



JULY 2010

**Recommendations to  
Foster System Reform  
for Adults with  
Serious Mental Illness**



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# EXECUTIVE SUMMARY

Serious mental illness in adults is a chronic condition that often requires long-term rehabilitative and support services for good clinical outcomes. This report summarizes discussions held at the November 12 and 13, 2009 National Action Meeting on Fostering System Reform for Adults with Serious Mental Illness sponsored by JANSSEN®, Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc. and puts forth recommendations supported by a majority of the participants. It is not, however, intended to represent the positions or policies of any of the participating organizations.

Recommendation	What is the issue?	What are we asking for?	What are the outcomes?
<b>#1</b> - The U.S. Department of Health and Human Services (DHHS) must design and implement a robust set of performance measures, including consumer measures, with risk-adjusted financial incentives.	Although a growing number of empirically-supported mental health treatments have emerged in recent years, the currently available body of data is insufficient for practitioners and payers to make fully informed decisions regarding which mental health interventions should be used in providing treatment for specific conditions.	DHHS should assist stakeholders, including researchers, practitioners, payers, and service recipients, to develop a set of standard service definitions that are consistent across states and incorporated into licensing and professional practice standards.	Standard outcome and performance measures would allow managers and policymakers to make better resource allocation decisions and offer appropriate incentives to improve outcomes.
<b>#2</b> - The U.S. Congress and relevant DHHS agencies should designate people with serious mental illness as a health disparities group in order to close the 25-year gap in life expectancy.	Mental illness has consistently been found to be the disability resulting in the greatest societal costs.	Congress and federal agencies should designate persons with serious mental illness as a health disparities population.	This designation would facilitate tracking and measuring of health disparities experienced by persons with serious mental illnesses, providing the opportunity to focus resources on addressing them.
<b>#3</b> - Congress and DHHS entities should support health information technology (HIT) for community behavioral healthcare systems and organizations as well as for mental health and substance use services. All federal HIT initiatives (including Health Information Technology for Economic and Clinical Health (HITECH)) should be required to have substantial involvement from behavioral health stakeholders, and any technology systems developed in the future must be capable of supporting behavioral health content and operational needs.	Healthcare providers, including those in primary care and behavioral healthcare, frequently have trouble accessing treatment information they need to coordinate care and meet their patients' overall healthcare needs.	Federal HIT initiatives, including those implemented under the HITECH Act, must have substantial involvement from behavioral health stakeholders to ensure that systems are capable of supporting behavioral health content and operational needs.	Ensuring full inclusion of all behavioral healthcare providers along with general healthcare providers in HIT implementation will improve efficiency and outcomes across the healthcare spectrum, including persons with serious mental illnesses as well as those with any health condition displaying behavioral health symptoms.
<b>#4</b> - Congress and other DHS entities should remove obstacles to the integration of mental health and general medical care by: 1) Ensuring that all Person Centered Medical Homes (PCMH)/Healthcare Home (PCHH) include ready access to behavioral health services as a core element; 2) Allowing Behavioral Health Centers (BHCs) to be designated as a PCMH/PCHH; and 3) Allowing BHCs to qualify as a Federally Qualified BHC (FQBHC).	Adults with serious mental illnesses have not received adequate healthcare. Health reform has brought increased attention to person-centered care, which in turn creates an opportunity to address these needs as new approaches are developed.	Person Centered Medical Homes (PCMH), or Healthcare Homes (PCHH), created or supported under federal programs must include mental health and substance abuse treatment expertise and capabilities.	The coordination and integration of primary care and behavioral healthcare made possible by these actions would result in less fragmentation and duplication of services and improved outcomes for the individuals served by the PCMHs/PCHHs and FQBHCs.
<b>#5</b> - DHHS, in particular the Centers for Medicare and Medicaid Services (CMS), should develop a national definition of "medical necessity" to include the full range of services needed by persons with serious mental illness.	It is clear that serious mental illness is a chronic condition that often requires long-term rehabilitative and support services for good clinical outcomes. This understanding should be incorporated in the definition of "medical necessity" to ensure that the full range of needed services is available to individuals with serious mental illness.	The Centers for Medicare and Medicaid Services (CMS), the principal payer for public mental health services, must provide guidance in the form of a definition of "medical necessity".	The definition for "medical necessity" set by CMS will provide a standard for other payers to follow in paying for a scope of services that meets the needs of individuals with mental illness, providers or services, and payers themselves.

