MENTAL HEALTH/SUBSTANCE ABUSE PROVISIONS WITHIN THE HEALTH SECURITY ACT

MENTAL HEALTH, SUBSTANCE ABUSE COVERAGE PROVISIONS
TITLE I (§§ 1115, 1122, 1127, 1131-1135)
Title II (§ 2001)

IN GENERAL

The comprehensive benefit package proposed in the Health Security Act includes a full range of mental health and substance abuse services, as described by § 1115 of the Act.

In general, § 1115 provides for the coverage of three categories of mental health and substance abuse services:

(1) Inpatient and residential mental health and substance abuse treatment;

(2) Intensive nonresidential mental health and substance abuse treatment; and

(3) outpatient mental health and substance abuse treatment, including case management, screening and assessment, crisis services and collateral services.

ELIGIBILITY

An individual is eligible to receive inpatient and residential, intensive nonresidential and outpatient treatment coverage if that individual:

(1) has or has had, during the one year period prior to the date of such treatment, a diagnosable mental health or substance abuse disorder; and

(2) is experiencing, is at significant risk of experiencing, would be experiencing, or would be at serious risk of experiencing a functional impairment in family, work, school or community activities.

As defined by the Act, a diagnosable mental health and substance abuse disorder is one that is listed in the most recent Diagnostic Statistical Manual (DSM; currently DSM-III Revised), except for codes for conditions not attributable to a mental disorder that are a focus of attention or treatment; is the equivalent of a DSM disorder, but is listed in the most recent International Classification of Diseases, Ninth Revision, Clinical Modification (currently Third Edition); or is listed in any authoritative text specifying diagnostic criteria for mental health or substance abuse disorders that is identified by the newly established National Health Board.

In addition, notwithstanding the above diagnosis eligibility limitations, an individual may receive case management services if a health professional, designated by the health plan in question, determines that the individual should receive such case management services. Case management services are those that assist individuals in gaining access to needed medical, social, educational or other services.

Further, regardless of any prior diagnoses, all individuals receiving health coverage are eligible to receive coverage for outpatient mental health and substance abuse treatment screening and assessment and crisis services

Finally, an individual is eligible to receive outpatient mental health and substance abuse treatment collateral services if the individual is a direct family member of an individual who is receiving inpatient, residential, intensive nonresidential or outpatient mental health or substance abuse treatment.

TYPES OF TREATMENT

Inpatient and Residential Treatment:

Coverage

Inpatient and residential treatment is a covered benefit under the Health Security Act when it is provided for purposes of treating an individual's diagnosable mental health issue or diagnosable substance abuse issue.

On an inpatient basis, treatment coverage is available to an inpatient of a hospital, psychiatric hospital[1], residential treatment center, residential detoxification center, crisis residential program or a mental health residential treatment program.

On the residential basis, treatment coverage is available to a resident of a therapeutic home or community treatment and recovery center for substance abuse.

The Act gives the newly established National Health Board the authority to determine which health professional services are covered on an inpatient and residential basis.

Limitations

In addition to depicting which inpatient and residential treatment services would be covered, the Act sets forth certain limitations to coverage.

First, the Act covers inpatient and residential treatment only when such treatment is provided in the least restrictive environment. The bill provides the following description for the least restrictive environment:

> the least restrictive inpatient or residential inpatient or residential setting that is effective and appropriate for the individual, and when least restrictive intensive nonresidential or outpatient treatment would be ineffective or inappropriate.

---

[1] The Act adopts the definition of "psychiatric hospital" that is provided by § 1861(f) of the Social Security Act.

In addition, the bill sets forth specific limitations with regard to the coverage of residential mental health treatment and residential substance abuse treatment.

Residential mental health treatment 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 is question. Meanwhile, residential substance abuse treatment is covered only if a health professional, as designated by the health plan in question, determines that the individual should receive such treatment. The health plan in question may choose the criteria on which its residential substance abuse treatment determination is to be based.

Finally, with regard to inpatient hospital treatment for substance abuse, inpatient and residential treatment coverage (as provided for by this section) is provided only for detoxification requiring the management of psychiatric conditions associated with substance abuse withdrawal. However, although medical detoxification is not covered by § 1115 of the Health Security Act benefit package, it is a covered benefit under § 1111 ("hospital services") of the Act.

Annual Limit

The Act sets forth a defined limit on the number of days inpatient and residential treatment an individual can receive coverage. Prior to January 1, 2001, this maximum number of days is generally limited to 30 days.

Nonetheless, the Act provides that an additional 30 days of inpatient and residential treatment coverage is available to an individual if one of the two following circumstances are met. First, an additional 30 days of inpatient and residential treatment coverage is available to an individual if a health professional designated by the health plan in question determines in advance that such individual poses a threat to that person's own life or the life of another.[2] Second, an additional 30 days of such treatment coverage is available to an individual if the medical condition of such individual requires inpatient treatment in a hospital to initiate a change or adjust a pharmacological therapy.

Intensive Nonresidential Treatment

Coverage

The comprehensive benefit plan secondly provides coverage for intensive nonresidential mental health and substance abuse diagnostic and therapeutic services which are provided to an individual to treat such person's diagnosable mental health or diagnosable substance abuse issue.

---

[2] The Act provides that such determination is to be made "in advance." Although somewhat ambiguous as to what "in advance" refers, it would seem as if the "in advance" language would require that the health professional determination be made only prior to the time additional days of coverage would be needed. As such, it does not appear as though the "in advance" determination would have to be made until after the initial 30 days of inpatient and residential treatment coverage were used up. This interpretation also seems common sensical. Otherwise, the health professional may be compelled to make the determination regarding life being threatened at a premature, and thus, inappropriate time, at least with respect to additional days of coverage.

This category includes coverage to an individual who is participating in a partial hospitalization program, a day treatment program, a psychiatric rehabilitation center program, or an ambulatory nonmedical detoxification program. In addition, coverage is provided to an individual receiving home-based mental health services or behavioral aid mental health services.

The Act gives the newly established National Health Board the authority to determine which health professional services are covered on an inpatient and residential basis.

Limitations

Health Security Act coverage for intensive nonresidential mental health and substance abuse treatment is subject to several limitations.

First, the health professional designated by the health plan in question must determine, based on criteria established by that health plan, that the individual is in need of intensive nonresidential treatment.

Next, the health plan in question is required to provide intensive nonresidential treatment only when such treatment satisfies one of the following four criteria:

(1) that such treatment will avert the need for, or is an appropriate alternative to, treatment in a residential or an inpatient setting;

(2) that such treatment will facilitate the earlier discharge of an individual who is receiving inpatient or residential care;

(3) that such treatment will likely restore the functioning of an individual with a diagnosable mental health or substance abuse issue;[3] or

(4) that such treatment will assist the individual to develop skills and gain access to support services that the individual needs to achieve the maximum level of functioning within the community.[4]

Finally, intensive nonresidential treatment consisting of detoxification is to be covered only when such detoxification is provided within the context of a treatment program.

---

[3] Although not specifically set out, it would appear as though "functioning" refers to the individual's ability to accomplish daily life activities, including, but not necessarily limited to, living independently, working, and learning.

[4] This fourth category could arguably be interpreted very broadly.

Annual Limit

Prior to January 1, 2001, the annual limit for intensive nonresidential treatment will be derived as follows:

> for each two days of coverage of intensive nonresidential mental health and substance abuse treatment, the number of covered days of inpatient and residential mental health and substance abuse treatment that are available to an individual under the 30 day limit, discussed *supra*, will be reduced by one day.

