Sheppard Pratt

November 1, 2021

The Honorable Ron Wyden
Chairman
U.S. Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Request for Information on Behavioral Health Care Needs

Dear Chairman Wyden and Ranking Member Crapo:

Thank you for your efforts to address to increase access to behavioral health care. Even before COVID-19, our nation was facing an impending mental health crisis. The need for behavioral health services is now greater than ever, and access to care, especially for those in the Medicaid population, is paramount with a looming crisis.

At Sheppard Pratt, the largest private, nonprofit provider of mental health, special education, substance use, developmental disability, and social services, we take great pride being an integral part of ensuring access to lifesaving mental health and substance use services for our most vulnerable. Sheppard Pratt served more than 70,000 individuals last year, largely from throughout Maryland but patients were seen from 41 other states and 19 countries at our 380 sites of services. Our main campus is just north of Baltimore and earlier this year, we opened a second hospital on a new 40-acre campus in Howard County, Md. We employ over 5000 with half working in the hospitals and schools and the other half at community service locations. For almost 30 years, Sheppard Pratt has been ranked as a top national psychiatric hospital by *U.S. News & World Report*.

In response to your request for input from stakeholders to better understand how Congress can better address the mental health care needs facing our nation, Sheppard Pratt is recommending the following actions: 1) Repeal the IMD exclusion and if not possible, modify the exclusion to allow certain high-performing mental health care providers receive Medicaid dollars; 2) Increase CMS reimbursement rates for behavioral healthcare providers to levels that are more consistent with their education and credentialing; 3) Incentivize step-down care options for psychiatric patients through appropriate CMS reimbursement; 4) Create a center of excellence program at SAMHSA that focuses on the development of comprehensive treatment recommendations for mental health patients; 5) Extend CMS telehealth reimbursements while eliminating the originating site and geographic requirements and allowing audio-only technology to be reimbursed at the same rate as video telehealth; and 6) Direct CMS to provide reimbursement for the supportive services that are most beneficial to improved outcomes for child patients. To further expand on these items, I offer the below comments:

Ensuring Parity

First and most importantly, true mental health parity cannot exist with the Institutions for Mental Diseases (IMD) exclusion as law. It discriminates against adult Medicaid beneficiaries by denying them access to specialized acute behavioral healthcare in psychiatric hospitals and residential treatment facilities. While the IMD exclusion was originally created with the good intention of ending the large-scale institutionalization of the mentally ill, it has become a barrier in recent years for those needing treatment for psychiatric illnesses or substance abuse. In some instances, the IMD exclusion has caused a

shortage of beds forcing care to instead occur in emergency departments or jails rather than a more appropriate setting.

While I support the full repeal of the IMD exclusion, I understand that this is unlikely to occur due to concerns that it would lead again to increased institutionalization as well as its potential very high cost. However, I believe that certain prescriptive exceptions to the exclusion can be made to ensure that top flight mental health care providers like Sheppard Pratt are not at the mercy of their State Medicaid programs to have access to the dollars required to provide these services. These high-performing institutions often serve as safety nets for the local hospital systems and receive the hardest of cases. Additionally, mental health institutions are often able to provide inpatient care at a lower cost than care at medical hospitals. To help address this inconsistency, Congress should modify the IMD exclusion to allow Medicaid funding to flow to the most high-performing nonprofit IMDs that meet certain thresholds related to the average inpatient length of stay, percentage of inpatients of the total patient number, and revenue related to inpatient care. This change would allow the most advanced mental health care hospitals and providers to receive Medicaid dollars while continuing to ensure that increased institutionalization does not occur.

Strengthening Workforce

As you are aware, Health Resources and Services Administration projected that by 2025 the shortage for mental health providers will reach approximately 250,000. Additionally, low reimbursement rates for behavioral health services in Medicaid and Medicare make it difficult for nonprofit providers like Sheppard Pratt to competitively recruit qualified staff. To help address this, Congress should require CMS reimbursement rates for behavioral healthcare providers to be increased to levels that are more consistent with their education and credentialing, comparable with how rates are set for other providers. Additionally, the legislation should to expand loan repayments and grant programs to the greatest extent possible to attract more mental health professionals to the workforce.

Increasing Integration, Coordination, and Access to Care

Step-down Care Reimbursement. Psychiatric inpatient bed numbers have been markedly reduced in recent decades often resulting in an increased number of psychiatric patients seeking treatment in hospital emergency departments and causing longer emergency department wait times for acutely ill psychiatric patients. This often leads to psychiatric boarding, or the time spent waiting in a hospital for an inpatient hospital bed or transfer to another facility for patients with primarily psychiatric conditions. Psychiatric inpatient beds stay occupied longer than needed because there are limited options for continued assistance after discharge so instead the patient remains admitted. Psychiatric patients, just like those with physical health conditions, must continue their recoveries outside of the hospital. Patients often need a supportive environment that may come with temporary or long-term housing, counseling and assistance with medication to help them stabilize and ideally thrive after they leave the hospital. This causes a lack of access to care issue for both the patients needing to be admitted into an inpatient facility and for those that need step-down care options for after discharge. Step-down care and is lacking in most communities throughout the country.

The deficit of step-down care and housing options for psychiatric patients being discharged from local hospitals has led to long and expensive waits in hospitals that burden patients, families and hospital staff. Studies indicate that transferring patients ready for discharge from a mental hospital to a community residential aftercare can have the potential to reduce total consumption of health services and costs without increased hospital admissions. To incentivize more step-down care options for psychiatric patients, CMS needs to reimburse for these services at the appropriate rates.