## **Background of Proceedings of the National Meeting on Fostering System Reform for Adults with Serious Mental Illness**

Informed by commissioned policy papers and by presentations from consumers, providers, policy experts, and government officials, the participants followed a prescribed process intended to yield a series of policy priorities that the field might adopt to secure advances for mental health service delivery in a reshaped national healthcare environment. It was agreed that the focus should be on the population traditionally served by the nation's public mental health systems, and it was further understood that the recommendations resulting from this effort should form a practical agenda, one that had a reasonable chance of adoption by Congress and the Obama administration.

On November 12 and 13, 2009, representatives of national mental health organizations and individual experts in mental health services, financing, and policy gathered in Washington, D.C. to develop an agenda for reforms in the provision of services for adults with serious mental illnesses. The meeting was sponsored by Janssen®, although Janssen® had no input into the development of meeting content or this report, other than ensuring transparent disclosure of its sponsorship and participation at the meeting.

All participants were offered reimbursement for travel and expenses within standard company limits. If reimbursement was accepted, written agreement of compliance with applicable employment or professional organization rules was required of the participant, along with documentation of expenses. Twelve faculty members and three speakers received payment from Janssen® to develop meeting content, present at the meeting, lead a discussion along with a paid facilitator or speak, as applicable, and agreed to similar disclosure and conflict of interest resolution requirements. All participants who were government employees were required to sign an agreement confirming that there were no conflicts of interest preventing their attendance and/or their participation as a faculty member or speaker, as applicable, and no honoraria was paid to any government employee. One Janssen® employee was allowed to participate in the meeting as an audience participant, and four Janssen® employees were allowed to only observe the entire meeting.

This report was authored by the meeting participants listed as authors in the Appendix, with editorial support from SRA Touchstone Consulting Group, Inc., which also coordinated meeting logistics and facilitated the meeting itself.

The timing, composition, and focus of the meeting reflected a broad understanding within the mental health community. Due to the impending reform of health care, the participants recognized a rare opportunity had emerged to address the need to reshape the nation's approach to mental health service delivery. Participants in the meeting shared a belief that thoughtful changes in policy, funding, and program design could result in greatly improved outcomes for individuals with mental illnesses as well as reduced disease burden, increased cost savings, and greater efficiency in healthcare as well as other areas of daily living. At the same time, attendees recognized that the opportunity to reform mental health service delivery could be lost without development of a targeted action agenda incorporating the community's disparate voices.

Invitations to participants were based on their contributions to mental health policy development over time. As such, the meeting's process focused on providing ample opportunity for each participant to be heard both in small groups and the plenary sessions instead of on providing background context about the issues. As the meeting turned to priority-setting, each participant was asked to make his or her recommendations. The list of possible policy statements was pared through a series of votes, while the meeting facilitators regularly sought consensus on the direction the group was taking. Thus, the policy priorities outlined here can be said to reliably reflect the group's thinking at the November meeting, acknowledging that below the top lines of consensus lay various viewpoints.

For each policy recommendation, selected pairs of participants have worked to write the details around the recommendations summarized here. To further ensure broad consensus, all the authors have convened periodically during the drafting process, and, through questions and suggestions to each other, have shaped these working documents. The next test for each recommendation will be the responses this report receives in the broader policy arena.

## Summary of Recommendations

The recommendations cover a broad range of topics and vary in their specificity, but they are connected to one another in at least two important ways. First, they reflect a strong belief that knowledge and information must be developed, disseminated, and sustained if our nation is to experience improved outcomes in mental health service delivery. Second, these recommendations inform the federal government what standards must be established to ensure that services delivered anywhere in this nation are of high quality.

Each recommendation addresses three areas:

- » Section 1: Challenges at hand / Opportunities for improvement;
- » Section 2: Actions that will address the challenges; and
- » Section 3: Anticipated outcomes / benefits.

## Recommendation #1

**The U.S. Department of Health and Human Services (DHHS) must design and implement a robust set of performance measures, including consumer-measures, with risk-adjusted financial incentives to facilitate a system that financially supports the best patient outcomes.**

**Challenge/opportunity:** Although a growing number of empirically-supported mental health treatments have emerged in recent years, the currently available body of data is insufficient for practitioners and payers to make fully informed, evidence-based decisions regarding which mental health interventions should be used to treat specific conditions. There is currently no ability to correlate treatment outcomes with such indicators such as economic status, housing situation, contact with the criminal justice system, or general health condition. The absence of this information also makes it impossible for payers to design a rational payment system that takes both quantity and quality of services into account. With health reform creating a demand for improved payment systems, an opportunity to introduce these elements has arrived.