That is, for each two days of intensive nonresidential treatment coverage, the annual limit for inpatient and residential treatment is to be reduced by one day. As such, two days of intensive nonresidential coverage signifies one day of inpatient and residential coverage, for annual limit purposes.[5]

In addition to this initial annual limit, the Act provides for an additional 60 days of intensive nonresidential treatment if a health professional designated by the health plan in question determines that such individual should receive additional intensive nonresidential treatment.[6]

Impact on Satisfying Out-of-Pocket Limit

The Health Security Act gives the individual the choice of one of three cost sharing schedules -- a lower cost sharing schedule, a higher cost sharing schedule, or a combination cost sharing schedule. Under any one of these plans, the Act provides financial security to the individual and family by instituting an annual out-of-pocket limit that an individual or family must pay. The out-of-pocket individual limit is $1,500, while the out-of-pocket family limit is $3,000.

Despite these provisions, however, the Act provides that, prior to January 1, 2001, out-of-pocket expenses for intensive nonresidential mental health and substance abuse treatment may not be applied toward any out-of-pocket limit if (1) such treatment is for a substance abuse treatment **or** (2) such treatment is pursuant to an additional 60 days of intensive nonresidential treatment coverage. As such, the only intensive nonresidential out-of-pocket treatment expenses that may count toward satisfying the $1,500 individual out-of-pocket limit or the $3,000 family out-of-pocket limit, prior to January 1, 2001, is for treatment provided for a mental health issue pursuant to the initial 30 day annual limit.

---

[5] Textually, the Act does not describe how the 30 day limit for inpatient and residential treatment would be impacted if the number of covered days for intensive nonresidential treatment is an odd or fractional number, as opposed to a round, even number.

[6] It would appear as though the health professional's determination must be within the parameters of the limitations discussed for intensive nonresidential treatment, *supra*.

Outpatient Treatment

The comprehensive benefit plan next provides coverage for outpatient mental health and substance abuse treatment. Such treatment is available with regard to an individual's diagnosable mental health or substance abuse disorder.

This treatment category includes coverage for outpatient setting screening and assessment, diagnosis, medical management, substance abuse counseling, relapse prevention, crisis services, somatic treatment services, psychotherapy, case management and collateral services.

Limitations

Outpatient treatment is covered only when it is provided by a physician or another person who is legally authorized by the applicable state to provide such services.

Further, coverage may not be provided unless a health professional designated by the health plan in question determines that the individual should receive such treatment.

Annual Limit

Psychotherapy and Collateral Services: Prior to January 1, 2001, outpatient psychotherapy and collateral service coverage is subject to the aggregate annual limit of 30 visits per individual. Additional visits may be covered to help prevent hospitalization or facilitate earlier hospital release for the individual. There is a limit to additional days that can be provided, as tied into the 30 day maximum for inpatient and residential treatment. Specifically, the 30 day limit for inpatient and residential treatment will be reduced by one day for each four additional visits provided for outpatient psychotherapy and collateral services coverage.[7] After the 30 days allotted for inpatient and residential coverage are exhausted, no more additional days of outpatient psychotherapy or collateral services will be provided. Decisions on coverage for additional visits are to be made by the health professional designated by the health plan in question.

Substance Abuse Counseling and Relapse Prevention: The number of days of inpatient and residential treatment that are annually available to the individual will be reduced by one day for each four visits for outpatient substance abuse counseling or relapse prevention. After the 30 days of inpatient and residential treatment coverage are exhausted, no visits for substance abuse counseling or relapse prevention will be covered.[8]

---

[7] Textually, the Act does not describe how the 30 day limit for inpatient and residential treatment would be impacted if the number of additional covered days for outpatient psychotherapy and collateral services treatment is an odd or fractional number, as opposed to a round, even number.

[8] Textually, the Act does not describe how the 30 day limit for inpatient and residential treatment would be impacted if the number of additional covered days for outpatient substance abuse counseling and relapse prevention is an odd or fractional number, as opposed to a round, even number.

In addition, prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of group therapy will be subject to its own annual limit of 30 visits per individual. In order for such group therapy to be covered, it must occur within one year after the individual has received inpatient, residential or intensive nonresidential mental health or substance abuse treatment with regard to a diagnosable mental health or substance abuse issue.

Impact on Satisfying Out-of-Pocket Limit

Prior to January 1, 2001, out-of-pocket expenses that an individual pays for outpatient mental health and substance abuse treatment may not be applied toward any out-of-pocket limit on cost sharing.[9]

Health Education Classes

Section 1127 of the Act provides that a health benefit plan in question, at its own discretion, may provide health insurance coverage for health education and training classes. Such classes may focus on reducing behavioral risk factors and promoting health activities. Such classes may concentrate on, among other things, stress management, support groups, smoking cessation, nutrition counseling and physical training. It would, therefore, appear as though health education classes relating to mental health and substance abuse could be covered under the comprehensive benefit plan.

Prescription Drugs

The Health Security Act would provide for the coverage of outpatient prescription drugs and biologicals, as well as amend the Medicare Program to provide for the coverage of outpatient prescription drugs and biologicals for Older Americans. Such coverage would appear to extend to psychotropic and other drugs to treat mental health disorders, such as thought and mood disorders, and substance abuse disorders.

COST SHARING PROVISIONS

In General

The Health Security Act would provide the individual the choice of one of three cost sharing schedules -- a lower cost sharing schedule, a higher cost sharing schedule, or a combination cost sharing schedule. All complying health plans must offer enrollees the choice of these cost schedules.

---

[9] See "Intensive Nonresidential Treatment" section, *supra*, for additional information on Health Security Act out-of-pocket maximums.

Under the lower cost sharing schedule, the individual would not be required to pay any initial deductible, but would be restricted to an in-network choice providers, services and items. An individual utilizing in-network providers, services or items, would not be required to pay any co-insurance for such in-network resources, and would only be responsible for a small co-payment, if any. The individual would also have the option to go out-of-network. There would be an out-of-network coinsurance obligation of at least 20 percent. Further, if coinsurance under the higher cost sharing option, *infra*, is greater than 20 percent, the National Health Board has authority to specify a higher percentage for out-of-network coinsurance obligations.

Under the higher cost sharing schedule, the individual would not be restricted as to an in-network choice of providers. As such, the individual would not have to be concerned as to whether a particular service or item was provided in- or out-of-network. The higher cost sharing schedule would require an initial deductible of $200 for an individual and $400 for a family for all items and services in the comprehensive benefit package. The higher cost sharing schedule would also require a coinsurance payment, typically 20 percent, for package services and items.

Meanwhile, under the combination cost sharing schedule, the individual would have access to the dual mix of lower cost sharing and higher cost sharing arrangements. If the individual chooses to utilize in-network services or items, that individual would pay in accordance with in-network lower cost sharing arrangements: no deductible, no coinsurance, and a small copayment, if any. If the individual chooses to utilize services or items that are not within the network, the individual would pay in accordance with the higher cost-sharing arrangement: initial deductible of $200 for an individual and $400 for a family and a coinsurance payment, typically 20 percent, for package services and items.

Mental Health and Substance Abuse, Specifically

Below is a table depicting the lower cost sharing and higher cost sharing payment arrangement provisions with respect to mental health and substance abuse services provided pursuant to the Health Security Act comprehensive benefit package. (From these higher cost sharing and lower cost sharing amounts, combination cost sharing amounts can also be determined.)

