HUB ANALYSIS DECEMBER 2020

Key Findings from the Medicaid MCO Learning Hub Discussion Group Series and Roundtable—Focus on Behavioral Health

The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and increasing advancements in health equity and health care transformation. We encourage you to share your experiences and feedback on future Medicaid MCO Learning Hub work so we can better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

In September and October 2020, the NORC team convened four discussion groups, one with each of its Medicaid MCO Learning Hub partners—Community Catalyst, the Association for Community Affiliated Plans (ACAP), America's Health Insurance Plans (AHIP), Families USA—and their affiliated Medicaid MCOs and advocacy experts to discuss the behavioral health needs of their members, the delivery of behavioral health services to Medicaid members, and how COVID-19 is affecting those needs. After assessing key themes, the team convened a roundtable with representatives from our four partners to discuss main findings and identify insights and opportunities to address those findings.

This brief, the second in a series detailing findings from group and roundtable discussions of key issues, will provide the Robert Wood Johnson Foundation (RWJF), its grantees, MCOs, and community-based organizations, among other stakeholders, with information on key behavioral health challenges pre- and during COVID-19, and local, state, and federal opportunities for addressing those challenges. Forthcoming briefs in this series will focus on the consumer voice and member engagement.

Ensuring adequate access to timely and well-coordinated behavioral health (BH) services, which includes both mental health and substance use disorders (SUDs), for Medicaid members is complex and challenging. COVID-19 has increased individuals' needs for BH care, particularly for those with pre-existing mental health conditions and SUDs. With in-person clinical services shut down or scaled back, the consequences of social distancing, fears about contracting COVID-19, limitations in transportation, increased unemployment and income limitations, challenges accessing telehealth technology for some populations, and feelings of isolation and anxiety have made access to needed BH services more challenging.

In a series of discussion groups and a roundtable with MCO Learning Hub partners, we asked MCO and consumer advocacy representatives to

- Describe BH needs pre-COVID-19 and perspectives on changes in BH needs during the pandemic;
- Discuss how the pandemic will change delivery of BH services in the future and concerns about the future delivery of BH services;
- Highlight potential solutions MCOs are implementing to address these challenges.

This brief highlights key findings from these discussions, including how MCOs address BH needs, facilitators or

barriers to their efforts, and policies that could improve access to and delivery of BH services to Medicaid members.

Key Findings from the Discussion Groups

This section presents central findings from across discussion groups on the BH needs of Medicaid members, how COVID-19 has affected these needs, and the integration of behavioral and physical health.

I. EXISTING CHALLENGES IN THE BH SYSTEM

Shortages among BH providers, including school-based and crisis response providers, limits member access to BH services

BH Providers. Both MCO and advocacy representatives noted a shortage of psychiatrists, subspecialists, and other BH providers available to meet the needs of Medicaid beneficiaries. Provider shortages often lead to long wait times for appointments: discussion group participants offered anecdotal reports of patients with BH needs seeking services at community health centers who sometimes wait up to three months for appointments in some subspecialties, like psychiatry. Some advocacy representatives reported that for Medicaid members can have limited access to inpatient and intensive BH services. Participants also expressed concerns that some BH providers do not accept Medicaid patients, further reducing their access to BH services.

School-based BH Service Providers. School-based BH providers can support children and adolescents by meeting them where they are. However, advocacy representatives noted a shortage of school-based BH providers, reporting that counselors, psychiatrists, and social workers often cover many schools and students, and have limited capacity to meet needs. A Health Resources and Services Administration (HRSA)[1] report estimates that by 2025, mental health and SUD social workers and school counselors will have shortages of over 10,000 full-time equivalents. An advocacy representative noted the difficulty that school-based BH services have in receiving funding, which can come through various mechanisms, including Medicaid for children and adolescents with individualized education plans (IEPs), though this may vary by state.

Crisis Response Providers. Advocacy representatives expressed concerns that law enforcement or emergency departments often handle crisis responses and noted a need to expand the crisis response workforce to better support members in BH crisis.

> **"One of the biggest issues we're faced with is the lack of crisis services, or rather, that crisis response is often a law enforcement response, where people in a mental health crisis risk being disproportionately jailed, put on the streets, or shot. Otherwise, we are experiencing very bad outcomes in terms of crisis intervention."**
> **— *Advocacy Representative***

Participants noted that there are opportunities to rethink how a BH crisis response system could create a system better equipped to manage mental health issues than a system centered on law enforcement or an emergency department. For example, participants described the Crisis Now model, which includes crisis hotlines, crisis intervention teams that work with law enforcement to respond to calls for people in crises, crisis counseling programs, and BH crisis stabilization centers, as well as other models.[2]

Varying reimbursement policies across states for peer support services and outreach efforts lead to limitations in access to BH services

Peer Support Services. The extent to which Medicaid reimburses for recovery support services and the mechanism through which those services are delivered vary by state. While Medicaid covers peer support services to some extent in many states, some advocacy representatives noted particular complexities and challenges having peer support specialists and recovery community organizations (RCOs), which are independent organizations led and governed by representatives of local communities of recovery. RCOs provide recovery-focused education, outreach, and peer-based recovery support services that are reimbursed by Medicaid. For example, an advocacy representative noted that although Texas approved Medicaid reimbursement for peer recovery supports and services, RCOs themselves are not approved to provide peer recovery support and services. Advocacy representatives highlighted the need to consider the role of peer support specialists, RCOs, and other recovery

[1] National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025 available at: https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf.

