	$0.00
Bridge work					0%	$0.00	0.075	$541.11	$40.39	0%	$0.00	0.074	70%	$541.11	$28.19	0%	$0.00	$0	1.00	0.80	$0.00
Inlays					0%	$0.00	0.004	$438.11	$1.58	0%	$0.00	0.004	70%	$438.11	$1.10	0%	$0.00	$0	1.00	0.80	$0.00
Prosthetic for genetic defects	0.002	70%	$1,360.51	$1.58	100%	$1.58	0.003	$185.25	$0.63	100%	$0.63	0.001	70%	$1,360.51	$1.09	100%	$1.09	$0	0.98	0.80	$0.85
General anesthesia					0%	$0.00	0.016	$125.70	$2.05	0%	$0.00	0.016	70%	$125.70	$1.43	0%	$0.00	$0	1.00	0.80	$0.00
4. Periodontics				$24.09		$0.00			$16.98		$0.00				$27.94		$0.00				$0.00
Periodontic surgery					0%	$0.00	0.044	$260.97	$11.49	0%	$0.00	0.044	70%	$260.97	$8.02	0%	$0.00	$0	1.00	0.80	$0.00
Periodontal maintenance	0.517	70%	$87.89	$24.58	0%	$0.00	0.017	$70.96	$1.23	0%	$0.00	0.361	70%	$87.89	$17.15	0%	$0.00	$0	0.51	0.80	$0.00
Other periodontal					0%	$0.00	0.041	$97.44	$3.95	0%	$0.00	0.040	70%	$97.44	$2.78	0%	$0.00	$0	1.00	0.80	$0.00
5. Endodontic services (root canal)	0.366	70%	$51.20	$13.65	0%	$0.00	0.061	$377.87	$23.13	0%	$0.00	0.061	70%	$377.87	$16.14	0%	$0.00	$0	0.91	0.80	$0.00
C. ORTHODONTICS				$0.00		$0.00			$27.58		$0.00				$27.58		$0.00				$0.00
Space maintenance (ages 3-10)					0%	$0.00				0%	$0.00	0.000	0%	$0.00	$0.00	0%	$0.00	$0	1.00	0.60	$0.00
Severe Malocclusion (ages 6-14)					0%	$0.00				0%	$0.00	0.000	0%	$0.00	$0.00	0%	$0.00	$0	1.00	0.60	$0.00
Other orthodontura					0%	$0.00			$27.58	0%	$0.00				$27.58	0%	$0.00	$0	1.00	0.60	$0.00
D. ORAL SURGERY BY DENTISTS				$5.19		$0.86			$12.65		$7.06				$0.83		$0.86				$0.07
1. Extractions	0.100	100%	$52.31	$5.23	0%	$0.00	0.121	$46.25	$5.59	0%	$0.00	0.013	100%	$52.31	$0.70	0%	$0.00	$0	0.38	0.80	$0.00
2. Surgical extractions	0.010	100%	$85.72	$0.86	100%	$0.86	0.050	$141.77	$7.06	100%	$7.06	0.001	100%	$95.72	$0.13	100%	$0.86	$0	0.65	0.80	$0.07
TOTAL				$136.90		$9.83			$331.50		$9.82				$333.10		$77.36				$68.63

Section A Scaler:	1.576
Section B Scaler:	0.696
Section D Scaler:	0.134

For Official Use Only

Estimated Cost of Oral Health Benefits Package -- Total U.S Population
Description of Proposed Oral Health Benefits for Children, Adolescents, & Adults (Under the age of 65)

SERVICE	ESTIMATED TARGET POPULATION (1995)	FREQ/YR	SERVICE MODIFIER	PROJECTED UTILIZATION RATE	COST/UNIT	TOTAL ANNUAL COST	PER CAPITA COST($)/YR
ORAL HEALTH ASSESSMENT							
ORAL EXAMINATION (INI./PER.)	220,875,947	1	100%	70%	$18	$2,841,789,939	$12.87
DENTAL RADIOGRAPHS (2 BW)	214,277,530	1	100%	70%	$16	$2,399,908,338	$11.20
DENTAL SEALANTS							
DENTAL SEALANTS (6-17 Y/O)	37,954,200	0.17	8%	50%	$19	$490,368,264	$12.92
PROFESSIONAL APPLIED TOPICAL FLUORIDE							
CHILD TF/HIGH RISK (2-18 Y/O)	64,143,947	2	45%	85%	$16	$785,121,916	$12.24
CHILD TF/NON-FL COMM (2-18 Y/O	64,143,947	2	55%	25%	$16	$282,233,368	$4.40
ADULT TF/HIGH RISK (19-64 Y/O)	150,133,583	2	10%	70%	$16	$336,299,225	$2.24
ORAL PROPHYLAXIS							
ORAL PROPHY (CHILD 2-14 Y/O)	47,678,263	1	60%	70%	$29	$580,721,245	$12.18
ORAL PROPHY (ADULT 15-64 Y/O)	164,765,583	1	45%	70%	$40	$2,076,046,343	$12.60
FLUORIDE SUPPLEMENTS							
DENTAL EMERGENCY							
EMERGENCY EXAM	226,374,000	1	15%	100%	$24	$814,946,400	$3.60
SEDATIVE FILLING	220,875,947	1	2%	100%	$32	$141,360,606	$0.64
EMERGENCY TX OF PAIN	226,374,000	1	1.5%	100%	$35	$118,846,350	$0.53
EXTRACTION (SINGLE)	220,875,947	1	10%	100%	$47	$1,038,116,953	$4.70
EXTRACTION (SURGICAL)	219,043,263	1	1%	100%	$86	$188,377,206	$0.86
TRAUMATIC WOUND TX	226,374,000	1	0.5%	100%	$55	$62,252,850	$0.28
ROUTINE RESTORATIVE SERVICES							
PRIMARY REST. (CHILD 3-10 Y/O)	29,446,000	1	1.1	70%	$45	$1,020,303,900	$34.65
PERM. REST. (CHILD 6-18 Y/O)	48,121,000	1	0.4	70%	$46	$625,188,032	$12.99
CORONAL REST.(ADULT 19-64 Y/O)	150,133,583	1	1.3	70%	$46	$6,339,240,400	$42.22
ROOT REST. (ADULT 19-64 Y/O)	150,133,583	1	0.4	70%	$46	$1,950,535,508	$12.99
PERIODIC MAINTENANCE CARE (S&RP)							
CHILD (15-18 Y/O)	14,632,000	1	10.0%	70%	$61	$62,478,640	$4.27
ADULT (19-64 Y/O)	150,133,583	1	54.0%	70%	$61	$3,461,780,152	$23.06
INTERCEPTIVE ORTHODONTICS (6-11 Y/O)							
SPACE MAINTENANCE (3-10 Y/O)	29,446,000	0.125	39.0%	70%	$166	$166,804,229	$5.66
CHILD (6-11 Y/O)	22,326,000	0.17	14.2%	70%	$3,130	$1,180,838,661	$52.89
ENDODONTIC SERVICES							
CHILD/ADOLESCENT (6-18 Y/O)	48,121,000	1	0.0256	70%	$400	$344,931,328	$7.17
MEDICALLY NECESSARY CARE (Specific Conditions)							
DENTAL PROSTHETIC SERVICES	1,250,000	0.2	---	70%	$1,252	$219,100,000	$175.28

DOC:OHBP1A.WK1 LJF (15APR93)

Estimated Total Cost	$27,527,589,854
Annual per capita cost/Targ. Pop	$121.60
Monthly per capita cost/Targ. Po	$10.13
Annual per capita cost/U.S. Pop.	$105.82
Monthly per capita cost/U.S. Pop	$8.82

Preliminary Staff Working Paper — For Illustrative Purposes Only

703 941 3951

Estimated Cost of Oral Health Benefits Package -- Total U.S Population
Description of Proposed Oral Health Benefits for Adults (18 to 64 years of age)
(Estimate Utilization Rate of 60 percent / 1994 adjusted dental fees)

