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"When we tug on a single thing in nature, we find it attached to everything else."
John Muir (1838 – 1914)

"How wonderful it is that nobody need wait a single moment before starting to improve the world."
Anne Frank (1929 - 1945)

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The Potential End to Mental Health Care Access As We Know It in Rhode Island

(DRAFT)

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January, 2013

(Please note: This document is a work in progress and is not fully developed at this time. Several of the sections below will be modified and expanded with further research and implementation of healthcare policies. A completed version will be available at www.rinas.info upon completion.)

I. Medicare Driven Reimbursement Reduction by Blue Cross/Blue Shield of Rhode Island (BC/BS). (Approximate 10% reduction in May 2012. Potential additional reductions on the way.)

We believe that the reduction in reimbursement for Behavior Healthcare services is shortsighted on several fronts. The cost of doing business for private practitioners rises every year. Rent, health insurance, employee expenses, continuing education requirements, operating costs, liability insurance, technology requirements have all increased. According to BC/BS, the last time the Medicare Index was analyzed by BC/BS relating to Behavioral Healthcare was in 2008**. Since that date, the CPI (Consumer Price Index) has risen 9% and inflation has increased by 8.3%.** Thus, clinical social workers continue to face increased costs, and now will have 10% less to pay for those costs of providing professional services.

Due to the increase in operating costs, from a logical standpoint and certainly the viewpoint of a provider, it should be unconscionable for reimbursement rates to decrease rather than increase. This raises serious validity questions for the clinical social worker concerning the process by which the rate reduction decision was made by BC/BS executives and Medicare. Clinical social workers, as other master level clinicians, already hold one of the lowest levels of provider reimbursement for mental health treatment and now their rates for

reimbursement are even lower. (There are over 2000 licensed clinical social workers in Rhode Island, many of whom provide reimbursable mental health services in agencies and in private practice. Social Workers represent, by far, the largest block of licensed mental health providers in the state with twice as many practicing licensed mental health professionals than all other disciplines combined. However, it is important to note that, for maximum consumer choice and effective treatment outcomes, all disciplines are needed enough though the services are provided through sightly differing ideologies. Every discipline is critical and effective.)

As devaluing of mental health treatment can have negative effects in the long term on the availability of mental health treatment in the State of Rhode Island. If reimbursement rates do not sufficiently sustain and compensate clinical social workers, they will choose to practice in venues other than private or group practice, thus reducing the available population of mental health providers in the State. We believe that consumers of behavioral healthcare services should have choices regarding professionals and venues for the services they need. Since BC/BS has 70% of the healthcare insurance market in Rhode Island and a sizable portion of the mental health provider portfolio, a loss of income of nearly 10% to clinical social workers will ultimately affect the level of mental health services available to Rhode Island residents. This would seem to be ill-advised as the demand for behavioral health treatment is likely to increase rather than decrease as a result of the aging of the baby boom population and its related needs for mental health services and to the overall societal de-stigmatization of mental health treatment.

Therapeutic services do make positive impacts in the living, learning, working and physical health of an individual's existence. Trauma and unresolved mental health issues can severely affect one or more of these areas. When individuals exhaust their personal support network trying to address unresolved mental health issues, the availability of professional help is of paramount importance. The key mission of a not-for-profit insurer should be to ensure access to required health treatment for all its subscribers. Therefore, BC/BS has a dual obligation to the subscriber and the provider to keep the system healthy, available and productive. We believe the recent reduction in the rates of reimbursement will weaken the vitality of the behavior health service system and impact negatively on these obligations. As other health insurance companies follow suit, the problem will become proportion to that increase.

II. Medicare and Insurance driven evidence based practice tool.

The current "buzzword" concept in mental health care and treatment is "evidence-based practice". We believe in evidence-based practice, however not in the global generic formats presented as tools by insurance companies. Successful mental health therapeutic services depends on a huge variety of variables. It is impossible for a pre/post "one-size-fits-all" generic evaluation tool to be used for each session or even at termination of services. We have spent several months researching for such tool and have not even come close to finding one. Yet, this is exactly the type of tool insurance companies have been discussing to use both to analyze the quality of the work done by the therapist and to measure client satisfaction. (We have not analyzed at this time the 2014 requirement by Medicare to evaluate services, so we are not ready to fully comment on this requirement. This area of the document will be expanded in the future as we explore this Medicare requirement.)

