NCIOM North Carolina Institute of Medicine
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TASK FORCE ON MENTAL HEALTH AND SUBSTANCE ABUSE
Meeting Summary

NORTH CAROLINA INSTITUTE OF MEDICINE
AUGUST 14, 2015
10:00 am - 3:00 pm

In attendance: Leigh Atherton, Grant Baldwin, Brandy Bynum, Andrew Cleninden, Patsy Coleman, Eric Christian, Sarah Dowdy, Glenn Fields, Elizabeth Fleming, Brendan Hargett, Brian Harris, Jessica Herrmann, Kathy Hudgins, Trish Hussey, Beth Melcher, Kay Locksman (Eva Meekins), John O'Brian, Marilyn Pearson, Theo Pikoulas, Carol Potter, Michelle Ries, Sy Saaed, John Santopietro, Starleen Scott Robbins, Luke Smith, Flo Stein, Bert Wood, Berkeley Yorkery, Adam Zolotor

CONSUMER PERSPECTIVE: BRANDY BYNUM, Associate Director of Rural Forward, NC Foundation for Advanced Health Programs

Ms. Bynum shared her experiences helping family members navigate North Carolina's behavioral health system in rural North Carolina. Brandy outlined the process that she went through with extended family to help a family member with severe mental health needs access services. She discussed going through all the steps outlined below.

Ms. Bynum's helped the entire group understand better the frustrations and road blocks that families face trying to navigate our mental health system. Additionally her comments highlighted areas for improvement and the need to remember that overall goal is to help improve the system so that it better serves consumers

OPERATING IN A GOOD AND MODERN HEALTHCARE ENVIRONMENT: John O'Brien, Senior Policy Advisor for the Disabled and Elderly Health Programs Group, Centers for Medicare and Medicaid Services

Mr. O'Brien's presentation is available online at http://www.nciom.org/wp-content/uploads/2015/05/MHSA_OBrien_8-14-15.pdf

Mr. O'Brien provided an overview of the SAMHSA/CMS Good and Modern Addictions and Mental Health Service System. The vision is full integration of mental health, primary care, and addiction services—range of high quality services to meet the needs of range of patient circumstances—grounded in the public health model. The results the system should result in include: a benefit package that funds recovery and resilience, improved program standards, common service definitions and performance expectations, flexible funding strategies (blending Medicaid, block grant, and state dollars), adequate number of competent professionals/providers. Principles of the system include MHSA as integral to overall health, must address health disparities, shared decision-making, engagement, evidence-based and evidence-informed strategies are the ones that will be funded, reimbursement strategies aligned with incentives and control costs. Core structures and competencies of system: consumer empowerment, IT, blended and braiding funding, payment structure chances, and quality improvement. The envisioned system covers a continuum of services including: health homes, prevention services, engagement services, outpatient and medication services, community and recovery support services, other recovery support services (HCBS) – esp. with aging population i.e. long term services and supports, intensive support services, out of home residential services, acute intensive services

Some Questions:

- Housing is an area of great concern. There seems to be a disconnect between housing policy and treatment policy?
    - Need good relationships between state housing authorities and governor's office; but even then it is very difficult to do good state-wide work.
    - Can also work with DOJ contract on housing, matching HUD regulations, etc.
- Can waivers be blended to create a unified support package?
    - CMS is willing to work with states on types of supports they are interested in covering under varying authorities

DMHDDSAS GAPS ANALYSIS: Carol Potter, RhD and Patsy Coleman, Quality Management Consultant, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services

Note: This presentation is not available online because it included preliminary data. If you would like to view the presentation, please contact Berkeley Yorkery.

Ms. Potter and Ms. Coleman discussed North Carolina's current public behavioral health service system including services provided, provider capacity, service gaps and community needs. They provided preliminary results of the current gaps analysis they are working on with all eight LME/MCOs. The gaps analysis is part of continuous assessment and evaluation process in order to determine what services are needed and know if funding is going to the right place. There is statutory requirement for state dollars and CMS requirement on Medicaid dollars. For the gaps analysis the LME/MCOS gather input from consumers, family, providers and other stakeholders. Data is used to assess outpatient, location-based, community/mobile, crisis/inpatient, and specialized services. In terms of access to and choice of providers – most people in NC have access to choice of 2 or more providers for outpatient services within 30 or 45 miles (dep. On urban vs. rural criteria). Funding streams and restrictions were discussed and their impact on the types of services available for different populations. Ms. Potter discussed data used to assess the adequacy of the provider network with a focus on distance to providers. Ms. Coleman discussed the array of behavioral health services available through the public system.

