

AOTA: Expanding Opportunity for Occupational Therapy in Mental Health at the Federal Level

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Identified Challenges for OT in Mental Health

- Lack of access to behavioral health specific fieldwork;
- Low reimbursement rates in mental health settings;
- Lack of public and policy maker awareness on the role of OT in mental health;
- Lack of opportunities for occupational therapy practitioners in community mental health settings;
- Challenges with reimbursement at the state level;
- State scope of practice laws;
- State definitions of “mental health provider”.

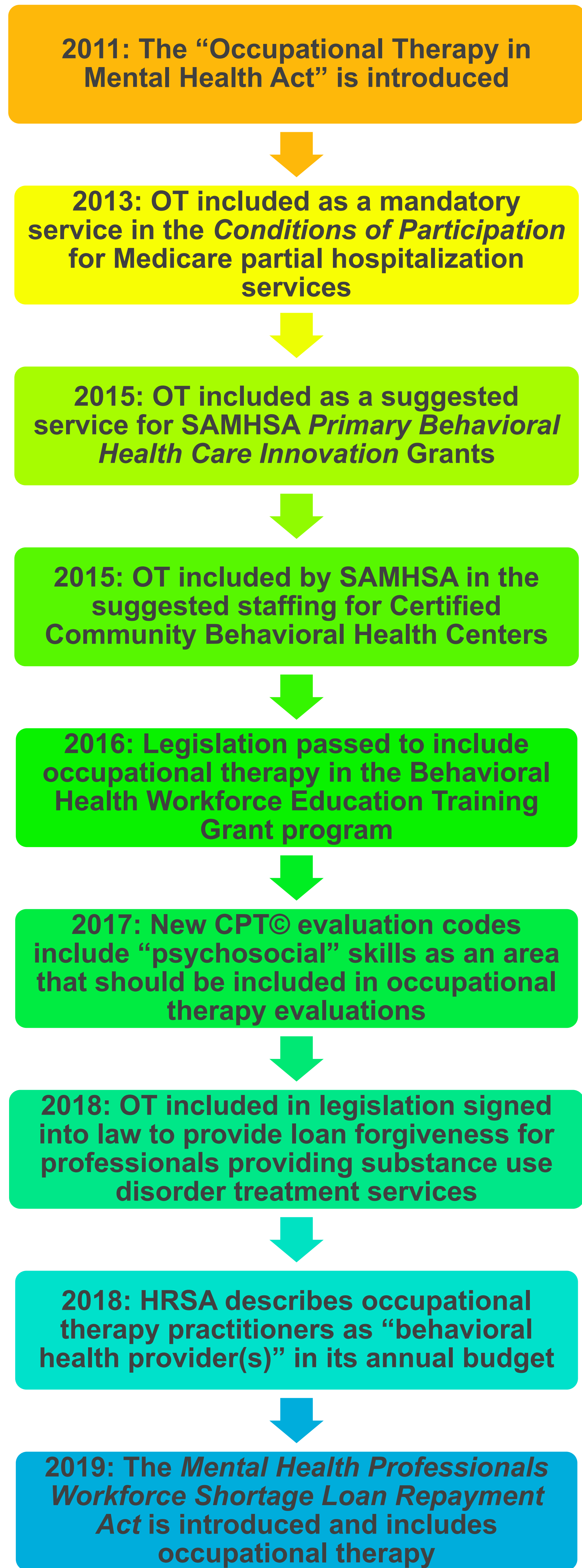
Federal Goals

- Increase visibility of occupational therapy in mental health among other mental health providers;
- Increase understanding of occupational therapy in mental health with Members of Congress;
- Increase understanding of occupational therapy in mental health within Federal Agencies;
- Include “occupational therapy practitioners” in a federal statutory definition of “mental health professional”;
- Include occupational therapy services as a part any new, federal mental health program;
- Expand mental health training opportunities to include occupational therapy.

Outreach and Engagement



Achievements



Myths Vs. Facts

Myth: Medicare does not recognize occupational therapy practitioners as professionals who provide services to people with mental illness.

Fact: Occupational therapy is a covered Medicare service for someone with a psychiatric diagnosis. Occupational therapy is a required part of Medicare partial hospitalization services and may be provided to a person with a diagnosed psychiatric illness, as long as standard coverage criteria are met. These services are billed through the CPT © codes for occupational therapy.

Myth: Including occupational therapy in a federal, statutory definition of “mental health professional” will automatically make occupational therapy practitioners Qualified Mental Health Professionals (QMHP) in every state.

Fact: Inclusion of occupational therapy in federal, statutory definitions of “mental health professional” will help to make the argument that states should recognize occupational therapy practitioners as QMHPs (as states often follow federal statute). However, this change will still have to be made on a state-by-state basis.

Beyond QMHP

For many, the ultimate recognition for occupational therapy practitioners in mental health is to be defined as “Qualified Mental Health Professionals” (QMHP) in every state.