Misuse of these tools can negatively affect both the assessment of the services and literally how the social worker and client interact in any given session. Both are susceptible to influence by the use of these tools. Inadvertently, therapists may change how they perform their work to meet the standards of the tool. We call this phenomena in the educational field "teaching to the test". Clients may also evaluate the service differently because they know the livelihood of their trusted helper is at stake.

Some of the variables that are of concern pertaining to a true understanding of measuring the effectiveness of the service include:

- **"Teaching to the test" syndrome.**
- Point in which the valuation is determined. For example: Clients often feel worse in the first few sessions as they begin to face the issues that brought him/her to the point of seeking therapy. An evaluating report at this time would appear to be negative.
- **Inaccurate perceptions:** I have known a number of clients with severe depression who were contemplating suicide and then sought help. After several weeks the client feels better and terminates service and states the service really did not help that much. However looking at the client history longitudinally, the same clients repeats this process over and over again because it is an effective coping mechanism. This is one example of how a generic evaluation tool could not pick up on the subtlety. There are many more examples like this with different types of mental health issues. These evaluation tools cannot take into account every variable in the client's and the therapist's that can affect treatment outcomes and, in my opinion, are not an accurate determination of effectiveness.
- **The cost of the implementing even a simple tool is prohibitive for many private practitioners.** Even if the cost is borne by the insurance company, they will not be able to afford to do a comprehensive evaluation tool that is individualized to the specific client and specific therapist. The danger that a generic tool is used for all types of services, methodologies and client/therapist relationships is a very real one because it is driven by cost. There is a reason, in my opinion, a generic tool has not been found to be adequate and safe to use. **Implementation of any tool that is not accurate is likely to result in "unfair restriction of trade litigation" further exhausting limited healthcare dollars**. There is good research looking at very specific modalities used for very specific age groups with the same diagnosis. This research shows that the services were very effective when the right modality is matched with the right type of client in the right diagnosis and the validation tool is designed with care and individuality.

We will be greatly expanding our analysis of this area in the future. In the meantime, used inappropriately, these tools could result limits on service availability based on faulty information, therefore limiting access.

III. Baby Boomer Demand on MH/SA Services and Decreasing Payment Structure by Medicare and Insurance Companies

The increase in demand for mental health and substance abuse services by retirement age individuals is inevitable. The inefficiency of Medicare to provide for adequate coverage for these services could not be more magnified than it will be the next 20 years. To understand why this is so, one needs to look at several factors and variables listed below:

- By 2030, baby boomers will push the retirement age population to a peak of 77 million. Coupled with a decrease in birth rates affecting working age revenues, funding for needed Mental Health services will be further comprised.
- Social Security is a " pay go" system. (Current workers pay for current retirees). In 1950 there were **sixteen workers** to every **one retired individual**. Currently there are **three** workers to **every retired individual** and by 2030 there will be **two workers** to **every retired individual**. Although increased economic productivity is higher due to technology, it is not enough to offset the negative affects caused by the ratio of worker to retired individual decline. This factor will definitely have a negative impact on available funds for healthcare, including mental health services. The remedies so far include reduction of fees paid to healthcare/mental healthcare providers. Drastic reductions that could take

place in the future will definitely impact on both access and quality.

- Rhode Island has a larger number of individuals 65 and older (14.4%) compared to the national average (13%). (2010)
- With lower funding available for healthcare, a disproportionate amount of this decrease will be absorbed by women, minorities, people with disabilities and retirement age individuals. Medicaid, Medicare, housing, healthcare/mental health care, tax revenues, community and institutional based services, leisure, family dynamics, and virtually every aspect of community will be affected by the change in age demographics.
- Social Security continues to be the largest share of income for many older Americans.
- The fastest-growing age demographic in the US is individuals 85 and older. There were 100,000 individuals 85 and older in 1900 and as of 2008 there were 5.7 million.
- The per capital cost of healthcare of individuals over 65 was $11,089 compared to under 65 was $2,793 in 2007. This figure is directly caused by the acquiring of disabilities associated with the onset of age related illness and conditions. By the time we reach the age of 55, 33% of people have a disability and in 20% of these individuals the disability causes a significant difficulty in one or more of major life areas. Whether the disability is a mental health or physical disability, both sometimes require mental health services.
- The United States was ranked 37th in the world according to a world health organization report in 2010 and we continue to decline in the rankings. This ranking is largely associated with the high cost of healthcare and lack of healthcare for minorities, women and people living in poverty.
- According to a study by Fidelity Investments, a 65 year old couple retiring this year with Medicare coverage will need $230,000, on average, to cover medical expenses in retirement.
- Research shows that the expected present value of lifetime uninsured health care costs for a typical married couple age 65 is about $197,000 – including insurance premiums, out-of-pocket costs, and home health costs. This estimate excludes nursing home care which would greatly increase this figure. ("What is the Distribution of Lifetime Health Care Costs from Age 65?". Webb & Zhivan 2010 - Boston College Center for Retirement Research.)
- Unlike former individuals living in past generations who resisted using mental health services. Due to great gains in the destigmatization of mental health issues, the baby boomer generation has used and will continue to use mental health services at a much greater level than previous generations.