SERVICE	ESTIMATED TARGET POPULATION (1995)	FREQ/YR	SERVICE MODIFIER	PROJECTED UTILIZATION RATE	COST/UNIT	TOTAL ANNUAL COST	PER CAPITA COST($)/YR
ORAL HEALTH ASSESSMENT							
ORAL EXAMINATION (INI./PER.)	160,402,000	1	100%	60%	$20.03	$1,927,711,236	$8.52
DENTAL RADIOGRAPHS	153,649,076	1	100%	60%	$17.81	$1,641,894,024*	$7.25
PROFESSIONAL APPLIED TOPICAL FLUORIDE							
ADULT TF/HIGH RISK (18-64 Y/O)	153,649,076	2	10%	60%	$17.81	$328,378,805	$1.45
ORAL PROPHYLAXIS							
ORAL PROPHY (ADULT 18-64 Y/O)	153,649,076	1	45%	60%	$44.52	$1,846,923,351	$8.16
DENTAL EMERGENCY							
already in HSA EMERGENCY EXAM	160,402,000	1	15%	100%	$26.71	$642,650,613	$2.84
SEDATIVE FILLING	153,649,076	1	2%	100%	$35.62	$109,459,602	$0.48
EMERGENCY TX OF PAIN	160,402,000	1	1.5%	100%	$38.96	$93,738,929	$0.41
EXTRACTION (SINGLE)	153,649,076	1	10%	100%	$52.31	$803,738,316	$3.55
EXTRACTION (SURGICAL)	153,649,076	1	1%	100%	$95.72	$147,072,895	$0.65
TRAUMATIC WOUND TX	160,402,000	1	0.5%	100%	$61.22	$49,099,052	$0.22
ROUTINE RESTORATIVE SERVICES							
not until 2001 CORONAL REST.(ADULT 18-64 Y/O)	153,649,076	1	1.3	60%	$51.20	$6,136,129,491	$27.11
ROOT REST. (ADULT 18-64 Y/O)	153,649,076	1	0.4	60%	$51.20	$1,888,039,843	$8.34
PERIO MAINTENANCE CARE (S&RP)							
ADULT (18-64 Y/O)	153,649,076	1	54.0%	60%	$67.89	$3,379,720,385	$14.93
MEDICALLY NECESSARY CARE (Specific Conditions)							
DENTAL PROSTHETIC SERVICES	933,000	0.125	---	60%	$1,393.51	$97,510,862	$0.43

DOC:OHC18-64.WK1 LJF (10NOV93) Revised cost est. using ARC info.
OHC-Requested

Estimated Total Cost	$19,092,067,404
Annual per capita cost/Targ. Pop	$84.34
Monthly per capita cost/Targ. Po	$7.03
Annual per capita cost/U.S. Pop.	$73.39
Monthly per capita cost/U.S. Pop	$6.12

* limited to 1 set of Bite-wings per 2 yr. or 1 Full mouth series per 5 yr.
therefore costs is reduced by 50 percent.

F:\HSA\EDLABOR\SUB\WILLIA.003 H.L.C.

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. WILLIAMS

Page 39, after line 18, insert the following:

(D) Annual fecal-occult blood tests for the purpose of early detection of colon cancer.

(E) Flexible sigmoidoscopies for the purpose of early detection of colon cancer every 3 years.

Page 40, after line 15, insert the following:

(D) Annual fecal-occult blood tests for the purpose of early detection of colon cancer.

(E) Flexible sigmoidoscopies for the purpose of early detection of colon cancer every 3 years.

DRAFT 5/12/94

MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS COMPARISON

Service	Clinton Health Security Act	Stark - Ways and Means
Inpatient hospital and Residential Services	Before January 1, 2001, 30 days plus an additional 30 days under certain circumstances.[1] Cost sharing: •Lower - no copayment •Higher - one day deductible, 20% coinsurance (expenses apply to o-o-p max)	•90 days general hospitals. •45 days psychiatric hospitals with a 190 day lifetime limit on psychiatric hospitals. •Up to 135 days per year intensive residential services[2], inpatient psychiatric benefits reduced by one day of inpatient care for every three days of residential. (The provision regarding the trade off needs clarification as to which of the annual inpatient limits is traded.) Secretary directed to develop standards for the appropriate management of these services. Cost sharing: •Hospitals no coinsurance. General plan deductible of $500 individual/$750 per family applies. •Cost sharing for residential not clearly specified.

[1]Includes general and psychiatric hospital, residential treatment centers, residential detoxification centers, crisis residential programs, mental health residential treatment programs, therapeutic family or group treatment homes, community residential treatment or recovery centers for substance abuse.

[2]Includes residential detoxification centers, crisis residential programs or mental illness residential treatment programs, therapeutic family or group treatment homes, community residential treatment centers, and recovery centers for substance abuse.

Service	Clinton Health Security Act	Stark - Ways and Means
Intensive Non-Residential Treatment	Before January 1, 2001, two to one substitute with inpatient treatment plus maximum of 60 additional days at plan discretion (partial hospitalization, day treatment, psychiatric rehabilitation, home-based services, ambulatory detoxification, behavioral aide services). Cost sharing: •Lower - no copayment, except $25 per visit for additional 60 days. •Higher - one day deductible, 20% coinsurance, except 50% coinsurance for additional 60 days. •Before 1/1/2001, expenses do not apply to o-o-p if for substance abuse, or for additional 60 days.	Partial hospitalization covered for individuals who would otherwise require inpatient psychiatric care. Covers 90 days per year of additional intensive community services (psychiatric rehabilitation, day treatment services for children, behavioral aide services, in-home services, case management services, and ambulatory detoxification services.. Cost sharing: •20% coinsurance

Service	Clinton Health Security Act	Stark - Ways and Means
Outpatient mental illness and substance abuse services	•Annual limit on some services before January 1, 2001 **Psychotherapy** -30 visits for psychotherapy and collateral services. -four to one substitution at discretion of plan. **Substance abuse counseling and relapse prevention** -four to one substitution at discretion of plan. -30 group therapy visits if received inpatient/residential or intensive non-residential treatment within 12 months. -outpatient detoxification covered only in context of treatment program. •Services without specified limit -screening and assessment, diagnosis, medical management, crisis services, somatic treatments, case management. <u>Cost sharing:</u> •<u>Lower</u> - $10 copayment, except $25 for psychotherapy and collateral services (before 1/1/2001) and no copayment for case management. •<u>Higher</u> - 20%, except 50% for psychotherapy and collateral services (before 1/2001) and none for case management. •Before 1/1/2001 expenses do not apply to o-o-p max.	Based on Medicare •No limits <u>Cost sharing:</u> •20% coinsurance for medication management brief office visits, and initial diagnosis, •20% coinsurance for outpatient psychotherapy services for children through age 18.* •50% coinsurance for other treatment services.

* Miller amendment uses 22

Service	Clinton Health Security Act	Stark - Ways and Means
Other mental health provisions	By October 1, 1998 States required to submit plans for integration.	States given broad flexibility to establish comprehensive managed mental health programs for low-income adults and children with serious mental illness or emotional disturbance. Programs allow individuals to receive benefit package without limits and , at state option, with reduced copayments. Federal coverment establish standards for program eligibility. State submit plan including additional Federal, State, and local funds to be used to finance the program.

AMENDMENT TO COMMITTEE PRINT (H.R. 3600) OFFERED BY MR. MILLER OF CALIFORNIA

Page 30, strike lines 16 through 19 and insert the following:

(which are subject to section 1115), except—

(1) medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is not covered under such section); and

(2) treatment of a substance abuse disorder that is necessary in order to ensure continuity of care for an individual receiving hospital services other than such treatment, where the individual was receiving substance abuse treatment covered under section 1115 prior to receiving such other hospital services.

Page 41, strike line 25 and insert "(c)), including case management.".

Page 42, line 1, strike "nonresidential" and insert "community services for".

Page 42, strike line 3 and insert "(d)), including case management.".

Page 42, line 11, strike "NONRESIDENTIAL, and insert "INTENSIVE COMMUNITY SERVICES,".

Page 42, line 14, strike "nonresidential" and insert "community services for".

Page 42, line 17, strike "management" and insert "management, screening and assessment, crisis services,".

Page 42, line 22, strike "disorder;" and insert "disorder or, in the case of an individual 5 years of age or less than 5 years of age, is at risk for such a mental disorder;

Page 43, strike lines 8 through 19 and insert the following:

(2) CASE MANAGEMENT.—An eligible individual who is receiving an item or service described in this section that does not consist of case management is eligible to receive coverage for case management in addition to coverage for such item or service.

Page 44, line 8, strike "nonresidential" and insert "community services for".

Beginning on page 44, strike line 19 through page 45, line 2, and insert the following:

(A) an inpatient of a hospital or a psychiatric hospital; or

(B) a resident of a residential treatment center, residential detoxification center, crisis residential program, mental illness residential treatment program, therapeutic family home, group treatment home, community residential treatment program, or recovery center for substance abuse.

Beginning on page 45, strike line 21 through page 46, line 5 (and redesignate provisions accordingly).

Beginning on page 46, strike line 15 through page 47, line 5 (and redesignate provisions accordingly).

