Rural Health Clinic Technical Assistance Webinar

This webinar is brought to you by the National Association of Rural Health Clinics and is supported by cooperative agreement UG6RH28684 from the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA). It is intended to serve as a technical assistance resource based on the experience and expertise of independent consultants and guest speakers.

Special Attributes of MFTs and MHCs and Engaging RHCs under the Mental Health Access Improvement Act

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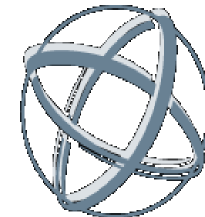

NATIONAL BOARD FOR
CERTIFIED COUNSELORS.

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Outline of Presentation

- Background on Medicare Part B Coverage of Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)

- Overview of Older Adult Mental Health Issues

- Skills and Attributes of MFTs and MHCs

Background
on
Medicare Part B Coverage
of
Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)

Medicare Mental Health Workforce Coalition

- American Association for Marriage and Family Therapy
- American Counseling Association
- American Mental Health Counselors Association
- Association for Behavioral Health and Wellness
- California Association of Marriage and Family Therapists
- Centerstone
- Center for Medicare Advocacy
- Michael J. Fox Foundation for Parkinson's Research
- National Association for Rural Mental Health
- National Association of Community Health Centers
- National Association of County Behavioral Health and Development Disability Directors
- National Board for Certified Counselors & Affiliates
- National Council for Mental Wellbeing
- National Council on Aging
- Network of Jewish Human Service Agencies
- The Jewish Federations of North America

Setting the Stage

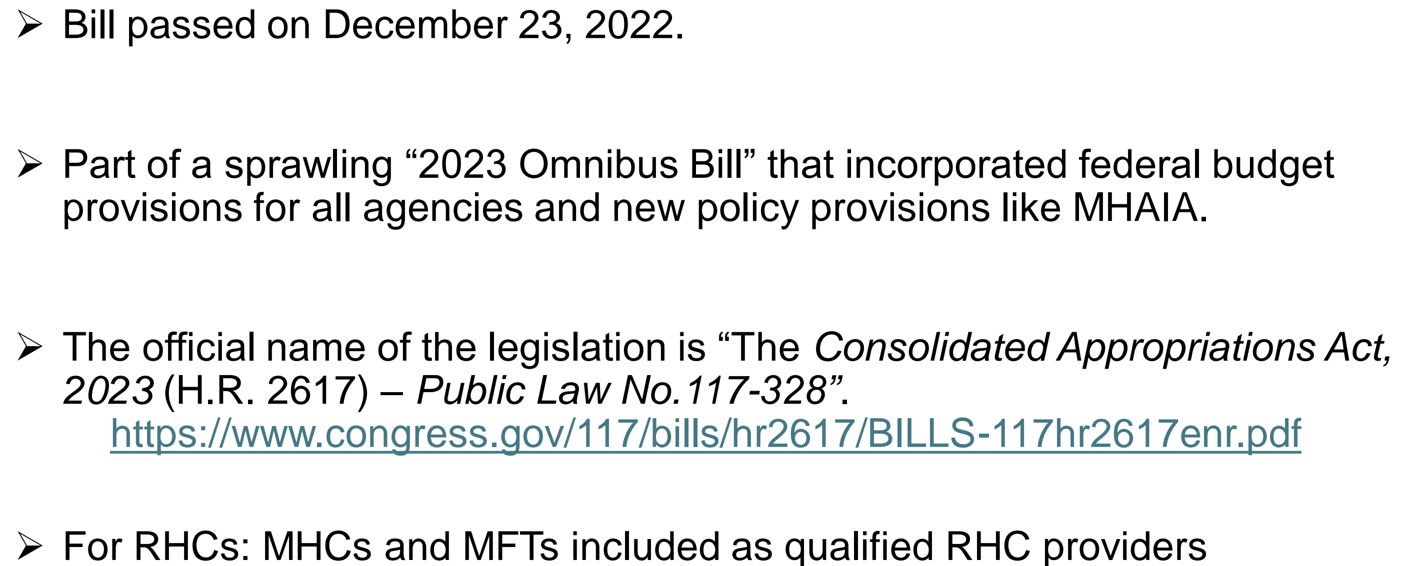
The Mental Health Access Improvement Act -- which recognizes marriage and family therapists MFTs) and mental health counselors (MHCs) as approved Medicare Part B providers -- passed as part of the 2023 Omnibus federal budget in December 2022.