**Actions:** DHHS should assist stakeholders, including researchers, practitioners, payers, and service recipients, in developing a set of standard service definitions<sup>1</sup> that is consistent across states and incorporated into licensing and professional practice standards. A set of key outcome variables must also be developed for use in claims payment. Current barriers related to confidentiality of medical information and proprietary measures from payers and insurers must be overcome so that researchers can use the resulting information to improve the understanding of empirically-supported treatments, as well as patterns of systems resource use. Based on these steps, structures must be developed to ensure pay for performance and to reward outcomes.

**Outcomes/benefits:** These actions would change mental health treatment from a series of trial-and-error tests to a data-driven decision process. Standard outcome and performance measures would allow managers and policymakers to make better resource allocation decisions and offer appropriate incentives to improve outcomes. Individual suffering would be reduced; treatment cycles would be shortened; and the field would be focused on providing more cost effective services with the highest likelihood of reducing symptoms and improving functioning.

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<sup>1</sup>Service definitions for health services, including behavioral health services, are sometimes also known as service codes, CPT codes (Current Procedural Terminology, developed by the American Medical Association), HCPCS codes (Healthcare Common Procedure Coding System, used by CMS for Medicare), or DSM-IV-TR codes for psychiatric illnesses (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision, published by the American Psychiatric Association). These definitions are used by providers to categorize the services being rendered to a patient and by payers and insurance plans to determine the medical necessity and the rate of reimbursement for the service. Service definitions are not standard across providers, payers or insurers. For example, each State Medicaid program has its own services definition, and these may differ from service definition used by insurers licensed in that State. Encompassed in the services definitions could be characteristics such as: type of service, what patient symptoms establish medical necessity for the service, length of service, discharge criteria, expected service delivery setting, required staff ratio, required staff credentials and experience levels, documentation requirements, expected outcomes, etc.

## **Recommendation #2**

**The U.S. Congress and relevant DHHS agencies should designate people with serious mental illness as a health disparities group in order to close the 25-year gap in life expectancy.**

**Challenge/opportunity:** Mental illness has consistently been found to be the disability with the greatest societal costs. Those with serious mental illness face unnecessary and unjust differences in health status, risk behaviors, health care, and mortality.

**Actions:** Congress and federal agencies should designate persons with serious mental illness as a “health disparities population.”

**Outcomes/benefits:** This designation would facilitate tracking and measuring of health disparities experienced by persons with serious mental illnesses, thereby providing the opportunity to focus resources on addressing these disparities.

## **Recommendation #3**

**Congress and DHHS entities should support health information technology (HIT) for community behavioral healthcare systems and organizations as well as for mental health and substance use services. All federal HIT initiatives including Health Information Technology for Economic and Clinical Health (HITECH) should be required to have substantial involvement from behavioral health stakeholders. Any technology systems developed in the future must be capable of supporting behavioral health content and operational needs.**

**Challenge/opportunity:** Current policy excludes community behavioral healthcare organizations and non-psychiatrist behavioral health clinicians from eligibility for federal funding assistance for health information technology under the HITECH Act. Healthcare providers, including those in primary care and behavioral healthcare, frequently have trouble accessing the treatment information they need to coordinate care and meet their patients’ overall healthcare needs. As awareness of the benefits of care coordination has grown, so has demand for addressing this exclusion in the HITECH Act.

**Actions:** Federal HIT initiatives, including those implemented under the HITECH Act, must have substantial involvement from behavioral health stakeholders to ensure that systems are capable of supporting behavioral health content and operational needs.

**Outcomes/benefits:** Ensuring full inclusion of all behavioral healthcare providers along with general healthcare providers in HIT implementation will improve efficiency and outcomes across the healthcare spectrum, including persons with serious mental illnesses and those with any health condition displaying behavioral health symptoms.

## **Recommendation #4**

**Remove obstacles to the integration of mental health and general medical care by: 1) Ensuring that all Person Centered Medical Homes (PCMH)/Healthcare Homes (PCHH) include ready access to behavioral health services as a core element; 2) Allowing Behavioral Health Centers (BHCs) to be designated as a PCMH/PCHH; and 3) Allowing BHCs to qualify as a Federally Qualified BHC (FQBHC).**

**Challenge/opportunity:** Demand for behavioral health services has increased rapidly in the past decade, but the capacity of both the public mental health system and the general healthcare system to provide behavioral health expertise and mental health and substance abuse treatment has failed to keep pace. As a result, adults with serious mental illness have not received adequate health care. Health reform has brought increased attention to person-centered care, which in turn creates an opportunity to address the increasing demand for behavioral health services as new approaches to person-centered care and integrated health services are developed.

