NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
900 17th Street, NW, Suite 420, Washington, DC 20006-2507 | Ph 202/393-6700 | Fx 202/783-6041 | naphs@naphs.org | www.naphs.org

VIA EMAIL: MentalHealth@finance.senate.gov

September 11, 2013

The Honorable Max Baucus
and
The Honorable Orrin G. Hatch
United States Senate
Washington, DC 20510

Dear Mr. Chairman and Sen. Hatch,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to respond to your August 1, 2013, letter to the mental health community.

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 700 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including inpatient care, residential treatment, partial hospitalization, and outpatient services.

COMMENTS

You specifically ask for ideas for improving the mental health system in the United States. We welcome your timely questions. As the nation looks to find the best possible ways to serve the overall healthcare needs of all Medicare and Medicaid beneficiaries, we also need to maintain sustainable programs for the future.

We share your optimism about the valuable role that behavioral health plays within overall health and your concerns about access to and coverage for quality care.

People with mental and addictive disorders are a very vulnerable population needing access to range of behavioral healthcare services, including life-saving inpatient psychiatric hospital care.

The demand for inpatient psychiatric care is increasing, while the number of inpatient psychiatric beds in many communities is lacking, resulting in growing visits to emergency departments. This means that people are not getting the right care at the right time, and this results in inefficiencies in the system.

The majority of Medicare beneficiaries receiving care in inpatient psychiatric facilities are low-income, have complex chronic illnesses, and medical comorbidities.

Many of these individuals are also enrolled in the Medicaid program. As the single largest payer for mental health services in this country, Medicaid is the safety net for people with serious mental illnesses.

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Our comments are intended to respond to the three specific questions raised in your letter.

What administrative and legislative barriers prevent Medicare and Medicaid recipients from obtaining the mental and behavioral health care they need?

Because behavioral health is integral to overall health, any modernization of the Medicare and Medicaid programs must take a close look at – and better meet – the needs of beneficiaries who live with mental and addictive disorders. Millions of Americans of all ages experience psychiatric and substance use disorders every year. Providing care in the right setting, at the right time, and with the right levels of support makes a difference in their lives, in their families' lives, and in their communities.

The fundamental change that needs to occur within both the Medicare and Medicaid programs is to finally bring true parity between behavioral health and other medical conditions. Currently Medicare is not subject to the parity law, and it provides a limited benefit for mental and addictive disorders. While Medicaid in some states offers a more robust behavioral benefit than Medicare, these benefits are optional to the states. In many cases, coverage requirements are unclear. And the federal mental health parity law does not apply to all aspects of Medicaid.

Congress has made it clear that there is strong bipartisan support for ensuring that behavioral health is an integral – and equal part – of overall health. With the passage of the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, Congress took a landmark step toward requiring parity between commercial health insurance plans for general medical care and for behavioral health care. This was neither a Democratic nor a Republican concept. It was an idea that advanced civil rights for individuals with behavioral health disorders. Both parties recognized the fairness and economic value of this approach. And so has the American public. In a recent national survey[1], Americans overwhelmingly agreed (93%) that mental health and addiction treatment services "should be covered and be part of any basic private health insurance plan."

The parity law was a national attempt to end the arbitrary barriers and limitations that had evolved in a piecemeal way within health insurance. The law has made significant strides in accomplishing this goal, but the job is not complete.

Congress can now take action to finish the parity job.

- **Congress can ask for regulatory clarity and full implementation of the federal parity law.** As we continue to await release of a final rule governing the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, one issue that, we believe, must be clarified in that final rule is "nonquantitative treatment limits (NQTLs)." The law makes it clear that insurers cannot use NQTLs to unfairly limit access to behavioral health care. However, further detail is required to help all parties fully understand – and enforce – what is meant by NQTLs. We urge Congress to ask regulators to specifically clarify that the parity law applies to the three-part scope of service (inpatient – intermediate – outpatient). Without this clarity, access to intermediate services (such as residential, partial hospitalization or intensive outpatient care) are in danger of disappearing. Regulatory clarification would improve both coverage and access.

  Congress can also provide the necessary resources to investigate complaints related to the federal parity law within the agencies of jurisdiction (Departments of Labor, Treasury, and Health & Human Services). Enforcement over the long term will help to ensure that the landmark parity law delivers the equality that it has promised America.