Page 47, after line 18, insert the following:

(E) ANNUAL AND LIFETIME LIMIT ON HOSPITAL TREATMENT.—Prior to January 1, 2001, such treatment, when furnished to an inpatient of a hospital that is not a psychiatric hospital, is subject to an aggregate annual limit of 90 days. Such treatment, when furnished to an inpatient of a psychiatric hospital, is subject to an aggregate annual limit of 45 days and an aggregate lifetime limit of 190 days per individual.

(F) ANNUAL LIMIT ON RESIDENTIAL TREATMENT.—Prior to January 1, 2001, such treatment, when furnished in a setting other than a hospital or psychiatric hospital, is subject to an aggregate annual limit of 135 days. The number of covered days of inpatient mental illness and substance abuse treatment that are available to an individual under the annual and lifetime limits described in subparagraph (E) shall be reduced by 1 day for each 3 covered days of residential mental illness and substance abuse treatment that are provided to the individual.

Page 47, line 19, strike "NONRESIDENTIAL TREATMENT.—" and insert "COMMUNITY SERVICES.—".

Page 47, line 21, strike "nonresidential" and insert "community services for".

Page 48, line 14, strike "nonresidential" and insert "community services for".

Page 48, strike lines 16 through 22 (and redesignate provisions accordingly).

Beginning on page 49, strike line 16 through page 50, line 14, and insert the following:

(B) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment is subject to an aggregate annual limit of 90 days, except with respect to individuals less than 22 years of age such annual limit shall be 180 days.

Page 50, line 16, strike "nonresidential" and insert "community services for".

Page 50, line 22, strike "nonresidential" and insert "community services for".

Page 51, strike lines 5 through 8 and insert "this subtitle.".

Beginning on page 52, strike line 8 through page 54, line 23 (and redesignate provisions accordingly).

Page 55, after line 12, insert the following (and redesignate provisions accordingly):

(f) UTILIZATION REVIEW REQUIREMENT.—

(1) IN GENERAL.—The mental illness and substance abuse services that are described in this section are not covered for an individual, after each applicable set of visits or set of treatment days described in paragraph (2) has been provided to the individual, unless the health plan in which the individual is enrolled determines, based on a utilization

review, that such services continue to be medically necessary or appropriate.

(2) SETS OF VISITS AND TREATMENT DAYS.—

(A) SETS OF VISITS.—The sets of visits referred to in paragraph (1) are—

(i) 1 initial set of 10 consecutive regularly-scheduled outpatient psychotherapy visits provided to an individual during a period that does not exceed 12 months; and

(ii) each subsequent set of 15 consecutive regularly-scheduled outpatient psychotherapy visits provided to the individual that immediately follows the initial set of visits described in clause (i) or another set of visits described in this clause.

(B) SETS OF TREATMENT DAYS.—The sets of treatment days referred to in paragraph (1) are—

(i) 1 initial set of 10 consecutive days of inpatient and residential mental illness and substance abuse treatment; and

(ii) each subsequent set of 15 consecutive days of inpatient and residential mental illness and substance abuse treat-

ment provided to the individual that immediately follows the initial set of treatment days described in clause (i) or another set of treatment days described in this clause.

(3) MODIFICATION OF NUMERICAL SETS BY BOARD.—The National Health Board may by regulation modify the number of visits or days that constitute a set referred to in paragraph (1).

(4) MODIFICATION OF NUMERICAL SETS BY STATES.—With respect to mental illness and substance abuse services that are provided in a State, the State may modify the number of visits or days that constitute a set referred to in paragraph (1), if the modification decreases such number below the number specified in paragraph (2) or specified by the Board under paragraph (3).

Page 86, strike the items relating to intensive nonresidential mental illness and substance abuse treatment, outpatient mental illness and substance abuse treatment, and outpatient psychotherapy and insert the following:

Intensive community services for mental illness and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate

Outpatient mental illness and substance abuse treatment (except psychotherapy for individuals at least 22 years of age, collateral services, and case management)	1115	$10 per visit	20 percent of applicable payment rate
Outpatient psychotherapy for individuals at least 22 years of age and collateral services	1115	$25 per visit until January 1, 2001, and $10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter

Page 97, after line 22, insert the following (and redesignate provisions accordingly):

(7) CONTINUITY OF CARE FOR MENTAL AND SUBSTANCE ABUSE DISORDERS.—Ensuring continuity of care for individuals who require mental illness and substance abuse services described in section 1115, but are not covered for such services because of annual or lifetime limits described in such section, by contracting with providers who provide mental illness and substance abuse services described in such section, unless suitable agreements with such providers cannot be reached.

Page 224, beginning on line 11, strike "Each carrier" through line 17 and insert the following:

(1) IN GENERAL.—Each carrier providing a health plan with an integrated health network (as

defined in section 1902(25)) shall enter into such agreements with health care providers or have such other arrangements as may be necessary to assure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled with the plan through such a network.

(2) SPECIAL REQUIREMENTS FOR MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.—Each carrier providing a health plan with an integrated health network shall enter into such agreements with health care providers or have such other arrangements as may be necessary—

(A) to demonstrate specifically that the carrier has the ability to provide, through such network, to individuals who have severe mental illness, serious emotional disturbance, or a substance abuse disorder, medically necessary or appropriate—

(i) inpatient and residential mental illness and substance abuse treatment (described in section 1115(c)) with respect to a diagnosable substance abuse disorder in a setting that is not a hospital or psychiatric hospital;

(ii) intensive community services for mental illness and substance abuse treatment (described in section 1115(d)); and

(iii) outpatient mental illness and substance abuse treatment consisting of case management (described in section 1115(e)(1)(H);

(B) to ensure that the items and services described in subparagraph (A) are provided to all individuals enrolled under the plan by providers who have a demonstrated ability to identify individuals who require such treatment and to deliver such treatment within a reasonable distance from the residence of an individual;

(C) to ensure continuity of care for individuals who require mental illness and substance abuse services described in section 1115, but are not covered for such services because of annual or lifetime limits described in such section, by developing appropriate plans and linkages with public agencies that may provide such services; and

(D) to ensure that the carrier has established, or is establishing, linkages with existing mental illness and substance abuse service de-

livery programs in the plan service area for services that are required under section 1115(g) to be provided through an organized system of care.

(3) SPECIAL REQUIREMENT TO CONTRACT WITH STATE-DESIGNATED PROVIDERS.—In the case of a carrier with respect to which a State has made a finding that the carrier has not satisfied the requirement in subparagraph (A) or (B) of paragraph (2), the carrier, if directed by the State, shall contract with providers designated by the State as having demonstrated experience in providing the services described in paragraph (2)(A).

AMENDMENT TO COMMITTEE PRINT (H.R. 3600) OFFERED BY MR. MILLER OF CALIFORNIA

Beginning on page 55, strike "The" on line 16 through page 56, line 10, and insert the following (and redesignate provisions accordingly):

A health plan sponsor shall ensure that mental illness and substance abuse services described in this section are furnished through an organized system of care, as described in paragraph (2), if—

(A) the services are provided to an individual less than 22 years of age;

(B) the individual has a serious emotional disturbance or a substance abuse disorder; and

(C) the individual is, or is at imminent risk of being, subject to the authority of, or in need of the services of—

(i) a public agency that serves the needs of children, such as an agency involved with child welfare or special education;

(ii) the juvenile justice system; or

(iii) the criminal justice system.

(2) REQUIREMENTS FOR SYSTEM OF CARE.—In this subsection, an "organized system of care" is a

community-based service delivery network, which may consist of public and private providers, that meets the following requirements:

Page 56, beginning on line 11, after "participation" insert "and coordination".

Page 56, beginning on line 13, strike "area (including" and insert "area, including".

Page 56, line 15, after "justice" insert "criminal justice".

Page 56, line 17, strike "treatment)." and insert "treatment.".

Page 56, line 25, strike "through" and insert "by".

Page 56, line 25, strike "or" and insert "and".

Page 57, line 1, strike "teams that" and insert "teams, which".

Page 57, line 6, strike "children" and insert "individuals".

Page 57, line 7, after "age" insert "who have a serious emotional disturbance or a substance abuse disorder".

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AMENDMENT TO COMMITTEE PRINT (H.R. 3600) OFFERED BY MR. MILLER OF CALIFORNIA

Page 564, strike lines 1 through 24 (and conform line 8 on page 560 and the table of contents accordingly).

Page 565, strike line 1 and all that follows through page 567, line 23, and insert the following part (and conform the table of contents accordingly):

PART 3—ASSISTANCE FOR STATE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

SEC. 3531. AVAILABILITY OF ASSISTANCE.