Being defined as a QMHP is an appropriate goal for some states; however, QMHP status may not be an appropriate goal in every state. For example, several states do not define mental health professionals at all. Others may define QMHP in such a way that occupational therapy practitioners would not want to be included in that definition. Finally, in some states it may be more productive to make small gains, and then build towards QMHP status.

Other considerations for state-level expansion of OT in mental health include:

- Revising the OT practice act in the state if it does not already include language regarding OTs role in mental health consistent with the model practice act;
- Advocating for OT mental health services to be reimbursed under Medicaid – including special mental health programs that are a part of Medicaid State Plan Amendments;
- Advocate for Inclusion of OT in other state-wide programs for people with mental and behavioral health disorders, including special programs related to psychiatric rehabilitation, assertive community treatment, Olmstead settlements and others.

For more in formation visit:
<https://www.aota.org/Advocacy-Policy/State-Policy/Issue-Campaign-Mental-Behavioral-Health.aspx>

Community Behavioral Health Centers: CCBHC Ambassadors

New Opportunity in Community Behavioral Health:

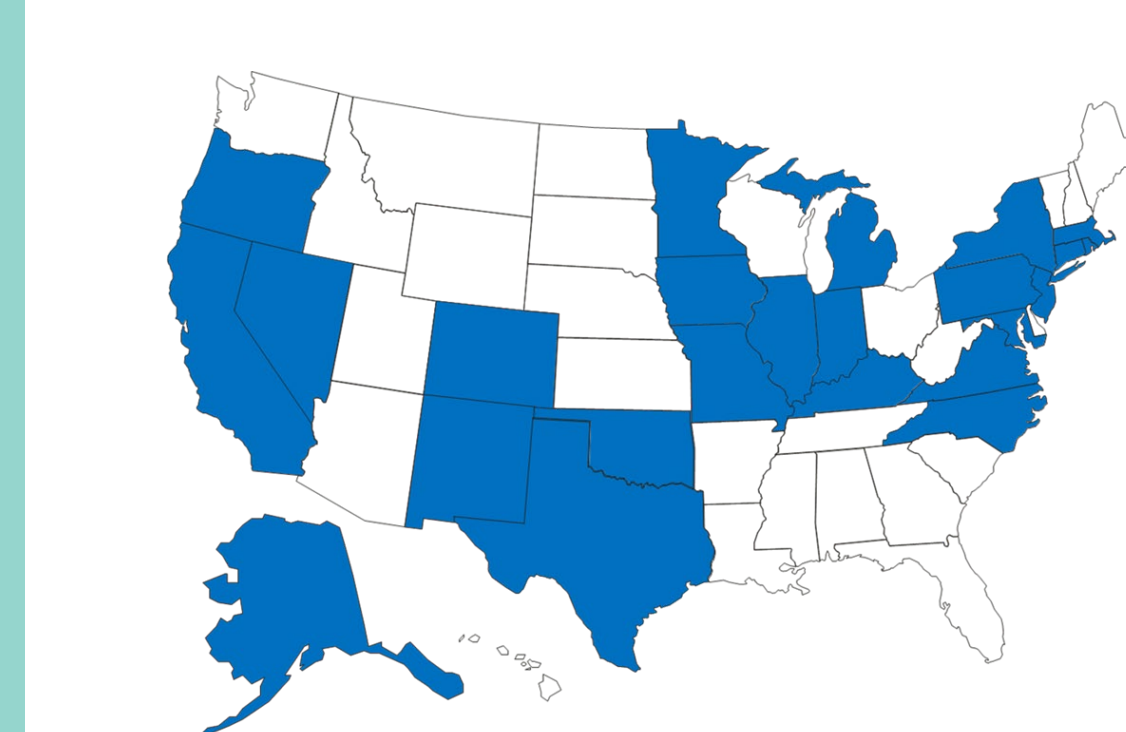
- April 2014 – Passage of the Excellence in Mental Health Medicaid Pilot Program;
- 8 State Medicaid Demonstration project;
- Expand access to behavioral health services by establishing Certified Community Behavioral Health Clinics (CCBHCs);
- In CBHCs must provide a specific set of intensive mental health services;
- Not FFS – money provided for cost of entire set of services.

Federal Advocacy:

- Federal agencies required to developed CCBHC criteria including staffing;
- Grassroots advocacy effort to include occupational therapy services in final criteria;
- Final criteria included occupational therapist among suggested staffing along with psychologist, social workers, and others.

State Advocacy:

- States applying for the program were required to get robust stakeholder input and form a steering committee;
- AOTA worked with states to appoint “CCBHC ambassadors” for each of the 23 planning grant states;
- Ambassadors advocated for inclusion of OT within state grant applications and within CCBHCs;
- Opportunity to raise profile of OT with state policy makers, even in states that did not receive planning grants.



Final CCBHC States:

- Minnesota
- Missouri
- New Jersey
- New York
- Nevada
- Oklahoma
- Oregon
- Pennsylvania

Contact Information

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