REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-11

Subject: Medicaid Coverage of Adults in Psychiatric Hospitals
(Resolution 114-A-10)

Presented by: William E. Kobler, MD, Chair

Referred to: Reference Committee G
(Jane C.K. Fitch, MD, Chair)

At the 2010 Annual Meeting, the House of Delegates referred Resolution 114 to the Board of Trustees. Introduced by the Nevada Delegation, Resolution 114-A-10 asked that the American Medical Association (AMA) "work with the Centers for Medicare and Medicaid Services to require state Medicaid programs to cover medically necessary hospital services for adult Medicaid patients suffering from acute psychiatric illnesses in any licensed hospital when public mental health hospital beds are not available." The Board of Trustees referred Resolution 114-A-10 to the Council on Medical Service for study.

This report provides an overview of access to psychiatric hospitals, including a discussion of the Institution for Mental Disease (IMD) exclusion; reviews the adequacy of psychiatric services and emergency department boarding and crowding issues; identifies relevant provisions in the Patient Protection and Affordable Care Act; considers workforce issues and the establishment of mental health medical homes; spotlights successful state activity; highlights related AMA reports, policy and advocacy; discusses potential avenues for additional AMA advocacy; and presents policy recommendations.

BACKGROUND

As noted in the whereas clauses of Resolution 114-A-10, 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.

A 2009 *Health Affairs* article reported that while a major focus of mental health policy in the past fifty years has been to eliminate state hospitals, the services these facilities provide are increasingly becoming acknowledged. According to the authors, for the first time in more than fifty years the state hospital population has started to increase in some states. (Fisher, Geller and Pandiani, 2009).

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 US 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 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.

The American Psychiatric Association (APA) adopted policy in 2007 supporting states having the opportunity to receive a federal exemption from the IMD exclusion for state hospitals and all nonprofits with more than 16 beds (e.g., private hospitals, community residential programs, and dual diagnosis residential treatment). To participate in the exemption, the APA advocates that a state must maintain its mental illness and substance abuse expenditures (excluding medication costs) from all sources at a level no less than the state's average expenditure over the preceding five years. These monetary sources include the state's Department of Mental Health, Department of Public Health, Department of Medical Assistance, Department of Developmental Services, Department of Corrections, Department of Social Services, Department or Division of Youth Services, and any other sources.

ADEQUACY OF PSYCHIATRIC SERVICES

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 and an authoritative source of research on issues arising from untreated mental illness, estimates that 50 public psychiatric beds per 100,000 population 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, with South Dakota and Mississippi coming closest to the recommended number, with 40.3 and 49.7 beds per 100,000, respectively. Nevada and Arizona maintain the least, with 5.1 and 5.9 beds per 100,000, respectively. 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 (Torrey, Entsminger, Geller, Stanley, and Jaffe, 2008).

While having a mental illness in general does not increase one's likelihood of committing a violent crime, a study of 81 American cities reported that public psychiatric hospital bed availability is inversely related to crime and arrest rates. The same study concludes that the reductions in public hospital beds must be considered in the context of public safety concerns and balanced with quality community mental health services (Markowitz, 2006). 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 emergency departments (EDs) for their care.

ED BOARDING AND CROWDING

The growing crisis in availability of public mental health hospital facilities results in long ED stays for adult Medicaid patients in need of inpatient treatment for acute psychiatric illnesses as they await available psychiatric beds. A 2008 American College of Emergency Physicians (ACEP) survey of EDs found that 79 percent of psychiatric patients are boarded in EDs. The survey found that more than 60 percent of psychiatric patients needing to be admitted stay in the ED more than four hours after the decision to admit has been made; 33 percent are boarded in the ED more than eight hours; and six percent are boarded more than 24 hours. ACEP concluded that the services for psychiatric patients in the United States are inadequate. As a result, psychiatric patients are using EDs for their acute care needs.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act of 2010 (ACA, Public Law 111-148) establishes the Medicaid Emergency Psychiatric Demonstration Project, beginning October 2011. The three-year demonstration project will allow eligible states to apply to the Department of Health and Human Services (HHS) for a grant to reimburse IMDs for stabilizing adult Medicaid patients with a psychiatric emergency condition. The impact of 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. 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 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. The health home is defined as a designated provider or health team selected by an eligible individual with chronic conditions to provide health home services. Qualifying providers must offer services including comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of health information technology. These services are consistent with Policy H-160.919 (AMA Policy Database), which outlines principles of the patient-centered medical home. For the first two years, states will be reimbursed by the federal government at 90 percent to provide these services. Each participating state is required to include a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management.