(a) IN GENERAL.—The Secretary may make grants to States for the development and operation of comprehensive managed mental health and substance abuse programs that are integrated with the delivery of items and services covered under the comprehensive benefits package. Such programs shall—

(1) promote the development of integrated delivery systems for the management of the mental health and substance abuse services provided under the comprehensive benefit package;

(2) give priority initially to providing services to low-income adults with serious mental illness or substance abuse disorders and children with serious

emotional disturbance or substance abuse disorders and provide for the phase-in of such services for all eligible persons within 5 years;

(3) ensure that individuals participating in the program have access to all medically necessary mental health and substance abuse services;

(4) promote the linkage of mental health and substance abuse services with primary and preventive health care services; and

(5) meet such other requirements as the Secretary may impose.

(b) EXCEPTION.—Nothing in this part shall be construed as preventing States that have separate administrative entities for mental health and for substance abuse services from establishing separate comprehensive managed care programs for such services and receiving assistance under this part for either or both programs.

SEC. 3532. REQUIREMENTS FOR A PLAN.

In order to receive a grant under this part, a State must have a plan for a comprehensive managed mental health and substance abuse program, which is approved by the Secretary. Such plan shall—

(1) describe the management, access, and referral structure that the State will use to promote and achieve integration of mental health and substance

abuse services with the delivery of items and services covered under the comprehensive benefits package for eligible individuals in the State;

(2) describe how the State will ensure that providers of specialized services will meet appropriate standards and provide assurances that the State has complied with section 1201(a)(7) as it affects mental health and substance abuse services;

(3) describe payment, utilization review, and other mechanisms that the State will use to encourage appropriate service delivery and management of costs;

(4) describe uniform patient placement criteria that the State will use to ensure placement in appropriate substance abuse treatment;

(5) describe the process the State will use to ensure that individuals will continue to have access to treatment through referrals from nonhealth public entities, such as the juvenile or criminal justice systems, or social service systems;

(6) specify the methods the State will use to ensure that individuals receiving services under the program have access to all medically necessary and appropriate mental health and substance abuse services;

(7) define terms that will be used by the State in determining the eligibility of individuals for services under the program;

(8) describe how health plans will use services under the comprehensive managed mental health and substance abuse programs established under this part;

(9) describe the sources of funding, including the medicaid program and the block grants authorized by title XIX of the Public Health Service Act, that will be used by the State, other than the grant received under this part, to operate the program, and provide the status of any request for a medicaid waiver relating to the delivery of mental health and substance abuse services submitted by the State to the Secretary;

(10) describe how the State provided for broad-based public input in the development of the plan, and the mechanism that will be used for ongoing public comment on and review of amendments to the plan; and

(11) describe grievance procedures that will be available for individuals dissatisfied with their health plan's participation in the comprehensive managed mental health and substance abuse program, and

mechanisms that will be available to review the performance of health plans and fee-for-service arrangements to ensure against undertreatment.

SEC. 3533. MAINTENANCE OF EFFORT.

States receiving assistance under this part shall maintain expenditures of non-Federal funds, including State medicaid expenditures and State substance abuse treatment expenditures required by title XIX of the Public Health Services Act, for all covered services for covered persons provided under the comprehensive managed mental health and substance abuse program at the level of such expenditures for the fiscal year preceding the first fiscal year for which the State receives such a grant. Such level must be adjusted annually for inflation in accordance with the general health care inflation factor (as defined in section 6001(a)(3)), but may be reduced in proportion to reductions in the State population.

SEC. 3534. ADDITIONAL FEDERAL RESPONSIBILITIES.

The Secretary shall, upon the submission of a State's plan—

(1) ensure the timely consideration of any request for a medicaid waiver relating to the delivery of mental health and substance abuse services submitted by the State to the Secretary,

(2) affirm that the State has met the responsibilities required under section 1201(a)(7), and

(3) affirm that carriers providing health plans in the State meet the requirements of paragraphs (2) and (3) of section 1407(a).

SEC. 3535. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under this part $100,000,000 for each of the fiscal years 1996 through 2000.

COMMITTEE ON EDUCATION AND LABOR

Subcommittee on Labor-Management Relations

U.S. House of Representatives

320 Cannon House Office Building

Washington, DC 20515

phone: (202) 225-5768
fax: (202) 225-3614

FACSIMILE TRANSMISSION SHEET

DATE: 5/11

TO: SHARMAN

FROM: Jon Weintraub__ Fred Feinstein__ Phyllis Borzi__ Rick Jerue__

Gail Brown__ Susie Ringel X Allison Hogue__ Tony Guiles__

NUMBER OF PAGES TO FOLLOW: 8

MESSAGE: Here's the rest of William's mental health pages — let me know if you need anything else —

Susie

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are as follows:

(A) Booster immunizations against tetanus and diphtheria every 10 years.

(B) Age-appropriate immunizations for the following illnesses:

(i) Influenza.

(ii) Pneumococcal invasive disease.

(2) TESTS.—The tests specified in this subsection are as follows:

(A) Annual Papanicolaou smears, pelvic exams, and clinical breast examinations for females.

(B) Annual mammograms for females.

(C) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every year.

(j) CLINICIAN VISIT.—For purposes of this section, the term "clinician visit" includes the following health professional services (as defined in section 1112(c)):

(1) A complete medical history.

(2) An appropriate physical examination.

(3) Risk assessment.

(4) Targeted health advice and counseling, including nutrition counseling.

(5) The administration of age-appropriate immunizations and tests specified in subsections (b) through (h).

(k) IMMUNIZATIONS AND TESTS NOT ADMINISTERED DURING CLINICIAN VISIT.—Notwithstanding subsection (j)(5), the clinical preventive services described in this section include an immunization or test described in this section that is administered to an individual consistent with any periodicity schedule for the immunization or test during the age range specified for the immunization or test, and any administration fee for such immunization or test, even if the immunization or test is not administered during a clinician visit.

SEC. 1115. MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.

(a) COVERAGE.—The mental illness and substance abuse services that are described in this section are the following items and services for eligible individuals, as defined in section 1001(c), who satisfy the eligibility requirements in subsection (b):

(1) Inpatient and residential mental illness and substance abuse treatment (described in subsection (c)).

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(2) Intensive nonresidential mental illness and substance abuse treatment (described in subsection (d)).

(3) Outpatient mental illness and substance abuse treatment (described in subsection (e)), including case management, screening and assessment, crisis services, and collateral services.

(b) ELIGIBILITY.—The eligibility requirements referred to in subsection (a) are as follows:

(1) INPATIENT, RESIDENTIAL, NONRESIDENTIAL, AND OUTPATIENT TREATMENT.—An eligible individual is eligible to receive coverage for inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment (except case management and collateral services) if the individual—

(A) has, or has had during the 1-year period preceding the date of such treatment, a diagnosable mental disorder or a diagnosable substance abuse disorder; and

(B) is experiencing, or is at significant risk of experiencing, functional impairment in family, work, school, or community activities.

For purposes of this paragraph, an individual who has a diagnosable mental disorder or a diagnosable substance abuse disorder, is receiving treatment for such disorder, but does not satisfy the functional impairment criterion in subparagraph (B) shall be treated as satisfying such criterion if the individual would satisfy such criterion without such treatment.

(2) CASE MANAGEMENT.—An eligible individual is eligible to receive coverage for case management if—

(A) a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such services; and

(B) the individual is eligible to receive coverage for, and is receiving, outpatient mental illness and substance abuse treatment with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder.

(3) SCREENING AND ASSESSMENT AND CRISIS SERVICES.—All eligible individuals enrolled under a health plan are eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of screening and assessment and crisis services.

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(4) COLLATERAL SERVICES.—An eligible individual is eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of collateral services if the individual is a family member (described in section 1011(b)) of an individual who is receiving inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment.

(c) INPATIENT AND RESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "inpatient and residential mental illness and substance abuse treatment" means the items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to—

(A) an inpatient of a hospital, psychiatric hospital, residential treatment center, residential detoxification center, crisis residential program, or mental illness residential treatment program; or

(B) a resident of a therapeutic family or group treatment home or community residential

treatment and recovery center for substance abuse.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient and residential mental illness and substance abuse treatment when provided to such an inpatient or resident.

(2) LIMITATIONS.—Coverage for inpatient and residential mental illness and substance abuse treatment is subject to the following limitations:

(A) RESIDENTIAL MENTAL ILLNESS TREATMENT.—Such treatment, when provided with respect to a diagnosable mental disorder in a setting that is not a hospital or a psychiatric hospital, is covered only to avert the need for, or as an alternative to, treatment in a hospital or a psychiatric hospital, as determined by a health professional designated by the health plan in which the individual receiving such treatment is enrolled.