Mental Health Centers of Excellence. The federal government also is behind in how it researches more holistic approaches to mental health treatment. Effective treatment options are crucial for people with mental illness. However, current treatments and the dominant model of mental health care do not adequately address the complex challenges of mental illness. Many patients do not respond to treatments. Many cycle through one treatment after another without any relief, hoping to eventually land on one that works. Others find treatments that work for them — but only for a while. Despite the need for mental health patients to have access to comprehensive care plans and treatments, the Substance Abuse and Mental Health Services Administration (SAMHSA) does not have a center of excellence program focused on tackling this problem. It has centers of excellence to help deal with certain parts of the problem, but these do not take a holistic approach to mental health care.

Within Substance Abuse and Mental Health Services Administration (SAMHSA), Congress should create a center of excellence program that focuses on the development of comprehensive treatment recommendations for mental health patients that includes supportive services, wraparound services, and social determinants of care where applicable. These centers of excellence would be licensed providers of mental health services that provide inpatient mental health services across both general and specialized units, including to patients that have been involuntarily admitted. The providers should also actively serve multiple municipal regions and provide a comprehensive continuum of outpatient services, including therapy and medication management for a variety of diagnoses. To ensure that a wide range of patient populations can be supported through these centers, the provider should provide services to patient populations that must include federal participation in Medicare, public mental health participation in state Medicaid program, and accept patients who are private pay/uncompensated care. Additionally, these centers should provide models of treatment and best practices that could be replicable at mental health providers across the nation.

Expanding Telehealth

The COVID-19 pandemic has made apparent how transformative and viable of an option telehealth can be for delivering acute, chronic, primary, and specialty care and the expanded coverage for mental health and addiction treatment services was vital for preserving access to care.

With the urgent need for additional telehealth services, Sheppard Pratt successfully launched our Virtual Crisis Walk-In Clinic. With a swift pivot from an in-person walk-in clinic (which we still continue to provide), we expanded our crisis services to telehealth—offering psychiatric triage and referrals to our other virtual and in-person care options through a secure, online platform. The Virtual Crisis Walk-In Clinic is available to any individual living in Maryland who needs urgent psychiatric care. Licensed therapists and clinicians schedule follow up virtual or in-person appointment for therapy and/or medication management or recommend inpatient admission once the assessment has been conducted. Our 10 outpatient locations throughout the state also shifted to provide both tele-therapy and tele psychiatry services during the pandemic. We have seen an increased demand for services and have been able to meet that demand by hiring additional Maryland licensed staff. We have also continued to provide virtual addiction services, partial day programs and intensive outpatient programs.

This virtual expansion equated to thousands of individuals who have been able to access the care they desperately needed—many of whom had previously been hindered by location, lack of transportation, or other common barriers. In fact, this service has eased burdens on emergency departments across the State at a time when all available beds are needed for our acute care patients. To date, our team has provided more than 350,000 telehealth visits and 212,000 telephonic visits since the beginning of the pandemic.

While Sheppard Pratt has used telehealth for over two decades, particularly for rural and underserved areas, the pandemic allowed Sheppard Pratt to scale telehealth to bring care to more vulnerable communities as well as patients in home, work, or other settings. As we are nearing what we hope is the end of the pandemic, the Committee should legislate the continued coverage of mental health and addiction treatment via telehealth for Medicare and Medicaid patients at rates that are comparable to those for in-person treatment. This coverage should also include reimbursement rate for behavioral healthcare delivered via audio-only technology at the same rate for video telehealth. Audio-only telehealth is critical for those without access to the necessary technology as well as patients that cannot travel to appointments or live in professional shortage areas. Additionally, Congress should eliminate the originating site and geographic requirements related to CMS reimbursement. These limitations all work to reduce access to mental health coverage and make it harder for providers to deliver care.

However, while telehealth is a vital part of expanding access to mental health care, it is best provided when part of a larger continuum of care so that patients have ready access to other in-person services when needed. Congress should ensure that while expanding telehealth care access and reimbursement it does not incentivize the creation of a marketplace that would provide sub-standard care.

Improving Access for Children and Young People

Wraparound services are generally considered among the most effective interventions for children with emotional, behavioral and mental health needs and are essential to any children's mental health system. However, for child patients facing difficult needs like those with autism or in urgent care facilities, these wraparound services are not covered so they are often not provided. As an example, the treatment regime for autistic children requires a high level of skill and dedication. These children can have complex behavioral problems and often have other comorbid conditions like anxiety, attention deficit hyperactivity disorder, or depression. While a typical pediatrician normally treats a child with a common ailment in 10 minutes, a developmental-behavioral pediatrician would need 40 minutes or more to follow up with an autistic child. Clinicians working with autistic children also often spend long hours helping families connect with community resources, such as school services, behavioral therapists and speech therapists. These additional services that clinicians provide are not typically reimbursable from insurance. Centers that specialize in autism care have a difficult time creating a billing model that does not lose money because of the reimbursement rates. Subpar reimbursement models for these types of services are a contributing factor into the limited care access available for children with severe mental health needs. As with other aspects of CMS reimbursement for mental health care, Congress should direct CMS to provide reimbursement for the supportive services that are most beneficial to improved outcomes for child patients.

Thank you for the opportunity to provide comments as you work on legislation to address barriers to mental health care. Should you or anyone on your staffs have questions, we would be happy to provide additional information or have a more thorough discussion. I look forward to following the progress of the Committee on this important legislation. Thanks again.

Sincerely,

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