MEDICAID forward

NATIONAL ASSOCIATION OF MEDICAID DIRECTORS

BEHAVIORAL HEALTH

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The COVID-19 public health emergency, its economic fallout, and longstanding racial and ethnic inequities are affecting the nation's mental health and wellbeing. These crises are also destabilizing the behavioral health care system, making it more difficult to meet the increased behavioral health needs of the population. Medicaid and CHIP, as the insurance provider for more than 77 million individuals, including many with complex physical and behavioral health needs, will play a vital role in supporting the recovery of our nation.[2] This framework, crafted by an Executive Working Group of Medicaid leaders and national behavioral health experts convened by the National Association of Medicaid Directors, offers states options to consider to promote the health and wellbeing of members and expand access to behavioral health services. It includes strategies along a continuum of need, ranging from upstream prevention and health promotion for all Medicaid beneficiaries to increasing access to behavioral health treatment for unique subpopulations in Medicaid.

ALL MEDICAID MEMBERS

	STRATEGIC OPTIONS	ACTION ITEMS
	Advance prevention by promoting mental health and wellbeing	
	1. Support mental health promotion and primary prevention.	
	2. Increase awareness of and linkages to other social services and supports.	• Screen members for social risk factors - or direct plans or providers to conduct this screening - and make referrals to needed supports.
	Streamline eligibility for services	
	1. Simplify or relax requirements for assessments.	• Temporarily suspend assessments and/or provide a grace period for them. • Form a workgroup to review policies and assessments.
	2. Move away from diagnostic and utilization criteria for service eligibility.	• Eliminate or add flexibility to state requirements for a child to have a diagnosis before accessing behavioral health services. • Check for racial bias in instruments and clinical quality measures. • Incentivize treatment, not just screenings, and align treatment with identified needs and social risk factors.
	Continue to promote integration of physical and behavioral health services	
	1. Incentivize screening and referrals between primary care and behavioral health providers.	• Incentivize plans and providers to advance behavioral health screening and referrals in primary care. • Make sure screening and referrals are bi-directional. • Encourage consultation between behavioral health and primary care providers.
	2. Advance integrated care delivery models.	• Work in partnership with stakeholders to identify integrated care models. • Remove barriers to co-location and integration of physical and behavioral health care.

[1] **September 2020 Medicaid & CHIP Enrollment Data Highlights**. Centers for Medicare and Medicaid Services. January 2021.

ALL MEDICAID MEMBERS [CONTINUED]

STRATEGIC OPTIONS	ACTION ITEMS
Build a comprehensive approach to addiction treatment	
1. Prevent addiction by addressing the root causes.	• Leverage evidence-based early child development and family support. • Incentivize trauma-informed care.
2. Increase access to community-based care.	• Expand medication assisted treatment (MAT). • Leverage telehealth to increase access to substance use disorder treatment. • Create e-consult support for primary care.
3. Increase access to specialized inpatient services as one component of comprehensive addiction treatment.	
4. Provide recovery supports.	• Cover peers and family peer specialists for all members with an addiction. • Provide support or incentivize plans to provide support to help people stay in recovery.
Strengthen and broaden crisis response systems	
1. Connect individuals in crisis with appropriate care.	• Leverage and support crisis hotlines for Medicaid members.
2. Ensure the right responders are dispatched to a crisis.	• Implement mobile crisis teams (MCTs). • Implement co-responder models.
3. Develop specialized settings to support individuals in crisis.	

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INDIVIDUALS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

	STRATEGIC OPTIONS	ACTION ITEMS
	1. Use crisis services to prevent incarceration.	
	2. Eliminate gaps in care that occur during the transition out of the criminal justice system.	• Ensure individuals who encounter the criminal justice system stay connected to Medicaid. • Direct health plans or providers to conduct in-reach. • Explore opportunities for Medicaid to cover services pre-release.

CHILDREN

	STRATEGIC OPTIONS	ACTION ITEMS
	1. Remove barriers to behavioral health services for children and their caregivers.	• Eliminate or add flexibility to requirements that children have a behavioral health diagnosis before they can access behavioral health services. • Address any policy barriers that prevent children and caregivers from receiving services together. • Remove or modify cumbersome prior authorization, service location requirements, or service limitations for behavioral health services.
	2. Develop a comprehensive strategy to support family emotional health and stability.	

OLDER ADULTS

	STRATEGIC OPTIONS	ACTION ITEMS
	1. Respond to the immediate health needs of older adults.	• Ensure access to care. • Support resilience of older adults. • Assess and respond to immediate resource needs.
	2. Transform behavioral health care for older adults.	• Incentivize evidence-based approaches to improved care. • Develop quality expectations and value-based payment arrangements for providers and health plans.

INDIVIDUALS WITH INTELLECTUAL & DEVELOPMENTAL DISABILITIES

	STRATEGIC OPTIONS	ACTION ITEMS
	1. Understand the needs of the population.	• Leverage data from providers, plans, and other state agencies. • Engage stakeholders to identify challenges and potential solutions.
	2. Ensure primary supports for stability.	• Enhance direct care workforce capacity. • Expand respite care coverage. • Enhance case management.
	3. Enhance behavioral health treatment for individuals with ID/DD.	• Incentivize collaboration between ID/DD and behavioral health providers. • Support specialized crisis services that can be tailored to those with ID/DD.

INDIVIDUALS EXPERIENCING HOMELESSNESS OR HOUSING INSTABILITY

	STRATEGIC OPTIONS	ACTION ITEMS
	1. Connect individuals and families experiencing homelessness or housing instability to Medicaid coverage.	• Perform a review of all enrollment processes. • Connect data across agencies.
	2. Identify members who may be experiencing homelessness or housing instability.	• Identify and use address markers in enrollment and encounter data that may indicate an individual or family is homeless. • Regularly match Medicaid enrollment or claims data with other data sources, like state homeless management information systems. • Encourage or require plans or providers to screen members for their risk of housing instability.
	3. Help members achieve and maintain housing through supportive housing.	
	4. Tailor services to the unique health care needs of this population.	• Work closely with Health Care for the Homeless Health Centers. • Implement care management services for individuals or families experiencing homelessness.

The COVID-19 public health emergency, its economic fallout, and longstanding racial and ethnic inequities are affecting the nation's mental health and wellbeing. Stress and loneliness are on the rise, and along with them depression, substance abuse, and suicide.[2] This will not be short lived. The trauma of this experience will have a lifespan of impact to which public and private sector leaders will need to respond. The challenge is made even greater given the reality that the pandemic and its economic fallout have destabilized and deepened existing cracks in the U.S. healthcare system, communities, and government infrastructures. Behavioral health care providers, in particular, are being stretched and taxed by the realities of the pandemic as they experience financial stress, and adapt to new models of care, reduced in-person interactions with patients, and their own experiences with the pandemic. This is adding new challenges onto the longstanding fragmentation between behavioral health and physical health systems in the U.S. The diminished vitality of the behavioral health system will make it even more difficult to meet the increased behavioral health needs of the population.

Medicaid and CHIP, as the insurance provider for more than 77 million individuals, including many with complex physical and behavioral health needs, will play a vital role in supporting the recovery of our nation.[3] To take this leading role, Medicaid and CHIP programs need evidence-backed, sustainable policy and program options that help them respond to this growing need and a constrained delivery system. These options need to address the unique needs of their state.

This framework, crafted by an Executive Working Group of Medicaid leaders and national behavioral health experts convened by the National Association of Medicaid Directors, offers states options to consider to promote the health and wellbeing of members and expand access to behavioral health services. It includes strategies along a continuum of need, ranging from upstream prevention and health promotion for all Medicaid beneficiaries to increasing access to behavioral health treatment for unique subpopulations in Medicaid.

Medicaid programs have a window of opportunity to stem the tide of the behavioral health impacts of the pandemic and its economic fallout through an immediate, short-term response. Medicaid programs can seize this window of opportunity by acting with as much urgency as they did at the height of the pandemic to ensure access to care and provider sustainability. Medicaid programs must also develop new long-term strategies to respond to the lasting behavioral health impacts from the pandemic, its economic fallout, and racial and economic injustices experienced by so many Medicaid members.

FRAMEWORK OVERVIEW

This framework begins in Chapter 1 by exploring five areas that Medicaid programs can address to meet the growing behavioral health needs of all members. Chapter 2 examines five special populations Medicaid programs serve and additional strategies that may be needed to meet their unique behavioral health needs. Chapter 3 outlines the leadership and operational "essentials for success" that support the policy and program options described in Chapters 1 and 2. The report concludes with an appendix that provides additional resources and state examples of the strategies described throughout the report.

While there are many strategies and options described in this report, this strategic framework is not intended to suggest or recommend a particular course of action for states. It is also not intended to be a complete list of strategies that Medicaid programs may pursue. Instead, it lays out a number of evidence-backed options for states to consider.