**Actions:** Person Centered Medical Homes (PCMH)/Healthcare Homes (PCHH) created or supported under federal programs must include mental health and substance abuse treatment expertise and capabilities. Additionally, the federal government should support the creation of Federally Qualified Behavioral Health Centers (FQBHC), to complement the safety net care already provided by Federally Qualified Health Centers (FQHC).

**Outcomes/benefits:** These actions would increase access to and capacity for behavioral health treatment services and would make possible coordination/integration of primary care and behavioral health care, resulting in less fragmentation, duplication of services, and improved outcomes for the individuals served by the PCMHs/PCHHs and FQBHCs. Also, overall healthcare costs would likely decline, as studies consistently show this impact when behavioral health treatment is provided in conjunction with treatment for many physical conditions.

## **Recommendation #5**

**DHHS, in particular the Centers for Medicare and Medicaid Services (CMS), should develop a national definition of “medical necessity” to include the full range of services needed by persons with serious mental illness.**

**Challenge/opportunity:** What services are medically necessary should be based on the patient’s condition and the best scientific understanding of that condition, and should not vary by payer. It is clear that serious mental illness is a chronic condition that often requires long-term rehabilitative and support services for good clinical outcomes. This understanding should be incorporated in the definition of “medical necessity” to ensure that the full range of needed services is available to individuals with serious mental illness. Inconsistent definitions of “medical necessity” for services typically provided to persons with serious mental illnesses result in variations in payment across plans or programs, inequitable patterns of care, and unpredictable outcomes for individuals in different service settings.

**Actions:** CMS, the principal payer for public mental health services, must provide guidance in the form of a definition of “medical necessity” that incorporates an accepted scientific understanding of serious mental illness that can be applied across jurisdictions and treatment settings.

**Outcomes/benefits:** Improved access to the range of needed services for individuals with serious mental illness resulting in improved outcomes. The definition for “medical necessity” set by CMS will provide a standard for other payers to follow in paying for a scope of services that meets the needs of individuals with mental illness, providers, and services, but also the needs of the payers themselves.



## Recommendation #1:

**The U.S. Department of Health and Human Services (DHHS) must design and implement a robust set of performance measures, including consumer outcomes, with risk-adjusted financial incentives.**

### Section 1: Challenges at hand / Opportunities for improvement

Evidence-based approaches and therapeutic approaches need to be constructed to inform and coordinate the activities of the diverse system serving persons with serious mental illness. These approaches must also be a part of redesigning the payment system so that providers are reimbursed not only for the quantity of the services they provide, but for the quality of the outcomes.

Currently mental health treatment is often a trial-and-error test of which therapeutic approach is most appropriate for any specific individual. Therefore, insufficient information exists regarding which varying client populations respond best to competing treatment approaches. A single database that addresses the kind of clinical, demographic, and outcome data needed to identify performance measures and make conclusions would provide the foundation for evidence-based practice in the treatment of mental illness.

### Section 2: Actions that will address the challenges

It is important that the DHHS develop a consolidated single database that encompasses ALL mental health patient information, including poverty-level, employment, housing, contact with the criminal justice system, and general health condition.

The development of a database and a set of benchmarks will require organized and coordinated action. With leadership and funding from the DHHS, actions should include:

- » The Centers for Medicare and Medicaid Services (CMS) programs (1) should fund and convene public discussion and research to develop standard service definitions and (2) should require the use of these standard service definitions by recipients of CMS funding. This includes developing and implementing standard service definitions that clearly capture what practitioners around the country do, how they are trained and licensed, and what criteria providers should employ to determine admission and discharge criteria for their services.
- » CMS, with public input, should develop and implement a set of key outcome variables that all providers would be required to report as part of their claim for payment.
- » CMS should develop and implement pay-for-performance structures that reward outcomes and incentivize the adoption of evidence-based practices. These structures must contain disincentives for avoiding the most difficult populations and incentives for adequately funding a sustainable, effective, and innovative delivery system. Action from CMS will be required to model these payment principles as the basis for Medicaid and Medicare.

