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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
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MEMORANDUM

March 25, 2014

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."

On Wednesday, March 26, 2014, at 10:00 a.m. in room 2123 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing titled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage." The majority has indicated that the hearing will focus on the implications of overcrowding in emergency departments for treatment of individuals with mental illnesses.

During the 113th Congress, the Subcommittee has held two hearings and one forum focusing on mental health issues, addressing mental health and gun violence, privacy issues surrounding the Health Information Portability and Accountability Act (HIPAA), and oversight of the Substance Abuse and Mental Health Services Administration (SAMHSA).[1] Rep. Murphy and other committee members have also introduced a number of mental health bills. Additionally, Rep. Waxman introduced gun violence legislation that included provisions to improve access to mental health services.

I. BACKGROUND

Serious mental illnesses include medical conditions such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, post-traumatic

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[1] House Committee on Energy and Commerce, *Forum on After Newtown: A National Conversation on Violence and Severe Mental Illness* (Mar. 5, 2013); House Committee on Energy and Commerce, *Hearing on Does HIPAA Help or Hinder Patient Care and Public Safety* (Apr. 25, 2013); House Committee on Energy and Commerce, *Hearing on Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill* (May 20, 2013).

stress disorder, and borderline personality disorder.[2] These conditions are described as severe when they have a significant and persistent manifestation. Approximately 11.4 million adults in the United States live with a serious mental illness each year.[3]

Most violent acts are not committed by people living with a serious mental illness and most people living with a serious mental illness are not violent.[4] Research suggests that those living with schizophrenia with controlled psychotic symptoms are no more violent than the population living without a serious mental illness.[5] In fact, people living with a serious mental illness are 11 times more likely than the general population to be victims of violence.[6]

Individuals with serious mental illness can be treated effectively. According to the National Alliance on Mental Illness, "between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports."[7] However, there are significant barriers to receiving treatment, including a shortage of treatment facilities, lack of access to a wide range of treatment services, and the stigma associated with serious mental illness and treatment. As a result, many individuals with serious mental illnesses are not receiving effective treatment or experience delays in treatment. On average, there is a 110-week delay between an initial episode of psychosis and the commencement of medical treatment.[8] For those individuals living with a serious mental illness, approximately 40% did not receive treatment in the past year.[9]

II. PSYCHIATRIC BOARDING IN EMERGENCY DEPARTMENTS

Budget cuts in recent years have contributed to limited treatment options available to individuals suffering from mental illness – including a lack of inpatient psychiatric beds and

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[2] National Alliance on Mental Illness, *What is Mental Illness: Mental Illness Facts* (online at www.nami.org/template.cfm?section=about_mental_illness).

[3] Substance Abuse and Mental Health Services Administration, *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (2010).

[4] Dr. Thomas Insel, Director, National Institute of Mental Health, National Institutes of Health, *Understanding Severe Mental Illness* (Jan. 11, 2011) (online at www.nimh.nih.gov/about/director/2011/understanding-severe-mental-illness.shtml).

[5] Dr. Linda A. Teplin et al., *Crime victimization in adults with severe mental illness,* Archives of General Psychiatry (Aug. 2005).

[6] *Id.*

[7] National Alliance on Mental Illness, *What is Mental Illness: Mental Illness Facts* (online at www.nami.org/template.cfm?section=about_mental_illness) (accessed Mar. 24, 2014).

[8] M. Marshall et al., *Association between duration of untreated psychosis and outcome in cohorts of first-episode patients,* Archives of General Psychiatry (Sept. 2005).