[2] **Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic - United States, June 24-30**. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report (MMWR). August 2020.

[3] **September 2020 Medicaid & CHIP Enrollment Data Highlights**. Centers for Medicare and Medicaid Services. January 2021.

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Strategic Options to Meet the Behavioral Health Needs of All Medicaid Members

Medicaid programs are seeing an increased need for behavioral health services among all members. While individual needs vary, from short-term, limited intervention to lifelong support, there are five areas where Medicaid can focus to meet the growing behavioral health needs of all members:

- Advance prevention by promoting mental health and wellbeing;
- Streamline eligibility for services by eliminating administrative barriers that prevent people from accessing needed behavioral health treatment;
- Continue efforts to promote integration of physical and behavioral health services;
- Build a comprehensive approach to addiction treatment that begins with prevention and addresses all addiction; and
- Strengthen and broaden crisis response systems.
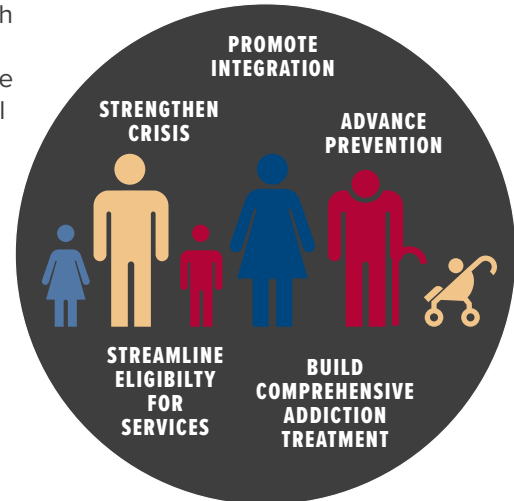
This chapter explores these five focus areas and outlines strategies and actions states can take to advance each one. State examples of these strategies are listed in the appendix.

ADVANCE PREVENTION BY PROMOTING MENTAL HEALTH AND WELLBEING

Many factors outside of health care – generally referred to as the social determinants of health – impact mental health and wellbeing.[4] The COVID-19 public health emergency and the economic fallout from it have increased the prevalence of these risk factors, such as lack of transportation, food insecurity, unemployment, homelessness, and toxic stress. Medicaid members experience many of these risk factors, and there are evidence-backed ways that Medicaid can intervene to promote psychological strengths and wellbeing.

1. Support mental health promotion and primary prevention. Medicaid agencies can partner with plans, providers, or other community organizations to conduct outreach to members and provide information about the signs of toxic stress, depression, or problematic substance use. They can also provide information about strategies to combat these issues and make resources available to members.

2. Increase awareness of and linkages to other social services and supports. Medicaid agencies can identify the social risk factors that members are facing and connect them to community resources and supports. These resources can reduce stress and instability for members and promote mental health and wellbeing.

- **Action Item: Screen members for social risk factors - or direct plans or providers to conduct this screening - and make referrals to needed supports.** Medicaid agencies can direct their plans or providers to screen members for social risk factors, like food insecurity or homelessness, and provide case management to address the identified needs.[5] In addition, the state can track the outcome of these referrals by requiring "closed loop" referrals.[6]

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[4] Social Determinants of Mental Health: Where We Are and Where We Need to Go. Current Psychiatry Reports. September 2018.
[5] Social Risk Factor Screening in Medicaid Managed Care. State Health and Value Strategies. October 2020; Addressing Social Determinants of Health Via Managed Care Contracts and Section 1115 Demonstrations. Center for Health Care Strategies and Association of Community Affiliated Plans. December 2018.
[6] Leading Edge Practices in Medicaid for Addressing Social Factors that Affect Health. State Health and Value Strategies. April 2019.

STREAMLINE ELIGIBILITY FOR SERVICES

Screenings, assessments, and utilization management are important strategies for Medicaid to ensure individuals get connected to the right amount, duration, and scope of services. However, these tools can also unintentionally delay access to needed mental health and addiction treatment. To help states meet the increased demand for behavioral health services, Medicaid programs can consider ways to streamline the process by which individuals are determined eligible for behavioral health treatment.

1. Simplify or relax requirements for assessments. States can examine existing policies and assessments and identify opportunities to streamline or shorten them.

- **Action Item: Temporarily suspend assessments and/or provide a grace period for them.** This can allow individuals to receive services quickly. Then the assessment can be conducted after the initial treatment is received so the state can determine what ongoing services are needed.

- **Action Item: Form a workgroup to review policies and assessments.** Workgroups can identify ways to provide quicker access to care or relax lengthy assessments. It is important for these workgroups to include the member perspective.

2. Move away from diagnostic and utilization criteria for service eligibility. Often Medicaid programs require a mental health or addiction diagnosis – or certain service utilization thresholds to be met – to authorize treatment for behavioral health services. Some states are moving away from these factors to focus on functional criteria, such as social challenges for children and adults.

- **Action Item: Eliminate or add flexibility to state requirements for a child to have a diagnosis before accessing behavioral health services.** These diagnoses are often not clinically appropriate to give to children, particularly children under five, and they create a label that may have lasting impacts on the mental health and wellbeing of the child. These requirements may also exacerbate inequities for Black, Indigenous, and Latinx youth as they may have different access to care or receive different diagnoses than other youth.

- **Action Item: Check for racial bias in instruments and clinical quality measures.** Diagnostic tools, service utilization metrics, and clinical outcome measures can have bias. When states are implementing any new screening tool or clinical quality measures, it is important to review the evidence for bias and analyze the data and compare it across demographics to understand outcomes for different populations.

- **Action Item: Incentivize treatment, not just screenings, and align treatment with identified needs and social risk factors.** Often Medicaid programs will use payment to encourage providers and plans to perform screenings and assessments. However, these payment structures may lead to a focus on screening alone, rather than treatment. It is important for payment to incentivize treatment that is responsive to the member's needs and social risk factors.

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Strategic Options to Meet the Behavioral Health Needs of All Medicaid Members [CONTINUED]

CONTINUE TO PROMOTE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES

In the years prior to the COVID-19 pandemic, states have worked diligently to enhance integration between physical and behavioral health for Medicaid members. While many models of integration have shown promising results in care quality and cost savings, physical and behavioral health services remain largely fragmented.[7] The pandemic has led to an increase in demand for behavioral health care services while at the same time magnifying the need for more person-centered, integrated care.

1. Incentivize screening and referrals between primary care and behavioral health providers. Care of individuals with mental health diagnoses accounts for nearly half of Medicaid spending.[8] The high cost of behavioral health care can often be attributed to a lack of early intervention for individuals with unmet behavioral health needs. Incentivizing screening and referrals for behavioral health needs in primary care is an essential first step to integration, especially given the rise of mental health issues and problematic substance use due to the pandemic.

- **Action Item: Incentivize plans and providers to advance behavioral health screening and referrals in primary care.** States can use various levers to increase the use of certain behavioral health screening tools (e.g., SBIRT, PHQ-9) and promote referrals to treatment, including establishing quality measures or creating payment incentives for screenings and referrals. The agency can also contractually require plans or providers to conduct screenings and referrals.

- **Action Item: Make sure screening and referrals are bi-directional.** Individuals with serious mental illness suffer from higher rates of co-occurring chronic health conditions and premature mortality.[9] Unfortunately, individuals with serious mental illness are less likely to receive screenings for common physical health conditions.[10] Similar to the action item above, Medicaid can also incentivize behavioral health providers or plans to screen and make referrals for physical health conditions.

- **Action Item: Encourage consultation between behavioral health providers and primary care providers.** Primary care providers may feel uncomfortable or unprepared to address the behavioral health needs of their patients. Consultation with behavioral health providers, including remote teleconsultation, can equip primary care providers with the expertise and confidence to identify, treat, and know when to refer patients for behavioral health services.

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[7] Integrating Physical and Behavioral Health Care. Promising Medicaid Models. Kaiser Family Foundation. February 12, 2014.
[8] Integration of Behavioral and Physical Health Services in Medicaid. Medicaid and CHIP Payment and Access Commission. March 2016.
[9] Early Mortality in SMI: Federal and State Policy Initiatives. Psychiatric Times. May 2020.
[10] Interventions to Increase Access to or Uptake of Physical Health Screening in People with Severe Mental Illness: a Realist Review. BMJ Open. February 2018.

CONTINUE TO PROMOTE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES [CONTINUED]

3. Advance integrated care delivery models. Individuals enrolled in Medicaid with behavioral health care needs are more likely to have co-occurring chronic physical conditions.[11] Medicaid programs can improve outcomes for members by changing the way health care is delivered through integrated care models. Although these models require long-term commitment, there are a number of short-term actions that states can take to begin to advance them.

