Behavioral Health Care System Advocacy

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

Mary Stiles, Maic D'Agostino, Heather Lutz, Payten Kleinhenz
OhioGuidestone | Cleveland, OH
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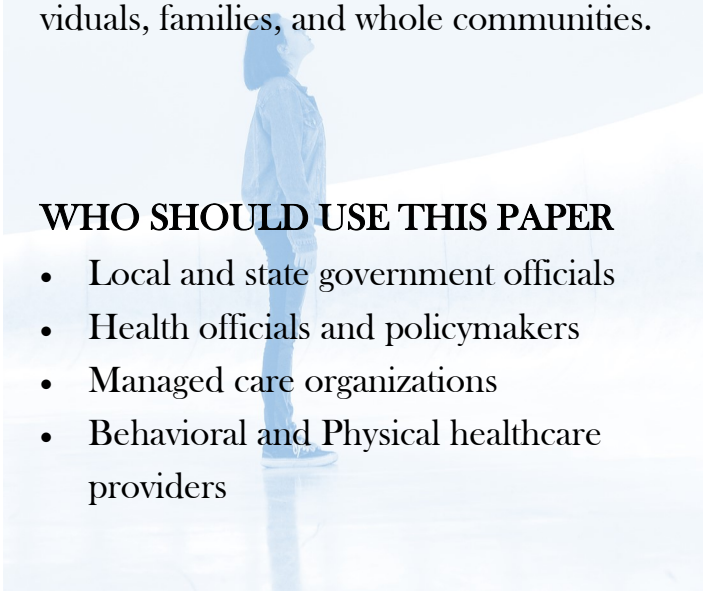
SUMMARY

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. Five 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 care behavioral and medical health care, federal funding restrictions and limitations, commercial insurance and parity, 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 us 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

- Local and state government officials
- Health officials and policymakers
- Managed care organizations
- Behavioral and Physical healthcare providers

TAKEAWAYS & ACTION ITEMS

- The U.S.'s 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 and health care must reflect public health best practices and frameworks such as the Three-Tiered approach: prevention, consultation and treatment.
- Funding mechanisms must be adjusted to allow for robust school-based behavioral health prevention, consultation and treatment as well as integrated medical and mental health care.
- Federal funding opportunities need to be expanded to respond to actual costs of doing business, especially in community practices and settings.
- Federal enforcement of health care insurance 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.

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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 who exist outside the realm of valued social identities.

All of this affects both the workforce in general (Peters et al., 2022) and clinical mental health providers in particular (Schwartz et al., 2020). In addition, schoolchildren and their families (Mitchell, 2021), teachers (Pressley et al., 2022), and social workers in child services (Ferguson et al., 2022) also are in particular need of immediate and long-term solutions to address and prevent a wide range of detrimental factors that affect their well-being 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 increased and innovative interventions, especially for children's mental health (Korte et al., 2022).

This moment calls for both nimble creativity and robust, redirected investment. Currently, the United States has some amount of funding for behavioral health treatment, but the funding is simply not being spent in a way to truly address the needs of communities. The funds are not used efficiently to drive the change needed.

In this paper, we discuss the most significant behavioral health-related issues facing communities treated at OhioGuidestone, Ohio's leader in community behavioral health care, with a particular focus on community-based mental 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.

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.

School-Based Services

As noted above, 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- not only treatment. 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 as a society are serious about addressing behavioral health challenges.

For the public health model to effectively address the behavioral needs of children, all three tiers must be available to every student at every school in our country. Right now, prevention (tier 1) funding is separate from consultation (tier) funding, which is separate from treatment funding. Although community behavioral health providers such as OhioGuidestone offer school-based services, our impact could be broader and more effective if funding mechanisms were dedicated across all three tiers for public health; instead of only limited to treatment (tier 3). Funding for school-based treatment services is generally only available for students with Medicaid coverage (Wolk et al., 2022). For students enrolled on commercial insurance plans, "school" is ordinarily an excluded place of service on such policies, leaving those students without funding to receive school-based treatment, as well as sustained access to prevention and consultation that could lead to earlier and more effective intervention.

