# Behavioral Health System Funding Structure and Implications for Universal Health Care

Cherryl Ramirez

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# A little history…

1963 **Community Mental Health Act** – to provide funding for community-based care as an alternative to institutionalization

1965 Amended to include staffing grants and added substance use disorders

1960's Many **states established community mental health centers** and county-based delivery systems

1975 **Amended CMHA** to add federal definition, access to all, community boards; FQ status

1980 Mental Health Systems Act – funded grants for CMHCs

1981 **Mental Health Systems Act repealed**; loss of "federally qualified" status; CMHC funding block granted

1984 Community Mental Health Services Act – enumerates covered mental health services

2008 **Mental Health Parity and Addictions Equity Act**

2017 **CCBHC Demo** – back to funding like FQHCs

# The Mental Health Parity and Addictions Equity Act

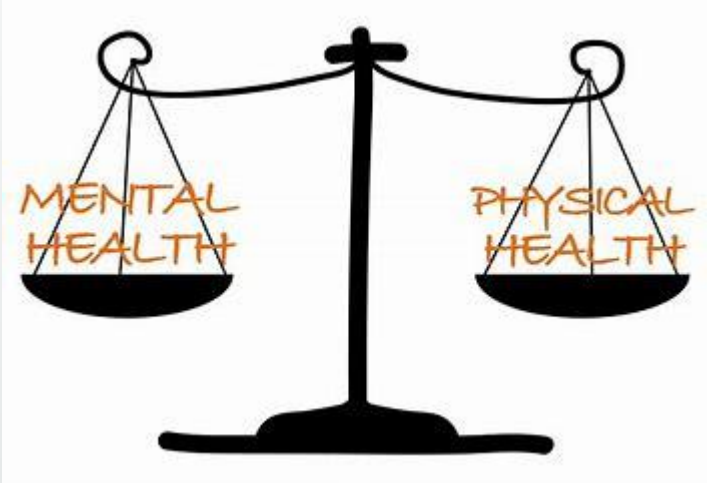
- Bipartisan law sponsored by Rep. Patrick J. Kennedy (D-RI) and signed into law by President George W. Bush in 2008
- The Federal Parity Law applies to most health plans except for Medicare
- Issuers and health plans have struggled with some of the more complex components of the law
- State and federal regulators have been slow to implement and provide guidance
- Final Rule comments with changes in reporting requirements due this year

# State Legislative Solutions

- Since beginning of 2018, numerous states introduced bipartisan legislation based on **model legislation, including Oregon – HB 3046 (2021)**
- Insurer and Medicaid MCO reporting requirements:
  - Requires insurers/MCOs to perform comparative analyses of how they design and apply managed care practices like prior authorization, step therapy, network design, reimbursement, many others
- Insurance department enforcement requirements
  - Specifies that departments shall enforce federal parity law and details how
- Insurance department and Medicaid agency reporting requirements
  - Requires detailed and publicly-available report to legislature
- Clarifies that mental health and substance use disorders must be defined as in DSM and ICD

# CCBHC Demo to Sustainability

- ***Excellence in Mental Health Care Act of 2014*** aspired to establish parity between mental health and physical health
- Led to the 2017 launch of an 8 state ***Certified Community Behavioral Health Clinic (CCBHC)*** demonstration project
- The CCBHC pilot was the largest commitment of resources to mental health this generation – ***an estimated 1.1 billion dollars***
- Federal match dollars allowed states to support chronically underfunded community mental health services through an enhanced Medicaid rate
- Oregon is one of the original 8 states funded, with 12 pilots located throughout the state
- CCBHC Sustainability and spread through State Plan Amendment – passed in 2024 Session (HB 4002)



# Certified Community Behavioral Health Clinics

- Mobile crisis, street outreach, basic needs and harm reduction
- Care coordination
- Prime model for community (re-) integration
- Peers are required staff