Health Homes and Advancing Behavioral Health

Health homes are a long-term strategy that Medicaid programs can consider to improve care delivery for members with mental illness and/or an addiction. This model provides intensive care coordination and disease management. There are five places in this framework where Medicaid programs can consider leveraging this model:

- **Promote integration of physical and behavioral health services;**
- **Build a comprehensive approach to addiction treatment;**
- **Eliminate gaps in care that occur in the transition between the criminal justice system and the community;**
- **Meet the unique health and social support needs of individuals experiencing homelessness; and**
- **Enhance behavioral health treatment services for individuals with ID/DD.**

- **Action Item: Work in partnership with stakeholders to identify integrated care models.** Various care delivery models have shown success at improving outcomes through integration of behavioral and physical health services. These include health homes, collaborative care, and certified community behavioral health clinics. States can work across agencies and with external stakeholders to identify which of these models would best meet the needs of their members and how to advance those models.

- **Action Item: Remove barriers to co-location and integration of physical and behavioral health services.** Medicaid agencies can identify and reduce barriers to co-location and integration of physical and behavioral health services, such as allowing behavioral health services to be rendered in primary care settings or removing restrictions on same-day billing.

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[11] [Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals](). **Kaiser Family Foundation. June 2017.**

BUILD A COMPREHENSIVE APPROACH TO ADDICTION TREATMENT

Medicaid plays a major role in delivering services for many of the 20 million Americans who suffer from an addiction.[12] Prior to the pandemic, almost 12 percent of Medicaid beneficiaries over age 18 had an addiction.[13] Experts believe this percentage will increase due to social isolation and toxic stress from the COVID-19 pandemic. To meet this growing need, Medicaid should consider a comprehensive approach to addiction treatment that begins with prevention and addresses all forms of addiction, not just opioid addiction.[14]

1. Prevent addiction by addressing the root causes. As the single largest insurer of children, Medicaid and CHIP programs can address risk factors that occur in early childhood and often lead to addiction.

- **Action Item: Leverage evidence-based early child development and family support.** Medicaid can support early childhood programs that help children and their caregivers in the first three years of life. Many of these programs are evidence-based, such as home visiting programs, and they mitigate risk factors for addiction later in life.

- **Action Item: Incentivize trauma-informed care.** Adverse childhood experiences (ACEs), like abuse or neglect, having a family member attempt suicide, or other trauma, increase an individual's risk of developing an addiction in adulthood.[15] Medicaid can incentivize providers and plans to identify ACEs and treat individuals in a trauma-informed way.

2. Increase access to community-based care. Medicaid programs have multiple levers they can use to build capacity in communities to treat all forms of addiction, not just opioid addiction. This includes building capacity in primary care to identify and address substance use disorders.

- **Action Item: Expand medication assisted treatment (MAT).** MAT can support recovery from opioid use disorder and alcohol use disorder. Medicaid programs can expand coverage of the forms of MAT, allow additional provider types to deliver MAT (e.g., physician assistants, nurse practitioners), limit prior authorization requirements on MAT, and review the agency's MAT policies to ensure they do not perpetuate stigma around this form of treatment.[16]

- **Action Item: Leverage telehealth to increase access to substance use disorder treatment.** Although it has limitations, telehealth can increase access to treatment in areas where there are few providers. Medicaid programs can allow for addiction treatment to be provided via telehealth by expanding the allowable sites of service, modalities, and provider types.[17]

- **Action Item: Create e-consult support for primary care.** This gives primary care providers an addiction treatment expert that they can turn to for advice, which increases primary care providers' comfort in treating addiction and empowers them to function at the top of their license. This can be used in pediatric and adult primary care.

3. Increase access to specialized inpatient services as one component of comprehensive addiction treatment. Because federal law prohibits Medicaid from paying for services provided in an institution for mental disease (IMD), a longstanding gap in Medicaid coverage for addiction treatment is partial hospitalization and residential treatment.[18] Medicaid programs can consider various federal authorities (1115 waivers, managed care authority, or state plan authority) to address this gap. It is important for these services to be part of a broader strategy to strengthen community-based treatment (see above).[19]

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[12] Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration. September 2020.

[13] Medicaid and the Opioid Epidemic. Medicaid and CHIP Payment and Access Commission. June 2017; Substance Use Disorders. Centers for Medicaid and CHIP Services.

[14] Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration. September 2020.

[15] Preventing Adverse Childhood Experiences. Centers for Disease Control and Prevention. 2019.

[16] Review of State Strategies to Expand Medication-Assisted Treatment. Technical Assistance Collaborative. May 2019.

[17] Medicaid Innovation Accelerator Program: Reducing Substance Use Disorders: Exploring Telehealth Delivery Methods for Substance Use Disorder Treatment. CMS. September 2019.

[18] Access to Substance Use Disorder Treatment in Medicaid. Medicaid and CHIP Payment and Access Commission. June 2018.

[19] Federal Legislation to Address the Opioid Crisis: Medicaid Provisions in the SUPPORT Act. Kaiser Family Foundation. October 2018.

BUILD A COMPREHENSIVE APPROACH TO ADDICTION TREATMENT [CONTINUED]

4. Provide recovery supports. Medicaid can play a role in ensuring that members have the non-clinical supports needed for recovery.

- **Action Item: Cover peers and family peer specialists for all members with an addiction.** Individuals with lived experience, such as certified peer specialists, recovery coaches, and family peer specialists, can improve outcomes for individuals with a substance use disorder.[20]

- **Action Item: Provide support or incentivize plans to provide support to help people stay in recovery.** This can include covering skills training and development, supported employment, and supported housing for individuals with an addiction.[21]

STRENGTHEN AND BROADEN CRISIS RESPONSE SYSTEMS

The COVID-19 pandemic and its economic fallout have had serious negative impacts on mental health and access to mental health services, further taxing an already overwhelmed crisis system. Calls made to the Substance Abuse and Mental Health Services Administration's National Helpline increased fivefold during the first month of the pandemic.[22] Unfortunately, the crisis system has faced challenges connecting individuals to ongoing care, and individuals experiencing a mental health crisis are more likely to encounter law enforcement than to access treatment.[23] Given the intersection of individuals covered by Medicaid and those who frequently interact with the crisis system, Medicaid can play a valuable role in supporting and informing a more robust, needs-driven crisis system.

1. Connect individuals in crisis with appropriate care. Mental health crises account for one in ten 911 calls across the country.[24] However, the 911 system is not designed to respond to behavioral health crises. In recognition of these challenges, Congress enacted the National Suicide Hotline Designation Act to establish "988" as the new, nationwide, 3-digit phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors. This National Suicide Hotline is expected to be completed by July 2022.[25] States can support programs, such as National Suicide Hotline or existing state and local programs, that intervene prior to or at the point of 911 and connect individuals to more appropriate care providers or settings.

- **Action Item: Leverage and support crisis hotlines for Medicaid members.** Crisis hotlines are staffed by trained call-takers, including peer specialists, who provide remote counseling to individuals in crisis as an alternative to calling police.[26] Crisis hotlines may be funded through a combination of state general fund and Medicaid dollars depending on the population served.[27]

[20] Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder. Medicaid and CHIP Payment and Access Commission. July 2019.
[21] Ibid.
[22] Flood Of Calls And Texts To Crisis Hotlines Reflects Americans' Rising Anxiety. National Public Radio. May 2020.
[23] Jailing People with Mental Illness. National Alliance on Mental Illness.
[24] The Daily Crisis Cops Aren't Trained to Handle. Governing. May 2016.
[25] Suicide Prevention Hotline. FCC.
[26] Behavioral Health Crisis Alternatives. Vera Institute of Justice. November 2020.
[27] Crisis Services: Meeting Needs, Saving Lives. Substance Abuse and Mental Health Services Administration. December 2020.

STRENGTHEN AND BROADEN CRISIS RESPONSE SYSTEMS [CONTINUED]

2. Ensure the right responders are dispatched to a crisis. Police are often the first and only responders dispatched to situations involving individuals experiencing a mental health crisis.[28] With little organized training in behavioral health, police must make decisions about the most appropriate path forward to connect individuals to behavioral health services or to arrest them. States may explore opportunities to ensure that trained behavioral health professionals are present or available to first responders during a crisis in order to safely de-escalate and manage the individual's needs.

- **Action Item: Implement mobile crisis teams (MCTs).** At the request of first responders or community members, teams composed of medics, crisis workers, and/or peers can be made available to respond to people in crisis and provide immediate stabilization, referral, and transportation to treatment.[29]

- **Action Item: Implement co-responder models.**[30] Behavioral health professionals, including peer specialists, can co-respond with officers as first responders to situations involving someone experiencing a behavioral health crisis.[31]

3. Develop specialized settings to support individuals in crisis. One in eight visits to the emergency department in the United States is related to mental health or substance use disorders.[32] While some are staffed by behavioral health providers, the emergency department is often the wrong setting for those experiencing mental health crises. Specialized settings dedicated to stabilization and ongoing treatment for behavioral health crises can more appropriately address the needs of the individual in crisis while relieving pressure on overburdened emergency departments, including crisis diversion facilities or stabilization centers.[33] States can work with these programs to ensure that they are enrolled Medicaid providers and their services are covered by Medicaid.

