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The [Deficit Reduction Act \(DRA\), P.L. 109-171](#), was narrowly passed by Congress (216-214 in the House on January 31) and signed by the President on February 8, 2006. It makes substantial changes to vital federal programs such as Medicaid, Medicare and TANF to reduce federal spending by \$40 billion over five years.

The law creates new options for states under the Medicaid program. These changes could fundamentally alter the way Medicaid operates, with particularly detrimental effects on people who need a wide range of intensive mental health services. The changes are designed to save the federal government money; some also yield savings for states and some will increase state costs. All will likely have very grave consequences for millions of children and adults with mental disabilities who rely on Medicaid for necessary health and mental health care.

In addition to its negative impact, however, the DRA includes some provisions that could improve Medicaid for adults and children with mental disorders, including greater flexibility to furnish community-based services.

Overall, the DRA is plagued with ambiguous legislative language. If Congress doesn't clarify it through passage of a technical corrections bill, and if the language is interpreted adversely by the Centers for Medicare and Medicaid Services (CMS), which administers Medicaid, this law could create even more problems.

1. Medicaid Coverage

Summary of Medicaid Changes

The DRA continues the trend for Congress and the Administration to give states increased flexibility under Medicaid. Most of it comes at beneficiaries' expense. Unlike the bill that originally passed the Senate, which saved money by reducing payments to Medicare managed care plans and to pharmaceutical companies for Medicaid drugs, the law as enacted hits hard at people who depend on Medicaid.

Moreover, the law creates a fundamental shift in the program. Expansion of the approach used by the State Children's Health Insurance Program (SCHIP) of furnishing private insurance-type ("benchmark") coverage is now extended to Medicaid. This ignores the history of Medicaid policy, which has deliberately included the types of services necessary to meet the extensive needs of people with disabilities, the elderly and those in poverty, and to ensure that all children in America (including those in low-income families) have access to early intervention and to hearing, vision and mental health services that ensure them of opportunities to succeed in life.

States that opt for a benchmark plan for some Medicaid beneficiaries will have benefit packages with very restricted coverage of mental health (limits on inpatient and outpatient stays)—packages that lack any coverage of the intensive community services offered through public mental health systems.

Furthermore, the imposition of cost-sharing on people who use Medicaid services undermines the program's core value, to make health care accessible to low-income people.

In sum, the DRA opens the door to unraveling of the Medicaid program. It is important, however, to note that all of these disastrous changes are authorized and permitted, but not mandated. States, not the federal government, will decide whether the DRA adds to the number of people who are uninsured and underinsured, or whether the Medicaid program will continue to protect the health and mental health of low-income people. Moreover, the law gives states some new options for covering children under Medicaid and expanding community-based services for some children and adults.

In its FY 2007 budget request to Congress (see the [February 23 Bazelon Center Action Alert](#)), the Administration requests further cuts in Medicaid and Medicare, including a 50% reduction in the reimbursement rate for targeted case management. It also serves notice that it will act administratively to redefine rehabilitation services and to restrict federal payment for certain school-based services and administrative costs.

The Bazelon Center and other advocates will call upon you to help alert Congress to the ramifications of these proposals and urge that no more changes be made to Medicaid, pending rollout of the DRA over the next year.

Case Management

Section 6052 of the DRA changes Medicaid’s targeted case management option and redefines the term “case management.” (Case management is often billed under other state services, such as Clinic or Rehabilitation services, as well as under the Medicaid option of Targeted Case Management. The new definition applies in all cases).

The DRA clarifies that to be eligible for targeted case management an individual must be:

- eligible for Medicaid, and
- part of the target population for targeted case management specified in the state plan.

It is critical for mental health programs to be able to continue billing Medicaid for covered targeted case management for an eligible individual who is in the state’s target population for this service, whether or not the individual is in the child welfare system or served by other programs. The DRA does not deny this coverage, but does leave open the interpretation of just how this will work in practice.

The law also specifies that Medicaid will not pay for certain services that have traditionally been furnished by child welfare system case managers. And it requires states to bill other funding sources that are “legally obligated” to pay for targeted case management services first, before charging Medicaid.

The new definition of targeted case management follows CMS policy as issued in a [January 19, 2001 policy letter](#), released at the end of the Clinton Administration. However, the DRA expands on the letter in its clarification of what services to children in child welfare may not be billed to Medicaid.

