Center for Evidence to Practice

Study Brief (April 2021)

Financial & Policy Challenges to Evidence Based Practice (EBP) Implementation: Insights from Louisiana Providers

Behavioral health providers in Louisiana shared, in focus groups and interviews, their perspectives on the financial and policy challenges to successfully implement and sustain evidence based programs with the Center for Evidence to Practice. Providers reported that reimbursement rates do not cover the actual costs of providing EBPs for children when compared to standard therapy. Specifically, the current reimbursement rates neglect to adequately cover EBP operating costs and are not competitive with reimbursement from commercial insurance or private pay clients. Furthermore, according to providers, the retention of EBP trained and certified clinicians and supervisors is a notable challenge to sustaining an EBP. Although all noted the quality and value of offering EBPs, providers were clear that sustaining EBPs in the current Medicaid system was in jeopardy without changes.

INTRODUCTION

Louisiana is investing in improving the quality and effectiveness of behavioral health services for children in the state by increasing the availability of evidence-based programs (EBPs). In 2017, the Louisiana Behavioral Health Provider Survey of Youth Related Services identified that few providers were adequately trained in and delivering EBPs.[1] In 2018, **Louisiana committed to increasing access to EBPs in the Medicaid system through a partnership with the Center for Evidence to Practice**.[2] Over the past two years, the Center for Evidence to Practice has **trained over 140 practitioners across the state in the following EBPs for children**[3]:

- Child-Parent Psychotherapy (CPP)
- Eye-Movement Desensitization and Reprocessing (EMDR),
- Parent-Child Interaction Therapy (PCIT)
- Youth PTSD Treatment (YPT)
- Preschool PTSD Treatment (PPT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Positive Parent Practices (Triple P)

Research on EBP implementation in behavioral health systems has long recognized that expert training is necessary to initiate these clinical programs but is not adequate to ensure widespread uptake and sustainability.[4,5] **System, organizational, financial, and policy changes are also needed to support these services**.[6,7,8]

With many providers now trained and delivering EBPs in the Louisiana Medicaid-funded behavioral health system, the Center for Evidence to Practice sought to understand how providers were perceiving current state implementation efforts. In interviews and focus groups, Louisiana **EBP providers shared their commitment and motivation to deliver EBPs but also warned that that financial and policy barriers to EBP delivery were a significant threat to the state's goal of increased access to behavioral health EBPs for the children and families who need them.**

METHODS

In November and December 2020, nineteen Medicaid-funded behavioral health providers were recruited to participate in interviews or focus groups. Five were independent practitioners, and 14 held leadership positions within behavioral health service agencies. They all had experience delivering EBPs and had participated in the Center for Evidence to Practice training or other programming. They were asked a series of questions about their motivations to deliver EBPs, the cost of delivering EBPs compared to treatment as usual, fiscal and policy barriers they experienced in providing EBP services within the Louisiana Medicaid system, and their recommendations for how to address these challenges. Through thematic analysis of those conversations, we summarized their perspectives on challenges to delivery of EBPs within the current Medicaid structures for behavioral health services.

RESULTS

EBPs support quality and value

Louisiana providers emphasized their **commitment to EBPs**, that they see the **value to the families they serve**, particularly for children who experienced trauma and for engaging children and their caregivers in treatment. They also reported that EBPs help support their efforts to **ensure quality in their organizations and their workforce** by improving clinical competency and providing practical structure for therapy, training, supervision, and career development.

EBP delivery incurs increased direct and indirect costs

The EBP training offered at no-cost through the Center for Evidence to Practice addresses a significant financial barrier to EBP implementation for providers. However, providers **struggle to cover additional costs of EBP implementation and delivery**. Consistent with the research literature,[9,10,11] Louisiana providers reported costs for EBP implementation such as materials, travel, staff time for training, preparation, practice, consultation, outcome measurement, longer sessions, EBP documentation, and managing referrals. Substantial indirect costs result from the additional out-of-session clinical and administrative time required for EBP training and delivery. The time invested in these activities limited clinicians' availability for in-session, billable activities (lost billing productivity) and reduced the size of caseloads they can carry. They noted that while these activities were most time-consuming while still training in the EBP, many continued through the stages of consultation, certification, and service delivery.