Assessing Your Current Crisis System

In order to strengthen and broaden the crisis response system, it is important to assess the status of your current crisis system. Medicaid programs can partner with their behavioral health agencies to identify any gaps and opportunities for improvement.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides two resources that states can leverage to assess their crisis delivery systems.

- **The National Guidelines for Crisis Care – A Best Practice Toolkit** provides national guidelines in crisis care; tips for implementing care that aligns with national guidelines; and tools to evaluate alignment of systems to national guidelines.

- **The Sequential Intercept Model (SIM) helps states identify strategies to divert people with mental health conditions and substance use disorders away from the justice system into treatment. The first intercept of the model provides strategies to connect individuals to treatment and services through crisis care.**

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[28] **Effectiveness of Police Crisis Intervention Training Programs**. Journal of the American Academy of Psychiatry and the Law. December 2020.

[29] **Behavioral Health Crisis Alternatives**. Vera Institute of Justice. November 2020.

[30] Note: in co-responder models, consider avoiding embedded co-response. Consumer organizations note that embedded co-response may perpetuate stigma by having behavioral health providers embedded in the same units as law enforcement. See: **Using CIT to Reduce Stigma, Trauma, and The Role of Police in Crisis Response**. National Alliance for Mental Illness. July 2020.

[31] **Behavioral Health Crisis Alternatives**. Vera Institute of Justice. November 2020.

[32] **Treating Mental Illness in the ED**. Association of American Medical Colleges. September 2019.

[33] **A Community Guide for Development of a Crisis Diversion Facility**. Arnold Ventures. February 2020; **National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit**. Substance Abuse and Mental Health Services Administration. 2020.

The strategies described in the previous chapter can help Medicaid meet the behavioral health needs of all Medicaid members. To advance Medicaid's ability to address the behavioral health crisis, additional strategies are needed to meet the unique behavioral health needs of special populations. This chapter outlines those strategies for five special populations: individuals involved in criminal justice, children, older adults, individuals with intellectual and developmental disabilities, and individuals experiencing homelessness or housing instability.

JUSTICE-INVOLVED INDIVIDUALS	INDIVIDUALS WITH DISABILITIES	CHILDREN	OLDER ADULTS	INDIVIDUALS EXPERIENCING HOMELESSNESS	SPECIALIZED SUPPORTS
ALL MEMBERS					GENERAL SUPPORTS
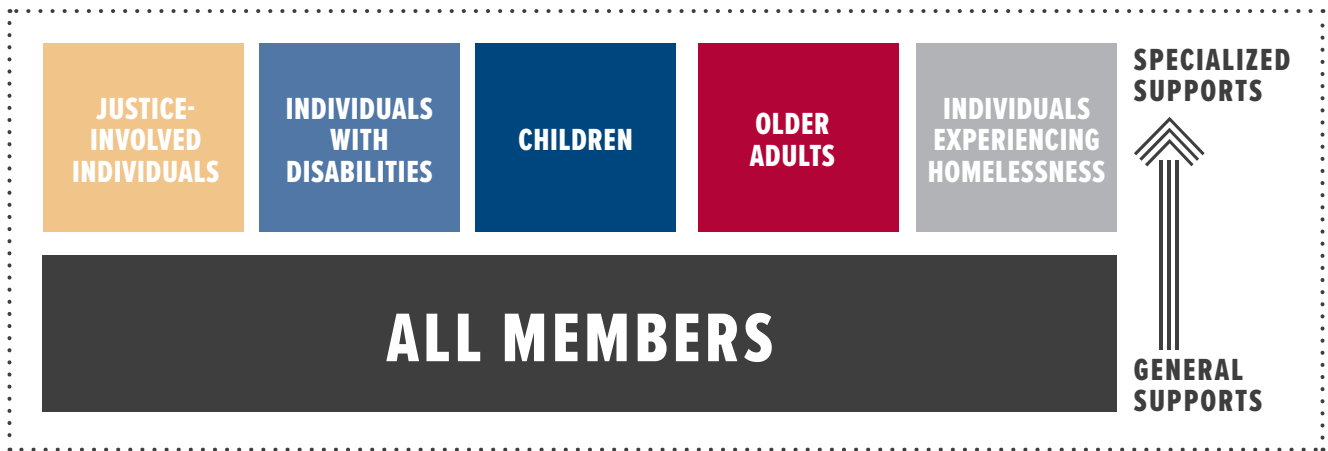
INDIVIDUALS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

On any given day, nearly 2.3 million individuals are incarcerated in prison or jail.[34] Since the expansion of Medicaid under the Affordable Care Act, many of these individuals are eligible for Medicaid when they leave the criminal justice setting. Medicaid has an opportunity to improve outcomes for these individuals, particularly for the significant portion of individuals released from incarceration who suffer from mental illness or addiction.[35]

1. Use crisis services to prevent incarceration. Medicaid, along with other state partners, can prevent justice involvement by ensuring individuals with addiction or mental health disorders get connected to treatment when they are in crisis.[36] This can help reduce the extent to which jails and hospital emergency rooms serve as the default treatment providers. These opportunities are articulated in Chapter 1, which focuses on Medicaid's role in crisis services.

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[34] Mass Incarceration: The Whole Pie 2020. Prison Policy Initiative. March 24, 2020.

[35] Substance Abuse and America's Prison Population. The National Center on Addiction and Substance Abuse at Columbia University. February 2010; 16% of individuals in state prisons and 17% of individuals in jails have mental illness. 53% of individuals in state prisons and 68% in jails have a substance use disorder. Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison. Substance Abuse and Mental Health Services Administration. 2017.

[36] Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. National Association of State Mental Health Program Directors. August 2020.

INDIVIDUALS INVOLVED IN CRIMINAL JUSTICE
[CONTINUED]

2. Eliminate gaps in care that occur during the transition out of the criminal justice system. Individuals leaving prison are 12 times more likely than the general public to die in the two weeks post-release, and this increased mortality is largely driven by overdose deaths.[37] Medicaid can leverage various strategies to ensure individuals get connected to care quickly upon release.

- **Action Item: Ensure individuals who encounter the criminal justice system stay connected to Medicaid.** For instance, Medicaid programs can choose to suspend, rather than terminate, Medicaid eligibility for individuals who enter the criminal justice system.[38] They can also provide application assistance, allow presumptive eligibility in prisons and jails, and smooth the process of renewals for these individuals to ensure they get connected and stay connected to coverage. This can facilitate Medicaid coverage of community hospital stays for people who are incarcerated and provide for continuity of services at re-entry.

- **Action Item: Direct health plans or providers to conduct in-reach.** Medicaid programs can require or incentivize health plans or providers to connect with members prior to leaving the justice system. Plans or providers can assess members' health and social support needs, find providers, schedule appointments, and provide linkages to other social supports.

- **Action Item: Explore opportunities for Medicaid to cover certain services pre-release.** The SUPPORT Act directed CMS to develop guidance on 1115 waiver opportunities to support individuals transitioning out of justice settings, including an opportunity for Medicaid to provide benefits up to 30 days prior to release.[39] This guidance has not been released, but states have proposed initiatives to provide services, like MAT or family therapy, prior to release to improve the transition between the criminal justice system and the community. (Family therapy can help to address disruption in family relationships and improve outcomes for children of incarcerated parents.)[40]

CHILDREN

Thirty-seven million children are enrolled in Medicaid and CHIP.[41] The children and families enrolled in Medicaid have low-incomes and often experience high levels of stress as they struggle to meet their basic needs of stable employment and housing, safe living environments, and adequate nutrition.[42] This stress has been exacerbated by the COVID-19 pandemic and its economic fallout as children and families that are enrolled in or likely qualify for Medicaid and CHIP have been most impacted.[43] Medicaid programs can consider the following strategies to address the social, emotional, and behavioral health needs of children and their caregivers.

[37] Release from Prison - A High Risk of Death for Former Inmates. New England Journal of Medicine. January 2007.
[38] Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System. The Commonwealth Fund. November 2020.
[39] The SUPPORT Act: New Tools in Medicaid to Address the Opioid Epidemic. State Health and Value Strategies. November 2018.
[40] 1115 SUD Demonstration Proposed Amendment: Continuity of Care for Incarcerated Members. Kentucky Department of Medicaid Services. November 2020; Supporting Children and Families Affected by Parental Incarceration. U.S. Department of Health and Human Services, Children's Bureau.
[41] Monthly Child Enrollment in Medicaid and CHIP. State Health Facts. Kaiser Family Foundation. August 2020.
[42] Child Poverty, Toxic Stress and Social Determinants of Health: Screening and Care Coordination. The Online Journal of Issues in Nursing. September 2018.
[43] Fewer Mothers and Fathers in the US are Working due to COVID-19 Downturn. Pew Research Center. October 2020.