Benefit	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient and Residential mental health and substance abuse treatment.	~~$25~~ per visit. → $10	Coinsurance of ~~50~~ 20 percent of applicable payment rate.
Intensive Nonresidential Mental Health and Substance Abuse Treatment.	No copayment for initial days, but $25 per visit for additional days (see "Intensive Nonresidential Treatment" Section for further explanation of "initial" and "additional" days, *supra*.)	Coinsurance of 20 percent of applicable payment rate for initial days, but 50 percent of applicable payment rate for additional days.
Outpatient mental health and substance abuse treatment (except psychotherapy, collateral services and case management.	~~$10~~ 25 per visit.	Coinsurance of ~~20~~ 50 percent of applicable payment rate.
Outpatient psychotherapy and collateral services.	$25 per visit until January 1, 2001, and $10 per visit after January 1, 2001.	Coinsurance of 50 percent of applicable payment rate until January 1, 2001, and 20 percent after January 1, 2001.
Case Management.	$10 per visit	Coinsurance of 20 percent of applicable payment rate.
Health Education Classes.	To be determined by health plan.	To be determined by health plan.
Prescription drugs and biologicals.	$5 per prescription.	Coinsurance of 20 percent of applicable payment rate.

In addition, under the higher cost sharing schedule, there is an initial deductible for inpatient and residential treatment and intensive nonresidential mental health and substance abuse treatment, which must be paid separate from and in addition to general higher cost sharing schedule deductible of $200 per individual and $400 per family. This deductible is equal to the cost of one day of such treatment provided. Further, under the higher cost sharing schedule, there is a separate and additional deductible for outpatient prescription drugs and biologicals. This deductible is $250 for such prescriptions and biologicals.

MENTAL HEALTH/SUBSTANCE ABUSE LOAN ASSISTANCE AND SUPPLEMENTAL GRANT PAYMENTS TO STATES
Title III (§§ 3441, 3501-3503)

IN GENERAL

The Health Security Act would create a new program to provide loan assistance to non-acute, residential treatment centers and community-based ambulatory clinics, as well as make supplemental substance abuse and mental health formula grant payments to the states. To carry out program activities, the Act authorizes $100 million in FY 95, $150 million in FY 96 and $250 million for each of FYs 97 through 2000.

LOAN ASSISTANCE PROGRAM

Under the program, the Secretary of Health and Human Services (HHS)[10] may reserve as much of the program monies to make loans and loan guarantees to public and private entities to assist such entities with the capital costs incurred by entities in the development of mental health and substance abuse non-acute, residential treatment centers and community-based ambulatory clinics.

From the text of the Act,[11] it appears as though loans and loan guarantees can be utilized for, among other things:

- the acquisition, modernization, expansion or construction of facilities;
- purchase of major equipment, including equipment necessary for the support of external and internal information systems;
- establishment of reserves required for furnishing services on a prepaid basis; and
- such other capital costs as HHS may decide.

---

[10] Although the Act authorizes the Secretary of Health and Human Services (HHS) to carry out the program, it is likely that program responsibilities will be delegated to HHS' Substance Abuse and Mental Health Services Administration (SAMHSA), with further delegations made to the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT).

[11] The Act provides that loan assistance for residential treatment centers and ambulatory clinics is to be made in accordance with the procedures of subpart C of Part 2 of subtitle E of Title III of this Act. Subpart C (§§ 3441-3446 of the Act) details a program on assistance for capital cost assistance for the development of community health plans and practice networks. In particular, subpart C includes provisions on: preferences and accessibility of services; use of assistance; loan and loan guarantee requirements and terms and conditions; right of recovery upon default; a 20-year right of recovery provision; provisions regarding construction or expansion of facilities; application for assistance provisions; and general program administration provisions. It could logically be argued that the residential centers and ambulatory clinics loan assistance initiative should be governed by all these above-mentioned provisions. However, one could also interpret the residential treatment centers and ambulatory clinic initiative's provisions to mean the incorporation of just some of the community health plan and practice network initiative provisions.

In making loans and loan guarantees, HHS must give priority to projects located in underserved areas, that is, for centers and clinics in areas with a health professions shortage or with significant numbers of medically underserved individuals.

SUPPLEMENTAL PAYMENTS TO STATES

Of the program monies not expended for the loan initiative, such remaining funds are to be equally divided in order to make supplemental grant payments to states under (1) the Prevention and Treatment of Substance Abuse Block Grant Program (the Substance Abuse Block Grant Program) and (2) the Mental Health Services Block Grant Program.

Supplemental monies are to be used to increase access to state mental health and substance abuse services. Purposes for which these additional funds may be used include:

- transportation and translation assistance, patient and community outreach, patient education, and other services HHS deems appropriate for increasing access to mental health and substance abuse services in the state;

- improving capacity of state and local service systems to coordinate, link and monitor mental health and substance abuse services, improving information systems, and establishing linkages between mental health and substance abuse services and primary care providers and health plans;

- providing incentives to integrate public and private systems for treatment of mental health and substance abuse treatment systems; and

- activities approved under the Substance Abuse Block Grant Program and the Mental Health Services Block Grant Program.

There is a maintenance of effort (MoE) requirement built into this supplemental grant assistance initiative. Specifically, in order to receive supplemental funds, a state must maintain expenditures of nonfederal amounts for substance abuse and mental health activities at the level spent in the fiscal year preceding the first year for which that state receives the supplemental grant. The Act gives HHS the authority to waive this MoE requirement under certain conditions.

HHS is to establish application and deadline procedures, as well as to set forth any agreements, assurances and information it deems necessary to make supplemental awards.

REPORT ON INTEGRATION OF MENTAL HEALTH SYSTEMS
Title III (§ 3511)

Prior to October 1, 1998, each state participating under the Health Security Act is required to submit a report to HHS on the measures utilized by that state to integrate its mental health and substance abuse services with those mental health and substance abuse services included within the comprehensive benefit package of the Health Security Act.

PILOT PROGRAM TO INTEGRATE MENTAL HEALTH, SUBSTANCE ABUSE SERVICES
Title III (§ 3521)

The Act mandates that HHS establish a pilot program to demonstrate model methods of achieving integration of mental health and substance abuse services by states with those mental health and substance abuse services that are included within the Health Security Act's comprehensive benefit package.

In carrying out the pilot program, HHS is to consider, among other things: the types of mental health and substance abuse items and services included within the comprehensive benefit package; optimal methods of treating individuals with long-term mental illness or substance abuse problems; the capacity of alliance health plans to furnish long-term treatment; modifications that should be made with regard to health plan mental health and substance abuse services; and the role of publicly-funded health providers in the integration of acute and long-term mental health and substance abuse treatment.

COMPREHENSIVE SCHOOL HEALTH EDUCATION, SCHOOL-RELATED HEALTH SERVICES
Title III (§§ 3601-3692)

The Health Security Act would establish a comprehensive school health education program for states and local education agencies and a school-related health services program. The programs would support K-12 comprehensive health education programs that address locally relevant priorities, as well as establish a national framework within which states can create comprehensive school health education programs.

Although these programs are not specifically targeted toward mental health or substance abuse, the initiative could still address issues relating to mental health and substance abuse. In fact, the Act's language on setting up a national framework for comprehensive school health education programs specifically include targeting "tobacco use, alcohol and other drug use."

There is authorized $50 million for each of the FYs 95 through 2000 to carry out the school health education grants program to state and local education agencies. Meanwhile, for the school-related health services program, there is authorized $100 million for FY 96, $275 million for FY 97, $350 million for FY 98 and $400 million for each of the FYs 99 and 2000 to carry out the program.

