COMMUNITY CATALYST

September 30, 2013

The Honorable Max Baucus, Chairman
The Honorable Orrin G. Hatch, Ranking Member
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510
MentalHealth@finance.senate.gov

Dear Chairman Baucus and Ranking Member Hatch:

Thank you for inviting the behavioral health community to submit ideas on how to improve the coverage and treatment system in the United States. We are glad you recognize that we need to do better for the one in four Americans who are affected by behavioral health issues. Our comments focus mostly on substance use disorders and are respectfully submitted for your consideration.

Our Organization

Community Catalyst, a national advocacy organization, has been giving consumers a voice in health care reform for more than a decade. We provide leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high-quality, affordable health care for everyone. Our contributions, which range from policy analysis and strategic assistance to managing national campaigns, enable consumer groups to provide leadership in the hard work of transforming the U.S. health care system. Since 1997, in states and communities across the country, we have been a catalyst for collaboration, innovation, and action in health care reform. Community Catalyst works on a range of health issues, including coverage, delivery system reform, non-profit hospital community benefit, social determinants of health, dental access, prescription drug access, and behavioral health.

Community Catalyst supports comprehensive care and supports for the full spectrum of behavioral health, and focuses specifically on (1) prevention of, and coverage and treatment for substance use disorders (SUD), and (2) implementing the Mental Health Parity and Addiction Equity Act (MHPAEA) and the associated parity provisions contained in the Affordable Care Act (ACA). As you know, 23 million Americans suffer from alcohol and drug addiction, but only a fraction get the treatment they need. Another 68 million Americans engage in risky use of alcohol or drugs that could lead to dependence or addiction. Community Catalyst works to prevent addiction, expand access to quality treatment and help people return to healthy lives. To learn more, we encourage you to visit us on the Web at www.communitycatalyst.org.

Responses to the Questions You Posed

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

Medicare Barriers

Medicare Needs Better Ways to Find Early Signs of SUD. Key to treating substance use disorders in the Medicare population is the ability for clinicians to *identify* these problems in the first place. The drug most abused by beneficiaries is alcohol. The U.S. Preventive Services Task Force recommends that "clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse." This protocol is known as SBIRT (Screening, Brief Intervention, and Referral to Treatment). Although multiple U.S. Department of Health and Human Services agencies award millions of dollars in grant money to disseminate SBIRT, and the White House Office of National Drug Control Policy is also supportive, SBIRT is under deployed. Medicare codes G0442 and G0443 do exist for SBIRT services, specifically screening and brief intervention for different lengths of time, but certain requirements limit the ability of SBIRT to reach patients: **(a) 15 minute time minimum.** An intervention must last 15 minutes to be Medicare reimbursable, but effective screens can take much less time; and **(b) Limits on who can bill.** Only physicians and some licensed clinicians (including psychologists and some Master's prepared social workers) can perform and bill Medicare for behavioral health services. Because most of these clinicians are already stretched in providing other services, and the cost of their labor is expensive, few clinicians are administering SBIRT.

Medicaid Barriers

Traditional Medicaid: Lack of Benefits. As you know, there is no federal requirement for behavioral health care in traditional Medicaid. This has a devastating effect on people with mental health and substance use disorders in states that have not opted to cover these illnesses in their Medicaid program. These are not rare health conditions; as you note in your letter, one in four Americans is impacted by these diseases. People with behavioral health conditions and low incomes are served by a patchwork of services funded with state and federal grants, or receive little or no care. Comprehensive and integrated benefits, including prevention, would better serve people with these chronic illnesses.

Medicaid Managed Care and Parity. States that have both behavioral health benefits and Medicaid managed care are subject to MHPAEA, but Administration officials have indicated that the Final Rule to implement MHPAEA expected this fall will not include final guidance on Medicaid managed care. This means that there is an insufficient enforcement mechanism – and little incentive – for state action to prevent plans from putting limits on behavioral health services that are different than those for physical health. These limits are unfortunately used in many states: both non-quantitative (e.g. prior authorization) and quantitative (e.g. more burdensome cost sharing or visit limits). The parity law was passed five years ago and consumers are still waiting for these protections.

MHPAEA-like rules are also included in the ACA to govern Medicaid expansion plans. We are concerned about the capacity of federal agencies to monitor state enforcement, and in rare cases, to enforce the law themselves. Additionally, many states will be expanding their benefits for substance use disorders significantly and might not be prepared to enforce parity.

Medicaid Needs Better Ways to Find Early Signs of SUD. Medicaid codes exist for SBIRT: H0049 for alcohol/drug screening and H0050 for brief intervention. However, these codes are not activated in

most states. Even in states where they are activated, physicians or other certain licensed professionals are required to do the SBI services. For these providers, the cost of administering SBIRT (including provider time) outweighs the reimbursement, so few perform SBIRT.

Institutions for Mental Disease (IMD) Exclusion: Barrier to Care Integration. When Medicaid was first implemented in the 1960s, state and local psychiatric hospitals held large numbers of people with mental illness. Because public funds were already being used, it was not necessary for Medicaid to pay for this care. Decades later, the IMD Exclusion exists as peculiar relic of history. Medicaid will pay for the care of income-qualified patients younger than 22 or older than 64 if they receive inpatient treatment in a psychiatric facility with 16 or more beds. Patients age 22-64, however, are disenrolled from Medicaid if they become an inpatient at an IMD. If they are discharged, they can be reenrolled in Medicaid. Care delivered in this manner is impossible to integrate. Barriers to integration such as the IMD Exclusion could be a contributing factor to why people with serious mental illness die 25 years earlier than they should because of preventable physical ailments (more on that in section II).