CHILDREN [CONTINUED]

1. Remove barriers to behavioral health services for children and their caregivers. Medicaid and CHIP programs must act swiftly to connect young children and their families to services to support their resiliency and recovery from the disruption and pain caused by the pandemic and its economic fallout.

- **Action Item: Eliminate or add flexibility to requirements that children have a behavioral health diagnosis before they can access behavioral health services.** Requirements for a specific behavioral health diagnosis to access care can lead to delays in care, especially for young children, as clinicians perform multiple screening and assessments and may hesitate to "label" a child.

- **Action Item: Address any policy barriers that prevent children and caregivers from receiving services together.** Children live in the context of their families, and Medicaid and CHIP programs can remove barriers and create incentives for children and caregivers to access care. States can also evaluate their definition of caregivers in the cultural context of the member and allow for grandparents and other extended family members to access services.

- **Action Item: Remove or modify cumbersome prior authorization, service location requirements, or service limitations for behavioral health services.** Life as we know it has been disrupted, for both Medicaid and CHIP members and providers. In light of this reality, states can take action to reduce administrative burden and accelerate access to care.

2. Develop a comprehensive strategy to support family emotional health and stability. Children's social and emotional development and behavioral health are not often top priorities for value-based payment agreements and programs focused on short-term cost containment efforts. However, there is an opportunity and obligation for Medicaid programs to invest in programming that supports the long-term health and wellbeing of children and families, and it can lead to long-term cost reduction in Medicaid and CHIP programs.

As Medicaid programs build a comprehensive strategy, there is a critical need to collaborate with other child-serving state agencies, including the Title V – Maternal and Child Health Program; Child Welfare; Department of Education; Department of Human Services or agencies that manage basic needs programs, such as SNAP, TANF, Energy Assistance, Child Support; and Early Childhood departments, agencies, or councils.

A comprehensive strategy might include elements such as:

- Coverage for a full range of evidence-based screening a referral, assessment, and treatment services for children and their caregivers.
- Quality and performance improvement initiatives focused on social and emotional development and family support to spur changes in pediatric practice.
- Formal collaborative arrangements with other child-serving agencies for design and implementation of behavioral health services for children.
- Investments in and establishment of ongoing payment models that support and incentivize high performing medical homes, team-based care models, and innovative care delivery such as group visits.
- Clarifying and expanding ways Medicaid can pay for team based care models and family support programs, such as home visiting, parent education, and community health workers and peer support services both within the medical home and in the community where young children and their families gather.
- Developing new ways to collect data that allows the state to analyze access, quality of services and outcomes for children and their caregivers together and by race and ethnicity.

Strategic Options to Meet the Behavioral Health Needs of Special Populations

OLDER ADULTS

Medicaid provides coverage to 12.2 million individuals who are also enrolled in the Medicare program. Older adults served by both programs have low-incomes, limited assets, and often complex health needs.[44] In states that have expanded eligibility to low-income adults, thousands of adults between 50 and 65 are enrolled as full Medicaid beneficiaries.

The COVID-19 pandemic has significantly impacted the health of older adults in this country. The impact has been most devastating on adults with low-incomes, Black and Hispanic older adults, and older adults residing in assisted living settings and nursing homes. Not only have these populations experienced high rates of infection and death, but also the impact of months of social isolation and loneliness. As one older adult noted, "if the virus does not kill me, loneliness will."[45]

1. Respond to the immediate health needs of older adults. State Medicaid agencies are actively working to support nursing facilities and other congregate care settings where older adults live to make them safe. State Medicaid agencies should also consider working closely with providers, managed care plans, and sister state agencies to understand and respond to the pressing behavioral health needs of older adults.

- **Action Item: Ensure access to care.** States can consider specific strategies and metrics to measure access to behavioral health care for older adults served by their Medicaid program. Older adults living in the community or in congregate care settings may face barriers to accessing care and may not have the capacity or technology to successfully use telehealth.

- **Action Item: Support resilience of older adults.** Older adults have experienced many hardships during the pandemic, but many have also exhibited strength and resilience.[46] One of the keys to resilience and social connectedness is regular contact and meaningful relationships with others. Medicaid programs can leverage their case management or managed care infrastructure to establish connections with older adults enrolled in the program. Medicaid programs can also leverage peer and family support services to support this resilience.

- **Action Item: Assess and respond to immediate resource needs.** Over 24 million adults over the age of 55 indicated it was somewhat difficult or very difficult to pay for usual household items during the Census Pulse Survey in early December.[47] Medicaid programs can partner with the state agency or department that administers Older American Act funds to ensure alignment and basic needs support for older adults enrolled in Medicaid.

2. Transform behavioral health care for older adults. Loneliness, depression, and suicide have long been recognized as emotional health challenges facing older adults. The pandemic and its economic fallout have only amplified these concerns and the effects will be felt for many years, especially by groups that were highly impacted.

- **Action Item: Incentivize evidence-based approaches to improved care.** Medicaid agencies can require or endorse evidence-based approaches for care delivery both within community-based practices and within facilities, such as hospitals or nursing homes. One example of an evidence-based approach comes from the Institute for Healthcare Improvement and the John A. Hartford Foundation. The Age-Friendly Systems "4Ms" framework and tools help care settings deliver whole-person care for older adults by focusing on What Matters, Medication, Mentation, and Mobility.[48]

- **Action Item: Develop quality expectations and value-based payments arrangements for providers and health plans.** A variety of tools and evidence-backed strategies exist to assess and address loneliness and social connectedness and quality care for older adults that focuses on their overall wellbeing and ability to actively participate in and direct their care.[49] Medicaid programs can include these tools and clinical outcomes as part of their clinical quality strategies.

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[44] **People Dually Eligible for Medicare and Medicaid**. Medicare-Medicaid Coordination Office. March 2020.
[45] **Experiences of Nursing Home Residents During the Pandemic**. Altarum. October 2020.
[46] **Older Adults and the Mental Health Effects of COVID-19**. Journal of the American Medical Association. November 2020.
[47] **Week 20 Census Bureau Household Survey**. United States Census Bureau. December 2020.
[48] **Age-Friendly Health Systems**. Institute for Healthcare Improvement and The John A. Hartford Foundation. December 2020.
[49] **Framework for Isolation in Adults Over 50**. AARP. May 2012.

Strategic Options to Meet the Behavioral Health Needs of Special Populations

INDIVIDUALS WITH INTELLECTUAL & DEVELOPMENTAL DISABILITIES

Individuals with intellectual or developmental disabilities (ID/DD) have a unique set of behavioral and physical health needs that differ from other populations enrolled in Medicaid. Individuals with ID/DD are 10 percent more likely than the general population to have a mental health diagnosis.[50] Unfortunately, individuals with ID/DD and co-occurring mental health conditions are often shuffled around the delivery system. This is often because ID/DD providers feel unequipped to manage a mental health diagnosis and mental health providers feel unequipped to manage an ID/DD diagnosis.

1. Understand the needs of the population. To effectively address the behavioral health needs of individuals with ID/DD, states must first understand the complex needs and challenges of this population and their caregivers.

- **Action Item: Leverage data from providers, plans, and other state agencies.** States can use both in-house data, as well as data collected by health plans and providers, to better understand member needs, including where individuals receive care and what services they are using. States can also leverage data from other state agencies that oversee this population, such as behavioral health, long-term care, and education agencies.

- **Action Item: Engage stakeholders to identify challenges and potential solutions.** Members and their caregivers are the most important source of information for states to engage to understand the needs of this population. Member advisory groups and collaboration with advocacy groups can guide state decision-making and illuminate the challenges for this population and potential solutions.

2. Ensure primary supports for stability. Disruptions to health care and school-based services during the pandemic have created significant challenges for individuals with ID/DD who often rely on ongoing supports, including habilitative services, home nursing care, or school-based services. It has also exacerbated workforce shortages, especially for the home health providers who support individuals with ID/DD.[51]

- **Action Item: Enhance direct care workforce capacity.** There are several strategies available to states to ensure network adequacy and support the direct care workforce serving individuals with ID/DD, including enhancing telehealth flexibilities, targeting funding for direct care providers, and reimbursing for family caregiving.

- **Action Item: Expand respite care coverage.** Respite care services allow family caregivers to take time from their caregiver responsibilities by providing community- or facility-based temporary care to individuals with ID/DD. These services are especially important now given the burnout that families are experiencing due to challenges brought on by the pandemic, including closure of schools and day programs.

- **Action Item: Enhance case management.** Given the complex needs of this population, case management services support individuals with ID/DD and their caregivers by helping them navigate and access the physical, mental, and social supports they need.

[50] Behavioral Health in the Medicaid Program—People Use and Expenditures. Medicaid and CHIP Payment and Access Commission. June 2015.
[51] Impact of COVID-19 on Organizations Serving Individuals with Intellectual and Developmental Disabilities. Avalere. April 2020.