[9] Substance Abuse and Mental Health Services Administration, *20 percent of US adults experienced mental illness in the past year, report says* (Nov. 27, 2012) (online at www.samhsa.gov/newsroom/advisories/1211273220.aspx) (press release).

insufficient outpatient mental health capacity. As a result, patients with serious mental illness who show up to the emergency room at crises points because of their limited treatment options elsewhere are forced to wait for extended periods of time for an inpatient psychiatric bed to become open either at the hospital or at a psychiatric facility.[10] A 2012 study revealed that 70% of surveyed hospitals reported "boarding" patients that they were unable to place in inpatient psychiatric beds or in specifically designated psychiatric hospitals, with one in ten reporting they had boarded patients for "weeks".[11]

The *Washington Post* summarized the problem:

> The "boarding" of mental health patients in hospital emergency departments is a widespread problem that experts say is on the rise, in part because of cutbacks in inpatient hospital beds. As states trimmed their budgets in the economic downturn, resources for mental health patients were among the casualties. Twenty-eight states and the District reduced their mental health funding by a total of $1.6 billion between fiscal 2009 and 2012 ... Maryland lost 145 — or 12 percent — of its public psychiatric beds between 2005 and 2010, and Virginia lost 252 of its beds, or 15 percent ... Meanwhile, more and more people are turning to emergency rooms for health care nationwide. ER visits increased by 32 percent from 1999 to 2009, and overall ER wait times for all sorts of ailments have also gone up, according to a Centers for Disease Control and Prevention report. Psychiatric patients make up 7 to 10 percent of emergency room visits, said a 2012 study in the Emergency Medicine International journal. For many patients suffering from psychiatric crises, this translates to longer waits in emergency departments, where they receive no treatment for days — and sometimes weeks — while social workers try to chase down open spots in psychiatric wards.[12]

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[10] Under the 1986 Emergency Medical Treatment and Labor Act, Medicare-participating hospitals that offer emergency services must examine any person who comes to the emergency room to determine whether the patient has an emergency medical condition. In the event of an emergency medical condition, the hospital must stabilize the condition or provide for an appropriate transfer to another facility. Centers for Medicare and Medicaid Services, *Emergency Medical Treatment & Labor Act (EMTALA)* (Mar. 26, 2012) (online at www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html).

[11] *Proceedings on the State Budget Crisis and the Behavioral Health Treatment Gap: The Impact on Public Substance Abuse and Mental Health Treatment Systems*, National Association of State Mental Health Program Directors (Mar. 22, 2012) (online at www.nasmhpd.org/docs/Summary-Congressional%20Briefing_March%2022_Website.pdf).

[12] *Psychiatric patients wait for ERs for days and weeks as inpatient beds are scaled back*, Washington Post (Jan. 22, 2013) (online at www.washingtonpost.com/local/psychiatric-patients-wait-in-ers-as-inpatient-beds-are-scaled-back/2013/01/22/28c61b5e-56b7-11e2-a613-ec8d394535c6_story.html).

The consequences of psychiatric boarding for patients with mental illness and for other emergency room patients are grave. The *Washington Post* reported last year that for patients with mental illness, the experience of being boarded at the hospital "can worsen a severe mental health crisis."[13] By taking up emergency department beds that would otherwise be available, boarding can also limit the access to emergency care for other patients.[14] Putting additional stress on emergency departments' resources for patients that are often uninsured can also place a financial burden on hospitals.[15]

Some hospitals and providers have begun looking at options to try to address the issue of boarding. Possible improvements include enhanced emergency room care of psychiatric patients through better training of emergency room staff; making better use of existing capacity in emergency rooms to enhance the flow of patients to available beds; greater collaboration between emergency rooms and community outpatient centers; coordination with law enforcement; investments in community crisis services; and other efforts to cut down on recidivism by investing further in outpatient services.[16]

Problems with lack of available treatment options for individuals with mental illnesses have also meant that jails and juvenile detention facilities have had to provide care for these individuals. Over half of inmates in state prisons and local jails have a recent history or meet symptoms of a mental disorder.[17] A 2004 Oversight and Government Reform Committee minority staff report found:

> Without access to treatment, some youth with serious mental disorders are placed in detention without any criminal charges pending against them. In other cases, such youth who have been charged with crimes but are able to be released must remain incarcerated for extended periods because no inpatient bed, residential placement, or outpatient appointment is available.[18]

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[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] *A Plan to Reduce Emergency Room 'Boarding' of Psychiatric Patients,* Health Affairs, (Sept. 2010) (online at www.calhospital.org/sites/main/files/file-attachments/plan_to_reduce.pdf).