Before passage of the law, over 400,000 MFTs and MHCs were not recognized providers in the Medicare program leaving a significant workforce gap for older adults seeking mental health care.

The legislation represented a major milestone for the organizations of the Medicare Mental Health Workforce Coalition (the Coalition) that worked tirelessly for passage over the last decade.

The passage of the bill is heartening news for many Medicare beneficiaries with mental health conditions who have not been able to access Medicare providers in our communities.

Passage of the Mental Health Access Improvement Act (MHAIA)



- Bill passed on December 23, 2022.
- Part of a sprawling “2023 Omnibus Bill” that incorporated federal budget provisions for all agencies and new policy provisions like MHAIA.
- The official name of the legislation is “The *Consolidated Appropriations Act, 2023* (H.R. 2617) – *Public Law No.117-328*”.
  https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf
- For RHCs: MHCs and MFTs included as qualified RHC providers

Counselors and MFTs are now eligible Medicare providers in the following settings beginning January 1, 2024:

- Private Practices
- Telehealth Platforms
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Skilled Nursing Facilities (SNFs) and related settings
- Medicare Hospice interdisciplinary teams
- Integrated Care Systems
- Medicare Innovative Delivery and Payment Programs

- Counselors and MFTs will have the ability to diagnose and treat older adults and people with disabilities who are covered by the Medicare program.
- Ability to diagnose and treat people with substance use disorders (SUDs) who are covered by the Medicare program.
- Ability to treat Dual-Eligible Beneficiaries

Medicare Physician Fee Schedule

- Provisions of the MHAIA legislation were integrated and interpreted for implementation through the Final Medicare Physician Rule issued last November.
- Rule provides guidance to Medicare Administrative Contractors (MACs) and stakeholders who serve as regional bodies that administer the provisions of the Physician Fee Schedule.
- The Coalition provided comments on specific items in the Fee Schedule.
- **For RHCs**:
  - MHCs and MFTs included in Medicare rules in sections where Clinical Social Workers are included.
  - MHCs and MFTs can be hired to serve as providers in RHCs in the same manner as other Medicare-eligible behavioral health providers

RHC Regulatory Changes

§405.2401 Scope and definitions

§405.2411 Scope of benefits

§405.2415 Incident to services and direct supervision

§405.2463 What constitutes a visit

§405.2468 Allowable costs

§491.8 Staffing and staff responsibilities

What do these changes mean?

- MFTs and MHCs can generate a Medicare encounter, reimbursable at the RHC's All-Inclusive Rate (AIR).
- MFTs/MHCs are subject to the same policies as a PA, NP, CNM, CP, and CSW in the RHC.
- MFTs/MHCs may serve as the RHC owner or an employee or be under contract.
- MFTs/MHCs can fulfill the requirement that a provider must be available to furnish care at all times the clinic is open.

§405.2463 What constitutes a visit.

(a) *Visit—General.*

(1) For RHCs, a visit is either of the following:

(i) Face-to-face encounter between a RHC patient and one of the following:

(A) Physician.
(B) Physician assistant.
(C) Nurse practitioner.
(D) Certified nurse midwife.
(E) Visiting registered professional or licensed practical nurse.
(G) Clinical psychologist.
(H) Clinical social worker.
(I) Marriage and family therapist.
(J) Mental health counselor.

Overview of Older Adult Mental Health Issues

What are the health challenges for rural older adults?

CDC paints a clear picture. When compared to their urban counterparts, rural Americans are:

- More likely to live in poverty and less likely to have health insurance.
- More likely to smoke, have high blood pressure, and be obese.
- Less likely to be physically active in their leisure time or use seatbelts.
- Rural Americans also live much further away from specialty and emergency health care providers, and they are more likely to die of heart disease, stroke, cancer, chronic lung disease.
- The Rural Health Information Hub reports that nearly 8.5 million rural Americans live with a mental health condition. Further, 90 million U.S. residents live in a Mental Health Professional Shortage Area (MHPSA); the vast majority of these residents are rural.

