

# Mental Health Liaison Group

September 30, 2013

The Honorable Max Baucus  
United States Senate  
Washington, DC 20510

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

Dear Mr. Chairman and Ranking Member Hatch:

On behalf of the millions of Americans living with mental and substance use disorders, their families and communities, the undersigned organizations write today in response to your August 2013 Open Letter requesting ideas for improving the mental health system in the United States.

As an advocacy coalition on mental health issues, the Mental Health Liaison Group (MHLG) has developed consensus positions on issues that we believe can make a critical difference in the lives of those who live with mental and addictive disorders. Highlights from our longstanding consensus recommendations are summarized below in response to the three questions you raised in your letter. We look forward to working with you to implement policies that will improve the lives of the millions of Americans who rely on Medicare and Medicaid for life-saving behavioral health services.

We greatly appreciate your leadership in focusing on these important issues.

***QUESTION: 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?***

## **EXCELLENCE IN MENTAL HEALTH ACT (S.264/H.R.1263)**

The MHLG has supported the *Excellence in Mental Health Act* ([3/18/13 MHLG letter](#)).

The individuals served by community providers tend to have poorer health than the broader population, with a higher prevalence of chronic illness, a higher incidence of catastrophic health events, and a higher prevalence of serious mental illness, substance abuse and co-occurring chronic health conditions. Yet, federal payment models and regulatory structures have not kept pace with the growing demand for community services. Meanwhile, steadily decreasing state funding streams are putting pressure on community providers to lower costs and produce savings for the healthcare system. The result is that mental health and addiction providers struggle to meet the need for care, while individuals who cannot access care often see their conditions deteriorate, in many cases ending up in the emergency department or the criminal justice system after a mental health crisis.

We need a better way to address mental illness and addictions in the U.S. – a solution that builds strong community treatment networks, supports individuals who are trying to change their lives, and preserves public health and safety. The *Excellence in Mental Health Act* (S. 264/H.R.1263) would bolster our

National organizations representing consumers, family members, advocates, professionals and providers  
c/o Trevor Summerfield, American Foundation for Suicide Prevention at [tsummerfield@afsp.org](mailto:tsummerfield@afsp.org),  
Julie Clements, American Psychiatric Association at [jclements@psych.org](mailto:jclements@psych.org) and  
Nancy Trenti, National Association of Psychiatric Health Systems at [nancy@naphs.org](mailto:nancy@naphs.org)

nation's community mental health and addictions system, providing new support for integrated and simplified treatment that will improve Americans' health and lower costs for the federal and state governments.

This legislation responds to the overwhelming bipartisan call at the beginning of 2013 to "fix" the public mental health system. Specifically, S.264/H.R.1263 requires federal certification of Community Behavioral Health Clinics who, in turn, would be mandated to provide a basic set of evidenced-based mental health services. A prospective payment system would be sufficient to support the provision of an array of intensive community-based interventions including: targeted case management, crisis mental health services, 24 crisis mobile teams, psychiatric rehabilitation, medication management, acute detoxification services, and peer counseling.

### **INFORMATION TECHNOLOGY**

The MHLG wrote ([9/12/13 MHLG letter](#)) in strong support for H.R. 2957, the *Behavioral Health Information Technology Act of 2013*, and a bill to extend the meaningful use incentives established through the *American Recovery and Reinvestment Act* to mental health and substance abuse providers and facilities.

The *American Recovery and Reinvestment Act* provides \$20 billion in incentives to health care providers and hospitals to establish interoperable electronic health record (EHR) systems throughout the nation. These benefits are extended to most physicians, chiropractors, dentists, optometrists, podiatrists and most hospitals. However, an important sector of the health care community is excluded—clinical psychologists, psychiatric hospitals, substance use treatment facilities and mental health treatment facilities.

The ultimate goal of widespread adoption of health information technology – to save American lives through improved coordination of care – is particularly relevant to persons with mental and addictive disorders. Recent studies have revealed that persons with serious mental illness die sooner than other Americans, and have an average age of death at 52. Health information technology (HIT) is the essential cornerstone of efforts to address this emerging public health crisis. HIT will enable behavioral health and substance abuse providers to effectively coordinate care across mental health and substance abuse service systems, primary care entities, and specialty medicine.

The *Behavioral Health Information Technology Act of 2013* would make important changes to Medicare and Medicaid to ensure that the incentives provided through ARRA for the meaningful use of electronic medical records would allow for these mental health and substance use providers, hospitals and facilities to be on par with the rest of the nation in regards to the electronic exchange of health information and as a result improve the health and safety of all patients.

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

### **PARITY**

The MHLG was a leader in advocating passage of the historic *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA). This law has laid the groundwork for

ensuring that disorders of the mind are treated no differently than those of the rest of the body. The principle that health insurance should not discriminate against individuals with mental and addictive disorders is fundamental. And progress has been made. For example, Congress passed legislation to phase-in adjustment of Medicare beneficiaries' copay for outpatient mental health treatment. Until that legislation, beneficiaries had been required to pay 50% of the cost of outpatient mental health treatment, compared to only 20% of the cost for other outpatient services.

