# Issue Review of Behavioral Health Care Access for Iowans

## Access to Behavioral Health Professionals

Seventy-five counties in Iowa are designated a mental health professional shortage area, leaving Iowans without adequate access to professionals trained in providing behavioral health care. As a result, Iowans are going without the care they need on a proactive basis in the outpatient/clinic setting and are often receiving their care on the "back end" of the delivery system, in hospital emergency rooms and inpatient care. Iowa hospitals are committed to serving their patients and recognize the importance of the providing behavioral health care as a responsibility in fulfilling their missions. However, the ability of Iowa hospitals to deliver this care is dependent upon the accessibility of behavioral health professionals, in particular psychiatrists, to keep inpatients beds staffed and open. As Iowa strives to become more attractive to new and growing businesses, it must not overlook the importance of access to quality behavioral health care. To draw more businesses and citizens to the state of Iowa, the accessibility of high quality health care must be a priority.

In a recent study by the National Institute of Health, researchers for the first time assessed the quality of mental health care that Americans receive. The findings indicate that only one-third of affected people received even "minimally adequate" care—defined by researchers as getting at least two months of appropriate medication and seeing a doctor at least four times, or undergoing at least eight psychotherapy sessions of 30 minutes or more. The particularly troubling fact revealed by the researchers was that, of those who did turn to traditional medicine, just 48.3 percent of those who went to psychiatrists received the minimally adequate care, compared with only 12.7 percent of those who went to general practice physicians. The report further states the reasons that care sometimes falls short vary, but can include problems with access to specialists because of geographic distance or lack of insurance, or the limited amount of time that practitioners can devote to each patient.

Iowa's 148 private practice psychiatrists work in 30 counties, leaving 69 counties with no psychiatric coverage. Iowa ranks 47$^{th}$ in the nation in the number of psychiatrists per resident, according to the Department of Health and Human Services. This figure fails to account for the number of psychiatrists who will no longer treat patients in inpatient hospital units. **Child psychiatrists in particular are in an extreme shortage in Iowa.** The July 10, 2005 *Des Moines Register* featured an article depicting the harmful effects of the shortage of psychiatrists on Iowans.

When a patient leaves a mental hospital, a follow-up appointment is recommended within two weeks of discharge. In Iowa, the average wait time for these appointments is two months. For every 100,000 Iowans, there are only 6.6 practicing psychiatrists, worse than in all but three other states: Idaho, Nevada, and Mississippi. Most psychiatrists are clustered in urban areas, out of reach for rural Iowans who often lack access and resources to transportation.

Without access to up-front care, patients' conditions deteriorate, and they may need hospitalization. This situation leads to much more costly care to Iowa and its 99 counties. According to the University of Iowa's physician work force tracking system**, Iowa had a net gain of only five psychiatrists over the past five years.** Further, the Centers for Medicare & Medicaid Services (CMS) has capped psychiatric residency slots at 13 in Iowa's only hospital with a psychiatric residency program.

Thirty-five percent of Iowa's mental health professionals are age 55 and older, according to a recent study by the Iowa Department of Public Health (DPH). Psychologists and other behavioral health

care providers are at the highest risk of having a shortage of all licensed health professionals. If this current trend is not reversed, their services can be expected to decline substantially during the next decade.

## Solutions

Paramount to recruiting and retaining psychiatrists and other behavioral health professionals is adequate reimbursement. Adequate reimbursement must be provided to the physicians and the providers employing behavioral health professionals to enhance access to care. Iowa's publicly funded behavioral health system, including the IA Plan for Behavioral Health, must recognize the cost to care for individuals needing behavioral health care.

Although CMS has a federal cap on the number of residency slots for which it will provide reimbursement, this does not prevent the state from independently funding residency slots. The approximate cost for each slot at the University of Iowa Hospitals and Clinics is $60,000. The state should establish funding at a minimum of 10 additional residency slots, with the requirement that upon completion of the residency program, the psychiatrist conduct work of behalf of an Iowa hospital for a period of three years. The Iowa Values Fund is a source of funding that could be directed to increased residency slots to attract new businesses and citizens by improving the quality and delivery of behavioral health care.