Older adults with mental health issues are more likely than younger adults to have:

- Functional impairment
- Poor mobility
- Symptom burden
- Longer hospital stays
- Health issues that put them at risk for loneliness

Haigh et al, 2018; Lampinen et al, 2003; Abdel-Kader 2009; Myers et al, 2012; Ilgen et al, 2010

Older adults are less likely than younger adults to:

- Pursue or engage in mental health or SUD treatment
- Survive a suicide attempt
- Receive adequate services especially if Black or Latino

Wang et al 2000; Bartels et al 1997; Jimenez et al 2013; SAMHSA, 2015; Huang et al, 2013

Depression

Unique presentation in later life

- Less likely to report depressed mood
- More likely: Anhedonia, sleep, fatigue, being slowed down, hopelessness, overall body aches and pains, and memory problems.

“Minor” or subsyndromal depression

- ~15% in the community
- Associated with decreased function in later life
- CBT self-help interventions effective
- Chronic minor depression triples risk of dementia

Fiske, Wetherell, & Gatz, 2009; Blazer, 2003; Alexopoulos, 2005; Fang et al., 2019; Corpas et al, 2022; Oh, et al., 2021

Depression and Health Behavior

- Depression can lead to poor self-care
- Non-adherence with medication regimens
- Decreased levels of physical activity
- Poor dietary habits
- Exacerbates existing medical conditions
- Causes medical conditions

Iovino et al, 2020; Roshanaei-Moghaddam et al, 2009; Vogelzangs et al, 2008; Walsh et al, 2013

Validated Depression Screening Tools

- **GDS**: Geriatric Depression Scale (Yesavage, 1988)
- **PHQ-9**: Patient Health Questionnaire – 9 Item (Kroenke, Spitzer, & Williams, 2001)

Evidence-Based Treatment for Depression

- Psychotherapy is equally effective in younger, older, and oldest old adults
- Cognitive Behavioral Therapy
- Interpersonal Psychotherapy
- Problem-solving Therapy
- Work with clients to help them manage anti-depressant medication

Cuijpers et al., 2020

Suicide Among Older Adults

- White males age 85+
- 85-90% older adults who die by suicide had major mental illness
- 1 of every 4 older adults who attempts suicide dies, compared to 1 in 25 for younger adults
- Risk factors: change in health status, grief, lack of purpose or meaning, dementia, social isolation and loneliness

Suicide Assessment for Older Adults

- Within a month before their suicide, ~45% of have seen primary care; 20% have seen mental health professional

- Asking about suicide risk does not encourage an attempt

- Ideation, intent, plan
  - Distinguish between wishes for death and plans to die

- Consider the means

- Columbia-Suicide Severity Rating Scale **(C-SSRS)**

Anxiety Disorders in Older Adults

- More likely to say “concern” rather than “anxiety”
- Focused on loved ones, general health concerns, sexual minority status, and the state of the world
- Less likely to describe feeling anxious or depressed and more commonly emphasize physical health or other bodily concerns.

Anxiety & Medical Conditions

- Overlap with medical symptoms – assess carefully
- Medication side effects may explain some anxiety symptoms
- New onset anxiety in late life may be a symptom of cognitive impairment
- Increased since COVID-19 for those with intolerance of uncertainty

Gosselin et al, 2022

Screening Tools for Anxiety Validated with Older Adults

- **GAD-7** -- Generalized Anxiety Disorder; 7 items; 4-point Likert
- **GAI** -- Geriatric Anxiety Inventory; 20 items Agree / Disagree
- **GAS** -- Geriatric Anxiety Scale; 30 or 10 items 4-point; Likert
  Subscales: somatic, cognitive, affective
- **PSWQ / PSWQ-A** -- Penn State Worry Questionnaire 16 or 8 items; 5-point Likert

Evidence-Based Treatment for Anxiety

- Cognitive Behavioral Therapy
    - Deep slow breathing
- Acceptance & Commitment Therapy
- SSRI/SNRI

Magnon et al., 2021

Substance Use

- Don’t assume anything about older adult substance use
- Because of physiological changes with normal aging, the same amount is increasingly potent in later life
- Interactions with medications
- Cognitive impairment
- Mental health
- Fall risk

Older Adult Risk Factors for Substance Use

- Male
- White
- Low socioeconomic status
- Undergoing life transitions
  - Retirement or death of a spouse
  - Identifying as part of the LGBTQ community
  - Being socially isolated
  - Experiencing health problems
- History of substance use and mental health problems