DESCRIPTION OF EXISTING FEDERAL SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAMS[12]

IN GENERAL

In addition to the mental health and substance abuse coverage and programs that are part of the Health Security Act, the federal government would continue to fund several other substance abuse and mental health formula and discretionary programs.

The bulk of this additional federal commitment would continue in the form of formula, or block, grants to the 50 states, Puerto Rico, the District of Columbia and the U.S. territories (*hereinafter*, states). Under these block grant programs, eligible entities receive mental health and substance abuse funds pursuant to a congressionally-defined mathematical formula, taking into account such factors as a state's population and taxable resources.

In addition, the federal government would sponsor several substance abuse and mental health categorical, or discretionary, grant programs. Under these programs, defined entities submit program applications pursuant to an established deadline in order to compete for funds with other eligible entities.

ADMINISTERING FEDERAL AGENCIES

The federal agency that administers most of these additional formula and discretionary grant programs are located within the Department of Health and Human Services (HHS).

There will continue to be the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of HHS' much larger Public Health Service.[13]

---

[12] Primary reference sources for this section were Administration's Office of National Drug Control Policy, National Drug Control Strategy: Budget Summary (1994); Department of Health and Human Services, 1994 Budget Request for the Department of Health and Human Services (1994); C. Edwards, et al. Guide to Federal Funding for Anti-Drug Programs (1993).

[13] Prior to the ADAMHA Reorganization Act of 1992 (P.L. 102-321), the forerunner to SAMHSA was the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Under ADAMHA were the Office for Treatment Improvement (OTI), the Office for Substance Abuse Prevention (OSAP), the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute of Mental Health (NIMH).

The 1992 Act made several changes with regard to how the federal government administered its major substance abuse and mental health programs. First, in an effort to put mental health at parity with substance abuse and better administer mental health service delivery programs, the Act created the new Center for Mental Health Services (CMHS). Next, in an effort to give mental health and substance abuse research full-fledged status within the National Institutes of Health (NIH), the Act moved NIDA, NIAAA, and NIMH into NIH, as equal partners with NIH's other research institutes and centers. The Act also renamed OTI the Center for Substance Abuse Treatment (CSAT) and OSAP the Center for Substance Abuse Prevention (CSAP). In addition, the Act created, among other offices, the Office for Women's Services, to more adequately focus on the special mental health and substance abuse needs of women.

Within SAMHSA are located:

- the Center for Mental Health Services, which is responsible for the federal government's major mental health service delivery programs;

- the Center for Substance Abuse Treatment (CSAT), which has responsibility for the federal government's major substance abuse treatment programs; and

- the Center for Substance Abuse Prevention (CSAP), which has oversight of the federal government's major health-related substance abuse prevention efforts.

Next, the National Institutes of Health (NIH), another division of HHS' Public Health Service, will continue to house: the National Institute of Mental Health (NIMH), which has oversight of the federal government's major mental health research initiatives; the National Institute on Drug Abuse (NIDA), which is responsible for the federal government's major drug abuse research initiatives; and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), which oversees the federal government's major alcohol abuse research. In addition, for FY 95, President Clinton has proposed a new NIH Office of AIDS Research. Under this new office, various AIDS research efforts would be undertaken, some of which would involve the mental health and substance abuse aspects of HIV/AIDS.

Other Public Health Service agencies which will continue to provide either direct or collateral mental health and substance abuse grant-in-aid assistance include the Health Resources Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC).[14]

Finally, within HHS is located the Administration for Children and Families (ACF). While ACF does not specifically prioritize mental health and substance abuse, several of its programs, nonetheless, have a direct impact on mental health and substance abuse treatment and health prevention efforts.

While HHS funds several health-related substance abuse prevention efforts, the Department of Education, through its Drug-Free Schools and Communities Programs Division, provides both formula and discretionary grant assistance for the prevention of alcohol and other drug use by this nation's youth.

FORMULA GRANTS TO STATES

The major federal mental health and substance abuse formula grant programs are the Mental Health Services Block Grant Program, the Prevention and Treatment of Substance Abuse Block Grant Program, and the Drug-Free Schools and Communities Formula Grant Program to States. Below are brief descriptions of federal mental health and substance abuse formula grant programs,

---

[14] Although Congress recently renamed the Centers for Disease Control the Centers for Disease Control and Prevention, the center continues to use the acronym, "CDC." (emphasis supplied).

as well as a statement of the Clinton Administration's commitment for the continuation and expansion of these programs.

Mental Health Services Block Grant Program

Brief Description of Program: This program, administered by the Center for Mental Health Services (CMHS), makes formula grants to the states to provide supplemental monetary assistance to states in providing comprehensive community mental health services to their respective citizens. Grant monies can be used for, among other things: programs and activities to reduce mental health hospitalizations among adults and children with severe and chronic mental health issues; mental health outreach activities for individuals who are homeless; initiatives aimed at providing children with serious mental health issues with a system of integrated services (including social, educational, substance abuse and juvenile services); and other programs aimed at increasing the effectiveness and existence of community mental health services. As is the nature of a block grant program, states have wide discretion to determine how to use their Mental Health Services Block Grant monies. Possible subgrantees under this program include: mental health consumer-directed organizations (including clubhouse models), psychiatric and psychosocial rehabilitation centers, and community mental health centers.

Clinton Administration Recommendation: For FY 95, President Clinton has proposed just under $280 million for this program. This amount is similar to the amount the program has received for the past few years.

PATH Program for the Homeless

Brief Description of Program: The CMHS Projects for Assistance in Transition for Homelessness (PATH) Program provides formula grants to the states in order to help them provide housing and social services to individuals who are homeless and who have substance abuse and/or mental health issues. Services provided under this program include, among others: outreach services; screening and diagnostic treatment services; community mental health services; alcohol and drug treatment services; rehabilitation services; case management services; and residential supportive services.

Clinton Administration Recommendation: For FY 94, the PATH Program received $29.5 million. The Clinton Administration proposes to continue the program with the same amount for FY 95.

CMHS Protection and Advocacy Program

Brief Description of Program: Through CMHS formula grants to the states, this program provides financial support and technical assistance for programs that work to further the rights and protections of individuals receiving care and treatment at mental health facilities. While states are the direct beneficiary of program funds, they must pass all monies to public and private nonprofit protection and advocacy systems.

Clinton Budget Recommendation: For FY 94, protection and advocacy grants received just under $22 million. The same amount is proposed for FY 95 under the Clinton proposal.

Prevention and Treatment of Substance Abuse Program

Brief Description of Program: Under this program, which is administered by the Center for Substance Abuse Treatment (CSAT), the states receive formula grants to support various state efforts and programs to prevent and treat substance abuse. With their respective allotments, states are required to: expend 35 percent of their grant for the prevention and treatment of alcohol use and abuse; and 35 percent of their grant funds for the prevention and treatment of the use and abuse of drugs other than alcohol. In addition, 20 percent of respective state allotments must be used for prevention efforts geared toward individuals not requiring substance abuse treatment. Further, a portion of formula grant monies, about 5 percent, is to be used to increase substance abuse services for pregnant women and women with dependent children. Finally, the formula grant program sets forth requirements for states to: address the substance abuse needs of specific populations, including individuals with HIV/AIDS and Tuberculosis; provide for a revolving loan fund to assist group homes for recovering substance abusers; and establish laws to restrict anyone under 18 from using tobacco products.

