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The Honorable Max Baucus
Chairman
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Orin Hatch
Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Senate Finance Committee Letter Regarding Mental Health Finance Issues

Dear Chairman Baucus and Senator Hatch:

Introduction

The National Association of State Mental Health Program Directors (NASMHPD) appreciates the opportunity to respond to the Senate Finance Committee Inquiry Letter regarding better solutions to improve the nation’s mental health system, specifically as it relates to the letter’s specified three categories: administrative and legislative barriers; improved outcomes under integrated care models; and cost-effective Medicare and Medicaid reform.

NASMHPD is the only member organization representing state executives responsible for the \$37.6 billion public mental health service delivery system serving 7.1 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association.

The answers below reflect not only the response from NASMHPD itself, but also from a multitude of states who provided specific and detailed responses to NASMHPD regarding the Senate Finance Committee’s questions. While we have kept the names of those states confidential for the purposes of this letter, several states have also submitted independent letters to the Committee.

The goal of the public mental health system is to provide services based upon a person’s mental health needs and their recovery process. NASMHPD and its members believe that a **balanced** public mental health system approach is needed to include both a competent state hospital system and a community based system—something that has proved to be problematic because of decreased capacity due to underfunding of both systems at all levels of government. From 2008 to 2012 the states cut **\$4.3 billion dollars** in funding from state mental health authorities. These cuts have stressed an already strained mental health system to, in some instances, well past their breaking point.

In addition, the implementation of the Affordable Care Act (ACA) appears to be having an impact on the mental health field. Particularly in states that have opted for the Medicaid expansion, data from the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that people with mental health challenges will have access to affordable health insurance coverage for mental health services that they've previously not had access to or services have been denied in the past. In addition, it appears that the law may have a significant impact on the mental health community because it builds on the Mental Health Parity and Addiction Equity Act of 2008 ensuring that mental health coverage is comparable to medical coverage.

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

IMD Exclusion

NASMHPD strongly encourages the **repeal of the institute for mental disease (IMD) exclusion**. The IMD exclusion was originally created in 1965 because federal policymakers did not want to supplant state and local efforts around what were then massive psychiatric hospitals. The exclusion states that any facility that has more than 16 beds and more than 51% of its patients between the ages of 21 to 64 with a mental illness is excluded from receiving federal Medicaid funds.

This antiquated provision has not kept up with the changing landscape of the public mental health system. First, it prevents the best possible of care to be provided to this age group thereby causing states not to be reimbursed for their treatment and patients being churned in and out of various institutions.

Second, the ACA's ongoing and upcoming cuts to the disproportionate share payments (DSH) to the states will produce an unforeseen problem with the IMD exclusion as many states had turned to these DSH payments to alleviate the lack of Medicaid dollars to state hospitals. A recent [NASMHPD Bulletin](#) explains the interconnections between DSH and the IMD exclusion.

NASMHPD's position is also in unison with the Nation Association of Medicaid Directors position (refer to their public [Comments Letter](#) they submitted to the Committee on Health, Education, Labor and Pensions; April 18, 2013).

Early Identification/Access to Services

Because of the recent tragedies, the mental health system has been in the spotlight. Congress, state leaders, the media and general public are seeking answers to why these acts occurred. NASMHPD feels that early identification and treatment intervention of mental health problems, particularly in the school settings, is one of the key components to possibly averting future tragedies. For this to occur there needs to be an increased level of cooperation and mutual assistance between the mental health system and the public school system. In order to best provide early intervention and treatment, integrating efforts between these two systems is critical. Our key suggestions include:

- Clarify, on a nationwide basis, when services are available "for the benefit of the child" vis a vis the parent's Medicaid status. At the moment there is no rule or guidance that defines this, and the CMS regions have been addressing this issue inconsistently.
- Provide health homes for children and youth to ensure collaborative care; the current health homes policy excludes children and youth.

Another key component to help increase early identification and also reduce the stigma still commonly associated with mental illnesses is through [Mental Health First Aid](#) – a "cookbook" of easy and early responses to help the "public identify, understand, and respond to signs of mental illnesses and substance use disorders." NASMHPD encourages the **promotion and funding** of Mental Health First Aid trainings.

Along the aging continuum, removing administrative barriers – such as Medicare’s lifetime limitation of 190 days for inpatient psychiatric care or allowing Medicare to cover essential community-based services such as case management or psychosocial rehabilitation – would be helpful. In addition, the expansion of the Medicare special needs health plans to include individuals with complex medical needs, including serious mental health conditions, would also be desirable.

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

Integrated Settings

People with a mental illness die 25 years early. Not because of their mental illness, but rather due to diabetes, cancer and all of the “normal” medical problems that plague everyone. NASMHPD’s [Technical Report](#) (October 2006) concluded that premature deaths occur due to the lack of integration between the mental health world and the physical health world. Not only is this obviously a bad result for the mentally ill, but it carries with it a host of associated issues ranging from lost tax revenues to increased health costs for a significant part of the U.S. population when most people are still relatively healthy (i.e., on a macro level the U.S. is losing productive healthy years and still paying for expensive end of life years).