- **Congress can address the unintended consequences of the continuing use of the outdated exclusion of Medicaid Institutions for Mental Diseases (IMDs) for the Medicaid expansion population under the *Affordable Care Act* (ACA)**. Application of this IMD provision – created at a time when the delivery system was focused on long-term care rather than the short-term, acute care focus of today – is playing out in various ways that harm beneficiaries' access to necessary community-based care at a time of scarce resources. IMDs (psychiatric

[1] Public Opinion Strategies survey. Conducted for the National Association of Psychiatric Health Systems. See https://www.naphs.org/resourcemanager/handlerresource.aspx?id=295. October 2012.

hospitals and residential treatment centers) treat a high proportion of Medicare and Medicaid patients.

1. **Congress can improve access to behavioral health care right now by passing clarifying language that says that the IMD exclusion DOES NOT apply to the new Medicaid expansion population under the ACA.** The essential health benefit package required by the ACA includes "mental health/substance use" as one of 10 required benefits. Hospital care is also one of the 10 essential health benefits. However, the essential health benefit final rule recently issued by the Department of Health and Human Services (HHS) applies the outdated Medicaid IMD exclusion to this new Medicaid expansion population. On the other hand, IMDs (community psychiatric hospitals and residential treatment centers) are able to participate in health plans sold on the new health insurance exchanges. Newly insured individuals under the Medicaid expansion program should have the same access, choice, quality, and cost-effective treatment for inpatient behavioral health care as they do for medical/surgical treatment. This is not just about fairness and equity; it is about Americans getting the right care, in the right setting, at the right time. Allowing psychiatric hospitals and residential treatment centers to participate in the Medicaid expansion program would also lower the cost of inpatient behavioral health (including hospital and residential treatment centers) care by providing more choice and competition.

2. **Broader repeal of the IMD exclusion is necessary. In the meantime, Congress can monitor the progress and inform the evaluation of the Medicaid Emergency Psychiatric Care Demonstration Project.** Starting in July 2012, 11 states and the District of Columbia began implementing the Medicaid Emergency Psychiatric Demonstration, which was authorized in the *Affordable Care Act*. The demonstration is a three-year, $75 million project allowing states selected in March 2012 to cover patients in non-governmental freestanding psychiatric hospitals and to receive federal Medicaid matching payments for patients ages 21 through 64. The goal of the demonstration is to expand the number of emergency inpatient psychiatric care beds available in communities. The Medicaid program is a vital source of support for people with mental and addictive disorders, funding more than 50% of state and local spending on mental health services. Non-governmental community-based psychiatric hospitals could help relieve this access problem; however, due to the statutory Medicaid IMD exclusion, patients receiving care in these hospitals are not covered for their care if they are between the ages of 21-64 and the hospitals cannot get Medicaid federal matching payments for these services. This demonstration is seeking to present a solution. In a June 1, 2009, Government Accountability Office (GAO) report (GAO-09-347) on hospital emergency departments, it was reported that difficulty in transferring, admitting, or discharging psychiatric patients from emergency departments was a factor contributing to emergency department overcrowding. We believe that this demonstration can set the stage for positive change, and it can save money. Any positive results from the demonstration can – and should – be extended nationwide.

- **Congress can pass legislation to extend Medicare and Medicaid funding for the implementation of health information technology (IT) incentives to behavioral health providers and facilities.** Legislation is needed to provide financial incentives for behavioral health providers, including psychiatric hospitals and residential treatment centers, to help them adopt health IT systems, just like other hospitals and clinicians. House legislation has recently been introduced (H.R.2957), and we expect the introduction of similar Senate legislation soon. Currently, the IT financial incentive program only applies to general acute care hospitals paid under the DRG system and physicians. Psychiatric hospitals and residential treatment centers are critical parts of the overall healthcare delivery system, and these organizations have made great strides in beginning to implement health IT to help improve the delivery of behavioral health care and to better coordinate with overall health care. But much more needs to be done. Financial support by the federal government will be critical to ensuring that these behavioral healthcare providers will be able to take the next step toward fully implementing health IT along with other hospitals and healthcare providers. This would ultimately reduce costs by more than

$1.7 million over 10 years, according to a 2013 Avalere Health study, by helping to prevent adverse drug-to-drug interaction. Also, a January 2013 study by Johns Hopkins University found that hospital readmission rates for the mentally ill fell by 39% when other mental health professionals were given electronic access to inpatient psychiatric records.

