Receiving Recognition: A Case for Occupational Therapy Practitioners as Mental and Behavioral Health Providers

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Importance: An analysis by the Substance Abuse and Mental Health Services Administration (SAMHSA; 2015a) found that an additional 10,000 mental health care providers will be needed by 2025 to meet the expected growth in demand for treatment of people with mental illness, substance use disorder, or both. Despite being the largest payer of mental health services in the United States, the Medicaid program has extremely low numbers of mental health providers (Frank et al., 2003).

Objective: This Health Policy Perspectives column is a collaboration among academics, clinicians, and students in the fields of occupational therapy and law in an effort to advance state occupational therapy associations' efforts to gain formal recognition of occupational therapy practitioners as Qualified Mental Health Providers (QMHPs) and/or Qualified Behavioral Health Providers (QBHPs).

Conclusion: Coordination among states to identify barriers and opportunities in this important advocacy effort are needed for continued successful inclusion of occupational therapy practitioners as QMHPs, QBHPs, or both.

What This Article Adds: This column will assist other states in their efforts by providing legislation, strategic advocacy examples, and a course of action.

People with mental and behavioral health conditions in states such as Indiana are vulnerable given the severe shortage of mental health providers there (Kaiser Family Foundation, 2019). For example, a 2014 report found that there were no psychiatrists practicing in 43 of Indiana's 92 counties (Maxey & Norwood, 2014). More than 30 counties do not have a primary mental health professional (LeDuc, 2018). In this column, we argue that states should recognize occupational therapists as mental and behavioral health providers—specifically, as Qualified Mental Health Providers (QMHPs), Qualified Behavioral Health Providers (QBHPs), or both—to address this provider shortage. Using Indiana as a case exemplar, we detail the flexibility under state and federal law to permit this recognition and, in turn, facilitate Medicaid coverage of occupational therapy services.

State Example: Indiana

The Indiana Occupational Therapy Association has been advocating to join other jurisdictions in the United States to reduce the mental health provider shortage by recognizing occupational therapy practitioners as mental health providers under the Medicaid Rehabilitation Option (MRO; Wilburn, 2017). In a 2018 decision letter, the state declined (Flynn, 2018). The Monitoring Legal and Policy Interventions and Barriers Project at Indiana University's McKinney School of Law, funded by the Addictions Grand Challenge, received a technical assistance request regarding information on the laws and policies that support the recognition of occupational therapists as mental health professionals. Their expertise yielded a memorandum that served three purposes. First, it provided background on occupational therapy and the role of occupational therapy in mental health treatment. Second, it detailed the laws that allow

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occupational therapists to be recognized as QMHPs and eligible for Medicaid option billing. Finally, it provided a summary of the efforts that had been made to recognize occupational therapists as QMHPs in Indiana.

The memorandum highlighted the licensing requirements for occupational therapists, stating that they are established by state law in all 50 states as well as DC and Puerto Rico (e.g., Code of Maryland § 10-101, 2020) and how licensing requirements for occupational therapists in Indiana are instituted by the state's Occupational Therapy Committee (Ind. Code § 25-23.5-2, 2019). Indiana has a continuing competency requirement of occupational therapists to maintain a license to practice (844 Ind. Admin. Code [IAC] § 10-7-1, 2019). Last, with limited exception, occupational therapists do not have direct access (Ind. Code § 25-23.5-2, 2019). Direct access would provide consumers the ability to receive occupational therapy services without a referral, typically provided by a medical doctor. The memorandum provided substantial evidence that occupational therapy can be an effective tool in the treatment of mental and behavioral health conditions (Castaneda et al., 2013).

Occupational Therapy Treatment in Mental Health

Occupational therapists provide services and interventions that support mental health and recovery-oriented approaches as part of their practice (Castaneda et al., 2013). Their training includes participation in at least one clinical fieldwork experience that focuses on psychosocial issues (Castaneda et al., 2013), and occupational therapy graduate programs offer advanced elective courses in behavioral health (Wilburn et al., 2020). Research indicates that occupational therapy can be an effective component of an interdisciplinary treatment of inpatient child psychiatric care (Gathright et al., 2016). Similarly, incorporating occupational therapy into the treatment of people hospitalized for schizophrenia reduces the time between rehospitalizations (Shimada et al., 2019).

In outpatient settings, occupational therapists can support people with behavioral health conditions with a variety of daily life activities, including medication adherence, peer interactions, hygiene and grooming, and time management (Castaneda et al., 2013; Lannigan et al., 2016). Research indicates that occupational therapy interventions improve education and work performance outcomes for adults living with a severe mental illness (Lannigan & Noyes, 2019; Urlic & Williamson, 2012). A systematic review of mental health treatment in children and youth found strong evidence that occupational therapy is effective in managing aggression, managing rejection, and preventing bullying (Arbesman et al., 2013).

