Behavioral Health Care System Advocacy

The Future of Behavioral Health Care: Addressing Behavioral Health Needs and Solutions at the Federal Level

OhioGuidestone | Berea, OH
www.ohioguidestone.org
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OhioGuidestone

WHERE NEW PATHS BEGIN

SUMMARY

Navigating through the aftermath of the COVID-19 pandemic calls for a nimble, creative and robust redesign of funding mechanisms and associated policies to invest in the United States' behavioral health care system. This paper identifies significant and high-potential opportunities to expand quality integrated health care through community behavioral health organizations. Six strategic areas briefly discussed as key opportunities and crucial areas needing a revision of funding mechanisms and policies are: school based behavioral health services, integrated behavioral and physical health care, federal funding restrictions and limitations, commercial insurance and parity, telemedicine for addiction treatment, and social determinants of health. By leveraging the impact and innovation of non-profit community-based mental health providers, such as OhioGuidestone, federal funding can be used more responsibly to create opportunities for communities and empower providers to serve their clients with high-level, integrated care. Amid the turmoil, the COVID-19 pandemic has provided an opportunity to scrutinize our current systems and rebuild them, first and foremost, to meet the needs of individuals, families, and whole communities.

WHO SHOULD USE THIS PAPER

- Government officials
- Health officials and policymakers
- Managed care organizations
- Behavioral and Physical health care providers

TAKEAWAYS & ACTION ITEMS

- The behavioral health care system continues to be fragile from before, during and continuing since the COVID-19 pandemic.
- Wealth and resources are available to the United States, but redesigned funding mechanisms are needed to better equip and sustain the overall healthcare system, especially at community-based levels.
- Policy and practice for population-wide health care must reflect public health best practices, i.e., the three-tiered approach for school-based services and community-based integrated care models (CCBHC and FQHC).
- Federal funding opportunities and mechanisms need to be redesigned to respond to actual costs of doing business, support community-based integrated care, and allow for robust school-based behavioral health services – which in turn will expand access to care and improve the health and wellness of communities.
- Federal support and enforcement of mental health parity requirements for commercial insurance is crucial to grow and sustain the behavioral health care workforce as needed to meet the continually growing behavioral health needs of the nation.
- Continuing the flexibility for prescribers to prescribe buprenorphine without requiring a prior in-person examination by the prescriber is critical to ensuring access to care for individuals with opioid use disorder.

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OhioGuidestone (Berea, OH)

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INTRODUCTION

As the world attempts to recover from the fallout of the COVID-19 pandemic, behavioral health care delivery continues to face many challenges. These systemic issues existed long before the pandemic, but — like many social problems — they were exposed and often exacerbated during the last few years (Leach et al., 2021).

Across the United States, the pandemic revealed burnout, anxiety, stress, fatigue, and a host of other physical and psychological symptoms impacting everyone from young children to older adults. These symptoms appeared everywhere from childcare centers to school systems and from a diversity of workplaces to retirement communities – having a particularly devastating impact on marginalized and minoritized U.S. populations.

All of this affects both the U.S. workforce in general (Peters et al., 2022) and clinical mental health providers in particular (Schwartz et al., 2020). School children and their families (Mitchell, 2021), teachers (Pressley et al., 2022), and social workers in child services (Ferguson et al., 2022) are in need of immediate and long-term interventions to address and prevent a wide range of detrimental factors that affect their wellbeing in the aftermath of COVID-19.

On the one hand, many states face severe behavioral health workforce shortages, including our own Ohio (Hernandez et al., 2021). On the other hand, the pandemic has caused profound psychological impacts across populations, leading to a surge in demand for effective, high-quality, and innovative interventions, especially for children's mental health (Korte et al., 2022) and substance use treatment.

This moment calls for both nimble creativity and robust, redirected investment. Currently, the United States has abundant funding for behavioral healthcare, but that funding is not used efficiently or effectively to truly address the needs of the communities. Change is needed.

In this paper, we discuss the most significant behavioral health-related issues facing communities served by OhioGuidestone, Ohio's leader in community behavioral health care, with a particular focus on community-based behavioral health services. Our purpose is to highlight these areas of concern as potential avenues of impact for innovation, policymaking, funding, and other strategic solutions, both immediate and long-term.