Under Medicaid law, case management services are services that will assist individuals in gaining access to needed medical, social, educational or other services. Specifically, under earlier policy and the DRA this includes:

- **Assessment**

The assessment determines service needs. Activities that are included are taking client history; identifying needs and completing related documentation; and gathering information from other sources (such as family members, medical providers, etc) to form a complete assessment,

- **Development of a Specific Plan of Care**

The plan of care must be based on information collected through an assessment. It lists the goals and actions to address the medical, social, educational and other services the individual needs. Included are activities that ensure the person’s active participation and work with the

individual (or the authorized healthcare decisionmaker) and others to develop goals and identify a course of action to respond to the assessed needs.

▪ Referral and Related Activities to Help Obtain Needed Services

Activities included are those that help link individuals with medical, social or educational providers or other programs that are capable of providing needed services, such as making referrals to providers for needed treatment and scheduling appointments for the individual.

▪ Monitoring and Follow-up Activities

This includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and is adequately addressing the individual's needs. Follow-up may be with the individual, family members, providers or other entities. The activities can be conducted as often as necessary to help determine such issues as:

- whether services are being furnished in accordance to the individual's plan;
- whether the services in the care plan are adequate; and
- whether there are changes in the eligible individual's needs or status and, if so, making necessary adjustments in the care plan and service arrangements with providers.

The DRA clarifies that case management *does not include*:

- direct delivery of an underlying medical, educational, social or other service to which the individual has been referred; or
- direct delivery of foster care services.

The DRA lists examples of foster care services that may *not* be billed to Medicaid targeted case management, specifically:

- research gathering and completion of documentation required by the foster care program;
- assessing adoption placements;
- recruiting or interviewing potential foster care parents;
- serving legal papers;
- home investigations;
- providing transportation;
- administering foster care subsidies; and
- making placement arrangements.

The DRA emphasizes that federal reimbursement is available for case management or targeted case management services only if no third party is liable to pay for such services. This standard appears to restate Medicaid's prohibition on payment for services for which another party is liable.

However, the law then states that this includes reimbursement under a medical, social, educational or other program. This statement raises concern. Many medical, social and educational programs pay for similar services, but they are underfunded and often targeted (legally or in practice) to individuals who are *not* Medicaid eligible. The question is which of

these programs (if any) will be determined “liable” to pay for services by CMS when it interprets the meaning of this statement.

Of particular concern is whether this language would be seen to supersede the section of current Medicaid law (Section 1903c of the Social Security Act) that authorizes payment for services in a child’s individualized education program (IEP) under the Individuals with Disabilities Education Act (IDEA). If Medicaid does not pay for such services when a child is Medicaid-eligible, it is highly unlikely that schools will include the services in the child’s IEP. Specific language exempts some other federal programs (e.g. for HIV) from this third-party liability. However, no explicit exemption is included for IDEA students. This is an instance where CMS policy will be very important.

The real test of whether the new definition will limit services that are vital to recovery is how it is interpreted by CMS in implementing regulations. The Bazelon Center and our campaign allies will closely monitor development of these rules in the months ahead.

Third-Party Payment Issue Applies to Other Mental Health Services

A separate but similar provision to that in the Targeted Case Management section of the law would apply to all Medicaid services. Section 6036 requires that other parties that are “by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service” be billed before Medicaid. This language seems more directly aimed at health plans and health insurers and not at public programs. However, final interpretation will be made by CMS.

States May Switch People into Private Health Plans

Section 6044 of the DRA allows states to modify the Medicaid benefit package for some beneficiaries. States can obtain an amendment to their state plan to shift people into what is called “benchmark coverage” or “benchmark-equivalent coverage.” This coverage is the same as that in the State Children’s Health Insurance Program (SCHIP).

States are limited in whom they may switch into these benchmark plans, which typically have significantly lower mental health benefits than current Medicaid. They may *not* shift the following categories of people:

- pregnant women with mandatory eligibility for Medicaid;
- blind or disabled individuals (including those on SSI or SSDI);
- dually eligible (Medicaid and Medicare) people;
- institutionalized individuals and beneficiaries qualifying for long-term care services;
- people with terminal illnesses or hospice patients;
- medically frail people and those who have special medical needs;
- children in foster care who are receiving services under Title IV-B and children receiving foster care or adoption assistance under Title IV-E.