As a specific subset of substance use providers, opioid treatment programs (OTPs) are the most targeted way occupational therapists can broaden the workforce. An OTP uses medication-assisted treatment combined with behavioral therapy to treat people with substance use disorders (SUDs). Many OTPs use all three U.S. Food and Drug Administration–approved medications (viz., buprenorphine [Belbuca, Buprenex], methadone [Methadose, Dolophine], and naltrexone [ReVia, Vivitrol]) in combination with counseling and wrap-around services (Jones et al., 2019) to treat people.

Between 2011 and 2017, more than 8,000 Indiana residents died from a drug overdose (Indiana University Richard M. Fairbanks School of Public Health at IUPUI, 2018). Opioid-related overdoses accounted for more than 1,000 deaths in 2018 alone in the state (National Institute on Drug Abuse, 2020). This highly regulated industry is still heavily burdened by stigma despite being considered the most effective method of treatment of opioid use disorder (OUD). Although the use of medication is important, perhaps the most effective parts of the comprehensive services provided are counseling and therapy. The scope of practice of occupational therapy bridges the therapeutic nature of mental and behavioral health services with medication management, life skills development, and personal interactions while balancing those with the client's needs. Given the shortage of credentialed, reimbursable providers who can provide comprehensive services to people with SUDs, OUDs, and co-occurring disorders, occupational therapists may help fill this void.

Federal Recognition for Occupational Therapists

As outlined by state and federal law, certain health services provided to Medicaid enrollees can be eligible for reimbursement (Rudowitz et al., 2019). The MRO allows for reimbursement of certain eligible mental health services

(Indiana Family and Social Services Administration, 2018). Federal law allows states to administer their Medicaid programs, leading to considerable state-to-state variability in the services covered (Crowley & O'Malley, 2007). Federal law lists occupational therapy as an option service under state Medicaid plans; however, it does not exclude occupational therapy from MRO eligibility (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Thus, several states have opted to recognize occupational therapists as mental health providers (Peters, 1984).

In addition, at the federal level, occupational therapists are recognized as mental health providers in a variety of settings, including Certified Community Behavioral Health Centers (CCBHCs) and forensic facilities, which may bolster the argument for state recognition of occupational therapy as an MRO. For example, in its 2018 Budget Justification to Congress, the Health Resources and Services Administration (HRSA) included master's entry-level programs that train occupational therapists as eligible for MROs under the Behavioral Health Workforce Education and Training Program (HRSA, 2019, p. 355). This program funds training that is intended to develop and expand the segment of the occupational therapy workforce that specializes in treating substance abuse and behavioral issues (HRSA, 2020). The program has received support from Congress through reauthorization in previous years (HRSA, 2019, p. 355).

SAMHSA also recognized the value of occupational therapists to the mental health and substance abuse profession. In 2015, SAMHSA included occupational therapists in their list of staffing suggestions for new CCBHCs (SAMHSA, 2015b, p. 13) and as potential recipients of Primary Behavioral Health Care Integration grants (SAMHSA, 2015c). Similarly, in 2013, the Centers for Medicare & Medicaid Services (CMS) added a requirement for occupational therapy services to be offered at Community Mental Health Centers as a condition for participation for partial hospitalization services (CMS, 2013). These centers provide partial hospitalization services to Medicare beneficiaries, including intensive mental health care services (CMS, 2011).

State Recognition for Occupational Therapists

Several states permit occupational therapists to be considered QMHPs under state law. Illinois, Maine, Massachusetts, Michigan, Missouri, Montana, Oregon, and Virginia explicitly authorize occupational therapists as QMHPs under their regulatory code. Oregon's regulatory code defines a QMHP to include a person with "a bachelor's degree in occupational therapy and licensed by the State of Oregon" (Oregon Admin. Rules § 309-032-0311, 2019). Montana's definition of licensed mental health professionals includes "an occupational therapist licensed to practice in Montana who has had at least three years' experience dedicated substantially to serving persons with serious mental illnesses and is working in a youth day treatment program or adult day treatment program" (Admin. Rules of Montana § 37.106.1902, 2016). In addition, the American Occupational Therapy Association (AOTA; 2017) found that the law in seven states and Puerto Rico permits occupational therapists to be classified as QMHPs for purposes of Medicaid reimbursement. Minnesota law defines mental health professionals to include those

> with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness (Minnesota Statutes § 245.462, 2019),

which can include occupational therapy.