SCHOOL-BASED SERVICES

Proposed Solutions:

⇒ **Offer combined funding source for the three tier school-based model of prevention, consultation and treatment.**

⇒ **Require "school" to be an eligible place of service for treatment on all insurance plans.**

Children and schools remain some of the most important areas of potential impact in addressing wide-ranging behavioral health issues post-pandemic. A primary goal of school-level intervention must be prevention of adverse health effects and promotion of wellbeing. As the largest provider of school-based behavioral health services in the state, OhioGuidestone has extensive experience in school-based services, from direct interventions for students and families to professional development for teachers and staff. We assert that we need to start with a responsive funding structure that expands and maintains access to prevention, consultation, and treatment services for school-aged youth if we are serious about addressing behavioral health challenges.

For the proven three-tier public health model (Bazyk, 2020) to effectively address the behavioral health needs of all children, all three tiers must be available to every student at every school across the country. We are currently far from this model's reality. Right now, prevention (tier 1) funding is separate from consultation (tier 2) funding, which is separate from treatment funding, if either are at all available in particular schools. The treatment tier (tier 3) is the only tier with a dedicated, but limited, funding stream. The result is a disjointed system that does not meet the needs of children in schools. Although community behavioral health providers such as OhioGuidestone offer highly effective school-based services, our impact could be broader and even more effective if funding mechanisms were dedicated across all three tiers for public health. We can address this challenge by developing a single source of combined funding for all three of these tiers.

Funding for school-based treatment services is generally only available for students with Medicaid coverage (Wolk et al., 2022). For students on commercial insurance plans, "school" is ordinarily an excluded place of service, leaving those students without funding to receive treatment in the school setting, as well as sustained access to prevention and consultation that could lead to earlier and more effective intervention. Prevention and consultation services are funded from separate sources, if available at all in schools.

Prevention, consultation, and early intervention works. When students receive prevention services and early intervention from teachers through consultation and early referral to behavioral health treatment, the ongoing cost in physical health care, behavioral health care, and criminal justice costs go down substantially (Wachino et al., 2021). In Ohio, the University of Miami, Ohio Department of Education and the Ohio Department of Mental Health and Addiction Services are working on building this model in schools using behavioral health coordinators. The challenge continues to be a lack of funding for the model (Center for School-Based Mental Health Programs).

The current funding structure has produced a disjointed system that does not meet the behavioral health needs of children in schools. We can address this challenge by developing a single source of combined funding for behavioral health prevention, consultation, and treatment services available for all youth – regardless of payer source – that leverages coordination among stakeholders to improve behavioral and physical healthcare and wellness.

For Framework See: Bazyk, S. (2020). Foundations of Every Moment Counts: Public Health Framework. Every Moment Counts. https://everymomentcounts.org/public-health-framework/

Public Health Approaches for Public Health Improvement

THREE TIER PUBLIC HEALTH APPROACH

Tier 1: PREVENTION
The first tier is prevention and includes social-emotional learning, mental wellness, and substance use prevention programming at all grade levels. It promotes positive coping skills, eliminates stigma, and encourages students to reach out for help when needed.

Tier 2: CONSULTATION
The second level is consultation. Consultation gives teachers access to behavioral health clinicians to develop specific skills for addressing challenging student behaviors — e.g., self-regulation strategies — and to identify targeted interventions for at-risk youth. The behavioral health consultants also provide more generalized training to improve the social-emotional learning of students in the classroom. Consultation is important because it provides students access to supports before a formal assessment and mental health diagnosis is required.

Tier 3: TREATMENT
The third tier is treatment. Treatment involves behavioral health counseling, psychotherapy, and interventions provided by either clinical paraprofessionals or licensed clinicians after a diagnostic evaluation. Treatment requires parental consent and the development of a formalized treatment plan.

INTEGRATED CARE

Proposed Solutions:

⇒ **Increase grants and funding for Federally Qualified Health Centers (FQHCs) and Certified Community Behavioral Health Centers (CCBHCs).**

⇒ **Remove administrative barriers and fund care coordination services necessary to bring individuals successfully into behavioral health services.**

Integrated care is the desegregation and coordination of physical and behavioral health care, leading to provision of care that addresses the needs of the whole person. Historically, however, physical health care and behavioral health care have been separated and siloed (Chung et al., 2021), even though symptoms and illness do not segregate in the body and there is no physical health without behavioral health. We have ever growing knowledge that informs of the vast interconnection of body systems from head to toe, as well as the multifactored connections between physical and mental health.