[2] More information on the Crisis Now model can be found here: https://crisisnow.com/library/

support services as a lower-cost option that can expand the capacity of the BH workforce.

Participants noted a need to find ways to pay for evidence-based care that can be provided by non-traditional mental health and SUD professionals, such as peer counselors, community health workers, and traditional healers.

Engagement. Both MCO and advocacy representatives noted that outreach and engagement are essential to providing necessary BH services to Medicaid members, especially those most at-risk. However, discussion group participants noted that efforts to identify and reach at-risk populations are essential but challenging. Participants said that it takes considerable time to build trust with individuals thinking about entering into substance use recovery, and to help them overcome distrust of the health care and BH system, and the stigma of receiving BH services. However, there is confusion about which outreach and member engagement services Medicaid covers.

> **"The outreach work we do, we spend maybe 3-12 hours working with an individual on gaining insurance, on accessing other services prior to ever being at a point of being able to bill… especially for someone who is new to this process, may have neglected to have health care coverage… someone who is suffering from homelessness, who is currently actively using, and that continuum of care is left out… All of this really has a lot of individuals falling through the cracks."**
> ***– Advocacy Representative***

In addition, other factors (e.g., lack of phones and addresses for transient populations) make outreach to people with BH needs difficult. MCO representatives noted that some outcome measures for retention and engagement reveal a lot of *"one and done"* metrics.

Participants also noted other challenges with Continuity of Care

A few participants noted challenges for individuals with complex conditions in maintaining continuity of care if they are discharged but do not have sufficient supports in place to assist in their recovery. In addition, advocacy and MCO representatives noted that Medicaid eligibility churn, including re-determination, hinders continuity of care. For justice-involved individuals in the phase of re-entry, for example, which is a very high-risk period in their lives, continuity of BH care is difficult to maintain. Yet, justice-involved individuals need improved handoffs and continuity of care.

II. EFFECTS OF COVID-19 ON ACCESS TO BH SERVICES

Increased BH needs during the COVID-19 pandemic result from concerns about the virus itself, social isolation, and its economic consequences

Rise in BH Needs for Medicaid Members. Discussion group participants highlighted the rise in BH needs among Medicaid members during the pandemic. Advocacy and MCO representatives noted that they have seen a dramatic increase in the need for acute mental health services, both for existing and new patients. This includes higher demand for services to treat depression, anxiety, acute opiate and other substance use and overdoses, and suicidal ideation. A crisis responder noted that calls to their crisis hotline have increased by over 400 percent over the last months.

> **"All behavioral health needs increased as a result of COVID. Alcohol and marijuana sales and overdose rates are up. There's a great need for residential and substance use disorder treatment. People who have never had mental health issues are having mental health crises. Psychiatric admission and suicides are up too, as well as moderate mental health issues; really all behavioral health needs are up. We're also finding that the BH providers are very stressed."**
> ***— Medicaid MCO Representative***

The general population as well as individuals in group homes or facility-based settings are experiencing challenges with social isolation due to social distancing requirements. For example, older populations who may also have limited ability to access technology and online media are at higher risk of social isolation. Advocacy representatives noted that, from an SUD perspective, social gatherings, meetings, and other peer supports are important to recovery, and social isolation can increase the risk of relapse.

Rise in BH needs for BH Providers. Participants noted that BH providers themselves are experiencing an increase in stress, trauma, and BH needs due to the pandemic. MCO representatives noted they have offered train-the-trainer sessions for BH supervisors on managing stress and reducing burnout during this challenging time. An MCO noted that North Carolina developed a Hope for Healers helpline to support providers and frontline staff caring for patients during COVID-19.

Rise in SDOH Needs for Individuals with BH Challenges. Participants noted that accessing services (e.g., food banks, housing supports) to address SDOH needs was already a challenge for individuals with BH needs, particularly those with severe functional impairments. These include lack of employment and housing and food security, among other factors. Participants highlighted that COVID-19 has further exacerbated SDOH needs, noting that Medicaid members have growing concerns about affordability of food for their children.

