From: Helene Gelber-Lehman [mailto:hgltraveling@gmail.com]
Sent: Tuesday, June 02, 2009 11:55 AM
To: EBSA, E-OHPSCA - EBSA
Subject: Comments re: Mental Health Parity Act

To Whom it May Concern:
Attached is a download-able and printable version of our comments re: the Mental Health Parity Act as well as some related legislative proposals. [They are also pasted into the text below]
These comments were originally forwarded to Adam M. Shaw, Senior Technical Advisor for CMS on May 28, 2009, who today advised that they be forwarded to you.
Please confirm that you received them.
Thank You for your expedient attention to this matter,
Yours Truly,
H.G. Lehman,Executive Director,
Association for the Rights of Disabled Consumers, Inc.

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Helene Gelber-Lehman, Executive Director

To: U.S. Dept. of Health and Human Services
Attention: Adam Shaw, Senior Technical Advisor, or [CMS-4137-NC]
7500 Security Blvd., Baltimore MD. 21244
BY EMAIL: adam.shaw@cms.hhs.gov

May 28, 2009

We are grateful for the opportunity to comment on the Paul Wellstone and Pete Dominici Mental Health and Addiction Equity Act of 2008 [MHPAEA].

The comments and proposals annexed, represent the collective feedback, ideas and experiences of members of the disabled community, compiled by the Association for the Rights of Disabled Consumers, Inc., [ARDC, Inc.] a non-profit 501C3, grass-roots organization established in New York City in 1974 by members of the disabled community who were dedicated to advocating for, and providing information and assistance to, others with physical and mental disabilities and their families.

Because certain aspects of the MHPAEA involve the Paperwork Reduction Act and the Regulatory Flexibility Act re: costs of administering the relevant treatment programs, etc. in addition to our comments re: the MHPAEA we have taken the liberty of including sketches of other related legislative proposals that—over the long term—could help to, a) restore Medicare [and Medicaid] portability to provide much-needed continuity of mental health-care to those who require continuous/ongoing treatment, and who are currently

denied care; b) create a "cyber-infrastructure" to substantially reduce the "paperwork" and costs and ease of administering, reporting, record keeping, billing and tracking lab tests and RX Medications, facilitating federal oversight and compliance requirements; c) allow aid [paying premiums and co-payments] to those who are economically challenged but not income-eligible for "poverty" benefits, by re-defining "poverty", providing tax-incentives to health care professionals who accept Medicare and Medicaid assignment; d) reduce the long-term burden of mental health/ addictions treatment through prevention vis-a vis mandatory nationwide emotional education and psychological support in our public schools, K-12; and e) protect the legal rights of those with "mental disability or illness" to obtain proper treatment; especially when they are economically challenged due to mentally and physical disabilities, and may not be entitled to a Guardian ad litem, because they are not "mentally incompetent" but "psychically injured or traumatized" and without equal access to justice, they will not get treatment and will be further traumatized by recent/ insidious forms of PTSD, caused by chronic homelessness and legal abuse, known as the "Legal-Abuse-Syndrome" * 1

**1 The Legal Abuse Syndrome is outlined and described by Karen Huffer, M.S. M.F.T. "Legal Abuse Syndrome(LAS) is a psychological trauma (a form of post traumatic stress disorder (PTSD)…that develops in individuals assaulted by ethical violations, legal abuses, betrayals…abbuse of power and authority and a profound lack of accountability in our courts….This stress can and does lead to physical illness. AMA statistics show that around 85% of all physical illness is directly attributable to stress. Legal Abuse Syndrome… leads to massive medical intervention costs, burdens insurance companies, and adds to Medicare and Social Security costs… whether it is regarding divorce, child custody, parental support, probate matters, personal injury, property disputes, legal or medical malpractice, criminal charges or other deeply personal issue.. Legal Abuse Syndrome(LAS) is a subcategory of PTSD.*

Yours Truly,

H.G. Lehman, Executive Director

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PART I

COMMENTS ON THE MHPAEA OF 2008.

Unless those who need Mental Health care can access *proper* treatment, and obtain treatment at the cost, frequency and consistency needed, Mental Health Parity may never become a reality, despite the enactment of the MHPAEA.

PROBLEMS OF TRUE PARITY IN MENTAL HEALTH SERVICES

- Currently, most MEDICARE + CHOICE PLANS typically serve the aged and appear to only employ mental health professionals qualified

to provide short-term "geriatric care" or in the use of psycho-tropic drugs.