Reimbursement rates do not support EBP sustainability

In Louisiana, EBPs for children are currently reimbursed at the same rate as standard therapy services (except Multisystem Therapy and Functional Family Therapy). Providers reported that these **current rates do not adequately cover EBP operating costs and are not competitive** with reimbursement rates from commercial insurance or private pay clients. Therefore, **there is a financial disincentive to offer EBPs** in lieu of less costly and less time-consuming treatment-as-usual (standard treatment services). Providers reported struggling to make budgets work and feel these rates send the message that EBPs are not adequately valued within the Medicaid behavioral health system.

Many providers spoke of their mission to provide EBPs to the children and families that need them; therefore, they seek alternative funding strategies, such as grants and diversifying payer mix to cover deficits. However, they feel limited in their capacity to expand EBP services, particularly within the Medicaid system, and some raised concerns about their ability to sustain the EBPs and to remain providers within the Medicaid network.

Retaining EBP trained clinician is a critical challenge to sustaining EBPs

Agency leaders **struggle to retain EBP trained and certified clinicians and supervisors** because current Medicaid reimbursement **rates do not support salaries and career development opportunities that are competitive,**

particularly within clinic-based outpatient services. They reported that after investing the time and resources in training clinicians in an EBP, they leave and "take the training with them." Agencies may not see a return on the investment of training time. Clinicians often go to other agencies or private practices that may not provide services to Medicaid-enrolled children and families. To buffer against the potential for EBP trained staff turnover, agencies seek to train multiple therapists in the model when they have the opportunity to do so.

Fiscal, policy and managed care processes need improved alignment with EBPs

Providers reported that current Louisiana staffing regulations, rates, and managed care practices were not aligned with increased delivery of EBPs within clinic-based outpatient services. In Louisiana, **clinic-based outpatient services require licensed clinicians yet are reimbursed at lower rates than Mental Health Rehabilitation (MHR), Community Psychiatric Support and Treatment (CPST)** services which do not require clinician licensure. Thus, this creates a financial disincentive for outpatient services and for investing in building EBP capacity within outpatient services. Lower rates in outpatient services result in challenges to pay qualified staff adequately and create career opportunities for CPST clinicians who become licensed and want to transition to clinic-based services. **Current staffing regulations prevent clinicians working toward licensure (e.g., trained students and recent graduates of clinical programs) from billing for outpatient services**; therefore, agencies cannot provide EBP training opportunities and career development pathways within outpatient services.

Some providers offer EBPs within MHR services; however, the Medicaid service descriptions and managed care processes in MHR are not well aligned with the EBP clinical models, resulting in barriers to EBP delivery.

CONCLUSIONS

Successful implementation of evidence-based programs requires changes at the clinical, organizational, and system levels. In partnership with the Louisiana Office of Behavioral Health and the Center for Evidence to Practice, Louisiana providers are making strides in building capacity to deliver EBPs for children and families. To ensure these advances, fiscal and policy considerations must match the priority to improve the quality of behavioral healthcare for youth and their families. As the state continues to invest in these high-value services, reimbursing the direct and indirect costs to sustain EBPs, retaining the specially trained EBP workforce, and increasing access and volume of these services in the Medicaid provider network are all critical matters to attend to.

Implementation researchers have identified financial factors as notable barriers to EBP implementation and sustainment[4,12], and Louisiana providers are echoing that challenge. For EBPs to be successfully integrated within a behavioral health system, the regulatory and fiscal context must align with EBP service requirements and costs. For example, reimbursements rates could be adjusted to account for the costs of delivering EBPs and to compete with other healthcare industry rates for outpatient psychotherapy services. Additional financial incentives may include contracting for EBP services, and, in the longer term, performance payments that are tied to increased delivery of EBPs (e.g., client engagement and retention). These financial strategies could be integrated within the Medicaid claims systems to improve EBP data tracking. They can also serve as the foundation for future strategies to support EBPs, such as improving referrals, quality improvement initiatives, and value-based reimbursements to demonstrate improvements in child-related behavioral health outcomes.