While they noted that the initial federal moratorium on evictions and the subsequent Centers for Disease Control and Prevention (CDC) eviction moratorium through December 2020 helped, they described how Medicaid members face increased housing insecurity as a result of unemployment and other factors. Participants noted that stressors around employment and food and housing insecurity further exacerbate BH needs or can lead to anxiety and depression. Participants also reported that secure housing is a priority for individuals in recovery from SUD and mental health challenges.

Long-term Impact of Pandemic on BH Needs. Advocacy representatives noted the importance of considering the residual, long-term effects of the pandemic. For example, providers are now starting to treat patients who were previously hospitalized with COVID-19 and who have trauma from their experience and may experience re-traumatization given the ongoing crisis. In addition, they are treating individuals grieving the loss of, in some cases, multiple family members.

> **"This is not a short-term, episodic area of need; [BH providers will be] dealing with the residual effects of this [pandemic] and the intersectionality of these issues for a long time."**
> ***– Advocacy Representative***

Advocacy representatives also highlighted the need to further consider the role MCOs can play in supporting school-based services, particularly given the growing recognition that children and adolescents are returning to school in-person and full time as COVID-19 restrictions are lifted. Children and adolescents may return to school with an unmet level of trauma, in an already uncertain situation at the same time that schools and districts are facing budget cuts. They said that this will be especially important in schools and communities with historic redlining, high rates of poverty, and systemic racism that often overlaps with geographical areas with high rates of Medicaid eligibility.

Underutilization of BH services during the pandemic has been largely due to uncertainty with how to access and deliver services

MCO representatives said there was an initial downturn in the use of BH services in spring 2020, when states began lockdowns and implementing social distancing restrictions. For example, MCO and advocacy representatives described:

- Curtailing of access to intensive home-based treatment programs, particularly affecting people with serious mental illness (SMI) and cognitive impairment, in some cases resulting in severe exacerbation of symptoms
- Inability to more easily move people through BH systems (e.g., individuals in group homes or facility-based settings not being able to see outpatient providers while in facilities, individuals staying longer than needed in residential facilities because fewer places were available for discharge)
- Challenges among some providers to deliver BH services remotely and/or effectively implement social distancing requirements within facilities
- Difficulty accessing personal protective equipment (PPE)
- Decreased outreach and engagement from providers to people in need of assistance who are unable to access it on their own, including individuals experiencing homelessness

As a result, participants reported that many people experienced access barriers to getting their BH needs met, resulting in underuse of services in the initial stages of the pandemic.

Federal, state, and MCO policies during COVID-19 helped maintain and improve access to BH services

Discussion group participants said that the rapid issuance of federal and state guidance on reimbursement for telehealth and medication-assisted treatment (MAT) helped promote ongoing access to care during the pandemic. Some states loosened regulations on who qualifies as an in-network provider, giving Medicaid beneficiaries access to out-of-state providers. Participants noted that these policies increased access, particularly for people who live in border regions. They also mentioned MCOs' loosened restrictions to expedite credentialing and waiving prior approvals for autism assessments and other services.

Advocacy representatives reported innovations in improving access to medications for individuals with BH needs during COVID-19. For example, new mail-in and pick-up/drop-off options (e.g., for opioid treatment programs) and drug testing have improved individuals' access to MAT and other SUD treatment and recovery services. There is also a need to continue to explore how these innovations can be leveraged beyond COVID-19 to improve access to medication. MCOs are also working with public health departments to increase access to resources and COVID-19 testing.

States and MCOs have been flexible with Medicaid-funded services normally received in person in schools. For example, a participant noted North Carolina applied for an Appendix K Waiver[3] to allow children and adolescents to receive Medicaid-reimbursed in-home services while attending school remotely rather than in person.

MCOs advanced funds to BH providers to cover financial gaps resulting from underuse of services due to COVID-19

MCO representatives voiced concerns about the costs associated with COVID-19, such as for PPE, the underuse of needed BH services, and the impact on providers already operating with small margins. A participant described that providers had reported a net reduction of 22 percent in revenue along with reduced employee hours and laid off or furloughed workers. Participants said that states asked MCOs to advance funds to providers in financial distress. For example, an MCO representative said that to keep providers solvent, they pivoted to an alternative payment arrangement instead of a fee-for-service model. In this case, the MCO funded providers by issuing payment based on 2019 performance rather than services rendered in spring 2020 when in-person care was deferred.

Participants observed that bundled payment models create incentives to have a long-term interest in patient outcomes. They also highlighted the importance of value-based payment models to help providers financially weather the reductions in utilization they have experienced during COVID-19.

MCOs noted that state Medicaid programs have not yet altered their funding to MCOs through clawbacks, due to lower utilization of the health care system during the pandemic, but fear future cuts

MCO representatives said that they have not yet experienced Medicaid cuts to programs.[4] However, given the strain of the pandemic on state budgets, they are concerned about the potential for future funding cuts and described wanting transparency from states on their plans. Discussion group participants noted that as states face severe budget pressures and consider budget cuts, they are concerned about the implication of cuts for sustaining flexibility, maintaining current services, and funding innovative BH and health equity programs.

