NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

MARCH 2017

IN THIS ISSUE

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Surgeon General's Report: Facing Addiction in America

Stephen Wyatt, D.O., Addictions Committee Chair

On November 17, 2016, Surgeon General Vivek Murthy, M.D. released for the first time a Surgeon General's report identifying the significant impact alcohol and other drug use has on the health of the nation.

This report (http://bit.do/SGR2016) establishes these diseases as a primary driver of trauma and illness in our society and the importance of addressing them consistently and without prejudice.

As a practicing physician for thirty-five years and specializing in addiction psychiatry the past quarter century, I have had a firsthand view of the often devastating effects substance use problems have on the patient, their families, and society. I have also had the honor to work with many patients and watch the phenomenal transformation that can take place when the disease is addressed appropriately and in a timely fashion.

The currency of this report was made more important as we watch the devastating impact of opioid overdoses and more recently heroin addiction. Too often this disease has taken our young people in the prime of their lives.

At Carolinas HealthCare System, we have established multiple initiatives to better address this within our patient population and the community, but there is much more to do. It is also important to recognize that beyond opioids, tobacco, alcohol and other drug addictions affect an even larger population with equally as devastating consequences.

Psychiatrists have an opportunity to be a beacon for Dr. Murthy's initiative. As stated in the report, substance use problems are the least well understood and treated diseases with the greatest impact on healthcare in the nation. I encourage all NCPA members to look at the report and find ways in which they can have a positive impact by addressing these problems in their own areas of medicine.

By coming together on this, we can pave the way in more appropriately addressing these problems. This will improve the health of our patients and further our position as a leader in healthcare delivery in the nation.

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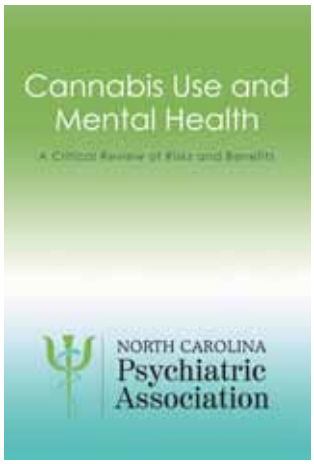

From the Editor

Drew Bridges, M.D., D.F.A.P.A

My reading selection for this issue is *My Lobotomy: A Memoir* by Howard Dully and Charles Flemming. This memoir tells the story of how lobotomies were used for a short period in the mid 20th century.

Twelve year old Howard Dully was taken by his stepmother to Dr. Walter Freeman, pioneer of the infamous "ice pick" lobotomy procedure. The boy was described as "moody, messy and rambunctious" and uncontrollable by his parents. The child was given the lobotomy with no explanation to him of what was to occur. The procedure helped send him on a downward spiral that included mental institutions, jail, and alcoholism.

Unlike most recipients of lobotomies of this era, Mr. Dully's story is one of redemption. In his forties he reclaimed his life. With help from Mr. Flemming he tells not only his own story but that of others who were treated in this manner. He confronted, without malice, his still living father about the ordeal.

I make this book recommendation cognizant of the passing of ***Granville Tolley***. Some of the readers of this column may remember the reading group he organized for residents and other students in the late '70s. He partnered with a professor of English Literature from the UNC English Department. We read mostly fiction and some memoir. He taught us that in addition to our formal training and relationships with our teachers, information and wisdom can come through being well-read.

NORTH CAROLINA Psychiatric Association news

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Big Health Care Systems, Big Business and Physician Values

The "Biggering" of Health Care

Tom Penders, M.D., D.L.F.A.P.A., President

This message will be the last of my term as your president of the NCPA. In prior communications I have proudly praised the effectiveness of our Society in implementing our mission -- to promote the highest quality care for North Carolina residents with mental illness, including substance use disorders; advance and represent the profession of psychiatry and medicine in North Carolina; and to serve the professional needs of its membership. The many efforts I have featured are the primary reason I have been honored to serve in the leadership capacity to which you have entrusted me.

> *"Increasingly physician decision-making is being biased by these corporate values. Increasingly those who voice concerns about corporate priorities are being excluded from participation, leaving many physicians shy about speaking out for fear of retribution."*

My final message will attempt to underline some trends in general health care and in mental health care that are increasingly, in my opinion, alarming. My goal here is to raise questions I believe should be addressed in the near future by NCPA and others that are dramatically eroding the position of all physicians, including psychiatrists, in their traditional roles as assurers of competency, quality and patient-focus.

During the past decade we have witnessed a crescendo of mergers of hospitals and physician practices into large systems of care. Today one quarter of physician practices are hospital owned. To paraphrase Dr. Seuss, provider organizations have been busy biggering and biggering. In 2010, there were 77 mergers of hospitals, 88 in 2011. Between 2012 and 2014, these numbers more than doubled. Additionally, healthcare executives anticipate greater consolidation into fewer numbers of larger systems. Coincidently, increasing numbers of physicians have become dependent on their participation with these organizations as they pursue their daily activities of caring for the needs of their patients

As of 2016, a majority of American physicians are employed, and a much greater proportion do not own their practices (independent contractor status). Since younger physicians are more likely to be employed, the trend toward physician dependence on large systems will certainly increase.