OhioGuidestone's placement within community-based settings uniquely situates us with a view of the impact of physical symptoms and illness on behavioral health, and vice versa. When an individual with severe medical and behavioral health needs engages in behavioral health services, their medical healthcare compliance increases substantially, which positively impacts one's health while also reducing the cost of medical care for chronic illnesses such as heart disease and diabetes (Horstman et al., 2022). Despite the clear value of integrated care — increased opportunity to improve health and trusted connections with clients — community behavioral health providers face barriers to bringing integrated care to life in their community settings. To make behavioral health integration with medical care possible, ample and uncomplicated funding mechanisms are needed for community behavioral health providers to provide necessary services and supports.

Additional policy shifts are needed as well since community behavioral health organizations, such as OhioGuidestone, are unable to receive payment for physical health services delivered by medical providers under current state licensing and Centers for Medicare & Medicaid Services (CMS) regulations. Community behavioral health organizations are well equipped and experienced with care coordination – a critical component of integrated care. The current funding mechanism for behavioral health care coordination further stifles client access to care. Aligning a payment process that supports the integration of medical and behavioral health will lead to significant reductions in cost spent on the physical health care side of client care (National Council for Mental Wellbeing, 2022), while also expediting the start of much needed behavioral health care services and establishing a sustainable path for integrated care approaches.

One solution is to support the integration of physical and behavioral health through increased grants and funding for Federally Qualified Health Centers (FQHCs) and Certified Community Behavioral Health Centers (CCBHCs). Continued and expanded investment in these areas would increase access and opportunities for integrated care — which, as noted above, is crucial for the future of behavioral health care and preventative public health. Further, FQHC's and CCBHC's have enhanced rate structures, which allow non-profit community-based behavioral health organizations to better function and serve under resourced and disadvantaged communities.

While FQHC and CCBHC funding and grant opportunities are effective and necessary to serve these communities, they are not

sufficient alone to improve access to integrated care. A second solution to integrate physical and behavioral health care is to provide community behavioral health providers with funding to support the care coordination services needed to adequately bridges these two systems of care. Typically, community behavioral health centers do not receive payment for services until there is a completed assessment and a behavioral health diagnosis, which creates further barriers and prevents the care coordination activities necessary to bring individuals successfully into behavioral health services. Some state Medicaid programs are eliminating the requirement for a behavioral health diagnosis prior to delivering certain behavioral health services, which will expand access to behavioral health care in those states. Action at the federal level through CMS and the Department of Health and Human Services to drive this change would greatly impact access to behavioral health care across the county. A bridge between these two worlds is critical to break down the silos and improve health care for all Americans.

FEDERAL FUNDING: RESTRICTIONS and FMAP

Proposed Solutions:

⇒ **Provide access to federal dollars with fewer restrictions to increase access and support better behavioral health outcomes in communities.**

⇒ **Permit non-profit federally approved indirect cost rates to be used in federal behavioral health funding opportunities.**

⇒ **Maintain increased FMAP when the PHE declaration expires on May 11.**

There is an incredible amount of federal investment in various high-need areas such as student wellness, opioid use treatment, and more. Because some federal dollars are rolled out with a high degree of restrictions and requirements, however, there is a disconnect between where the dollars are spent and what various communities actually need.

Some federal funding opportunities are developed with the best intentions, but are inadvertently adverse to community-based non-profit behavioral health organizations, such as the recent Substance Abuse and Mental Health Services Administration (SAMHSA) Advancing Wellness and Resiliency in Education (AWARE) grant. The AWARE funding appropriately seeks to enhance the school behavioral health infrastructure, but requires several full-time (FTE) equivalent commitments from the state education, mental health and local education agencies (SAMHSA, March 2022). It is incredibly challenging as a community behavioral health center to meet these grant requirements, which are not necessary for a successful implementation of the three-tier public health model in schools. Community partnerships, collaboration between providers, and letters of commitment are critical to the success of these services, but specific requirements for FTE individuals to be identified in the application process, especially during a critical behavioral health and other workforce shortage, is a barrier that prevents access to care.