INDIVIDUALS WITH INTELLECTUAL & DEVELOPMENTAL DISABILITIES [CONTINUED]

3. Enhance behavioral health treatment for individuals with ID/DD. Despite high rates of co-occurring conditions, individuals with ID/DD often face barriers to access mental health diagnosis and treatment services. An ID/DD diagnosis can overshadow behavioral health related issues, making it difficult to recognize and treat underlying behavioral health issues. In addition, providers who are equipped to manage both ID/DD and behavioral health needs are few and far between.[52] Medicaid can focus on enhancing behavioral health services that recognize the unique needs of individuals with ID/DD.

- **Action Item: Incentivize collaboration between ID/DD and behavioral health providers.** Collaboration between ID/DD and behavioral health providers allows for more person-centered, fully integrated care to assess and address an individual's complex set of needs. For example, Medicaid agencies can do this by supporting tele-consultation between ID/DD and behavioral health providers, establishing quality/performance requirements, or using payment to incentivize this coordination.

- **Action Item: Support specialized crisis services that can be tailored to those with ID/DD.** Individuals with ID/DD are more likely to be admitted to the emergency department for both physical and mental health concerns.[53] However, given the varied and complex presentations of behavioral health crises for this population, general first responders may not be equipped to address the needs of these individuals.[54] States can work with community partners, crisis responders, and providers to ensure that crisis response for individuals with ID/DD includes the appropriately trained staff to meet the unique needs of this population.

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[52] **Policy Recommendations: Addressing the Mental Health and Wellness of Individuals with Intellectual Disabilities**. Hogg Foundation. August 2014.
[53] **Understanding and Improving Care for Individuals with Intellectual and Developmental Disabilities in the Emergency Department**. International Review of Research in Developmental Disabilities. September 2014.
[54] **Crisis Services: Meeting Needs, Saving Lives**. Substance Abuse and Mental Health Services Administration. December 2020.

INDIVIDUALS EXPERIENCING HOMELESSNESS OR HOUSING INSTABILITY

Prior to the COVID-19 pandemic and its economic fallout, the number of individuals experiencing homeless or housing instability was on the rise, and the current crisis has only exacerbated this trend.[55] These individuals, most of whom are eligible for or enrolled in the Medicaid program, often suffer from serious mental illness, substance use disorders, physical and mental disabilities, and other chronic health care conditions.[56] They often utilize significant health care services and incur high health care costs.[57] Individuals experiencing homelessness or housing instability are also particularly vulnerable to physical and psychological impacts of the pandemic and its economic fallout.

1. Connect individuals experiencing homelessness or housing instability to Medicaid coverage. Getting enrolled in Medicaid is the first step in ensuring that individuals can access behavioral health treatment. However, completing the enrollment process can be challenging for individuals experiencing homelessness or housing instability because they may not have the required identification and income documentation paperwork, and may lack access to the internet or a place to receive mail.

- **Action Item: Perform a review of all enrollment processes.** Medicaid programs can work with members, providers, and community service organizations to identify and eliminate enrollment requirements that may be particularly challenging for individuals experiencing homelessness or housing instability.

- **Action Item: Connect data across agencies.** Medicaid agencies can make important eligibility and enrollment information available to sister-state agencies or other community partners who engage with individuals experiencing homelessness or housing instability (e.g., housing assistance, homeless shelters).

2. Identify members who may be experiencing homelessness or housing instability. Medicaid members experiencing homelessness or housing instability have a unique set of physical and behavioral health care needs and face a specific set of challenges. However, states, plans, and providers often lack the necessary data to identify these members and are therefore unable to address their needs.

- **Action Item: Identify and use address markers in enrollment and encounter data that may indicate an individual or family is homeless.** For example, individuals or families experiencing homelessness may use homeless shelters, clinics, or social services agencies as an address in their Medicaid applications. States can also ask providers to use special zip codes in patient addresses to indicate that their patient is homeless.[58]

- **Action Item: Regularly match Medicaid enrollment or claims data with other data sources, like state homeless management information systems.** States can work across agencies and with plans to develop integrated databases with indicators of homelessness.

- **Action Item: Encourage or require plans or providers to screen members for their risk of housing instability.** Questions to identify whether an individual or family is experiencing homelessness or housing instability can be included in screening for social risk factors. This information can help inform the provider, as well as the plan or state, about the unique care needs of the individual.

[55] **Homelessness Was on the Rise, Even before the Pandemic**. Joint Center for Housing Studies of Harvard University. December 2020.
[56] **Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples - Issue Brief**. Kaiser Family Foundation. January 2017.
[57] **Supportive Housing for Chronically Homeless Medicaid Enrollees: State Strategies**. Center for Health Care Strategies. January 2016.
[58] **Improving Care for Medicaid Beneficiaries Experiencing Homelessness**. State Health and Value Strategies. September 2015.

INDIVIDUALS EXPERIENCING HOMELESSNESS OR HOUSING INSTABILITY [CONTINUED]

3. Help members achieve and maintain housing through supportive housing. Access to housing can have a significant impact on individuals' mental and physical health.[59] While the Social Security Act does not permit Medicaid to pay for housing, states have flexibility to use Medicaid dollars to provide "supportive housing services," which help individuals find or maintain housing through a variety of activities, such as tenancy support services for individuals at risk of homelessness and housing transition services for individuals experiencing homelessness. Supportive housing programs across the country have resulted in improved physical and behavioral health outcomes and reductions in service utilization and costs.[60]

4. Tailor services to the unique health care needs of this population. Individuals or families experiencing homelessness or housing instability are at higher risk for multiple co-occurring chronic behavioral and physical health conditions, leading to poor health outcomes and higher costs.[61] Unfortunately, these individuals or families also face myriad barriers to addressing their complex needs. States can make decisions about care delivery that account for these realities.

- **Action Item: Work closely with Health Care for the Homeless Health Centers.** There are nearly 300 health centers that are dedicated to meeting the needs of individuals or families experiencing homelessness. State Medicaid programs can learn a lot about the behavioral health needs of individuals experiencing homelessness or housing instability by visiting these health centers and establishing regular communications with them.

- **Action Item: Implement care management services for individuals experiencing homelessness.** Medicaid programs can use behavioral health providers to deliver intensive care management services that address the comprehensive health care and social needs of individuals experiencing homelessness.[62] These services may also be linked to financial or housing assistance services.

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[59] **Medicaid and Permanent Supportive Housing**. Health Affairs. October 2016.
[60] **Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples.** Kaiser Family Foundation. January 2017.
[61] **Improving Care for Medicaid Beneficiaries Experiencing Homelessness**. State Health and Value Strategies. September 2015.
[62] **Ibid.**

There are eight leadership and operational ingredients that support the success of the policy and program options described in this framework. These "essentials for success" are not pre-conditions for the work described in this report. Rather, Medicaid leaders should seek to advance these factors in tandem with the behavioral health options described above.

LEADERSHIP, VISION, & COLLABORATION

Identifying and ensuring action on key priorities is perhaps one of the most essential responsibilities of a leader. Medicaid Directors and senior behavioral health leaders have a critical role to play to develop a vision and focus on the behavioral health and wellbeing of members now and in the future. In addition, Medicaid leaders must work beyond just the Medicaid program and ensure alignment with other state agency- and community-based partners to maximize impact and guarantee a long-term commitment to meeting the behavioral health needs of the people in their state. This includes close collaboration with each state's behavioral health agency.

MEMBER ENGAGEMENT

Medicaid members should be an active partner in developing and designing behavioral health initiatives, not a passive recipient. This will ensure that the Medicaid agency's efforts have the desired impact of improving the mental health and wellbeing of members. Opportunities to engage members might include:

- Leveraging the Medical Care Advisory Committee;
- Developing a behavioral health member advisory group;
- Conducting listening session(s) with members;
- Engaging consumer-facing organizations; and
- Visiting behavioral health providers and community-based organizations around the state.
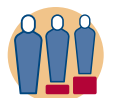
EQUITY

Racially and ethnically diverse populations have less access to mental health services, are less likely to receive needed care, and are more likely to receive poor quality care when treated.[63] Medicaid leaders should bring an equity lens to any strategies aimed at addressing the behavioral health needs of members. To be effective, care, systems, and providers must be culturally responsive to members. Some potential ways to do this include:

- Examining Medicaid and public health data to identify and understand where disparities exist;
- Sharing power by including Medicaid members who are Black, Indigenous, and People of Color in the policy-making and decision-making process; and
- Adopting a systematic process for evaluating the equity impact of all policy decisions (i.e., using an equity tool in policymaking).

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[63] **Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications. Health Affairs**. February 2014.