Interestingly, opinion surveys of physicians who are working under such arrangements report that there has been no improvement in the quality of services that they are able to offer their patients. Many respond by reporting a decline in their ability to pursue their core value of patient care. A dizzying array of new reporting requirements and regulations has served, for many physicians, as distractions from patient care. The perception

that a focus by big healthcare is increasingly that of improving the profitability of these systems is one of the most important causes of the well-documented epidemic of physician burnout.

North Carolina psychiatric physicians are, perhaps, more prone to these processes as provider mergers of both hospitals and payment agencies (LMEs) have progressed over the last five years. In the public mental health system, not only have the payors merged, but there has also been pressure for regionalization of the provider community and for service delivery agencies to merge and consolidate. Agencies that once had seasoned, full-time medical and clinical directors, along with psychiatrists and other mental health clinicians providing care, now stretch that medical leadership over vast regions of the state, if they have chief medical officers at all.

The NC Department of Health and

Continued on page 13...

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Changing Landscapes: Observations and Insights from Capitol Hill

Laura Willing, M.D., APA Jeanne Spurlock Congressional Fellow and recent graduate of UNC

The first six months of my fellowship have been a whirlwind of activity, new experiences, exciting accomplishment, and frustrating partisan process.

Prior to beginning this fellowship, I interviewed with several senators and senate committees working on mental health care specifically and health care in general. I was most excited by Senator Chris Murphy's (D-CT) commitment to leading the charge for the Mental Health Reform Act in the Senate.

Once I began working in his office, I continued to be impressed by the Senator and staff's commitment to improving mental health care access, coverage, and parity for all of our citizens. Much of my time in the early months was devoted to mental health reform. I worked with the health team to meet with stakeholder groups, hold forums and town hall discussions with patients, and navigate the slippery path towards passing a law.

There were certainly times when it did not seem likely that the Mental Health Reform Act would be passed in 2016. However, once the 21st Century Cures Act was identified as a vehicle for passing mental health reform, things moved quickly. Two different versions of mental health reform, one from the House and one from the Senate, needed to be reconciled. This meant negotiations between Republicans and Democrats in both the House and the Senate.

There were a lot of competing priorities at the table, and I was glad to be able to share my clinical experiences when advocating for certain programs and funding of new grants. It was very helpful to have first-hand knowledge of ED boarding, difficulties with adequate provider networks, integrated care models, and the need for early intervention.

When President Obama signed the 21st Century Cures Act into law on December 31st, there was a genuine feeling of joy and accomplishment throughout the office. This law, in addition to providing $1 billion to states to combat the opioid epidemic, included many provisions that are so important to our profession and to our patients. Among other things, the Helping Families in Mental Health Crisis Reform Act of 2016 will authorize grants for integrated care models, strengthen parity laws, establish new programs for prevention and early intervention for infants and children, create a new Telehealth Child Psychiatry Access Program, authorize programs targeting first-episode psychosis, and prioritize increasing the mental health workforce.

Then the landscape on Capitol Hill began to change. The election results in November were a surprise for many in Washington, D.C. Starting after the election, and intensifying in 2017, there was a palpable shift in tone and energy felt throughout Capitol Hill, and indeed across the country. Previously, when I daydreamed about what I could work on after Mental Health Reform passed, I envisioned bills related to mental health parity, developmental disabilities, and strengthening mental health provisions in the Children's Health Insurance Program (CHIP).

So far in 2017, the Senate has spent most of its energy related to healthcare on repealing the ACA, debating whether or not a replacement is needed first, considering Tom Price's nomination for Secretary of Health and Human Services, and discussing block granting Medicaid. While this is not necessarily what I expected to be the focus of my time on the Hill, I am honored to have the ability to work hard and fight for my patients' rights and needs. I am attending hearings and briefings on the ACA and Medicaid, writing research memos, listening to constituent's stories and experiences, and promoting continued access and coverage for mental health care in the future. I have a close-up view of a new chapter in our democracy, and I am thankful for the chance to be engaged in the process.

Editors Note: Dr. Willing is a child psychiatrist and a former resident member of the NCPA Executive Council. She proposed and developed an advocacy elective with NCPA during her final year of residency, where she organized White Coat Wednesdays, served as Doctor of the Day at the General Assembly and actively engaged in advocacy work for the profession here in NC. She was awarded the APA Spurlock Congressional Fellowship that has her working for a congressman this year in DC.

The Opioid Death Epidemic: One Man's View

David Smith, M.D., NC Psychoanalytic Society Representative

It has been 100 years since drugs were banned in the United States and Britain and yet today we not only have an epidemic of opioid use, heroin use, and opioid addiction, we have an epidemic of overdose by opioids. This is a terribly serious problem, and we have to do something about it. Nationally in the USA, approximately 125 people die each day from drug overdoses. Approximately 78 of them are from their heroin and painkillers.[1]

One of the first things to do as a scientist approaching a problem is to try to understand the causal factors. In the early 20th century experiments were done with rats in cages. A rat was placed in a cage and given a choice to drink a cocaine water, alcohol infused water, or pure water. You know the outcome of these experiments. The rat chose to drink the alcohol or cocaine mixture and literally drank itself to death. This experiment established accepted theory with regard to substance abuse. Given a choice rats, and by extension human beings, will choose to ingest drugs to their death.

However, in the 1970s, Dr. Bruce Alexander, Ph.D., now Prof. Emeritus at Simon Fraser University, thought through these early experiments and decided that he would recreate the experiments with changes that were in accordance with what we know about rats. He added other rats, toys, tunnels, cheese, and other items to the cages that the typical rat would be involved with. He discovered that not a single rat died of an addiction. He came to the realization that it was the cage more than the availability of the drug that determined the addiction. There have been several attempts to discredit Dr. Alexander's work but attempts to recreate the work found his concepts held up.

