



**Association for Behavioral  
Health and Wellness**

*Advancing benefits and services  
in mental health, substance use  
and behavior change.*

September 30, 2013

The Honorable Max Baucus  
Chairman  
U.S. Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Orrin G. Hatch  
Ranking Member  
U.S. Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

Thank you for contacting the mental health community for feedback on ways to improve the mental health system in the United States. The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to respond with our thoughts and concerns.

ABHW is the national voice for companies that manage behavioral health and wellness services. ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health to approximately 125 million people in both the public and private sectors. ABHW and its member companies use their behavioral health expertise to improve health care outcomes for individuals and families across the health care spectrum.

Below, please find ABHW's response to the three questions you posed at the end of your letter. We look forward to working with you to find solutions to ensure Americans suffering from mental illness and substance use disorders receive the best possible health care.

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

- Variety of Quality Metrics
- Lack of Adoption of Electronic Health Records
- Privacy Constraints in 42 CFR Part 2
- Medicare Reimbursement Constraints on Telehealth/Telepsychiatry
- Licensed Mental Health Counselors and Marriage and Family Therapists Exclusion for Medicare Recipients
- Institutions for Mental Disease Exclusion
- Need for Greater Acceptance and Uniformity for Peer Support Services, Especially in the Medicare Space

- Absence of Medicare Coverage for Residential Treatment When Medically Necessary
- Impediments to Providing Integrated Treatment for Patients With a Dual Diagnosis

While working to provide care for Americans with behavioral health needs, we oftentimes face administrative and legislative barriers that prevent Medicare and Medicaid recipients from obtaining the behavioral health care they need. One such barrier is the variety of quality metrics on which health plans need to report, creating an often inconsistent, confusing, costly, and burdensome process. Instead of facing separate standards from the state level, federal level, and private sector, it would be useful to have a small core set of uniform metrics. This would also prove more beneficial for data collection and comparison, development of pay for performance models, and provider profiling.

Another hurdle is the lack of adoption of electronic health records (EHRs) in behavioral health settings. Some key licensed behavioral health providers cannot qualify for an incentive payment through the EHR Incentive Program administered by the Centers for Medicare and Medicaid Services (CMS). Without access to these funds, the uptake in use of EHRs by certain behavioral health providers is diminished. EHRs help facilitate integrated/coordinated care, enhance e-prescribing, and track clinical outcomes; these benefits are lost if behavioral health providers are behind on EHR implementation. The Behavioral Health Information Technology Act, S. 1517, would extend health information technology assistance eligibility to mental health and substance use disorder professionals and facilities. This is an investment in integration. To the extent the members of the Senate Finance Committee can encourage their colleagues to support S. 1517 and help bring it to the Senate floor, we would be greatly appreciative.

An additional barrier relates to privacy constraints in 42 CFR Part 2 (Part 2). Part 2 protects client-identifying information that would reveal a client as an alcohol or drug client, either directly or indirectly. Part 2 was created after Congress recognized that the stigma associated with substance use disorders and the fear of prosecution deterred people from entering treatment. While a laudable goal, these special protections create barriers to integration, such as: inhibiting electronic exchange of health information, reducing the effectiveness of clinical reports to physicians, and delaying data transmission to providers. Individuals with substance use disorders will often go to different providers so that they can obtain multiple prescriptions for medications to which they are addicted; without access to a patient's record, this behavior is hard to detect and treat. We request that the Finance Committee work to align Part 2 with the HIPAA privacy rule to allow transmission of Part 2 data without written authorization for treatment, payment, and operations purposes.

Telehealth/telepsychiatry has been proven to drive important advancements for our patients, expanding access to care, improving health outcomes, reducing the inappropriate use of psychotropic medications in skilled nursing and other settings, and reducing costs. Telepsychiatry has the ability to reach a broader range of behavioral health consumers, including children and adolescents who appreciate the use of technology when communicating with their behavioral health care providers, and patients who reside in areas where there is a shortage of behavioral health providers. It also helps provide access to elderly patients who may have difficulty leaving their homes to travel to an appointment. However, the fact that each state has its own eligibility guidelines, combined with confusion around licensure requirements, prevents Medicare and Medicaid recipients from obtaining the care they need. At least 40 states provide Medicaid reimbursement for telepsychiatry. Medicare reimburses for telepsychiatry at the same rate as a face-to-face visit and reimburses a set amount per session for the staff person presenting with the patient. However, Medicare imposes three major restrictions on the use of telepsychiatry. These restrictions are geography-based (the consumer must be located in a non-metropolitan statistical area), facility-based (the consumer must be located in a qualifying facility and accompanied by a qualified staff person), and procedure-based (it must be an approved procedure for telehealth). Reforming these

barriers, particularly the definition of all Skilled Nursing Facilities as shortage areas for the purposes of psychiatry, would improve access to and quality of care for people with behavioral health needs.