Substance Use Issues

- Alcohol
  - >2 for men; >1 for women
- Cannabis on the rise
- Rx medication misuse vs. mismanagement
- Opioids
  - 3.6% in adults aged 50-64 and 1.2% in adults over 65
  - 1999-2019 – 1,886% increase in opioid deaths age 55+

Screening Tools for Substance Use Validated with Older Adults

- **AUDIT / AUDIT-C** -- Alcohol Use Disorders Identification Test; 10 or 3 items; Frequency rating
- **MAST-G, SMAST** -- Michigan Alcohol Screening Test; 24 or 10 items; Yes/No
- **SAMI** -- Senior Alcohol Misuse Indicator; 5 items; Checklist
- **CUDIT-R** -- The Cannabis Use Disorder Test; 8 items; Likert

Interventions for Older Adults

- SBIRT: Screening, Brief Intervention and Referral to Treatment
- Cognitive Behavioral Therapy
- Motivational Enhancement Therapy
- 23% of treatment centers designed to accommodate older adults
- Seniors in Sobriety

Skills and Attributes of MFTs and MHCs

By the Numbers

- 400,000 MFTs and Counselors serve on the frontlines of our mental health delivery system and are ready to provide needed care to older adults with mental health conditions in rural health clinics
- Medicare did not include MFTs & MHCs as recognized providers prior to 2024. We had an under-utilized workforce – not a Medicare workforce shortage.
- MFTs and MHCs practice in several rural and frontier areas where there is a lack of access to Medicare providers.

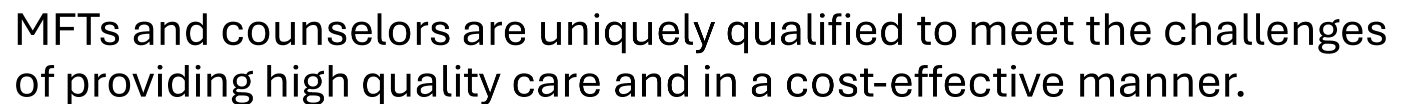
Attributes of the Counseling and MFT Professions

- Primary mental health providers who provide psychotherapy and other services for the betterment of the mental health and emotional well-being of their clients.
- Trained to address the causes and the symptoms of depression, anxiety, trauma, trauma, PTSD, substance use, and other mental health disorders.
- Qualified by graduate education, supervised experience, and state licensing to use evidence-based approaches to treat mental health disorders and are holistically trained to address social, cultural, integrated behavioral health, and physical wellness.
- Rigorously qualified to provide a wide spectrum of services and in many practice settings and locations such as underserved areas (e.g., rural areas).
- All public and private payers recognize mental health counselors and MFTs.

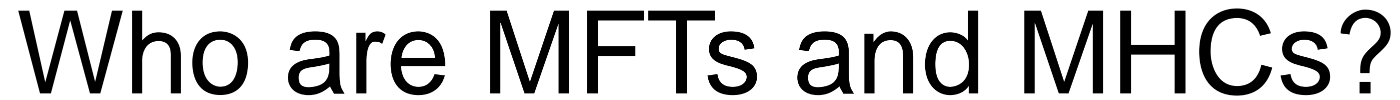
MFTs and MHCs are Primed & Ready to Address the Needs of RHCs

Items critically important for improving quality and outcomes:

1. The skill and training of practitioners
2. Understanding emotional influences on disease – critical in PC setting and achieving integration
3. The use of evidence-based treatments
4. Trained in trauma-specific or trauma-informed approaches
5. Improve communication
6. Cultural competence



MFTs and counselors are uniquely qualified to meet the challenges of providing high quality care and in a cost-effective manner.

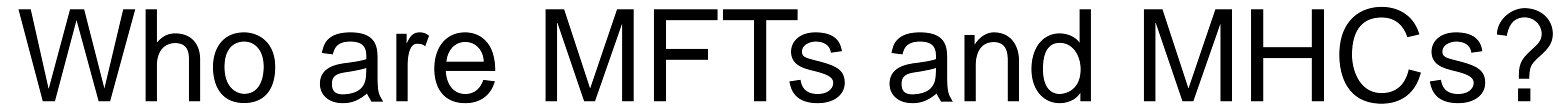


- MFTs and MHCs are compassionate, empathetic people who want to make a significant difference in the lives of others.

- A skillful MFT and counselor lead a client with a mental health or substance use conditions on a journey of growth and self-discovery that allows the individual to overcome obstacles, reach personal goals and lead a productive life.