This leaves groups of children, seniors and parents vulnerable to being switched into less adequate plans.

States may also choose to exempt other categories of Medicaid beneficiaries from being moved into benchmark plans if they pick up this option.

This leaves at risk other adults who, while they may have very serious mental health care needs, are not defined as a “person with a disability,” and all children who are not in foster care.

These provisions thus represent, potentially, a huge step backward for certain low-income children and single adults who need mental health care. However, if states do not take this option (or exclude from it all children as well as adults who have serious mental illnesses) then there will not be a problem.

- ***Effect on EPSDT***

States that pick up the option to use benchmark plans must nonetheless make available to all children under age 19 an additional “wrap around” benefit, consisting of early and periodic screening, diagnostic and treatment services (EPSDT) as defined in current Medicaid law. This means children under age 19 must continue to receive any medically necessary Medicaid-covered service, whether or not that service is covered or defined in the state Medicaid plan.

However, the statute says nothing about whether children between 19 and 22 have lost their EPSDT protection. Current EPSDT protections could still apply to these youth.

For children entitled to the “wrap around” benefit, the law creates dual benefit packages (the benchmark benefit and the additional wraparound benefit). This could leave some children falling through cracks. Some families will not know they can obtain the wraparound benefit; others may find their child inappropriately denied the additional benefit and still others may receive the wraparound benefit but encounter discontinuity in providers and treatment plans.

Additionally, no specificity is given or standard used to determine what would be considered “wrap around.” Accessing it will likely prove difficult for families and an administrative maze for the benchmark-plan insurers.

- ***Benchmark Plan Coverage***

The benchmark plans that can be used as models for the new benefit include:

- the standard Blue Cross/Blue Shield preferred provider plan (equivalent to FEHBP, the federal employees health benefits plan);
- a state employee plan;
- the HMO plan in the state with the largest non-Medicaid enrollment; or
- coverage approved by the Secretary of Health and Human Services.

Benchmark-equivalent coverage is defined as a benefit that has an aggregate actuarial value at least equivalent to one of the above benchmark plans. However, for mental health services and

prescription drugs (as well as vision and hearing services), the benchmark-equivalent coverage need be only 75% of the actuarial value. The statute sets forth a standard to determine the actuarial value.

Services covered under any of these plans need only include:

- inpatient and outpatient hospital services;
- physicians' surgical and medical services;
- laboratory and x-ray services;
- well-baby and well-child care, including age-appropriate immunizations; and
- other appropriate preventive services, as designated by the Secretary of HHS.

Clearly this package fails to cover critical services for people who need mental health care. It would be particularly inappropriate and inadequate for children and adults with serious mental disorders.

States have the option to provide a wraparound benefit to any of the beneficiaries who are moved into benchmark plans, offering the possibility that individuals who need mental health care could be protected.

Expanded Access to Home- and Community-Based Services

Section 6086 gives states, at their option, the ability to provide home- and community-based services (H&CBS) to elderly individuals and people with disabilities with incomes up to 150% of the federal poverty level without requiring a waiver or demonstrating cost neutrality. A state need only amend its Medicaid plan to provide any of the services now covered under H&CB waivers. However, states may use stricter level-of-care eligibility criteria for individuals it chooses to include.

Under the DRA, this option applies not only to populations currently eligible for H&CB waivers—individuals with physical and developmental disabilities and those over age 64 in an Institution for Mental Diseases in states that have covered IMD services as a state option, and individuals of any age in a nursing facility that is not an IMD— but also to adults from ages 22 through 64 who have a mental disorder. This is because the provision previously in place for H&CB waivers regarding cost-neutrality between the new community services and a covered Medicaid institutional service does not apply. Accordingly, it is now irrelevant that adults between 24 and 65 are not covered for institutional services in an IMD.

However, this option could lead to a very limited program. The DRA allows states to limit the number of people served and to maintain waiting lists. It fails to set a standard for the pace at which a state must work to shorten waiting lists. States electing this option may also chose to provide the services in limited areas without having to meet Medicaid's state-wideness requirement.