A further obstacle that is preventing Medicare beneficiaries from receiving behavioral health care is that Licensed Mental Health Counselors (LMHCs) and Marriage and Family Therapists (MFTs) are excluded from participating in the Medicare program. These two groups of providers, which represent 40 percent of the licensed workforce, are fully qualified to deliver behavioral health services in all 50 states; but their services are not. Along with telehealth, inclusion of these disciplines would greatly enhance timely access for Medicare recipients, especially in rural and frontier communities. Medicare beneficiaries are overdue for gaining access to these providers to ensure they can receive necessary behavioral health services. Senators Ron Wyden and John Barrasso have introduced The Seniors Mental Health Access Improvement Act, S. 562, which would add LMHCs and MFT services under part B of the Medicare program; and we would like to see this bill reported out of your committee.

The exclusion on Institutions for Mental Disease (IMDs) is another major concern. IMDs, inpatient facilities with more than 16 beds and a patient roster with more than 51 percent of people with severe mental illness, are excluded from federal Medicaid matching payments for the population between the ages of 22 and 64. Not only is a facility unable to be reimbursed by Medicaid, but individual patients' eligibility for Medicaid is terminated while they are inpatients in an IMD. As a result, in order to receive treatment for medical disorders not related to their severe mental illness, they must be discharged from the IMD, reinstate their Medicaid eligibility, be treated in a medical/surgical setting, and then be readmitted to the IMD. In some areas of the country an IMD may be the only facility in the area, and the exclusion inhibits ABHW members' ability to contract with these providers for care.

Peer Support Services (PSS) have led to improved outcomes for beneficiaries and are explained as such below. PSS are specialized therapeutic interactions conducted by self-identified current or former consumers who are trained to offer support and assistance to others in the recovery and community-integration process. While they are effective services, broader utilization of PSS will require a number of systemic changes. Currently, Medicaid pays for licensed peer specialists in 31 states; and Medicare does not allow for these services at all. In order to adopt the use of PSS more widely, the number of states paying for licensed peer specialists needs to increase. Consistent reimbursement and billing policies (in both Medicaid and Medicare) for PSS will also help reduce the administrative hurdles and allow for wider acceptance and utilization of PSS. In addition, the current training and certification standards for peers is very diverse; such variance creates confusion, inconsistency, and an additional barrier to the adoption of PSS in the public and private sectors. The creation of a national standard for peer training and certification would be very helpful.

Currently, Medicare does not pay for residential treatment. While our goal is to deliver evidence-based home and community therapies, sometimes residential treatment is what is medically necessary for the patient. Since Medicare does not pay for residential treatment, individuals who cannot afford to pay for this coverage on their own need to look for community resources that may pay for their care. Flexibility to tailor interventions around an individual's demonstrated need would help people obtain appropriate care.

The final obstacle we would like to bring to your attention is the barriers to providing integrated treatment for people with mental illness who have coexisting problems with substance use. There is significant overlap and comorbidity between mental illness and substance use disorders. Based on emerging evidence, both are diseases of the brain; and yet we continue to fund them in two different streams. This leads to two distinct treatment delivery systems – one for mental illness and another for

substance use disorder – with ineffective coordination and integration between the two. Separate licensing and oversight authorities at the state level creates a costly administrative burden and prevents providers from being able to deliver evidence-based treatment to patients with a dual diagnosis; resulting in additional increased costs, compromised outcomes, and organizational complexity.

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

- Health Homes
- Peer Support Services (PSS)

Integrated and coordinated care is a critical component of treatment for individuals with a behavioral health illness. This type of care treats the whole person – both behavioral and physical health conditions. All ABHW members, whether they are “carve-outs” or “carve-ins,” are integrating and/or coordinating care for behavioral and physical health; and we look forward to continuing to find innovative ways to do this. Historically, there has been a lack of effective coordination between behavioral and physical health; but states and the federal government are pursuing purchasing structures that combine the two, which is a step in the right direction. Further steps include more behavioral health training for primary care providers and encouraging colocation.