SOUND ADMINISTRATION

Medicaid programs need to adopt a clear and structured process for selecting, resourcing, and measuring behavioral health strategies. This will ensure the state can effectively navigate the unique political and bureaucratic landscape in which Medicaid operates as a public sector program. For example, Medicaid leaders will need to:

- Articulate the goal the agency is seeking to achieve and the strategic option(s) that will advance that goal (it is important to prioritize at this stage);
- Identify the resources the Medicaid agency will need to achieve the identified goal (these resources may include new funding or personnel, time, sister state agency support, data, stakeholder buy-in, and political will); and
- Select the measures that will be used to assess success and ensure the necessary data can be collected for those measures.

DATA

Data are essential to Medicaid's work around behavioral health. Medicaid agencies need to analyze their data (and sister state agency data, where possible) to effectively identify gaps and needs of members, including minorities, select interventions to address those needs, tailor the interventions to the population, and continuously evaluate and improve those interventions.

Medicaid can also help to ensure clinicians have the data they need to deliver person-centered, integrated care. Health information exchanges are one tool to support this. Medicaid and sister state agency partners can also provide technical assistance that helps clinicians sort through the complex rules around the exchange of substance use disorder data.

PAYMENT

Payment is one lever that Medicaid agencies can use to incentivize the desired change in care delivery. There are four principles that Medicaid programs may want to consider around payment for behavioral health care.

1. Quality. Incentivize quality, coordination, and outcomes, rather than the quantity of services delivered;
2. Flexibility. Allow providers to respond to behavioral health needs in the most clinically appropriate manner, such as using face-to-face care or telehealth, or using dyadic or two-generational approaches to care for young children and their caregivers;
3. Stability. Ensure behavioral health providers that were destabilized by the pandemic can continue to participate in Medicaid provider networks; and
4. Diversity and Task Sharing. Incentivize providers to use a diverse workforce, like community health workers, peers, and family peer specialists, and to function at the top of their license.

WORKFORCE

Many states faced behavioral health workforce shortages prior to the COVID-19 public health emergency. The pandemic will likely exacerbate these shortages as clinicians retire, close their business due to financial strain, or stop participating in Medicaid provider networks. This will happen at the same time as demand for services increases. Workforce solutions will require cross-agency and cross-sector collaboration, including with the department of public health, medical schools, community colleges, and others. For example, solutions might include:

- Expanding the workforce to non-traditional providers, like family caregivers, community health workers, traditional healers, and other culturally appropriate providers;
- Supporting primary care providers in the delivery of mental health and addiction treatment;
- Reducing administrative burden on clinicians; and
- Leveraging telehealth where appropriate and effective.

CHANGE MANAGEMENT AND TECHNICAL ASSISTANCE

Transformative efforts require significant time, energy, and sustained efforts. States will be more successful at supporting the changes they desire if the work is supported by sound change management practices, both internally and externally. Direct technical assistance will also help plans, providers, and members be successful in the new care delivery environment. It can make an initiative more sustainable for providers by reducing the financial burden on those providers to purchase their own tools and supports. It also can help states expand the workforce by providing training to new provider types, like peers and family caregivers.

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APPENDIX

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STATE EXAMPLES AND RESOURCES

MEDICAID
NATIONAL ASSOCIATION OF MEDICAID DIRECTORS
forward

ADVANCE PREVENTION BY PROMOTING MENTAL HEALTH AND WELLBEING

STATE EXAMPLES

Support mental health promotion and primary prevention.	North Carolina released a toolkit that provides information about resources about how to manage mental health needs during the pandemic.
Increase awareness of and linkages to other social services and supports.	California plans to require its health plans to conduct individual risk assessments that identify social risk factors, like lack of transportation and food insecurity.
	Massachusetts requires its plans to screen all members for their social support needs.
	Rhode Island requires its plans to refer individuals to social services and supports and monitor the outcome of those referrals.

RESOURCES

Addressing Social Determinants of Health via Managed Care Contracts and Section 1115 Demonstrations, Center for Health Care Strategies & Association of Community Affiliated Plans, December 2018.

Leading Edge Practices in Medicaid for Addressing Social Factors that Affect Health, State Health and Value Strategies, April 2019.

Opportunities in Medicaid and CHIP to Address the Social Determinants of Health, Centers for Medicaid and CHIP Services, January 2021.

Preventing Adverse Childhood Experiences, Centers for Disease Control and Prevention, 2019.

Social Determinants of Mental Health: Where We Are and Where We Need to Go, Current Psychiatry Reports, September 2018.

Social Risk Factor Screening in Medicaid Managed Care, State Health and Value Strategies, October 2020.

STREAMLINE ELIGIBILITY FOR SERVICES

STATE EXAMPLES

Simplify or relax requirements for assessments.	Arizona formed a task force to address behavioral health concerns arising due to the pandemic.
Move away from diagnostic and utilization criteria for service eligibility.	Colorado implemented a policy allowing six visits with a licensed behavioral health provider in a primary care setting without a diagnosis of a covered behavioral health condition.
	Illinois is assessing its behavioral health screening tools for racial and ethnic bias.
	Illinois has a longstanding, robust structure to support behavioral health screenings. The state is reviewing this and identifying opportunities to ensure treatment is incentivized.

CONTINUE TO PROMOTE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES

STATE EXAMPLES

Incentivize screening and referrals between primary care and behavioral health providers.	Louisiana requires MCOs to employ a full-time behavioral health medical director who is charged with developing training for primary care providers on specific behavioral health screening tools and collaborative care models, as well as provide all primary care providers with a current list of referral providers, including behavioral health providers, on a quarterly basis.
	Minnesota requires that managed care plans provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care clinics.
	Pennsylvania's Telephonic Psychiatric Consultation Service Program increases the availability of peer-to-peer child psychiatry consultation teams to primary care providers and other prescribers of psychotropic medications for children.
	Virginia requires its health plans to demonstrate the ability to cover specialty consultant services (e.g., telepsychiatry) to interested primary care providers and contract with network behavioral health providers that can provide assessments and other services via telehealth, as needed.
	Washington requires its plans to submit a quarterly report on bi-directional behavioral and physical health integration to the Medicaid agency.
Advance integrated care delivery models.	CCOs bidding for contracts with Oregon's Medicaid program must identify and address billing and policy barriers that prevent behavioral health providers from billing for services from a physical health setting.
	Vermont implemented a hub and spoke system for supporting people with opioid use disorder.

RESOURCES

Costs of Using Evidence-Based Implementation Strategies for Behavioral Health Integration in a Large Primary Care System. Health Services Research. November 2020.

Early Mortality in SMI: Federal and State Policy Initiatives. Psychiatric Times. May 2020.

How Arizona Medicaid Accelerated the Integration of Physical and Behavioral Health Services. The Commonwealth Fund. May 2017.

Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now? National Association of State Mental Health Program Directors. August 2019.

Integration of Behavioral and Physical Health Services in Medicaid. Medicaid and CHIP Payment and Access Commission. March 2016.

Interventions to Increase Access to or Uptake of Physical Health Screening in People with Severe Mental Illness: a Realist Review. British Medical Journal. February 2018.

BUILD A COMPREHENSIVE APPROACH TO ADDICTION TREATMENT

STATE EXAMPLES

Prevent addiction by addressing the root causes.	California is conducting a statewide effort to screen members for Adverse Childhood Experiences (ACEs). The state is reimbursing Medicaid providers for conducting the trauma screening.
	Colorado provides home visiting services through its targeted case management benefit.
	South Carolina has a "pay-for-success" initiative to support Nurse Family Partnership services in the state.
Increase access to community-based care.	Massachusetts' Consultation Service for Treatment of Addiction and Pain (MCSTAP) provides support for primary care providers treating addiction.
	Michigan removed prior authorization requirements for MAT.
	New York continues to leverage telehealth for substance use disorder treatment (the state was using telehealth for addiction treatment prior to the pandemic).
	Virginia's Office-based Opioid Treatment Program permits mid-level practitioners to deliver MAT.
	Washington State's Partnership Access Line (PALs) allows pediatric providers to consult with a psychiatrist on demand, and it is jointly financed by Medicaid and commercial insurers.
Increase access to specialized inpatient services as one component of comprehensive addiction treatment.	Idaho expanded access to inpatient services through a state plan amendment.
	Louisiana and Ohio have an approved 1115 waiver to provide specialized inpatient services.
Provide recovery supports.	Georgia provides skills training for individuals with mental illness through its coverage of psychosocial rehabilitation.
	New York provides supported employment for members with significant behavioral health needs.
	Oklahoma and Arizona are two states that provide peer support for beneficiaries with an addiction. Arizona also supports a training academy for peers.

RESOURCES

Access to Substance Use Disorder Treatment in Medicaid. MACPAC. June 2018.

Federal Legislation to Address the Opioid Crisis: Medicaid Provisions in the SUPPORT Act. Kaiser Family Foundation. October 2018.

Key Substance Use and Mental Health Indicators in the United States: Results from the National Survey on Drug Use and Health, 2019. SAMHSA. September 2020.

Mandatory Medicaid State Plan Coverage of Medication Assisted Treatment. CMS. December 2020.

