

**BEHAVIORAL HEALTH ADMINISTRATION**

2985 Drew St. (MS 1014)

Clearwater, FL 33759

November 8, 2021

The Honorable Ron Wyden

*Chairman*  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, D.C. 20510

The Honorable Mike Crapo

*Ranking Member*  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, D.C. 20510

Re: Barriers and priorities to address to improve the nation’s behavioral health

Submitted via email to [mentalhealthcare@finance.senate.gov](mailto:mentalhealthcare@finance.senate.gov)

Dear Chair Wyden, Ranking Member Crapo and honorable members of the Senate Finance Committee,

BayCare Behavioral Health (BCBH) is pleased by your invitation to share our insights into opportunities and challenges to improve behavioral health care in the United States. Since 1971, BayCare Behavioral Health has provided a wide range of mental health and substance use services for children, adults and families in the Tampa Bay region. BCBH’s approximately 1,500 team members – including therapists, nurses, psychiatrists, psychologists, APRNs and other providers – serve more than 70,000 individuals each year, discharge over 15,000 patients from inpatient psychiatry units and provide over 750,000 ambulatory visits.

**Systems of care, not just individual services, are essential to address behavioral health.**

Robust and intentional communication and coordination between the different components of the system of care is essential to prevent people from falling through the cracks.

BayCare provides a fully integrated continuum of care, including inpatient hospitalization, residential mental health and substance use services, outpatient behavioral health and substance use services, including medication management, mobile crisis response and law enforcement partnerships. BayCare Behavioral Health also provides community-based specialized care teams to address complex behavioral health challenges. Many of these teams are consistent with national models like the Assertive Community Treatment (ACT) model.

BCBH also created the **Community Health Activation Team (CHAT). CHAT partners with local schools** to provide mindfulness, stress management and substance use resistance education and helps people find the behavioral health services they need. Team members **also participate in local organizations, such as coalitions addressing substance use, homeless services and human trafficking, strengthening and connecting the network of community care.**

**Federal and state funding are essential for behavioral health services, but funding structures often exacerbate the gaps between different systems of care, hindering optimal outcomes**

**Grant funding is often overly restrictive**, which makes strategic planning and investment difficult and leaves patients caught between siloes of care. For example, many patients have **“too much” income to qualify for the indigent care system but can’t afford comparable care in other systems**. Housing and Urban Development (HUD) funded homeless services are not adequate, and **homelessness exacerbates the behavioral health needs of many of our patients, but most behavioral health funding cannot fund housing**. Once grant funding sunsets it is often hard to continue innovative, grant-initiated strategies due to limited third party reimbursement.

**Federal partners as well as state and private** **payers collect extensive data from providers. Reporting these data is often duplicative and burdensome, the frustration of which is compounded by inconsistent reporting of data insights from government partners back to providers.** The federal government should leverage its data analytics capacity to provide data and quantitative insights to providers and policy makers. Data sharing across healthcare systems for the most part remains siloed and, when accessed, is mostly unusable due to lack of interoperability between provider systems.

**The workforce shortage is a massive barrier to optimal care.**

**Health Resources and Services Administration (HRSA) has important programs** to address behavioral health in resource-constrained areas. BCBH applauds recent added investment in these programs and **has suggestions to maximize the impact of these HRSA programs:**

* HRSA’s National Health Service Corps (NHSC) considers **most hospitals and inpatient settings ineligible**, but inpatient settings face the same resource and provider constraints as their surrounding communities. **This limitation should be removed.**
* NHSC loan repayment requirements are based on hours of care provided. This mechanism effectively **excludes supervisors**, because many of their work hours are administrative so they can’t meet NHSC hours requirements. This policy limits our ability to retain developing leaders who want to work in underserved areas.

**Public and private payment policy exacerbates workforce challenges.**

**Most community behavioral health agencies use masters prepared therapists** (clinical social workers, mental health counselor/professional counselors and marriage and family therapists) **interchangeably but only clinical social workers can bill Medicare directly.** This limitation complicates scheduling and utilization and can impair job satisfaction. **HR 432/S 828** addresses this workforce challenge and should be passed into law.

Medicaid is the leading payer for mental health and substance use treatment, but **low Medicaid reimbursement rates hinder the ability for community providers to attract and retain clinicians.**

**Private insurers often implement overly burdensome utilization management techniques**, including prior authorization, cumbersome appeal processes and inappropriate denials of service. These techniques take up provider time and reduce access for individual patients. The difficulty of navigating insurance payment and the relatively low returns from doing so lead many private practitioners to avoid insurance altogether, accepting only out of pocket payment. This situation dramatically reduces the number of providers available to most people. It also makes it very difficult to quantify the supply and demand for services overall, since privately paid care is effectively invisible to providers and policy makers trying to assess need.

**Managed care companies compete for staff with behavioral health providers**, so often case managers and therapists earn a better salary limiting, reviewing and denying care rather than providing it. While insurers theoretically offer case management or care coordination for their customers, what they offer is usually inadequate and not flexible enough to integrate productively with community and inpatient providers analogous services. This leads to overlapping and duplicative services as providers continue to shoulder the burden of coordinating care even when payers employ capable staff to offer the necessary service.

**In addition to workforce shortages, policy barriers complicate behavioral health treatment.**

**Medication Assisted Treatment (MAT) is the most effective, evidence-based treatment for substance use disorders.** The X waiver created by the Drug Addiction Treatment Act of 2000 (DATA 2000) decreases access by adding unnecessary regulatory. Recent efforts by the administration have reduced the burden slightly, but not removed the requirement. **S 445/ HR 1384 “Mainstreaming Addiction Treatment Act of 2021” removes the X waiver and will increase access to this critical, evidence-based treatment.**

**Telehealth, including audio-only services**, is an important way to increase access. While the 2021 Consolidated Appropriation Act contained an expansion of telehealth for behavioral health, the requirement for in person services every 6 month reduces the positive impact of this change.

BayCare Behavioral Health is grateful for the opportunity to share ideas to improve the behavioral health system. Strengthening a seamless, adequately funded system of care, reducing regulatory burden and breaking down siloes and other barriers to high-quality care will improve the quality of life for all of our communities. We are eager to provide more information on any of these topics or other areas in which our experience might be helpful. Sam Picard, BayCare’s Community Engagement Coordinator for Behavioral Health would be the best first point of contact: [Samuel.Picard@BayCare.org](mailto:Samuel.Picard@BayCare.org), mobile: 215-760-6459.

Sincerely,

Gail Ryder

Vice President, BayCare Behavioral Health