Health homes colocate care and provide a real opportunity to focus care on the whole person, especially when behavioral health is at the core. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. This is especially important for individuals with a behavioral health illness who may be reluctant to seek care and have a higher rate of premature death due to health issues. Research has shown that through this model, patients tend to receive better care and more coordinated care at a lower cost. Missouri was the first state to implement health homes. This program required Missouri to spend 10 percent of its money, and the federal government provided 90 percent (for two years). Only certain services were covered, but the funds could cover transportation to medical appointments, follow-up care by case workers, and home visits to ensure patients are following their care coordination plans. This model proved a net savings to the state of four million dollars. It decreased behavioral health admissions by two million dollars, decreased emergency department visits by almost one thousand, and reduced emergency department charges for psychiatric encounters by about five hundred thousand dollars.

New York Medicaid is moving all fee-for-service behavioral health services to specialized integrated managed care plans in 2014. The program design includes two types of plans with specialized behavioral health features. Both are to provide integrated physical and behavioral health services for adults and children with serious mental illness or addiction disorders. The plans will provide all Medicaid state plan services for physical health, behavioral health, pharmacy, long-term care, and health homes.

An example of services that lead to improved outcomes for beneficiaries, assist in integrating care, and help decrease the burden on the existing behavioral health workforce are Peer Support Services (PSS). Peer support is designed on the principles of consumer choice and the active involvement of persons in their recovery process; peers also help reduce hospitalizations and other emergency interventions. ABHW recently conducted a survey of our companies, and the resulting report found that specialty behavioral health organizations view PSS as a valuable component of a comprehensive approach to wellness. ABHW members have seen that PSS are an effective component of behavioral health

treatment and have a positive impact on consumers, purchasers, and payers. In one example, an ABHW member designed a program to facilitate access to primary medical care, behavioral health treatment, and support services. The program used a patient-centered medical home with peer specialists driving enrollees to appointments, assisting with housing applications, and teaching life-coping skills. In approximately three years, the data reflecting the use of services revealed a 10-percent reduction in inpatient services within six months of enrollment. The program also showed a 35.9-percent decrease in inpatient costs and a 36-percent decrease in medical spending. The value and beneficial opportunity presented by PSS programs is clear, and public policy should do what it can to support the offering of PSS.

### **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?**

- Payment Reform
- Wraparound Services
- Duals Demonstrations

In addition to suggestions we have made throughout this letter, we have a few further recommendations for ways we can cost-effectively reform Medicare and Medicaid while at the same time improving access to and quality of care for people with behavioral health needs. ABHW members suggest payment reform that shifts from a fee-for-service model that pays based on volume to one that is outcome-based. A payment system that rewards performance, rather than quantity of service delivered, would reduce costs and improve care. There is concern among our members that Medicare's low provider payment discourages providers from participating in the program, which in turn decreases access and results in limits on available services. Moving to an outcome-based payment model will encourage creative and different ways to reform payment.

Furthermore, community-based wraparound services for individuals with complex needs allow people to live in their community. These social supports such as supported employment, supported housing, wellness plans, and transportation have been proven to help people recover and keep patients out of unnecessary inpatient hospital stays. They also keep the goal of recovery at the forefront by helping to maximize function and quality of life. Medicaid waivers have helped to allow for the provision of wraparound services, but the Medicare benefit is not as flexible. We encourage the Medicare program to recognize the benefit of community-based wraparound services and allow Medicare to reimburse for these services for individuals with complex needs.

Finally, ABHW and its member companies support the duals demonstrations because we believe they will discover improved, innovative, and cost-effective ways to deliver coordinated quality care to patients who are eligible for both Medicare and Medicaid. In order to do this, however, it is necessary to have a blended funding stream which streamlines administrative requirements and allows for flexibility of benefits that can be tailored to the individual and provide a continuum of services. Some states have incorporated large quality withholds in their programs, and we see these as problematic. However, overall we support the continuance of these demonstrations; and we would be happy to talk with you further about our members' experience with providing care to this population. It will be important to monitor the lessons learned and incorporate them into our public policy as we move forward.

Thank you again for directing your attention toward these very important issues. We appreciate the opportunity to share our input and look forward to working together as we reform our country's mental health system. If you have any questions, please contact Rebecca Murow Klein at (202) 449-7658.

Sincerely,

A handwritten signature in cursive script that reads "Pamela Greenberg".

Pamela Greenberg  
President and CEO, ABHW