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Senator Ron Wyden, Chairman  
Senator Mike Crapo, Ranking Member  
Committee on Finance  
United States Senate  
Washington, D.C. 20510-6200

Dear Chairman Wyden and Ranking Member Crapo:

Thank you for the opportunity to provide input to U.S. Senate Committee on Finance on the issues of behavioral health care needs and access to care. I am a parent of two adult children who have experienced serious mental illness, bipolar disorder and treatment resistant depression, that began when they were in their teens, a founder and board president of a clubhouse program in Miami, [The Key Clubhouse of South Florida](#), and a mental health advocate, working as Vice President of the [Florida Mental Health Advocacy Coalition](#). I also served for nine years on the board of [Thriving Mind](#), the regional Managing Entity for state-funded behavioral health services in our county.

In response to your request for input from stakeholders, I would like to make the following suggestions. These are based on my own experiences as a caretaker for my daughters in the private health insurance realm, and from what I've learned over the last 13 years about the publicly funded mental health system from serving on boards and committees, and by personal relationships with many people living with serious mental illness.

### **Strengthening Workforce**

**What policies would encourage greater behavioral health care provider participation in these federal programs?**

- **Increase reimbursement rates for Medicaid providers** to incentivize psychiatrists and other mental health practitioners to accept Medicaid, or to remain long in the field.

COMMENT: Our advocacy group interviewed the VP for Finance of a very large and successful hospital chain the South Florida. This hospital chain had recently published a stakeholder survey that rated mental health services as the top priority for the company. However, the company has never operated a Department of Psychiatry or offered psychiatric hospital beds. We asked them why. The VP told us that it was financially

unfeasible for them to operate psychiatric beds because of low Medicaid reimbursement rates for psychiatric illnesses.

### **Increasing Integration, Coordination and Access to Care**

#### **What programs, policies, data, or technology are needed to improve access to care across the continuum of behavioral health services?**

- **Repeal the IMD Exclusion:** Communities need more psychiatric beds and residential treatment facilities. For this reason, the IMD exclusion needs to be repealed. It can take months to test and identify appropriate medication for people experiencing the onset of a serious mental illness. One of the greatest tragedies of the mental health system in the Miami-Dade County community is the endless cycling in and out of crisis hospitalizations of people with serious mental illnesses because they are not afforded appropriate inpatient treatment because of lack of beds and lack of treatment focused on long-term recovery. This leads inevitably to people unnecessarily becoming homelessness and interacting with law enforcement.

COMMENT: My own daughter needed eight months in a private residential treatment center after we spent 10 years trying to help her, before the right combination of medication was determined. She gradually transitioned out of the treatment center and into independent living.

There is nothing comparable to this excellent residential treatment program for the much larger population of people in the public behavioral health care system to the she received. The cost of operating a similar residential treatment program with public funds is assumed to be prohibitive, but the cost of untreated schizophrenia, bipolar disorder or major depressive disorder over a person's lifetime is far more costly to the entire community.

- **Provide funding for states and regions to develop integrated behavioral health care data systems.** One of our community's greatest challenges is integrating patient data on behavioral health treatment between our safety net system (funded through the mental health and substance block grants), the Medicaid and Medicare funded systems, and other behavioral health providers. A person with a serious mental health condition who starts out in the safety net system but then transitions into the Medicaid system literally disappears from one data system and goes into another without any medical history following them. (In Florida, because it does not have Medicaid Expansion, the only way an adult with serious mental illness qualifies for Medicaid-funded treatment services is to qualify for SSI or SSDI.) This same person may end up incarcerated and lose their Medicaid benefits, only to resurface in the safety net system upon release. Meanwhile, their complete treatment history is not maintained and they may be prescribed medications that were already proven to be ineffective, or other factors about their medical history are not transferred between providers.

**How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?**

- **Provide funding incentives for states to support the development of comprehensive behavioral health crisis response systems.** Our state is moving at a glacial pace in recognizing and supporting the creation of effective behavioral health crisis response systems in Florida communities. Our state advocacy coalition is very much involved in educating legislators about 988 and the need for a complete behavioral health crisis response system but we are finding that there is a great deal of confusion and not a lot of support for this idea.

We have also done a great deal of research on different crisis response systems around the country, including CAHOOTS. We've learned that the CAHOOTS program does not operate in a vacuum. It relies on a solid foundation of support services to which its mobile response team can refer people after they have administered the first response services. It also works "in cahoots" with the local police department, something not so easily accomplished in many communities.

It could be helpful if SAMHSA created financial incentives for states to use mental health block grant funds to support more and new types of mobile response systems plus the underlying infrastructure needed to create functional 988 call centers. Simply recommending that they do so is not enough.

**How can providers and health plans help connect people to key non-clinical services and supports that maintain or enhance behavioral health?**

- **Actively promote effective recovery-oriented, non-clinical programs, such as the accredited clubhouses.** As someone who has been deeply involved in the Clubhouse International movement, I have witnessed the profound impact of the 220+ U.S. clubhouses in helping people with severe and persistent mental illnesses reduce their use of behavioral health crisis services and get the support they need to prepare for and find employment in the community. In addition to building our own clubhouse here in Miami, now connected with supportive housing in the same building, I've visited accredited clubhouses in five other U.S. cities and in Amsterdam. Because of the 37 Clubhouse International standards we follow, they all function similarly and with great benefit to their members. These programs are incredibly cost-effective (members can attend year-round for approximately \$5,000-\$6,000 a year per person) compared with the results they achieve.

Our clubhouse does not interact with any health plan, although we know that health plans could benefit by helping its patients enroll in clubhouse services and reduce the costs of emergency behavioral health care. How could this be encouraged? Perhaps SAMHSA could highlight the role of clubhouse in reducing hospitalization and supporting recovery and employment. There are few independent research studies of nonclinical programs like clubhouses that have a much greater impact on the entire lifetime of a person living

with serious mental illness than any short-term hospitalization or crisis stabilization service.

### **Ensuring Parity**

**How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicaid fee-for-service programs impact access to care and patient health?**

- **Require states to meet certain standards in the implementation of Medicaid programs providing behavioral health services, including parity for behavioral health.** States have wide latitude on how they administer their Medicaid programs. Here in Florida, Medicaid has been transferred to private health companies operating as “Medicaid Managed Care” programs. A recent “External Quality Review Technical Report” on these programs showed that none of the companies met the minimum performance targets for behavioral health care. (Attached is the report, see p. 11 ff.).

We have also heard from our local behavioral health providers that essential behavioral health treatment services for people with mental illness are being routinely denied by these companies. In addition, these providers have to be approved by several MMA programs in order to receive Medicaid reimbursements for their clients who are enrolled in different MMA programs. This has led to additional paperwork.

We do not know yet whether our state will continue to work with these companies despite their below-level standard of behavioral health care. It would be helpful if the federal government required states to meet certain standards in their implementation of Medicaid programs.

Once again, thank you for this opportunity to provide feedback. The behavioral health system is immensely complex and difficult for people to access and manage. I hope that Congress can have a role in making it more easily accessible and effective, leading to greater outcomes for people living with behavioral health conditions.

Sincerely,



Amy McClellan