States that select this option can then cover (for people it selects as eligible) a range of community services that includes supported employment, respite care, family support and other

community services. Services permitted under this option, however, must be services that could have been covered through the H&CB waiver authority.

Optional Buy-In for Children with Severe Disabilities

The Family Opportunity Act, championed by Senators Charles Grassley (R-IA) and Edward Kennedy (D-MA) and Representatives Pete Sessions (R-TX) and Henry Waxman (D-CA) and long advocated by the Bazelon Center, has been included in the DRA (Section 6062). However, it is a scaled-back version of [the original bill](#).

As enacted within the DRA, the Family Opportunity Act would help address many problems that families face when they are unable to access needed health care for their children who have severe disabilities. Rather than relinquishing custody to the child welfare system to obtain the intensive services Medicaid offers or staying impoverished to meet the Medicaid income-eligibility requirements, more families could get the assistance they need for their child by purchasing Medicaid coverage from the state. This will help families stay intact and allow parents to maintain a job and even accept raises.

However, the program is a state option. States may offer parents with incomes up to 300% of the federal poverty level (\$58,500 for a family of four) the opportunity to buy into Medicaid on a sliding-scale basis if their child under age 18 has a severe mental illness or other severe disability meeting the SSI standard of disability.

States can phase the program in over four years:

- children 0 to 6 years old can be eligible in 2008;
- children 7 to 13 years old, in 2009, and
- children 14 to 18 years old, in 2010.

States may elect to cover children at a faster pace and in families with higher incomes. But they must do so only with state funds, with no federal financial participation.

Parents who are offered employer group health insurance for which the employer pays 50% of the annual premium must elect such coverage if they want to buy into Medicaid. Medicaid then would pay for services that are not covered by the private health plan but are covered under Medicaid. In these cases, a state must reduce its premium by an amount that reasonably reflects the contribution the family has paid for the private coverage.

If parents do not have access to employer group health insurance that meets this criterion, then Medicaid would be the primary payer.

States may charge a premium up to the full cost of the coverage, so long as it does not exceed 5% of family income for those with incomes up to 200% of the federal poverty level, or 7.5% of family income for those between 200% and 300% of the poverty level. In cases of undue hardship, states may waive the premium. Also, states are forbidden to terminate a child's

Medicaid eligibility based on failure to pay the premium until the failure continues at least 60 days from the premium's due date.

Home- and Community-Based Services Waivers for Children

The DRA also deals with a longstanding problem in states' ability to secure waivers to provide home- and community-based services for children with serious mental disorders. Currently, these children cannot be covered unless they are at risk of placement in a hospital. However, many children with serious mental disorders are at risk of placement in a residential treatment center, not a hospital.

Section 6063 of the DRA creates a five-year demonstration, starting in FY2007, to allow up to 10 states (awarded on a competitive basis) to test the cost-effectiveness of providing H&CB alternatives to psychiatric residential treatment centers.

The demonstration received an appropriation of \$218 million spread over five years (\$21 million in 2007; \$37 million in 2008; \$49 million in 2009; \$53 million in 2010 and \$57 million in 2011).

The waivers funded through this demonstration are subject to the same requirements as existing 1915c waivers, including budget-neutrality rules. At the end of the demonstration period a state may continue the home- and community-based services for children already enrolled in the program.

Money Follows the Person Demonstration Grant

Section 6071 of the DRA establishes a state demonstration-grant program that provides an enhanced federal Medicaid match as an incentive for states to move people who need long-term care services from institutions to community settings. The enhanced match would be available for up to 12 months after the person's transition. States could move people from nursing homes (including individuals with mental illnesses), intermediate care facilities for the mentally retarded and IMDs (those over age 64 in states that have covered such services).

The demonstration program will increase home- and community-based services for Medicaid-eligible individuals who require long-term care and eliminate legal, budgetary or other barriers to the flexible use of Medicaid funds to provide these services. In the process, it should promote individual choice, continuity of services and quality.

Roughly \$1.8 billion is provided for such grants over five years beginning, January 1, 2007.

Increased Cost-Sharing and New Premiums

States now have significant new authority, effective as of January 1, 2007, to impose premiums (including an enrollment fee or similar charge), deductions and co-payments for groups of Medicaid-eligible individuals and for services. Prior law limits cost sharing to a co-payment of

no more than \$3 for any service. Moreover, for the first time Medicaid beneficiaries can be denied coverage for failure to pay their premium within 60 days and denied a service if they fail to pay co-payments.

