

NACHC POLICY PAPER:

# LANDSCAPE FOR COMMUNITY HEALTH CENTER INTEGRATION OF BEHAVIORAL HEALTH & SUD/OD SERVICES

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## BACKGROUND

Community Health Centers (also known as Federally Qualified Health Centers or “health centers”) have long been at the forefront of providing high quality, cost effective care to underserved rural and urban communities across the country. Health centers have been leaders in integrating medical care, behavioral health, dental care, pharmacy, and other services all under one roof. As communities across America cope with a dramatic increase in the prevalence of substance use disorder (SUD), including opioid use disorder (OUD), health centers are meeting this challenge by providing much needed SUD services to their patients.

At the same time, federal and state policymakers are seeking to identify roles for health centers to play in alleviating the opioid epidemic. To ensure that policy recommendations serve the best interest of health centers and their patients, NACHC conducted a landscape analysis to: 1) assess what services health centers currently offer in each state, and 2) understand the barriers that prevent health centers from implementing, expanding, and sustaining integrated behavioral health and SUD services.

The analysis looked at a range of states recognizing that policies, regulations, geography and more dictate what health centers can and should provide to their patients. NACHC interviewed representatives of 14 state Primary Care Associations (PCAs) and over 20 health centers in those same states and others to gain insights into needs and opportunities. The 14 states selected for interviews were: Alaska, Arizona, Connecticut, Georgia, Kansas, Kentucky, Maine, New Jersey, Ohio, Washington, West Virginia, Wisconsin, Utah and Tennessee.

The PCAs that were interviewed each offered a broad state view and were all well-versed in which factors facilitated the creation of integrated care models at some health centers, while also identifying needs and barriers for those who had not yet integrated behavioral health or SUD services into their primary care model. The interviewed health centers were all early adopters and gave a sense of what it took to create an integrated care model as well as the facilitators and barriers to sustaining these models. Detailed below are the key findings from this assessment.

## SUMMARY OF FINDINGS

### FINDING 1: ROLE OF FEDERAL GOVERNMENT

Interviewees were asked how current federal efforts were enhancing or inhibiting work toward providing integrated SUD and primary care services on the state or health center level. Many expressed concerns that Congressional proposals to address OUD were often focused on the needs of predominantly rural white populations, thereby hindering efforts to

provide care for other vulnerable communities and for those with other types of SUDs. Others noted that grant funding and other initiatives did not consider the unique role of health centers in caring for the underserved. Further, the failure to take into account a health center’s specific infrastructure needs make legislators’ desired “treatment on demand” a difficult proposition.

Health centers are unlikely to engage fully in federal efforts without a better understanding of

how the work will affect their state and local efforts.

#### KEY INSIGHTS FROM INTERVIEWEES

- Interviewees felt that federal grants do not account for all levels of readiness and seem to be more beneficial to those that are more advanced. Policymakers may not fully recognize that other health centers need additional funding and time to build capacity.
- Interviewees felt that while grant funding may assist health centers to start SUD/ODU treatment programs, it does not account for sustainability of these services. Both federal and state policies should build off the work started via grant funding and encourage more sustainable models.
- Interviewees felt that the federal government is only focused on opioids but health centers are seeing all sorts of SUDs. And even within OUD efforts the focus may be too narrow because, while Medication-Assisted Treatment (MAT) is an integral solution, it is not the only solution.

### FINDING 2: INTEGRATION FACILITATORS

Health center and PCA interviewees were able to identify a few key factors that facilitated the creation of integrated care settings. Most interviewees felt that health centers that started as Community Mental Health Centers (CMHCs) and later became FQHCs had an advantage because they already had a behavioral health system in place. Even if these health centers did not provide MAT at first, they had behavioral health services, staffing, and expertise that made it easier to incorporate OUD treatment protocols during this epidemic. Medicaid expansion gave early adopters a reliable funding source that helped initiate and sustain integration. Even when Medicaid did not cover

all behavioral health services, its existence offered a platform where health centers could build an initial set of services with hope of expanding payment for additional services rendered over time. In that regard, health centers identified strong PCAs and informed legislative champions as key facilitators for the current and future funding, development, implementation and expansion of access to reimbursed integrated care. Finally, many of the early adopters stated that long-term foundation and philanthropic partners were critical sources of support for education, training, and initial startup funds needed to prepare staff for the changes in business practices

#### KEY INSIGHTS FROM INTERVIEWEES

- Interviewees feared losing Medicaid expansion, because without expansion they felt it would be too hard to continue integrated care.
- Interviewees in non-expansion states wanted to see Medicaid expanded. If their state was to expand Medicaid via 1115 waiver, they hoped to see sensible state waivers.
- Interviewees wanted to have a clear understanding of how applying work requirements, drug screening, and other add-on measures to Medicaid eligibility would affect vulnerable patients and communities, including individuals with a SUD.