Clinton Administration Recommendation: For FY 95, President Clinton has announced the administration's desire to increase funding for the federal government's Substance Abuse Block Grant Program. Funded just over $1.48 billion in FY 94, the program would receive a $310 million increase in FY 95, to more than $1.77 billion, under the Clinton proposal. These additional funds would be specifically earmarked for states to assist the hard-core drug user. This recommendation is consistent with the position of the Clinton Administration and the Office of National Drug Control Policy that more can and must be done to treat the chronic drug user.

Drug-Free Schools and Communities Formula Grant Program

Brief Description of Program: Under this program, administered by the Department of Education's Drug-Free Schools and Communities Division, the 50 states, Puerto Rico, the District of Columbia and the U.S. territories (*hereinafter*, states) receive formula grant allotments to assist state and local education agencies in providing community-based and school-setting drug and alcohol abuse education, prevention and referral assistance to this nation's youth. Formula allocations are based on states' respective school-age population. Among the many programs and activities that can be funded under this program are: substance abuse counseling programs for students, parents and other family members; referral programs for substance abuse treatment and prevention; public education efforts using health professionals and former substance abusers; primary prevention and early intervention services; and family programs, including those that raise substance abuse awareness levels.

Clinton Administration Recommendation: Although authorization for the Drug-Free Schools and Communities Formula and Discretionary Grant programs expires at the end of FY 94, President Clinton recommends reauthorizing and expanding the focus of the programs. Under the Clinton proposal, the Drug-Free Schools and Communities programs would be renamed the Safe and Drug-Free Schools and Communities programs. As such, the program would be extended to include activities to prevent violence as well as drug use. Funding-wise, the President proposes $480 million for the new formula program in FY 95. This is more than a $110 million increase above the roughly $370 million provided for the Drug-Free Schools and Communities Formula Grant program in FY 94.

Title XX Social Services Block Grant Program

Brief Description of Program: This program, although not specifically a mental health or substance abuse program, incorporates mental health and substance abuse elements. In brief, the program makes formula grants to states to help them provide various and sundry social services aimed at reducing and eliminating economic dependency. Pertinent services that can be supported by the block grant program include services for individuals with severe mental health and/or substance abuse issues. States have wide latitude as to how formula allotments are used.

Clinton Administration Recommendation: The Clinton Administration recommends $2.8 billion for this block grant program. This amount is identical to the amount provided in FY 94 for the Title XX Program, except that a later FY 94 supplemental appropriation of $1 billion was made to support the new Community Empowerment Initiative.[15]

DISCRETIONARY GRANT PROGRAMS

In General

As stated, *supra*, the large portion of federal mental health and substance abuse funds are allocated on a formula basis. However, the federal government also administers several mental health and substance abuse discretionary grant programs. While it is not suggested that the following list of mental health and substance abuse programs is exhaustive, the list, nonetheless, provides a good, and arguably comprehensive, understanding of what mental health and substance abuse programs currently exist within the federal government today.

SAMHSA's Center for Mental Health Services Programs

Children's Mental Health Program: The Comprehensive Community Mental Health Services for Children with Emotional Disturbances Program provides comprehensive community mental health services to children with serious mental health issues. Services that may be provided under this program include: diagnostic and evaluation services; intensive day treatment services; intensive home-based services; emergency services; outpatient services; respite care; therapeutic foster care services; and child-to-adult transitional services. Eligible to receive program funds on a competitive basis are state and local organizations and private nonprofit entities. For FY 95, President Clinton would continue to fund this program at $3.5 million.

---

[15] In particular, a total of $1 billion of the $3.8 billion appropriated for the Social Services Block Grant program in FY 94 was earmarked for the new Community Empowerment Initiative. Under this initiative, nine empowerment zones and 95 enterprise communities in the nation's most economically depressed areas will be established. Among other things, empowerment zones and enterprise communities can utilize initiative monies for drug and alcohol prevention and treatment programs to provide comprehensive services for pregnant women, mothers and their children. Social Services funds will be distributed in FYs 94 and 95

CMHS's Consolidated Demonstration Program: For FY 95, the Clinton Administration proposes the consolidation of several CMHS demonstration programs which functioned separately in FY 94 and prior fiscal years. Reasons for the consolidation include reducing the number of discrete grant announcements for drug control programs, simplifying application procedures for prospective grantees, and improving efficiency of the grant review process. Programs that would be consolidated under the Clinton plan include the following:

ACCESS Program for the Homeless -- The Access to Community Care and Effective Services and Supports (ACCESS) Program provides funds to expand mental health and substance abuse programs for individuals who are homeless. Eligible to receive program funds on a competitive basis are community-based public and private nonprofit organizations. For FY 94, this program received $21.4 million.

CMHS Community Support Program -- The CMHS Community Support Program is designed to promote the development of comprehensive, community-based systems of care for adults with serious and chronic mental health issues. Demonstration programs funded under this initiative are designed to help both the individual with mental health issues and the individual's family. State mental health agencies are eligible to receive program funds. For FY 94, the program received $24.4 million.

Clinical Training and AIDS Training -- Under this program, funds are available to train personnel in delivering mental health services to underserved populations, including children, adolescents and adults with mental health issues. There are four types of training available under this program: institutional clinical training; individual faculty scholar awards to enhance the futures of teachers in mental-health related fields; state human resource development awards; and training for depression awareness, recognition and treatment.

The total amount the Clinton Administration recommends for the proposed consolidated program is $47.3 million for FY 95.

CASS Program for Children and Adolescents: The Child and Adolescent Service System (CASS) Program provides competitive grants to state mental health authorities and agencies to help states increase services for children and adolescents with serious mental health issues and their families. Funds may be used for, among other things, developing local infrastructure for systems of care, linking human resources for local systems of care, and implementing service delivery approaches to address specific state concerns.

Center for Substance Abuse Treatment Programs

Capacity Expansion Program: This program, replacement for the discontinued Drug Treatment Waiting List Reduction program, provides funds to states to help them reduce drug treatment and rehabilitation waiting lists. Funds under the program are awarded to states where the demand for drug treatment waiting lists far exceed current treatment capacity. In FY 95, the proposed budget recommends $6.8 million for this program, down from $10 million in FY 94. However, according to the 1994 National Drug Control Strategy, this decrease will be more than offset by the creation of a new $35 million Hardcore Treatment Initiative, *infra*.

CSAT's Consolidated Demonstration Program: For FY 95, the Clinton Administration proposes the consolidation of several CSAT demonstration programs which functioned separately in FY 94 and prior fiscal years. Reasons for the consolidation, according to the 1994 National Drug Control Strategy, include reducing the number of discrete grant announcements for drug control programs, simplifying application procedures for prospective grantees, and improving efficiency of the grant review process. Programs that would be consolidated under the Clinton plan include the following:

- *Program for Pregnant and Post-Partum Women* -- This program provides funds to substance abuse treatment for pregnant women and post-partum women and their children. Treatment can be provided on either a residential or outpatient basis. Funds may be used for this population for such things as: prenatal and postnatal health care; day-care for children when the individual is in therapy or receiving rehabilitative services; counseling on HIV/AIDS; and counseling on domestic violence and sexual abuse. Public and private nonprofit organizations are eligible to receive program funds. For FY 94, the program received $54.2 million. Under the FY 95 consolidation, $54.2 million would also be provided for such activities;

- *Criminal Justice Treatment Setting Grants* -- This program provides grants to public and private nonprofit organizations that provide substance abuse treatment to individuals under criminal justice supervision. For FY 94, the program received $34 million. Under the FY 95 consolidation, the program would be provided $23.5 million;