(B) RESIDENTIAL SUBSTANCE ABUSE TREATMENT.—Such treatment, when provided with respect to a diagnosable substance abuse disorder in a setting that is not a hospital or a psychiatric hospital, is covered only if a

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health professional designated by the health plan in which the individual receiving such treatment is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

(C) LEAST RESTRICTIVE SETTING.—Such treatment is covered only when—

(i) provided to an individual in the least restrictive inpatient or residential setting that is effective and appropriate for the individual; and

(ii) less restrictive intensive nonresidential or outpatient treatment would be ineffective or inappropriate.

(D) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment is subject to an aggregate annual limit of 30 days. A maximum of 30 additional days of such treatment shall be covered for an individual if a health professional designated by the health plan in which the individual is enrolled determines in advance that—

(i) the individual poses a threat to his or her own life or the life of another individual; or

(ii) the medical condition of the individual requires inpatient treatment in a hospital or a psychiatric hospital in order to initiate, change, or adjust pharmacological or somatic therapy.

(E) INPATIENT HOSPITAL TREATMENT FOR SUBSTANCE ABUSE.—Such treatment, when provided in a hospital or a psychiatric hospital with respect to a diagnosable substance abuse disorder, is covered under this section only for detoxification requiring the management of psychiatric conditions associated with withdrawal from alcohol or drugs. The items and services described in this section do not include medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is covered under section 1111).

(d) INTENSIVE NONRESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "intensive nonresidential mental illness and substance abuse treatment" means diagnostic or therapeutic items or services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to an individual—

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(A) participating in a partial hospitalization program, a day treatment program, a psychiatric rehabilitation program, or an ambulatory detoxification program; or

(B) receiving home-based mental illness services or behavioral aide mental illness services.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as intensive nonresidential mental illness and substance abuse treatment when provided to such an individual.

(2) LIMITATIONS.—Coverage for intensive nonresidential mental illness and substance abuse treatment is subject to the following limitations:

(A) DISCRETION OF PLAN.—An individual shall receive coverage for such treatment if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

(B) TREATMENT PURPOSES.—Such treatment is covered only when provided—

(i) to avert the need for, or as an alternative to, treatment in residential or inpatient settings;

(ii) to facilitate the earlier discharge of an individual receiving inpatient or residential care;

(iii) to restore the functioning of an individual with a diagnosable mental disorder or a diagnosable substance abuse disorder; or

(iv) to assist such an individual to develop the skills and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

(C) ANNUAL LIMIT.—

(i) IN GENERAL.—Prior to January 1, 2001, the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 2 covered days of intensive nonresidential mental illness and substance

abuse treatment that are provided to the individual, until such number is reduced to zero.

(ii) ADDITIONAL DAYS.—After the number of covered days referred to in clause (i) has been reduced to zero with respect to an individual, the individual shall receive coverage for a maximum of 60 days of intensive nonresidential mental illness and substance abuse treatment if a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such treatment.

(D) DETOXIFICATION.—Intensive nonresidential mental illness and substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for intensive nonresidential mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance

paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle if such treatment is provided—

(i) with respect to a diagnosable substance abuse disorder; or

(ii) pursuant to subparagraph (C)(ii).

(e) OUTPATIENT TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "outpatient mental illness and substance abuse treatment" means the following services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder in an outpatient setting:

(A) Screening and assessment.

(B) Diagnosis.

(C) Medical management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

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(2) LIMITATIONS.—Coverage for outpatient mental illness and substance abuse treatment is subject to the following limitations:

(A) HEALTH PROFESSIONAL SERVICES.—Such treatment is covered only when it constitutes health professional services (as defined in section 1112(c)(2)).

(B) DISCRETION OF PLAN.—An individual shall receive coverage for outpatient mental illness and substance abuse treatment consisting of substance abuse counseling and relapse prevention if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment. This subparagraph does not apply to group therapy covered pursuant to subparagraph (C)(ii)(II).

(C) ANNUAL LIMITS.—

(i) PSYCHOTHERAPY AND COLLATERAL SERVICES.—Prior to January 1, 2001, psychotherapy and collateral services are subject to an aggregate annual limit of 30 visits per individual. Additional visits may be covered, at the discretion of the

health plan in which the individual receiving treatment is enrolled, to prevent hospitalization or to facilitate earlier hospital release, for which the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits. After such number has been reduced to zero, no additional visits under the preceding sentence may be covered.

(ii) SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION.—

(I) IN GENERAL.—Except as provided in subclause (II), the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits for substance abuse counseling and relapse preven-

tion that are covered for the individual under subparagraph (B). After such number has been reduced to zero, no visits for substance abuse counseling and relapse prevention may be covered, except as provided in subclause (II).

(II) GROUP THERAPY.—Prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of group therapy is subject to a separate aggregate annual limit of 30 visits, if such therapy occurs within 12 months after the individual has received, with respect to a diagnosable substance abuse disorder, inpatient and residential mental illness and substance abuse treatment or intensive nonresidential mental illness and substance abuse treatment. The provisions of clause (i) and subclause (I) do not apply to therapy that is described in the preceding sentence.

(D) DETOXIFICATION.—Outpatient mental illness and substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for outpatient mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle.

(f) SPECIAL DELIVERY REQUIREMENTS FOR SERVICES PROVIDED TO CHILDREN.—

(1) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—The mental illness and substance abuse services described in this section shall be included in the comprehensive benefit package with respect to an eligible individual under 22 years of age only if such services are provided through an organized system of care described in paragraph (2).

(2) REQUIREMENTS FOR SYSTEMS OF CARE.—In this subsection, an "organized system of care" is a community-based system established by an appli-

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COMMITTEE ON EDUCATION AND LABOR

Subcommittee on Labor-Management Relations

U.S. House of Representatives

320 Cannon House Office Building

Washington, DC 20515

phone: (202) 225-5768
fax: (202) 225-3614

FACSIMILE TRANSMISSION SHEET

DATE: 5/11

TO: SHARMAN

FROM: Jon Weintraub___ Fred Feinstein___ Phyllis Borzi___ Rick Jerue___

Gail Brown___ Susie Ringel X Allison Hogue___ Tony Guiles___

NUMBER OF PAGES TO FOLLOW: 7

MESSAGE: Here are mental health pages on the 2 programs - I'll fax the benefits section next

- let me know if you need more.

tion that are covered for the individual under subparagraph (B). After such number has been reduced to zero, no visits for substance abuse counseling and relapse prevention may be covered, except as provided in subclause (II).

(II) GROUP THERAPY.—Prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of group therapy is subject to a separate aggregate annual limit of 30 visits, if such therapy occurs within 12 months after the individual has received, with respect to a diagnosable substance abuse disorder, inpatient and residential mental illness and substance abuse treatment or intensive nonresidential mental illness and substance abuse treatment. The provisions of clause (i) and subclause (I) do not apply to therapy that is described in the preceding sentence.

(D) DETOXIFICATION.—Outpatient mental illness and substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for outpatient mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle.

(f) SPECIAL DELIVERY REQUIREMENTS FOR SERVICES PROVIDED TO CHILDREN.—

(1) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—The mental illness and substance abuse services described in this section shall be included in the comprehensive benefit package with respect to an eligible individual under 22 years of age only if such services are provided through an organized system of care described in paragraph (2).

(2) REQUIREMENTS FOR SYSTEMS OF CARE.—In this subsection, an "organized system of care" is a community-based system established by an appli-

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cable health plan for the provision of mental illness and substance abuse services described in this section that meets the following requirements:

(A) The system has established linkages with existing mental illness and substance abuse service delivery programs in the plan service area (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

(B) The system provides for the participation of multiple agencies and providers that serve the needs of children in the area (including agencies and providers involved with child welfare, education, juvenile justice, health care, mental health, and substance abuse prevention and treatment).

(C) The system provides for the involvement of the families of children to whom mental illness and substance abuse services are provided in the planning of treatment and the delivery of services.

(D) The system provides for the development and implementation of individualized treatment plans through multidisciplinary or

multiagency teams that are recognized and followed by the applicable agencies and providers in the area.

(E) The system ensures the delivery and coordination of the range of mental illness and substance abuse services required by children under 22 years of age.

(F) The system provides for the management of the individualized treatment plans described in subparagraph (D) and for a flexible response to changes in treatment needs over time.

(g) OTHER DEFINITIONS.—For purposes of this subtitle:

(1) CASE MANAGEMENT.—The term "case management" means services that assist individuals in gaining access to needed medical, social, educational, and other services.