WORKFORCE AND THE MENTAL HEALTH MEDICAL HOME

According to the AMA Masterfile, there were 35,671 practicing psychiatrists in 2009, compared to 34,534 in 1999. While the number of practicing psychiatrists has increased somewhat, there exists an overall mental health workforce shortage. A recent review of the mental health workforce in the US found that nearly every county (96 percent) in the nation had unmet needs for psychiatrists and nearly one in five US counties (18 percent) had unmet needs for non-prescribing mental health professionals, defined as psychologists, advanced practice psychiatric nurses, social workers, licensed professional counselors, and marriage and family therapists (Thomas, Ellis, Konrad, Holzer, and Morrissey, 2009).

An October 2010 report from the Center for American Progress reveals that given the shortage of mental health professionals, particularly psychiatrists, mental health services are increasingly being provided by primary care physicians. The report found that more than a third of patients who receive treatment for mental health disorders rely solely on primary care physicians. The report suggests that as health care reform provides a central role for primary care in the delivery and coordination of health care services, especially for the chronically ill, mental health services could be better integrated into primary care (Russell, 2010). The idea of establishing mental health homes is gaining momentum and interest not only from the federal government, but also from practitioners who view this model as necessary in the provision of comprehensive mental health care.

STATE ACTIVITY

Providing adequate mental health services to the Medicaid population of many states is a daunting task in the current financial and political environment. Surmounting the challenges, Minnesota has been at the forefront of reform since the Minnesota Mental Health Action Group (MMHAG) began in 2003 as a public-private partnership to take action to improve the state's mental health system. By 2007, Minnesota's legislative session included approximately $34 million earmarked for the Governor's Mental Health Initiative, which to this day focuses on improving the accessibility, quality and accountability of publicly funded mental health services.

A March 2009 report from the Minnesota Department of Human Services (DHS) outlined the collaboration and recommendations of a group of stakeholders to reduce the number of unnecessary patient days in acute care facilities. The steering committee of this group included members representing child and adult mental health advocates, community mental health providers, hospitals, counties, health plans, rural health programs and DHS staff.

Minnesota has applied for and received a federal community mental health services block grant for 2009-2011. The proposed investments and system reforms of the grant include: adopting a consistent mental health benefit across all DHS health care programs; implementing an intensive mental health outpatient treatment benefit; increasing the percentage of care provided through integrated health care networks and demonstrating methods to improve the coordination between mental health care, physical health care and social services; addressing workforce shortages and infrastructure instability by increasing rates for certain mental health services and providers; developing accountability and system management investments; improving county financial incentives for ensuring community-based service access for the uninsured; and ensuring statewide access to services by targeting grant funds to support the service delivery infrastructure.

RELATED COUNCIL ON MEDICAL SERVICE REPORTS

The Council previously studied the availability of psychiatric beds in Council on Medical Service Report 2-A-08, "Access to Psychiatric Beds and Impact on Emergency Medicine." The report presented information on the financing of mental health care services, outlined issues surrounding the IMD exclusion of Medicaid patients, and reviewed ED crowding and boarding of psychiatric patients. Council Report 2-A-08 recommended reaffirming Policy H-130.945[3], which supports the establishment of local, multi-organizational task forces with representation from hospital medical staffs, to devise local solutions to the problem of ED overcrowding, ambulance diversion, and physician on-call coverage and encourages the exchange of information among these groups. In addition, the report recommended modifying Policy H-185.974 to support parity of coverage for mental illness, alcoholism and substance use.

The recommendations of Council Report 2-A-08 also established policy that the AMA support efforts to facilitate access to both inpatient and outpatient psychiatric services, and the continuum of care for mental illness and substance use disorders, ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for the care of patients with mental illness (Policy H-345.978).

Council on Medical Service Report 3-A-09, "Emergency Department Boarding and Crowding," outlined the effectiveness of measures implemented to mitigate boarding and crowding in EDs as a follow-up to Council Report 2-A-08. Council Report 3-A-09 acknowledged ACEP's instrumental role in addressing ED boarding and crowding and established policy recommending collaboration between organized medical staff and ED staff to reduce ED boarding and crowding, the

dissemination of best practices in reducing ED boarding and crowding, and the use of evidence-based and consistent performance measures (Policy H-130.940).