### Section 3: Anticipated outcomes / benefits

The design and implementation of robust performance measures and pay-for-performance techniques will simultaneously improve outcomes, reduce healthcare costs, and empower providers with information to better serve their clients. By receiving treatments tailored to individual needs, clients may recover more quickly from other medical ailments; homeless shelters will need to serve fewer individuals; and jails and courts will be less burdened with inappropriately placed adults who really only need mental health treatment. Therefore, investments in building a performance outcome infrastructure will more than pay for themselves in offsetting healthcare, criminal justice, and housing costs.

## Recommendation #2

**Congress and relevant DHHS agencies should designate people with serious mental illness as a health disparities group in order to close the 25-year gap in life expectancy.**

### Section 1: Challenges at hand / Opportunities for improvement

A growing body of data suggests that persons with serious mental illness receive poorer quality of care, have more medical problems, and die younger than the general population. The DHHS is charged with collecting data on health disparities for racial and ethnic subpopulations as well as individuals with disabilities. However, persons with serious mental illness are not currently designated as a health disparities population by the federal government. Such a designation would reduce the morbidity and mortality for adults with serious mental illness.

### Section 2: Actions that will address the challenges

Congress and relevant federal agencies should designate and treat persons with serious mental illness as a health disparities population and charge the Secretary of DHHS with collecting and tracking data separately for this population.

**FACT:** People with mental illness in the public mental health system die on average 25 years earlier than the general population.<sup>2</sup>

Federal agencies such as the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics, a division of Center for Disease Control and Prevention (CDC), are responsible for collecting disparities data for 476 indicators as part of the Healthy People 2010 report. To do so, they aggregate data from more than 60 surveys and other sources. Most of these data are collected through agencies that are under the DHHS.

The Secretary of DHHS should charge the Center for Mental Health Services (CMHS) with reviewing these sources of information with the goal of developing an operational definition of serious mental illness that can be used across all federal agencies involving health care policy, health care operations, and/or public health. Examples of criteria for defining the population should include measures of mental health symptomatology or a history of having received services from a public sector mental health provider.

Once this definition is established, disparities should be tracked separately for key indices and presented as part of public health reports, including Healthy People 2010 and the National Center for Health Statistics.

### Section 3: Anticipated outcomes / benefits

Measuring care for persons with serious mental illness is the first crucial step towards reducing the morbidity and mortality seen in this population. Key indicators to measure for this population include mortality, obesity, cigarette smoking, physical inactivity, sexual health, substance abuse, and other risk factors. Measures of access to and quality of care should be collected separately for persons with and without serious mental illnesses. Progress on these measures should be tracked over time at a national and regional level.

<sup>2</sup> Statistics, National Institute of Mental Health, <http://www.nimh.nih.gov/health/statistics/index.shtml>

## Recommendation #3

**Congress and DHHS entities should support health information technology (HIT) for community behavioral healthcare systems and organizations as well as for mental health and substance use services. All federal HIT initiatives including Health Information Technology for Economic and Clinical Health (HITECH) should be required to have substantial involvement from behavioral health stakeholders. Any technology systems developed in the future must be capable of supporting behavioral health content and operational needs.**

### Section 1: Challenges at hand / Opportunities for improvement

Primary care and other health care providers routinely complain that they do not have the access to the behavioral health treatment information they need to coordinate care and meet their patients' overall needs. Instead, providers are frequently forced to undertake treatment of their patients' mental health and substance abuse disorders without access to the expert diagnosis and treatment recommendations previously delivered by the behavioral healthcare providers. For this reason, it is clear the meaningful use of HIT and EHRs must be extended to all providers of mental health services.

As such, there is a serious disconnect between these issues and the HITECH Act as they relate to the care of Americans with serious mental illnesses. Although the HITECH Act authorizes \$20 billion in outlays for assistance in HIT implementation, very little funding is available to clinicians and organizations that serve individuals with serious mental illnesses.

Current policy is that only psychiatrists may access these incentive payments – this leaves more than 90% of the clinical workforce of the behavioral health safety net and Community Behavioral Healthcare Organizations ineligible for HIT implementation support.

This exclusion is inconsistent with the strong support demonstrated by Congress and the Obama Administration to expand and improve behavioral health care in the United States through the passage of the Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010. Including the full range of behavioral health providers in HIT reform is essential to achieving the goals of this legislation.