### FINDING 3: STIGMA

Every interviewee identified stigma as a persistent barrier to integrated and high-quality SUD services. The stigma persisted at many

levels and, over time, made it difficult for health system partners to develop, pay for, evaluate and sustain high quality SUD services even as the

Affordable Care Act (ACA) required such services. Although a lot has been done to eliminate stigma associated with SUD (i.e., the biased view that addiction is a “moral failure”), much work remains to be done to ensure that patients can access care, including MAT, without being subject to bias or discrimination. Stigma held by policymakers and the public have somewhat decreased against certain people with OUD, but remains prevalent for individuals with low income and people of color battling OUDs and SUDs of various types. In these instances, the law enforcement response continues, and this reality makes it hard for health centers to engage and retain patients.

Even some health center leadership and staff may have their own stigma against those with SUDs which has slowed the acceptance and implementation of behavioral health services, including MAT, for patients with SUD, even as this omission worsens other health outcomes metrics. Finally, patients have reported when they feel judgement from the staff and larger system it makes them less likely to ask for and engage in services. Successful health centers have ongoing education and stigma reduction. However, federal, state, local and public stigma remains and can often serve as a disincentive to embrace integration.

#### KEY INSIGHTS FROM INTERVIEWEES

- Interviewees felt that focusing only on opioids is increasing stigma against people who use other substances.
- Interviewees stressed that health center leadership, board members and staff (including but not limited to providers) often need training/education to decrease stigma to embrace integrated care.
- Interviewees noted that community stigma against patients with OUD can make health centers hesitant to integrate these services for fear of patients not coming in for other health care services.

#### FINDING 4: OPERATIONAL NEEDS

Every health center and PCA talked about the need to develop infrastructure to better serve patients with SUD. Their perception of infrastructure gaps was comprised of several different components. The first was a lack of time, funding, and training for staff to understand the importance of integrated care and then to use that newly developed understanding to effectively implement SUD services and/or integrated care. There was frustration that policymakers seemed to think that health centers can simply add treatment with buprenorphine or naloxone and patients will become drug free. Interviewees requested training on many levels. Self-identified clinical training needs included:

- how to provide behavioral health and SUD services (i.e. how to screen or do a brief intervention);
- how to bill/code for services;
- how to add these pieces into an EMR and make sure all the patient consents are in place to allow for team-based care; and
- how to develop the formalized relationships needed to refer a patient needing more specialized care.

Once staff have clinical training, they need to understand how to include services within the health center’s current workflow. This individualized process has to cater to the needs of each health center’s capacity and the needs of its patient population. Health centers need

funding for staff to have time to create and test workflow changes to ensure the process meets the needs of staff and patients, and promotes efficient and effective care. Federal and state resources rarely cover these processes leaving health centers in a bind.

Finally, health centers need time to develop a way to collect and understand data, and to make

improvements based on data analysis. Many federal grants require substantial reporting of data for which significant investments are still needed to improve the mechanisms for reporting and rapid-cycle feedback. Improvements to data reporting could lead to more reliable assessments of impact on improved outcomes and continuous quality improvement.

#### KEY INSIGHTS FROM INTERVIEWEES

- Interviewees noted that external funding is needed for implementation costs including trainings and workflow processes, but also for other initial start-up costs including EMR changes and provider salaries.
- Health centers need trainings and models to help them initiate necessary changes; few viewed the current resources and trainings as useful or tailored to the health center model.
- Some rural and/or frontier health centers have so little staffing capacity that they may need unique partnership models that will have to incorporate reimbursable telehealth and perhaps tele-support services.

#### FINDING 5: WORKFORCE CHALLENGES

Interviewees noted there are simply not enough primary care or behavioral health providers available to meet the needs of their patients. In addition, because health centers have limited funding, which often leads to lower salaries than other health system partners; it is hard to recruit and retain the staff needed for successful implementation and integration of SUD services.

In addition to workforce shortages, interviewees noted other workforce barriers including: arcane certification and licensing requirements, restrictive nurse practitioner (NP) and physician assistant (PA) scopes of practice, and reimbursement rules that do not allow certain types of providers to bill within health centers

#### KEY INSIGHTS FROM INTERVIEWEES

- Interviewees noted that the federal government and states should work with provider partners to develop creative long-term solutions to the workforce crisis; these must include but not be limited to expanded loan repayment. Some states are piloting promising new models (e.g., Ohio and California).
- Interviewees stressed that both primary care and behavioral health providers are needed. Ideally, a new workforce would be taught to work in integrated care settings.
- Many interviewees stated that easing licensing, certification and interstate reciprocity rules could increase workforce at the margins, but that alone is not enough.
- Retention is also an important factor and can be improved with better reimbursement for behavioral health services, which can then translate to better salaries, more case management and support services, and more recognition of and payment for integrated care services.

