Statement of Dr. LaMarr D. Edgerson, LMFT, NBCCH

Before the

Oversight and Investigations Subcommittee of the House Committee on Energy and Commerce

On

Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage

March 26, 2014

American Mental Health Counselors Association
801 N. Fairfax Street, Suite 304
Alexandria, Virginia 22314
703-548-6002
www.amhca.org

My name is Dr. LaMarr Edgerson and I wish to thank the Chairman and Ranking Member for the opportunity to testify today at this very important hearing on the psychiatric bed shortage. My doctorate is in psychology with a special focus in traumatic stress. I am a Clinical Mental Health Counselor, Licensed Marriage and Family Therapist and Board Certified Clinical Hypnotherapist. The population we are focusing on today is the population that I primarily serve.

Over the past year, I have served as Director at Large for the American Mental Health Counselors Association also known as AMHCA. I am here representing AMHCA's 7100 members. I am also a board member and past president of the New Mexico Mental Health Counselors Association. Clinical mental health counselors (CMHCs) are primary mental health providers who offer high quality, comprehensive, integrative, cost effective services across the lifespan. They are uniquely qualified licensed clinicians trained to provide mental health assessment, prevention, diagnosis, and treatment.

I grew up in the welfare system with inadequate insurance, but since the age of 18 years I have provided health care for patients. My career began as an enlisted member of the U.S. Air Force where I served for 20 years as a medic in the dental services area. I now see children, adults and families in a private practice in Albuquerque, New Mexico. My specialty is post-traumatic stress disorder.

I am very familiar with the inadequate mental health care system and the practice of boarding due to the lack of access to timely effective care. Evidence all around us demonstrates the nation's mental health care system is in crisis. It is

generating increased demand for inpatient psychiatric beds while simultaneously decreasing their supply.

Because patients have trouble accessing services in the community—including prevention, early screening, medication management and therapy—they use the emergency department for basic and intermediate care. Our current mental health system still suffers from, and is largely a reflection of, the poor transition from inpatient institutions to community-based treatment and the lack of funding for care.

I. Moderate and Severe Mental Health Conditions Can Turn into Crisis Situations

More people end up in emergency rooms, on the streets homeless, or in our nation's jails and prisons as their conditions worsen due to a lack of timely, needed mental health care services—or critically important follow up care.

Many people who need mental health services do not receive any treatment: Over 60 percent of adults with a diagnosable disorder do not receive mental health services, and nearly 90 percent of people with substance use disorder (SUD) do not receive specialty treatment for their problem. Individuals with lower incomes are more likely to have a mental health problem than those with higher incomes, and survey after survey indicates that cost is a major barrier to receiving care.

Many of the recent surveys on the use of mental health services indicate that public mental health delivery systems are in crisis—with increasing demand for inpatient psychiatric beds but a decreasing supply. Emergency Department (ED) directors report that psychiatric evaluation teams would not come to evaluate patients in the ED if there are no inpatient psychiatric beds available to place patients, further delaying definitive treatment. Because patients have trouble accessing services in the community—including prevention, early screening, medication management and therapy—they use the ED for basic, intermediate and crisis-related care. Our current mental health system still suffers from, and is largely a reflection of, the poor transition from state institutions to community-based treatment and the lack of local funding.

II. Psychiatric Boarding

Through the various roles I've held in mental health I am familiar with the practice of psychiatric boarding due to the lack of access to timely effective care.

A nationwide survey conducted by the American College of Physicians of more than 6,000 emergency departments, showed that 70 percent reported what is known as "boarding psychiatric patients" for hours or days, and 10 percent reported boarding persons with psychiatric conditions for several weeks.

The net effect of "boarding" is to reduce access to emergency department beds for those that are the victims of heart attacks, strokes, and auto accidents. Reductions in mental health program spending during the recession came at a

price. The hardest hit initiatives are those providing mental health services to lower-income people and uninsured adults, many recently lost health insurance coverage in the recession. These consumers are often individuals who are ineligible for Medicaid and fall through coverage cracks.