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

The Missouri experience with Medicaid health homes has a number of lessons for how successful integrated models can be replicated. The state opted to build two health homes: "Primary Care" is for Medicaid beneficiaries primarily with chronic physical ailments; "Community Mental Health Center (CMHC) Healthcare Home" is for beneficiaries whose primary chronic illness is related to behavioral health, but many of whom have significant chronic physical ailments as well. This is a key point, as people with serious mental illness die 25 years earlier on average than their peers, the majority from preventable physical diseases.

The state took two key steps. The first step: Missouri created a disease registry for the high cost Medicaid beneficiaries who were auto-enrolled. To construct it, they used patient claims data to build the patient's history and clinical values from the annual required metabolic screening (obesity, cholesterol, triglycerides, blood pressure, and blood sugar). These data were combined into an electronic disease registry available to all providers. (Note: HIPAA allows for a broad range of providers to have access to this information to coordinate care; substance use disorder diagnosis history is allowed to be shared among providers, however SUD treatment history is not currently sharable in this form). The second step: nurse care managers identified care gaps and acted on them to improve treatment and compliance. These gaps could be related to medication adherence or unmet health needs that become visible because of the metabolic screen. Nurse care managers worked with clinical social workers, who had been retrained to be wellness coaches for patients.

Early evidence that this approach is effective for CMHC Healthcare Home patients includes a median 45 percent reduction of clinic patients not using asthma medication appropriately. There are also early signs of fewer hospitalizations. Missouri health homes for physical and behavioral health saved $83.26 per member per month net (after the cost of the monitoring was subtracted). More on Missouri's project is available here.

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 needs?

Medicare

Revise SBIRT Payment Requirements. As described above, SBIRT is endorsed by the U.S. Preventive Services Task Force to combat alcohol misuse, yet it barely reaches Medicare beneficiaries. Removing the 15 minute minimum time requirement and allowing for trained paraprofessionals to perform SBI would go a long way toward screening more people. Both of these changes would make SBIRT for beneficiaries more economically viable.

Medicaid

Implement the Behavioral Health Provisions of the Affordable Care Act at the Federal and State Levels. We cannot talk about access to and quality of care for Medicaid beneficiaries with behavioral health needs without emphasizing the need to fully implement the behavioral health provisions of the Affordable Care Act. It is one of the most important pieces of behavioral health legislation in the history of our country, giving millions of people regular access to services they need to treat their chronic disease through both private and public insurance.

Encourage or Require SBIRT Use and Expand Authorized Providers of SBIRT to Include More Types of Clinicians and Paraprofessionals. At a minimum, the federal government could do more to encourage states to activate and promote existing SBIRT codes; this could include webinars and educational materials, including letters directed at state Medicaid officials. States could also be encouraged to make the administrative decision to allow trained paraprofessionals to conduct SBIRT. Wisconsin has developed a model that makes performing SBIRT economically viable by focusing their SBIRT efforts around paraprofessionals. Other states are investigating using school nurses and peer recovery specialists.

Share Lessons from States with Large Numbers of SUD Treatment Providers; Encourage Treatment Providers to Become Medicaid Providers. Most states will not have enough Medicaid SUD treatment providers to meet the needs of consumers in the early days of expansion. States with larger SUD provider networks could be highlighted on federal webinars or through technical assistance provided by contractors so the strategies used to build this network can be shared. While the *coverage* system will change in January 2014, the *treatment* system will not change immediately. The federal government could also lead an effort across states to urge treatment providers to get certified as Medicaid providers.

Fully Implement the 2008 Parity Law. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 is still awaiting a final rule, and Administration officials have indicated that a final rule will not include the Medicaid managed care provisions. A final rule covering Medicaid managed care and subsequent federal and state enforcement would help protect consumers.

Support Ongoing Efforts to Integrate Behavioral Health and Primary Care. Medicaid health homes (described above in section II) and the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) both provide resources so providers can learn how to further integrate care. The Missouri health home project is a net cost saver because it has demonstrated how to control chronic illnesses and keep people out of the hospital. CIHS gives technical assistance to behavioral health providers that are either delivering or coordinating primary care; many lessons are being developed there as well. Committee on Finance members should continue to support sustained funding for Medicaid health homes, including the two years of enhanced match for coordinating services currently available. The committee could also invite a leader from CIHS to testify before the Committee on Finance as they develop innovative ways to keep patients healthy and save money.

Revise IMD Exclusion to Not Disenroll Psychiatric Inpatients. As noted above, the IMD exclusion aggressively disenrolls Medicaid beneficiaries age 22-64 who have an inpatient stay in a psychiatric facility with 16 or more beds. While full repeal of the IMD Exclusion would allow people with behavioral health issues to be treated no differently than people with other serious ailments, it is likely cost-prohibitive in the current fiscal environment. Therefore we recommend that the Committee on Finance consider ways to reduce the discrimination against people with such serious behavioral health issues that they need to be hospitalized. The first step could be to end the Medicaid disenrollment of people who are admitted to an IMD. With this change, beneficiaries can receive care at an IMD if their physician deems it most appropriate, and then can continue to receive Medicaid benefits to cover other services.

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Thank you again for the opportunity to submit ideas on how to improve the coverage and treatment system for these chronic diseases. If my staff or I can be of further assistance, please do not hesitate to contact us. Tom Emswiler, our policy analyst for substance use disorders, can be reached at (617) 275-2863 or temswiler@communitycatalyst.org.

Sincerely,

Robert Restuccia
Executive Director
Community Catalyst