Participants also expressed concern with how this year's utilization rates will affect determinations of provider rates next year and beyond, particularly considering potential future COVID-19 waves or pent-up demand for services. Discussion group participants noted that this could be the *"perfect storm of more demand and less money."*

Rapid transition to telehealth during COVID-19, despite some early challenges, improved access to BH services

Discussion group participants described provider resistance to telehealth prior to the pandemic. MCO representatives said that, early in the pandemic, some BH providers were not comfortable with telehealth or had challenges transitioning from in-person to telehealth visits. MCO representatives described spending a significant amount of time educating and training BH providers to use telehealth and understand state and federal guidance around telehealth reimbursements.

Participants also noted that some providers (e.g., SUD providers) struggled more than others to adopt telehealth. Smaller, independent providers sometimes could not afford the technology or licenses needed to offer telehealth services. MCO representatives said some plans purchased telehealth software licenses for providers who could not afford them.

[3] Appendix K is a standalone appendix that may be used by states during emergency situations to request amendment to approved 1915(c) waivers.

[4] MCOs are paid using actuarially sound rates developed with data from the prior two years. For example, 2020 rates were developed using data for services delivered by MCOs in 2018. Despite this statement by MCO representatives during discussion groups, afterwards the discussion partners noted that they are aware of recent rate cuts and implementation of new risk corridors by states and Medicaid programs. MCOs could be negatively impacted and see a reduction in their rates because of COVID-19 in 2022.

> **"In our area, there was literally nothing virtual for BH. That was a world they did not know how to maneuver and it was a challenge to get them comfortable with the transition. Now that they're getting more comfortable with it, I think that's going to change how we provide care."**
> ***— Medicaid MCO Representative***

After receiving guidance and technical support, participants noted that many providers successfully transitioned to telehealth. Despite some BH providers' initial resistance to moving to telehealth, participants said that many providers recognized telehealth could enable ongoing patient care in a way that could be safer for both patients and providers. For example, a crisis response provider said that though crisis responders initially thought they could not provide crisis services via telehealth, it is working surprisingly well and crisis response providers have become more comfortable with its use to engage individuals in a crisis. MCO representatives also noted they are working to gather and disseminate BH telehealth best practices to providers.

However, participants agreed that telehealth is not the solution for all populations. For example, individuals with intellectual and developmental disabilities (IDD), SMI, chronic mental illness, or on medication due to severity of symptoms largely need in-person care.

Participants noted offering telehealth visits has led to increased access to BH services

Participants noted that many Medicaid members are happy receiving BH care via telehealth and feeling more connected to care, including to crisis providers and peer recovery support providers.

Participants reported that some populations, who may have not engaged with the BH system previously due to limited transportation, lack of childcare or other challenges, including stigma around receiving BH services, now receive services through telehealth. Participants said that providers are seeing a reduction in their *"*no-show*"* rate. In addition, advocacy representatives reported that various mutual aid and peer support groups have moved online. Participants noted that the use of telehealth may help reduce stigma for individuals who did not want to be seen going into a BH provider's office.

> **"What we heard loudly from members when we asked them about their experience so far with telehealth is that compared with getting on a bus and transferring, etc... turning on a phone or computer was much faster. So in some ways telehealth has increased access for those without reliable transportation, though obviously it doesn't improve access for everyone; some people are going to prefer in-person visits."**
> ***— Medicaid MCO Representative***

Some providers may experience challenges meeting this new demand, which may require broadening the BH reimbursable workforce

MCO and advocacy representatives expressed concerns about the capacity of the BH system to meet increasing demands for services, even with telehealth. As BH needs increase due to COVID-19 and with existing workforce shortages, longstanding limitations in BH capacity and provider shortages are exacerbated. For example, MCO representatives said that they are examining staffing ratios and seeing a need for more providers to meet the demand.

> **"Telehealth has meant providers are happier and members are happier to get access to services, but as an MCO looking at that productivity, are we going to be able to meet that demand? We may need to change our BH delivery model."**
> ***— Medicaid MCO Representative***

Sustaining coverage and access to telehealth post-COVID-19 is key to meeting BH needs

Both MCO and advocacy representatives said that telehealth should remain available as a medium of care delivery in a post-COVID-19 world. Participants noted that many providers and consumers have been satisfied with telehealth and want many of the federal and state regulatory flexibilities put in place during the public health crisis to continue post-COVID-19. Participants anticipate a hybrid system that combines both telehealth and in-person care. As a participant described, telehealth may *"not be the 'end all, be all' but [it] is actually filling a gap and keeping patients and providers safer."* Participants noted a need to better understand provider and member satisfaction with telehealth and quality of care compared to in-person visits, return on investment, and its impact on access and health outcomes.