- Required to serve most acute and persistent behavioral needs
- 20 hours of primary care onsite
- Treatment planning is person-driven


- Adhere to national CLAS standards (culturally and linguistically appropriate services)
- Community-based needs assessment
- Report disaggregated data by REALD/SOGI

- PPS (Prospective Payment System) allows non-billable activities
- Everyone is served, regardless of address or ability to pay
- CCO negotiates capitated rate; OHA wraps the rest with enhanced federal match

# Continuum of Adult Behavioral Health Services in a sample county

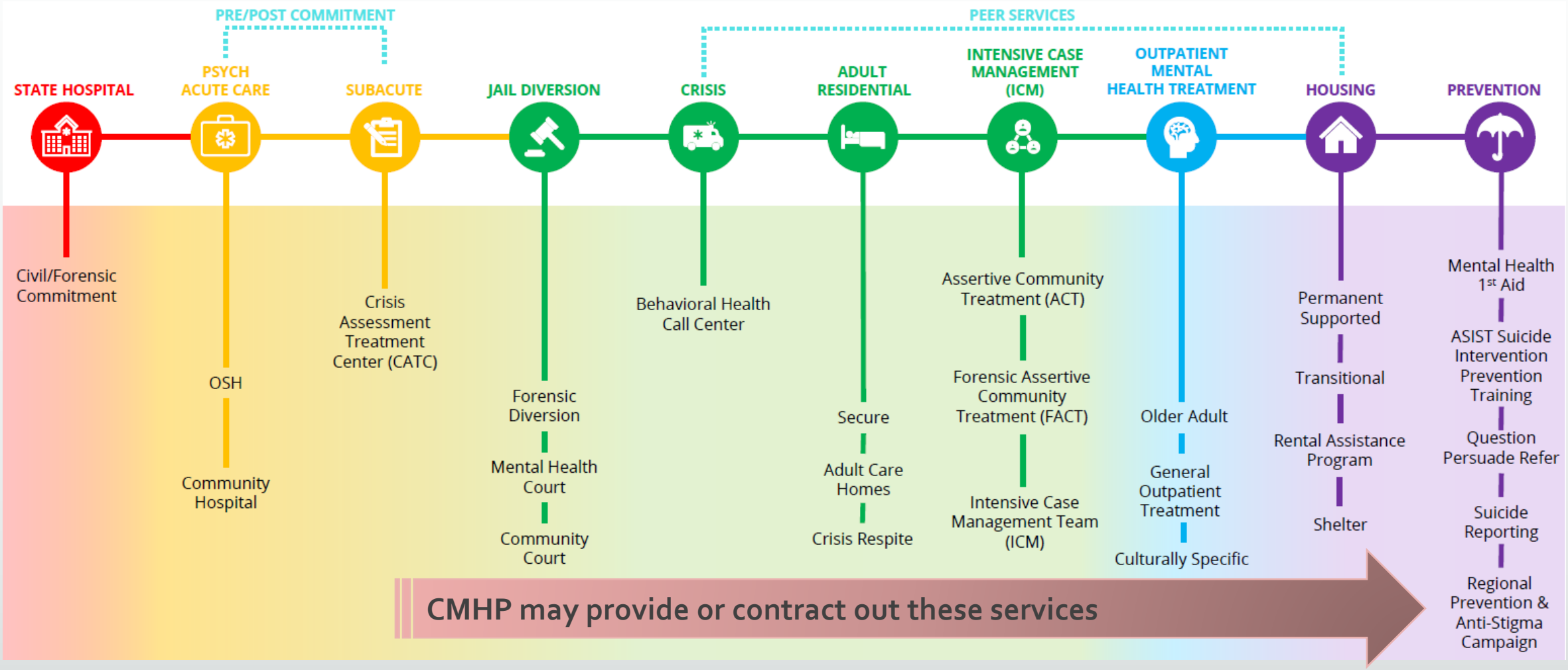
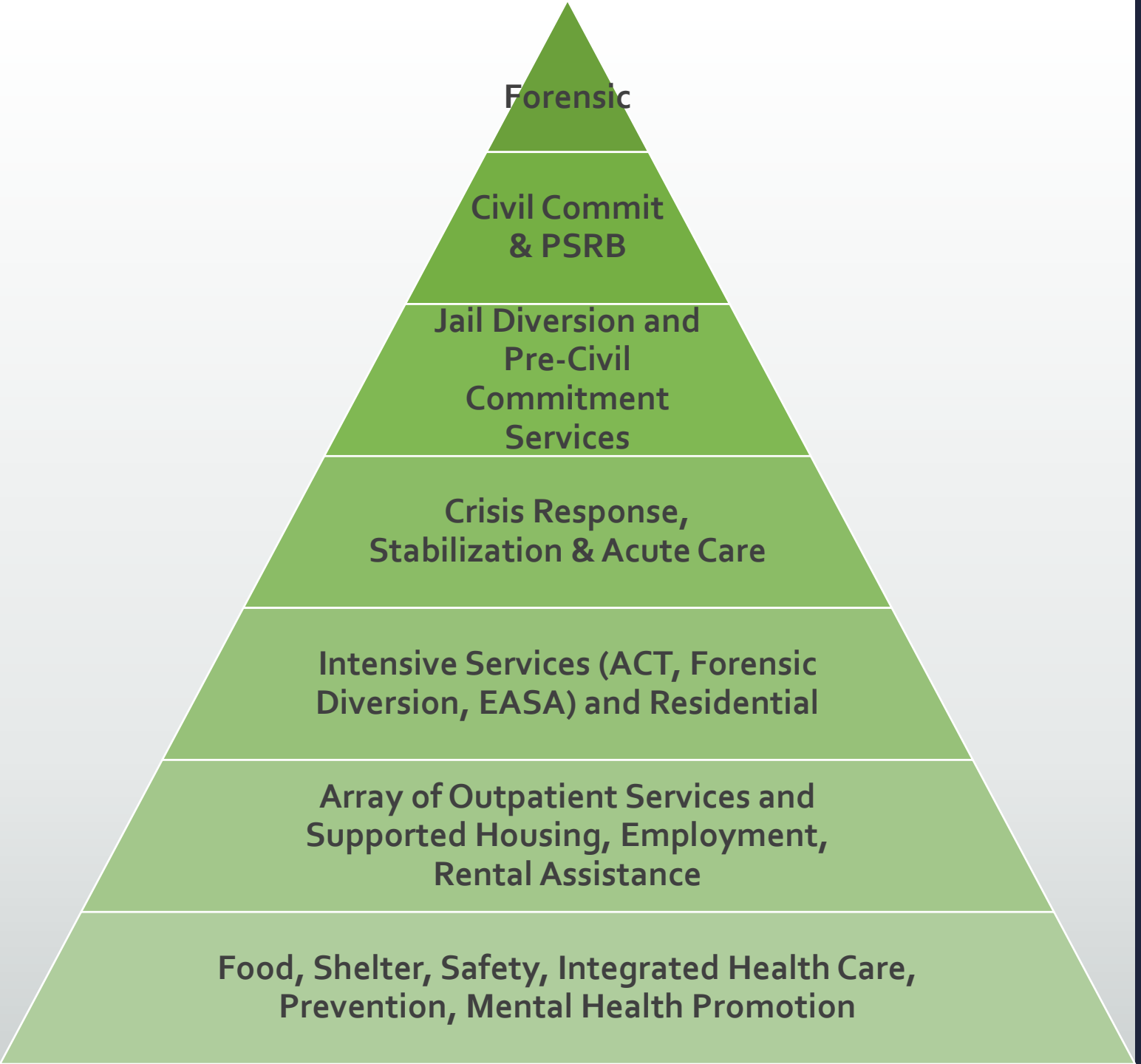
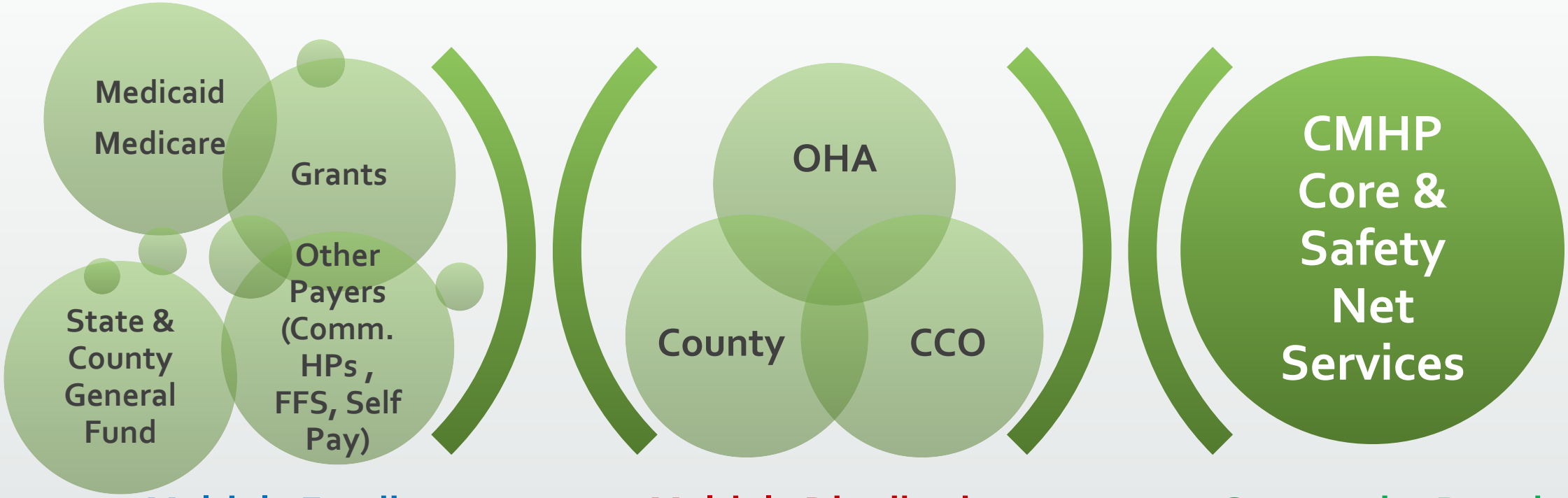



