

IHA Legislative Position 2012

Behavioral Health Delivery System



★ Background

Hospitals continue to focus on behavioral health in Iowa as a system in dire need of reform. Patients in need of services wait too long for appointments or beds in a treatment facility which too often results in Iowans accessing treatment system through hospital emergency rooms or law enforcement. Coupled with a fractured delivery structure that does not provide the same access or services to citizens in different parts of the state, Iowa now finds itself in a critical situation.

The Iowa Hospital Association applauds action taken by the Iowa General assembly in 2011 to sunset Iowa's current county-driven system in 2013 and the activity of interim work groups to create a detailed plan for legislative review in 2012. IHA and member hospitals had representatives on the various work groups and provided perspectives regarding how to best care for patients. IHA challenges the General Assembly to not let the opportunity to reorganize the state's service delivery system slip by in 2012.

★ Action Needed

Restructuring Iowa's behavioral health system should not boil down into strictly a budget debate. While financing issues have to be considered, IHA has identified the following priority recommendations that could transform Iowa's behavioral health system to more effectively deliver services and ultimately reduce health and societal costs associated with untreated behavioral health concerns:

- **Pilot Project for Sub-Acute Services.** Of pressing need in Iowa are more sub-acute beds for patients who do not require the acute care services provided by hospital inpatient units, but who are not ready to transition fully back into society. The Mental Health Institute (MHI) Task Force convened in 2009 concluded that sub-acute care is a necessary portion of the continuum of care that is missing in Iowa and also noted that this is a role that could be filled via one or more of the state's four MHIs. IHA recommends that a pilot project expanding sub-acute care at one of the state's MHIs be developed and funded to address this need, with the potential for expanding the pilot to other communities across the state. Development of sub-acute care services would free up acute care beds across the state, resulting in greater local access and less travel time for patients and law enforcement.
- **Mental Health Commitments.** Due to the lack of inpatient psychiatric hospital bed space and behavioral health practitioners, IHA supports amending the mental health commitment process in Iowa Code chapter 229 so that it is as efficient as possible while still protecting the rights of citizens. Chapter 229 currently does not recognize the increased role of psychiatric advance registered nurse practitioners who practice independently in the state. With Iowa's extreme shortage of psychiatrists, the state should remove as many barriers as possible for these practitioners to assist with mental health treatment in rural Iowa. Furthermore, chapter 229 does not provide for efficiencies though technology such as faxed or e-mailed orders and phone or web testimony for hearings which would save time of practitioners which could be spent with patients. While some jurisdictions permit these practices, these types of efficiencies have not been uniformly accepted across the state as they should.
- **More Standardized County Mental Health Service Delivery.** Hospital advocates share the DHS goal of a more coordinated mental health delivery system than the county-led system currently in place. The current system has resulted in inequitable services available to Iowans and provides administrative difficulties for regional and state-wide providers, like hospitals providing inpatient psychiatric care, which interact with 99 different counties with different

benefit plans. IHA supports a uniform system that will increase efficiency, eliminate fragmentation, and provide consistent services and outcomes for Iowans. In addition, the Iowa General Assembly should increase the county property tax caps for the provision on mental health services. Should the General Assembly choose regionally-oriented models, special attention should be given to the needs of border communities that may be better served by opening up regional care across state lines.

- **Children’s Mental Health Services.** Many children’s mental health services are provided through Iowa’s 14 Psychiatric Medical Institutions for Children (PMICs). PMICs focus exclusively on quality care for children so they can more effectively be integrated back to the home environment. However, Iowa’s daily reimbursement rate for PMICs is the lowest in the nation. With a growing number of juvenile commitments, the system is becoming more strained and access to these services is deteriorating. In fact, a growing number of juvenile commitments are now being placed in surrounding states. Iowa should repeal its acuity based system for PMIC reimbursement and return to a cost based system that would enable the creation of necessary step-down programs and more targeted case management. Additionally, Iowa should establish a two-tiered licensure system for PMICs in order to recognize the full range of services provided by the larger facilities.
- **Transportation Services.** Transportation services must be included as a core benefit in any redesigned behavioral health care system, particularly given federal EMTALA provisions which indicate that hospitals may be liable for involuntarily-committed patients who are not transported to an inpatient facility via ambulance services.
- **Expand Telemedicine Opportunities for Behavioral Health Services.** Another mechanism that has been employed in the corrections setting and other areas such as radiology interpretation is a broader use of telemedicine services to oversee mid-level practitioners. Two barriers exist for the expansion of telemedicine services: (1) lack of payment recognition from Medicaid and other third-party payers and (2) Iowa Board of Medicine issues with the supervisory authority for some services (such as inpatient mental health services) by out-of-state physicians. Appropriate inpatient behavioral health telemedicine services should be identified and paid for by Medicaid, and the use of telemedicine services should be viewed more liberally by the Board of Medicine and the Department of Inspections and Appeals.
- **Substance Abuse Treatment.** The funding for substance abuse treatment is a responsibility of the state through the Iowa Department of Public Health (IDPH), 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. The IDPH 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 hospital. Since the vast majority of behavioral health patients (paid for through DHS) have a co-occurring substance abuse problem (paid for through IDPH), an even better approach would be to consolidate these payment streams through a single state agency.
- **Behavioral Health/Physical Health.** Many behavioral health patients also have physical disorders or conditions that must also be treated. Currently there is little coordination between traditional Medicaid (physical health) and the Iowa Plan (behavioral health) regarding payment for these services. Hospitals often receive payment from only one funding source, covering only a portion of the overall care costs. The Iowa Medicaid Enterprise should be required to coordinate these services to more accurately reflect the total cost of treatment for Medicaid patients.