- Unless all private and government health care plans are ***required*** to employ psychologists or other trained professionals, qualified to treat a full range of long-term Mental Disabilities –listed in the current Diagnostic and Statistical Manual of Mental Disorders [DSM] --and if there are none in the area, to allow for "remote" out of plan care to those who have special needs that are not otherwise provided for by the plan-- then many who desperately need mental health care, will never get proper care or proper diagnostic evaluation and despite the good intentions of the MHPAEA, Mental Health Parity will remain an unrealized ideal.
- Not every mental disability responds well to psycho-tropic drugs.
- Those with Mental Disabilities who require long-term specialized care, and cannot be treated with psycho-tropic drugs, are frequently refused proper care-- --or worse-- given improper treatment –and left to suffer from life-long iatrogenic disease, because proper treatment and qualified professionals are unavailable through the "provider groups".
- For Example, The State of California passed the KNOX KEENE ACT, as it's local form of MENTAL HEALTH PARITY. *3 However, only certain diagnoses are covered. Those with diagnoses other than those listed in KNOX-KEENE, are not entitled to treatment under current California law.

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*3 The Knox Keene Act only mandates treatment of specific "mental" conditions, leaving those who are diagnosed with conditions not listed in the KNOX_KEENE ACT, virtually with no right or access to treatment.

- In California, Mental Health Providers currently charge 2 1/2 times more for their co-payments as do any other specialist or the primary care physician, , [$25.00 as opposed to $10.00] thereby creating massive economic disincentives for those who most need treatment, to obtaining it.

PRESERVATION OF THE THERAPEUTIC ALLIANCE IS ESSENTIAL TO QUALITY CARE

- Many who require ongoing care for Mental Disabilities, require continuity of care. It is elemental in the field of psychology, that maintenance of a "bond" between treatment professional and patient - known as the "therapeutic alliance"--is one the most powerful and critical tools to healing those with life-long Mental Disabilities.
- Those who require long-term therapy, due to psychic injury or trauma, often require more frequent visits than one would ordinarily make to their primary care physician or other specialists and therefore even if the co-payments were on par with those charged by other specialists, patients who need more frequent care, are less able to afford

appropriate treatment and may never get any treatment or inadequate treatment.

- Additionally, if the treatment of a person with a mental disability is interrupted or terminated because the patient must travel outside the "service area" of the plan, for extended periods, [or is too ill or is injured and cannot appear personally for treatment] this ruptures the necessary therapeutic alliance and continuity of care that is needed for success of the healing process. Currently none of the health care providers have any billing code or provision for providing remote, telephonic counseling or therapy, to maintain the therapeutic alliance and provide ongoing support, when the patient cannot, for whatever reason, appear personally.
- Furthermore, if a patient has a mental disability for which there is no qualified provider in their "plan" the plan must provide "out of plan" care for this individual, regardless of the geographic area of the qualified provider.
- And if the patient has no means of traveling to the office of the qualified provider, remote access to therapy and treatment must be provided. Without doing so, the patient would be effectively denied proper care.

REGULATIONS FOR MENTAL HEALTH PARITY

- ✓ ALL PRIVATE HEALTH PLANS, MEDICARE + CHOICE PROGRAMS, MEDIC-GAP, MEDICARE SUPPLEMENTS OR MEDICARE FEE-FOR-SERVICE-PLANS MUST PROVIDE QUALIFIED PROFESSIONALS to treat each and every mental disability or condition listed in the Diagnostic and Statistical Manual of Mental Disorders[DSM] .
- ✓ If there are no qualified professionals in the geographic area served by the "plan" the either vouchers must be provided so that the patient can seek out proper care, or "remote-access" to telephonic or video consultations must be facilitated.
- ✓ Remote telephonic treatment must be made available, also to those who begin treatment at their residence, and then travel temporarily outside of the geographic sphere of their "provider group", to maintain the "therapeutic alliance".
- ✓ Medicare Co-payment schedules for frequent therapy must either be reduced to those similarly charged by the primary care physician, or "capped", so as to avoid providing a dis-incentive to receiving proper treatment, regardless of the frequency of care needed.

Without these changes, those suffering from Mental Disabilities who most need care, will be unable to access proper care and will face massive economic dis-incentives to obtaining treatment.