But discrimination remains. (See [4/23/07 MHLG letter](#).) Coverage of inpatient services in psychiatric facilities is capped at 190 days per a beneficiary's lifetime. Medicare does not cover such important service settings as crisis residential programs, therapeutic family or group treatment homes, and residential detoxification and substance abuse treatment centers. Medicare's coverage of core mental health professionals is limited, reducing beneficiaries' choice of provider and access to care. Medicare does not cover such important community-based services as psychiatric rehabilitation, intensive case management, and day treatment. The unfortunate result is that most Medicare beneficiaries in need of mental health treatment are not seen by a mental health specialist.

MHLG has written ([1/25/13 MHLG letter](#) to President Obama) in support of fully implementing key provisions of the *Affordable Care Act (ACA)*, including mental health and addictions parity requirements. Continued leadership in ensuring full and effective implementation of the ACA is needed.

#### **ELIMINATE THE MEDICARE 190-DAY LIFETIME LIMIT**

The MHLG wrote in support of ending the discriminatory Medicare 190-day lifetime limit (in [8/11/11 MHLG letter](#) on the *Medicare Mental Health Inpatient Equity Act*, [H.R. 2783](#); also wrote in [4/23/07 MHLG letter](#)).

This critical legislation eliminates the discrimination against mental illnesses that continues to exist in the Medicare program as Medicare beneficiaries are still limited to 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.

Through passage of landmark legislation, the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, Congress put coverage for mental health and addictive disorders on par with other medical disorders. Also that year Congress passed important legislation to phase-in equalization of the Medicare outpatient coinsurance for mental and physical health. The *Affordable Care Act (ACA)* specifically includes mental health and substance abuse parity benefits in the essential benefit package to be offered through new healthcare exchanges for small businesses and the individual market. And those benefits must be offered in accordance with the federal parity law. We must now finish the parity job and finally give Medicare beneficiaries the full parity that other individuals now have.

We urge Congress to eliminate the Medicare 190-day lifetime limit for psychiatric hospital care. This would improve access to inpatient psychiatric care by allowing Medicare patients coverage in

freestanding, psychiatric hospitals. The elimination of the 190-day limit will equalize Medicare mental health coverage with private health insurance coverage, offer beneficiaries the choice of inpatient psychiatric care providers, increase access for the most seriously ill, improve continuity of care and create a more cost-effective Medicare program.

#### **EXPANSION OF MEDICARE OUTPATIENT PROVIDERS**

The MHLG supports expansion of eligible Medicare outpatient providers ([4/23/07 MHLG letter](#)).

Expanding Medicare's coverage of state-licensed mental health professionals would enhance beneficiary choice of provider and access while not broadening existing outpatient services.

#### **MEDICAID EMERGENCY PSYCHIATRIC CARE DEMONSTRATION**

The MHLG wrote in support of the Medicaid Emergency Psychiatric Care Demonstration that was authorized as part of the *Affordable Care Act* ([3/13/09 MHLG letter](#)). The three-year demonstration is now in progress. Congress should continue to monitor the demonstration programs.

The *Medicaid Emergency Psychiatric Care Demonstration Project Act* established a demonstration program to provide Medicaid patients equal access to all community inpatient psychiatric services.

The Medicaid program is a vital source of support for people with mental disorders, funding more than 50% of state and local spending on mental health services. During such uncertain times, the mental health needs of all Americans should be a high priority, especially the needs of those Americans who are in crisis. Today, millions of Americans are under the tremendous stress of losing their jobs, homes, and most of their savings.

Emergency psychiatric care delivered in both general hospitals and freestanding psychiatric hospitals is an integral component of community-based care for persons with severe mental disorders. A crisis in access to emergency care services has been growing for those who have severe mental disorders. Community-based inpatient psychiatric beds have declined by more than 30% during the last decade or so. As a result, a substantial increase in admissions at remaining hospitals has taken place. The decline in psychiatric beds has led individuals to seek care in already overcrowded emergency rooms or travel far distances to receive emergency inpatient psychiatric care.

In this demonstration, states applied for Medicaid funds to improve access to inpatient psychiatric care by allowing adult Medicaid patients (IMD exclusion) coverage in freestanding, non-governmental psychiatric hospitals for the stabilization of their psychiatric emergency condition.

The goal of the demonstration program is to ensure that Medicaid patients receive the right care, at the right time, in the right setting. As a result, the delivery of mental health services under Medicaid becomes more efficient and cost-effective.

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

**INTEGRATION**

The MHLG has written in support of expanding opportunities for mental health providers to be part of integrated health care that addresses patients' physical and behavioral health needs ([1/12/10 MHLG letter](#)).

