



November 3, 2015

Honorable Fred Upton  
Chairman  
Committee on Energy  
and Commerce  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has completed a preliminary analysis of the direct spending effects of title V of H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015, as introduced on June 4, 2015. As described below, title V contains language that makes the implementation of certain provisions contingent on a certification by the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) that the provisions would not increase net costs. At the request of your staff, CBO estimated the cost of those provisions with and without this language.

CBO estimates that, as introduced, title V of H.R. 2646 would increase direct spending by about \$3 billion over the 2016-2024 period. Without the language that makes implementation of certain provisions contingent on the certification by the Chief Actuary of CMS, CBO estimates that the title would increase direct spending by between \$46 billion and \$66 billion over the 2016-2025 period.

Title V of the bill would:

- Expand the number and type of mental health services that states may cover under Medicaid if the Chief Actuary of CMS certifies that a certain provision would not increase net Medicaid spending;
- Prohibit both Part D plans under Medicare and state Medicaid programs from using certain tools to restrict access to drugs used to treat mental health disorders;

- Eliminate the 190-day limit on Medicare coverage of stays in an inpatient psychiatric facility (IPF) if the Chief Actuary of CMS certifies that the provision that would not increase net Medicare spending; and
- Expand the Certified Community Behavioral Health Clinics demonstration program.

### **Enhanced Medicaid Coverage Relating to Certain Mental Health Services**

Section 501 would expand access to behavioral health services offered under Medicaid. Under the section, states would be required to allow Medicaid payments to be made for primary care and mental health services that are provided on the same day at a community mental health center or federally qualified health center. The section also would give states the option to receive federal reimbursement for medical assistance provided to eligible nonelderly adults at institutions for mental diseases (IMDs). However, section 501 could take effect only if the Chief Actuary of CMS certified that providing that assistance would not increase program spending.

Under current law, the federal government does not make matching payments to state Medicaid programs for most services provided to nonelderly adults in IMDs. (The federal government makes matching payments to Medicaid programs for services provided to children and the elderly in IMDs.) Under a policy that would allow states to provide such services through the Medicaid program, CBO expects that most services for otherwise eligible individuals that are currently financed by state and local governments without a federal matching payment would instead be financed by Medicaid.

Data on how much states spend on IMD services used by adults aged 21-64 are not available. CBO based its estimate of this provision on several data sets collected by the Substance Abuse and the costs of Mental Health Services Administration and the National Association of Psychiatric Health Systems. The data report the number of behavioral health facilities and the number of admissions to and clients served by those facilities. The data also report health insurance status at time of admission into behavioral health facilities.

The estimated effects of this section on federal Medicaid spending are highly uncertain and would depend largely on:

- The extent to which coverage for services provided in IMDs is provided currently to adults enrolled in Medicaid managed care plans;
- The amount that states spend on such services using state mental health agency budgets for individuals who are eligible for Medicaid; and
- Whether the policy would lead to an increase in the number of inpatient psychiatric beds available.

Despite the uncertainty, CBO expects that CMS would determine that providing federal reimbursement for medical assistance in IMDs would increase net spending under Medicaid. Thus, CBO estimates that, as introduced, section 501 of the bill would not affect direct spending because the provision would not take effect. If the bill did not make the benefit expansion contingent upon the certification, CBO estimates that section 501 would increase direct spending by between \$40 billion and \$60 billion over the 2016-2025 period.

### **Access to Mental Health Prescription Drugs**

Under current law, Medicare Part D plans must cover substantially all prescription drugs in each of six classes until the Secretary of Health and Human Services has established criteria for determining which prescription drugs in those classes are of clinical concern and must continue to be covered. CMS has taken initial steps toward developing such criteria, and CBO expects that such criteria are likely to be implemented during the coming decade under current law. CBO expects that establishing such criteria will hold down Part D spending because manufacturers of drugs that lose the protection of required coverage will offer larger rebates to get Part D plans to include their products on the plan's formulary.

Section 502 would make permanent the requirement that all prescription drugs in two classes (antidepressants and antipsychotics) must be covered. CBO estimates that provision would increase Medicare spending by \$700 million over the 2016-2025 period because rebates paid to the government for prescription drugs in those classes would be lower.

Section 502 also would prohibit state Medicaid programs from using certain tools to restrict access to drugs used to treat mental health disorders outside of a prior authorization program. CBO estimates that prohibition would increase direct spending by about \$800 million on net over the 2016-2025 period. On average, states that implement some utilization management for mental health drugs spend less of their overall prescription drug benefit on mental health drugs than states with no controls over utilization. However, CBO expects that state Medicaid programs would still be able to use some utilization management tools under the prior authorization authority (such as preferred drug lists) to control access to mental health drugs. Therefore, the estimated cost of the provision is less than it would be if all utilization management tools were prohibited.

### **Elimination of the 190-Day Lifetime Limit on Coverage of Inpatient Psychiatric Hospital Services**

Under current law, a beneficiary covered by Part A of Medicare is eligible to receive hospital inpatient care for serious mental illness or alcohol- and drug-related problems in either a general hospital or an institutional psychiatric facility. For care received in an IPF, Medicare will pay for up to 190 days of inpatient psychiatric hospital services over a beneficiary's lifetime. For most elderly beneficiaries enrolled in both Medicare and Medicaid, state Medicaid programs pay for IPF services for beneficiaries who have exceeded Medicare's 190-day limit.

Section 503 would eliminate the 190-day limit on Medicare coverage of IPF days if the Chief Actuary of CMS certifies that the provision would not increase net Medicare spending. CBO expects the Chief Actuary would conclude that the provision would increase Medicare spending. Thus, CBO estimates that, as introduced, section 503 would not affect direct spending because the provision would not take effect.

If the bill did not make the benefit expansion contingent on the certification, CBO estimates that section 503 would increase federal spending by \$3.0 billion over the 2016-2025 period. That net increase in spending has two components. The Medicare program would spend an additional \$3.6 billion for IPF services. That increase would be partially offset by an estimated \$0.6 billion in federal Medicaid savings, stemming from the shift of coverage for IPF services from Medicaid to Medicare. Elimination of the 190-day limit in Medicare would interact with the expansion of Medicaid coverage of IMD services under section 501, because both provisions would affect payment for IPF services for dually

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eligible individuals who are under age 65. The effects of that interaction are included in the estimated cost of section 501.

**Demonstration Programs to Improve Community Mental Health Services**

Section 505 would expand the Certified Community Behavioral Health Clinics demonstration by increasing the number of states that can participate in the demonstration from 8 states to 10 states and increasing the number of years the demonstration can operate from two years to four years. Because payment rates for services provided in certified community behavioral health clinics would be higher under the demonstration than under current law, CBO estimates that the provision would increase direct spending in Medicaid by \$1.8 billion over the 2016-2025 period.

If you wish further details on this estimate, we would be pleased to provide them. The CBO staff contact is Chad Chirico.

Sincerely,

A handwritten signature in black ink, appearing to read "Keith Hall". The signature is fluid and cursive, with the first name "Keith" and last name "Hall" clearly distinguishable.

Keith Hall

Director

cc: Honorable Frank Pallone Jr.  
Ranking Member

Honorable Tim Murphy