Medicaid and Home Visiting: The State of States' Approaches. Johnson Group Consulting. January 2019.

Medicaid and the Opioid Epidemic. MACPAC. June 2017.

Medicaid Innovation Accelerator Program: Reducing Substance Use Disorders: Exploring Telehealth Delivery Methods for Substance Use Disorder Treatment. CMS. September 2019.

Peer and Family Career Academy. Arizona.

Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder. MACPAC. July 2019.

Review of State Strategies to Expand Medication-Assisted Treatment. Technical Assistance Collaborative. May 2019.

Section 1115 Waivers for Substance Use Disorder Treatment. MACPAC.

STRENGTHEN AND BROADEN CRISIS RESPONSE SYSTEMS

STATE EXAMPLES

Connect individuals in crisis with appropriate care.	Arizona's Medicaid agency operates regional 24-hour crisis telephone lines to respond to individuals in need and dispatch mobile response teams if necessary.
	Kentucky requires its plans to have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel 24-hours per day.
Ensure the right responders are dispatched to a crisis.	The Colorado Co-Responder Program, which is jointly funded by Medicaid and state and local dollars, pairs officers and behavioral health professionals who respond to 911 calls with a suspected behavioral health component.
	Colorado, Delaware, and Minnesota are three states where paramedics or other first responders can connect with tele-behavioral providers remotely in order to assess patient needs and make referrals.
	Tennessee's crisis services program has 13 mobile crisis teams throughout the state funded through a combination of state general fund and Medicaid dollars.
Develop specialized settings to support individuals in crisis.	Arizona directs plans to cover services provided by 24-hour crisis stabilization/observation and detox facilities, 24-hour outpatient clinics, and crisis respite.
	Rhode Island developed a special Medicaid rate for "BH Link," the state's crisis diversion facility.
	Tennessee's crisis stabilization and walk-in units are funded with a combination of state general fund dollars and Medicaid dollars.

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INDIVIDUALS INVOLVED IN CRIMINAL JUSTICE

STATE EXAMPLES

Use crisis services to prevent incarceration.	In Utah, Salt Lake County leverages its crisis system to prevent incarceration by immediately connecting individuals to treatment.
Eliminate gaps in care that occur during the transition out of the criminal justice system.	Kentucky leverages its community mental health centers to do in-reach.
	Massachusetts created three affidavits as a way to verify zero income, state residency, and incarceration status for applicants who have no other way to verify these eligibility factors.
	Massachusetts is piloting an initiative where two behavioral health providers conduct in-person visits with inmates to develop individualized treatment plans and provide case management.
	New Mexico was an early adopter of efforts to suspend, rather than terminate, eligibility for individuals entering the criminal justice system.
	Ohio requires its plans to engage with people identified as high risk and participate in a video conference with their managed care plan prior to release.
	Utah, New York, and Kentucky have proposed 1115 waivers to allow Medicaid to cover treatment in the 30 days prior to release. Kentucky's proposal would provide family therapy in its bundle of pre-release services.
	Washington State and Arizona support information exchange between Medicaid and the corrections department.

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CHILDREN

STATE EXAMPLES

Remove barriers to behavioral health services for children and their caregivers.	California recently released a new policy to create access to family therapy benefits before a diagnosis of a behavioral health condition is required.
	Colorado implemented a policy allowing six visits with a licensed behavioral health provider in a primary care setting without a diagnosis of covered behavioral health conditions.
	Florida, North Carolina, and many other states used the 1135 waiver authority to change policy for prior authorization of services.
Develop a comprehensive strategy to support family emotional health and stability.	North Carolina developed an Early Childhood Action Plan that outlines a cohesive vision and plan so that North Carolina's young children are healthy, grow up safe and nurtured, and are well-supported to be learning and ready to succeed.
	Raise Up Oregon is the state's Early Learning System Plan that aims to improve school readiness and ensure "children are raised in healthy, stable and attached families."
	Vermont has a Trauma Informed System of Care Policy that guides state agencies to recognize and respond to trauma and toxic stress that can impact family health and child development and to respond in all policies, procedures, and practices, and to actively resist re-traumatizing the people they serve.

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OLDER ADULTS

STATE EXAMPLES

Respond to the immediate health needs of older adults.	Colorado acted to ensure that home health and hospice services were available through telehealth.
	Ohio Medicaid developed the "friendly caller" program to provide social supports to isolated seniors.
Transform behavioral health care for older adults.	Washington State's Medicaid Transformation Demonstration supports unpaid caregivers of older adults who are enrolled in Medicaid but not currently accessing Medicaid-funded LTSS. It also helps individuals avoid or delay impoverishment by providing certain services for individuals who are "at risk" of needing Medicaid LTSS but do not meet Medicaid financial eligibility criteria.

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INDIVIDUALS WITH INTELLECTUAL & DEVELOPMENTAL DISABILITIES

STATE EXAMPLES

Understand the needs of the population.	New Hampshire used all-payer claims data from 2010 to 2014 to better understand the needs of people with ID/DD in the state.

North Carolina's ID/DD State Stakeholder Group, which consists of representatives from the ID/DD community, including members, family, providers, and advocacy organizations, provides feedback and recommendations to the state on proposed changes to their HCBS waivers.

In 2018, Texas adopted a statewide stakeholder input process for the ID/DD managed care carve-in. |
| Ensure primary supports for stability. | Hawaii is implementing a comprehensive, multi-agency ID/DD/Behavioral Health Case Management System.

North Carolina will launch a new tailored health plan in 2022 focused on providing care management services for individuals with significant behavioral health needs and ID/DD.

Ohio pays family caregivers, including parents/guardians of minor children to provide waiver services under its Home Care waiver.

Tennessee introduced a coordinated care model for the full range of health care services for a portion of the ID/DD population, which includes a nurse case manager, who manages an integrated plan of health care for the individual's physical and behavioral health care needs across services and delivery settings.

Washington temporarily allows out of state respite for more than 30 days on a case by case basis and expanded settings where respite services may be provided (e.g. hotels, shelters, schools, churches) through its Appendix K waiver. |
| Enhance behavioral health treatment for individuals with ID/DD. | The Massachusetts Child Psychiatry Access Program (MCPAP) offers support and consultation to Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) providers working with youth and young adults with autism spectrum disorder or intellectual disabilities who are having a behavioral health crisis.

New York's Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD) offers crisis prevention and response services to people who have both developmental disabilities and complex behavioral needs, as well as to their families and those who provide supports.

Texas contracted with University of Texas Health Science Center at San Antonio (UTHSCSA) to develop web-based training modules to educate providers on best practices in treating individuals with ID/DD and behavioral health needs. |

RESOURCES

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INDIVIDUALS EXPERIENCING HOMELESSNESS OR HOUSING INSTABILITY

STATE EXAMPLES

Connect individuals experiencing homelessness or housing instability to Medicaid coverage.

Kentucky has condensed its 20-page application into a one-page online form to streamline the enrollment process throughout the pandemic.

Identify members who may be experiencing homelessness or housing instability.

Connecticut matched Medicaid claims data to HMIS data provided by the Connecticut Coalition to End Homelessness to identify single adult Medicaid beneficiaries identified as homeless in 2012.

Massachusetts matched data from the City of Boston's Continuum of Care on individuals experiencing chronic homelessness with Medicaid data on coverage status, service use, costs, and expenditures. This analysis helped advance state and local conversations about potential housing and service partnerships to better serve individuals experiencing chronic homelessness.

Massachusetts requires its plans to screen members for risk of homelessness and health-related social needs, including housing stabilization and support services.

Washington has created an integrated client database with longitudinal data from more than 30 data systems.

Help members achieve and maintain housing through supportive housing.

Florida's Behavioral Health and Supportive Housing Assistance pilot provides necessary services for individuals ages 21 and older with an SMI and/or substance use disorder who are homeless or at risk of homelessness due to their behavioral health diagnosis.

Through an 1115 waiver, Illinois provides pre-tenancy and tenancy support services for individuals with behavioral health needs at risk of homelessness or inappropriate institutionalization.

Through their 1915(c) waiver, Louisiana provides housing transition and stabilization services for individuals with ID/DD transitioning from an intermediate care facility back to the community.

Through a state plan amendment, Minnesota provides housing stabilization services to several at-risk populations, including individuals with a mental health condition, substance use disorder, or physical injury that required a residential level of care and are now in the process of transitioning to the community.

Tailor services to the unique health care needs of this population.

Through their 1115 waiver, Maryland provides tenancy-based case management services to high-risk, high-utilizing Medicaid enrollees who are at risk of institutional placement or homelessness.

Massachusetts' managed care model contract requires plans to develop protocols for providing care management activities at adult and family shelters and for members experiencing homelessness.

Massachusetts offers resources, information and a support line to assist hospital staff in placing individuals who are experiencing homelessness or housing instability.

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ESSENTIALS FOR SUCCESS

RESOURCES

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