AMA
AMERICAN MEDICAL ASSOCIATION

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

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

Dear Chairman Baucus and Ranking Member Hatch:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing in response to your request for input on how to improve the mental health system under the Medicare and Medicaid programs. We applaud your leadership in focusing attention on this critically important topic in light of the prevalence of mental illness in general, and more specifically, in the Medicare and Medicaid populations.

Environmental Scan

The statistics on mental illness are sobering. One in four Americans—over 60 million people—live with a diagnosable psychiatric disorder, and 13 million of these individuals are affected by a serious or severe mental illness such as schizophrenia, major depression, or bipolar disorder. The rate of mental illness among young people during their teenage years is especially alarming, with one in five individuals between the ages of 13 to 18 experiencing a mental disorder each year. Over 20 million Americans currently need treatment for a problem with alcohol or drugs. While the good news is that effective treatments for mental illness and substance use are available, the bad news is that millions of individuals with mental and substance use disorders do not, or cannot, access treatment and care. As you note in your August 1 letter, over half of adults and approximately half of young people with mental illness receive no treatment. The prevalence of mental illness combined with the lack of treatment results in serious consequences in terms of quality of life, high health care costs, and lost earnings. Suicide has become the second-leading cause of death among children aged 12 to 17 years old and the tenth leading cause of death in the United States. The Institute of Medicine has reported that the vast majority of all people who die by suicide have an undiagnosed or untreated mental illness.

Mental illness is also very prevalent in the Medicare and Medicaid populations, especially among dually eligible patients. Approximately one in four Medicare beneficiaries and one in ten Medicaid beneficiaries live with a diagnosable psychiatric disorder. Medicaid currently is the largest payer for mental illness services. The high rate of mental illness in patients dually eligible for both programs poses significant challenges to the Medicare and Medicaid programs; approximately 50 percent of the dual-eligible population lives with at least one psychiatric or cognitive disorder, and approximately 40 percent of the

dual-eligible population experiences mental and medical co-morbidities. Dually eligible beneficiaries are the sickest, most costly population in the health care system. This group represents 21 percent of Medicare beneficiaries, but it accounts for 36 percent of Medicare spending. In comparison, this population comprises 15 percent of Medicaid enrollees and 39 percent of total Medicaid spending. Dually eligible individuals consume an average of $30,000 per capita in health care services annually. In 2011, approximately $300 billion was spent collectively by states and the federal government for individuals who qualify for both Medicare and Medicaid.

Barriers that prevent Medicare and Medicaid recipients from obtaining the mental and behavioral health care they need

While the Affordable Care Act (ACA) includes provisions designed to expand access to mental health services, significant challenges exist in making expanded access a reality. These obstacles include: the lack of incentives in the traditional fee-for-service reimbursement system to encourage integrated and coordinated care delivery of mental health care with medical care; physician workforce shortages affecting both primary and specialty care, including psychiatry; inadequate incentives to encourage psychiatrists and primary care physicians providing mental health services to participate in Medicaid; fragmentation in delivery and financing of services to the dually eligible population; and limitations on a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federally regulated Opioid Treatment Program. These obstacles will be discussed in more detail below along with our recommendations on addressing them.

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

<u>New payment and delivery models for integrating and coordinating care between mental health and medical care</u>

There is a growing recognition that mental health treatment should be integrated with medical care. The AMA agrees with the American Psychiatric Association (APA) that the integration of psychiatric and medical care can play a key role in reducing overall health care costs, improving quality and population health, and reducing morbidity and mortality among patients with psychiatric and substance use disorders. It is estimated that 50 percent of care for mental health disorders is delivered by primary care providers; primary care physicians are often the initial point of contact for screening, assessing, and treating mental health issues, whether during annual physicals or other scheduled appointments. However, Medicare's traditional fee-for-service (FFS) system is a barrier to allowing psychiatrists to help primary care physicians manage patients with depression and other mental health disorders. Current Medicare policy that will not pay for consultations or team meetings imposes a barrier to the communication that is necessary among treating clinicians for effective integrated care. One way to begin to address these problems would be to start paying for non-face-to-face and care coordination services. Within the context of the current FFS system, adoption of such a policy is one way that Medicare could begin to promote the care improvements and lower spending that physicians can achieve through participation in alternative payment models (APMs).

