MEDICARE MENTAL HEALTH IMPROVEMENT ACT OF 1995

HON. FORTNEY PETE STARK
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES

Thursday, April 6, 1995

Mr. STARK. Mr. Speaker, today I am introducing the Medicare Mental Health Improvement Act of 1995. This bill will improve the mental health services available to Medicare beneficiaries. It represents an urgently needed change in benefits to reflect contemporary methods of providing mental health care and prevent unnecessary hospitalizations.

The bill expands Medicare Part A and Part B mental health and substance abuse benefits to include a wider array of settings in which services may be delivered. It eliminates the current bias in the law toward delivering services in general hospitals. It permits services to be delivered in a variety of residential and community-based settings. Through use of residential and community-based services, costly inpatient hospitalization can be avoided. Services can be delivered in the setting most appropriate to the individual's needs.

In 1991, as a nation we spent approximately $58 billion for treatment of mental illness and another $17 billion for substance abuse disorders. Medicare expenditures in these areas for 1993 were estimated at $3.6 billion or 2.7 percent of Medicare's total spending. Over 80 percent of that cost was for inpatient hospitalization.

In addition to these direct medical costs there are also enormous social costs resulting from these disorders. It has been estimated that severe mental illness and substance abuse disorders cost $78 billion per year in lost productivity, lost earnings due to illness or premature death, and costs for criminal justice, welfare and family care giving.

Mental disorders affect about 22 percent of the adult population in a 1 year period; 2 to 3 percent of the population experience severe mental illness or substance abuse disorders. This population is very diverse. Some people experience problems of recent origin that never recur, given appropriate treatment. Others have severe problems that persist for a long period of time. Mental illness and substance abuse disorders include many different diagnoses, levels of disability and duration of disability. Therefore, the people affected have many different needs.

Diagnosis and treatment of mental illness and substance abuse have changed dramatically since the Medicare benefit was designed. No longer are treatment options limited to large public psychiatric hospitals. The great majority of people can be treated on an outpatient basis, recover quickly and return to productive lives. Even those who once would have been banished to the back wards of large institutions can now live successfully in the community.

In recent years, the range of settings for care has diversified and providers have become more specialized. Treatments are more numerous and more effective than ever before. Treatment for mental disorders is in many cases just as effective as treatment for many physical disorders. For many people, however, appropriate treatment is inaccessible because they lack adequate insurance coverage. Medicare benefits have not kept pace with advancements in the field of mental health.

This bill would permit Medicare to pay for a number of intensive community-based services. In addition to outpatient psychotherapy and partial hospitalization that are already covered, beneficiaries would also have access to psychiatric rehabilitation, ambulatory detoxification, in-home services day treatment for substance abuse and day treatment for children under age 19. In these programs, people can remain in their own homes while receiving services. These programs provide the structure and assistance that people need to function on a daily basis and return to productive lives.

They do so at a cost that is much less than inpatient hospitalization. For example, the National Institute for Mental Health in 1993 estimated that the cost of inpatient treatment for schizophrenia can run as high as $700 per day, including medication. The average daily cost of partial hospitalization in a community mental health center is only about $90 per day. When community-based services are provided, inpatient hospitalizations will be less frequent and stays will be shorter. In many cases hospitalizations will be prevented altogether.

This bill will also make care management available for those with severe mental illness or substance abuse disorders. People with severe disorders often need help managing many aspects of their lives. Case management assists people with severe disorders by making referrals to appropriate providers and monitoring the services received to make sure they are coordinated and meeting the beneficiaries' needs. Case managers can also help beneficiaries in areas such as obtaining a job, housing, or legal assistance. When services are coordinated through a case manager, the chances of successful treatment are improved.

For those who cannot be treated while living in their own homes, this bill will make several residential treatment alternatives available. These alternatives include residential detoxification centers, crisis residential programs, therapeutic family or group treatment homes and residential centers for substance abuse. Clinicians will no longer be limited to sending their patients to inpatient hospitals. Treatment can be provided in the specialized setting best suited to addressing the person's specific problem.

Inpatient hospitalization, of course, will remain an important avenue of treatment for some beneficiaries. Currently, the law contains a bias toward providing inpatient services in general hospitals. That bias results from the payment differences between psychiatric hospitals and general hospitals.

Right now in psychiatric hospitals, benefits may be paid for 190 days in a person's lifetime. This limit was established primarily in order to contain Federal costs. In fact, CBO estimates that only about 1.6 percent of Medicare enrollees hospitalized for mental disorders or substance abuse used more than 190 days of service over a 5-year period.

In general hospitals, benefits are available for 90 days in a benefit period and a person may have numerous benefit periods throughout his or her lifetime. This can result in people who have almost used up their 190 lifetime days in a psychiatric hospital being forced to receive services in a general hospital.