Gaps Analysis

Questions and Comments:

- How services are transferred over LME/MCO lines, issues around network adequacy, what is consumer responsibility for addressing issues of accessibility (and engagement and empowerment issues around this responsibility)
    - This varies by type of services/length of services and other considerations, was identified as an area ripe for improvement.
- Where does telepsychiatry fit in?
    - As an outpatient service, due to reimbursement codes
- Difficulty in coordinating primary and specialty care and how to know if DMA or the LME/MCO is the payer for services and who keeps this data.
    - Standard outpatient therapy codes may go to MCO, but not others – confusing for patient managers.
    - Discussed proportion of expenditures by service category
    - LMEs have different approaches to how they use services and in what ratios
- Too much money in inpatient bucket – this needs to be shifted to other types of services
- Many individuals have now bought private coverage (would have been covered with Medicaid expansion), but end up not being able to afford services
- Child SA expenditures are low – why? Does this overlap with MH spending? Confused issue around multiple diagnoses?
    - This has been a chronic issue. There is a reluctance to diagnose with SAD – MH diagnosis leads to IEP, etc., but SAD diagnosis not eligible for these types of services.

Discussion of Potential Recommendations

Participants noted ideas/topics on post-its, then put post-its on white board, grouped by theme:

I. Distance / Telehealth (Tele-psychiatry)
   a. Distance is a big factor
   b. Approved clinical sites – currently schools are not included but should be
   c. Clarification for providers regarding technology & requirements for HIPAA
   d. Increased use of tele- counseling / medicine to improve distance to provider

II. Housing
   a. Recovery housing access
   b. Housing options to support service provision

III. Integrate Care Billing
   a. Lack of formal education and training of licensed mental health professionals in integrated behavioral health care & health psychology in primary / specialty care
   b. Sustainability of primary care Integration Services
   c. Building in better primary care training
   d. Addition of SA rates & penetration of services
   e. Clarification of billing for integrated care clinicians
   f. Complicated billing flows for integrated settings
   g. Pathways between HCBS & PC
   h. Collaborative (data-driven) geo-mapping and care coordination between health care providers (hospitals, EMS, FQHC, Health dept., DSS)
   i. Could clinical pharmacists help fill the gaps where patients can't access services?
   j. More conversion of PCPs
   k. Billing for BH in primary setting (i.e. SBIRT)

IV. Services
   a. Increased access to medication assisted treatment
   b. Increased access to recovery supports
   c. Mobile Crisis
   d. Outpatient services provided in the home
   e. Non-intensive home care for youth
   f. Flexibility of reimbursement for services
   g. Providers moving towards increased utilization of outpatient services through MCO monitoring

V. Special Population

   a. Uncovered population services not eligible for public benefits who are uninsured (i.e. undocumented Latinos)

VI. Timeliness / Open Access
   a. Timeliness of care standards across payers
   b. Timely access is not a reality and does not capture patient readiness due to long waits
   c. Same day access to services (waitlist service)

VII. Too Much Spending on Inpatient
   a. Think of new or enhances strategies to reduce input costs
   b. Why are we spending so much on inpatient services? Why are our EDs having such a long wait for people who need admission and there is no bed availability
   c. Reduced inpatient beds at state hospitals has pushed up activity at community hospitals and EDs. Reduce overall access for the range patients who need hospitalization.
   d. Consider alternative vs. inpatient

VIII. Transitions
   a. How to connect individuals through various levels of care without losing them?
   b. IDD and mental health coordination treatment and placement
   c. Coordination of services across MCO areas
   d. Transitional care services (i.e. case management)
   e. Improve hospital –to-community transition. The process is often too lengthy and costly.
   f. Some of the “supports” service category should be required for all LME/MCOs to offer (i.e transitional care or inpatient follow up)

IX. Workforce
   a. Creating a homegrown workforce, especially in rural counties where there are limited clinicians. (solution: encouraging existing direct line staff to pursue advanced degrees)
   b. Need more robust workforce development, including re-training
   c. Livable / adequate wages for direct care workers