Policy changes and reimbursement rates could support and stabilize the EBP trained workforce within the Medicaid provider network. This could include exploring policies to allow for EBP training and billing by clinicians working toward licensure under the supervision of a trained EBP supervisor. Furthermore,

competitive EBP outpatient rates to retain EBP trained clinicians, and advancement opportunities for experienced EBP clinicians and supervisors could be further explored.

In partnership with Medicaid, managed care organizations and EBP providers, further alignment and integration of consistent EBP assessment, documentation, authorization and audit processes could be established in recognition of the existing research supporting EBP quality, consistency, and likelihood of improved outcomes. Louisiana has already recognized the importance of EBPs to improve the overall quality of the behavioral health services youth and families access. Accompanying this access with processes easing referral to, and utilization of, EBPs will help sustain these critical services throughout the state, now, and into the future.

Authors: Ronnie Rubin, PhD, Stephen Phillippi, PhD, and Willandra Whiting, MPH

For more information, contact the Center for Evidence to Practice at https://laevidencetopractice.com/contact-us/

This brief is from the LSU Health Science's School of Public Health's Center for Evidence to Practice. The Center was created to bring more evidence-based behavioral health practices to communities across the state of Louisiana. We seek to identify strengths and gaps in Louisiana's child and youth behavioral health system; make evidence-based support and intervention available when and where youth and families need them; promote excellence and accountability in service provision; and, encourage a ready workforce through education and support efforts.

[1] Phillippi, S., Beiter, K., Thomas, C., & Vos, S. (2020). Identifying gaps and using evidence-based practices to serve the behavioral health needs of Medicaid-insured children. *Children and Youth Services Review. 115*.

[2] https://laevidencetopractice.com/about-us/

[3] https://my.visme.co/view/8rexq7ne-center-for-e2p-2020-annual-report

[4] Aarons, G. A., Hurlburt, M., & Horwitz, S. M. C. (2010). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), 4–23. https://doi.org/10.1007/s10488-010-0327-7

[5] Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*. doi:10.1186/1748-5908-4-50.

[6] Dopp, A. R., Narcisse, M.-R., Mundey, P., Silovsky, J. F., Smith, A. B., Mandell, D., Funderburk, B. W., Powell, B. J., Schmidt, S., Edwards, D., Luke, D., & Mendel, P. (2020). A scoping review of strategies for financing the implementation of evidence-based practices in behavioral health systems: State of the literature and future directions. *Implementation Research and Practice, 1*. https://doi.org/10.1177/2633489520939980

[7] Powell, B. J., Waltz, T. J., Chinman, M. J., Damschroder, L. J., Smith, J. L., Matthieu, M. M., Proctor, E. K., & Kirchner, J. E. (2015). A refined compilation of implementation strategies: Results from the Expert Recommendations for Implementing Change (ERIC) project. *Implementation Science*. https://doi.org/10.1186/s13012-015-0209-1

[8] Raghavan, R., Bright, C. L., & Shadoin, A. L. (2008). Toward a policy ecology of implementation of evidence-based practices in public mental health settings. *Implementation Science, 3,* 26. https://doi.org/10.1186/1748-5908-3-26

[9] Hagele, D., Potter, D., Seifert, H. T. (2020). Clinical Servicer Delivery Time Model (Case-level time estimates). *North Carolina Child Treatment Program. https://www.ncchildtreatmentprogram.org/implementation-support/*

[10] Lang, J. M., & Connell, C. M. (2016). Measuring costs to community-nased agencies for implementation of an evidence-based practice. *The Journal of Behavioral Health Services & Research, 44*(1), 122–134. https://doi.org/10.1007/s11414-016-9541-8

[11]Roundfield, K. D., & Lang, J. M. (2017). Costs to community mental health agencies to sustain an evidence-based practice. *Psychiatric Services, 68*(9), 876–882. https://doi.org/10.1176/appi.ps.201600193[4]

[12]Stewart, R. E., Adams, D. R., Mandell, D. S., Hadley, T. R., Evans, A., Rubin, R., Erney, J., Neimark, G., Hurford, M. O., & Beidas, R. S. (2016). The perfect storm: Collision of the business of mental health and the implementation of evidence-based practices. *Psychiatric Services, 67*(2), 159–161. https://doi.org/10.1176/appi.ps.201500392.