COVID-19 and racial injustice have exacerbated disparities in BH care

Prior to COVID-19, the BH system struggled with health disparities

Discussion group participants noted a disproportionate underuse of BH services by some marginalized racial and ethnic groups as compared to their percentage of the population, including Black, Latinx, and Asian American communities.

Participants pointed to various factors that contribute to the underuse of BH services by some racial and ethnic minority groups. Historic biases towards communities of color and racism in the health care and BH care system have led to their distrust of the health care system. In addition, stigma associated with seeking BH care may be greater in some cultures. Furthermore, advocacy representatives noted a lack of access to culturally and linguistically appropriate BH services. For example, discussion group participants noted a lack of sufficient SUD treatments provided in Spanish or that are culturally appropriate. In addition, certain racial and ethnic groups may face challenges accessing outpatient or ambulatory care in their communities. As a result, some groups, for example Black populations, tend to rely more on acute services and inpatient residential services as opposed to outpatient and ambulatory care.

Beyond disparities by racial and ethnic groups, participants also observed other disparities in BH care. These include access to SUD treatment between urban and rural communities, with urban communities more likely to have access to methadone treatment while rural and suburban communities have more access to buprenorphine. This highlights a need to increase provider capacity and bolster infrastructure to ensure that supply meets need, particularly among underserved populations.

> **"The greatest need is access. Even in metropolitan areas, there is a lack of access. We haven't spoken strongly about the fact that folks in the inner city rely on community health centers. Those who have serious and persistent mental illness and SUD have to wait [in long lines]. And then there are issues with SDOH. The last issue would be implicit bias. Those who do get care don't feel like they're heard, and they drop off."**
> ***— Medicaid MCO Representative***

COVID-19, paired with racial injustice, are widening disparities in BH needs

Advocacy representatives described increases in need for BH services among the Black population, which is being disproportionately impacted by COVID-19 as well as by police brutality and racial injustice, which has given rise to social unrest in the country. Racial injustice and increased exposure to racial violence are exacerbating racism- and race-related trauma among the Black population; this trauma paired with the COVID-19 pandemic is resulting in an increased need for BH services to treat depression, anxiety, suicidal ideation, and substance use. Advocacy representatives fear a surge in grief and trauma in Black communities.

> **"We talk a lot about what we consider to be a double pandemic. There are disparities related to how frequently African Americans in particular are contracting COVID and dying at higher rates than any other group of people. There is the traumatic impact of that on top of what is happening across the country with how many African Americans are killed [by the police or by racial violence], and that being exposed and circulating around the media. That has significant psychological impact; there is a lot of hopelessness and the suicide rate is higher for African Americans as well as domestic violence, substance use… Those are compounding stressors and people are just not doing well mentally and spiritually."**
> ***— Advocacy Representative***

Participants described other widening disparities in BH needs and access. For example, LGBTQ individuals who may have had to return home to live with family who may not accept their gender identity and sexual orientation may be experiencing increased BH needs and challenges in finding a private space to engage in mental health services.

Advocacy representatives also noted that communities with limited English proficiency (LEP) already had challenges accessing BH services prior to COVID-19, but now face more challenges accessing interpretation and translation services over digital platforms during COVID-19. Digital platforms themselves are generally in English, so it can be difficult for individuals with LEP to get online and understand how to navigate the technology.

Telehealth, while improving access to care for some individuals, may further exacerbate disparities for others and increase the technological divide

Discussion group participants noted that underserved racial and ethnic groups and other Medicaid beneficiaries may disproportionately face challenges obtaining phones, phone minutes and data, and technology to access telehealth. Older adults may not be as tech savvy and may be uncomfortable using telehealth. Affordable broadband is not available everywhere, which can limit access to telehealth in some communities. Individuals, including children and adolescents and others needing access to BH services, may have a hard time finding a private space in homes during a telehealth consult.

> **"We, too, have seen more people with access to providers that wouldn't have had this access before… But with internet access, we have large portions of our state that do not have any service, whatsoever. So, it's just not an option for them. But also, in our population, the access isn't everyone's barrier. Sometimes it's knowing what to do with it. It's assumed that everyone knows how to use technology and uses email and knows how to download a PDF, but they don't. And that's been a huge barrier for just knowing about things that are going on within programs or things that they might have access to."**
> ***— Advocacy Representative***

Thus, while access to BH care has improved for many Medicaid members, those with more serious BH needs, as well as certain racial and ethnic groups and other populations who were already facing disparities in the BH health care system, continue to face challenges accessing BH care and using telehealth services.

Participants noted a need for culturally and linguistically appropriate BH care to help reduce disparities in BH care as well as race/ethnicity data

Discussion group participants noted a need for health care navigation supports for racial and ethnic groups and other populations. As underserved populations may be marginalized or face SDOH needs, MCO representatives said that their role is to help identify providers and work closely with people in the community to reach all Medicaid members and support virtual visits as much as possible.