IV: Extremely high co-pays and deductibles within the insurance payment structure. ($25 - $65)

Due to the frequency of service need, 12 to 36 plus sessions a year, the personal cost from high co-pays and deductibles charged to the individual, becomes prohibitive for many clients. For example: a client who needed 12 sessions in one year would result in co-pays of $300 - $780 to complete treatment. (This is not counting costs associated with deductibles.) If the client needed 50 sessions for the year the co-pay costs would be $1,250- $3,250. Even though these co-pays may be in the affordable range for some individuals, for moderate to low income individuals, they would be prohibitive and the client would be forced to make decisions between family needs and treatment needs or go without service.

Virtually every aspect of a person's life is affected by the status of mental health. Family, activities of daily living, employment, leisure and community involvement are all critically important to successful living. We believe that prohibitive costs associated with obtaining needed services will result in significant increase of community problems overall and devastation to individuals and family systems.

V: " Specialty practice designation" as opposed to "primary practice designation".

A grievous error was made when the original Medicare designations were designed. Under most insurance plans, a provider is designated either as " primary care" or " specialty care". These designations have had a very negative impact on the affordability of mental health services due to high co-pays. (One only has to look at their insurance card to understand this effect.) Ideally, there should be two primary care categories, one for physicians and one for behavioral healthcare. This would eliminate the problem of differential co-pays and also act to destigmatize behavioral healthcare services. As long as behavioral healthcare is counted as a specialty care service, clients will be negatively affected by the cost for treatment and access limited.

VI: Apparent Trend of Insurance Company Preference for Large Practices Versus Small Private Practice

Although there is no definite commitment expressed by insurance companies to favor large practice centers as opposed to smaller private practices, reading between the lines it would seem to be moving in that direction. If this occurs, it will directly impact on consumer choice and availability, geographic proximity to home and availability. We will continue to monitor this potential.

VII: Potential Side Effect of the Healthcare Affordability Act - Insurance Exchanges and Tiered Insurance Policies

Although creating health insurance exchanges increases transparency and greatly enhances the choices for consumers, which we support, a very negative potential side effect is that exchanges will make it much easier for low-quality, high deductible, high co-pay companies to move into the Rhode Island market. The Massachusetts system has had many successes in expanding coverage, however, a closer look at the insurance options offered, demonstrates the potential for the above process. Rhode Island has almost 30 insurance mandates, including mental health parity (1988), many of which have not traditionally been covered by other insurance companies and some of which will not be covered under the Affordable Healthcare Act services. This potential problem needs close monitoring and advocacy intervention if negative effects result.

VIII: Perceived Mental Health High Utilization

There has been a mantra expressed by some insurance companies about the high utilization of mental health services in Rhode Island. Although we are not privy to the proprietorial studies mentioned by the insurance companies, and therefore do not have a comparison of our state to other states, in some ways it may not matter. We believe, due to a very effective and early mental health parity law and advocacy efforts by the National Association of Social Workers – Rhode Island Chapter; Rhode Island Mental Health Association; the Rhode Island Mental Health Advocates Office; the Rhode Island Council of Community Mental Health Organization and others, great gains have been made destigmatizing mental health services in a higher usage of services. It is our firm belief, if there is higher mental healthcare utilization does indeed exist, we would applaud higher utilization as a healthy part of the Rhode Island community.

IX: Assault on Group Work Modalities

Group therapy, in all its modalities, have proven effectiveness and are very cost effective. Due to very low

reimbursement rates and high co-pays, this option to consumers is almost non-existent in Rhode Island. Benjamin Franklin's saying expresses the applicable operational concept perfectly; "Penny wise, pound foolish."

This section to be developed.