The group then spent some time discussing some of the issues around distance and telehealth:

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- Relationship to quality measures

- Consumer perceptions of if it's okay are related to effectiveness of treatment – willing to travel far if the services are considered worth it; also related to frequency of services
- Issues of people with SUD who cannot drive
- How to support providers in these areas? Not reasonable to expect providers where the patient load will not support them. So must get creative about telemedicine and other IT applications. Get services to people rather than people to services.
- Sandhills– services limited to telepsychiatry and some remote screening
- What are access points for receipt of telehealth services? Phone apps, so anywhere. Linking people to care through iPad apps.
- What is current thinking around the acceptability of these kinds of services, esp. for special populations? People are open to it – LMEs can write it into contracts. Open access helps, but in combo with planned appointments (some people bumped if they aren't as acute, etc.).
- This is immensely complex when we are talking about access from home, apps, etc. – variation with severity of illness, etc. – very different with a diabetic patient vs. a depressed and suicidal patient. HIPAA compliance – what are issues and solutions?
- There are many apps that can bridge people between appointments – wellness, etc.

The issues around telebehavioral health will be discussed in more depth at our September 18th meeting. We will be discussing issues related to integrated care at our October 16th meeting and workforce issues at our final cross-cutting working group meeting on November 6th.

PRIVATE INSURANCE ADEQUACY OF NETWORK ASSESSMENT: Joel Kostin, PhD, Magellan Healthcare

Dr. Kostin's presentation is available online at http://www.nciom.org/wp-content/uploads/2015/05/MHSA_Kostin_8-14-15.pdf

Dr. Kostin presented information on how Magellan Healthcare, which is the behavioral health care provider for Blue Cross Blue Shield of North Carolina, determines the adequacy of its behavioral health care network for the commercially insured population. He also discussed the types of services covered and which types of health professionals are reimbursed for covered services.

Dr. Kostin highlighted some of the differences between the public and private systems, including:

- Under private insurance, home and community based services are generally not covered, and home-based services not covered unless patient is confirmed as homebound
- Regulations for mental health parity have removed some barriers, and there is a greater range of services available through the private sector. Most companies have gone to integrated deductibles, which is often a barrier to coverage. Some (esp. newly insured) people can afford premiums, but not copays or deductibles.
- Telehealth is a new benefit under their plans. In the past, only with attending physician consulting with a peer physician remotely.

Some Questions and comments:

- Use of HIT and ability to apply predictive modelling to large datasets allows identification of at-risk members and targeted outreach
- Are commercial payers providing MI?
    - Yes – trained for past 10 years in this.
- Is there any analysis of ER usage by patients with MH/SA disorders? Any initiatives to promote awareness of other services?
    - BCBS plans an outreach campaign about additional resources
- Is this partial parity?
    - Because additional barriers (ie copays, etc.) – parity has to be more all-encompassing.

ACCESSING SERVICES PRESENTATIONS

PATIENT ACCESS TO BEHAVIORAL HEALTH SERVICES: A CCNC PERSPECTIVE: Theo Pikoulas, PharmD, BCPP, Associate Director of Behavioral, Health Pharmacy Programs, Community Care of North Carolina

Dr. Pikoulas' presentation is available online at http://www.nciom.org/wp-content/uploads/2015/05/MHSA_Pikoulas_8-14-15.pdf

Dr. Pikoulas presented information on where patients with behavioral health concerns who are in the public system receive care. He presented information on how patients with behavioral health needs who access services through their primary care provider are referred for treatment within the LME/MCO system. He provided information on how this system is working well and where there are challenges. Some of the positives of the referral process include: patients report timely access, providers chosen based on proximity to patient's address, some LME/MCOs have expanded care coordination criteria, and the monthly meetings between CCNC network and LME/MCOs to address problems. Some of the challenges highlighted include: long process for call line (30+ minutes), inconsistency in follow up, wait time for appointments can vary widely, communication problems (esp. with SA patients), inconsistency in provider choice by address.

Dr. Pikoulas also highlighted some areas for improvement including the relatively low number of behavioral health providers who take Medicaid, the need for more work around care transitions, and the opportunities presented by the Community Pharmacy Enhanced Services Network (CPESN), an open network of pharmacies (200+) who are providing expanded pharmacy services – to increase access, overcome barriers to receiving medications.

