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An Interview with…

Laura Nelson, MD and Principal in Mercer's government sector and a board-certified psychiatrist …

Laura brings extensive Medicaid managed care clinical and administrative expertise to the Mercer team in the areas of mental health, substance use disorders, and intellectual/developmental disabilities. Her experience ranges from direct care within inpatient and outpatient settings to state-level executive leadership positions in public health, behavioral health, and intellectual/developmental disabilities. Prior to Mercer, she served as Arizona's state behavioral health director.

Dr. Nelson, what do you see as major, current challenges related to behavioral health for states?

AHCA/ACA

One significant, and perhaps the most obvious, challenge is preparing for whatever happens related to the repeal and replacement of the Affordable Healthcare Act. All states are waiting to respond to what could be some significant changes. States that expanded Medicaid under the ACA have noticed a significant influx of individuals seeking behavioral health treatment, particularly for substance use disorders. States worry about how to continue to provide the same level of support and access to these services if the substantial federal support for expansion ends. Proposed shifts to a per capita allotment or grant funding approach for Medicaid could also create additional challenges for meeting the behavioral health needs of Medicaid members, since these conditions are often chronic and can be costly to treat effectively. States may be faced with making difficult decisions about eligibility or covered benefits in order to operate within a fixed funding amount.

Laura Nelson, MD
Principal

EDUCATION
Doctorate of Medicine
Medical University of South Carolina

Bachelor's degree, Biology,
Magna Cum Laude
Middlebury College, Vermont

Psychiatric residency
Banner University Medical Center
Phoenix, Arizona

EXPERIENCE
21 years
professional experience

CORE COMPETENCIES
State behavioral health systems

Managed care contractor monitoring

Cross system partnerships

Recovery-oriented behavioral health service systems

Intellectual disabilities

AFFILIATIONS
Medical License, Arizona

Board Certified, American Board of Psychiatry and Neurology

Physician waiver for buprenorphine

President, Board of Directors, National Association of State Mental Health Program Directors, 2011-2012

Board Member, Stand Together and Recover (S.T.A.R.), a peer-run organization, 2012-present

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The OPIOID EPIDEMIC and growing problem with Fentanyl

States are actively trying to respond to and reverse the opioid epidemic. Making naloxone (which reverses opioid overdose) more readily available and trying to limit prescription opioid medications for acute, non-cancer-related pain are definite positive steps. But nationally we are still struggling with preventing and effectively treating addiction. As access to prescribed opiate pain medications has become more difficult, individuals have turned to heroin or other illicit drugs. The United States is now seeing a huge influx of synthetic fentanyl, some forms of which are magnitudes more potent than heroin. Overdose deaths from fentanyl are occurring with a very small ingestion of this dangerous drug. Treating people with addiction requires a true bio-psycho-social approach—one that addresses the co-occurring medical, mental health and psychological, and social needs such as unstable housing, unemployment, and lack of natural supports. We applaud states that are establishing targeted task forces that include representatives from all of these disciplines to tackle this epidemic. When it comes to treatment for opioid addictions, access to medication-assisted treatment such as buprenorphine, naltrexone, and methadone is a definite tool states need in their toolboxes, as is access to peer recovery coaches and the ability to offer a range of service settings based on level of need of the member. Some states are trying to navigate the occasional need for access to more intensive residential care with the restriction in the Medicaid managed care final rule pertaining to the use of institutions for mental disease (IMD).

What actions should state agencies take to combat the opioid epidemic?

States should assess the current continuum of care available to individuals with addictions and identify opportunities to incorporate new levels of care, medication assisted treatment and recovery coaches into their Medicaid programs. States should also consider Medicaid waiver applications if they are interested in seeking authorization to use IMD settings beyond the current limit of 15 days in a month without losing the federal match. Lastly, states should look to identify opportunities and implement initiatives that link treatment quality and outcomes to performance based contracting.

Dr. Nelson, what other observations have you noticed related to state behavioral health programs?

MERGING OF STATE AGENCIES/DEPARTMENTS

Historically, most funding for mental health and substance use disorders came from state general funds, local counties, or federal block grant dollars. The programs were administered by state

agencies that may have been separate from the agency administering the state's Medicaid program. Over the years, many of these behavioral health services were incorporated into Medicaid state plans or waivers in order to leverage federal matching funds. This was followed by states shifting from a fee-for-service program to managed care programs for these services. And now, with the growing emphasis on integrated care, states are carving behavioral health care into traditional physical health managed care organizations (MCOs) to manage the behavioral health services as well. Because of this evolution, the state agencies solely responsible for mental health and substance use disorders are now working much more closely with the state Medicaid agency, and, in some states, merging with the Medicaid agency. We are likely to see more of this approach, since it is intended to eliminate any duplicative functions and be more cost effective by streamlining the structure, data systems, administrative functions and care coordination activities. With these types of mergers, however, it will be important that we not lose the focused commitment to serving individuals with behavioral health conditions. I think there is a fear that behavioral health will somehow get overlooked when it comes to funding decisions. However, these types of agency integration decisions can be implemented successfully and in a manner that retains the institutional knowledge and recovery-based infrastructure states are looking for.

How does Mercer work with states in this regard?

Let me start by saying that not all states are considering integration, nor is it necessary for them. If those decisions are made, however, Mercer can help state agencies think about administrative structures and efficiencies as well as key monitoring and oversight activities, roles, and responsibilities. We can also assist states in development of language for integrated contracts, readiness reviews of managed care plans and ongoing monitoring reviews.

You've worked on the state side of the table, what do you enjoy about sitting on the consulting end?

I love being involved with numerous states at the same time. It allows us the ability to pull from a variety of experiences, innovations and best practices – and take that perspective to new challenges! I'm really excited about seeing this movement to truly implement a holistic, bio-psycho-social perspective in other areas of healthcare. This viewpoint is inherent to behavioral health assessments and treatment, but has been less emphasized in the physical health field in years past. In order to meaningfully impact a person's quality of life – and the healthcare system, for that matter – we cannot separate the brain from the body in treatment.