Mental Health in Arkansas

A Clinical Perspective

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Handout #5
Re: E-2

Current Oversights: Pre Service

All RSPMI services to clients ages twenty and younger must be referred by their current Primary Care Physician (PCP) and must be continuously re-approved at a minimum of every six months.

An extensive Diagnostic Assessment must be completed to determine appropriateness of care, diagnosis, level of need, and minimum services nece4ssaryn to effectively treat. A Psychiatric Diagnostic Assessment must be completed to ensure accuracy and indicate any additional needs. A Treatment Plan (prescription for services) must be developed with the client/family, multi-disciplinary team and signed by all parties, including the psychiatrist.

With the exception of an extremely limited package, all services (not to include Crisis Intervention) must be approved by Beacon (preciously known as Value Options). Medical Necessity must be clear when requesting the Prior Authorizations. Extensions of units and new Prior Authorizations must be completed and approved on Medical Necessity for continued care.

All services provided must follow strict definition guidelines clearly outlined in RSPMI Guidelines. They must follow regulations not only on content, but also on location of services, length of service and documentation of service.

Current Oversights: Post Service

Services are currently reviewed at a minimum of every three months, clearly showing progress or decline. A new Treatment Plan is developed and must follow the same procedure as the original in becoming the new updated prescription for services

Beacon On-Site Inspections of Care (IOC)

Beacon Retrospective Reviews

Accreditation Body On-Site visits

Beacon Desk Reviews

Office of Inspector General Reviews

Other State and Federal Reviews i.e.: Medicaid, Medicare

Division of Childcare Licensing for many of our providers

Provider in house reviews

MANAGED CARE

Managed care organizations derive their credibility under the assumption that, in their absence, care is over-utilized or inefficiently utilized. Of course, the downside of MCO's is the price at which such utilization oversight comes. According to the Milliman Report on Risk Based Managed Care released in June of this year, an average of 14% of an MCO risk based contract is diverted to administrative and underwriting costs. So, even a breakeven contract for a Medicaid MCO would require a 14% reduction in medical claims costs on the backs of providers or clients or both to support the MCO administration.

A related problem with the introduction of managed care into the healthcare plan is the idea of using a financial tool to control a clinical product. This disparity can create imbalances in the form of various incentives and disincentives to certain types of service provision, provider assumed insurance liability for treating cases after exceeding financial caps or being denied continued authorization by the MCO, and gatekeeping and other care access restrictions imposed by the MCO. All of these methods of limiting services ignore the issue of underserved populations that already exist in Arkansas. Scarcity-based health care solutions are not the answer for Arkansas.

In the July/August 2010 issue of *Social Work Today, reported in an article titled,* " Managed Care Trends and Mental Health Practice" the following information was provided:

As a result of the new law and in response to rising costs, clinical social workers in community health centers have faced unprecedented demands in record keeping and billing and have had to assume more responsibility for justifying the need for services. The need for mental health services can be more subjective than the need for medical services, making these requirements more difficult on mental health providers. In the past, authorizations for mental health visits and outpatient treatment reports most often were either not required or could be completed by individuals not directly involved in the care of health center clients.

The companies wanted to ensure that treatment was necessary and as efficient as possible. As a result, managed care companies have established stricter requirements on the authorization of mental health visits and are requesting that mental health providers directly report on client progress to the companies before visits are approved. With the high patient volume in community health center settings and the various requirements established by individual managed care companies, it can be difficult for clinical social workers to incorporate this process into their daily workflow.

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Credentialing requirements for clinical social workers are becoming more stringent as managed care companies struggle to cut costs. While mental health parity has increased the amount of reimbursable services provided by clinical social workers, the process by which individual clinical social workers can contract with managed care companies has become more cumbersome. Additionally, it is becoming more difficult for new clinical social workers to become credentialed, as companies are deciding to credential only highly experienced providers. This trend is becoming progressively more problematic as community health centers are often staffed by new social workers trying to obtain their clinical licensure. It also causes competition as health centers try to attract and retain providers who already fit credentialing criteria. In doing so, community health centers may lose the opportunity to screen new employees on the basis of their clinical skills rather than their seniority in the profession and will likely lose out on opportunities to hire talented clinicians.