- Trained to treat their clients in a holistic manner, working in tandem with professionals in education, medicine and related fields to get to the complex roots of each individual client's unique struggles.

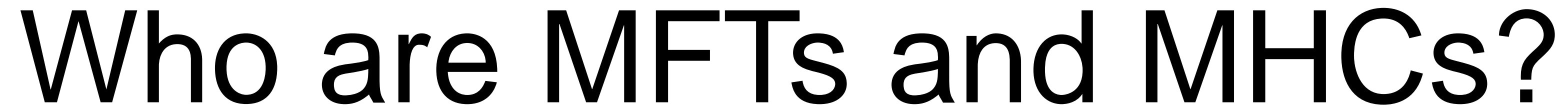
- Methods of assisting clients are diverse, as are the locations in which MFTs and MHCs work.



Who are MFTs and MHCs?

- Trained and experienced in diagnosing & treating psychological disorders, support clients through difficult life experiences, and teach skills and attitudes needed to bring about behavior change.
- Help patients work through personal issues like anger management, depression, suicidal thoughts, aging, parenting, self image, relational problems, stress or addiction.
- By assisting clients with clinical conditions such as depression, they help people avoid the serious complications associated with untreated MI, which can include health problems, poverty, etc.

- Use a variety of techniques to help their clients.
- Teach people new ways to solve problems and react to “stressors”.
- Many counselors and MFTs see a wide variety of clients while others specialize in certain conditions or populations.



Who are MFTs and MHCs?

- Employed by rural health clinics, community mental health centers, substance abuse treatment facilities, general and specialty hospitals, universities and private businesses. Many also run their own practices.
- Often operate as part of a multidisciplinary care team that includes psychiatrists, psychologists, social workers, case managers and others invested in the client's welfare.
- Make referrals to community agencies, treatment programs, other medical professionals and any other resources needed.
- Practitioners provide significant tele-health services in their practices -- telephone and online counseling.

Licensing and Accreditation

Education

- MFTs and counselors must hold a master's degree in their respective profession from an accredited institution. Requires approximately 6-7 years of study beyond the high school level.
- While graduate programs in generally accept students from all academic backgrounds, undergrad coursework in psychology, human development & social work is desirable.

Training

- Accredited training programs include extensive, supervised field experience in the form of practicums and internships.
- Counselors: There are specified standards for training, with accreditation available from the Council for Accreditation of Counseling and Related Educational Programs (CACREP), if programs qualify by meeting the standards. Standards include 60 credit hours with specified course work and supervised experience.
- MFTs: The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) is the accrediting body for MFT academic programs. COAMFTE accredits 121 MFT programs.

Licensing and Accreditation

- Licensure of MFTs and MHCs is mandatory in all states. This usually requires a master's degree and 2000-4000 hours of supervised clinical experience. In many states, they must pass a knowledge exam prior to practicing.
- To maintain licensure & certification, MFTs and counselors must engage in continuing education (CE) during their careers.
- Experienced MFTs and counselors often hold administrative or supervisory positions at agencies and treatment facilities. Many return to school to pursue doctorates.
- National Board for Certified Counselors (NBCC):
  - NBCC awards 2 levels of certification for mental health professionals. The entry-level National Certified Counselor (NCC) credential requires completion of required coursework and 3000 hours of work experience. Candidates must also pass the National Counselor Exam.
  - Experienced professionals can pursue additional credentialing as a Certified Clinical Mental Health Counselor (CCMHC). Candidates must be certified as NCCs, meet rigorous education and experience requirements, submit recordings of clinical sessions and pass the National Clinical Mental Health Counseling Examination (NCMHCE).

Responding to the Ever-Changing Marketplace

- The professions are responsive to health care marketplace changes within the political & social climate of health care.
- This flexibility is a necessary aspect of remaining vital and viable as a provider in the health care sphere.
- MFTs and MHCs have demonstrated flexibility and integrate new competencies that are consistent with today's value-based care and managed care environment.

Benefits MFTs and MHCs Provide in Primary Clinic Care and Integrated Care Settings

Benefits provided in an integrated setting include helping patients:

- Cope with their medical illness.
- Adhere to medical regimens.
- Understand emotional influences on disease.
- Improve communication with their physician and nurse.
- To ultimately prevent the worsening or return of a disease.

Thank You and Questions

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