(2) DIAGNOSABLE MENTAL DISORDER AND DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The terms "diagnosable mental disorder" and "diagnosable substance abuse disorder" mean a disorder that—

(A) is listed in the Diagnostic and Statistical Manual of Mental Disorders, Third Edi-

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tion, Revised or a revised version of such manual (except V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment);

(B) is the equivalent of a disorder described in subparagraph (A), but is listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text; or

(C) is listed in any authoritative text specifying diagnostic criteria for mental disorders or substance abuse disorders that is identified by the National Health Board.

(3) PSYCHIATRIC HOSPITAL.—The term "psychiatric hospital" has the meaning given such term in section 1861(f) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(1), a facility of the uniformed services under title 10, United States Code, that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital;

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital; and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(3), a facility operated by the Indian Health Service that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital.

SEC. 1116. FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.

The services described in this section are the following items and services:

(1) Voluntary family planning services.

(2) Contraceptive devices that—

(A) may only be dispensed upon prescription; and

(B) are subject to approval by the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act.

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except to the extent inconsistent with the purpose described in subsection (a), subpart C of part 2 of subtitle E applies to such assistance to the same extent and in the same manner as such subpart applies to loans and loan guarantees under section 3441.

PART 2—AUTHORITIES REGARDING PARTICIPATING STATES

Subpart A—Report

SEC. 3511. REPORT ON INTEGRATION OF MENTAL HEALTH SYSTEMS.

(a) IN GENERAL.—As a condition of being a participating State under title I, each State shall, not later than October 1, 1998, submit to the Secretary a report on (including a plan for) the measures to be implemented by the State to achieve the integration of the mental illness and substance abuse services of the State and its political subdivisions with the mental illness and substance abuse services that are included in the comprehensive benefit package under title I. The plan required in the preceding sentence shall meet the conditions described in section 3074(b).

(b) REQUIRED CONTENTS.—With respect to the provision of items and services relating to mental illness and substance abuse, the report of a State under subsection (a) shall, at a minimum, contain the following information:

(1) Information on the number of individuals served by or through mental illness and substance abuse programs administered by State and local agencies and the proportion who are eligible persons under title I.

(2) The following information on services furnished to eligible persons:

(A) Each type of benefit furnished.

(B) The mental illness diagnoses for which each type of benefit is covered, the amount, duration and scope of coverage for each covered benefit, and any applicable limits on benefits.

(C) Cost sharing rules that apply.

(3) Information on the extent to which each health provider furnishing mental illness and substance abuse services under a State program participates in one or more regional or corporate alliance health plans, and, in the case of providers that do not so participate, the reasons for the lack of participation.

(4) The amount of revenues from health plans received by mental illness and substance abuse providers that are participating in such health plans and are funded under one or more State programs.

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(5) With respect to the two years preceding the year in which the State becomes a participating State under title I—

(A) the amount of funds expended by the State and its political subdivisions for each of such years for items and services that are included in the comprehensive benefit package under such title;

(B) the amount of funds expended for medically necessary and appropriate items and services not included in such benefit package, including medical care, other health care, and supportive services related to the provision of health care.

(6) An estimate of the amount that the State will expend to furnish items and services not included in such package once the expansion of coverage for mental illness and substance abuse services is implemented in the year 2001.

(7) A description of how the State will assure that all individuals served by mental illness and substance abuse programs funded by the State will be enrolled in a health plan and how mental illness and substance abuse services not covered under the benefit package will continue to be furnished to such enrollees.

(8) A description of the conditions under which the integration of mental illness and substance abuse providers into regional and corporate alliances can be achieved, and an identification of changes in participation and certification requirements that are needed to achieve the integration of such programs and providers into health plans.

(9) If the integration of mental illness and substance abuse programs operated by the State into one or more health plans is not medically appropriate or feasible for one or more groups of individuals treated under State programs, a description of the reasons that integration is not feasible or appropriate and a plan for assuring the coordination for such individuals of the care and services covered under the comprehensive benefit package with the additional items and services furnished by such programs.

(c) GENERAL PROVISIONS.—Reports under subsection (a) shall be provided at the time and in the manner prescribed by the Secretary.

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Subpart B—Pilot Program

SEC. 3521. PILOT PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a pilot program to demonstrate model methods of achieving the integration of the mental illness and substance abuse services of the States with the mental illness and substance abuse services that are included in the comprehensive benefit package under title I.

(b) CERTAIN CONSIDERATIONS,—With respect to the provision of items and services relating to mental illness and substance abuse, the Secretary, in carrying out subsection (a), shall consider the following:

(1) The types of items and services needed in addition to the items and services included in the comprehensive benefits package under title I.

(2) The optimal methods of treatment for individuals with long-term conditions.

(3) The capacity of alliance health plans to furnish such treatment.

(4) The modifications that should be made in the items and services furnished by such health plans.

(5) The role of publicly-funded health providers in the integration of acute and long-term treatment.

PART 3—ASSISTANCE FOR STATE MANAGED MENTAL HEALTH PROGRAMS

SEC. 3531. AVAILABILITY OF ASSISTANCE.

(a) IN GENERAL.—The Secretary may make grants to States for the development and operation of comprehensive managed mental health programs that meet the requirements of section 3532.

(b) ELIGIBILITY OF STATE.—In order to receive a grant under this part, a State shall submit to the Secretary (at such time and in such form as the Secretary may require) an application containing such information and assurances as the Secretary may require.

SEC. 3532. REQUIREMENTS FOR PROGRAM.

A State comprehensive managed mental health program meets the requirements of this section if the program—

(1) promotes the development of integrated delivery systems for the management of the mental health services provided under the comprehensive benefit package;

(2) gives priority in providing assistance on behalf of low-income individuals who are adults with serious mental illness or children with severe emotional disturbance (in accordance with standards of the Secretary promulgated under section 3533);

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(3) ensures that individuals participating in the program have access to all medically necessary mental health services; and

(4) meets such other requirements as the Secretary may impose.

SEC. 3533. STANDARDS RELATING TO DETERMINATIONS OF INCOME AND SEVERITY OF ILLNESS.

(a) IN GENERAL.—The Secretary shall promulgate standards to be used by States to determine whether an individual is a low-income individual who is an adult with a serious mental illness or a child with a severe emotional disturbance for purposes of section 3532(2).

(b) SEVERITY OF ILLNESS OR DISTURBANCE.—Under the standards promulgated pursuant to subsection (a), the determination of whether an adult has a serious mental illness or a child has a severe emotional disturbance shall be based on the individual's anticipated need for services (as determined on the basis of the individual's medical history or a prediction of future medical needs) and on whether the individual is expected to need mental health services for a period of at least 1 year.

SEC. 3534. REPORTING REQUIREMENTS.

With respect to each year for which a State is receiving a grant under this part for the establishment and operation of a comprehensive managed mental health program, the State shall submit a report to the Secretary containing the following information with respect to the year:

(1) The management, access, and referral structure which the State uses under the program to promote and achieve integration of mental health services provided to residents of the State.

(2) Detailed specifications of the methods used by the State under the program to ensure that individuals receiving services under the program have access to all medically necessary and appropriate mental health services.

(3) The definition of an adult with a serious mental illness and a child with a severe emotional disturbance used by the State in determining the eligibility of individuals for services under the program.

(4) A description of sources of funding used by the State (other than the grant received under this part) to operate the program during the year.

SEC. 3535. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under this part $100,000,000 for each of the fiscal years 1996 through 2000.

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AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MRS. UNSOELD

Page 72, line 16, strike "discretion." and insert "discretion, except that the plan shall offer smoking cessation classes to pregnant women enrolled in the plan.".

Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, Virginia 22003

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(703) 941-7400
FAX (703) 941-3951

Date: 5/13

---------*Please Deliver Immediately*----------

To: Jennifer Klein

From: Gordon

Re:

Memo: With Miller's dental limited to one exam / year with radiographs (but no prophylaxis) and:
30% coinsurance
$10 copayment / visit
Average premium increase is 0.77% (i.e. a little less than 1%).

We are transmitting ___ pages (including this transmittal sheet).

Cost Estimate Information:

Emergency Care	Already in the Williams' Substitute	
Preventive and Diagnostic Care	Limits:	Costs (in Billions):
Oral exams	1/yr	$1,928
Radiographs	1/2yr BW* or 1/5yr FMS**	821
Sealants	------- no adults	
Fluorides	High Risk ONLY	328
Cleanings	1 @/yr	1,847
Treatment	no restorative, prosthetics, orthodontics for adults	
Special Needs Patients:		
Orthodontics	Severe Malocclusions ONLY for children age 6-12	
Dentures	Special needs patients ONLY	1.530
Medically Necessary Oral Health Care	Patient population as defined in amendment	
TOTAL:		**$6.454**

* BW = Bite Wing Radiographs
** FMS = Full Mouth Series

A study just prepared for Hay Huggins (last week) will show the Special Needs patient costs to equal $1.558 B. The result is an increase in cost of $28 Million, largely due to use of 65% utilization rates.

