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TASK FORCE ON MENTAL HEALTH AND SUBSTANCE ABUSE
Meeting Summary

NORTH CAROLINA INSTITUTE OF MEDICINE
JANUARY 8, 2016
10:00 am - 3:00 pm

Task Force members in attendance: Mary Edwards, Kenny Burrow, Mike Howard, Tana Hartman Thorn, Dawn Lillard, Adrienne Mims, Jessica Herrmann, Brandy Lineberger, Mary Lynn Piven, Gina Upchurch

Co-Chairs in attendance: Representative Josh Dobson

Steering Committee members in attendance: Jehan Benton-Clark, Eric Christian, Starleen Scott Robbins, Flo Stein, Ellen Schneider

Guests/Speakers in attendance: Maggie Farrington, Jessican Hermann, Paula Hartman-Stein, Paul Nagy, Sabrina Teferi, Brandy Lineberger, Grant Baldwin, Debbie Webster

NCIOM staff in attendance: Adam Zolotor, Berkeley Yorkery, Michelle Ries, Diana Dayal

NOTE: PDF copies of all presentations available online at http://www.nciom.org/events/?task-force-on-mental-health-and-substance-abuse

WHAT DO MEDICARE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS COVER
Sabrina Teferi, JD
Health Insurance Specialist, Medicare Fee for Service Branch Division of Financial Management and Fee for Service Operations Centers for Medicare and Medicaid Services

Ms. Teferi provided an overview of Medicare, from program structure to coverage of Mental Health and Substance Abuse Services. The Medicare program is broken down into Part A (Hospital Insurance), Part B (Medical Insurance), Part C (Medicare Advantage Plans), and Part D (Medicare Prescription Drug Coverage). Medicare Advantage Plans are a combination of Part A and B, and allow for adding on Part D to cover prescription drugs as well. Federal law stipulates Medicare reimbursement for all services, including mental health, and outlines strict guidelines on coverage of preventative services. Eligible Professionals (EPs) must meet certain qualifications and continue to exclude licensed professional counselors (LPCs). Other services discussed included outpatient and inpatient psychiatric hospital services.

Discussion:
- Unclear why Medicare does not pay for Methadone outside of inpatient
- Why are only primary care physicians and nurse practioners included for alcohol misuse screening and counseling billing?

- Concerns that Medicare Advantage programs attract low income patients yet providers do not accept Medicare Advantage for mental health services or have very high copays
- LPC is not listed as eligible professional (EPs) and could only be changed by Congress
- Telemedicine is covered under Medicare but includes stringent requirements

BARRIERS TO UTILIZING MEDICARE MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Paula Hartman-Stein
Clinical Geropsychologist
Medicare correspondent, The National Psychologist
Senior Fellow, Department of Life-Span Development & Gerontology, University of Akron

Dr. Paula Hartman-Stein presented a historical perspective on mental health and substance abuse services offered through Medicare in the last fifty years and addressed barriers to care today. Starting with an overview on OBRA in 1987 through recent integration with psychological service providers. Medicare reimbursement rates were discussed and Dr. Hartman-Stein explained rate determination according to the resource-based relative value scale. The Physician Quality Reporting System (PQRS) is a Medicare initiative to report on quality measures linked to clinical services. For mental health providers, barriers include PQRS, privatization of Medicare, audit anxiety, and lack of training in working in integrated primary care settings. Dr. Hartman-Stein highlighted future integration of mental health in primary care and telehealth as key future directions.

ENGAGING PRIMARY CARE PROVIDERS IN OLDER ADULT MENTAL HEALTH

Adrienne Mims, MD, MPH, FAAFP, AGSF
Vice President, Chief Medical Officer
Alliant Quality

Dr. Adrienne Mims from Alliant Quality QIP introduced her presentation with an overview of quality improvement organizations and current issues in the mental health system. Primary care provides 56% of the mental health treatment for the total American population receiving care. Concerning data from inpatient psychiatric facilities (IPFs) indicates that only half of mental health patients receive 30-day follow-up after hospitalization. As part of a pilot study to improve behavioral health care, Alliant is recruiting primary care practices to integrate mental health screening and care management for 2016 data collection.