We know that 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 in partnership with the 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 the lack of a single source of funding (Center for School-Based Mental Health Programs).

The current funding structure has produced a disjointed system that does not meet the mental 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.

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

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

Integrated care is the integration of physical and behavioral health care, leading to provision of care that addresses the needs of the whole person as there is no physical health without behavioral health. Historically, physical health care and behavioral health care have been separated and siloed (Chung et al., 2021), even though symptoms and illness do not segregate as such. We have ever growing knowledge that informs of the vast interconnection of body systems from head to toe, as well as the multifactored connection 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 a client 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 (i.e. frequency of behavioral health appointments compared to physical health appointments) 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. 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, such as initial client engagement in response to a medical provider referral for mental health services, delays payment for these services until after a client receives a behavioral health assessment and diagnosis- which occurs across several appointments, further stifling client access to care. Current state licensing and Centers for Medicare and Medicaid Services (CMS) regulations also impede full implementation of integrated care by limiting coverage of services delivered by medical providers within behavioral health care centers (although this limitation does not exist for behavioral health care providers in hospital-based medical facilities). [

Some states are eliminating the need 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 have a profound impact on the 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.

Creating a provider payment process that aligns with integrated medical and mental health care 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 state and national integrated care approaches. **Developing a single funding source for integrated care is critical to fully address the needs of the whole person and produce whole person health and wellness.**

FEDERAL FUNDING: RESTRICTIONS, FMAP, AND FQHCs

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

For example, SAMHSA has released grant opportunities for AWARE funding to support school behavioral health infrastructure (SAMHSA, March 2022). The AWARE grant requires full-time equivalent (FTE) commitments from the state education agency, state mental health agency, and a local education agency. It is incredibly challenging to meet these grant requirements, which are not necessary for a successful implementation of these types of services in schools. Letters of commitment, partnerships, and collaboration are critical to success, but FTE requirements that require the individual to be identified in the application during a critical workforce shortage is an unnecessary barrier that prevents access to care. Similarly, State Opioid Response funding from SAMHSA has included a 5% cap on administrative costs (SAMHSA, May 2022). Caps of this nature create a significant financial loss for the behavioral health organization receiving the funds. Most of these organizations are non-profit community behavioral health centers that do not have an available margin to cover the loss. As a result, the impact of these funds is limited significantly, while also limiting community based organizations who can –and should- apply because of their specific expertise to deliver quality care in community settings. Community behavioral health centers are continually demonstrating themselves as collaborators with families and communities on the ground delivering care. We know what needs to happen in the communities we service to partner and address their needs. Access to dollars with less complicated rules and restrictions would allow for a shift to outcome-driven funding from federal sources to adequately support organizations to best meet the needs of our 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. If and when the declaration expires, 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.

Additionally, increased grants for Federally Qualified Health Centers (FQHCs) could expand access and opportunities for integrated care — which, as noted above, is crucial for the future of behavioral health care and preventative public health. FQHCs have high rate structures, which allow non-profit community-based mental health organizations to better function and serve underresourced communities. However, FQHC grant opportunities are too few and far between.

Commercial Insurance and Parity

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 (White, 2019). In addition, commercial insurance payers require independently licensed clinicians to provide behavioral health services. Meanwhile, federal government, state Medicaid, and non-profit organizations fund the training of independently licensed clinicians as sites that train and employ trainees and preliminary licensed clinicians. Commercial insurance should be required to do their part by fully participating in the behavioral health clinician training and licensing system to support the growth and sustainability of the behavioral health care workforce