> **"For our plan, it's taking a step back and trying to understand why we're not seeing BH utilization in certain groups. Do we not have the right type of outreach or is it the messaging? We're looking at how to address this under-utilization and understanding the importance of collaboration. It's looking at whom we should be working with and it does impact this racial/ethnic question of underutilization."**
> ***— Medicaid MCO Representative***

In addition, advocacy representatives noted an absence of evidence-based practices that are defined by the community and account for the cultural preferences of individuals. These cultural preferences may include traditional healing for Native American communities, peer-led groups for specific populations such as refugees, and gender-affirming support groups for LGBTQ communities.

Advocacy representatives described a need for provider training on cultural sensitivity. At a minimum, they noted providers must acknowledge that institutionalized racism exists at a systemic and individual level, and that it is compounded by community stressors and limited access to resources that affect Black, Latinx, and other marginalized populations. They noted providers need better training in culturally competent approaches to treatment that is connected to individuals' lived experience, as well as implicit bias and anti-racism training.

> **"In our mental health system, our partners continue to tell us about the lack of access to culturally and linguistically appropriate mental health services in both the county system and the Medi-Cal managed care system. The second big piece really is the role of racism and implicit bias, not just in our general health care system, but in our mental health system as well. And then the third piece is kind of related, which is many communities of color that we work with talk about the lack of services that speak to their culture."**
> ***— Advocacy Representative***

In addition, participants pointed out insufficient race/ethnicity and subpopulation-demographic data on patients accessing BH services, so most of what they are hearing is anecdotal. They said this is a missed opportunity to understand the extent of the disparities and to target outreach efforts accordingly, and highlighted that access to race/ethnicity data can lead to a better understanding of

disparities and tailored BH programs. Participants noted, however, that some individuals may not want their age reported and people of color in particular may not want their race or ethnicity reported.

III. INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH

Most participants agreed on the benefits of integrated BH and physical health services

Across discussion groups, participants noted a preference for integrated physical and behavioral health systems, saying that integration offers the opportunity for the various systems to share clinical information about an individual and coordinate their care. Multidisciplinary teams and care managers can become an early source of information for integration. Participants noted that members prefer a ***"one-stop shop"*** where they can see a primary care provider and a therapist during the same visit. However, participants said that in integrated systems, it is important to ensure that BH is not "drowned out" by the physical and medical aspects of care.

> **"We are a fully integrated plan and all the plans here contracting for Medicaid are required to be. We see the benefit to having the right people with the right specialties at the table to discuss the most clinically complex members, whether medical or BH is the primary diagnosis. We do work together. We can see each other's clinical information, can tell if there was a medical visit or hospitalization, we can see the notes and what they were there for. Because we're contracted with the outpatient mental health clinics, we want to keep the same continuum of care not just within the health plan but also requiring that our outpatient clinic needs to be involved. So they have to be involved in the treatment plan when a patient is in the hospital, providing information to the inpatient staff."**
> ***— MCO Representative***

A few participants noted some benefits to a carved-out BH system. One participant felt that one of the carved-out states in which they operate has provided unparalleled BH provider networks, which increases access for Medicaid members. An advocacy representative said that a carved-out system gives individuals more choices and opens up the landscape to freely refer clients to any provider in the Medicaid system. However, they said that this model requires effective care navigation managers and effective partnerships among providers.

In addition, participants noted variances in how providers have weathered the reduction in utilization based on integration. For example, a participant stated that providers with integrated primary and BH care did better at adapting and responding to COVID-19 demands than nonintegrated providers, while another noted that carved-out BH providers seemed to be more financially resilient during COVID-19. Participants also noted differing perspectives on the resilience of providers by model type. For example, a participant said that in a survey of providers, "hardest hit" providers were those paid via fee-for-service models, while the most resilient have been providers paid prospectively, like federally qualified health centers and others paid via capitated models.

However, participants noted the need for better integration at both the MCO and provider level

At the MCO level, integration needs to be reflected in data sharing processes, utilization management, case management, and other administrative functions. Participants noted that some MCO plans have separate operations' divisions, workforces, and care management staff and teams, which makes a truly integrated system challenging.

Participants also described the need for integration at the provider and practice level as well, integrating BH into primary care to help connect individuals to specialty mental health and SUD care when needed. Advocacy representatives stated that their consumer groups have noted that if providers lack integration (based on evidence-based practices and best practice), it can result in ineffective patient engagement.

> **"It's window dressing to say we're integrated. Then we go into the store and see that providers don't even speak to each other. We have a long way to go."**
> ***— Advocacy Representative***

An advocacy representative noted that integration "is about changing practice, which requires strong leadership at the state level with a good vision and playbook of expectations for providers to be on the hook for integrating care. All those things require an immense amount of talent, resources, and energy." While some participants noted that when BH is carved out to a specialized company, there may be some additional challenge with integration. However, there are still ways to ensure that care is integrated in these carved out models.