While there is an erroneous presumption amongst lay people that any licensed mental health professional is qualified to treat any mental health disorder, this is a false belief tantamount to the fallacy that any general practitioner is qualified to treat a rare form of cancer or genetic disorder.

THOSE DENIED PROPER MENTAL HEALTH CARE OR GIVEN IMPORPER CARE, MUST HAVE READY ACCESS TO PRO BONO LEGAL COUNSEL TO PROTECT THEIR RIGHTS TO TREATMENT. [See CIVIL GIDEON ACT of 2009, pp. 10-12]

PART II:

REDEFINING POVERTY: UPDATING THE OBSOLTE STATISTICAL MODEL

The current statistical model that defines poverty in the USA is obsolete, and must be updated.

Background

In 1963 during the Johnson Administration a woman named Mollie Orshansky devised a statistical model to define poverty based on a then- appropriate-ratio of cost of food [Dep't of Agriculture's Economy Food Plan] and cost-of -shelter [then used for pre-qualification for mortgages or rents].

Ms. Orshansky received several Congressional honors for devising this statistical model, however years later she acknowledged that her model had become obsolete due to the disproportionate increases in cost of housing, to food.

Notwithstanding Ms. Orshansky's efforts to correct the problem, Congress has, to date, refused to update the model used to define poverty.

The Department of Health and Human Services (HHS) still uses the original Orshansky Model to determine eligibility for MEDICAID, to determine "qualified" Medicare Beneficiaries" [for assistance with Medicare Preimums, etc] and other poverty-based benefits such as food stamps and scholarships.

Because eligibility for poverty-based benefits continues to rely on this obsolete statistical model, there is an alarmingly large portion of our nation, the working poor and those who are living with incomes marginally above the income-eligibility level for poverty benefits, that are truly living in poverty but remain ineligible for assistance.

Patricia Galbraith –an economist with the Madison Poverty Institute, wrote a book entitled, THE POVERTY LINE, suggesting that more appropriate calculations of poverty are employed by the Department of Housing and Urban Development (H.U.D.) and are used to determine eligibility for the Section 8 housing voucher program, in lieu of the Orshansky Model. Use of this more appropriate model is long overdue.

Proposed Solution

The Department of Health and Human Services (HHS) must take action to update the Orshansky Model and/or adopt policies defining poverty, similar to those employed by the Department of Housing and Urban Development (H.U.D.) to determine eligibility for MEDICAID, to determine "qualified Medicare Beneficiaries" and other poverty-based benefits such as food stamps and scholarships.

* * *

PART III: MENTAL DISABILITES PREVENTION ACT of 2009

EMOTIONAL EDUCATION MUST BE REQUIRED IN EVERY PUBLIC SCOOL IN THE USA

Our public school education currently fails to adequately prepare our citizens for life or to become responsible voters, parents and productive members of society.

By Mandating all public school curriculum [and private school curriculum, if any federal monies are received by them] to provide an emotional education curriculum, K-12 , Many mental and physical disabilities caused by "psychic injury" in early childhood, could be prevented.

The reactions of children to "psychic injury" often result in substance abuse, addictions, and life-long mental and/or physical disabilities which drain our economy, fill our prisons and welfare rolls, and destroy the bodies, minds and spirits of our children who are the future of our country.

MANDATED EMOTIONAL EDUCATION, INCLUDING CRITICAL THINKING SKILLS, K-12 to include ongoing classes and discussions re: a) Healthy Family Systems, b) critical thinking skills, geared towards discerning truth in rhetoric; improving the "emotional IQ" re: social relationships with peers, family members, members of the community at large; c) age-appropriate social skills, and parenting skills; d) age-appropriate skills in analyzing political and religious rhetoric… will give our children the kind of ongoing emotional education that they need to prepare them for being the future of our country.

Mandatory EMOTIONAL EDUCATION would also facilitate "intervention" and psychological and social support by school teachers, counselors, and peers through the open dialogue encouraged in support groups and classes.

Those children who are being abused or victimized at home or in their communities by dysfunctional family systems or dysfunctional environments, can quickly be identified and provided with necessary counseling and intervention.

Abuse by dysfunctional family systems, is often is underlying causation for substance abuse; unwanted pregnancies; mental disabilities; and gang activity.

Because children are not taught at an early age to identify --or appropriately articulate their feelings—they have not ability to deal with seriously dysfunctional or abusive environments.