[17] Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates,* Bureau of Justice Statistics (Sept. 2006).

[18] House Committee on Government Reform, Minority Staff, *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States* (July 2004) (online at webharvest.gov/congress110th/20081212023841/http://oversight.house.gov/Documents/20040817121901-25170.pdf)

The report found that two-thirds of juvenile detention facilities were holding youth waiting for mental health treatment, and that in a six-month period, nearly 15,000 incarcerated youth were waiting for mental health services. [19]

III. THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND THE AFFORDABLE CARE ACT IMPROVE ACCESS TO MENTAL HEALTH TREATMENT

A. The Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provides important protections regarding equivalency of coverage for medical/surgical and mental health/substance use disorder services that will expand access to mental health treatment. The final regulation implementing MHPAEA went into effect on January 13, 2014, and generally applies to plan or policy years beginning on or after July 1, 2014.[20]

MHPAEA applies to large employers' insurance plans, Medicaid managed care, and the Children's Health Insurance Program and requires that financial requirements (such as deductibles and co-payments) and treatment limitations (such as number of visits) for mental health and substance use disorder services are "no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits."[21]

The Affordable Care Act significantly expanded the protections in MHPAEA and health insurance coverage for mental health services.[22]

B. The Affordable Care Act

1. *Expanded Access to Treatment through the Affordable Care Act*

The Affordable Care Act (ACA) provides affordable and quality insurance coverage to tens of millions of Americans. The ACA also requires that all new individual and small group insurance plans cover mental health and substance use disorder services as one of ten Essential Health Benefits. Plans are required to cover these services at parity with medical and surgical

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[19] *Id.*

[20] U.S. Department of the Treasury, U.S. Department of Labor, and U.S. Department of Health and Human Services, *Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program;* 78 Fed. Reg. 219 (Nov. 13, 2013) (final rule).

[21] Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (accessed Mar. 24, 2014).

[22] *Id.*

benefits, significantly expanding access to these lifesaving services.[23] Individuals are now able to compare high-quality health insurance plans and purchase affordable coverage, often with the help of tax credits and cost-sharing reductions, through the federal and state Health Insurance Marketplaces set up through the ACA. A report by the American Mental Health Counselors Association found that 6.6 million uninsured adults with serious mental health and substance use conditions will be eligible for health insurance coverage - including coverage for mental health and substance use conditions - through these marketplaces.[24]

The ACA also gives states the ability to expand Medicaid coverage to individuals with incomes below 138% of the federal poverty level. The federal government will cover the full cost of this Medicaid expansion through 2016, and slowly decrease its matching rate to cover 90% of the cost to states by 2020.[25] States expanding their Medicaid programs must offer Essential Health Benefits -- including coverage for mental health and substance use conditions -- to newly-eligible beneficiaries and cover these services at parity with medical and surgical benefits.[26] Twenty-five states plus the District of Columbia have expanded their Medicaid programs, and as many as 8.9 million Americans have been determined eligible for Medicaid and CHIP since October 1, 2013.[27]

However, 25 states have not yet moved forward with Medicaid expansion.[28] As a result, an estimated 3.7 million uninsured adults with mental health and substance use conditions will

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[23] Healthcare.gov, *Essential Health Benefits* (online at www.healthcare.gov/glossary/essential-health-benefits/) (accessed Mar. 24, 2014); Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (accessed Mar. 24, 2014).

[24] American Mental Health Counselors Association, *Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion will Punish Americans with Mental Illness* (Feb. 2014).

[25] Kaiser Family Foundation, *Quick Take: Who Benefits from the ACA Medicaid Expansion?* (June 14, 2012) (online at kff.org/health-reform/fact-sheet/who-benefits-from-the-aca-medicaid-expansion/).

[26] Healthcare.gov, *Essential Health Benefits* (online at www.healthcare.gov/glossary/essential-health-benefits/); Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html).