### Section 2: Actions that will address the challenges

Meaningful use of HIT and Electronic Health Records (EHRs) must include providers of mental health services in order to achieve improvements in quality, safety and efficiency:

1. Congress should add Community Behavioral Healthcare Organizations and MH/SU services as eligible groups for HIT implementation assistance under the HITECH Act and support inclusion of these groups in subsequent initiatives and legislation related to HIT.
2. The DHHS Office of the National Coordinator for Health IT should require that all federal HIT initiatives (including the HITECH Act) have substantial involvement from behavioral health stakeholders and that systems developed are capable of supporting behavioral health information content and behavioral health care providers' operational needs. mental health services.

### Section 3: Anticipated outcomes / benefits

Ensuring full inclusion of all behavioral healthcare providers in HIT implementation will significantly enhance efforts to address the healthcare and behavioral healthcare needs of all Americans, especially those with serious mental illnesses. The majority of persons with complicated serious medical illness also have mental illness and/or substance abuse disorders. Coordinating care by assuring full participation and interoperability between general healthcare and behavioral healthcare providers will improve outcomes and efficiency.

**FACT:** Nationally, 49% of Medicaid beneficiaries with disabilities have a psychiatric illness, and co-occurring psychiatric illness is represented in three of the top five most prevalent pairs of disease among highest cost beneficiaries.<sup>3</sup>

<sup>3</sup>Kronick, Rick, Melanie Bella, and Todd P. Gilmer. The Faces of Medicaid III: Redefining the Portrait of People with Multiple Chronic Conditions. Center for Health Care Strategies, Inc. October 2009. Page 2.

## Recommendation #4

**Congress and other DHHS entities should remove obstacles to the integration of mental health and general medical care by:**

- 1. Ensuring that all Person Centered Medical Homes (PCMH) / Healthcare Homes (PCHH)<sup>4</sup> include ready access to behavioral health services as a core element;**
- 2. Allowing Behavioral Health Centers (BHCs)<sup>5</sup> to be designated as a PCMH/PCHH; and**
- 3. Allowing BHCs to qualify as a federally Qualified BHC (FQBHC).**

### Section 1: Challenges at hand / Opportunities for improvement

Mental illness is the leading cause of disability in the United States for people between the ages of 15 and 44.<sup>6</sup> People with serious mental illness die sooner than other Americans. Three out of every five people with serious mental illness die from preventable, co-occurring serious diseases such as asthma, diabetes, cancer, heart disease, and cardiopulmonary conditions.<sup>7</sup>

Despite these grim data, persons affected by serious mental illness can be encouraged knowing that:

- » Treatment for mental health and substance use disorders is effective, and
- » Increased mortality and morbidity are largely due to modifiable risk factors.

However, bleak outcomes remain a reality for persons with serious mental illness. This is largely a result of those people having less access to treatment and poorer quality of care than those without mental illness because of:

- » Stigma and discrimination;
- » Under-funding of publicly supported physical and behavioral health care systems;
- » Lack of capacity in behavioral health care delivery settings; and
- » Fragmentation of service delivery.

#### FACTS:

- » In 2007, almost one in four stays in U.S. community hospitals involved depression, bipolar disorder, schizophrenia, and other mental health and substance use disorders.<sup>8</sup>
- » The national health expenditure on treatment of mental illness in 2005 was \$142 billion<sup>9</sup>— second only to those for circulatory diseases.<sup>10</sup>

<sup>4</sup> A care delivery organization that integrates patients as active participants in their own health and well-being. Patients are cared for by a physician-led medical team that coordinates all aspects of their patients' preventive, acute and chronic needs, using the best available evidence and appropriate technology.

<sup>5</sup> Specialized (for-profit) managed care organizations focusing on mental health and substance abuse benefits. These organizations offer employers and public agencies a managed mental health and substance abuse benefit.

<sup>6</sup> Statistics, National Institute of Mental Health, <http://www.nimh.nih.gov/health/statistics/index.shtml>

<sup>7</sup> Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006, [www.nasmhpd.org](http://www.nasmhpd.org)

<sup>8</sup> Care of Adults with mental health and substance use disorders in U.S. community hospitals, (HCUP Fact Book No.10; AHRQ Publication No. 07-0008) Agency for HealthCare Research and Quality, 2007.

<sup>9</sup> Charles Roehrig, George Miller, and Craig Lake, "National Health Spending By Medical Condition, 1996-2005," Health Affairs, vol. 28, no. 1 (February 2009).

<sup>10</sup> Nearly half of circulatory system expenditures are attributable to heart conditions, which consist primarily of coronary heart disease, congestive heart failure (CHF), and dysrhythmias. Hypertension, cerebrovascular disease, and hyperlipidemia account for most of the remainder.