BY REQUIRING EMOTIONAL EDUCATION IN OUR PUBLIC SCHOOLS, MANY LIFE-LONG MENTAL DISABILITIES AND SUBSTANCE ABUSE PROBLEMS WILL BE PREVENTED

PART IV:

CIVIL GIDEON [OR QUASI GUARDIAN AD LITEM] ACT OF 2009

The judicial system in this country fails to protect the rights of the disabled -- especially those with Mental Disabilities -- in our civil court system [and also in our or Federal Immigration System] by failing to provide pro bono counsel to those who can not otherwise defend their rights in civil matters. Especially their rights to obtain proper treatment for a mental disability.

All citizens have a constitutional right to inherit, and to defend their rights to property; to their families; to their rights for appropriate treatment; but those with physical or mental disabilities, don't have any practical way to obtain equal access to justice.

Current Probate and Civil law-- only allows a court to appoint an attorney for a disabled beneficiary or potential heir to an estate—or in other civil matters-- if and only if they are determined to be mentally incompetent. Many people who suffer from mental disabilities are not mentally incompetent, but are severely "psychically and emotionally injured or traumatized".

Only in the instance of finding one "mentally incompetent" [or if the party is a child, alcoholic, in prison, or overseas in the military and considered "Under disability"], will the Court be required by law to appoint a guardian ad litem [GAL] .

However-- because the GAL is not required to take the persons' who's rights they purportedly are assigned to protect, into account--the GAL has in inherent conflict of interest and will often settle against the best interests of their charge, just to make a quick and easy buck.

All too often, GAL's are assigned by Courts from attorney-pools that are populated by a patronage-driven system. These attorneys stand in line for cushy fiduciary appointments, and rarely act in the best interest of the person who's rights they are appointed to protect.

Because of this Conflcit-of-Interest, most people who suffer from mental and physical disabilities [but who are perfectly mentally competent] do not want a GAL assigned to protect their interests.

If a disabled heir or defendant is not determined to be mentally incompetent--they are not eligible for a guardian ad litem [GAL], even if they are unable to afford counsel and cannot, due to extreme "psychic or emotional injury or trauma, adequately defend their rights in court, without competent counsel to assist them.

OUR JUDICIAL SYSTEM IS ARCHAIC IN THE WAY IT VIEWS MENTAL ILLNESS!

JUDICIAL LAW RE: APPOINTMENT OF PRO BONO COUNSEL MUST BE REVISED.

If an attorney who represents a client in court is determined to have been incompetent in their representation of the client, that attorney is liable for suit against him/her and a new trial can be granted based on attorney incompetence.

However, if a disabled person who is found to be mentally competent but is obviously not emotionally or physically able to represent their own interests in court --by virtue of lacking sufficient legal training or knowledge—and having disabilities that create insurmountable obstacles to obtaining that information or training, these folks have no similar legal recourse to obtain a new trial if they fail to adequately protect their own rights in a civil legal proceeding.

LAWYERS OFTEN CHERRY-PICK THEIR CASES

Many of the so-called "super-lawyers", with glowing reputations for success, get their glowing reputations by cherry-picking their cases to insure a good "win record" and decline case that are not a "sure and easy win".

Any case that would require hours of research or preparation--when it is not certain that the statutory fees and commission would warrant an aggressive defense—are often abandoned.

Along with those cases, go the rights of the disabled person. For without counsel in most civil or probate proceedings, the average disabled persons has little chance of properly defending their rights.

Knowing this, unscrupulous probate attorneys often deliberately create complications that dissuade court assigned GAL's from aggressively defending the disabled client's rights, because litigating the matter may not yield the best result *for the attorney*.

PUNITIVE DAMAGES AND HEFTY SANCTIONS MUST BE ASSESSED AGAINST ATTORNEYS WHO ABUSE THE LAW IN CIVIL ARENAS !

Currently there are new ethical guidelines coming into play for attorneys who act in opposition to pro se litigants. But there must be pro bono attorneys available to those who cannot afford to retain counsel, to enforce these new guidelines and to protect the rights of disabled people in civil matters, when they are unable to do so themselves, but are not mentally incompetent.

For CONGRESS to continue to avoid this critical issue, is to make a mockery of our judicial system, because equal rights under the law will remain a joke in a country where those who most need protection of their rights to property and their inheritance, are not treated equally under the law.

Without a CIVIL GIDEON--OR QUASI GUARDIAN AD LITEM LAW that would allow the client to direct the litigation--the fabric of a democratic society will continue to erode, because there will be no equal access to justice or due process rights for those who are economically challenged due to disability.