A lack of effective data sharing across the physical health and BH care systems, and among BH providers, leads to less coordinated care

Participants said that it is hard to get primary care and BH providers to collaborate and work across integrated health records systems. MCO representatives noted a need for better information sharing among providers, including real-time and retrospective data sharing on the use of services and meaningful clinical information (e.g., admission, discharge, transfer [ADT] data from emergency departments to BH providers) to improve continuity and coordination of care for individuals with BH needs.

In addition, participants described that, in some states, it is up to the county to decide what information may be shared across providers, which may limit the data availability of some populations (e.g., children with mental illness). In addition, MCO representatives noted misinformation and a lack of understanding about 42 Code of Federal Regulations (CFR) Part 2[5] and Health Insurance Portability and Accountability Act (HIPAA) regarding what information on a patient's BH diagnoses and treatment can be shared and with whom, which can hinder care coordination and may have patient safety implications.

Siloes in mental health and SUD systems are challenges for financing and quality of care

Discussion group participants also noted a lack of integration within BH care systems, which resulted in siloes among systems. One participant said that there is a bifurcated system in California, as the county oversees BH services for individuals with SMI and Medi-Cal managed care oversees services for people with mild to moderate BH needs. Another participant commented that Texas has siloes among mental health and SUD systems, which they believe are not supportive of recovery-oriented and evidence-based systems of care. For example, the certification processes for BH and SUD are separate—with different rules, educational requirements, and training programs. An advocacy representative noted that siloes within BH and intellectual and developmental disabilities (IDD) systems disrupt the ability of individuals with IDD to receive appropriate mental health services and continuity of care.

> **"If you happen to be a person [with IDD] who needs behavioral or mental health services that exceed what's typically available in the disability bucket, you're kind of at a loss. Those two things are not integrated… We have very few subspecialists who are really honed at treating both. We send a lot of our Medicaid patients out of state. We don't have robust residential or inpatient crisis services happening here, which presents a huge problem for continuum of care, because they get discharged and they have no one for medication management. It definitely contributes to increased costs and the level of persons experiencing crisis."**
> ***— Advocacy Representative***

Individuals with BH needs, for example, may also need support for pain management and MAT and overdose prevention, and may be at high risk for other physical conditions such as hepatitis C and endocarditis. Both MCO and advocacy representatives noted that some markets have a need for better integration across mental health, SUD treatment, and physical health care that also takes into account SDOH needs.

Insights and Opportunities for Improving BH Needs for Medicaid Members—Highlights from a Roundtable Discussion

After the discussion groups with Medicaid MCO and advocacy representatives took place, the MCO Learning Hub convened a roundtable with representatives from the four partner organizations: Community Catalyst, the Association for Community Affiliated Plans, America's Health Insurance Plans, and Families USA. The roundtable focused on key takeaways from the discussion groups and potential opportunities for addressing the challenges described in these meetings. Here, we present insights and opportunities proposed by roundtable participants on ways to strengthen the role of MCOs, states, and other key

[5] The 42 CFR Part 2 regulations protect patient records for the treatment of SUD. The COVID CARES Act enacted the Protecting Jessica Grubb's Legacy Act, which more closely aligns the federal privacy standards with SUD patient records with HIPAA. The bill intended to relieve data sharing issues exacerbated by COVID-19, but the changes have not yet gone into effect.

stakeholders—including community-based organizations (CBOs)—in addressing BH-related barriers for Medicaid members.

I. EXPAND THE BH WORKFORCE

Discussion group participants highlighted the shortage of BH providers and other BH supports as limiting members' access to services. Roundtable participants also described challenges with sustainable financing of the nontraditional workforce; for example, peer support specialists are often hired through grant-funded programs for one initiative or are attached to a specific plan or BH provider. As a result their sustainability is subject to the end of grant or program funds. Participants noted a need for more consistent investment in community infrastructure and nontraditional workforce options to provide BH supports. They also described a need for more investments in and reimbursement of nontraditional workforce supports and services, such as peer support specialists and RCOs.

Roundtable participants also discussed the high cost of credentialing (e.g., cost of undergraduate, graduate school, licensure costs, fees, etc.) as cost-prohibitive for some people who would otherwise want to pursue a BH career. MCO and advocacy representatives noted opportunities to think about ways in which the capacity of the BH workforce can be bolstered, particularly given the increased demand for BH services.

Insights and Opportunities

- Explore ways in which MCOs can play a role in advocating for a broader BH workforce, such as advocating for changes in state-specific licensure requirements and encouraging the use of peer support specialists and other nontraditional BH providers. In addition, they can advocate for educational incentives and career ladders for the nontraditional BH workforce.
- Promote multi-payer mechanisms of funding for the nontraditional BH workforce, rather than tying them to specific plans, demonstrations, or grants.