ALLIANCE BEHAVIORAL HEALTHCARE ACCESS TO CARE: Beth Melcher, PhD, Chief of Program Development and Evaluation. Alliance Behavioral Health Care

Dr. Melcher's presentation is available online at http://www.nciom.org/wp-content/uploads/2015/05/MHSA_Melcher_8-14-15.pdf

Dr. Melcher presented information on how eligible patients access behavioral health services through the LME/MCO system. The LME/MCOs have call lines that provide 24/7/365 telephonic crisis and access

to care services for Medicaid patients and others eligible for care through the public system. The LME/MCO is responsible for customer service – screening, entry, referral – access to care. After the intial screening to determine severity of need and eligibility, Medicaid recipients and uninsured members can be scheduled for an initial appointment for a full clinical assessment by a network provider of choice within 2 hours if emergent, 2 days if urgent, or within 2 weeks if routine. LME/MCOs also provide post crisis planning, appointment follow-up, and some enhanced services, including transition assistance and care coordination for some populations.

Dr. Melcher also highlights some current initiatives to increase access including Open Access, integrated healthcare teams, co-location, and public awareness marketing campaigns to reduce stigma, outreach to kids, and brand awareness to drive people to website.

Some questions and comments:

- Do we need to reprioritize services? Are we funding some services because access is easier even though that might not be the best mix of services?
    - In home services have to achieve approval based on achieved outcomes – must meet fidelity to a specific model
- Can money shift to other form of workers who can provide in home services?
    - Cost shift in care of MH and SA patients from private to public sector. Prior to ACA, 80% was paid by public sector. Strategies were developed around this, and now private sector is learning about how to expand services. Parity is in litigation – residential care, for example – if covered by health insurance, it also must be covered for behavioral health care
- Everyone is trying to move to pay for performance, but we need to measure outcomes
- Shared risk pilots with providers – pay on monthly basis, must reach outcomes. MCOs have authority to do this kind of pilot project. How to evaluate these pilots so they can be brought to scale?

DISCUSSION OF POTENTIAL RECOMMENDATIONS

I. Array of Services
    a. ACFS – community/home based systems of care inclusion within private sector
    b. Consistent across the state & inclusion of long term recovery supports
    c. Evidence based services funding
    d. Array of services in not always sufficient to avoid hospitalizations ; Need ACTT Plus
    e. Crisis
        i. Increased mobile crisis and crisis respite for child / adolescent consumers
        ii. Funding assistance for more FBCS
        iii. Crisis and inpatient services (there is a lack of facilities)

II. Challenges Accessing Services
   a. No good step down from intensive in-home back to outpatient
   b. Effectiveness of telephonic case management
   c. Costs associated with tele-health (i.e hardware, internet service providers) that limits patient's ability to access such services
   d. Need standardized interpretation of 42 CFR. Many screening intake staff are over – interpreting and not sharing information they should be sharing
   e. STAX – need more and front-end release of information
   f. Ways to better coordinate with commercial insurance & MCO regarding enhanced services
   g. High deductibles & copays for accessing services
   h. Private insurers should examine the public-side access lines
   i. Knowing what is available & where; educating & communicating new family members & individuals served
   j. Access for dually eligible and Medicare is limited due to federal Medicare issues where LPLs and LMFTs cannot service those patients
   k. Billing
      i. Elimination of Y-code billing by substance abuse professionals has further decreased access – what can be done?
      ii. Consumer choice is no longer a reality under MCO regulations. Provider network consolidation models eliminate choice

III. Choice of Providers / Limited Network Availability
   a. Need statewide coalition of all of the entities involved in recruitment and retention
   b. Getting a system in place where communities of individuals with experience can rate & comment on providers (i.e Yelp)
   c. No choice available if network is over consolidated
   d. Access for dually eligible and Medicare is limited due to federal Medicare issues where LPLs and LMFTs cannot service those patients

IV. Consumer Engagement

a. Community education on alternatives to ED's for BH cases
b. Consumer / family empowerment ; model / plan (i.e. employing family navigators)
c. Connect / educate and engage people to advocate for the care they need