Allowable levels for state-imposed premiums and co-payments vary by family income, and some groups are exempted from premiums. States need not treat all people on in a group the same way, but may set different rules on cost-sharing for different subgroups of Medicaid beneficiaries.

No charges can be imposed for preventive services, services to children in foster care or receiving adoption assistance, or services to terminally ill or institutionalized individuals who receive only a personal-needs allowance.

The statute is unclear as to whether adults with family incomes below 100% of the federal poverty level will be exempted from premiums.

Although some groups are exempt from premiums, none are exempted from cost-sharing.

- Children in the lowest income groups (up to 133% of poverty for those under age 6 and up to 100% of poverty for those between 6 and 17) can only be charged \$3 for non-preferred drugs or non-emergency use of the Emergency Room. No other cost-sharing can be imposed on this group.
- Children between 100% and 150% of poverty who are in an optional eligibility group (that is, children under 6 with family incomes between 133% and 150% of poverty and children 6-17 with family incomes between 100% and 150% of poverty) can be charged up to 10% of the cost of the service, as well as \$3 for non-preferred drugs and \$6 for non-emergency use of the Emergency Room. Total cost-sharing is capped at 5% of family income.
- Other children can be charged a premium, up to 20% of the cost of most services, 20% of the cost of non-preferred drugs and an unlimited amount for non-emergency use of the Emergency Room. Total cost-sharing (including premium charges) is capped at 5% of family income.
- Adults with incomes below poverty can be charged premiums and cost-sharing with no apparent limits (this may be a drafting error) and \$3 for non-preferred drugs. There is no aggregate cap on charges (possibly due to a drafting error).
- Adults with incomes between 100% and 150% of poverty cannot be charged premiums and cost sharing can be up to 10% of the cost of the service, \$3 for non-preferred drugs and \$6 for non-emergency use of the Emergency Room. Total cost-sharing is capped at 5% of income.

- Adults with incomes above 150% of poverty can be charged premiums, cost-sharing up to 20% of the cost of the service and 20% of the cost of non-preferred drugs. Total cost-sharing is capped at 5% of income.

Cost-sharing amounts are to increase each year. The Secretary of HHS is required to index these allowable amounts by the medical consumer price index. Accordingly, these amounts and income levels will rise on a regular basis.

With respect to medications, states can waive higher cost-sharing for non-preferred drugs when a physician determines that the preferred drug is not effective for the individual or causes adverse effects.

Before individuals can be charged for non-emergency use of the Emergency Room, the following conditions must be met:

- An alternate non-emergency services provider must be available and accessible to the individual.
- After a medical screening examination and a determination that the individual does not have an emergency medical condition, the hospital must:
 - a) inform the person that a payment may be required;
 - b) supply the name and location of an alternate accessible and available non-emergency services provider;
 - c) inform the person that the alternative provider can offer services with a lower co-payment or none; and
 - d) provide a referral to coordinate scheduling of the treatment.

The hospital must supply this information before it can provide non-emergency services to an individual in the Emergency Room.

The DRA as enacted protects people with incomes between 100% and 150% of the poverty level from having to pay premiums or higher co-payments. However, the law includes no such language protecting people with incomes *under* 100% of poverty. Earlier versions of the bill included that protection, and it is unlikely that Congress intended to have those with the lowest income be charged more for Medicaid than people with higher incomes. It is generally assumed, therefore, that this is a drafting error. However, it is at this time law. Unless a technical corrections bill is enacted, states will have the flexibility to charge individuals living in abject poverty for access to health and mental health care. It is hard to imagine their doing so.

2. Medicaid Eligibility

Eligibility Restored for Some Children with Disabilities

Section 6065 of the DRA restores Medicaid eligibility for children under 21 years old who meet the “presumptive” eligibility requirements for Supplemental Security Income (SSI). Eligibility will occur on the date of application or the date when SSI eligibility is granted, whichever comes later. This section took effect on January 31, 2006.