During the Vietnam War it was estimated that approximately 20% of American soldiers were using heroin. The archives of General Psychiatry brought this impending drug epidemic to our attention as the troops returned to America. However, there was no epidemic. In fact, only 5% of the 20% of troops maintained their opioid use after they returned. They became involved with their families, their jobs, and friends, and only a small percentage required attention from the criminal justice system or the services of mental health professionals.

In the year 2000, Portugal had arguably the worst drug problem in Europe. Approximately 1% of its population was addicted to heroin. Drugs users were incarcerated. Politicians of several parties came together and decided to investigate this. Scientists and researchers brought the recommendation to decriminalize all drugs and, most importantly, use the money that would have been spent on incarceration for treatment and to reconnect these individuals to society by providing jobs and micro-loans. This led to a 50% reduction in addiction.

Dr. Peter Cohen in the Netherlands conducted a study of addiction and determined that "bonding" was the most determinative factor in protecting against addiction. He argued that having work, being involved with other people that you love, and having meaningful connections in life was highly protective against the use of opioids. Bonding with the society and avoiding isolation was key. Again, it seems that the "Cage" (the social cage) is one of the most determinative predictors of addiction.

The New York Times reported "while crack cocaine addiction was centered in cities, opioid and meth addiction are ravaging small communities like those in Dearborn County, Indiana, where 97% of the population is white." Large parts of rural and suburban America, overwhelmed by the heroin epidemic and concerned about the safety of diverting people from prison, have moved in the opposite direction from what Dr. Cohen, Dr. Alexander, and the country of Portugal recommends. Prison admissions in these counties with fewer than 100,000 people have risen and politically conservative counties have continued to send more drug offenders to prison reflecting the changing geography of addiction.[1]

Aaron Negangard, the elected prosecutor in Dearborn County Indiana said last year "I am proud of the fact that we send more people to jail than other counties. That's how we keep it safe here." This small county sent more people to prison than San Francisco and Durham, NC combined.[1]

However, other areas of the country are approaching these problems in a different fashion. "In one of the most striking shifts in this new era, some local police departments have stopped punishing many heroin users. In Gloucester, Massachusetts, those who walk into the police station and ask for help, even if they are carrying the drugs or needles, are no longer arrested. Instead, they are diverted to treatment, despite questions about the police departments' unilateral authority to do so. It is an approach being replicated by three dozen other police departments around the country."[1]

My message is that it's the "cage" that people live in that is the predominant causative agent in addiction. It's not that doctors are inappropriately prescribing narcotic

Continued on page 14...

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MACRA FAQ's

Jennie Byrne, Practice Transformation Committee Co-Chair

Here are some Frequently Asked Questions that NCPA has been receiving regarding MACRA and payment reform. The APA has great information on its website, so we have tried to answer these questions briefly and then provide the website link that will give you more information.

Q: What is MACRA?

A: MACRA stands for "Medicare Access and CHIP Reauthorization Act." It is the next step in the transformation of health care reimbursement under Medicare. The first MACRA final rule and regulations were published in the November 4, 2016 Federal Register. For more information on the final rule, watch the APA webinar entitled "MACRA Final Policy Overview" (http://bit.ly/2leO4fP).

Q: Do I have to participate in MACRA?

A: Many psychiatrists will be exempt from participation in MACRA if they fall below a "low-volume threshold"; it is estimated that for 2017 reporting about one-half of all psychiatrists will be exempt. CMS has defined the threshold if the psychiatrist or group practice had:

1. Medicare Part B charges less than or equal to $30,000
2. Provided care for 100 or fewer Part B enrolled Medicare patients

For the 2017 reporting year, the low-volume threshold periods are either September 2015 through August 2016 or September 2016 through August 2017. To figure out whether or not you are exempt, please refer to the CMS website: https://qpp.cms.gov/

Q: How do I get started in MACRA?

A: We strongly recommend that you go to the APA website and review the MACRA 101 primer (http://bit.ly/2m52DRh).

Q: Do I have to have an EHR?

A: Most likely the answer is YES. Watch the APA webinar entitled "MIPS Advancing Care Information Category" (http://bit.ly/2lE48sf). Also refer to the CMS website tool for Advancing Care Information: https://qpp.cms.gov/measures/aci

Q: What is the timeline? What do I need to do first? By when? What next?

A: This is best summarized in a graphic from CMS:

Performance:
The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can join and provide care during the year through that model.

Send in performance data:
To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment by significantly participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback:
Medicare gives you feedback about your performance after you send your data.

Payment:
You may earn a positive MIPS payment adjustment for 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you may earn a 5% incentive payment in 2019.

https://qpp.cms.gov/

Q: Are there good reasons for me to participate in MACRA?

A: YES – there will be monetary consequences to you and your practice if you do a good job of participating in MACRA. If you are exempt from MACRA but are in-network with private insurance, it might also help you to participate in MACRA. We anticipate that private insurance will soon follow suit with the MACRA guidelines for outcome reporting. To better understand why quality reporting should be important to you as a psychiatrist, watch the APA webinar (http://bit.ly/2lDZ6vT) entitled "Quality Reporting 101: A How-To Guide for Psychiatrists"

Q: What measures are other psychiatrists using?