They are also shunted into nursing homes. A recent study found that, among nursing home residents who did not have a cognitive impairment, such as Alzheimer's disease, 13 percent exhibit mental disorders. While some general hospitals and nursing homes are up to this task, others are ill-equipped to meet the needs of people with severe mental illness or substance abuse problems.

Under the provisions of this bill, beneficiaries who need inpatient hospitalization can be admitted to the type of hospital that can best provide treatment for his or her needs. Inpatient hospitalizations would be covered for up to 60 days per year. The average length of hospital stay in 1992 for an adult was 16 days and for an adolescent was 24 days. The 60 day limit, therefore, would adequately cover inpatient hospitalization for the vast majority of Medicare beneficiaries, while still providing some modest cost containment. Restructuring the benefit in this manner will level the playing field for psychiatric and general hospitals.

The bill I am introducing today is an important step toward providing comprehensive coverage for mental health. Timely treatment in appropriate settings will lessen health costs in the long run. It will also lessen the social costs of crime, welfare, and lost productivity to society. This bill will assure that the mental health needs of Medicare beneficiaries are no longer ignored. I urge my colleagues to join me in support of this bill.

A summary of the bill follows:

IN GENERAL

The bill revises the current mental health benefits available under Medicare to de-emphasize inpatient hospitalization and to include an array of intensive residential and intensive community based services.

PART A PROVISIONS

The bill permits benefits to be paid for 60 days per year for inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse. The benefit is the same in both psychiatric and general hospitals.

The following ''intensive residential services'' are covered for up to 120 days per year: Residential detoxification centers; crisis residential or mental illness treatment programs; therapeutic family or group treatment home; and residential centers for substance abuse.

Additional days to complete treatment in an intensive residential setting may be used from inpatient hospital days, as long as 15 days are retained for inpatient hospitalization. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of inpatient services.

A facility must be legally authorized under State law to provide intensive residential services or be accredited by an accreditation organization approved by the Secretary in consultation with the State.

A facility must meet other requirements the Secretary may impose to assure quality of services.

Services must be furnished in accordance with standards established by the Secretary for management of the services.

Payment for intensive residential services would be the lesser of reasonable cost under 1816(v) or customary charges less the amount the provider may charge under 1866(a)(2)(A).

Inpatient hospitalization and intensive residential services would be subject to the same

deductibles and copayment as inpatient hospital services for physical disorders.

PART B PROVISIONS

Outpatient psychotherapy for children and the initial 5 outpatient visits for treatment of mental illness or substance abuse of an individual over age 18 have a 20-percent copayment. Subsequent therapy for adults would remain subject to the 50 percent copayment.

The following intensive community-based services are available for 90 days per year with a 20-percent copayment (except as noted below): Partial hospitalization; psychiatric rehabilitation; day treatment for substance abuse; day treatment under age 19; in home services; case management; and ambulatory detoxification.

Case management would be available with no copayment and for unlimited duration for ''an adult with serious mental illness, a child with a serious emotional disturbance, or an adult or child with a serious substance abuse disorder (as determined in accordance with criteria established by the Secretary).''

Day treatment for children under age 19 would be available for up to 180 days per year.

Additional days of service to complete treatment can be used from intensive residential days. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of intensive residential services.

A non-physician mental health or substance abuse professional is permitted to supervise the individualized plan of treatment to the extent permitted under State law. A physician remains responsible for the establishment and periodic review of the plan of treatment.

Any program furnishing these services (whether facility-based or freestanding) must be legally authorized under State law or accredited by an accreditation organization approved by the Secretary in consultation with the State. They must meet standards established by the Secretary for the management of such services.

THE CATO INSTITUTE'S DRUG DECEPTION

HON. GERALD B.H. SOLOMON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 6, 1995

Mr. SOLOMON. Mr. Speaker, I would like to bring attention to the truth about proposed legalization-decriminalization policies. Members have recently heard from the CATO Institute announcing a policy forum questioning the usefulness of continuing ''the unwinnable war'' on drugs. This forum is clearly just a thinly-veiled attempt to legitimize CATO's own prolegalization position.

However, what CATO refuses to publicly acknowledge are the devastating results of legalization-decriminalization policy, as evidenced in the Netherlands, where such a policy has been in place since the early 1980's. The president of the Dutch National Committee on Drug Prevention, K.F. Gunning, M.D., reports that crime and drug use have skyrocketed since the implementation of legalization in the Netherlands. According to the Dutch Government, their legalization-decriminalization has resulted in: A 250-percent increase in drug use since 1993; a doubling of marijuana use by students since 1988; armed robberies up by 70 percent; shootings up by 40 percent; car thefts up by 60 percent.