Ironically, all of the cuts in mental health spending are adding costs to other service sectors and public agency budgets. Due to public mental health cuts, we are simply increasing emergency department costs, increasing acute care costs and adding to the caseloads in our criminal, juvenile justice and corrections systems. The unintended consequences of cutbacks including increased homelessness and unemployment take a devastating toll on other public agencies, and most importantly on our most vulnerable mental health consumers.

A terrible toll is emerging from the Iraq and Afghanistan wars that will be taken on our service members and we expect that various public agency budgets will be called upon to address the needs of many in this population who are unable to obtain services through the VA due to access problems. This is a pressure cooker preparing to explode. The current system is not designed, nor prepared to meet these significant needs.

We at AMHCA believe policymakers have been going down the wrong paths in addressing the problem of hospital boarding – a symptom of a larger problem. Make no mistake – the primary culprit behind this problem is not the Medicaid

inpatient psychiatric hospital exclusion, which is part of the access problem, as well as budget cuts and the reduction in psychiatric hospital beds.

No Mr. Chairman and members of the committee. The most significant barrier to accessing timely, effective, quality, mental health treatment is the lack of continuous health insurance coverage that provides comprehensive mental health benefits from inpatient care services to prescription drugs, to outpatient care, to prevention programs. All of those essential benefits are provided in health plans governed by the Affordable Care Act and new state Medicaid Expansion programs and some are available to Medicare beneficiaries.

III. Health Insurance is the Pass-Key to Timely and Consistent Care

We need to make sure that people with mental illness get the treatment they need at the onset of their symptoms, and after release from hospitals, jails, and prisons to prevent relapse.

Cutbacks in mental health care continue to occur despite the evidence that early treatment and prevention for mental illness and substance use programs is effective. Among many other benefits, effective and timely mental health services increase quality of life and productivity for people with mental illness.

When persons with mental health conditions or substance use disorders do not receive the proper treatment and supportive services they need, crisis situations often arise affecting individuals, families, schools, and communities. We need only follow the news to see the impact of improper care. Adequate health

insurance coverage can help people long before they find themselves in a crisis situation.

IV. New Medicaid Expansion Program and People with Serious Mental Health Conditions

The point of the Medicaid Expansion program is to treat people long before they need emergency department services. This can be accomplished via mental illness prevention, early screening and detection, as well as integrating primary care and mental health services for people suffering with several chronic conditions with the use of evidence-based care and treatment.

Continuous and stable health insurance coverage is the pass-key to cost-effective, efficient timely mental health services in the United States. All of us who have health insurance are fortunate that we have “better-sleep-at-night coverage” for our families. Unfortunately, not all Americans can say that.

This past December an article was printed in the George Washington University School of Medicine and Health Science. It was entitled, Innovations: Psychiatric Boarding – A Seven Pronged Approach to a Growing Problem by Ms. Nalini K. Pande. The article cited an important historical statistic that “the number of psychiatric beds plummeted from about 400,000 in 1970 to 50,000 in 2006. The movement to deinstitutionalize psychiatric patients has been partially offset by an increase of 50,000 additional private and general hospital psychiatric beds during this time,” but clearly a large gap still remains in the treatment of America’s

mentally ill. The article further cites a study, which estimates that "psychiatric boarding costs nearly four million dollars a year in lost revenue from service that could have been provided in lieu of boarding at ONE 450-bed teaching hospital."

Ms. Pande states, "We shifted the focus to outpatient care, but the funding did not shift with it. With a lack of outpatient facilities to absorb psychiatric patients, these patients find themselves getting dropped off in an emergency department, because folks don't know of another place to take them. As patients wait – some for hours, some for days – their psychiatric mental health starts to deteriorate. So, a patient who came in with a minor psychiatric illness subsequently turns into a patient with a major situation."

AMHCA members know the burden of mental illness in the U.S. is significant due to increasing numbers of uninsured people with mental illness, as well as an underfunded mental health system. The new state Medicaid expansion program has the potential to achieve that goal for millions of currently uninsured Americans and specifically would afford people with mental health diagnoses greatly expanded access to mental health and substance use treatment in an integrated and community-based setting, with a person-centered treatment focus.