CIVIL GIDEON is necessary to protect a disabled person's right to proper health care. All too often, those with mental or physical disabilities who most need care, go without treatment, because they are unable to protect their own rights and cannot obtain counsel to defend them.

For there to be true MENTAL HEALTH PARITY, our judicial system must be brought into the 21st century in it's posture and in it's laws re: those who are psychically injured or traumatized.

* * *

MEDICARE PORTABILITY ACT OF 2009

PART V:

SYNOPSIS:

Clearly, the original legislative intent for Medicare was to provide affordable, portable and nationwide health-care for our most vulnerable citizens, our aged and disabled.

This corrective legislation is proposed to remedy problems created by recent Medicare Legislation, [ie. the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003]. These errors eliminated the portability of Medicare Services by locking

Medicare recipients into Medicare+Choice-plan-contracts for an entire year and legislatively enabling these plans to have "residency requirements" for enrollment.

Prior to 2006 when the Medicare Modernization Act instituted the Nationwide Enrollment period, [Nov. 15-Dec. 31] Medicare recipients could "opt-out" of any plan within a month and default to "original" Medicare or enroll in a different plan.

After the enactment of the Nationwide Enrollment and "lock-in" period in 2006, if a Medicare recipient should move-- or have to travel outside the area of their residence—they are denied all rights to their Medicare benefits [save Emergency Room treatment] for up to a full year.

The subsequent legislation, appears to not only have contravened the original legislative intent by effectively extinguishing the portability of Medicare, but alos has had the constructive effect of denying Medicare recipients --who enroll in one of the "affordable" Medicare+Choice Plans because they require continuous care-- their constitutional right to travel; their Medicare rights; their rights to due process and equal protection; and rights to anti-discrimination under the ADA and the ADA Amendments Act of 2008.

While it may appear on the surface, that every Medicare Recipient is given a free "choice" of plan or "non-plan", this is not so, in practical reality.

Most Medicare beneficiaries living on fixed incomes who require ongoing care—and who are not currently income-eligible for Medicaid or other "poverty-based" aid—are economically coerced into enrolling in a Medicare+Choice Plan.

Because they do not have access to a crystal ball—that would allow them to foresee the future a year in advance-- they have no way of knowing at the time of choosing a plan, whether their lives will take a turn that will require them to leave the geographical area serviced by their "Plan".

Those who must leave the geographic area served by their "plan" are [under the current legislation] are faced with a choice of going without life-or health sustaining treatment for up to a full year, or remaining virtual hostage to the "provider plan".

The (proposed) **MEDICARE PORTABILITY ACT OF 2009** will facilitate compliance with the MEDICARE MENTAL HEALTH PARITY ACT OF 2008; foster healthy competition amongst federally funded health care providers, to improve the quality of mental and physical health care in this country, allowing those with rarer conditions, to seek proper treatment wherever it is available, through vouchers for out-of-network providers and through video or telephonic conferencing.
It will allow aged and disabled Medicare recipients [as well as those who qualify for Medicaid] to use and enjoy their Medicare benefits at their residence – or wherever they travel in the USA, without undue delay, as was originally intended by Congress--regardless of economic status or whether they opt for a private Medicare+Choice

Program, Medi-Gap Policy; Medicare supplement; Supplemental Medicaid; straight, fee-for-service Medicare or any other Medicare program.

LEGISLATIVE HISTORY OF THE PROBLEM

- Medicare was originally enacted by congress to provide affordable, portable health care nationwide, to any aged or disabled U.S. citizen, eligible for Social security- which is a tax-based program.

- Several decades later, Congress enacted THE BALANCED BUDGET ACT OF 1997, which enabled private health plans to act as primary providers of MEDICARE+CHOICE PROGRAMS and created "residency requirements" for enrollment.

- Then, in 2003 the MEDICARE MODERNIZATION ACT of 2003, inter alia, created a nationwide "lock-in" enrollment period, [Nov. 15-Dec. 31]. This aspect of the Medicare Modernization Act became effective Jan. 1, 2006.