## FINDING 6: BIAS REGARDING MEDICATION ASSISTED TREATMENT (MAT)

Every state interviewed had at least one to two health centers that offered either buprenorphine or naltrexone as an adjunct to other services. However, interviewees expressed frustration that policymakers were often only promoting MAT to the exclusion of other behavioral health services and services for other types of SUDs. Some communities may not have an overwhelming opioid problem but do have methamphetamine and alcohol concerns that are overlooked with the overarching funding and emphasis on OUD.

Interviewees noted that there are also stigma, leadership, and implementation barriers to providing MAT. Stigma-related barriers include the need to educate health center partners (like other health, social and public partners) that

MAT is not simply a “substitution” for opioids; that the need to provide different MAT medications should be based on patient’s needs and not moral judgement; and that MAT for OUD is a standard of care. Health centers need leaders who are ready and willing to champion the inclusion of MAT and who are willing to seek funding that will help them develop the infrastructure necessary for its inclusion. Additionally, while health center grants may help offset some costs for uninsured patients in need of MAT, long-term needs can cause even discounted 340B-priced drugs to be cost-prohibitive. Finally, in some states, increased support is needed for other services, including methadone, as well as enabling services such as transportation to ensure that patients make their daily appointments.

### KEY INSIGHTS FROM INTERVIEWEES

- Many interviewees expressed frustration that as opposed to medications for other chronic diseases, MAT is sometimes offered based on peoples’ moral judgements instead of clinical needs.
- Interviewees stressed that both leadership and staff need education about the evidence behind MAT, as well as training on how to use it.
- Interviewees noted that health centers rarely consider Methadone treatment for OUD, and MAT for other SUDs (e.g. alcohol use disorder) are rarely discussed. Health centers need to understand all types of MAT so they can refer patients to the type that best fits their needs.

## FINDING 7: PRIVACY

As in other health care settings, health centers found compliance with SUD specific privacy requirements, known as 42 CFR Part 2,<sup>ii</sup> to be a major barrier to integrated care. Health centers highlighted the delicate balance of privacy versus law enforcement access for their

vulnerable patient populations. However, interviewees wanted the federal government to develop a better solution such as global consent forms, or realigning SUD treatment information standards with HIPAA privacy laws to facilitate appropriate sharing of health information.

### KEY INSIGHTS FROM INTERVIEWEES

- Interviewees noted that health centers that have not initiated integrated care are often overwhelmed by the privacy hurdles. Scalable integration would require the federal government to make compliance easier/more understandable.
- Interviewees particularly noted the importance of considering the specific and complicated issues that health center patients from marginalized populations may struggle with, including lack of

trust in the health system and/or law enforcement, histories of trauma, and language barriers, when considering SUD privacy policies.

### FINDING 8: RURAL BARRIERS

Federal and state policies do not always provide the funding or support necessary to ensure that rural patients have adequate access to care. To help alleviate pronounced workforce shortages in rural communities, interviewees requested more robust options for telehealth reimbursement - not just reimbursement for health centers irrespective of their status as the originating or distant site, but reimbursement for different types of providers, including but not

limited to Marriage and Family Therapists (MFTs) and Licensed Clinical Social Workers (LCSWs).

In addition to telehealth, interviewees identified a need for improved access to transportation, especially if Congress enacts policies that promote additional MAT engagement. Many states noted that Medicaid is reducing, not increasing, access to transportation for patients and view these changes as detrimental to health center patients.

#### KEY INSIGHTS FROM INTERVIEWEES

- Interviewees stressed that workforce challenges are more intense in rural settings and will require increased incentives.

### FINDING 9: SUSTAINABILITY

Funding was a consistent concern related to most issues discussed in the interviews, including questions on who pays for training, start-up hiring costs, EMRs, and data changes. Initial adoption of this technology usually only requires a one or two-time grant to get health centers started, but this funding does not address long-term sustainability for SUD or integrated care services. Interviewees repeatedly identified barriers to sustainability that affected all aspects of care, including retaining providers, funding, access to affordable medications, and paying for and supporting social determinant needs. As policymakers seek to address gaps in access, they must develop policies that support sustainability, including:

- ensuring reimbursement for screening, brief intervention and referral for services
- coverage for counseling and other behavioral health services
- case management reimbursement
- funding to address social determinants of health (e.g., housing, transportation, etc.)