Unfortunately, 25 states are refusing to participate in the New Medicaid Expansion Program, which will continue to leave millions of uninsured persons with serious mental health conditions, out in the coverage cold.

Nearly 4.0 million of the 6.7 million uninsured people with a mental illness who are eligible for health insurance coverage through the Medicaid Expansion initiative will go uncovered because those 25 states are refusing to participate in the new Medicaid initiative.

In our recent report entitled, ***Dashed Hopes, Broken Promises, More Despair: How the Lack of State Participation in the Medicaid Expansion Will Punish Americans With Mental Illness,"*** AMHCA details the drastic impact that living in a state without Medicaid Expansion has on health insurance coverage **for adults who have mental health conditions.**

Key findings from the AMHCA report include:

- Nearly 4 million uninsured people (3.7 million) who have a serious mental illness, are in serious psychological distress or who have a substance use disorder are eligible for health insurance coverage through the new Medicaid Expansion program in the 25 states that have rejected participation in the initiative.

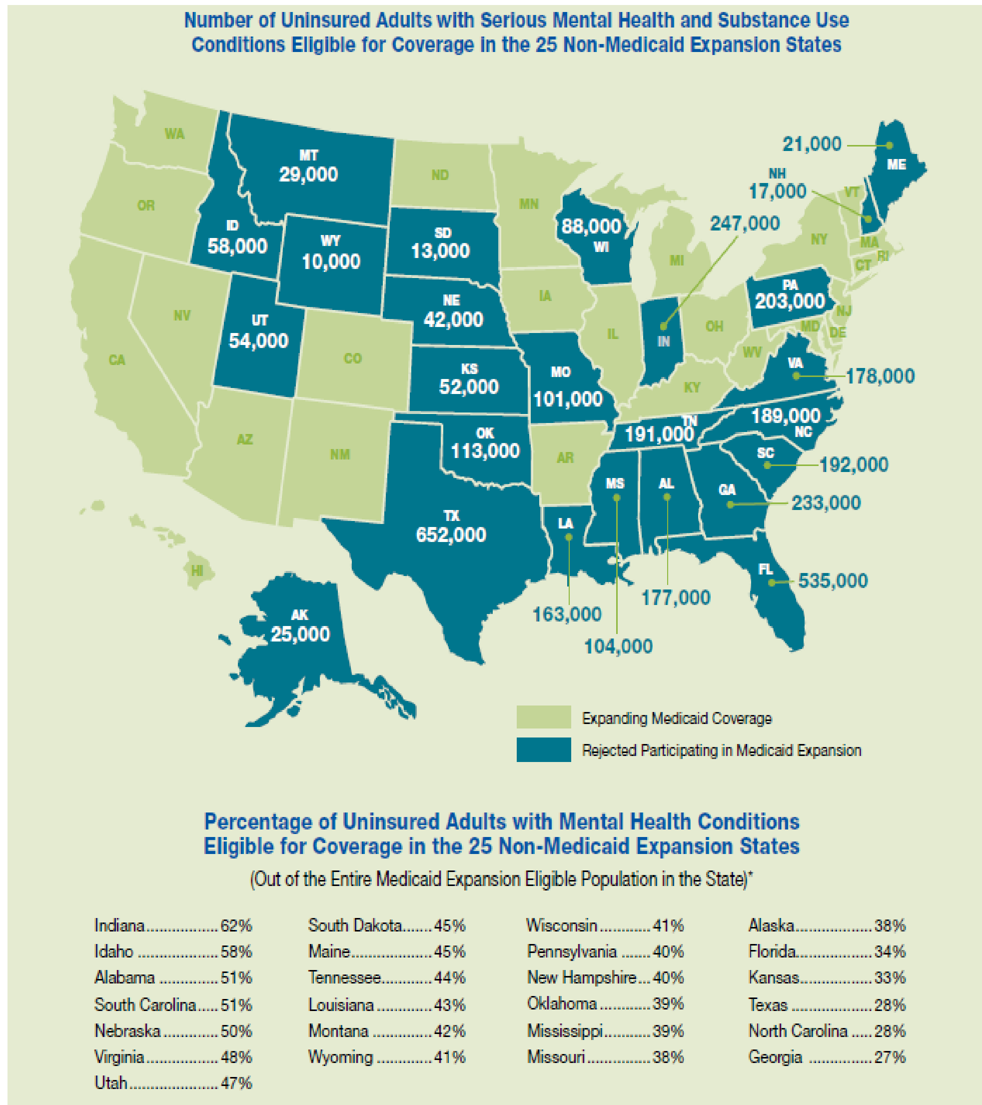
- Nearly 75 percent (2.7 million adults) of all uninsured persons with a mental health condition or substance use disorder who are eligible for coverage in the non-expansion states (3.7 million), reside in these 11 Southern states that have rejected the Medicaid Expansion: Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South