- From thereon in, Medicare recipients who opted to enroll in these plans have been,
    a) obligated to pay monthly Medicare Premiums to the Federal Government;
    b) contractually obligated to pay monthly premiums to the private MEDICARE+CHOICE PLAN for the full calendar year;
    c) must comply with a "residency requirement" to join a plan; and
    d) must relinquish all rights to their Medicare benefits for a full year to the "plan" and if they leave area served by "the plan", they forfeit all their Medicare Rights, with the exception of Emergency or Urgent care.
- _____
- 1 *Until 2006--when the "lock-in" enrollment period was implemented--those who opted for a MEDICARE+CHOICE PLAN, could "opt-out" at any time and revert back to the Original Medicare fee-for-service program.*

- Those Medicare recipients who require life/health sustaining continuous care, were put in an unimaginable dilemma, rendered hostage to their "plan, unable to exercise their right to travel.

- By enacting the 2003 legislation, it appears that congress not only contravened it's original intent to create Medicare as a Nationwide, affordable and "portable" health care program for our most vulnerable citizens, but appears to have impermissibly infringed on Medicare recipients' "constitutional right to travel"; due process rights; equal protection rights and anti-discrimination rights as protected by the ADA and the ADA Amendments Act of 2008. *2 See *Shapiro v Thomson*.

*2 In Shapiro v. Thomson, 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed.2d 600 the U.S. Supreme Court ruled that imposing a one year residency requirement for receiving public benefits, was unconstitutional. In Shapiro v Thomson and 2 other related cases, three families who were receiving welfare, disability benefits and aid to families with dependent children [AFDC], were denied benefits in the state to which they traveled because those states imposed one year residency requirements before allowing them to receive public benefits, to which they were otherwise entitled. **"** *The majority [of the U.S. Supreme Court] held that the waiting-period requirement is unconstitutional because it 'has a chilling effect on the right to travel.' Id., at 336. The majority also held that the provision was a violation of the Equal Protection Clause of the Fourteenth Amendment because the denial of relief to those resident in the State for less than a year is not based on any permissible purpose... This Court long ago recognized that the nature of our Federal Union and our constitutional concepts of personal liberty unite to require that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement?* ***…Congress is without power to enlist state cooperation in a joint federal-state program by legislation which authorizes the States to violate the Equal Protection Clause… the Court holds that congressionally imposed requirements violate the Due Process Clause of the Fifth Amendment. It thus suggests that, even if residence requirements would be a permissible exercise of the commerce power, they are 'so injustifiable as to be violative of due process.' Ante, at 642. While the reasons for this conclusion are not fully explained, the Court apparently believes that, in the words of Bolling v. Sharpe, 347 U.S. 497, 500, 74 S.Ct. 693, 694, 98 L.Ed. 884 (1954), residence requirements constitute 'an arbitrary deprivation' of liberty. Katzenbach v. Morgan, 384 U.S. 641, 651, 86 S.Ct. 1717, 1723, 16 L.Ed.2d 828, n. 10 (1966). …"***

- The "residency requirement" also renders it impossible--for a Medicare Recipient who must travel frequently or for extended periods, outside of the area of their residence--to acquire health care from a plan more geographically appropriate to their needs, or a plan that may have providers in another part of the country that specialize in treating their medical condition;
- The residency requirement also denies the Medicare Recipient the opportunity to obtain a 2nd opinion from a specialist outside of the service area of the plan, and effectively removes all incentives to healthy competition to provide quality health care.

- If a Medicare recipient is severely economically challenged-- but ineligible for Medicaid or other poverty based programs *3 See Part II, REDEFINING POVERTY. Pp.4—they are effectively deprived of treatment…or at the very least, face extreme economic dis-incentives to accessing proper care.

MANDATING A TIME-LINE TO CREATE A CYBER-INFRASTRUCTURE TO FACILITATE PORTABILITY AND COST-SAVINGS

By creating CYBER-INFRASTRUCTURE and directing the Department of Health and Human Services to establish a fixed timeline [5-8 years] for requiring all licensed Health Care Professionals [not just those who currently accept Medicare or Medicaid assignment] to computerize their Medical Records and Billing systems, using software that will be easily integrated into a nation-wide network, the ease of record-transfer and

cross billing of Medicare [and Medicaid] will facilitate the portability of Medicare and Medicaid; will ultimately reduce the administrative costs of all health-care, nationwide; will create a mandatory, Federal qualitative standard for health care in this country; will create incentives for healthy competition for excellence of service amongst providers; and increase the mobility, economic and social advantages of those who suffer from disabilities that require ongoing or continuous care and will allow for true Mental Helath Parity by allowing continuity of care vis a vis telephonic or video therapy to preserve the essential "therapeutic alliance".