A: Since MACRA is so new, there are no standards for measurements yet. However, you can get some great ideas from the APA webinar entitled "MIPS Quality Category" (http://bit.ly/2m4Onbi). Also refer to the CMS website tool for Quality Measures and Improvement Activities:

https://qpp.cms.gov/measures/quality

https://qpp.cms.gov/measures/ia

Q: How are other psychiatrists incorporating this into their practices?

A: Again, since MACRA is so new we don't have data yet. If you are interested in learning with your peers, we have two suggestions.

1. Consider being part of the APA Mental Health Registry pilot project that helps your practice report and understand data gathered from your patients. For more information, please visit: https://www.psychiatry.org/psychiatrists/registry
2. Consider joining the NCPA Practice Transformation Committee. We will be actively working on ways to guide members as we move into this next step of health care reform. Contact kkranze@ncpsychiatry.org for more information.

Q: How much time will it take?

A: This will be highly variable depending on the sophistication of your practice, your electronic medical record, and your administrative staff support.

Q: How do I make this of value to my patients?

A: Get involved now! Although it can seem confusing and overwhelming, there are many choices within the MACRA program to make it fit your needs and your patients. The NCPA and the APA are here to help so if you have specific questions please contact us.

APA Mental Health Registry: PsychPRO

In early 2016, the APA Board of Trustees approved the development and implementation of a mental health clinical data registry *PsychPRO*. The registry is designed to collect data that will help psychiatrists make decisions related to patient care and will help members avoid administrative burdens. The mental health registry will:

- Help psychiatrists avoid payment penalties and instead achieve bonuses for meeting CMS quality reporting requirements.
- Reduce the burden of submitting Performance-in-Practice data and obtaining ABPN MOC Part IV credit to maintain board certification and hospital credentialing.
- Provide a national research database with aggregate de-identified data to develop new quality measures that capture the value of psychiatric care, develop new diagnostics and therapeutics, identify gaps in care and inform APA educational programs, and assist in updating DSM-5 and support advocacy initiatives.

PsychPRO is still in the developmental stages with the help of beta testers, including NCPA's own ***Dr. Stephen Buie***. If you are interested in participating in the registry, we encourage you to email registry@psych.org to be added to the queue. Once the registry has been launched the APA will begin to train additional members to participate. Currently, psychiatrists need to be using an EHR to participate in the registry. The registry has been designed to be fully integrated with your EHR software; after the initial three week installation process the registry will automatically pull and de-identify data.

For more on the development and benefits of APA's registry, read the Psych News story: http://bit.ly/2m1mjJh or view the FAQs: https://psychiatry.org/psychiatrists/registry/faq

What Psychiatrists Need to Know About . . . Enforcing Mental Health Parity

From the APA Legal Department

The future of the Affordable Care Act (ACA) is unknown, and many members are concerned about the impact of possible ACA repeal on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA is a separate statute that applies to large group employer plans of 50 of more employees, Medicaid managed care arrangements and nonfederal government plans that do not opt out. The ACA expanded MHPAEA to include almost all insurance products on the market. Patients need our help in dealing with possible parity issues and ensuring access to care. The following are ways you can help:

Work with your patients to recognize potential parity violations and complain when they experience one.

A. Preauthorization, including blanket preauthorization requirements for all mental health or substance use disorder (MH/SUD) services, treatment facility preauthorization requirements not applied to medical/surgical services, or more stringent medical necessity review or prescription drug preauthorization requirements than those applied to medical/surgical services;

B. Fail-first protocols, requiring an individual to fail to achieve progress with a less intensive form of treatment before a more intensive form is covered;

C. Probability of improvement requirements, for example, offering coverage of continuing treatment only if improvement is demonstrated or probable;

D. Written treatment plans, requiring treatment plans completed by specified professionals, within a certain time, or on a regular basis where similar requirements are not applied equally to medical/surgical coverage;

E. Other limits or exclusions, including:

- Excluding chemical dependency services in event of noncompliance,
- Excluding coverage for residential treatment,
- Geographical limitations on MH/SUD services not imposed on medical and surgical services, or
- Facility licensure requirements not imposed on medical/surgical facilities.

It can be difficult to demonstrate an actual parity violation, but there is no need for you to do the legal analysis. You should report any suspected violations to the enforcement authorities (https://www.hhs.gov/mental-health-and-addiction-insurance-help).

Complain when your patients experience parity violations.

One of the most common things the APA has heard from regulatory authorities is that violations cannot exist because no one is complaining! Twenty states (including North Carolina) have been granted money by the federal government to enforce parity in the state. Regulators need to hear from you to know where to look for problems. You must not be silent.

If you or your patients experience one of the issues above, go to this consumer portal, and complain. https://www.hhs.gov/mental-health-and-addiction-insurance-help

Help your patients ask for documents from their insurance plan when their care is denied.

The Substance Abuse and Mental Health Services Administration (SAMSHA) has recently issued a new consumer rights publication that specifies what documents patients are entitled to get from their plans when their MH/SUD care is denied.

SAMSHA has made it clear that the patient is entitled to information both on the MH/SUD side of the plan and from the medical/surgical side of the plan to determine if MH/SUD is treated differently. These documents include: the plan's medical necessity criteria, utilization review standards, and its analyses performed to verify whether the plan complies with MHPAEA.