*Image from OHA 2023 MH system overview presentation*




The public BH system strives to meet social needs to prevent escalation to crisis and acute care, or legal system involvement

# Public BH System Funding Distribution Structure

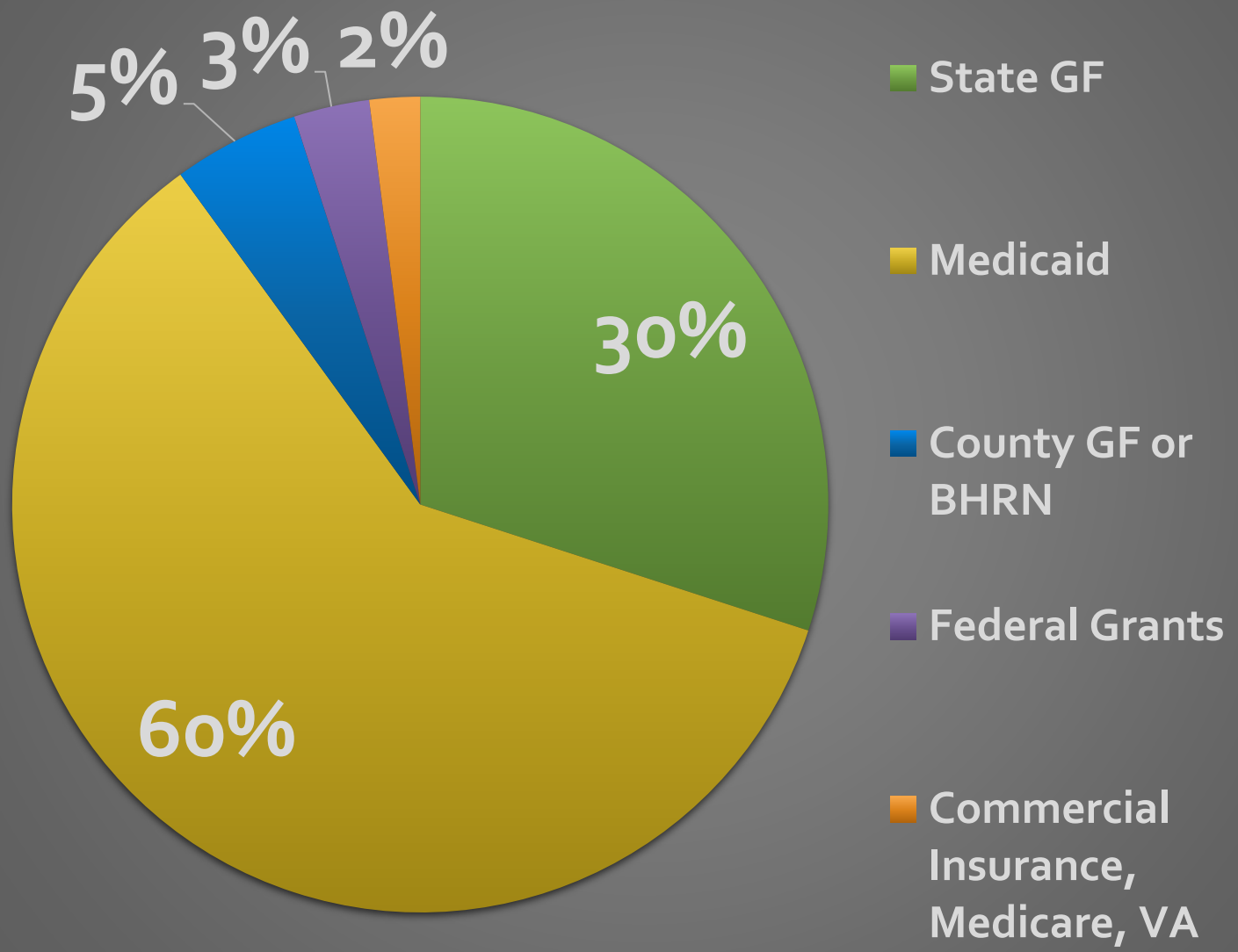



**Multiple Funding Sources**

**Multiple Distribution Entities**

**Community Based System**

# Typical Community Mental Health Program Funding Mix



# Behavioral Health Reimbursement Challenges

*According to data from the Mental Health and Addictions Certification Board, the behavioral health system is equally dependent on both licensed and unlicensed providers. Unlicensed behavioral health providers are more diverse as a group than licensed providers.*

- Services by unlicensed providers for people with the highest mental health needs are almost solely covered by Medicaid or state general funds and federal block grants.

- Most team-based, multi-faceted or capacity-based services are not fully reimbursed by payers because they don’t fit into billing codes.

- Licensed MH clinicians have an additional 2-3 year post-graduate internship requirement before they can practice on their own, with at least 100 hours of supervision at a minimal cost of $100 per hour, paid for by the intern or the host agency.

# Which BH services will be included in a universal health plan?

**Service array** – Are supported housing, education, employment and social needs services in?

**Provider type** – Are unlicensed clinicians and peer support specialists covered?

**Facility-based care** – Are services for people in institutional settings (Oregon State Hospital, jails and prisons) in?

**Reliance on current funding** - How much would we continue to rely on State general funds, federal block grants and marijuana, tobacco, and alcohol taxes to support the public BH system?