The largest barrier in some, but not all, states was the denial of reimbursement for multiple services on the same day, or “same day billing.” Many states will not allow providers to bill for a primary care and behavioral health visit on the same day meaning the health center must absorb these costs and subsequently jeopardize their whole operation.

#### KEY INSIGHTS FROM INTERVIEWEES

- Interviewees recommended more education around the issue of “same day billing”, and that Medicaid should eliminate any barriers to providing care and reimbursement for these services.

- As the federal government and states promote solutions to the opioid epidemic, interviewees noted they must develop and implement payment and other policies that will sustain SUD services past this current crisis.

### **FINDING 10: NON-MEDICAID EXPANSION STATES HAVE FEWER OPTIONS**

States that have not expanded Medicaid have the fewest integration options. Many interviewees from non-expansion states noted that funding for SUD services is often limited due to minimal state resources. Additionally, many states often do not provide robust reimbursement for SUD services and, without adequate funding, the health centers are not able to provide the needed community-based SUD care.

Health centers in non-expansion states are more likely to have large numbers of uninsured patients, making them more heavily reliant on their federal Section 330 grant funds to cover the costs of comprehensive behavioral health

services – dollars that can only be stretched so far. Medicaid expansion allows for many of those dollars to be freed up and new Medicaid revenue to be invested into behavioral health and SUD services. Therefore, health centers whose patients experienced Medicaid coverage gains are better positioned to be able to provide comprehensive and integrated services. Research recently published by the Kaiser Family Foundation affirms the interviewees insights on the impact Medicaid expansion has had on health centers' integration efforts.<sup>iii</sup>

The interviewees expressed a desire to work with their peers to learn from and develop best practices in these states.

#### **KEY INSIGHTS FROM INTERVIEWEES:**

- Interviewees noted that Medicaid expansion is an important piece toward integration. However, even in states that have expanded their Medicaid programs, benefits may still be extremely limited, coverage may be restricted to certain populations, or reimbursement may not be permissible or adequate to cover the cost of care.

### **FINDING 11: LACK OF SERVICES FOR SPECIAL POPULATIONS**

Special populations<sup>iv</sup> (e.g., pregnant women, individuals who were incarcerated and/or homeless, and tribal populations) face additional barriers because of confluence of factors including stigma and a lack of tailored resources. Few health centers or PCAs that were interviewed in this assessment had a thorough understanding of how health centers can best address or scale care to these populations. Some health centers discussed efforts to provide

naltrexone to patients leaving jail, deliver MAT to pregnant women, and offer culturally-sensitive SUD services to tribal populations. However, few had fully developed programs that were targeted towards a range of special populations.

More education and advocacy are needed to help these unique populations.

#### **KEY INSIGHTS FROM INTERVIEWEES:**

- Interviewees noted that care for special populations is built onto existing integrated care services, but health centers have to develop a basic system before adapting for special higher risk populations.

- Specifically related to pregnant woman, interviewees noted that they need training, education, and resources to target postpartum women with SUD.

### OTHER FINDINGS:

Competition between Community Mental Health Centers (CMHCs) and FQHCs can hinder integration efforts. Interviewees felt state funding restrictions often create this competition. Many states only pay for low intensity behavioral health services in CMHCs. These policies discourage integration and holistic care as each entity is incentivized to

compete against the other to protect their funding. If a health center still tries to integrate care, there may be animosity over concerns of “patient stealing” even if the health center is forfeiting the cost of care. States should change reimbursement regulations to promote the integration of staff and billing across both types of centers.

### CONCLUSION:

Widespread integration of behavioral health and primary care services at health centers will require federal, state and health center coordination, funding, and education to alleviate the myriad barriers to the provision of integrated behavioral health and SUD services. These changes will likely come with time, but in the meantime, there are a number of shorter-term efforts that could facilitate early and middle stage adopters to embrace an integrated care model for the most vulnerable populations.

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<sup>ii</sup> [42 CFR Part 2](#) (See NACHC’s Comments [here](#).)

<sup>iii</sup> Zur, J., Tolbert, J., Sharac, J., & Markus, A. (2018, July). *The Role of Community Health centers in Addressing the Opioid Epidemic*. Retrieved from <https://www.kff.org/report-section/the-role-of-community-health-centers-in-addressing-the-opioid-epidemic-appendix/>.

<sup>iv</sup> The term “special populations,” as used here, includes, but is not limited to the following: homeless individuals, individuals with disabilities, pregnant women, formerly incarcerated individuals, and tribal populations.