Iowa has a responsibility to ensure Iowans, whether Medicaid enrollees or those receiving services through the county funded system, have access to behavioral health professionals. In addition to providing funding for new psychiatric residency slots, medical education payments to Iowa hospitals for training psychiatric and allied behavioral health professionals should be increased. Medical education payments are tied to the Medicaid inflationary factor. FY 2006 is the first time since FY 2000 that an inflation factor was provided to the Medicaid appropriation. The Iowa Legislature must increase medical education payments and dedicate the payments to training behavioral health professionals. By increasing the number of behavioral health professionals, Iowans will have more access to less costly outpatient/clinic services, lowering the number of costly inpatient admissions and emergency visits that are billed to the state and counties.

Iowa should provide additional funds to broaden the use of telemedicine and alleviate the pressure of worker shortages. Real-time telemedicine is effectively being used by several Iowa hospitals, but financial assistance is needed to expand this option throughout the state. In addition to up-front financial assistance, telemedicine services must be reimbursed adequately by Iowa's publicly funded behavioral health system.

Federal regulations require hospitals with psychiatric units to have available on-call psychiatric coverage 24 hours a day. Given the extreme shortage of these professionals, hospitals are struggling to find adequate coverage. Psychiatrists are over-worked and either leaving the state due to their work load or refusing to treat inpatients. As a result, hospitals are often not staffing all the licensed psychiatric beds because they do not have enough psychiatrists to treat patients. This also leads to an access problem in terms of bed availability.

The availability of preventive, proactive, outpatient care, whether it be counseling alone or in combination with psychotropic medication, is imperative to Iowa citizens. Not only is it better medicine, it also provides great savings to the state and counties resulting from less frequent and costly hospitalizations that require longer periods for recovery.

## Access to Inpatient and Residential Level of Care

Iowa currently ranks 31st in the nation in the number of available behavioral health beds per capita. Since 1987, the number of beds available for individuals in need of behavioral health care at Iowa's mental health institutes (MHIs) has declined by 51 percent. With the closure of these beds, Iowans are turning to their community hospitals for acute inpatient psychiatric care. Community hospital emergency departments continue to see a growing number of individuals in need of emergency behavioral health care. Due to the bed reductions, waiting lists have been implemented at MHIs which has put a strain on hospitals and community residential providers looking for placement of individuals in need of a MHI long-term acute care stay. Patients admitted to a hospital distinct part psychiatric units that are in need of longer-term care must wait weeks and sometimes months for placement at an MHI. Further, residential facilities are hesitant to admit a patient that has been admitted to an acute care setting should the individual's behaviors become unmanageable for residential facilities that do not have the resources in place to safely care for such individuals.

Despite the reduction in beds, the MHIs continue to be a critical element in the continuum of care for the seriously mentally ill. Iowa's community hospitals are serving patients that would more appropriately be served in the MHI long-term acute care setting; and because of this inpatient psychiatric hospital beds are not available to those in need of short-term care. Iowa also lacks the capacity at the community residential level to care for displaced individuals.

The state has been working to close MHI beds in efforts to be consistent with the Olmstead Supreme Court decision to allow individuals to live in the least restrictive community setting. However, Iowa has not efficiently or effectively built community residential resources for individuals to transition from the acute inpatient level of care. Though unintended, a negative consequence has occurred with the closure of so many MHI beds. Individuals are not able to live in the least restrictive environment because community providers are hesitant to admit patients who may need patient acute care with the knowledge that MHIs have waiting lists and community hospitals beds are generally at capacity.

## Solutions

Community hospital inpatient psychiatric units are the appropriate setting for patients needing **short-term** acute inpatient psychiatric care. IHA supports a system that provides a continuum of care for those needing psychiatric services. In Iowa there is a missing level of care; sub-acute. Sub-acute care is the level between inpatient acute psychiatric care and community residential care. Sub-acute care provides supports and services to individuals that are not ready for residential care, and would fail in the residential setting if placed prematurely. The existing MHI facilities have the physical capacity and resources to provide this level of care. Plans should be made to convert campus buildings for use by alternative programs operated by government and/or non-government providers to develop less intensive step-down programs to serve difficult-to-place individuals.