Documentation of Nationality Now Required

Section 6037 requires individuals to present documentation of citizenship or nationality when they apply for Medicaid benefits or when their eligibility needs to be checked and recertified (see the [February 28 Bazelon Center Action Alert](#), *Danger—Red Tape Ahead!*). To be eligible for Medicaid services, an applicant will have to show a U.S. passport, certificate of U.S. nationality (or other document specified in the immigration and nationality act) or a birth certificate and a picture ID. (Whether the document must be an original is not stated, but a photocopy may be unacceptable.)

This requirement goes into effect June 31, 2006. The Secretary of HHS is required to develop an outreach plan to educate people who are likely to be affected, but it is very possible that many low-income individuals will not be aware of the rule or have the required documentation on hand. Advocates and others who work with individuals who rely on Medicaid should inform them of this change in policy and assist them in collecting the necessary papers.

3. Hurricane Relief

Sections 6201-6203 of the DRA provide Medicaid waivers to allow federal funds to be used to meet the health care needs of people who were forced by last year's major hurricanes to leave their home communities. The funds are to reimburse states that the Secretary of HHS deems eligible. Through the waivers, these states will be paid for their *non-federal* share of Medicaid and SCHIP expenditures for health care for hurricane evacuees and for uncompensated health care for evacuees who lack insurance. (No waiver is required for the federal share.) Two billion dollars were appropriated for this relief.

4. Family-to-Family Health Information Centers

Section 6064 of the DRA requires the Secretary of HHS to fund family-to-family health information centers to conduct outreach to families, health professionals, schools and other entities and provide information to help families make informed health care decisions. The centers will be staffed by health professionals and families who have expertise in federal and state public and private health care systems.

The centers' goals are to improve access to cost-effective treatment and health outcomes for children with disabilities or special health care needs. They will provide information about available resources, offer training and guidance on caring for children with disabilities, identify successful healthcare delivery models for such children and develop a model of collaboration between families and health professionals.

Funding will cover centers in 25 states in fiscal year 2007, in 40 states in 2008 and in all states by 2009. This provision was originally part of the Family Opportunity Act.

5. Temporary Assistance to Needy Families (TANF)

The DRA reauthorized the TANF program until 2010. No new funding is provided, although \$200 million is appropriated in new funds for child care.

TANF is particularly important to people with disabilities. According to a Government Accountability Office (GAO) report, adults who receive TANF benefits are three times more likely to have at least one physical or mental health impairment than adults who do not receive benefits under the program.

Unfortunately, many of the changes made by the DRA will be disastrous for recipients who need services and supports to achieve self-sufficiency. These include increased work-participation rates required of states, development of a standardized set of approved (and narrow) work activities and a requirement that work-participation rates apply to separate state programs, as well as to TANF. Separate state programs often assist two-parent families, some families with disabilities and some families in which the parent is in college when they need additional services or exemption from work requirements.

3.

The Secretary of HHS must issue TANF regulations by June 30, 2006 to address:

- when an activity can count as one of the federally listed work activities;
- uniform methods for reporting participation hours;
- documentation needed to verify reported hours; and
- circumstances under which a parent who resides with a child receiving assistance should be included in the work-participation rates.

HHS can impose significant penalties on states that do not develop procedures to ensure consistency with the new regulations.

It is very important that these new rules maintain states' current flexibility to meet the needs of TANF recipients who face barriers to work, such as people with depression and other mental illnesses. Otherwise, these individuals will be sanctioned for failing to comply with the new requirements. Barriers include lack of appropriate health care, substance abuse treatment, child care, education, accessible housing and employment supports. Studies find adults with disabilities disproportionately represented among former TANF recipients who have lost assistance—often their only source of income—due to a sanction.

The Bazelon Center will work with the [Consortium of Citizens with Disabilities](#) to develop comments on the proposed rules. We will post these comments on our website and encourage advocates to use them as a model for their own.

NewsBytes

Bipartisan Amendment Aids Senate Budget Resolution

Senators Arlen Specter (R-PA) and Tom Harkin (D-IA) were successful in [amending the budget resolution to increase discretionary program spending by \\$7 billion for fiscal year 2007](#).

The amendment passed on a 73-27 vote, prior to approval of the resolution 51-49. This amendment allows education and public health programs, including those administered by the Substance Abuse and Mental Health Services Administration, to be funded overall at fiscal year 2005 levels. This is good news for programs that faced potential cuts outlined in the President's budget proposal (see our [February 23 Action Alert](#)), such as the mental health block grant, and to help fund increases.