Carolina, Tennessee, Texas and Virginia.

- More than 1.1 million uninsured people who have serious mental health and substance abuse conditions live in just two states — Texas (625,000) and Florida (535,000). These more than 1.1 million individuals are eligible for coverage under the new Medicaid Expansion program, but won't receive it. Since officials in Texas and Florida (and other 23 states) have said they will not participate in the initiative, they are leaving their most vulnerable citizens without health insurance, even though the federal government will pay for it at 100 percent for the first three years.

In the Dashed Hopes report, AMHCA projected the number of adults with mental health conditions who are eligible for coverage through the New Medicaid Expansion Program, under the Traditional Medicaid program, as well as through the new health insurance marketplaces.

The decision by state officials to not participate in the Medicaid Expansion means that these 25 "Left Behind States" are going to commit millions of their fellow citizens who are suffering with a mental illness—as well as millions more with chronic or serious conditions—to poor health, more poverty, and more despair.



Indiana	62%	South Dakota	45%	Wisconsin	41%	Alaska	38%
Idaho	58%	Maine	45%	Pennsylvania	40%	Florida	34%
Alabama	51%	Tennessee	44%	New Hampshire	40%	Kansas	33%
South Carolina	51%	Louisiana	43%	Oklahoma	39%	Texas	28%
Nebraska	50%	Montana	42%	Mississippi	39%	North Carolina	28%
Virginia	48%	Wyoming	41%	Missouri	38%	Georgia	27%
Utah	47%						

The passage of the Affordable Care Act was a major milestone in long-standing efforts to ensure access for all Americans to appropriate, high-quality and affordable mental health care and prevention and treatment services.

Many of the most prominent features of the ACA were instrumental in establishing the **centrality** of overall mental health services within the overall

health care delivery system —such as the designation of mental health and addiction services as one of the ten categories of essential health benefits (EHB)

As originally conceived, this designation of essential health benefit provides for a comprehensive range of prevention and treatment services to be covered, including early identification and screening, early interventions, acute treatment, and chronic care management activities such as case management.

The early implementation of the Medicaid Expansion is already reshaping the delivery of services. For example, it is moving the field toward the integration of services with primary care, which has significant workforce implications in regard to team approaches, better coordination, as well as the new roles and responsibilities for staff. As screening for mental illness and substance abuse become more commonplace in primary care, more and more people will be identified as needing services.

V. Medicare Provider Access Must be Improved

AMHCA is very concerned with Medicare beneficiary access to outpatient mental health services. The Substance Abuse and Mental Health Services Administration and the Administration on Aging have documented the extent of behavioral health problems among older adults such as alcohol or medication misuse or abuse, depression, and anxiety. Behavioral health problems can have a great impact on older adults and are associated with decreased quality of life, diminished adherence to treatment plans, poor physical health, and overuse of

medical services. Despite the impact of behavioral health problems, they often go undiagnosed and undertreated. Older adults that do access behavioral health care often do so through primary care providers, and treatment is too often limited to administration of prescription medications. Furthermore, service providers are often poorly equipped to address behavioral health problems with co-occurring medical disorders, resulting from their inability to include appropriate providers in their practice arrangements, and insufficient physician time to screen, diagnose, and treat both physical and behavioral health problems.