These programs could be used as a placement between the hospital and community settings, a difficult transition for many individuals with significant needs. MHIs not only have the physical space but also the necessary services, e.g., dietary, recreation, education, etc, that could meet the needs of this population as they are integrated into the community. MHIs also have resources in place to respond accordingly in the event of an emergent situation and in the event an individual may need to revert to the acute level of care. Further, those in need of acute inpatient care would be able to access that care more promptly by allowing persons to move into less restrictive environments when they are ready for such care. Expanding upon this level of care will decrease recidivism and decrease overall costs for the state and its 99 counties. Additionally, this plan would allow both hospital distinct part units and MHIs the ability to transition patients to a lower level of care more efficiently while providing the necessary supports for individuals to transition successfully. Existing precedent for this level of care is in the Inpatient Residential Treatment

Center at the MHI in Mt. Pleasant for substance abuse services, and in states such as Pennsylvania and Minnesota. Through the IowaCares Waiver, this level of care could be funded using the state and federal partnership of the Medicaid program.

An alternative to providing sub-acute care in unused MHI space would be to expand community residential capacity, **only** in the case where the facility has proper supports and resources in place, such as 24 hour access to a crisis response team trained in safely caring for behavioral health patients.

An alternative to providing sub-acute care in unused state MHI space would be to expand community residential capacity to provide this level of care, **only** in the case where the facility has proper supports and resources in place, such as 24 hour access to a crisis response team trained in safely caring for behavioral health patients.

*These recommendations are consistent with those presented by the MHI Redesign Team Report, April 2005 to the MHDDBIMR Commission.*

## Involuntary Hospitalization

Given the closure of over half of the state's MHI beds and the resistance from residential providers to accept patients for concerns of recidivism, both the state and counties have been able to shrug their responsibilities to pay for behavioral health services due to full bed capacity and the absence of a contract requiring reimbursement for services.

### Substance Abuse

Iowa hospital emergency departments are inundated with patients needing treatment for substance abuse. The funding for substance abuse treatment is a responsibility of the state through the DPH, yet this does not include detoxification. Currently the funding is insufficient to reimburse substance abuse treatment, and hospitals often absorb these costs. Further, if the state does not have a contract with the treating provider, payment is not rendered. Counties are liable for funding substance abuse treatment under certain circumstances at the MHIs only because of their liability for the cost of treatment at MHIs.

### State Cases

When an individual is involuntarily committed and does not have a county of legal settlement or any other source of payment, the individual is deemed a "state case", and the state is then financially liable for payment of the commitment. However, there are often disputes regarding the county of legal settlement, and if the facility does not have a contract with the state, the facility is not reimbursed for its services.

## Solutions

Legislation was passed during the 2005 Legislative Session requiring counties to contract with a 135B licensed hospital for mental health involuntary commitments, or pay for services at an alternate hospital should the contracting hospital not be able to accept the individual.

This same language should be adopted to require the state to pay for state cases involuntarily committed at a contracting 135B licensed hospital, or an alternative 135B licensed hospital should the original hospital not be able to admit the patient.

The DPH should establish contracts with 135B licensed hospitals to pay for substance abuse services and a one-to-three-day hospital stay for detoxification for those clients who have no funding source for substance abuse treatment. If the contracting hospital is unable to admit the patient, payment should be made for services at an alternate 135B licensed hospital.

## The Iowa Plan for Behavioral Health

### Quality Indicators

Considerable question has been raised regarding the IA Plan's performance indicator of patients receiving follow-up care within seven days of discharge from a hospital. The IA Plan contractor is reporting that 87 percent of the plan's subscribers are receiving follow-up care within the seven days following discharge from a hospital. According to the 2003 Health Plan Employer Data and Information Set (HEDIS), the compliance rate for this performance indicator ranged from 46.5 percent to 52.6 percent, and the 90$^{th}$ percentile score was 64.4. Meeting the objective of follow-up services within seven days is particularly difficult given the behavioral health professional shortage in Iowa and the fact that the average wait time for a follow-up appointment is two months. Iowa hospitals do not dispute the fact that patients should be receiving follow-up care in a close timeframe following discharge. However, hospitals do question the validity of the data considering it is reported to the DHS, DPH, and the Iowa General Assembly to illustrate the contractor's performance. The HEDIS performance indicator indicates the follow-up care must be an *actual visit.* The IA Plan contractor is indicating it meets the seven-day follow-up criteria if the patient is contacted via telephone post discharge.

