National Alliance on Mental Illness
3803 N. Fairfax Drive, Suite 100, Arlington, VA 22203
703-524-7600
www.nami.org

National Association of Psychiatric Health Systems
900 17th Street, NW, Suite 420, Washington, DC
202-393-6700
www.naphs.org

April 28, 2016

The Honorable Orrin G. Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of the National Alliance on Mental Illness (NAMI) and the National Association of Psychiatric Health Systems (NAPHS), we want to thank you for convening today's important hearing on "Mental Health in America: Where Are We Now?." We appreciate your focus on this vital issue.

Mental Illnesses are the leading cause of disability and contribute to premature death, yet millions of Americans face discrimination when they need the help the most.

Medicaid is the single largest funding source for people living with mental illnesses, but a little-known provision in the law called the Medicaid Institutions for Mental Disease (IMD) Exclusion prevents adult Medicaid beneficiaries (ages 21-64) from accessing short-term, acute care in psychiatric hospitals.

The IMD Exclusion is discriminatory and for years has disadvantaged Medicaid beneficiaries living with serious mental illness. People are not getting the psychiatric hospital treatment they need, putting families and communities at risk. In the end, this is—pure and simple—a fairness issue. A Medicaid insurance card covers hospital treatment for all other medical conditions, but adults with mental illnesses cannot use their Medicaid insurance card for inpatient psychiatric care in a psychiatric hospital. No other disorder limits hospital choice in the way the IMD Exclusion does.

The Medicaid IMD Exclusion was part of the original Medicaid program in 1965 and was intended to ensure that the states (rather than the federal government) would be primarily responsible for the costs associated with inpatient psychiatric treatments. Long ago, in 1965, the vast majority of inpatient psychiatric care was provided in state mental hospitals and was primarily long-term, custodial care.

Of course, this is no longer the case. Today the vast majority of inpatient psychiatric hospital care is provided in the community in general hospital psychiatric units or freestanding, non-governmental psychiatric hospitals. Inpatient stays today for psychiatric illnesses are measured in days (on average less than 10 days), not in weeks or months.

Over the past two decades, there has been a major decline in the number of inpatient psychiatric beds throughout the country. This has resulted in an increased number of individuals ending up in emergency rooms where they stay for days (and sometimes weeks) before being able to get the crisis inpatient hospital stabilization treatment they so desperately need. A Government Accountability Office (GAO-09-347) report on hospital emergency departments concluded difficulties in transferring, admitting, or discharging psychiatric patients from emergency departments were factors contributing to emergency department overcrowding.

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Community psychiatric hospitals could help relieve these backups if Congress made a targeted, exception to the IMD Exclusion for short-term, acute, psychiatric hospital treatment.

A question that is sometimes asked by policymakers and advocates is whether modifying the IMD Exclusion would lead to more institutionalization. The answer is that this is about people who are in major crisis and need hospitalization to keep them safe. Hospital stays in the community are short and focus on crisis stabilization, helping people continue their recovery in the community.

Some also ask, why not invest in community care instead of hospitals? This is not a question of "either/or." What is needed is a partnership in care. Hospitals are handling the most acute needs of that person (so they don't hurt themselves or others), and then hospitals work with their community partners to handle the next step. This is not dissimilar to someone who has a heart attack, who needs hospitalization to stabilize the situation and then moves onto a rehabilitation facility and then home with continuing supports. What is needed are reforms to the IMD Exclusion that expand access to acute inpatient care and quality measures that ensure connection to outpatient services after short-term stay in a hospital. In addition, reforms to the IMD Exclusion should also address the disparity that currently excludes non-elderly adults with mental illness from community services funded under state waiver programs.

There are many approaches that have been identified to address the growing crisis of the shortage of inpatient psychiatric beds in this country. And there is growing bipartisan support in both the House and Senate to address the discriminatory and outmoded IMD Exclusion. There are comprehensive mental health reforms bills that have been introduced in the Senate and House, including the *Mental Health Reform Act of 2016* introduced by Senators Bill Cassidy (R-LA) and Chris Murphy (D-CT) which includes a targeted, exception to the IMD Exclusion to cover short-term, psychiatric hospital treatment.

Making a change to the IMD Exclusion is the right thing to do and will result in more timely access to life-saving inpatient treatment, reduced emergency backlogs, and a more cost-effective system.

We look forward to continuing to work with the Committee to address this unfair and discriminatory policy, so that individuals living with mental illnesses can get the right care at the right time.

Sincerely,

Mary Giliberti, J.D.
Chief Executive Officer
National Alliance on Mental Illness (NAMI)

Mark Covall
President and CEO
National Association of Psychiatric Health Systems (NAPHS)