We suspect that many plans do not actually do the required analysis under MHPAEA and therefore cannot comply. SAMHSA's Consumer Rights publication provides a wealth of information and patients need to take advantage of it. To view SAMHSA's publication visit: http://bit.ly/2m1vQQi

If you need assistance once a document request is made or if the documents are not produced, please contact Maureen Bailey at mbailey@psych.org.

Do not substitute a consumer complaint to enforcement authorities for an appeal.

Patients have only a limited amount of time to appeal a denial of a claim. ***Filing a complaint with a regulatory agency is not a substitute for an appeal***. Please help your patient appeal denials and be sure to include in the appeal that the action may violate MHPAEA. Also include a request for the documents in the SAMSHA publication above.

Many denials are reversed on appeal, particularly when the appeal advances to the external stage and an independent third party. Don't give up: when the patient's claim is not appealed, the plan wins.

Post the APA's parity rights poster in your office.

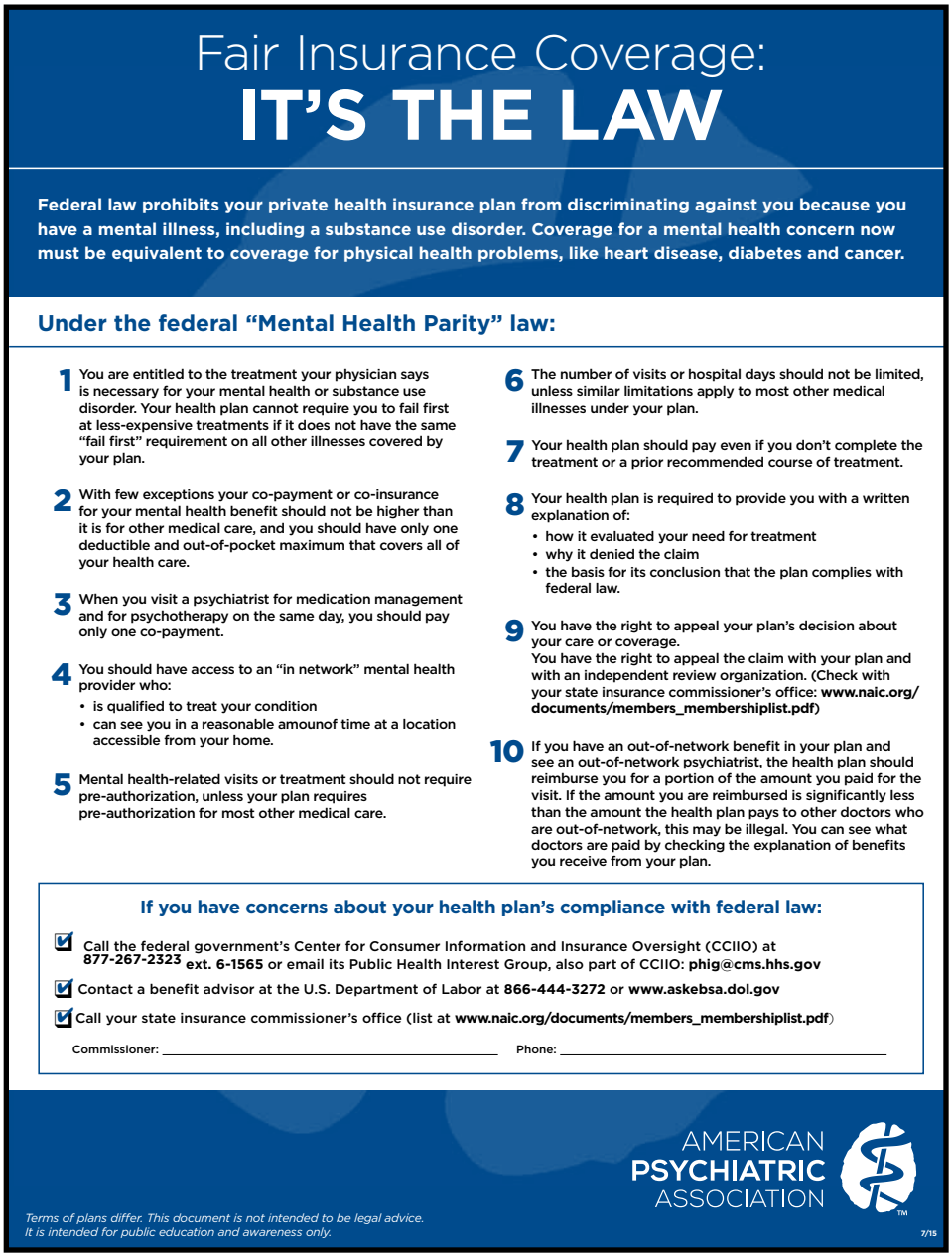
This poster clearly explains the parity law and the steps to take when a violation is suspected. The poster can be found here:

https://psychiatry.org/File%20Library/Psychiatrists/Practice/Parity/Parity-Poster.pdf

Tell the NCPA and the APA about your experiences.

APA is in regular contact with state and federal authorities tasked with enforcing the parity laws and they need feedback about patients' experiences getting MH/SUD care which may implicate the parity laws. If APA is able to collect sufficient data, APA can better relay to the authorities what is working and not working with parity enforcement.

For patients, parity means reasonable access to care. For psychiatrists, it means the ability to practice medicine without unnecessary interference so that you can spend your time in patient care rather than intentional hurdles to block care. Psychiatrists have made substantial gains in making parity a reality, but it requires vigilance and your participation. Keep up the good work!



