NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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February 1, 2017

The Honorable Michael C. Burgess, M.D.
U.S. House of Representatives
Washington, DC 20515

The Honorable Gene Green
U.S. House of Representatives
Washington, DC 20515

Dear Reps. Burgess and Green,

On behalf of the National Association of Psychiatric Health Systems (NAPHS), we want to thank the House Energy and Commerce Subcommittee on Health for convening today's important hearing entitled' "Strengthening Medicaid and Prioritizing the Most Vulnerable." We appreciate your focus on this vital issue and respectfully request that this letter be submitted as part of today's hearing record.

Chairman Burgess was correct when he stated that "Medicaid is a critical safety net program that serves some of our most vulnerable patients in our districts." NAPHS and the more than 800 hospitals and mental health and addiction treatment organizations we represent also agree with the Chairman's statement that "It is critical that Congress refocus taxpayer dollars on the most vulnerable to ensure that they get the care they need."

We want to thank the Subcommittee on Health for actions taken last year on mental health reform. As you are so intimately aware, mental Illnesses are the leading cause of disability and contribute to premature death, yet millions of Americans most vulnerable citizens face discrimination when they need the help the most. We especially want to thank Rep. Tim Murphy for his leadership role in getting mental health reforms passed into law.

But more needs to be done. 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 vulnerable 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

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associated with inpatient psychiatric treatments. In 1965, the clear 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 most 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 that difficulties in transferring, admitting, or discharging psychiatric patients from emergency departments were factors contributing to emergency department overcrowding.

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 individuals with mental and addictive disorders (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.

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 bipartisan support in both the House and Senate, largely because of Rep. Murphy's continuing efforts as the leading advocate and the principal sponsor of legislation providing for Mental Health Reform and efforts to address the discriminatory and outmoded IMD exclusion.

Per the Centers for Medicare and Medicaid Services (CMS), "due to the IMD exclusion, many Medicaid enrollees with acute psychiatric needs, such as expressing suicidal or homicidal thoughts, are diverted to general hospital emergency departments, which often lack the resources or expertise to care for these patients. For the Medicaid beneficiary, this may result first in a delay in treatment, and then when treatment is provided, inadequate care. General hospitals may delay the provision of care until a bed becomes available, or inappropriately assign them to medical beds."

Today, because inpatient psychiatric care is an integral component of community-based care for people living with mental illnesses, it makes no sense from a public-policy or from a patient-centered perspective to limit the inpatient psychiatric hospital settings that people in need of this life-saving service can access. And that is exactly what the IMD exclusion does.

Just as for medical problems, people living with mental illnesses rely on their doctors and hospitals for ongoing care and treatment. When they need life-saving treatment, they want to go to the hospital and doctors that have been treating them over time. Restricting access to psychiatric hospitals through the IMD exclusion means that patients may not be able to go to the hospital that their doctor recommends or where their doctor has inpatient practicing privileges.

If we look at overall medical costs, there could be tremendous savings when untreated behavioral health disorders (such as depression or alcoholism) are addressed in the right setting. A patient getting mental health and substance use treatment reduces costs. If there is early intervention and collaborative care, studies show significant savings. With medications, patients' do not always need to go to the hospital, and this saves money. When we invest in mental health across the board, we will achieve financial savings and better outcomes.

We need to rebuild the infrastructure of the mental health and substance use health system to invest in the American people.

Making a change to the Medicaid 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,

Mark Covall
President and CEO

cc: The Honorable Tim Murphy