- *Target Cities Grants* -- This program provides funds to cities with populations in excess of 315,000 to improve drug treatment services within those cities. Funds may be used for, among other things, improving treatment facilities, enhancing outreach, improving case management and improving treatment services to targeted populations (including individuals who are homeless or have HIV/AIDS). For FY 94, the program received $34.8 million. Under the FY 95 consolidation, the program would be provided $28.2 million;

- *Critical Populations Grants* -- This program provides grants to enhance treatment programs that address specific populations, as CSAT determines from year to year. Funds may be used for such things as: intake and assessment; vocational and educational evaluation, counseling and training; counseling for HIV/AIDS; and various treatment services. While only the states can receive grants directly from CSAT, states can further subgrant their monies to other entities. For FY 94, the program received $43.7 million. Under the FY 95 consolidation, the program would receive $23.6 million;

- *AIDS Demonstration Program* -- Under this program, outreach services are provided to those substance abusers deemed most at risk of acquiring HIV and related diseases. Specifically, funded projects are required to target injecting drug users and other high-risk substance abusing populations. While only the states can receive grants directly from CSAT, states can further subgrant their monies to other entities. For FY 94, the program received $18.3 million. Under the FY 95 consolidation, the program would receive $8.3 million;

- *Campus Treatment Grants* -- Under this program, funds are provided to test and improve residential drug treatment models. Thus far, CSAT has funded campus programs in Houston, Texas, and Secaucus, New Jersey. For FY 94, the program received $9.4 million. Under the FY 95 consolidation, the program would not receive any funding;

- *Comprehensive Community Treatment Program* -- Under this program, grants are awarded to projects that demonstrate a comprehensive and model community treatment approach to combatting substance abuse problems. For FY 94, the program received $27.5 million in FY 94. Under the FY 95 consolidation, the program would also receive $27.5 million; and

- *Hardcore Treatment Initiative* -- In addition to preexisting CSAT demonstration programs, the Clinton Administration's FY 95 budget proposes to create a new Hardcore Treatment Initiative to develop and test models for integrating service systems for persons with severe addictions into primary health and specialty substance abuse treatment systems. This program, in addition to the set-aside that would be established for the FY 95 Substance Abuse Block Grant Program, *supra*, would significantly increase the total number of federally-assisted treatment slots (by 30,854) and the number of persons receiving federally-assisted treatment services (by 55,980). According to the 1994 National Drug Control Policy, this hardcore treatment initiative is especially important for health care reform, as "[d]emonstrations are needed of different models of integrating substance abuse services into managed care systems, and the impact of different linkage systems on treatment outcomes." The $35 million for this initiative would be made available through a transfer from the Special Assets Forfeiture Fund.

In all, the FY 95 consolidated program would receive $200.2 million.

Addiction Treatment and AIDS Training: Funded $8.2 million in FY 94, CSAT's Addiction Treatment and AIDS Training Program, which provides training funds in those areas, would also receive $8.2 million in FY 95, under the Clinton budget request.

Center for Substance Abuse Prevention Programs

CSAP's Consolidated Demonstration Program: For FY 95, the Clinton Administration proposes the consolidation of several CSAP demonstration programs which functioned separately in FY 94 and prior fiscal years. Reasons for the consolidation, according to the 1994 National Drug Control Strategy, include reducing the number of discrete grant announcements for drug control programs, simplifying application procedures for prospective grantees, and improving efficiency of the grant review process. Programs that would be consolidated under the Clinton plan include the following:

- *High-Risk Youth Programs* -- Under this program, public and private nonprofit organizations receive funding to implement models to prevent substance abuse among high-risk youth, as well as provide early intervention for youth who are developing substance abuse problems. For FY 94, the program received $63.3 million. Under the FY 95 consolidation, the program would receive $59.2 million;

- *Community Partnership Demonstration Program* -- Under this program, public and private nonprofit organizations receive funds to develop comprehensive, coordinated and wholistic strategies to prevent substance abuse within their jurisdictions. For FY 94, the program received $114.7 million. Under the FY 95 consolidation, the program would also receive $114.7 million;

- *Pregnant and Postpartum Women and Infants Program* -- This program, which is similar to CSAT's Program for Pregnant and Post-Partum Women, is being phased out in light of CSAT's women's program. For FY 94, the CSAP Pregnant and Postpartum Women and Infants Program received $43.4 million. Under the FY 95 consolidation, the program will receive $42.5 million. A total of $20.5 million of the FY 95 $42.5 million amount will go for the following activities: $10 million to continue to expand prevention activities focusing on adolescent women; $4 million for intervention strategies targeting women in life transition; $1.9 million to redesign CSAP's National Resource Center to become the National Women's Resource Center; $3 million to develop and implement a women's education campaign to prevent alcohol and other drug abuse during pregnancy; and $2 million to train health providers to instruct female patients on the risks of combining alcohol and other drugs and prescription drugs.

In addition, the consolidated program would include a $2.7 million violence prevention program, a $1.3 million workplace substance abuse program and a $5.3 million substance abuse prevention evaluation program. In all, $223.1 million would be available in FY 95 for consolidated program activities.

CSAP Training Program: Under CSAP's training program, funds are provided for (1) substance abuse curriculum development and training, (2) community substance abuse prevention training, (3) substance abuse counselor training, (4) faculty development in alcohol and drug abuse, (5) a national volunteer substance abuse prevention training center, and (6) evaluation of training and technical assistance activities. For FY 94, $14.5 million was appropriated for CSAP training. For FY 95, the Clinton administration has requested $16.5 million.

Public Education and Dissemination: For FY 94, a total of $10.8 million was available for substance abuse public education and dissemination activities. This includes grants made to sponsors of substance abuse prevention-related conferences. For FY 95, a total of $13.8 million would be available for such activities.

National Institutes of Health

National Institute of Mental Health: The National of Mental Health (NIMH) is the federal government's chief research agency on mental health. Conducting its research initiatives on both an extramural (out-of-house) and intramural (in-house) basis, NIMH carries out its mission of conducting and supporting biomedical and behavioral research, health services research, research training, health information dissemination, treatment research, promotion of mental health activities, and the study of factors that influence behavior. Recent NIMH priorities have included research with regard to adults with severe mental health issues, children and adolescents with mental health issues, schizophrenia and other serious mental health issues, and mental disorders in special

populations.[16] For FY 94, NIMH received $613.4 million. For FY 95, the Clinton proposal would decrease NIMH's budget to $545.2 million. A reason for this decrease in funding is to allow for the establishment of an Office on AIDS, from which additional monies may be transferred back to NIMH for AIDS-related research.

National Institute on Drug Abuse: The National Institute on Drug Abuse (NIDA) is the federal government's chief research agency on drug abuse. NIDA's general mission is fourfold: (1) to study and evaluate the causes and consequences of drug abuse; (2) to discover ways of improving drug abuse treatment and prevention; (3) to collect information on the incidence and prevalence of drug abuse; and (4) to train investigators in basic and clinical research relating to drug abuse. To satisfy its responsibilities, NIDA conducts both extramural (out-of-house) and intramural research. NIDA priorities generally include basic biomedical research, neurobehavioral research, prevention research, treatment (including medications development) research, and epidemiological research. For FY 94, NIDA received more than $400 million. For FY 95, the Clinton Administration would provide only $292 million. However, in addition to this FY 95 amount, $151.7 million would be transferred to NIDA from the newly-established Office on AIDS Research.