Journal of Mental Health Counseling April 2001
"The Impact of Managed Care on Mental Health Counselors: A Survey of Perceptions, Practices, and Compliance with Ethical Standards"

A growing body of literature has identified the numerous ethical challenges that managed care presents to mental health professionals (Acuff et al, 1999, Cooper & Gottlieb, 2000; Glosoff, 1998). These challenges fall into two broad categories: (a) difficulties in supporting the client's right to quality care as a priority over the professional's relationship with the reimburser and (b) problems in protecting the privacy of client disclosures. Managed care presents mental health professionals with conflicts-of-interest and a feeling of divided loyalties (Strom-Gottfried, 1998; Watt & Kallmann, 1998) as they try to promote the welfare of clients. Because treatment plans must conform to MCO protocols (Miller, 1996) and be approved by MCO representatives in order to get payment for reimbursement, counselors are not free to plan and implement treatments independently. When their professional judgments differ from MCO protocols, counselors feel pressured to decide whether to use treatment plans they view as inferior (thereby risking harm to the client) or risk the denial of reimbursement (and lose a source of income).

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services published an article, "Managed Mental Health Care: Findings from the Literature, 1990-=2005". Material for this report was prepared by The Lewin Group for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), under Task Order Number 280-03-2701. Although most reports including this one do note increased access and reduction in cost, the following issues are noted:

The populations most often discussed in the managed mental health care literature as being at risk for harm are adults with severe mental illnesses such as schizophrenia or bipolar disorders, and children with SEDs who require access to outpatient mental health treatments, more expensive inpatient and residential settings, and a variety of supportive social assistance programs.

Studies indicate that persons with SMIs may experience limitations in access to care in a carve-out, compared to persons with mild to moderate mental health conditions (Huskamp, 1998). These adverse effects include disruptions in continuity of care that affect these patients' ability to adhere to recommended medication schedules and receive outpatient visits following hospital discharge.

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The President's New Freedom Commission: Goals and Recommendations for a Transformed Mental Health System Goal 2: Mental health care is consumer and family driven
Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance;

SAMHSA's Principles for Systems of Managed Care Consumer Participation and Rights
Managed care systems should—

Meaningfully involve consumers and family members in the planning, development, delivery, evaluation, research, and policy formation of managed care systems, including the determination of "medically necessary" services;
Respect consumer choice of services, providers, and treatment and assure consumer-informed voluntary consent. Individual treatment plans should be based on the preferences and needs of consumers and families with children;

Note: When an MCO defines medical necessity and evidence based treatment limitations, this limits the mental health care provider's ability to have flexibility in treatment decision making tailored to the needs of an individual client, as well as the client's ability in this decision making process. It is imperative that clients are active participants in their treatment for the process to be successful.

MORATORIUM:

The assertion that releasing the moratorium will somehow solve a service quality and accountability problem among providers seems to inadequately consider a couple of issues:

1. 75% of counties in Arkansas are underserved for psychiatric services. This deficit in the Arkansas mental health talent pool extends not only to physician boarded psychiatric services but to licensed ancillary professional services as well. Experienced RSPMI providers have long understood that recruiting and retention of mental health professionals is the single greatest impediment to building a comprehensive mental health network in the state.
2. Because of this employee driven market, salary costs for professionals such as psychiatrists and licensed therapists has been driven to the edge of sustainability. Bringing additional providers will not increase accountability and availability of services; more likely, it will exacerbate an existing talent pool problem and increase the cost of professionals across the state.
3. Additionally, DHS would incur significant costs to manage, certify and train additional providers, decreasing its focus on more important and effective quality improvements. The state has spent close to a decade training and eliminating providers to maximize performance. Because of the extensive set of performance requirements under RSPMI, new providers would incur a lengthy "ramp up" period to become proficient at providing RSPMI services. It would be costly to begin the process again.

Focusing on Solutions

The most important factor that must be focused on clinically is the impact on medically necessary services that are needed to ensure efficient, quality care for the individuals and families in Arkansas, while ensuring that we are being fiscally responsible.

New programs that will soon impact the situation are those such as the current Prison Reform that is being processed. Ensuring the quality and acceptable level of care these individuals receive will not only effect their lives, their families lives, but the communities in which they reside.

Medicaid and RSPMI providers groups across the state have met and discussed cost saving measures that can effectively be put in place that will not negatively impact the persons being served. These groups included the Alliance for Health Improvement, the Behavioral Health Providers Association and the Community Mental Health Providers Association.