Discussion:

- Ideal outcome is integration of a behavioral health specialist in every primary care setting
- Current primary care can effectively only address needs such as strict medication and limited motivational interviewing but face barriers of lack of training on reimbursement
    - Serious and persistent mental health patients face struggles when transitioning from private insurance to Medicare as it is up to physician to decide to accept Medicare plan

    - Other access issues if different Medicare provider between physician and patient
    - Primary care and behavioral health integrated practices exist in NC – Carolina Family Health Centers (Wilson, Edgecombe, Nash), FQHCs, private practices
- PQRS system as barrier for physicians, but recognize importance for Federal government to measure and regulate quality
    - Of those who are Medicare billers, only 50% report via PQRS in 2014
    - Behavioral health providers are not commonly recognized as healthcare professionals and therefore do not necessarily identify with PQRS requirements
    - Need to develop incentives for EMRs for quality metrics for behavioral health
- NC Medicare billing by Palmetto can override policies and has Advisory Council

MENTAL HEALTH FIRST AID

Tara L. Bohley, LMFT, MPA
Clinical Assistant Professor/Program Coordinator
Behavioral Healthcare Resource Program, School of Social Work
University of North Carolina at Chapel Hill

Rachel Johnson
Mental Health Program Coordinator, Justice Section
Division of Mental Health Developmental Disabilities and Substance Abuse Services
North Carolina Department of Health and Human Services

Ms. Bohley and Ms. Johnson presented an overview of the Mental Health First Aid program. The standard 8 hour course helps people identify, understand, and respond to signs of mental illnesses and substance abuse disorders. The program ranges in cost from free to up to a $30 fee, depending on the hosting organization. North Carolina had over 16,000 Mental Health First Aid trainees as of last year. The National Council has set a goal of training 1 million individuals through 2016, with current numbers at around 500,000.

Discussion:

- Expanding into workplace faces challenges for full day training
- Opportunities for cross-promotion like CPR certification is available at Red Cross
- Need for statistics on how often this training is necessary for outcomes
- Conclusion that program is not just specific to older adults but to entire population
    - People who work with older adults will seek out the module once advertised
    - Training could be recommendation as CMS intervention

IMPACT Model Pilot Project: Improving Depression Care for Older Adults

Eric Christian, MAEd, LPC, NCC
Manager of Behavioral Health Integration
Community Care of Western North Carolina

Mr. Mr. Christian presented the Behavioral Health Integration program of Community Care of Western North Carolina. In this program, liability for treatment stays with the primary care provider; scoring is required but up to the provider to discern. Unlike traditional primary care mental health, medication management is not the first line of treatment. Patients are screened for full behavioral health by mental health care manager at every primary care visit but only treated for depression, anxiety, but psychiatrist to address more serious conditions. The goal of the pilot program at the end of 3 years is to demonstrate the cost-offset and value to the population.

Role of LME/MCOs in Meeting the Mental Health and Substance Abuse Needs of Older Adults

Maggie Farrington, MA, LPC
Provider Relations Specialist- Lead
Provider Network Department
Smoky Mountain LME/MCO

Ms. Farrington discussed the current scope of LME/MCOs in mental health and substance abuse treatment for the older adult population in North Carolina. According to the mandate for Comprehensive Care Centers, all LME/MCOs must accept anyone for treatment, though implementation is challenging in some areas. Every LME/MCO is obligated to have someone in network able to see any type of patient; however, Medicare billing does not require that specialists have training for treating older adults. If no eligible provider is available within a certain area, LME/MCO must cover cost with state funds. It is unclear how this translates to accessibility limitations for some patients.