National Institute on Alcohol Abuse and Alcoholism: The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is the federal government's chief research agency on alcohol use and abuse. NIAAA's research duties include research on the social, behavioral and biomedical etioligy of alcohol use and abuse; the mental and physical consequences of alcohol; and the social and economic consequences of alcohol abuse and alcoholism. Recent NIAAA research priorities have included the topics of genetics and molecular biology, biochemistry and metabolism, neuroscience, alcohol and pregnancy, alcohol-related mental health issues, treatment, prevention, intentional and unintentional injuries and epidemiology. NIAAA conducts its programs on both an extramural (out-of-house) and intramural (in-house basis). For FY 94, NIAAA received $185.67 million. For FY 95, the institute would be funded at $182,498. A small amount of additional monies may be transferred back to NIAAA from the newly-established Office on AIDS Research for Alcohol/AIDS-related research.

Other Public Health Health Service Programs

Health Resources Services Administration Programs: Several programs administered by HRSA impact the area of substance abuse, and, to some extent, mental health.

HIV/AIDS Programs: There is strong link between HRSA HIV/AIDS programs and provision of substance abuse services, as intravenous drug use is a primary cause of HIV/AIDS. The Ryan White Title I Emergency Grants Program provides formula grants to cities most impacted by the spread of HIV/AIDS. The Ryan White Title II HIV Care Program provides both formula grants to states to fund local HIV care consortia and discretionary grants to public and private nonprofit organizations to support HIV care and treatment projects of national significance. Finally, Title III Early Intervention Program Grants provide discretionary grants to public and private nonprofit organizations to provide early HIV intervention services. In addition, HRSA also administers a

[16] In tribute of NIMH research and mental health research, in general, this decade of the 1990's has been declared the Decade of the Brain.

Pediatric AIDS Health Care Program and a HIV/AIDS Dental Reimbursement Program. In FY 94, a total of $602 million was available for HRSA AIDS Programs. For FY 95, the Clinton Administration proposes nearly $700 million for such programs.

Homeless Programs: HRSA administers the Primary Health Care and Substance Abuse Services for the Homeless Program, which provides individuals who are homeless with a wide array of health services, including substance abuse and mental health assistance. In addition, the agency runs the Health Care Services for Homeless Children Program, which provides primary health services to homeless children and children at risk of becoming homeless. Public and private nonprofit organizations are eligible to receive federal funds under these two programs. For FY 94, a total of $63 million was available for these programs. For FY 95, the Clinton Administration would also provide $63 million for such programs.

Centers for Disease Control and Prevention (CDC) Programs: CDC administers HIV/AIDS projects which are of particular pertinence to the area of substance abuse. HIV/AIDS Project funds are available to assess the risks of HIV/AIDS, implement HIV/AIDS prevention programs, and develop HIV/AIDS prevention technologies. For FY 94, there was $543.2 million available to for such projects. The Clinton Administration recommends the same such amount for FY 95.

Administration for Children and Families Programs

Runaway and Homeless Youth Consolidated Program: Under the Clinton Administration's FY 95 budget request, the Runaway and Homeless Youth (RHY) Drug Abuse Prevention and Education Program, funded $14.6 million in FY 94, would be consolidated with the other RHY programs, the Basic Centers Program and Transitional Living Program, into one large program. However, despite the consolidation, the 1994 National Drug Control Strategy indicates that $14.6 million will be specifically earmarked for activities previously funded under the RHY Drug Abuse Prevention and Education Program. Such activities include a wide range of support for special substance abuse education and prevention programs for runaway and homeless children.

Abandoned Infants Assistance Program: This program provides funding support for projects to prevent the abandonment of infants and young children exposed to drugs or HIV/AIDS, as well as provides support for programs that reunify and strengthen families with substance abuse problems. For FY 95, a total of $14.6 million, the same amount as provided in FY 94, would go for such substance abuse activities.

Temporary Child Care/Crisis Nurseries Program: Under this program, funds may be used by states to support respite care for infants and children, including those infants and children who have been exposed to drugs or HIV/AIDS. In addition, funds can be utilized to support crisis nurseries for abused and neglected children, including those from substance abusing families. In FY 94, the program received nearly $12 million. For FY 95, the Clinton Administration has requested that the program be consolidated into the much larger (nearly $1 billion funded) Child Care and Development Block Grant Program. Still, activities akin to those supported under Temporary Child Care/Crisis Nurseries Program could still be carried out under the block grant program.

Emergency Child Abuse Prevention Program: Under this program, funds are available to provide family and protective services to children of substance abusing families. In FY 94, $19 million was available for this program. For FY 95, the Clinton Administration has recommended that funds under the program be redirected to other child abuse and neglect programs for more effective use by states at the community level. Nonetheless, the 1994 National Drug Control Policy indicates that $19 million would be utilized in FY 95 for activities similar to those of the Emergency Child Abuse Prevention Program.

Youth Gang Substance Abuse Prevention Program: Under this program, funds are provided to allow public and private nonprofit organizations to conduct community-based, comprehensive and coordinated activities to reduce and prevent youth gangs that engage in substance abuse activities. For FY 94, $10.6 million was available for this program. For FY 95, the Clinton Administration recommends that the program be coordinated under a new Youth Initiative, which would include activities broader than those defined by the Youth Gang Substance Abuse Prevention Program. Nonetheless, according to the 1994 National Drug Control Policy, $10.6 million would still be used in FY 95 for activities previously supported under the Youth Gang Program.

Department of Education Drug-Free Schools Progrmas

In addition to the Drug-Free Schools and Communities Formula Grants Program (to be expanded and renamed the Safe and Drug-Free Schools Formula Grants Program under the Clinton FY 95 proposal), the Department of Education's Drug-Free Schools and Communities Division also administers several other discretionary grant programs.

FY 94 Programs: In FY 94, the division administered:

- *The School Personnel/Counselor Training Program*: This program was funded $13.6 million, to improve substance abuse training programs for elementary and secondary school personnel;

- *National Programs*: These programs received an aggregate of $59.5 million, to improve substance abuse programs at institutions of higher education (IHE), to support IHE projects to develop and implement quality drug abuse education curricula, and to support model activities for substance abuse prevention; and

- *The Emergency Grants Program*: This initiative received just under $25 million in FY 94 to provide additional funds to school districts demonstrating the greatest need for additional monetary resources to combat student drug use and abuse.

In addition, legislation to create a new Safe Schools is likely to pass Congress in the near future. If this legislation does become law, an additional $20 million would be available in FY 94 for the program, which is similar in design and mission to the Emergency Grants Program.

FY 95 Programs: Although the authorization for the Drug-Free Schools Programs end at the close of FY 94, the Clinton Administration has proposed to reauthorize, expand and rename the programs the "Safe and Drug-Free Schools and Communities Programs." As mentioned, the Clinton

Administration would provide $480 million for the formula grants program. In addition, the following programs would be administered in FY 95:

- *The Safe Schools Program*: For FY 95, $100 million would be made available in FY 95 for the Safe Schools Program, of which 95 percent would support school districts with serious school crime, violence and discipline problems;

- *Postsecondary Education Programs*: $16 million would be available to support grants to colleges and universities for model programs and strategies to promote safety of students attending such schools by preventing violent behavior and the illegal use of alcohol and other drugs by students; and

- *National Programs*: For FY 95, $64 million would be available to support several drug and violence prevention activities, including training, demonstrations, direct services to school systems with special needs, research, program evaluation and the development and dissemination of information and materials.

programs, therapeutic family or group treatment homes, and residential centers for substance abuse treatment; inpatient services are limited to 60-days yearly with no lifetime limit; intensive community services including psychiatric rehabilitation services, behavioral aide services, in-home services, and ambulatory detoxification are covered; intensive — residential community services limited to a maximum of 120 days per year, residential services may be substituted for inpatient services as long as the residential services do not exceed the cost in an inpatient setting estimated for an individual to complete treatment; Includes State waiver outpatient psychotherapy visits for children and adolescents up to age 18 are covered; day treatment for children limited to a maximum of 180 days per year; and states would have broad flexibility to establish comprehensive, managed, mental health programs for low-income adults and children with serious mental illnesses or emotional disturbances to allow them to receive the national mental health benefit without limits and receive state assistance with low copayments.