- **Congress can pass legislation to eliminate the discriminatory Medicare 190-day lifetime limit.** Although parity applies to private health insurance plans, it does not apply to Medicare—the largest federal health insurance program. Medicare beneficiaries continue to be limited to just 190 days of inpatient psychiatric hospital care during their lifetime. This lifetime limit does not apply to psychiatric units in general hospitals, and there is no such lifetime limit for any other Medicare specialty inpatient hospital service. The 190-day lifetime limit is problematic for patients being treated in psychiatric hospitals as they may easily exceed the 190 days if they have a chronic mental illness. Unlike beneficiaries seen in other types of hospitals, most Medicare beneficiaries treated in inpatient psychiatric facilities (IPFs) qualify for Medicare because of disability, according to the Medicare Payment Advisory Commission (MedPAC). Patients being treated in inpatient psychiatric facilities tend to be younger and poorer than the typical Medicare beneficiary. Congress can bring the Medicare program up to the standard of all other insurance plans by – once and for all – eliminating the discriminatory Medicare 190-day lifetime limit.

- **Congress can provide oversight of current demonstrations to coordinate care for individuals eligible for both Medicare and Medicaid ("dual eligibles").** It will be important to ensure that innovations to coordinate care serve the complex needs of this population and support access to necessary services (rather than limiting consumer choice or adding unnecessary obstacles to behavioral health care). Care coordination should be the cornerstone of improving care for dual eligibles because it will save money and improve access to critical services needed by dual eligibles. Dual eligibles should continue to receive the protections of the Medicare program, such as national quality standards and clear guidelines on medically necessary care. Medicare is a national program, and all Medicare beneficiaries should be treated the same whether they are dually eligible or not. Medicare beneficiaries should not be shifted into state-run Medicaid programs.

- **The financial stability of the Medicare and Medicaid programs must be a top national priority.** Ensuring financial stability for these critical programs will require modernizing the programs, which must include covering the most cost-effective services and ensuring that beneficiaries receive the right care at the right time. A critical step to be certain that patients get the right care at the right time is to provide coverage for the full continuum of services. A key parity principle is that all levels of mental health and addiction services must be covered…just as we do for general medicine. If your child is in a car accident, it's understood that they may need physical rehabilitation after they leave the hospital as well as outpatient follow-up as part of their recovery process. Intermediate levels of care (such as skilled nursing facilities, rehabilitation hospitals, and long-term care facilities) are all covered services in health plans for a reason. Similarly, if a child faces a life-threatening mental or addictive disorder, they may need intermediate and outpatient care. In behavioral health, these levels of care include such services as residential treatment, partial hospitalization, and intensive outpatient follow up.

  NAPHS urges Congress and the Administration to ensure that a full continuum of hospital, intermediate, and outpatient services are available for mental and addictive disorders in the Medicare, Medicaid, and private health insurance programs.

- **Ensuring that America's youth have access to a full array of behavioral health services is essential to long-term overall health.** Young people – who are served primarily by Medicaid – are in need of particular attention. Children and adolescents with emotional and substance use disorders (and their families) are one of the most at-risk populations served by the Medicaid program and one of the populations that can benefit most from early and appropriate behavioral healthcare interventions. As Congress and the states work to reform Medicaid, it is important that the needs of this population be understood – and met. Doing so appropriately saves money, saves lives, changes futures, and ensures healthy communities.

Congress has made it clear over the years that it is necessary to provide a comprehensive array of services to children and youth. Congress has made children and youth a priority within Medicaid. The federal government set the tone for serving children and youth by mandating comprehensive assessments and periodic screenings and by providing a package of Medicaid services (embodied in targeted case management, rehabilitation, and services offered in the under-21 benefit) to provide a comprehensive array of services essential to ensuring that children and families receive the services they need. As a result, Medicaid has played an essential role in ensuring comprehensive coverage for young people with emotional and substance use disorders. Without Medicaid, there is no access to or coverage of mental health care for many of our country's most vulnerable – and treatable – children and youth.

In today's world, it is more essential than ever to recognize – and preserve – the lifeline that Medicaid provides in the lives of children with emotional and substance use disorders.

A full continuum of services for young people must be available – including inpatient, residential, and outpatient services. Placement in the wrong level of care is costly. Finding the right level of care to match the intensity of a child's needs helps to prevent incarceration, injuries to self or others, and recycling through levels of care that are not sufficient to meet complex needs.

How can Medicare and Medicaid be cost-effectively reformed to improve access to and quality of care for people with mental and behavioral health needs?

Parity is cost-effective.
Each of the recommendations outlined above would go a long way toward improving access to behavioral health care by eliminating historic, arbitrary barriers to necessary care.

