

## Q&A: COVID-19 Behavioral Health Policies Affecting CYSHCN: What to Keep, Modify, or Discard?

Below are responses to questions the panel was unable to answer during the webinar.

### Respondents

- **Margaret (Meg) Comeau, MHA**, Senior Project Director, Center for Innovation in Social Work & Health at Boston University
- **Debra Manners, MSW, LCSW**, President & CEO, Sycamores
- **Nicole Pratt**, Senior Parent Professional Trainer, SPAN Parent Advocacy Network
- **Helen DuPlessis, MD, MPH, FAAP**, Principal, Health Management Associates

### Q&A

**In some states there are wait lists for waiver services, certain therapies, and respite care. What ways can providers and advocates support families in accessing these types of services?**

Waiting lists are a significant barrier to accessing needed care through Medicaid in many states. Although providers cannot always break through this logjam, it is important for the referring provider to track the status of those referrals and resulting services in case there are alternatives to meet the client's/family's needs. In some states, including New Jersey, these services may be provided by other non-Medicaid programs (e.g., state agencies for the developmentally disabled). When that is not the case, one policy option to address this issue is to expand access to Medicaid through a state plan amendment (SPA), which unlike a waiver doesn't allow waiting lists for eligible individuals.

A state plan amendment is used to launch a new program or benefit (including optional benefits) or to change the existing Medicaid state plan and must be approved by the Centers for Medicare and Medicaid Services (CMS) before going into operation. Advocates, including individual providers and families, can be instrumental in helping make the case for expanding Medicaid to better serve individuals with disabilities who, for whatever reason, cannot access a home and community-based service waiver.

One such option for children under age 19 is called the [Tax Equity and Fiscal Responsibility Act state plan option \(TEFRA SPA\)](#), sometimes referred to as the Katie Beckett option. In a state that adopts a TEFRA SPA, children who meet an institutional level of care requirement become eligible for Medicaid along with the comprehensive [Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\) child health benefit](#) that goes with it. Family income is not counted under TEFRA.

Another option is a [Medicaid buy-in program](#). Some states allow families of children with disabilities to "buy in" to the Medicaid program for their disabled child by paying a premium. Under the [Family Opportunity Act's Medicaid buy-in policy option](#), children under age 18 who meet the Supplemental Security Income (SSI) disability criteria and whose family income is under 300% of the federal poverty level can access Medicaid. Some states have created their own Medicaid buy-in programs with different criteria such as a sliding-fee scale for premiums with no income limit.

For children with private insurance, [mandated benefits](#) are a policy option that states have used to ensure access to certain services that are not typically covered. Some examples of services that are required to be covered by existing [state mandated benefit laws](#) include payment for medical foods and formulas, certain types of treatment for Autism Spectrum Disorders, and hearing aids. [Self-insured plans](#) (those funded by employers themselves and sometimes called "Employee Retirement Income Security Act (ERISA)" plans and government plans are exempt from state mandated benefit laws.

The Catalyst Center at Boston University is a federally-funded technical assistance resource for state Title V programs, Medicaid agencies, and other stakeholders such as family leadership organizations. The

Catalyst Center team can help answer further questions about policy options to improve coverage and financing of care for children and youth with special health care needs. Please feel free to reach out via email at [cyshcn@bu.edu](mailto:cyshcn@bu.edu) or visit [catalystctr.org](http://catalystctr.org).

**What are some ways to provide behavioral health training and education to providers, caregivers, and families without adding more and overwhelming them?**

When considering the training of primary care providers (PCPs) we have to consider training both the pipeline (i.e., providers currently in, or soon to start training) as well as the existing workforce. Addressing the pipeline is easier – we can and should incorporate more practical behavioral health training into medical and other professional school curricula. We should also encourage rotations for these trainees in settings where behavioral health is already integrated into primary care practices (that means we must go out of our way to recruit those types of clinical preceptors). The curricula for medical and other professional schools continue to expand and that certainly must be managed, but programs can start by being deliberate about including those types of exposures in trainees' basic (i.e., required) as well as elective rotations.

Building behavioral health competencies and skills in the current workforce is a bit trickier because many who are already in the healthcare workforce may not be interested or willing to expand their scope to include more behavioral health. Where there are opportunities for integrating behavioral health into primary care practices, those providers can incorporate specific training and exposure for primary care providers into their multidisciplinary team rounds as well as offering continuing education seminars focused on how to diagnose and manage common behavioral health issues in primary care. Behavioral health providers, especially psychiatrists, actually have an incentive to do this because they are often overwhelmed with clients, many of whom could be managed by PCPs if those PCPs were better prepared.

A best practice for educating families and caregivers is to build these trainings into routine settings and make them easily accessible. For example, in New Jersey there are centers that provide training for families and caregivers in schools, community colleges, and other community settings. Visit the [SAMHSA national helpline](#) to learn more. Local [Family-to-Family Health Information Centers](#) (associated with Family Voices affiliates) may also know of local resources and provide some behavioral health training themselves.

**What are some of the root causes of scarcity in the pediatric mental and behavioral health workforce and how do we increase the workforce, including expanding representation from a diverse set of communities?**

Among the most significant root causes are inadequate provider payments and our lack of innovation in expanding the pipeline of behavioral health providers. Regarding provider payments – there is a gross mismatch between salaries for traditional primary care and behavioral health providers and the costs of post-graduate training (and the resulting financial debt individuals incur). This mismatch drives providers to higher-paying specialty disciplines and practice locations and away from primary care and behavioral health, in general, and away from high provider shortage areas, in particular.

One solution to the mismatch between educational debt and low primary care and behavioral health reimbursement and salaries is to provide more opportunities to forgive or repay school loans. Moreover, offering higher levels of loan forgiveness in hard-to-staff areas can serve as an incentive to draw new providers to those areas. Additional retention programs may be needed to retain providers in those areas. Another solution is to address the low reimbursement rates for behavioral health providers and PCPs compared to specialists. Families can help by advocating for better payment for these providers (having a provider ask for better pay seems self-serving to policymakers).

There are several ways we should be addressing the pipeline issues. First, we need to be very deliberate about expanding the types of providers who can serve this population of children and families (and be reimbursed for providing those services). Team care that includes paraprofessional navigators and peer counselors should be the rule rather than the exception. These roles can provide the support and “glue” that is so often needed by clients and families in between visits to a licensed provider. We also know from research that there is a lack of information getting to young people in high schools, community colleges, and colleges about the many different potential workforce roles they could fulfill in behavioral health (and which we hope to expand). There are also opportunities to expand the number of training spots for nurse practitioners, physician assistants, primary care physicians, and psychiatrists in our existing training programs. We would have more success building a pipeline if potential behavioral health roles were expanded, training spots were increased, and those roles and training opportunities were promoted as career options.

The California Future Health Workforce Commission recognized the looming workforce crisis we are facing, especially for primary care and behavioral health, and identified priorities and proposed a series of initiatives to address the crisis. Because the Commission made recommendations to the governor, a number of these initiatives have been included in the state budget. The report that includes those priorities and recommended initiatives: [Meeting the Demand: Final Report of the California Future Health Workforce Commission](#).