## Section 2: Actions that will address the challenges

Removing obstacles to access to treatment and poor quality of care will require the following steps toward integration:

1. **Person-Centered Medical Homes (PCMH) / Healthcare Homes (PCHH)** - Congress should enhance legislation supporting PCMHs and/or PCHHs to include behavioral health capacity and stepped care.<sup>11</sup> This would affirming that behavioral health is a central part of healthcare that combines a focus on supporting a person's capacity to set goals for improved self management, using community resources, and personal support systems. A PCMH/PCHH home would accept 24/7 accountability for a population and would provide the following services: preventive screening and health services; acute primary care; women and children's health services; behavioral health services; management of serious health conditions; and end of life care. The PCMH/PCHH home would be implemented bi-directionally: providers would identify people in primary care settings with behavioral health conditions and serve them there unless they required stepped specialty behavioral healthcare; and also providers would identify and serve people in behavioral healthcare settings that need routine primary care and "step" them to a healthcare home that is based in a medical primary care organization for more complex care.
2. **Medicaid PCMH/PCHH Demonstration Projects** - Congress should establish legislation to authorize a ten-state Medicaid demonstration program which would co-locate primary care capacity with community-based mental health and substance abuse providers. The goals of this integrated treatment approach is to improve the health outcomes of people with serious mental illness using a care management plan that includes:
  - » Regular screening, registry tracking, and measurement of explicit general health care goals;
  - » A designated point of contact responsible for communicating with the beneficiary and for facilitating communications with health care and community providers;
  - » Self-care education of participants in recognizing and managing their symptoms;
  - » Education for family members, physicians, and other providers, as appropriate; and
  - » Active coordination of community services including peer-to-peer counseling, transportation, personal assistance, housing, and other required services.
3. **Federally Qualified Behavioral Health Centers (FQBHC)** - Congress should establish a definition for FQBHCs that would: (1) establish federal status for Community-based Health Organizations (CBHOs) who volunteer to meet the standards of an FQBHC; (2) clearly identify treatment objectives and updates the minimum core services required; and (3) clearly define national standards for an FQBHC. In return for this new federal status, providers working within FQBHCs will be asked to meet new provider accountability standards.
4. **Co-location Grants for Primary and Behavioral Health Care Integration (PBHCI)** - Congress should authorize and increase appropriations for expanding the Substance Abuse Mental Health Services Administration (SAMHSA) PBHCI Co-location Grants program. The purpose of this program is to improve the physical health status of people with serious mental illnesses by supporting communities' efforts to coordinate and integrate primary care services into publicly-funded community mental health and other community-based behavioral health settings. The expected outcome is that grantees will build the necessary partnerships and infrastructure to develop or expand their offering of primary healthcare services for people with serious mental illness, resulting in improved health status. To date, grants have been awarded to 13 behavioral health care organizations.

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<sup>11</sup> Care adjusted in stages according to failure of lack of effect of lower intensity interventions.

### **Section 3: Anticipated outcomes / benefits**

Addressing serious disease is a priority for the nation, and serious diseases such as mental illnesses and co-morbid physical/mental health illnesses account for such a large percentage of overall health spending. The organizational challenges abound, including: creating additional service capacity to ensure timely access to treatment; using levels of care and benefit package designs in clinical processes; reviewing internal utilization management processes to ensure preauthorization, appropriate referrals, and cycle management procedures to enhance timely collections; and responding to the demand for measureable results that manages the total healthcare expenditures of consumers. Person-Centered Medical/Healthcare Homes, Medicaid Medical/Healthcare Home Demonstrations, FQBHCs, and Co-location Grants offer practical solutions to addressing these complex problems by—bringing real-world experience to the table; addressing the needs and wishes of consumers and families; shifting the focus from treating an acute illness to managing the health of defined populations; and offering opportunity for uniform data collection and outcome analysis, especially to those living with serious health conditions.

## **Recommendation #5**

**DHHS, in particular the Centers for Medicare and Medicaid Services (CMS), should develop a national definition of “medical necessity” to include the full range of services needed by persons with serious mental illness.**

### **Section 1: Challenges at hand / Opportunities for improvement**

Definitions of “medical necessity” for persons with serious mental illness are nonspecific and variable across payers, providers, and service settings. Depending on the payer and provider, the same service for a single patient can be deemed “medically necessary” in one plan and “not medically necessary” in another. This provides a challenge to those planning care for these persons, and to payers who frequently must decide what services are related to treatment for mental health issues.