FAX TRANSMISSION FROM

CONGRESSMAN GEORGE MILLER
(D-CALIFORNIA)

TO: Jennifer Klein / Jack Lew

FR: Daniel Weiss

TOTAL NUMBER OF PAGES INCLUDING THIS ONE: 12

DATE: 5/13/94 *TIME:* 3:30 pm

MESSAGE: If you need the legislative language, let me know.

Rep. George Miller, 2205 Rayburn Bldg., Washington, DC 20515 (202)225-2095

Coalition for Oral Health

1625 Massachusetts Ave., NW, Suite 502
Washington, DC
20036-2212

May 13, 1994

TO: Daniel Weiss

FROM: Marty Liggett

SUBJECT: Dental Amendment Cost Estimates

Per our conversation earlier today, here are the details underlying our estimates. The chart below summarizes the costs of medically necessary oral health care and special needs patients. Specific numbers and assumptions are spelled out in detail in the attached letters from the American Association of Hospital Dentists. Please note that their estimates are comprised of two subtotals.

Page 2 of this memo describes the proposed preventive benefits for adults (ages 18-64) included in the amendment, with detailed assumptions listed.

Our amendment would never cover cast restorations (caps, gold crowns, bridge work), or cosmetic services.

President
John McFarland,
NNOHA

Vice President
Hermine McLaran,
AAPHD

Treasurer
Nik Petrovic,
ADTA

Secretary
Gene Bartlow,
AADR

Director
Martha Liggett,
AADS

Medically Necessary Oral Health Care
Cost Projections Summary Sheet

Category	# Patients	Costs (in Millions)
Chemotherapy	174,556	$ 71
Diabetes	809,200	349
Heart Defects	22,320	9
Hemophilia	11,560	4
HIV	289,200	118
Orphan Diseases	346,800	149
Radiation	14,450	6
Renal Dialysis	171,088	72
Transplantation	13,838	5
Dev & Acq MXF Def*	17,480	46
Dev Disabilities	1,676,200	723
TOTAL PROJECTED ANNUAL COSTS:		**$1,552**

* Dev & Acq MSF Def = Developmental and Acquired Maxillofacial Defects

Phone: (202) 667-9433
Fax: (202) 667-0642

May 12, 1994

Pertinent data for Dental Amendment
Description of Proposed Oral Health Benefits for Adults (18-64 years of age)
Estimated utilization rate of 60 percent/1994 adjusted dental fees

Service	Estimated Target Population	Frequency/ Year	Service Modifier Rate	Projected Utilization	Cost/ Unit	Total First Year Projected Cost (in Billions)
Preventive and Diagnostic Care:						
Oral Exams	160,402,000	1 x/yr	none	60%	$20.03	$ 1.928
Radiographs	153,649,076	1 x/2yr or 5yr	none	60%	17.81	.821
Sealants	NA	NA	NA	NA	NA	NA
Fluorides	153,649,076	2 x/yr	10%	60%	17.81	.328
Cleanings	153,649,076	1 x/yr	45%	60%	44.52	1.847
					TOTAL:	**$ 4.924**

ASSUMPTIONS:

1. Target population: There are two different population numbers used because there are 160 million adults ages 18 - 64, of whom 153 million have teeth; every one of the 160 million require oral exams, while only those with teeth get cleanings, x-rays, and fluoride treatments.

2. Frequency per year: This figure refers to limitations on the number of times per year the service will be provided. Most services are only covered annually. This is a more severe limitation than is commonly seen in the private sector, where 2 exams and cleanings may be covered each year. Radiographs are subject to the following limitations: not more than one set of bitewing x-rays every 2 years or one full mouth series of x-rays (or panographic x-ray) every 5 years.

3. Service modifier: A service modifier is an adjustment to reflect the need for the service. Fluorides: An estimate of 10 percent was used in the model to project the proportion of adults at increased risk of active dental disease and who would benefit from professionally applied fluoride treatments. The National Institute of Dental Research (NIDR) conducted a 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors and reported that the decayed component (D) of caries scores (unrestored tooth surfaces) comprised approximately 8 percent in employed adults and 9 percent in seniors of the decayed and filled tooth scores (DFT). Cleanings: Approximately 89 percent of the adult population aged 18 and older is classified as dentate (with some teeth). The proportion of dentate adults requiring "oral prophylaxis" (cleanings) is estimated at 45 percent. The projection is based on data from the 1985-86 NIDR National Survey of Oral Health in U.S. Employed Adults and Seniors -- 43.6 percent of employed adults (dentate) aged 18-64+ years were reported with gingiva bleeding in at least one site.

4. Utilization rate: National dental care utilization data (NHIS, 1989) reports an annual utilization rate of approximately 50% for adults. Because this amendment would bring preventive dental care to individuals currently without it, a significant number of those newly eligible for coverage will be low income adults. For these people, finances are not the only barrier to access, and their utilization rates are significantly below the overall adult average. Adult utilization of Medicaid dental benefits, for example, averages 35%, as reported by the Department of Health Policy and Epidemiology, Harvard School of Dental Medicine. A 60 percent utilization rate for basic services was used, which provides quite a large "cushion".

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5. Cost/unit: Cost estimates for individual clinical-based services are based on 1985 median fees (50th percentile of general practitioner fees) from the most recent [illegible]rehensive survey of dentists conducted by the American Dental Association and adjusted to 1994 dollars.

6. Only first year cost projections are given. The out years should be costed at the Consumer Price Index rate, using whatever assumptions are being applied to the bill generally. Growth in the price of dental services continues to be lower than the CPI for physician and hospital services. The preventive services proposed are least subject to upward inflation. Thus an annual increase at the CPI rate should be used.

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of Hospital Dentists

April 29, 1994

Mr. Mike Carter
Hay Huggins Co, Inc.
1500 K St., N.W.
Suite 1000
AAHD Washington, DC 20005

Dear Mr. Carter:

On behalf of the American Association of Hospital Dentists, I would like to thank you for this opportunity to assist you in costing out a "medically necessary oral health care" add-on to Mr. Dingell's proposal. We currently define medically necessary oral health care as "a direct result of, or having direct impact on a medical condition". The provision of this care provides for elimination of infection, pain and reestablishment of function.

Examples of various medical conditions which require adequate and appropriate medically necessary oral health care include diabetes, cancer, heart defects, hemophilia, HIV disease, organ transplantation, renal dialysis, congenital and heredity disorders and those diseases we consider orphan diseases such as Sjogren's Syndrome.

The enclosed cost-out for medically necessary oral health care includes the disease entities which I have mentioned above and defines the critical services that must be provided to effect optimal health outcomes. We have made a number of assumptions in the calculations which include:

- The total number of cases documented under each disease entity is the calculated total of individuals between 18 and 65. That is, we have made the assumption that those under 18 would be covered under the Health Security Act and those over 65 would be considered under any future proposed Medicare changes. Our calculation is based on 1990 census data.

- We have made the assumption that utilization for these services would be on the order of 65%. The Public Health Service currently estimates that utilization for the population at large currently is between 55% and 60%.

- The cost estimates and disease category definitions assume that this is an add-on to the existing Health Security Act.

- The chemotherapy category is a "catch-all" for all those receiving chemotherapy including patients with leukemia.

- The patients in the HIV category include those on disease-related therapies, i.e., not including those who are asymptomatic. These patients will necessitate approximately two exams per year or more due to their suppressed immune status and continually changing oral health status.

- Under the orphan disease category we must note that Sjogren's Syndrome patients may have an increased need for cleanings and fluoride treatment. This population will require more regular and routine protection of their hard and soft tissues due to the nature of the disease process.

- The estimates for the developmental and acquired maxillofacial defects include patients with ectodermal dysplasia as well as those receiving surgical resection for head and neck cancers. This group is covered under the radiation and/or orphan disease categories for the Initial Workup and Treatment as well as the Primary Care Maintenance. However, this group does necessitate the additional services of functional restorations.

- Elimination of infection has been estimated by a non-random survey to approximate the cost of extracting six teeth. Clearly there are some individuals who present with no need for extractions and others who present for extraction of entire sets of teeth. This estimate is anecdotally accurate and appropriate.

- The Dental Fees used for the respective calculations were taken from the 1993 ADA Survey of Dental Fees with the exception of functional restorations for Developmental and Acquired Maxillofacial Defects. Frequencies were gathered from the Journal of Prosthetic Dentistry and the cost from personal communication.