At the same time, cost-offset studies have consistently demonstrated the economic value of early identification and intervention on both the long-term health of individuals and the well-being of communities (in terms of reduction of absenteeism, accidents, lost productivity, incarceration, etc.).[2], [3]

Quality must be clinically-driven.
It is essential to have responsive, accountable, and clinically effective treatment for mental and substance use disorders. A number of quality / performance measure initiatives are now in place, including Medicare's Inpatient Psychiatric Facility Quality Reporting (IPFQR) program and The Joint Commission's Hospital-Based Inpatient Psychiatric Services (HBIPS) core measures. These programs have evolved with extensive input from clinicians as well as other stakeholders and with the long-term goal of providing data back to the field that can be used to continuously improve treatment. These are complex systems that should be given an opportunity to reach their full potential. Rather than piling on more and more measures, every effort should be made to avoid duplicative or excessive reporting. Data for data's sake is an expense and can take away from the time devoted to direct patient care. The field needs practical information and the time to make meaningful use of the data it is now reporting to change clinical practice. Any quality reporting you require should be examined in light of whether it helps clinicians drive organizational change that can make a real difference in their patients' lives.

What are the key policies that have led to improved outcomes for beneficiaries in programs that have tried integrated care models?

Integration of behavioral health and general health care is very important because 29% of adults with medical conditions also have a mental health problem. And 68% of adults with a mental health condition also have medical conditions, according to researchers.[4]

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[2] Sacks et al. "State Costs of Excessive Alcohol Consumption, 2006," *American Journal of Preventive Medicine.* Vol. 45, No. 4. October 2013. Available online ahead of print at http://www.ajpmonline.org/webfiles/images/journals/amepre/AMEPRE_3854-stamped-081313.pdf.

[3] Washington State Department of Social and Health Services, Management Services Administration Research and Data Analysis Division. (2003). Washington state supplemental security income (SSI) cost offset pilot project: 2002 progress report. Estee, S. and D. Nordlund. See http://162.99.3.205/post/Washington-State-Supplemental-Security-Income-(SSI)-Cost-Offset-Pilot-Project-2002-Progress-Report.aspx.

Depression has been shown to increase overall health care costs by 50% to 100%. The increase in costs associated with depression is particularly large with patients with multiple chronic medical disorders.[5]

One approach that deals with the integration of behavioral health and general health is "Collaborative Care."[6] The key principles of Collaborative Care are: 1) care coordination and care management support for patients initiating treatment in primary care; 2) regular/proactive monitoring using validated clinical rating scales, such as the PHQ-9 for depression; and 3) regular psychiatric consultation for the primary care treatment team regarding patients who are not improving.

Coverage of Collaborative Care, say researchers[7], can improve medical and mental health outcomes and functioning. It also has the potential to reduce overall health care costs, especially in high-risk populations with co-occurring mental and medical illnesses. The principal barrier to wider implementation of this evidence-based intervention is that the financing of this type of care approach is inconsistent and variable.

Other integration strategies include psychiatric consultation/liaison services (where mental health professionals provide behavioral health services at the bedside of persons who are recovering from a heart attack, stroke, or other major medical illnesses). These psychiatric consultation/liaison services can improve outcomes, reduce hospital lengths of stay, and prevent readmissions.

We know that behavioral health is integral to overall health. However, in order to truly achieve better outcomes and lower overall healthcare costs, we need a more integrated delivery system, and we need to develop payment systems that incentivize this type of coordinated care.

CONCLUSION

Thank you for your consideration of our comments. We look forward to working with the Senate Finance Committee and the entire Congress to ensure that all Americans continue to have access to high-quality, life-saving behavioral healthcare services.

We would be happy to provide detailed information on any of the recommendations included in this letter. Please feel free to contact me (202/393-6700, ext. 100) or NAPHS Director of Congressional Affairs Nancy Trenti, J.D. (202/393-6700, ext. 103).

Sincerely,

/s/

Mark Covall
President/CEO

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[4] TrendWatch. "Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs & Outcomes." American Hospital Association. January 2012. Druss, BG and Walker ER (February 2011). *Mental Disorders and Medical Comorbidity. Research Synthesis Report No. 21.* Princeton, NJ. The Robert Wood Johnson Foundation.

[5] Unutzer J, Schoenbaum M, Harbin M. "Collaborative Care for Primary/Co-Morbid Mental Disorders: Brief for CMS Meeting July 27, 2011 (updated August 4, 2011)."

[6] Ibid.

[7] Ibid.