Fair Insurance Coverage:
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Federal law prohibits your private health insurance plan from discriminating against you because you have a mental illness, including a substance use disorder. Coverage for a mental health concern now must be equivalent to coverage for physical health problems, like heart disease, diabetes and cancer.

Under the federal "Mental Health Parity" law:

1. You are entitled to the treatment your physician says is necessary for your mental health or substance use disorder. Your health plan cannot require you to fail first at less-expensive treatments if it does not have the same "fail first" requirement on all other illnesses covered by your plan.
2. With few exceptions your co-payment or co-insurance for your mental health benefit should not be higher than it is for other medical care, and you should have only one deductible and out-of-pocket maximum that covers all of your health care.
3. When you visit a psychiatrist for medication management and for psychotherapy on the same day, you should pay only one co-payment.
4. You should have access to an "in network" mental health provider who:
   - is qualified to treat your condition
   - can see you in a reasonable amounof time at a location accessible from your home.
5. Mental health-related visits or treatment should not require pre-authorization, unless your plan requires pre-authorization for most other medical care.
6. The number of visits or hospital days should not be limited, unless similar limitations apply to most other medical illnesses under your plan.
7. Your health plan should pay even if you don't complete the treatment or a prior recommended course of treatment.
8. Your health plan is required to provide you with a written explanation of:
   - how it evaluated your need for treatment
   - why it denied the claim
   - the basis for its conclusion that the plan complies with federal law.
9. You have the right to appeal your plan's decision about your care or coverage.
   You have the right to appeal the claim with your plan and with an independent review organization. (Check with your state insurance commissioner's office: **www.naic.org/documents/members_membershiplist.pdf**)
10. If you have an out-of-network benefit in your plan and see an out-of-network psychiatrist, the health plan should reimburse you for a portion of the amount you paid for the visit. If the amount you are reimbursed is significantly less than the amount the health plan pays to other doctors who are out-of-network, this may be illegal. You can see what doctors are paid by checking the explanation of benefits you receive from your plan.

If you have concerns about your health plan's compliance with federal law:

- ☑ Call the federal government's Center for Consumer Information and Insurance Oversight (CCIIO) at **877-267-2323 ext. 6-1565** or email its Public Health Interest Group, also part of CCIIO: **phig@cms.hhs.gov**
- ☑ Contact a benefit advisor at the U.S. Department of Labor at **866-444-3272** or **www.askebsa.dol.gov**
- ☑ Call your state insurance commissioner's office (list at **www.naic.org/documents/members_membershiplist.pdf**)

Commissioner: _____ Phone: _____

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Terms of plans differ. This document is not intended to be legal advice. It is intended for public education and awareness only.

7/15

A Point of Personal Privilege...

Robin B. Huffman, Executive Director

As I joined a large group of people to pay our final respects to ***Granville Tolley, M.D., D.L.F.A.P.A.***, I was poignantly aware of my start with NCPA 17 years ago. Dr. Tolley holds a special place in my heart and my career: my first interview for the job as NCPA Executive Director was with him and my predecessor, Katherine Hux (Catlett).

Dr. Tolley and I spoke of many things that long-ago January afternoon in 2000. I still quote one of the things he said to me when I asked how psychiatrists felt about having most psychiatric medications prescribed by non-psychiatric physicians—was there "competition" between the physician groups? Dr. Tolley patiently explained to me that psychiatrists needed their medical colleagues to take care of "garden variety" mental illness. That the two specialties needed to work with each other in order to care for all the people with mental illness. That conversation sealed my views on the importance of integrated care, of collaborating with physicians and other professionals.

> "Listening to what was the history of mental health care in NC and the history of NCPA, reinforced for me what a special privilege I have working at NCPA."

Over the years I had opportunities to work with Dr. Tolley, even though it had been years since he had been NCPA's president (1984). In addition to chairing the search committee for a new NCPA executive director, he continued to serve on the Executive Council as our representative to the APA Assembly of District Branches. (It is my understanding that he missed being personally awarded the George Ham Alumni Award at UNC because he was in Washington attending the APA Assembly and doing that work for his profession.) It was but one of many accolades Dr. Tolley earned over the years.

But my sense is that he didn't just win awards, he made meaningful contributions. He was a leader. He started things. He made things happen. He was one of many psychiatrists who proved that psychiatrists are good administrators and medical leaders! But he also found time for the arts, literature, music, opera, dancing and walks on the beach. Two of my favorite memories are from NCPA Annual Meetings….one in the mountains and one at the beach. In Asheville I have such a vivid picture of watching Dr. Tolley dancing with his wife Nancy to the sounds of a bluegrass band at Taylor Ranch. And on Sunset Beach, walking perhaps a little slowly, he and I followed the guide on a "turtle watch" walk that was part of the activities of the meeting. It was such a lovely evening and conversation, including him lobbying me to hold a future meeting in Charlotte, timed so that he could enjoy an evening at the opera while we there!

As I sat on the church pew beside Katherine Hux Catlett at the funeral service, we both craned our necks to catch glimpses of other psychiatrists in the chapel. I was touched to see those in attendance—***Billy Royal, Thad Monroe, Jack Bonner,***

Cheryl McCartney, Peggy Dorfman, Margery Sved, Guiliana Gage (to name a few of the members I recognized or were introduced to for the first time), many of whom also served their profession as Presidents of NCPA. Spending time with these folks after the service, hearing them tell stories about each other and Dr. Tolley, listening to what was the history of mental health care in NC and the history of NCPA, reinforced for me what a special privilege I have working at NCPA.

