HEALTH CARE TEAM
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SACRAMENTO’S MENTAL HEALTH CRISIS

Requested Action:
- Evaluate the Institutions for Mental Disease (IMD) exclusion demonstration project to determine its role to expand access to behavioral health services to the most vulnerable and consider eliminating the current IMD Medicaid (Medi-Cal) reimbursement exclusion for facilities with 17 or more beds.
- Support the finalization of the proposal to allow Medicaid capitation payments for enrollees subject to the IMD exclusion and eliminate the state option to allow behavioral health services to be carved out of Medicaid managed care benefits in the Medicaid Managed Care proposed rule.
- Monitor implementation of Representative Doris Matsui’s Excellence in Mental Health Act demonstration.
- Support federal funding for demonstration projects that focus on case management programs specifically targeting individuals with behavioral health needs who are homeless or are frequent users of hospital EDs, including case management and navigation programs.

Background
Building on the momentum of the enactment of Representative Matsui’s Excellence in Mental Health Act (2014), investment in mental health services must continue. In California, there are fewer than 6,400 inpatient psychiatric beds for a population of over 38 million. Sacramento County alone has a population of more than 1.4 million with less than 400 inpatient psychiatric beds. Sacramento is uniquely vulnerable because it serves as a hub for psychiatric treatment of patients from the surrounding 19 counties that have no inpatient psychiatric services.

Mental Health Crisis in Sacramento County Update
Between FY 2009 and FY 2012, California endured cuts totaling $764.8 Million or 21% of 2008 budgets. The devastating effects of these cuts hit Sacramento in May of 2009, when Sacramento County’s Mental Health Treatment Center (SCMHTC) reduced its acute inpatient psychiatric beds by 20%. Five months later, inpatient bed capacity was further reduced to 50 beds and the County’s Crisis Stabilization Unit (CSU), the County’s primary point of service for psychiatric emergencies, was closed overnight. The impact of budget cuts and the closure of Sacramento’s CSU have been felt throughout the community and had an immediate impact on patients, law enforcement, emergency medical services, and health systems. Since the close, health systems have experienced

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an average of 1600 visits per month to Emergency Departments (EDs) by individuals seeking behavioral health treatment.

In response, hospitals have engaged with the community and developed pilot programs and innovative approaches to appropriately manage patients. Despite these innovations, the influx of individuals seeking behavioral health care through local EDs has strained systems, resulting in prolonged wait times for patients experiencing medical emergencies, behavioral health crises, and extended ED lengths of stay for individuals requiring inpatient psychiatric hospitalization. Individuals who require acute psychiatric services are often escorted by law enforcement to hospital EDs, where they languish for hours on gurneys, chairs, or in hallways before they are evaluated by a behavioral health clinician and transferred to an appropriate setting of care, if appropriate. The ‘boarding’ of individuals requiring behavioral health treatment affects wait times for all individuals seeking medical attention and continues to impair local health systems’ ability to expedite throughput and serve the broader community.

Today, EDs continue to be the only option for individuals in mental crisis. Since the crisis began, hospitals have seen dramatic increases in the volume of patients seeking behavioral health evaluations. Some facilities in 2015-2016 saw ED volume for behavioral health spike three times the number in 2007. Law enforcement wait times for behavioral health drop-offs to an ED and average lengths of stay for individuals with behavioral health needs have also seen significant increases. Current data shows the average length of stay, from admission to discharge, for all individuals requiring behavioral health evaluations is 19.5 hours in any Sacramento-area ED. Sacramento also experiences a high percentage of individuals placed on 5150 holds (72 hour-involuntary psychiatric holds) at an average rate of nearly 57%, compared to the 14.7% national admission rate average for all ED visits in the U.S. These rates of involuntary psychiatric holds and admission are staggering and highlight a limited ability of an ED to mitigate and manage behavioral health crises.

Since 2009, the four health systems in the Sacramento Region have made significant investments to improve the quality of care provided to behavioral health patient populations in the acute medical setting and ED. These services have cost health systems and the community millions of dollars annually to sustain, often with minimal reimbursement. Despite the millions invested to improve the evaluation and management of behavioral health patients in the ED, outcomes have been stagnant with regard to wait times and access to appropriate, quality care. A growing body of literature demonstrating the effectiveness of psychiatric emergency services and crisis stabilization units across the country and throughout California has driven the four health systems, the Sierra Sacramento Valley Medical Society, and first responders in Sacramento to build a Mental Health Improvement Coalition to work with Sacramento County leaders to make crisis stabilization open to all individuals and law enforcement/EMS drop off the central focus of rebuilding an appropriate and adequate behavioral health system of care.

