

 NATIONAL  
ASSOCIATION  
OF PSYCHIATRIC  
HEALTH SYSTEMS

ADVOCATING FOR BEHAVIORAL HEALTH

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March 26, 2014

The Honorable Tim Murphy  
U.S. House of Representatives  
Washington, DC 20515

Dear Rep. Murphy,

On behalf of more than 700 hospitals and mental health and addiction treatment organizations who serve people of all ages, we are writing to thank you for holding today's hearing titled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage." We would respectfully request that this letter be submitted as part of today's hearing record.

We also applaud your introduction of the *Families in Mental Health Crisis Act* (H.R.3717), which will address many of the longstanding treatment barriers that people face all too often when they seek mental health and addiction treatment services.

Two key questions your hearing today is addressing are:

- Why are psychiatric patients often boarded in emergency departments? and
- What short-term and long-term options are available to mitigate the harmful impacts of psychiatric boarding?

For far too long, the Medicaid law, which provides the single largest funding source for those living with mental illnesses, has discriminated against people with these disorders. The Medicaid Institution for Mental Diseases (IMD) exclusion prevents adult Medicaid enrollees (ages 21 to 64) from accessing short-term, acute care in psychiatric hospitals. The IMD exclusion is penalizing the disabled and poor. And people are not getting the psychiatric hospital treatment they need, putting families and communities at risk.

Inpatient beds in the U.S. have dropped from more than 550,000 beds in 1955 to 40,000 today. Between 1990 and 2000, inpatient psychiatric beds per capita declined by 44% in state and county mental hospitals, 43% in non-governmental psychiatric hospitals, and 32% in general hospital psychiatric units. This major decline in psychiatric beds has resulted in people with mental and addictive disorders being housed in emergency departments (EDs) for days or weeks, waiting for psychiatric treatment. When EDs are backlogged, everyone suffers as people with other critical illnesses have to wait longer for treatment.

According to the Centers for Medicare and Medicaid Services (CMS), "due to the IMD exclusion, many Medicaid enrollees with acute psychiatric needs, such as expressing suicidal or homicidal thoughts, are diverted to general hospital emergency departments, which often lack the resources or expertise to care for these patients. For the Medicaid beneficiary, this may result first in a delay in treatment, and then when treatment is provided, inadequate care. General hospitals may delay the provision of care until a bed becomes available, or inappropriately assign them to medical beds."

Today, inpatient psychiatric care is delivered in the community in short-term, acute care settings, including freestanding psychiatric hospitals. Inpatient psychiatric care is an integral component of community-based care for people living with mental illnesses, and it makes no sense from a public-policy

or from a patient-centered perspective to limit the inpatient psychiatric hospital settings that people in need of this life-saving service can access. And that is exactly what the IMD exclusion does.

Just as for medical problems, people living with mental illnesses rely on their doctors and hospitals for ongoing care and treatment. When they need life-saving treatment, they want to go to the hospital and doctors that have been treating them over time. Restricting access to psychiatric hospitals through the IMD exclusion means that patients may not be able to go to hospitals that their doctor recommends or where their doctor has inpatient practicing privileges.

There is broad support for eliminating the IMD exclusion. In responses to a Senate Finance Committee open letter to the mental health community requesting input on how to improve the U.S. mental health system, 242 stakeholders responded. A February 2014 summary noted that "many letters argued that the IMD exclusion has the overly broad effect of preventing Medicaid patients from receiving otherwise quality residential or psychiatric hospital care. In fact, it was asserted that the exclusion prevents a category of care (specialty psychiatric residential or hospital care) that could be critical to some patients in need. A common recommendation was to eliminate this exclusion," the summary said.

In the end, this is – pure and simple – a fairness issue. A Medicaid insurance card covers hospital treatment for all other conditions, but adults with mental illnesses cannot use their Medicaid insurance card for inpatient care in a psychiatric hospital. No other disorder limits their choice of hospitals in the way the IMD exclusion does.

Modifying the IMD exclusion is not just the right thing to do; in the end, it will result in more timely access to life-saving inpatient treatment, reduce emergency backlogs, and make the system more cost-effective.

Clearly, modifying the IMD exclusion would expand access to timely inpatient psychiatric care and at the same time reduce unnecessary time spent in the emergency department. Yet, there are many other reasons why people end up in emergency departments, including not being able to access outpatient community services. Early intervention and support services can help people better manage their mental illness, thereby reducing the need to seek emergency psychiatric care. It is paramount that a full continuum of services is available so that people living with mental illnesses can receive the right care at the right time, thereby improving outcomes and saving money.

Thank you, again, for holding this hearing and introducing the *Families in Mental Health Crisis Act*. We look forward to working with you and all members of Congress and the Administration to make the mental health and addiction care delivery system more responsive to the needs of people living with these disorders.

Sincerely,



Mark Covall  
President and CEO