### Community Reinvestment Fund Allocation

To qualify for the 2.5 percent community reinvestment fund allocation, providers submit suggestions that will qualify a particular program to receive funding. Fund allocations are distributed in piece meal fashion and fail to address broader gaps within Iowa's publicly funded behavioral health delivery system.

### Solution

IHA urges the IA Plan to change the way it reports its compliance with the seven-day follow-up criteria from making a phone call, to the patient actually making a *visit* to see a behavioral health practitioner. Collecting and reporting this data in this manner is consistent with HEDIS standards and is consistent with the way in which other health plans collect and report this data. Reporting this data in a consistent manner with the HEDIS definition will more clearly illustrate the issue of lack of available behavioral health practitioners in Iowa. This measurement should not penalize hospitals in establishing contracted payment rates.

The IA Plan contractor should structure the disbursement of Community Reinvestment funds by identifying on a broad scale, gaps within Iowa's publicly funded delivery system where care is needed and then administer the funds on a basis that fills this gap statewide. Identification of gaps in services should be made in conjunction with the provider community, including hospitals.

## The Transformation of Iowa's Publicly Funded Behavioral Health System

For over two decades, the Iowa legislature has recognized the enormous road blocks within Iowa's publicly funded behavioral health system. In response, it has directed several bodies over the years to make recommendations for transformation. Most recently, that charge has been given to the MHDDBIMR Commission. In December 2003, the Iowa Legislature and Governor received a detailed report from the Commission to transform the current system. To date, none of those recommendations have been acted upon, noting a lack of data detailing the cost of the recommendations.

### Solution

IHA supports the adoption of many of those recommendations; first and foremost, the replacement of the definition of Legal Settlement with a definition of Legal Residency, and secondly, the adoption of a standardized functional assessment tool, such as the LOCUS tool. The Iowa Legislature must work with the Commission to help shape its recommendations and to support

them to the entire General Assembly. Further, the Legislature should allow the Commission to move forward in identifying and implementing the recommendations that could be adopted administratively. Iowa should not continue to expect its citizens to devote endless hours to making recommendations over the course of more than 20 years, only to never have legislative action implementing such recommendations. Many of those tax dollars spent on transformation work could have been devoted to Iowans in need of services.

## Mental Health Parity

During the 2005 legislative session, HF 420 provided mental health parity for biologically-based mental illnesses. This is a good start to acknowledging the prevalence of mental health diagnoses, but more must be done. The mental health parity legislation was very limiting in defining what qualifies as a biologically-based mental diagnosis and does not recognize substance abuse. Substance abuse costs our society more than $260 billion a year for comorbidities, law enforcement, and treatment; but less than 2 percent of that amount goes for treatment. One in 10 Americans suffers from some kind of alcohol or drug problem in any given year. One in eight children have a parent with an addiction problem that impacts his or her life. This is in part due to health plans and employers failing to recognize the additional $110 billion in lost productivity due to one of the nation's most serious health problems. As the costs of health care rise, the willingness to treat someone with substance abuse diminishes as it is perceived they have done it to themselves, rather than what it actually is, a disease. Co-occurring disorders should be seen as the expectation among persons with mental illnesses, not the exception. Treatment and funding systems must be designed with this in mind.

In recent studies at the George Washington University Medical Center, researchers learned that in states with substance abuse parity laws, the pressure on state budgets eased by cutting health, criminal justice, and welfare costs; and increases the number of individuals entering treatment.

## Solution

Iowa's mental health parity legislation must include all mental health diagnoses, and substance abuse disorders. In doing so, Iowa will have a more productive workforce and a greater return on investment.

*Note: This information is a result of three IHA Mental Health Task Force meetings held in 2005.*