Similarly, federal State Opioid and Stimulate Response (SOR) funding from SAMHSA in-

cludes a newly added 5% cap on administrative costs (SAMHSA, May 2022), rather than accepting a federally approved indirect cost percentage. Caps of this nature create a significant financial loss for behavioral health organizations on the front line of the opioid epidemic. Most organizations receiving these funds are non-profit community behavioral health centers that do not have available financial margins to recover this loss. As a result, the impact of these funds becomes significantly limited, while also limiting community based organizations who can (and should) apply because of their specific expertise to deliver quality substance use disorder care in community settings. These restrictions limit substance use services even though the need is tremendous and growing across the country.

Community behavioral health centers are on the ground day after day delivering care and are poised to address the needs in the communities we serve. Access to federal dollars with appropriate checks and balances, but fewer restrictions, would allow the funding to have the greatest impact and drive the best outcomes. A shift to outcome-driven funding at the federal level would allow organizations to better meet the needs of communities. Moreover, a federal policy change that permits an organization's federally approved indirect cost rate to be used in all federal behavioral health funding opportunities, would help ensure that federal funding has the greatest impact on the health of affected communities.

Other important areas of federal funding profoundly impact behavioral health care, too. During the pandemic, the Federal Medical Assistance Percentage (FMAP) — the percentage of Medicaid paid by the federal government — was increased as part of the public health emergency declaration. When the declaration expires on May 11, this enhanced percentage should remain at the higher rate to support greater investment in behavioral health at the state level. Not doing so could also mean loss of coverage for millions of people (Williams, 2022). By retaining the higher percentage, vital funds can directly benefit those in need of Medicaid coverage.

By reducing federal funding barriers and retaining a higher FMAP, significant dollars can be wisely spent on upstream solutions that both address communities' greatest needs and prevent higher long-term health care costs.

COMMERCIAL INSURANCE and PARITY

Proposed Solutions:

- ⇒ **Increase federal support and enforcement of parity rules — both rate parity and coverage of providers with parity.**
- ⇒ **Require coverage for trained and certified behavioral health paraprofessionals (e.g., peer specialists and qualified behavioral health specialists) with urgency.**

Commercial insurance is a significant challenge across the country as it relates to behavioral health care. Behavioral health care payment rates on the commercial side in many states are significantly lower than Medicaid reimbursement rates (White, 2019). In addition, commercial insurance payers require independently licensed clinicians to provide behavioral health services, and do not cover services provided by licensed clinicians and certified behavioral health paraprofessionals. Meanwhile, the federal government, state Medicaid, and non-profit organizations, as sites that train and employ trainees and preliminarily licensed clinicians, are funding the training of independently licensed clinicians to benefit commercial payers. Commercial insurance should be required to do their part by fully participating in the behavioral health clinical model – through rates and covered providers – to support the growth and sustainability of the behavioral health care workforce, and the system as a whole.

There is a critical behavioral health workforce shortage across the country. Independently licensed clinicians are in incredibly short supply and are critically important to the supervision of the licensed clinician and paraprofessional workforce across the country (Nenn, 2022). The exclusion of both licensed providers (master's level educated clinicians) and trained paraprofessionals (peer specialists and qualified behavioral health specialists) from coverage by Medicare and commercial health plans has a significant impact on access to behavioral health services for all Americans. As a result of this exclusion, the scarce number of independently licensed behavioral health providers primarily serve commercial insurance members and are unavailable to supervise the workforce needed to support the behavioral health of all Americans.

Independently licensed practitioners must have a minimum of two years of supervised work in most states. As a result, many licensed behavioral health providers begin their careers with a community behavioral health organization that serves primarily Medicaid clients. Some practitioners stay for two to three years while gaining experience toward independent licensure at the cost of state Medicaid and the federal government though the FMAP match. After a few years, many licensed clinicians become independently licensed and leave to work in a more lucrative (and self-sustaining) private practice funded by commercial insurance and self-payment. Non-profit community behavioral health providers thus bear the burden of training the commercial insurance behavioral health workforce at Medicaid rates that are insufficient to cover workforce costs in most states. This is a cyclical process that results in a benefit only to commercial insurance; and a churn of unrealized workforce investment for non-profit community behavioral health centers.