Vitally important integrated health care provisions would appropriately move health care delivery toward an interdisciplinary team-based approach that coordinates traditional diagnostic and therapeutic services, and, if necessary, coordinates care and links individuals to other providers and community services. We support the furtherance of such integrated interdisciplinary health care systems through Medicaid medical home (or "health home") efforts.

**SUICIDE PREVENTION**

The MHLG has supported all efforts at suicide prevention ([8/13/13 MHLG letter](#)).

The Mental Health Liaison Group supported the *Garrett Lee Smith Memorial Act Reauthorization of 2013*. This legislation renews the commitment to critically important youth and college suicide prevention programs administered by the Substance Abuse and Mental Health Services Administration, ensuring they are best designed to meet the needs of those they are intended to serve.

The *Garrett Lee Smith Memorial Act* (GLSMA) has supported youth suicide prevention grants in 49 states, the District of Columbia and Guam, 48 Tribes or Tribal organizations, and 138 institutions of higher education since it was first authorized in 2004. Unfortunately, more than 38,000 Americans die by suicide annually and suicide remains the second-leading cause of death for adolescents and young adults between the ages of 10 and 24 and results in 4,800 lives lost each year, according to the Centers for Disease Control and Prevention.

While much has been achieved thanks to the successful grants supported by the GLSMA, there remains much to do. According to the Centers for Disease Control and Prevention, "a nationwide survey of youth in grades 9-12 in public and private schools in the United States (U.S.) found that 16% of students reported seriously considering suicide, 13% reported creating a plan, and 8% reporting trying to take their own life in the 12 months preceding the survey." The 2012 American College Health Association's National College Health Assessment II noted that 44.6% of students surveyed reported feeling that things were hopeless and 29.5% reported feeling so depressed it was difficult to function during the past 12 months.

Since its creation in 2004, the *Garrett Lee Smith Memorial Act* has provided resources to communities and college campuses all across the country, and supported needed technical assistance to develop and disseminate effective strategies and promising practices related to youth suicide prevention.

Our organizations support all three elements of the GLSMA, which provide a comprehensive approach to addressing the national problem of youth suicide. Specifically, the State and Tribal

program fosters the creation of public-private collaborations and the development of critically needed prevention and early intervention strategies. Next, the Campus Suicide Prevention Program enhances services, outreach and education for students with mental health or substance use disorders and calls for the development of best practice for the delivery of such services. Finally, the Suicide Prevention Resource Center provides information and training to States, Tribes, and tribal organizations, institutions of higher education, and public organizations or private non-profit groups in an effort to prevent suicide among all ages, particularly among high risk groups, such as youth.

**FOR FURTHER INFORMATION**

MHLG thanks you for your leadership and stands ready to work with you on the goal of improving behavioral health in America. We invite you to contact our work group co-chairs Nancy Trenti at 202/393-6700, ext. 103, and Ron Honberg at 703/516-7972 for comments or with questions.

Sincerely,

Alliance for Children and Families  
American Art Therapy Association  
American Association for Geriatric Psychiatry  
American Association for Marriage and Family Therapy  
American Association for Psychoanalysis in Clinical Social Work  
American Association for Psychosocial Rehabilitation  
American Association of Pastoral Counselors  
American Counseling Association  
American Dance Therapy Association  
American Foundation for Suicide Prevention  
American Group Psychotherapy Association  
American Mental Health Counselors Association  
American Occupational Therapy Association  
American Psychiatric Nurses Association  
\*American Public Human Services Association  
\*American Society of Clinical Psychopharmacology  
Anxiety and Depression Association of America  
Association for Behavioral Health and Wellness  
Center for Clinical Social Work  
\*Center for Integrated Behavioral Health Policy  
\*Child Welfare League of America  
Children and Adults with Attention-Deficit/Hyperactivity Disorder  
Clinical Social Work Association  
Clinical Social Work Guild 49, OPEIU  
\*Corporation for Supportive Housing  
Eating Disorders Coalition for Research, Policy & Action  
\*Education Development Center  
First Focus  
\*Grantmakers In Health  
The Jewish Federations of North America

Legal Action Center  
National Alliance on Mental Illness  
National Alliance to Advance Adolescent Health  
National Association for Rural Mental Health  
National Association of Alcoholism and Drug Abuse Counselors  
National Association of Anorexia Nervosa and Associated Disorders  
\*National Association of Counties  
National Association of Psychiatric Health Systems  
National Association of School Psychologists  
National Association of Social Workers  
\*National Association of State Medicaid Directors  
\*National Business Group on Health  
\*National Child Traumatic Stress Network  
National Council for Community Behavioral Healthcare  
\*National Foundation for Mental Health  
Mental Health America  
\*Religious Action Center of Reform Judaism  
\*Schizophrenia and Related Disorders Alliance of America  
School Social Work Association of America  
State Associations of Addiction Services  
\*TeenScreen National Center for Mental Health Checkups  
The Trevor Project  
Treatment Communities of America  
Tourette Syndrome Association  
U.S. Psychiatric Rehabilitation Association  
\*ZERO TO THREE

\*Observers