This lack of specificity has resulted in a service system that is idiosyncratic and unreliable for persons with mental illness whose care typically requires a variety of social services, such as housing and employment services, to attain their goal of community integration and recovery. SAMHSA suggests five dimensions to defining “medical necessity”: contractual scope, standards of practice, safety and intrusiveness, determinations of medical versus social services, and cost. Currently, the term “medical necessity” does not sufficiently define whether services meet a professional standard of practice and whether a patient has a particular clinical need. Instead, payers, rather than clinicians or other persons involved in direct care, often control the patient’s access to care. Alternative levels of care payments, such as step down services<sup>12</sup>, are usually considered “medically necessary” only under unusual circumstances, such as when a person is ready for discharge from an inpatient bed but no suitable community alternatives are available. A national standard definition of “medical necessity” that addresses the full range of proven treatments and services can also make available step down services that are less costly than inpatient care.

### **Section 2: Actions that will address the challenges**

Medicaid is the largest payer of public mental health services in the United States, so any change in its definition of “medical necessity” will have a significant impact on behavioral health service delivery and supports. Given that Medicaid is administered at the state level, funding and programmatic implementation is highly idiosyncratic and dependent on political and ideological trends. Congress should amend the Wellstone-Domenici Parity Act of 2008 to include a federal definition of “medical necessity”; and include funding for its implementation.

The definition of “medical necessity,” developed by CMS, should be applicable to all programs serving adults with serious mental illness over which it has regulatory authority. These include, but are not limited to, state Medicaid, Medicare, and their managed care sub-contractors. The definition to be developed by CMS should be based on existing models such as the one adopted by the Michigan Medicaid program, which is aligned.

With the ten components of recovery<sup>13</sup> published by SAMHSA as an outcome of the New Freedom Commission on Mental Health. DHHS should staff and fund technical assistance for and should monitor the implementation of the definition of “medical necessity” across both federal and private health care financing.

#### **The addition to the Michigan Medicaid’s definition of “medical necessity” states:**

“Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment [which are]...Designed to assist the consumer to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.”

<sup>12</sup> Services which represent a reduction from a more restrictive setting or to prevent placement in a more restrictive setting.

<sup>13</sup> The ten components are: Self-direction, Individualized and Person-Centered, Empowerment, Holistic, Non-Linear, Strengths-based, Peer Support, Respect, Responsibility, and Hope. The National Consensus Statement on Mental Health Recovery is available on the following SAMHSA website: <http://mentalhealth.samhsa.gov/publications/allpubl/sma05-4129/>.

### **Section 3: Anticipated outcomes / benefits**

A single national definition of “medical necessity” will produce a wider range of treatment options that allows for more individually tailored care, and results in better coordination of care relative to the needs of adults with serious mental illness. A national definition of “medical necessity” will result in improved outcomes and in benefits that accrue at multiple levels, including:

- 1) The person with a severe mental health issue - Adults with mental illness will benefit greatly by such a broader definition of “medical necessity” because it will enable them to exercise greater choice and self-determination.
- 2) The provider and practice setting - Providers will no longer have to keep track of multiple conflicting and confusing “medical necessity” definitions across the many federally funded healthcare benefits and will have greater latitude in making recommendations for needed healthcare services. While costs for direct care may be higher within the immediate context of mental health treatment, it is very likely that any such increase in direct costs would be offset by cost savings in administrative costs to both providers and payers.
- 3) The community and larger society - More importantly, from a societal perspective, there will be substantial cost savings related to reductions in the marginalization of persons with mental illnesses and other related conditions of mental illness including poverty, homelessness, unemployment and underemployment, crime, substance use, and other co-occurring health conditions . Aside from any cost savings, the principal anticipated benefit is the improved quality of life for persons with mental health issues through increased self-determination, community integration, and recovery.

## **C**ONCLUSION

These recommendations call for federal leadership in the development and support of policy that will improve services for adults with serious mental illnesses. With enactment of national health reform legislation, the nation is at a watershed moment in which much of its health care system will be realigned. Serious mental illness is the medical condition with the largest societal burden. Health care reform cannot succeed in its goals of improving access to care, containing cost, and improving the quality of health care in America unless it addresses the specific healthcare policy issues specific to the serious mental illness challenges presented in this report. It is imperative, therefore, that federal leaders act on these recommendations promptly in the health reform implementation process.



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The recommendations listed in this document were developed out of the November 12 – 13, 2009 meeting by the following participants.

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