Federal support and enforcement of parity rules both in rate parity and a requirement for commercial insurance payers and Medicare to cover behavioral health providers (both licensed and trained paraprofessionals) with parity — meaning an inability to arbitrarily limit qualified providers from providing services — is critically needed. All payers should be required to cover services provided by behavioral health professionals delivered within their scope of practice or certification, which in all

states would at a minimum include master's level licensed behavioral health providers, such as licensed clinical social workers, licensed professional clinical counselors, licensed marriage and family therapists, and licensed chemical dependency counselors.

While Medicare has made a change to cover additional licensed clinicians effective January 1, 2024, a more urgent response, including coverage of the trained and certified paraprofessional behavioral health workforce (e.g., peer specialists and qualified behavioral health specialists), and a requirement for commercial insurance to do the same would have an overwhelming impact on the workforce crisis and access to services.

Moreover, the exclusion of licensed behavioral health providers by commercial insurance is incredibly taxing on the workforce. Licensed providers at non-profit community behavioral health organizations often see Medicaid clients with higher acuity levels and greater challenges relating to social determinants of health. These organizations lose the ability to provide licensed clinicians with a more balanced caseload that would make space to support their own mental and emotional health and resist burnout and subsequent exit from the community behavioral health workforce. Furthermore, clients with high acuity needs would have access to a wider diversity of clinicians to partner with in caring for a wider range of their needs.

If commercial insurance rates were required to be in parity with Medicaid rates and physical health rates, and services were permitted to be delivered by non-independently licensed clinicians and trained paraprofessionals, community behavioral health providers could balance the acuity levels of client caseloads, stabilize the workforce, and expand quality access to behavioral health care across the country.

TELEMEDICINE FOR ADDICTION TREATMENT

Proposed Solutions:

⇒ **Transition Ryan Haight Act waiver of the in-person requirement to initiate buprenorphine from COVID PHE to the Opioid Epidemic PHE, which does not have an end date.**

⇒ **Allow the in-person evaluation for opioid use disorder to be conducted by a nurse or medical assistant, and the prescriber would visit with the client through telehealth for buprenorphine treatment.**

The increased access to care for patients with substance-use disorders that was made possible during the pandemic is in jeopardy with the end of the public health emergency. Prior to the COVID-19 pandemic, the Ryan Haight Act of 2008 amended the Controlled Substances Act to prohibit prescribing of controlled substances via online forms and included requirements for in-person evaluations prior to prescribing controlled substances.

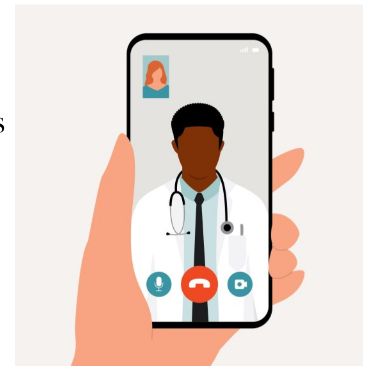
The Ryan Haight Act was designed to reduce potential harms to patients who are prescribed controlled substances. Unfortunately, the law was written prior to the advent of contemporary telemedicine, and the law's current limited exceptions to the in-person visit do not adequately contemplate how telemedicine works today. The in-person physical exam is especially problematic for behavioral health providers because

mental health and substance use disorder care does not typically require a physical exam to the same extent as a physical heath service.

Individuals with opioid use disorders are dying at unprecedented levels, and those individuals need access to life-saving medications such as buprenorphine. During the COVID-19 pandemic, the DEA loosened remote prescribing restrictions for the duration of the public health emergency, including waiving the requirement for an in-person evaluation prior to prescribing certain controlled substances as long as other requirements were met. The loosened restrictions improved access to care for patients with substance use disorders, but that access is now in jeopardy because the in-person exam requirement is set to snap back into place at the end of the public health emergency on May 11.

The American Hospital Association recently submitted a letter to the DEA specifically requesting that the DEA transition the waiver of the in-person requirement to initiate buprenorphine prescribing to the Opioid Epidemic PHE, which does not have an anticipated end date. (AHA Letter, December 1, 2022.) Transitioning these flexibilities would be part of addressing the ongoing opioid epidemic and would allow access to potentially life-saving medications for those with an opioid use disorder. Ohio law currently permits prescribing buprenorphine without a prior in-person visit, but without a change, the DEA's more stringent restrictions will limit access to care. The DEA had and continues to have the legal authority to allow telemedicine prescribing of controlled substances, including buprenorphine.