The House is expected to consider its version of the budget resolution the week of March 27.

Senate Committee Approves Bill to Gut Parity Laws

Last week, the Senate Health, Education, Labor and Pensions Committee approved harmful legislation that would preempt many consumer protections in health insurance regulated by states. This would primarily affect individual and small-group plans, and would have no impact on self-insured employer plans. The Health Insurance Marketplace Modernization and Affordability Act of 2005 (S. 1955) would undermine mental health parity laws in 39 states as well as various other health insurance consumer protection laws. The Bazelon Center joined in opposition to this legislation and supported a letter by the [Mental Health Liaison Group](#) to the committee chairman, Mike Enzi (R-WY).

The legislation will next be considered on the Senate floor.

Cuts in Housing Vouchers Ahead

According to a [report by the Center for Budget and Policy Priorities](#), the Bush Administration's proposed budget for the Housing Choice Voucher Program (HCVP) for 2007 would force many communities to reduce the number of rental-subsidy vouchers. As a result, people with disabilities would have even more difficulty than they do now finding decent housing they can afford.

The HCVP allows people with disabilities to rent housing of their choice in the community at a rent level generally between 30% and 40% of their incomes, with the balance subsidized by the federal government.

Under the Administration's funding formula, each housing agency's funding level is based on the amount it was eligible to receive the previous year, adjusted by an inflation factor set by HUD based on two-year-old data. Because the formula does not take into account either the actual number of vouchers the agency distributed in the previous year or any recent changes in local voucher costs, it leaves many agencies with insufficient funds to continue all of the vouchers currently in use.

What You Can Do

Call or write your member of Congress and insist that:

- The fiscal year 2007 budget must call for full funding of the Housing Choice Voucher Program and reject the "dollar-based" formula proposed to allocate voucher funding.

- The formula should be revised to better reflect housing agencies' actual costs and actual number of vouchers in use. If that occurs, the Administration's proposed funding level for 2007 would be sufficient to continue all of the 2 million vouchers now in use.

You can find the name and contact information for your Representative at congress.org.

Federal Grant Opportunity for Mental Health and Criminal Justice Collaboration

The Department of Justice has announced that on March 24, 2006 it will release grants authorized under the Mentally Ill Offender Treatment and Crime Reduction Act (P.L. 108-414), championed by Senators Mike DeWine (R-OH) and Ted Strickland (D-OH).

The Department of Justice received \$5 million in FY 06 for development and expansion of mental health and criminal justice collaboration programs at the state and local level. The programs can include pre- and post-booking diversion, mental health courts and other court-based approaches, transition programs and re-entry. Law enforcement training is also included.

The Bureau of Justice Assistance will administer the program. Potential applicants are encouraged to review the solicitation when it is released and to submit applications.

Forced Treatment Law Fails in New Mexico

The New Mexico legislature adjourned on February 16 without passing House Bill 174, the local version of the so-called "Kendra's Law" that would have imposed forced outpatient treatment on people with psychiatric disabilities. Without a special session, the state legislature is not scheduled to meet until next year. While the measure ultimately passed the House despite a number of committee meetings that heard powerful testimony from opponents, its movement slowed in the Senate in consideration of several amendments. Ultimately the clock ran out.

The implications go well beyond New Mexico, said Bazelon Center senior staff attorney Michael Allen, who had traveled to New Mexico to assist local advocates' efforts to defeat the bill. "This victory for a sane mental health policy will resound across the country," he noted, "refocusing public attention where it should be—on adequate funding for the services and supports needed by people with mental illnesses."

Harvey Rosenthal, executive director of the [New York Association of Psychiatric Rehabilitation Services](http://www.nyap.org) and a member of the Bazelon Center's board of trustees, also went to New Mexico in early February to urge the legislature to "reject the false solution of forced treatment." Allen and Rosenthal will return to New Mexico later this year to provide technical assistance to policymakers and advocates who are working on the state's mental health transformation agenda. "Now that the cloud of forced treatment has lifted," Allen added, "we can all get down to the real business of consensus building, and constructing a system that will meet New Mexico's needs."

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