The number of registered addicts in the Netherlands has risen 22 percent in the past 5 years, and there were 25,000 new addicts in 1993 alone. In addition, the number of organized crime groups in the Netherlands has increased from 3 in 1988 to 93 in 1993. For good reason, the American public has zero tolerance for legalization schemes.

Mr. Speaker, drug legalization has clearly been a disastrous mistake for the Netherlands. If organizations like CATO achieve their goals, drug legalization will worsen the crime and drug problem in America as well.

IN HONOR OF HERIBERTO QUINDE-OBANDO

HON. THOMAS J. MANTON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 6, 1995

Mr. MANTON. Mr. Speaker, I rise today to honor Mr. Heriberto Quinde-Obando, a gentleman I am proud to represent in the Seventh Congressional District of New York.

Mr. Speaker, on March 16, I had the pleasure of joining Mr. Quinde-Obando and members of his family in my Washington office to celebrate Mr. Quinde-Obando's 80th birthday.

Mr. Speaker, for more than half of his 80 years, Mr. Quinde-Obando has lived in Woodside, Queens, which is part of my District. Mr. Quinde-Obando began his life in Guayaquil, Ecuador in South America. He moved to New York City is 1948 where he started a new life and began his career as an electronics technician. Mr. Quinde-Obando is well known for his contributions to his community and involvement in a number of civic organizations. Mr. Quinde-Obando's achievements demonstrate the great success immigrants have had in this country and his selfless devotion to our community serves as a shining example for all of us to follow.

Mr. Quinde-Obando has been particularly involved in the New York Intercontinental Lions Club since 1982. At the New York Intercontinental Lions Club, Mr. Quinde-Obando has successfully held several executive positions including director, chairman for social events, chairman of the health fair, club secretary, third, second, and first vice president, and president. He was selected Lion of the Year in 1984 and has received many other honors from his fellow Lions over the years. Mr. Quinde-Obando become a member of Lions International in 1980.

In addition to his charitable work, Mr. Quinde-Obando is a recognized leader within the Hispanic American community in Queens, helping unite his fellow Hispanic American neighbors on many issues important to Queens. He served as the president of the Queens Hispanic Day Parade Committee in 1992 and was also a member of the Hispanic task force in 1990. As a member of the Hispanic task force, Mr. Quinde-Obando was instrumental in helping retain Federal funds for transportation, education, job training, and housing.

Mr. Quinde-Obando also has served on the Woodside senior citizens advisory board and is a member of St. Sebastian's Parish. Having met many members of the Quinde family, I know that Heriberto Quinde-Obando has also been a loving and dedicated husband, father, and grandfather.

Mr. Speaker, I know that my colleagues will join me in commending Heriberto Quinde-Obando for his outstanding service to his family, church, and community.

TRIBUTE TO DAVID B. CRABIEL

HON. FRANK PALLONE, JR.

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 6, 1995

Mr. PALLONE. Mr. Speaker, on Sunday, April 30, 1995, Mr. David B. Crabiel, director of New Jersey's Middlesex County's Board of Chosen Freeholders, will be presented the Hubert H. Humphrey Friend of Labor Award at the 4th annual Middlesex AFL–CIO awards and scholarship brunch.

Mr. Speaker, it is a great honor to pay tribute to David Crabiel, a dedicated family man who has, since he became the youngest member of the Milltown Rescue Squad at age 16, selflessly dedicated his adult life to public and community service. Having been in public service as an elected official in various positions since 1960, Mr. Crabiel has held himself to an exemplary standard of citizenry.

Entering public life as a councilman, in 1967 Mr. Crabiel was elected mayor of Milltown, a position in which he served for 11 years before being appointed to the Middlesex County Board of Chosen Freeholders. Elected a freeholder after his appointed term expired, Mr. Crabiel served on the board through 1991 and was reelected in 1993. Wielding a distinguished record of leadership and service, he has, unsurprisingly, risen to a leadership position on the board, where he currently serves as Freehold director.

While this record is impressive by itself, it tells only have the story. In addition to the public positions he has held, Mr. Crabiel has generously donated his talents to several different community causes. To cite just a few examples, he has served as honorary chairman of the Melvin H. Motolinsky Research Foundation, as a member of the board of directors of the Cerebral Palsy Association, and as honorary cochair of the Middlesex County Human Relations Commission.

Mr. Speaker, it is a great pleasure and honor for me to pay tribute to a man whose life has been dedicated to the betterment of his community and the service to others. Personifying altruism through public and community service, Mr. Crabiel has truly set a standard which members of all communities would do well to follow.

TRIBUTE TO BILL NYSTROM

HON. BARBARA B. KENNELLY

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 6, 1995

Mrs. KENNELLY. Mr. Speaker, I rise today to honor the memory of Mr. Bill Nystrom, who