[27] Centers for Medicare and Medicaid Services, *Medicaid & CHIP: January 2014 Monthly Applications and Eligibility Determinations Report* (Feb. 28, 2014) (online at medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/January-2014-Enrollment-Report.pdf)

[28] Kaiser Family Foundation, *Current Status of State Medicaid Expansion Decisions* (Jan. 28, 2014) (online at kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/).

be unable to obtain health insurance coverage through the ACA's Medicaid expansion. This includes nearly 800,000 individuals with a serious mental illness; over 1.5 million individuals suffering from serious psychological distress, such as panic, anxiety, and mood disorders; and nearly 1.4 million individuals dealing with a substance use disorder.[29]

Health insurance through the ACA stands to greatly benefit people with mental health and substance use conditions by making early treatment and prevention services more accessible, which will avert crisis situations from arising in the first place.[30]

2. *Medicaid Emergency Psychiatric Demonstration Program*

Current law prohibits the federal government from providing Medicaid matching funds for inpatient treatment of adults ages 21 to 64 in psychiatric institutions that have more than 16 beds, known as institutions for mental disease (IMDs). Section 2707 of the ACA authorizes a demonstration program providing Medicaid reimbursement to private IMDs for emergency inpatient psychiatric care.[31]

Twenty-seven private IMDs in 11 states and the District of Columbia are participating in the study. The demonstration began in 2012 and is scheduled to end in December 2015, with a final evaluation report available in September 2016. In its December 2013 report to Congress, the Centers for Medicare and Medicaid Services (CMS) states: "[W]e do not have enough data to recommend expanding the demonstration at this time; given the limited data, however, we recommend that the demonstration continue through the end of the current authorization, December 31, 2015, to allow a fuller evaluation of its effects."[32]

Stakeholder groups expect that the demonstration will show that eliminating the IMD exclusion will increase the number of inpatient beds, lead states to reallocate savings to improving community-based services, reduce psychiatric boarding in emergency rooms, decrease hospital readmissions, and decrease overall Medicaid costs.[33]

3. *Health Homes*

Section 2703 of the ACA gives states the option to create Health Homes to coordinate care for individuals with chronic conditions in the Medicaid program. Individuals who have one serious and persistent mental health condition, two chronic conditions (including mental health,

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[29] American Mental Health Counselors Association, *Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion will Punish Americans with Mental Illness* (Feb. 2014).

[30] *Id.*

[31] Centers for Medicare and Medicaid Services, *Report to Congress on the Evaluation of the Medicaid Emergency Psychiatric Demonstration* (Dec. 1, 2013).

[32] *Id.*

[33] *Id.*

substance abuse, asthma, diabetes, heart disease, and being overweight), or one chronic condition with risk for a second would be eligible.

Health Homes would provide services such as comprehensive care management, health promotion, transitional and follow-up care, patient and family support, and referrals to community and social support services to patients with these conditions. CMS will provide an enhanced Medicaid matching rate of 90% for Home Health services.[34]

CMS has approved Health Home state plan amendments in 14 states. Another 11 states and the District of Columbia have submitted plans to CMS for approval.[35]

IV. WITNESSES

The following witnesses have been invited to testify:

Lisa Ashley
Parent of a son with serious mental illness

Jeffrey L. Geller, M.D., M.P.H.
Professor of Psychiatry and Director of Public Sector Psychiatry
University of Massachusetts Medical School

Jon Mark Hirshon, M.D., M.P.H., Ph.D., FACEP
Task Force Chair, 2014 American College of Emergency Physicians National Report Card on Emergency Care
Associate Professor
Department of Emergency Medicine, University of Maryland School of Medicine

Michael C. Biasotti
Chief of Police
New Windsor, NY
Immediate Past President of New York State Association of Chiefs of Police
Parent of a daughter with serious mental illness

Thomas J. Dart
Sheriff
Cook County Sheriff's Office

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[34] Centers for Medicare and Medicaid Services, *Health Homes* (online at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html) (accessed Mar. 24, 2014).

[35] Centers for Medicare and Medicaid Services, *State Home Health CMS Proposal Status* (Mar. 2014) (online at www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v31.pdf).

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