To prevent these years lost, NASMHPD recommends:

- Continuing the funding and implementation of **health homes** and, possibly in the future, *behavioral health homes*. There is enormous potential to create integrated settings that provide care across the entire spectrum of maladies – particularly if Congress and CMS ensure that they remain operationally flexible to address the unique problems presented by persons with a serious mental illness.
 - To incentivize states to participate in health homes, CMS should provide a slightly higher rate when a provider is participating in a health home or other similar arrangement for that particular client; and allow CMS payments for non-licensed providers (i.e., peer specialists) for certain activities such as pill counts, appointment reminders and home visits.
- Allocating **additional funding for states** to transform their mental health system into an integrated care model. One such example was the state of Washington establishing a public-private partnership to develop the AIMS Center and Mental Health Integration Program. Both programs have been successful in effectively providing treatment for common mental health conditions such as depression and anxiety, improving quality outcomes, and reducing medical costs. Due to state budget cuts, small pockets of funding could help alter how services are provided to people with mental health challenges while saving both the state and federal funding.

Privacy and Health Homes

One essential part of health homes will be the flow of information to and from health homes, and that flow of information will be more important for behavioral health consumers. This is a controversial topic for the behavioral health world, regardless of whether the records are currently covered by HIPAA, 42 CFR Part II, or state privacy laws. There are a large number of people and advocates who firmly and correctly believe that preservation of privacy is a critical part of these records. At the same time, doctors overwhelmingly argue that having a complete clinical and medication file is essential to providing coordinated and effective medical care in the modern world.

Health homes, in order to operate effectively, will need privacy concerns to be tilted towards the above described doctors viewpoint, and this will require federal legislative assistance. There are two levels that the federal government could choose. Both rest on the concept of providing payment claims data to all providers. The lower version would be simply to include a list of all providers seen in the last several years, as well as a complete list

of all medications (including Part D). The larger version would be to also include the clinical and short term medical histories. These records should be stripped of all pricing information, and information sharing should be limited to only providers (i.e., courts, employers, etc. should not have access to these records). All of these records already exist, and are provided to CMS for both Medicaid and Medicare. These records are not currently returned back to states and providers – there is only a one-way flow of information. Additional nuances of the above suggestions could be to deem state agencies (such as the state Medicaid agency) as providers, or to make all of this information available to the exchanges. Missouri has already piloted a limited version of these suggestions, and has created a web portal. It includes all government based fee-for-service transactions, but does not yet include private entities.

Our recommendation is that Congress and all states reconsider how to balance privacy with the need to have complete health records.

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

Use of Peer Support

Over the past decade, one of the biggest advances in the provision of mental health services is the increased use of peers, particularly whole health peers. Peer support, an evidence based practice, has repeatedly shown that by integrating peers (people with a lived experience of their own past mental health problems) into settings where mental health services are being provided has significantly improved the outcomes for consumers. Thirty-one states, and the District of Columbia, currently bill CMS for peer support in at least some settings. Last year, Georgia became the first state to be approved by CMS to bill Medicaid for peers that assist in whole health services, a critical service in providing better integrated care to people with mental health challenges.

NASMHPD feels that increasing the use of peers would significantly benefit the entire mental health system. This strategy could be accomplished by the following recommendations:

- Encouraging the use of peer support in all settings, either by legislating or influencing CMS, would lead to not only better health results on a large scale, but would also decrease costs for both the federal and state governments. In addition, increased use of peers would assist in minimizing the impending workforce shortages caused by increased demand for services generally, and a lack of people entering fields like psychiatry, psychology and affiliated professions.
- Expediting the manner in which state plans are reviewed by CMS. Currently obtaining a change or a waiver in a state plan takes 18-36 months, providing a large barrier to states willing to implement peer support, as well as a number of state plan or waiver based programs such as supported housing or employment (both evidence based).

Increased Efficiencies through Optimal Treatment Settings

It's all too common for a person with mental health challenges to receive treatment in settings, such as jails/prisons or emergency rooms, that tend to be the most expensive and least effective places to deliver treatment. Treating a person in these settings typically costs between \$150,000 and \$200,000 on an annualized basis. According to a September 26th Wall Street Journal article, the City of Los Angeles jail system has a mental health budget of \$35 million, and a staff of 300. The jails for Los Angeles, New York and Chicago alone serve as many people as over a quarter of the entire nation's state institutions. Similarly, Rhode Island found that between 2005 and 2009 visits to emergency rooms for psychiatric conditions increased 27 percent.

The goal is then simple - divert people away from receiving services in these expensive settings and instead serve them in the community.