I am grateful for those members I have come to depend on for wise counsel over the years. I am grateful for those members whom I have never personally met but whose membership makes our work happen. I am grateful for the young professionals who have chosen "the right profession" to quote APA CEO Saul Levin as he told residents and fellows at Wake Forest in February. And today, I am grateful for A. Granville Tolley and the role he played in so many lives in North Carolina.

...President's Column continued from page 3

Human Services has recently announced its intention to eliminate the designation of "CABHA" and the previous requirement for certain, expensive outpatient psychiatric services for more seriously ill patients to be delivered only from such designated agencies. This may be a commendable move for NC Medicaid, but with the dissolution of CABHA, the requirement of an agency to have a psychiatric medical director goes away as well. There is very real concern that medical oversight of our community mental health system will fade as those without clinical training ask: "what does a medical director even do?"

Individuals who are involved in the development of policy affecting providers in these mega-systems have become increasingly removed from those who are delivering patient care. The medical input into these decisions is increasingly being provided by full-time administrative physicians. Questions can be reasonably raised as to whether the traditional values that have historically driven physicians, including psychiatrists, are being diluted by this structure as corporate decision making is focused on fiscal and regulatory concerns and less on patient outcomes and experience.

Increasingly, physician decision-making is being biased by these corporate values. Increasingly, those who voice concerns about corporate priorities are being excluded from participation, leaving many physicians shy about speaking out for fear of retribution.

In addition, the focus on big-system policies has created an environment where independent physician practices are being squeezed out. In the public Medicaid system, psychiatrists could no longer simply enroll directly in Medicaid, but are required to sign contracts that were originally designed for large agency providers.

It took more than five years of vigorous advocacy for a standard contract to be developed and vetted by the LME/MCOs to be used by "licensed independent practitioners." (NCPA and our colleagues failed at our attempt for this contract to be simple.) In addition, legislation was slipped into the final budget bill last summer that, by spring 2018, requires any state money that is paid for healthcare to be paid only to providers who have electronic health records and are connected to the NC Health Information Exchange Authority. This is one more hurdle for solo practitioners to continue to practice as they have.

Of all the factors studied, the most significant correlate to patient care quality is physician satisfaction. Many years ago, Kenneth Arrow, a Nobel Prize winning economist, and Talcott Parsons, the well-known sociologist, argued that physician professionalism is vital to patients and should be the dominant factor in development of policy affecting the consumers of health care services.

Professionalism means many things, but above all, they argued, it means putting the patient first. Physician satisfaction enhances the physician-patient bond. Physician satisfaction does not require high salaries or plush office suites. What is does require is creation of environments where physicians are always able to put patients first.

The effect of the "biggering" of systems of psychiatric care delivery are uncertain. What we know is that big "non-profit" systems are becoming increasingly profitable. The many attempts to document that this has made a difference in the care of patients who rely on these systems remain indeterminate.

At NCPA it has been a consistent theme of staff and leadership to attempt to counter the many processes leading to diminishing physician influence. The NCPA is, in some ways, a port in the storm for physicians who are embattled on many fronts by their dependence on big systems. NCPA can and has been the most effective group in support for keeping the focus of psychiatrists in providing the finest care to the patients they serve.

The support and participation of its members has always been and is likely to become increasingly critical to counter the effects of the corporate over the clinical ethic.

...Opioid Epidemic continued from page 6

drugs. There are many opportunities to purchase cheap heroin on the streets. And by far most people treated with opioids for pain relief do not abuse these medications.

The opposite of addiction is "connection," to paraphrase Dr. Cohen. These people cannot bear to be present in their own lives. Certainly opiates diminish physical pain, they also certainly diminish emotional pain. It's the emotional pain, the disconnection, the absence of a meaningful relationship with people in society that is highly determinative of opioid addiction

For additional reading about addiction and "the causes found in the social cage" consider Johann Hari: *Chasing the Scream*, highly recommended and endorsed by diverse figures such as Bill Maher, the San Francisco Chronicle, Norm Chomsky, and Amy Goodman. Consider also the work of Dr. Bruce Alexander: *The Globalization of Addiction* for which he received a high commendation from the British Medical Association's annual book award in 2009. (Johann Hari has an excellent Ted talk which stimulated much of my thoughts on this, and I borrowed material from his talk to compose this essay).

The North Carolina Psychiatric Association will be sponsoring a program on the opioid epidemic in 2017. I look forward to seeing how it addresses problems I see in my practice. For the most part, the people I see who have developed an opioid addiction did not begin the addiction in a doctor's office trying to get OxyContin for the management of their joint pain, and then started taking heroin on the street. What I find in my practice is the estrangement, disconnection, loneliness, and syndromal psychiatric illnesses that play a significant role as individuals self-medicate.

I suggest that current evidence supports the hypothesis that help comes through the reconnection of these individuals in a meaningful way to a more adaptive social cage (jobs, friends, loved ones). Psychiatric and other mental health services should substitute for the process of placing these people in smaller cages, including jail. We should work to create a socially enriched cage that promotes bonding and leads to alternatives to drug addiction.

The opinions in this editorial are my own although I have borrowed liberally from several figures and have tried to give attribution when appropriate.