6. **Family Planning and Services for Pregnant Women-** All pregnancy related services; family planning services; voluntary planning services; pediatric attendance at high-risk deliveries; contraceptive drugs and devices; well-baby and newborn services are covered.

7. **Home Health Care Services and Hospice Care-** Up to 100 days of post-hospital skilled nursing facility care; home health services; and hospice care are covered.

8. **Outpatient Laboratory, Radiology, and Diagnostic Services-** Outpatient laboratory services are covered as such is defined by Medicare Part B.

9. **Outpatient Prescription Drugs and Biologicals-** Outpatient prescription drugs, biological products, insulin, and home infusion drugs (as specified in this act) are added to items and services covered under Medicare parts B and C as such is amended in the Health Security Act.

10. **Outpatient Rehabilitation Services-** Outpatient rehabilitation services are covered as such is defined by Medicare Part B including but not limited to outpatient physical therapy, occupational therapy,

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

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

(A) Annual papanicolaou smears and pelvic exams, for females who are at risk for cervical cancer, unless three consecutive annual pap smears have been negative and it has been determined that the female is not at risk for sexually transmitted disease.

(B) Annual screening for chlamydia and gonorrhea for sexually active females unless they are determined by the health care provider not to be at risk for sexually transmitted diseases.

(C) Mammograms for females every 2 years in consultation with their physician.

(D) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every 2 years.

(h) INDIVIDUALS AGE 50 TO 65.—For an individual at least 50 years of age, but less than 65 years of age:

(1) IMMUNIZATIONS.—The immunizations specified in this subsection are booster immunizations against tetanus and diphtheria every 10 years.

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

(A) Annual papanicolaou smears and pelvic exams, for females who are at risk for cervical cancer, unless three consecutive annual pap smears have been negative and it has been determined that the female is not at risk for sexually transmitted disease.

(B) Annual screening for chlamydia and gonorrhea for sexually active females unless they are determined by the health care provider not to be at risk for sexually transmitted diseases.

(C) Mammograms for females annually.

(D) Cholesterol every 5 years.

(3) CLINICIAN VISITS.—The clinician visits specified in this subsection are 1 clinician visit every 2 years.

(i) INDIVIDUALS AGE 65 OR OLDER.—For an individual at least 65 years of age who is enrolled under a health plan:

(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) Papanicolaou smears and pelvic exams for females who are at risk for cervical cancer every 2 years.

(B) Mammograms for females every 2 years.

(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 (i)(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), including individuals with multiple mental disorders or mental retardation and mental illness, who satisfy the eligibility requirements in subsection (b):

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

(2) Residential mental illness and substance abuse treatment (described in subsection (e)).

(3) Intensive nonresidential mental illness and substance abuse treatment (described in subsection (f)).

(4) Outpatient mental illness and substance abuse treatment (described in subsection (g)), 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, screening and assessment, crisis services, 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 or, in the case of a child 5 years of age or less, is at risk of a mental 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 the individual is eligible to receive coverage for, and is receiving, 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.

(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) HEALTH PROFESSIONAL.—

(1) IN GENERAL.—The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient, residential, intensive nonresidential, and outpatient mental illness and substance abuse treatment.

(2) RULE OF CONSTRUCTION.—Nothing in section 1861(e) of the Social Security Act, including paragraph (4), shall be construed as requiring that individuals receiving items and services under this section be under the care of a physician when such individuals are under the care of a mental health or substance abuse health professional in a State in which such care is permitted by State law.

(d) INPATIENT TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "inpatient 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 an inpatient of a hospital or psychiatric hospital.

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

(A) 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.

(B) 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).

(C) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment, when furnished to an inpatient of a hospital or psychiatric hospital is subject to an aggregate annual limit of 30 days, 15 of which may not be reduced in substitution for other covered services.

(e) RESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "residential mental illness and substance abuse treatment" means the items and services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to a resident of a residential treatment center, residential detoxification center, crisis residential program, mental illness residential treatment program, therapeutic family home, therapeutic community, group treatment home, community residential treatment program, or recovery center for substance abuse.

(2) LEAST RESTRICTIVE SETTING.—

(A) IN GENERAL.—Such treatment is covered only when—

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

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

(B) ANNUAL LIMIT.—

(i) Prior to January 1, 2001, the number of covered days of 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 (d)(2)(C), shall be reduced by 1 day for each 4 covered days of residential mental illness and substance abuse treatment that are provided to the individual, until such number is reduced to 15. The Secretary may increase the reduction period under clause (i) if the Secretary determines that such an increase is actuarially equivalent of the 15 days of inpatient treatment being substitutes for residential treatment.

(ii) The limit contained in clause (i) shall not apply to substance abuse treatment provided in a therapeutic community, halfway house, recovery center or other comparably inexpensive residential substance abuse treatment facility, as determined by the Secretary.

(f) 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—

(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.

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

(A) 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.

(B) 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.

(g) 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) Medications management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

(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) 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.

(h) MANAGEMENT OF CARE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE.—

(1) PROVISION OF TREATMENT.—Quality managed care techniques may be utilized by plans to ensure that all necessary care is provided in the most appropriate, cost-effective setting, and that unnecessary care is not provided.

(2) QUALITY MANAGED CARE.—The term "quality managed care" refers to the administration of benefits through methods, such as central intake, clinician-to-clinician preauthorization, precertification, and utilization review. Plans may utilize specialized behavioral managed care entities to administer benefits if such entities are certified by the State as proficient in the use of quality managed care techniques that facilitate the provision of clinically appropriate, cost-effective, and confidential treatment, providing continuity of care between and among treatment sites.

(3) TREATMENT DECISIONS.—Treatment placement decisions shall be based on publicly available criteria, such as medical necessity, with inpatient treatment regarded as the placement of last resort.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting health plans from providing mental health and substance abuse treatment through fee-for-service arrangements.

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

(1) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—Health plans shall ensure that the mental illness and substance abuse services described in this section and furnished to an eligible person are furnished through organized systems of care, as described in paragraph (2), if the eligible person is a person under 22 years of age who has a serious emotional disturbance or a substance abuse disorder, and who is, or is at imminent risk of being, involved with one or more public child-serving agencies, including child welfare, special education, and juvenile or criminal justice.

(2) REQUIREMENTS OF SYSTEM OF CARE.—As used in this subsection, the term "organized system of care" means a community-based service delivery network, which may consist of public and private providers, 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 and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile or criminal 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 by multidisciplinary and 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 individuals under 22 years of age who have a serious emotional disturbance or a substance abuse disorder.

(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.

(j) 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, Fourth Edition, 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) MEDICATIONS MANAGEMENT.—

(A) IN GENERAL.—The term "medications management" refers to the prescription, use, monitoring, and review of medication for treatment of a mental disorder or pharmacotherapy for the treatment of a substance abuse disorder, including no more than minimal medical psychotherapy or counseling.

(B) VISIT.—For purposes of medications management, the term "visit" in section 1135 means one week of treatment.

(4) 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.