Independently licensed clinicians are in incredibly short supply and are critically important to the supervision of the other licensed clinician workforce across the country (Nenn, 2022). The exclusion of licensed providers, who are master's-level trained clinicians, from coverage by commercial health plans has a significant impact on access to behavioral health services for all Americans. As a result of this exclusion, the limited amount 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. Many licensed behavioral health providers begin their careers with a community behavioral health organization that serves primarily Medicaid clients. Those workers stay for two to three years while training experience toward independent licensure at the cost of Medicaid and the federal government though the FMAP match. After about two to three years, these licensed clinicians often become independently licensed and then leave to work in a more lucrative private practice funded by commercial insurance and self-payment. Nonprofit community behavioral health providers thus bear the burden of training the commercial insurance behavioral health workforce at Medicaid rates that are significantly lower than commercial insurance rates in most states. This is a cyclical process that results in a benefit only to commercial insurance.

Federal enforcement of parity rules and a requirement for commercial insurance payers to cover behavioral health providers with parity — meaning an inability to arbitrarily limit qualified providers from providing services — is critically needed. Commercial insurance payers should be required to cover services provided by health professionals delivered within their scope of practice, which in all states would 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. This requirement would have an overwhelming impact on the workforce crisis and access to services.

The exclusion of licensed behavioral health providers by commercial insurance is incredibly taxing on the workforce. Licensed providers at nonprofit 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 include higher and lower need clients. The stress of seeing primarily high need clients is contributing to the burnout of staff and individuals leaving the workforce.

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, community behavioral health providers could balance the acuity levels of client caseloads, stabilize the workforce, and expand access to behavioral health care across the country.

Social Determinants of Health

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 no direct and ongoing funding available to address social determinants of health.

Several MCOs have some programming and grants available to address critical community-level issues such as food insecurity, affordable housing, and transportation. **However, no federal minimum exists for Medicaid programs to address these social determinants of health. This is a vital 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 extremely 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. Simple requirements and funding shifts, such as requiring that MCOs pay for transportation for Medicaid and Medicare patients to physical and behavioral health appointments would have a significant impact on compliance with medical and behavioral health treatment.

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 they have been unable to arrive at true value-based risk models that incorporate these components. This can be remedied via federal policy through CMS. There an opportunity to establish minimum requirements for behavioral health service expectations from Medicaid that address issues such as food insecurity, workforce development, housing, and transportation — typical barriers to access to care for individuals receiving Medicaid coverage.

Conclusion

Imagine your car is making strange noises, not driving properly, and you have no idea what is causing the problem. If solving this issue were like navigating our health care system, it could go something like this:

First, you are required to take the car to a shop to check the brakes. But to pay for the brake check, you need to reach out to a different place to coordinate that payment. The technician determines that your brakes are fine but you need to have the engine checked, but you can't do it there. Instead, you must take your car to a *different* location; may be very far away. To pay for the engine check, you need to contact yet *another* unaffiliated service to coordinate that payment. Now you have to take additional time off from work to go and talk to the engine mechanic. You repeat everything that you were told by the brake specialist about the issues. The engine mechanic thanks you for the information and then schedules you to come another day to bring the car back again. In the meantime, you get another bill from the engine shop, which needs to be paid in a different way.

Streamlining these services would not only save time and money, it would greatly reduce auxiliary stress and address root problems much quicker, which in turn would lead to better car operations. Now insert yourself in place of the car in this metaphor. Health care should not be a labyrinthine process of navigating care systems and insurance billing, additional moderators such as transportation and time off work, and then the work of actual health interventions and everyday life. These issues become further compounded and complicated among groups of peoples with historical, structural and systemic marginalizing and disadvantaging social, economic, and environmental experiences.

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 and Medicaid — and in the long term — thanks to systemic problems such as gaps in funding for coordinated school services, integrated care, and addressing 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 nonprofit 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 us an opportunity to scrutinize our current systems and rebuild them, first and foremost, to meet the needs of individuals, families, and whole communities.**

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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
343 West Bagley Rd.
Berea, OH 44017
www.ohioguidesotneorg
844-622-5564