Occupational Therapists Under the Medicaid Rehabilitation Option in Indiana: A Blueprint for Other States

The Family and Social Services Administration (FSSA) is responsible for administering Indiana's Medicaid programs and reviews Medicaid disability claims, including those under MRO billing (FSSA, n.d.). FSSA has the authority to draft the rules under the Indiana Administrative Code (Ind. Code § 12-15-1, 2019). In March 2018, FSSA's Office of Medicaid Policy and Planning denied a request to recognize licensed occupational therapists as QBHPs for MRO billing that was submitted by the Indiana Occupational Therapy Association (Flynn, 2018). Pursuant to the Indiana Administrative Code, providers who may obtain reimbursement through MRO billing include those listed as "licensed

professionals" or those who qualify as QBHPs (405 IAC § 5-21.5-1, 2019). QBHPs are defined in the state code as professionals who have at least 2 yr clinical experience treating people with a mental illness under the supervision of "enumerated professionals" after completing a master's or doctoral degree. Enumerated professionals include licensed psychiatrists, physicians, psychologists or psychologists endorsed as a health service provider in psychology, clinical social workers, mental health counselors, marriage and family therapists, and licensed clinical addiction counselors.

Including occupational therapists on this list, and therefore recognizing them as QBHPs, would entitle reimbursement through MRO billing for treating Medicaid patients with a mental health or SUD diagnosis (405 IAC § 5-21.5-1, 2019). The Indiana Administrative Code explicitly states that Medicaid reimbursement is not available for occupational therapy psychiatric services (405 IAC § 5-22-11, 2019); however, this provision would not be applicable in the context of occupational therapy services, which are psychosocial only and not psychiatric. Only licensed psychiatrists are authorized to provide psychiatric services (405 IAC § 5-21.5-15, 2019); no other health care provider has this authority. States may find similar language in their own Medicaid provisions, confusing policy makers, health care administrations, and consumers alike.

In its response letter to the Indiana Occupational Therapy Association, FSSA cited federal law as rationale for its decision to exclude occupational therapists from the QBHP list (Flynn, 2018). It stated that Indiana Medicaid's current list of licensed professionals for MRO services aligns well with current federal law and regulations, citing 42 U.S.C. § 254(a; 3; E; i) and 42 U.S.C. § 295 (Flynn, 2018). Federal law—42 U.S.C. § 295—states what the term *mental health professional* means for purposes of public health services and health professions education; the statute identifies a mental health professional as a person with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, SUD prevention and treatment, marriage and family counseling, school counseling, or professional counseling.

Despite a lack of recognition for purposes of MRO, Indiana occupational therapists are currently making an impact on mental health and SUD treatment at Hope Academy, a tuition-free high school in Indianapolis for students in recovery from an SUD (Hope Academy, n.d.). Occupational therapists regularly collaborate with Hope Academy to work with students on life skills and tasks the students performed before developing an addiction (Gill, 2019). Reintroducing these skills helps the students regain independence and experience the enjoyment from tasks they previously performed (Gill, 2019). Moreover, a variety of organizations and individuals have submitted letters of support for the recognition of occupational therapists as QBHPs to FSSA, including Mental Health America of Indiana and AOTA (McCaffrey, n.d.; Pudeler, n.d.). This issue will likely continue to be of interest to advocates and practitioners.

Other State Approaches to Recognition

The approach Indiana has taken may be a helpful guide for other states wishing to pursue mental health recognition for occupational therapy; however, there is no one-size-fits-all approach. Just like occupational therapists in Indiana did, it is important to identify the opportunities in a state for recognition as well as the barriers that exist. Some states—such as California and New Mexico—have added more language to their legislation to describe the role of occupational therapy in mental health. In California, after several conversations with Medi-Cal regarding reimbursement for occupational therapists working in mental health, a determination was made that the state's legislation did not have sufficient language to support the role occupational therapists play in mental health; therefore, along with other practice act updates, language was added: "Through engagement in everyday activities, occupational therapy promotes mental health by supporting occupational performance in people with, or at risk of experiencing, a range of physical and mental health disorders" (CA Bus & Prof Code § 2570.2, 2018). Other states have attempted, through legislative processes, to add occupational therapists and occupational therapy assistants to the statute that defines QMHPs. In Virginia, after advocacy efforts to include occupational therapy as a service within the state's CCBHC plan were unsuccessful (not all states received these grants, and not all states include occupational therapists in the grant),

legislation was enacted in 2017 that allowed occupational therapists and occupational therapy assistants to become QMHPs.

Conclusion

Recognizing occupational therapists as QBHPs could decrease the care shortage in behavioral and mental health services for Medicaid beneficiaries. Including occupational therapists as part of the interdisciplinary team for people with a mental illness or SUD can improve health outcomes by developing social, work, and educational skills (Lannigan & Noyes, 2019; Urlic & Williamson, 2012). We hope that by sharing Indiana's trajectory of advocacy, education, and policy other states will benefit from this blueprint and continue their respective grassroots efforts, reclaiming the recognition of the profession in its full depth and breadth in supporting the mental and behavioral health of all consumers.

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