Council Report 2-I-08, "Acceptance of TRICARE Health Insurance," outlined issues associated with mental health care for military personnel and veterans. The Council report highlighted severe gaps in the access, delivery and quality of mental health services for service members. Since then, a March 2010 Institute of Medicine (IOM) report was issued assessing the readjustment needs of veterans, service members and their families. The IOM report noted that while the physical needs of veterans are being met, for the most part, their mental health needs are still not being adequately addressed. In addition to many other suggestions, the IOM report recommends that more mental health professionals are needed to help military personnel and veterans deal with post-traumatic stress syndrome, depression, substance use, suicidal ideation, domestic violence, marital problems, and other issues that this population commonly experiences.

RELATED AMA POLICY AND ADVOCACY

AMA policy supports access to mental health services, including an adequate supply of psychiatrists, appropriate payment for all services provided, and adequate funding levels for public sector mental health services (Policies H-345.981, D-345.997, D-345.998 and H-345.980). Furthermore, the AMA supports medical, surgical and psychiatric service integration, and payment to ensure medically appropriate treatment is provided when an individual has multiple health care needs (Policies H-345.983 and H-285.921). The AMA encourages treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement (Policy H-345.995).

The AMA supports the patient-centered medical home as a way to provide patient care without restricting access to specialty care and supports allowing any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home (Policy H-160.919). The AMA supports mental health insurance parity for mental illness, alcoholism, and related disorders under all governmental and private insurance programs and has developed model state legislation for state medical associations and specialty societies to promote legislative changes assuring parity for mental health coverage (Policies H-165.888, H-185.974, H-345.992[1], D-180.998 and D-185.994).

The AMA is a member of the Coalition for Fairness in Mental Illness Coverage, which has been active in supporting mental health parity. In 2008, the AMA actively participated in negotiations that produced the mental health parity provisions that were signed into law as part of H.R. 1465, the "Emergency Economic Stabilization Act." The "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act" extends parity protections for mental health and substance use disorder benefits in all aspects of health plan coverage, including day/visit limits, dollar limits, coinsurance, copayments, deductibles and out-of-pocket maximums.

DISCUSSION

The establishment of the Medicaid Emergency Psychiatric Demonstration Project by the ACA provides states the opportunity to explore mental health service provision in the absence of the IMD exclusion. This demonstration project allows states to experiment with the request in Resolution 114-A-10, which asks state Medicaid programs to cover medically necessary hospital services for adult Medicaid patients suffering from acute psychiatric illnesses in any licensed hospital when public mental health hospital beds are not available. The Council believes that the

AMA should monitor the Medicaid Emergency Psychiatric Demonstration Project established in the ACA for consistency with AMA policy, especially the impact on access to psychiatric care.

The Medicaid state plan option established by ACA, which allows states to offer a "health home" for a mental health condition, 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 Council supports evolving models of mental health care homes as long as the care is appropriately supervised by a psychiatrist.

Several sources have substantiated research demonstrating that an increase in outpatient services is needed when inpatient psychiatric services are lacking. The Council believes that the AMA should encourage states that maintain low numbers of inpatient psychiatric beds per capita to increase the availability of comprehensive community based outpatient psychiatric services.

The Council believes that Minnesota sets an example for other states to follow, as it has committed financial resources, time and energy to reforming the state's mental health care system. As such, the Council recommends that the AMA reaffirm Policy H-345.978, which supports efforts to facilitate access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders and Policy H-130.945[3], which supports the establishment of local multi-organizational task forces with representation from hospital medical staffs to address the problem of ED crowding.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 114-A-10 and that the remainder of the report be filed:

1. That our American Medical Association monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders. (Directive to Take Action)

2. That our AMA support the evolution of psychiatrist-supervised mental health care homes. (New HOD Policy)

3. That our AMA encourage states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services. (New HOD Policy)

4. That our AMA reaffirm Policy H-345.978, which supports efforts to facilitate access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-130.945[3], which supports the establishment of local multi-organizational task forces with representation from hospital medical staffs to address the problem of ED crowding. (Reaffirm HOD Policy)

Fiscal Note: Implement at estimated staff cost of $1,144.

References are available from the AMA Division of Socioeconomic Policy Development.