Older Adult Mental Health Needs-- At least 5.6 million to 8 million older adults– nearly one in five - have one or more mental health or substance use conditions which present unique challenges for their care. Unfortunately, fewer than 40% of older adults with mental and/or substance use disorders get treatment. Of those who receive treatment, most go initially to primary care physicians, who often cannot provide even minimally adequate care.

The single greatest statutory barrier that prevents Medicare beneficiaries from obtaining mental health and behavioral health care is the exclusion of Clinical Mental Health Counselors (CMHCs) and Marriage and Family Therapists (MFTs) from participating in the program. These two provider groups, 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 covered due to their more recent recognition for independent practice in the states. Other

federal agencies now recognize these two professions for independent practice, including the National Health Service Corps, the Department of Veterans' Affairs and DoD/TRICARE. It is long past time for Medicare beneficiaries to gain access to these providers to ensure they have access to necessary mental health services. Representatives Chris Gibson and Mike Thompson have sponsored legislation HR.3662 that adds CMHCs and MFTs) services under part B of the Medicare program and we urge you to act on this legislation.

Covered mental health professionals recognized by Medicare presently include psychiatrists, psychologists, psychiatric nurse specialists and clinical social workers. MFTs and CMHCs are not Medicare-covered providers despite the fact they have education, training and practice rights equivalent to or greater than existing covered providers. HR.3662 does not change the mental health benefit or modify the MFT/CMHC state scope of practice, but it will allow Medicare beneficiaries who need medically necessary covered mental health services to obtain these professionals' services. In essence, this bill only increases the pool of Medicare qualified providers that beneficiaries can choose from without changing the covered services.

Lack of Access in Rural and Underserved Areas--Approximately 77 million older adults live in 3,000 mental health professional shortage areas. Fully 50 percent of rural counties in America have no practicing psychiatrists, psychologists, or social workers. However, many of these mental health

professional shortage areas have CMHCs and MFTs whose services are underutilized due to lack of Medicare coverage. About 50 percent of rural counties have no practicing psychiatrists or psychologists. CMHCs and MFTs are often the only mental health providers in many communities, and yet they are not now recognized as covered providers within the Medicare program. These therapists have equivalent or greater training, education and practice rights as currently eligible provider groups that can bill for mental health services through Medicare.[i]

Medicare Inefficiency--Currently, Medicare is a very inefficient purchaser of mental health services. Inpatient psychiatric hospital utilization by elderly Medicare recipients is extraordinarily high when compared to psychiatric hospitalization rates for patients covered by Medicaid, VA, TRICARE, and private health insurance. One-third of these expensive inpatient placements are caused by clinical depression and addiction disorders that can be treated for much lower costs when detected and treated early through the outpatient mental health services of CMHCs.

Underserved Minority Populations--The United State Surgeon General noted in a report entitled *Mental Health: Culture, Race, and Ethnicity* that "striking disparities in access, quality, and availability of mental health services exist for racial and ethnic minority Americans." A critical result of this disparity is that minority communities bear a disproportionately high burden of disability from untreated or inadequately treated mental disorders.

Integration of behavioral and physical health care is key--Accountable Care Organizations and other initiatives that integrate physical and mental health care are demonstrating considerable health care cost reductions and quality improvements. Health care practices that provide integrated patient care can avoid unnecessary tests, provide integrated behavioral health and medical health diagnoses, and can readily prescribe psychiatric medications to support patient care. Most importantly, they report improved patient outcomes with lower costs. In many of these models, older adults receive screening and treatment for behavioral health problems in their primary care setting, and receive care from both their primary care provider and a behavioral health specialist that is co-located within the primary care team. Alternatively, some specialized behavioral health clinics and centers have embedded primary care practitioners within their practices to provide integrated care to patients. Effective integrated care teams develop a comprehensive plan to address physical and behavioral health care needs, and share patient care information. The behavioral health provider can support medication management prescribed by the primary care provider and can deliver brief evidence based behavioral health interventions, such as problem-solving therapy, interpersonal therapy, or brief alcohol interventions. The effectiveness of treatment is measured and tracked, and treatment is changed or intensified if a patient does not show improved clinical outcomes.