References:

1. NYT12/30/2016

Your Voice Matters

Nathan Copeland, M.D.

With the North Carolina state legislature now in session and bills getting introduced and passed, it is important to know what is happening at the state level. Fortunately, the North Carolina General Assembly (NCGA) and the North Carolina Psychiatric Association (NCPA) websites have everything you need to stay informed, involved, and influential!

First, you can follow all bills that have been introduced and their subsequent votes through the NCGA Legislation/Bills section (http://www.ncleg.net/Legislation/Legislation.html). Or you can browse bills by year and find the most recent bills gaining traction. For reference, the "S" next to a bill means it is in the State Senate, and the "H" next means a bill is in the House. Finally, you can simply search the text of bills for keywords in the "search criteria."

For example, if you were to use this latter feature and searched for "mental" in this year's session, you would retrieve "House Bill 18" on the "Use of Electronic Procurement and Contract Management Systems." Sound boring? It is! But since you sorted for text with the word "mental" included, you will notice that page 11 of this bill deals with "The establishment and administration of a statewide telepsychiatry program." Now it's exciting!

Secondly, this year we will be increasing our efforts to keep you informed about bills and policy that will affect your practice and patients. We will do the heavy searching, sorting, and reading so you don't have to. Please visit our website (www.ncpsychiatry.org) to see the latest news and follow our advocacy efforts.

Lastly, we will be reaching out to you to help contact legislators. It is our intent this legislative session to hold, not a single large-event advocacy day, but a series of weekly "White Coat Wednesdays." Let NCPA know of your interest and we will help you make your voice heard in Raleigh! You are our greatest resource, and we hope you will join us in letting our opinions be known.

It will be an exciting year, and together we can improve the mental health of North Carolina!

APA Announces 2017 Honorees

Congratulations to the following NCPA members who have achieved Distinguished Fellowship, Fellowship, Life Member, and/or 50-Year member status! New honorees will be formally recognized at the APA Annual Meeting in San Diego in May. Please note, honorees listed below may hold additional distinctions other than those most recently awarded.

Distinguished Fellow
Jennie Byrne, M.D., Ph.D.
Stanley Oakley, M.D.
Gerald Plovsky, M.D.
Wayland Stephens, M.D.
Thomas Thompson, M.D.

Fellow
Ria Battaglino, M.D.
Erin Dainer, M.D.
William Felkel, M.D.
Caroline Haynes, M.D., Ph.D.
Jun He, M.D., Ph.D.
Erica Herman, M.D.
Alyson Kuroski-Mazzei, D.O.
Kerry Landry, M.D.
Jonathan Leinbach, M.D.
John Nicholls, M.D.
Fathima Reyman, M.D., M.P.H.
Beth Ridgway, M.D.
Jennifer Rucci, M.D.
Pheston Shelton, M.D.
Jagannath Subedi, M.D.
David Susco, M.D.

Life Member
Jean Aycock, M.D.
James Bellard, M.D.
Karen Billmire, M.D.
Stephen Buie, M.D.
William Chen, M.D.
Mary Christenbury, M.D.
Wilson Comer, Jr., M.D.
Michael De Witt, M.D.
Palmer Edwards, M.D.
Veeraindar Goli, M.D.
James Groce, M.D.
Anne Hendricks, M.D.
Lu Leidy, M.D.
Esther Lyons, D.O.
Andrew Myerson, M.D.
Bruce Noll, M.D.
Stanley Oakley, M.D.
Thomas Owens, M.D.
Karl Schroeder, M.D.
Jeffrey Simon, M.D.
William Simons, M.D.
Royce Waltrip, M.D.
Pamela Wright-Etter, M.D.
Jay Yeomans, M.D.
Jean Zula, M.D.

50 Year Member
William Bodner, M.D.
Eugene Mindel, M.D.

Member Notes...

Lisa Lindquist, M.D., a Resident Fellow Member at UNC was recently published in the Journal of Neuropsychiatry and Clinical Neurosciences. To read the article Traumatic Brain Injury in Iraq and Afghanistan Veterans: New Results From a National Random Sample Study visit http://bit.ly/2ljFL2K

Wake Forest University School of Medicine has the elite honor of joining the platinum level of the APA's 100% Club for the 9th year in a row. A new benefit of the 100% Club for Platinum level programs is a grand rounds program with the CEO of the APA, Saul Levin, M.D. Dr. Levin presented to the program on February 17.

From Left to Right: ***Raj Patel, M.D.,*** *Suzanne Watson,* ***Preston Gentry, M.D., Carson Felkel, M.D., Josephine Mokongho, M.D., Kelley-Anne Klein, M.D., Melisa Tyndall, M.D., Luciana Giambarberi, M.D., Rahn Bailey, M.D., Phillip Smith, M.D.,*** *Saul Levin, M.D.,* ***John Bocock, M.D., Heather Douglas, M.D., Emily Boothe, M.D.,*** *Predrag Gligorovic, M.D.,* ***Sheila Maurer, M.D., Kelechi Emereonye, M.D., Richard Blanks, M.D.***

NORTH CAROLINA
Psychiatric
Association

North Carolina Psychiatric Association
A District Branch of the American Psychiatric Association

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Calendar of Events

March 14, 2017
Deadline to submit your NCPA Ballot

April 12, 2017
Addictions Committee

April 23, 2017
Executive Council
Raleigh, NC