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The Mental Health Improvement Coalition has produced some significant results. In September 2015, the Sacramento County Board of Supervisors formally adopted their FY 2015-16 Budget, including:

- A $28.4 million augmentation to mental health care “rebalancing” that includes three yet-to-be built 16 bed (total of 48 beds) crisis residential facilities using SB 82 funding for capital costs;
- $13 million for additional staffing to expand the County’s Crisis Stabilization Unit;
- A County Mental Health Navigator on weekdays in several area Emergency Departments; and
- A $2.2 million Mental Health Mobile Community Support Team.

Despite these gains, much more needs to be done to adequately address the current mental health crisis in Sacramento County. The Mental Health Improvement Coalition continues to work with the County to find workable and innovative solutions to relieve the pressure on the community and, more importantly, address the needs of patients.

**Institutions for Mental Disease (IMD) Exclusion Demonstration**

Established in 1965, the Institutions for Mental Disease (IMD) Exclusion originated at a time when state-operated psychiatric facilities were a primary setting for behavioral health care and patients were admitted for long-term stays. The policy prohibits federal Medicaid reimbursement for inpatient care provided to individuals between the ages of 21 and 64 in IMDs, such as private, freestanding, acute psychiatric hospitals with more than 16 beds. The lack of funding and underpayment for behavioral health care services has led to the continual decline in the number of inpatient psychiatric beds, thereby limiting access to care for many who suffer from behavioral health and substance use disorders. This exclusion has been carried forward in and applied to the new Medicaid expansion population under the Affordable Care Act (ACA).

The IMD exclusion frequently forces Medicaid beneficiaries to seek emergency psychiatric care in community hospitals whose emergency departments are often crowded and which may not be the most appropriate sites to handle psychiatric emergencies. Congress established the Medicaid Emergency Psychiatric Demonstration Program in 2010 to test whether allowing federal Medicaid matching payments to freestanding psychiatric hospitals for emergency psychiatric cases would improve the quality of, and access to, care and reduce Medicaid program costs. The demonstration provided up to $75 million over three years to enable IMDs in 11 states and the District of Columbia to receive Medicaid reimbursement for treatment of patients aged 21 to 64 who require treatment for psychiatric emergencies. Sacramento County is one of a few counties in California participating in the demonstration.
We are encouraged by the preliminary data from HHS indicating that allowing such coverage is reducing utilization and lowering costs. The demonstration program was recently extended through legislation until HHS completes its final evaluation of the demo or until September 30, 2016, whichever occurs first, as long as the extension would not increase Medicaid costs. It also allows the Secretary of HHS to extend the demonstration project for additional three years and expand it to other states, subject to the same budget neutrality standard. This is critically important because of Medicaid's central role in covering persons with mental illness. Findings from the demonstration project will show eliminating the prohibition against federal payments to institutions for mental diseases will improve psychiatric care and reduce state Medicaid program costs. We urge Congress and CMS to continue to examine, through the Medicaid Emergency Psychiatric Demonstration project, whether eliminating or restricting the scope of the IMD exclusion can improve access to care and help reduce costs.

**Medicaid Managed Care**

Enrollment in California’s Medicaid (Medi-Cal) managed care delivery system has increased from 55% to 80% over the last five years by transitioning numerous populations into Medi-Cal managed care. In June 2015, CMS proposed a rule to modernize Medicaid managed care regulations intended to update regulations to better align them with existing commercial and Medicare Advantage rules.

In the rule, CMS proposes to allow states to pay a capitation payment to managed care plans for enrollees aged 21 to 64 who are subject to the IMD exclusion, but it urges the agency to consider expanding the 15-day limit on an enrollee’s stay. Specifically, CMS’s proposed change would allow states to pay managed care plans for the care provided to adult enrollees who have a short-term stay of no more than 15 days in an IMD, as long as the facility is an inpatient psychiatric hospital or a sub-acute facility providing short-term crisis residential services. According to CMS, 7.1% of those aged 18–64 currently meet the criteria for a serious mental illness. Further, an estimated 13.6% of uninsured adults within the Medicaid expansion population have a substance use disorder. These data underscore the need to improve access to short-term inpatient psychiatric and substance abuse disorder treatment. In addition, to further improve access to care for this vulnerable population, CMS proposes to eliminate the state option to allow behavioral health services to be carved out of Medicaid managed care benefits. Such carve-out arrangements create barriers to the integration of behavioral and physical health care and inhibit the sharing of information across care settings.

**Case Management**

It has become increasingly clear that mental health and physical health are intertwined. Many people with psychiatric conditions suffer from chronic health challenges. Treatment of both in a coordinated fashion is necessary for success. Less restrictive and less expensive mental health care options include case management programs and navigation programs to link patients with
behavioral health needs to appropriate levels of care. Many of these programs are funded through hospital community benefit programs and have not been integrated in reimbursement models or care models outside of ED’s. When combined with rigorous discharge planning that connects patients discharged from acute psychiatric facilities to outpatient services in the community, case management serves as an important purpose in reducing the number of psychiatric crises that lead to recidivism. We ask Congress to study discharge planning best practices and to fund best practices once established.