In the context of reforming Medicare, it is difficult to project greater cost effectiveness at significantly reduced costs than the concepts we have discussed. The nation has a proven resource in LMHCs and MFTs who are well qualified and dedicated behavioral health specialists.

VI. Opportunity to Re-Strengthen Mental Health Systems

Mr. Chairman, with the Medicaid Expansion program picking up the costs associated with uninsured people with mental illness, we have a unique and special opportunity to address one of the primary concerns that you have been highlighting in your hearings sponsored over the last year: Increasing access to mental health services by shoring up public mental health systems that have been essentially dismantled by state budget cuts,

Savings that accrue to states through the Medicaid Expansion could be funneled back in a way to re-strengthen state public programs especially at the community-level.

If a state chooses to opt out of the new Medicaid expansion initiative those State officials need to be fully informed about the potential problems their people will face while trying to access needed psychiatric inpatient care and community services. This potential perfect storm of budget and DSH cuts, coupled with a growing uninsured population with mental health conditions, and decreasing bed capacity, demands serious consideration and an immediate solution. The answer is for all states to participate in the New Medicaid Expansion Program.

Through the new Medicaid expansion, community mental health centers and other publicly supported community behavioral health providers would engage individuals earlier in the onset of their mental illness or substance abuse. It has been proven that early intervention and treatment result in better health outcomes at lower costs especially through programs that focus on high-cost Medicaid recipients with co-occurring mental illness and chronic medical conditions. With the federal government picking up most or all of the cost of Medicaid Expansion, the expense to individual states is low, making it even easier for states to opt in.

Although a few states are poised to spend additional “general revenue” funds to begin to reverse decades of underfunded programs, several states continue to propose budget cuts in mental health care. Despite the clear evidence that severe budget cuts have led to underfunded and inadequate services to address the needs of people with mental illnesses, states are simply turning their backs on their most vulnerable citizens. This is not the country America was designed to be, nor is it the country the world perceives us to be.

For reasons beyond my understanding our current mental health (and actually the overall health-care) system is designed to delay treatment until many individuals with severe mental health conditions become very sick and suffer serious consequences before treating them. Young people who show early signs of mental health disorders often do not receive treatment because of a lack of health insurance, stigma or simply because they lack information regarding what

they're suffering from or how receive proper assistance. Study after study, survey after survey, research after research, all show that delayed treatment is associated with incomplete and prolonged recovery.

VII. Connecting the Dots to a Better Mental Health System

In summary, please allow me to connect the dots.

The Medicaid Expansion will provide health insurance coverage to millions of people with serious mental health conditions who have had a difficult time accessing needed and timely services and reduce the chances dramatically of reaching a crisis situation.

Money that the states will save by transferring the costs of treating uninsured people with mental illness to the Medicaid Expansion effort can then be utilized to develop a strong infrastructure of community-based services that will decrease the need for inpatient beds in many cases. However, it should be known that the infrastructure in place today is inadequate in most, if not all, places.

AMHCA recognizes that a range of options for responding to youth and adults in crisis is needed, including mobile crisis teams, 24-hour crisis stabilization programs, and inpatient beds in community hospitals.

Many experts of our troubled mental health system agree: We must lessen reliance on costly and traumatizing crisis and inpatient care, and transition to a community-based model of care. The New Medicaid Expansion Program and

Medicare provider expansion will go a long way to getting us to the implementation and scaling up of that goal and model.

That is far more rational and humane approach than our current-crisis driven system which sends people to costly hospital ERs, overnight shelters and jails, ultimately causing psychiatric boarding and unending growth in emergency room budgets and corrections.

We can and must immediately begin the trek towards improving mental health services in our country; ensuring quality, safety and adequate oversight; and improving access to recovery-based care, especially the community.

The lives of these individuals, and many innocents, are on the line.