- The restorative component under Primary Care Maintenance was calculated for cavities on the crown and root surfaces, respectively. The Public Health Service has estimated that a factor of 1.3 surfaces is restored on the crown in the general population and 0.4 surfaces restored on the root structure. The average restoration cost of $51.20 was used to compute the final cost.

- Fluoride treatment will apply only to patients at high risk for cavities. Therefore although we have assigned fluoride treatment to all medically compromised groups, most treatment will be limited to chemotherapy, HIV, orphan diseases, and radiation.

There are special needs patient populations which include children with baby bottle syndrome and those with handicapping malocclusions which have not been included in this cost out. Baby bottle syndrome is assumed to be covered under the existing Health Security Act. However, handicapping malocclusions due to malformed jaws is an issue and condition which should be addressed for adults as well as children. The reestablishment of function for these individuals is critical for their day-to-day existence.

As a final note, we made some estimates on the potential cost of not providing the medically necessary dental care. For example it is estimated that between 10-15% (personal communication) of all patients undergoing head and neck radiation for malignancy will develop a condition called osteoradionecrosis without appropriate oral care. Osteoradionecrosis occurs when blood vessels in the path of the radiation beam become thicker causing impaired circulation to the jaw bone resulting in bone death. Individuals in poor dental health frequently develop osteoradionecrosis due to tooth and gum-related infections. In 20% of these cases, patients must undergo extensive and expensive hyperbaric oxygen therapy. This estimate alone is in excess of 60% higher than the <u>total</u> cost of care provided to the <u>entire</u> radiation patient population!

Please feel free to contact me if you have any questions or comments concerning these figures. We feel our estimates are sound. Again, anecdotal evidence indicates that not providing the medically necessary oral health care can ultimately cost the system magnitudes higher in terms of adverse health outcomes and real dollars. Thank you very much for this opportunity.

Sincerely yours,

John S. Rutkauskas, MS, DDS
Executive Director

JSR/bw
cc: Ms. Dorothy Moss, ADA Washington Office
Mr. Craig Palmer, ADA Washington Office
Federation Board of Directors

Medically Necessary Oral Health Care					
65% UR	Chemotherapy (174,556)	Diabetes (809,200)	Heart Defects (21,320)	Hemophilia (11,560)	HIV (289,200)
Initial Workup and Treatment					
a. Exam	3,971,149	18,409,300	507,780	262,990	6,579,300
b. Radiograph	5,105,763	23,669,100	652,860	338,130	8,459,100
c. Periodontal Scaling to Reduce Inflammation	7,601,914	35,240,660	972,036	503,438	12,594,660
d. Fluoride Treatment	1,701,921	7,889,700	217,620	112,710	2,819,700
e. Elimination of Infection	34,492,266	159,897,920	4,410,432	2,284,256	57,145,920
Subtotal	52,873,019	245,106,680	6,760,728	3,501,524	87,596,680
Primary Care Maintenance					
a. Periodic Exam 1x/yr	1,928,844	8,941,660	246,636	127,738	9,586,980
b. Bitewings 1x/yr	1,815,382	8,415,680	232,128	120,224	3,007,680
c. Prophylaxis 2x/yr	884,990	41,026,440	1,131,624	586,092	1,466,240
d. Restorative					
I. Coronal Caries	11,618,447	35,009,228	965,653	500,132	12,511,948
II. Root Caries	2,323,684	10,772,070	297,124	153,887	3,849,830
Functional Restoration					
Subtotal	18,571,347	106,165,078	2,873,165	1,488,073	30,422,678
Total	71,444,360	349,271,758	9,633,893	4,989,597	118,021,358

Medically Necessary Oral Health Care					
65% UR	Orphan Diseases (346,800)	Radiation (14,450)	Renal Dialysis (171,088)	Transplantation (13,838)	Developmental and Acquired Maxillofacial Defects (17,480)
Initial Workup and Treatment					
a. Exam	7,089,700	328,736	3,892,252	314,815	
b. Radiograph	10,143,900	422,663	5,004,324	404,762	
c. Periodontal Scaling to Reduce Inflammation	15,103,140	629,298	7,450,882	602,645	
d. Fluoride Treatment	3,381,300	140,888	166,811	134,921	
e. Elimination of Infection	68,527,680	2,855,320	33,806,988	2,734,389	
Subtotal	105,045,720	4,376,907	50,321,257	4,191,532	
Primary Care Maintenance					
a. Periodic Exam 1x/yr	3,832,140	159,673	1,890,522	152,910	
b. Bitewings 1x/yr	3,606,720	150,280	1,779,315	143,915	
c. Prophylaxis 2x/yr	17,502,760	732,616	8,674,162	701,586	
d. Restorative					
I. Coronal Caries	15,003,955	625,165	7,401,951	598,687	
II. Root Caries	4,636,602	295,936	2,277,523	184,211	
Functional Restoration					46,558,000
Subtotal	44,642,177	1,963,670	22,023,473	1,781,309	46,558,000
Total	149,687,897	6,340,577	72,344,730	5,972,841	46,558,000

of Hospital Dentists Chicago, IL 60611
312.440 2661

May 4, 1994

Mr. Mike Carter
Ray Huggins Co, Inc.
1500 K St., N.W.
Suite 1000
Washington, DC 20005

Dear Mr. Carter:

It's been a pleasure to continue to work with you on the important issue of medically necessary oral health care. As I had mentioned to you over the phone, one population which we neglected to include is that of the profoundly and severely developmentally disabled. I have enclosed the spread sheet for this medical category.

AAHD

Please find below a sample calculation for the group of radiation patients.

Radiation Therapy Patients

- Those receiving radiation therapy of the head and neck, including those with Hodgkins Disease -- 25,000 per year for all ages.
- Approximately 57.8% of the population is in the 18-65 age group based on 1990 census data.
- 14,450 therefore would potentially be covered under the proposed plan. With a 65% utilization rate, approximately 9392.5 individuals would access services.
- Fees: these estimates are taken from the 1993 ADA survey of dental fees at the 50th percentile. The only exceptions are those for examinations under initial workup and treatment which were calculated at the 80th percentile due to the extensive nature of the exams and estimates for restorations which were calculated at $51.20 by the Public Health Service.

a. Examination	$ 35.00	x	9392.5	=	$ 328,738
b. Radiograph	$ 45.00	x	9392.5	=	$ 422,663
c. Periodontal	$ 67.00	x	9392.5	=	$ 629,298
d. Fluoride Treatment	$ 15.00	x	9392.5	=	$ 140,888
e. Elimination of Infection	$304.00	x	9392.5	=	$2,855,320
					$4,376,907
a. Periodic Exam	$ 17.00	x	9392.5	=	$ 159,673
b. Bitewings	$ 16.00	x	9392.5	=	$ 150,280
c. Prophylaxis	($ 39x2)	x	9392.5	=	$ 732,616
d. Restorative Coronal	$ 51.20 x 1.3 surfaces	x	9392.5	=	$ 625,165
Root	$51.20 x 0.4 surfaces	x	9392.5	=	$ 192,358
					$1,860,092
				Total	$6,236,999

- Cost of treatment for osteoradionecrosis as a result of not providing care:

  10-15% of 14,450 will develop osteoradionecrosis due to inadequate oral care.

  Additionally, 20% of 1445 will necessitate hyperbaric oxygen therapy to treat the problem at a cost of $35,000 per case.

  289 cases of hyperbaric oxygen therapy x $35,000 = $10,115,000

  This is in excess of 60% of the $6,236,999 of total care provided to all radiation patients.

  Please let me know if there are any further questions.

Sincerely,

John S. Rutkauskas, MS, DDS
Executive Director

JSR/bw
cc: Ms. Dorothy Moss, ADA Washington Office
Mr. Craig Palmer, ADA Washington Office
Federation Board of Directors

Medically Necessary Oral Health Care	
65% UR	Developmental Disabilities (1,676,200)
Initial Workup and Treatment	
a. Exam	38,133,550
b. Radiograph	49,020,850
c. Periodontal Scaling to Reduce Inflammation	72,998,510
d. Fluoride Treatment	16,342,950
e. Elimination of Infection	331,217,120
Subtotal	507,753,980
Primary Care Maintenance	
a. Periodic Exam 1x/yr	18,522,010
b. Bitewings 1x/yr	17,432,480
c. Prophylaxis 2x/yr	84,963,340
d. Restorative	
I. Coronal Caries	72,519,117
II. Root Caries	22,313,574
Functional Restoration	
Subtotal	215,770,521
Total	723,524,501

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