Integrated care models are being developed and tested in both the private and public sectors. The Center for Medicare and Medicaid Innovation has funded 106 projects to test new care delivery models. Fifteen of these projects are focused on testing integrated care arrangements for mental health, and potentially have significant implications for improving the delivery of mental health care. The AMA urges Congress to continue supporting these projects and provide the resources and flexibility needed so that existing projects can be expanded and additional trials funded.

Streamlining and improving care for dual eligibles

As described earlier, the dually eligible population presents some of the most significant challenges to the Medicare and Medicaid programs. The provision of health care to individuals in this category often results in fragmented care due to misaligned incentives between the two programs. Medicare is responsible for acute care provided by physicians and hospitals, diagnostic tests, and prescription drugs. Medicaid covers some long-term supports and services, and in some states assists with paying for Medicare premiums and cost-sharing. Although each program is accountable for providing specific health care services, care is often poorly coordinated, which can result in unnecessary and costly care, or alternately, inadequate care. For example, whether patients receive covered services can often depend on their treatment location, which can negatively impact their recovery. Streamlining the coverage provided by Medicare and Medicaid so that the programs work more effectively and efficiently together is critical to providing higher quality care and to reducing health care costs. The ACA provided CMS with the authority to streamline dual eligible coverage. CMS is working with a number of states through demonstration projects to improve quality, reduce costs, and improve the experience for dually eligible beneficiaries. Given the diversity of medical needs within the dually eligible population, it is unlikely that one approach to integrated delivery of care will address all of this population's health care needs. The AMA believes that these pilots should be carefully monitored and evaluated to see if they achieve their intended goals and if so, Congress should continue to support the dual eligible demonstration programs.

Improving delivery of and payment for inpatient and outpatient psychiatric services

Public mental health hospital facilities are the primary settings in which adult Medicaid patients, aged 21-64, can receive inpatient hospital treatment when they are experiencing acute psychiatric episodes. A historic trend to "deinstitutionalize" the chronically mentally ill has resulted in decreasing the number of inpatient and residential psychiatric beds in public mental health hospitals from approximately 400,000 nationwide in 1970 to 50,000 in 2006. The loss of public inpatient psychiatric beds was only partially offset by the combined increase during the same time of an additional 50,000 private and general hospital psychiatric beds. At the same time, community-based services and treatment that were supposed to help compensate for the loss of inpatient beds have not been sufficiently funded. As a result, increasing numbers of chronically mentally ill individuals often have no place to go for comprehensive treatment. Rather than being integrated into the community, this population has been supplanted into other facilities such as nursing homes, homeless shelters, jails, and prisons, while a growing number routinely visit emergency departments (EDs).

The influx of patients with psychiatric illnesses seeking care in EDs has been identified as a trigger exacerbating medical personnel resources and causing emergency department overcrowding and "boarding" in the ED by psychiatric patients. Overcrowding and boarding of psychiatric patients in EDs

not only results in delayed and inadequate care for the mentally ill, but also increases the backlog of patients in the emergency department which affects emergency care for all patients. The large number of patients seeking psychiatric care in EDs is a reflection of a larger systemic problem—the lack of comprehensive mental health care services across the continuum of care, which could include outpatient and community resources, dual substance use and mental health services, dual mental health and medical services, and inpatient psychiatric care.

A 2008 report from the Treatment Advocacy Center, a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illnesses as well as an authoritative source of research on issues arising from untreated mental illness, estimates that 50 public psychiatric beds per 100,000 individuals is a minimum number to adequately provide needed services. The Treatment Advocacy Center reports that most states maintain less than half the minimum number suggested. The report also states that the widespread use of community treatment programs and assisted outpatient treatment have been proven to decrease the need for inpatient hospitalization. Without an adequate number of public psychiatric beds nationwide, and a severe lack of alternative inpatient and outpatient treatment resources, a growing number of Medicaid patients with emergency mental health needs routinely visit EDs for their care. Increasing resources for comprehensive community based outpatient psychiatric services could help alleviate this problem.