We have been advised by health care professionals, that the two largest dis-incentives to accepting
Medicare or Medicaid Assignment, are, a) the paperwork involved in billing and record keeping, and b) the reduced rates at which health care professionals are permitted to bill for services.

Creating cyber-infrastructure for Health Care is geared towards removing these dis-incentives by using Federal Stimulus monies and graduatally-declining tax incentives be to induce health care providers nationwide, to rapidly computerize all their medical and billing records, giving greater incentives, the sooner they get their medical records and billing "on-line".

Once an integrated cyber-infrastructure is in place, medical records, lab tests; billing, etc. can instantly be transferred via e-mail with one click of the mouse; lab tests can easily be billed by copying the insurance provider and CMA through e-mail, cc:'s thereby reducing the eventual cost of paperwork and documentation.

As a result of this cyber-infrastructure, the burden of accepting Medicare Assignment by "providers" will be lessened and tax incentives will compensate health-care providers for accepting Medicare and Medicaid assignment, for the lost income due to lower billing rates.

PROPOSED SOLUTIONS TO REMEDY THE LACK OF PORTABILITY AND REMOTE ACCESS TO TREATMENT

- ✓ Repeal the portion of the 1997 Balanced Budget Act that created a "residency requirement" for enrollment in Medicare+Choice Programs;
- ✓ Repeal the portion of the 2003 Medicare Modernization Act that mandates a yearly "lock-in period.
- ✓ Enact legislation creating "stimulus" incentives and "tax" incetives to Providers to rapidly computerize their records and billing procedures;
- ✓ Enact legislation that will allow Medicare+Choice Plans and Medicaid to provide "vouchers' for out of plan providers, when the travel outside the area served by the "plan".
- ✓ Or alternatively, allow rapid dis-enrollment and re-enrollment in a more geographically suitable "plan" so every Medicare or Medicaid recipient can

access ongoing care in the area to which they have traveled, without interruption in treatment;

- ✓ Update the statistical model used to calculate poverty for the purpose of providing financial assistance to those Medicare beneficiaries who currently are not income eligible for Medicaid but are too economically challenged to pay "plan premiums", Medicare Premiums and co-payments for ongoing care.

COST-SAVING CYBER-INFRASTRUCTURE WILL FACILITATE PORTABILITY AND OVERALL MEDICARE ADMINISTRATION

By using a portion of the "FEDERAL STIMULUS MONIES" to assist Health Care Providers in meeting a Federally Mandated time-line [between 5-8 years] during which, all health care professionals and all Private Health Plans [not just those who currently accept Medicare or Medicaid Assignment] will be required to computerize their medical records, coding and billing systems; using computer software that can be integrated with a Nationwide Network [such as the program and software currently used by the VA, nationwide] , we can create a Nationwide Cyber- Infrastructure that will : a) facilitate the overall administration of Medicare in conjunction with any private or state-licensed health-care programs, anywhere in the USA; b) make fluid the rapid transfer of records/medical information nationwide between private, state or federal providers instantaneously, thus easing the burden of implementation; c) facilitate billing, cross billing or "out-of-area- or out-of-plan providers, via a "voucher system" to enable Medicare [and Medicaid] recipients to easily obtain care by providers, specialists or to obtain 2nd and third opinions re: their treatment plan, wherever they travel ; d) facilitate remote-video and/or telephonic consultations for treatment; e) facilitate Mental Health Parity and continuity of the "therapeutic alliance"; f) foster healthy competition in the Health Care Industry generally, by increasing healthy competition amongst providers, giving incentives for them to attract patients outside their "provider group", allowing them to have financial incentives to, once again, begin to strive for excellence in their specialty. and g) this ACT-- and nationwide use integratable software-- will provide a vehicle for much needed "transparency", enabling FEDERAL OVERSIGHT of all private and governmental MEDICARE+CHOICE PLANS, MEDICARE SUPPLEMENT PLANS, MEDI-GAP POLICIES, MEDICAID PROVIDERS and PHARMACIES nationwide-- without having to disrupt the ongoing "partnership" between private and government sectors that currently share the costs of health care delivery to our most vulnerable citizens; facilitate Federal Oversight re: billing to avoid fraud and duplication; tracking of RX pharmaceuticals, and will prevent conflicting RX's or abuses of "controlled substances".