To accomplish this goal, NASMHPD recommends:

- Provide adequate and timely access to community-based services that supports a person's mental health needs throughout their recovery process by **preserving mental health funding**, such as the Mental Health Block Grant (and possibly broadening its scope to permit true preventative measures) and **increasing the amount of "seed money" types of funding** (be it Block Grant or new funding). These funding approaches would allow states to create a person-centered delivery model of care that would shift costs from these expensive treatment settings. For example, many states have reduced services to vital public health safety nets such as crisis hotlines, community-based screenings and mobile crisis teams (both police and mental health crisis teams), due to recent budget reductions. Without these public health safety nets, the person seeking crisis mental health services is driven back to expensive treatment settings like emergency rooms.
- Increase the use of peer specialists in emergency rooms, drop-in centers and other community-based alternatives (e.g., clubhouses), and as navigators, particularly in court settings (e.g., Tennessee has piloted a program showing promising results). Employing peer specialists in these settings can save both the federal and state budgets from over-use of jails and emergency rooms.
- Expand the use of mental health courts, particularly juvenile courts, and police crisis intervention team (CIT) units. Recipients of mental health courts and CIT programs are less likely to be incarcerated, re-offend and have better mental health outcomes.
- Provide a better continuum of Medicaid and other support services when a person transitions to and from jail to help decrease relapses. The gaps in Medicaid coverage often create an insurmountable obstacle when a person is suffering with a serious mental illness, and telling a consumer still suffering from his/her personal problems that housing may be available in nine months, or to see their case worker at this address next Tuesday, is frequently unrealistic.
- Address the mental health workforce shortage issue by increasing HRSA funding to provide residency training, particularly with psychiatry—an area of enormous need and shortages. This funding opportunity would increase patients' access to psychiatrists instead of having to wait months before an initial visit/consultation.
- Increase funding or allowances of telehealth services (regardless of location or health-shortage), particularly in western and rural states.
- Increase collaboration between the Veterans Administration (VA) and state mental health providers. At the most basic level, states are often unaware of when units are returning, and thus unaware that increased vigilance may be necessary. On a services level, the VA and states need to work better with each other – and by doing so more effective care (and avoidance of expensive ways of providing care) is emphasized. This care should not only include the veterans themselves, but also their family members. This is a critical issue given the number of veterans who upon their return appear to be in need of behavioral health services.

Increased Efficiencies through Payment System Reform

In a typical medical/surgical setting, events are discrete and identifiable. The health system has been created within that context. The mental health system is instead increasingly focused on the whole person, and the multitude of services that need to occur simultaneously in order for recovery and medical progress to occur.

NASMHPD recommends that both Medicaid and Medicare change from billing on a discrete, services based, approach to one based more on wellness and rewarding providers whose patients improve holistically. There are several ways for Congress to directly accomplish this, or to influence CMS to:

- Permit increased use of bundled rates. A bundled rate, in its simplest form, is a Medicaid or Medicare rate that bills for a multitude of these simultaneous services. Over the last decade these bundled rates have increasingly been frowned upon by CMS – this has had the unfortunate consequence of making effective mental health care much harder. Permitting a bundled rate that is also less clinically based and more recovery/community based would also help to change the model away from one based on discrete interactions, such as with many other forms of medical treatment, which are poorly matched to mental illness treatment because mental health services attempt to address the whole individual by a large group of providers
- Prioritize, within the Medicaid and Medicare constructs, the use of incentive payments to providers for holistic care. Oklahoma, as well as other states, has piloted ways to incentivize wellness. These approaches have thus far been incredibly popular (even with providers) and have produced more effective care. NASMHPD would further recommend that this pilot be expanded to a true whole health based initiative
- Address the inability to have multiple billings on the same day. In medical/surgical settings a person has a doctor's visit and then leaves. In the mental health world a person may have a series of visits and interactions on a continuous basis in a multitude of settings. Similarly, the "medically necessary" standard may not be the best for behavioral health services, and this standard often stands in the way of essential services necessary for a behavioral health consumer.
- Permit increased CMS reimbursement for services, such as outreach, employment or housing based services. Again, in the mental health world the whole person is being treated – not just a broken arm or heart. And treating the whole person so that recovery is achieved can frequently require a very different billing system than what exists within the medical/surgical world.
- Additional suggestions from our members included revisiting Medicaid spend downs, as the large deductibles are often a barrier for care for the seriously mentally ill, and clarification of the Medicaid Buy-In Program, as well as other programs, which can create a conflict between working and receiving services. In the case of the Medicaid Buy-In Program, some of the guidance is unclear and further rulemaking could dramatically increase results.

If the Senate Finance Committee should have further questions about NASMHPD's comments, please contact NASMHPD's Executive Director, Dr. Robert Glover, at Bob.Glover@nasmhpd.org.

Sincerely



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Executive Director