A Medicaid statutory provision called the Institution for Mental Disease (IMD) exclusion prohibits payment for mental health services received in an IMD. An IMD is defined by the U.S. Department of Health and Human Services (HHS) as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." An institution is considered an IMD if it is established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. According to HHS, it is the federal government's policy that long-term psychiatric care, primarily for adults, is the responsibility of the states. This long-standing federal policy results in the IMD exclusion, which poses a barrier to accessing inpatient psychiatric care.

HHS is funding a three-year Medicaid Emergency Psychiatric Demonstration Project that allows eligible states to apply to HHS for a grant to reimburse IMDs for stabilizing adult Medicaid patients with a psychiatric emergency condition. This demonstration project will expand the number of emergency inpatient psychiatric care beds available in communities by providing states with federal Medicaid matching payments for patients in non-governmental freestanding psychiatric hospitals. There are reports from at least one hospital participating in the demonstration project, the Psychiatric Institute of Washington, that they have been able to help alleviate the burden of the most acutely mentally ill on EDs in the city. A final report from HHS will be submitted to Congress in December 2013 containing recommendations on whether the demonstration project should be continued beyond 2013 and if it should be expanded on a national basis. The AMA is closely monitoring this demonstration project and will review the report once it is issued to assess the project's impact on access to psychiatric care and treatment of substance use disorders.

The ACA also established a Medicaid state plan option beginning in January 2011, which allows states to offer a medical or "health home" to Medicaid individuals with certain chronic conditions, including a mental health condition or substance use disorder. This state plan option is an opportunity for states to experiment with a more comprehensive approach to mental health care. The mental health care home

model holds the same potential as quality outpatient mental health treatment, which has been proven to decrease the need for inpatient hospitalization. The AMA supports evolving models of mental health care homes as long as the care is appropriately supervised by a psychiatrist.

Substance use disorders

Substance use disorders are common in the United States, affecting a disproportionate share of adolescents and young adults. More attention needs to be devoted to both screening for alcohol and drug use, and to treatment for substance use disorders, including office-based brief interventions with behavioral components, and/or referral for appropriate treatment of substance use disorders. Restrictions imposed by Pharmacy Benefit Managers working for Medicaid and Medicare on the duration of treatment, medication dosage, or level of care may inappropriately impair a patient's access to medically necessary pharmacological therapies for opioid use disorder, and should be removed.

Physician workforce shortage and Graduate Medical Education (GME)

According to the Association of American Medical Colleges (AAMC), 45,000 new physicians will be needed by 2020 in order to fill the anticipated gap created by physicians who are approaching retirement and to treat the country's projected number of senior citizens. AAMC predicts that an additional 6,000 to 8,000 residencies—in addition to the 16,000 currently supported by Medicare—will be needed each year over the next 20 years to close the projected physician shortfall. This projected shortage affects both primary care and specialty care, including psychiatry and addiction medicine. According to government surveys, 90 million Americans live in communities with less than one psychiatrist per 30,000 residents. The AMA strongly supports the preservation of GME financing, which provides critical resources to teaching hospitals to train residents in both primary care and specialty fields. In addition, as we have previously expressed on numerous occasions to the Senate Finance Committee and members of Congress, the current Medicare cap on funding residencies must be lifted so that our nation's future physicians can be trained.

Conclusion

Reforming the nation's mental health system will not be easy. Yet, ensuring access to inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders is critical if we are to adequately care for our nation's most vulnerable citizens.

Thank you for the opportunity to share our thoughts with you. We look forward to continuing to work with you and your staff as you consider ways to improve the mental health system for our most vulnerable patients.

Sincerely,

James L. Madara, MD