Another potential solution would be for the DEA to allow the in-person evaluation to be conducted by a nurse or medical assistant, and the prescriber would visit with the client through telehealth. This would support clients having better access to life-saving medications while recognizing the shortages in prescribers that existed even prior to the pandemic.



Breaking down barriers to care for individuals with opioid use disorders saves lives. Individuals with an opioid use disorder are less likely to seek life-saving care if that care is difficult to access. The in-person assessment requirement limits access, especially for individuals in rural areas or who face other barriers to seeking in-person care. Allowing continued use of telehealth to prescribe buprenorphine will address this critical access to care issue.

SOCIAL DETERMINANTS of HEALTH

Proposed Solutions:

⇒ **Establish minimum requirements of Medicaid and Managed Care that address social determinants of health and barriers to access to care.**

⇒ **Require state Medicaid programs to provide transportation to behavioral health appointments.**

Managed care organizations (MCOs) continuously proclaim that addressing social determinants of health is critical to reduce medical spending across the board (McCarthy et al., 2022). However, there is not direct and ongoing funding available to address social determinants of health.

Several MCOs have programming with limited funding available to address critical community-level issues such as food insecurity, affordable

housing, and transportation. Yet, no federal minimum requirement exits for state Medicaid programs to address social determinants of health. This is a missed opportunity.

The failure to address social determinants of health is leading to the spending of millions and millions of dollars in medical expenses and causing preventable, long-term adverse health outcomes (D'Agostino & Pope, 2020). Establishing minimum expectations and minimum requirements for Medicaid and Medicare programs through CMS to address social determinants of health would allow the government to have some oversight into how we are addressing these very important issues and not merely restating their importance without funded opportunities to change this narrative.

The federal government must take the lead in driving improved outcomes for social determinants of health. Hospitals and health care providers, in general, do not have an incentive to address social determinants of health because current value-based risk models do not typically incorporate these components. This can be remedied via minimal federal policy changes. There is an opportunity to establish minimum requirements of Medicaid and MCOs that address issues such as food insecurity, workforce development, housing, and transportation- typical barriers to access to care. Minimal actions, such as requiring state Medicaid/MCOs to pay for the transportation of Medicaid and Medicare patients to physical and behavioral health appointments, would have a significant impact on compliance with medical and behavioral health treatment and increase access to care for millions of Americans.

CONCLUSION

Streamlining, integrating, and increasing coordination and access to care in these areas would not only save time and money, but it would reduce auxiliary stress and address root problems more quickly, which in turn would lead to better physical and behavioral health outcomes. The labyrinthine process of navigating care systems and complicated payment structures causes poor health outcomes among populations that, at a minimum, should have access to adequate physical and behavioral health care.

The United States is the richest country in the world. Yet the future of behavioral health care in the country is in jeopardy. This is true both in the short term — due to issues such as the current workforce crisis and disparities between commercial insurance, Medicare, and Medicaid — and in the long term —due to systemic problems such as gaps in funding for coordinated school services, access to integrated care and medications for opioid use disorder, and the response to social determinants of health.

The issue is not a lack of funding. However, the current funding mechanisms and structures hamper best practices and inhibit innovation, which negatively affects public health on all three levels of the prevention model: upstream primary prevention that address social determinants of health, secondary prevention that reduces the impact of risk factors, and downstream treatment of illness.

By leveraging the impact and innovation of non-profit community-based behavioral health providers, such as OhioGuidestone, federal funding can be used more responsibly to create opportunities for communities and empower providers to serve their clients with high-level, person-centered, integrated care. Amid the turmoil, the COVID-19 pandemic has provided us an opportunity to scrutinize the current U.S. behavioral health care delivery systems and rebuild them, first and foremost, to meet the needs of individuals, families, and whole communities.

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OhioGuidestone

WHERE NEW PATHS BEGIN

With compassion and respect, OhioGuidestone helps people across the lifespan navigate the most difficult times of their lives. As the state's leader in community behavioral health care, we focus on the needs of the whole person, empowering them to take steps towards a healthier future.

OhioGuidestone provides a complete continuum of prevention services and mental health and substance use treatment, focusing on responsive person-centered care to approximately 26,000 people each year through telehealth and locations across Ohio.

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