> **"You really need to divorce workforce from the payer. You need to think about having multi-payer alignment, a mechanism to support a uniform model across the state, supporting workforce a certain way, or supporting payment a certain way. Right now it's tied to specific plans or even an initiative, demonstration, or grant; there's no way to build a sustainable workforce over time."**
> ***— Advocacy Representative, Roundtable***

- Clarify state and MCO rules on the use and reimbursement of peer supports services and which types of organizations can deliver these supports.
- Promote value-based payment approaches that incorporate the nontraditional BH workforce.

> **"We need to make better connections with the non-health care reimbursed system that takes care of folks—that's the piece we need to think about more. There have been some improvements with funding and accountable care delivery service models. There are more opportunities to explore there and connect these two systems in ways to more meaningfully connect back to members."**
> ***– MCO Representative***

II. IMPROVE ACCESS TO BH SERVICES

Discussion group and roundtable participants asserted that increased BH needs during the COVID-19 pandemic paired with existing BH health care system challenges have highlighted and exacerbated problems with member access to BH services. Participants described opportunities to improve member access to BH services.

Insights and Opportunities

- Advocate for increased Medicaid BH reimbursement rates so that providers are more likely to accept Medicaid patients. Relatedly, increase education around what type of outreach and engagement services are covered by Medicaid.
- Encourage MCOs to fund navigators, community health workers, and/or case managers who can help individuals with BH needs navigate the health care system and other health and social services. For example, advocacy representatives pointed to ongoing MCO investments in case management services for CBOs that provide mental health and mental health-related supports.
- Explore ways in which MCOs can collaborate with CBOs and trusted health entities to promote messaging and emphasize the importance of BH services in improving access. For example, MCOs can connect with community health centers and build up community resources, such as supporting efforts to offer kiosks (or phones) to provide telehealth for individuals without access to a cell phone or computer.
- Consider BH care models that divert crisis care away from law enforcement and emergency departments. Some MCO representatives described the Crisis Now model and other frameworks that are being developed

to offer alternatives and a broader continuum of services.

- Explore ways in which other payers beyond Medicaid, including commercial payers and Medicare, can also support nontraditional BH infrastructure services such as peer support services and crisis care systems.
- Consider ways to maintain hybrid telehealth/in-person options for members. There is strong support from both MCO and advocacy representatives to retain telehealth as part of the mix of services. In addition, consider ways to increase member access to telehealth (e.g., funding for wi-fi, smartphones, tablets) and promote education around how to use these services.
- Advocate for maintaining flexibilities available during the pandemic in a post-pandemic world, e.g., waiving restrictions on delivering MAT to SUD patients, loosening networks to allow members to see out-of-state providers, and advocate for these policies at the federal level.

> **"What has been a positive consequence of COVID is that it has broken and shattered our view of what are acceptable standards of health care. We had an idea that it has to be this way and all of a sudden it's been disintegrated and reformulating itself. Most striking is the individuality of it. We have people who are fine with a 20-minute brief phone therapy intervention and some who say I need to come in… I recognize this is an opportunity to promote person-centered systems that are flexible… Let's take the best of this and continue it in a way that is as person-centered as possible..."**
> **— *Advocacy Representative***

III. PROMOTE BETTER INTEGRATION ACROSS PHYSICAL AND BH AS WELL AS ACROSS MH AND SUD

While most discussion group and roundtable participants agreed that integrated BH and physical health services provide a benefit, they highlighted existing siloes that make coordination of care and continuity of care difficult. Some participants also mentioned opportunities for integration within carved-out BH models. Discussion group and roundtable participants described that, even in states with integrated BH and physical health care models, better efforts to promote integration are needed. In addition, there is a need for better integration of mental health and SUD within the BH system.

Insights and Opportunities

- Promote better integration of care delivery systems at the policy, payer, and provider levels to break down existing siloes between BH and physical health, as well as between mental health and SUD. This includes integration of BH clinicians into primary care practices and co-location of services, even within carved-out BH models.
- Promote the cross-training of BH providers across mental health and SUD care delivery, as well as specialized cross-training on certain populations that are higher risk (e.g., people with disabilities).
- Consider reimbursement processes that promote integration, including payment for primary care and BH services rendered on the same day.
- Promote standards for interoperability of EHR systems to encourage improved data sharing across physical and BH. In addition, consider opportunities to provide state Medicaid agencies and BH providers with technical assistance to promote meaningful adoption of EHR exchange of information with other treating providers.
- Clarify 42 CFR Part 2 and HIPAA restrictions for data sharing across mental health and SUD providers.

IV. IMPLEMENT STRATEGIES THAT ADDRESS DISPARITIES

Discussion group and roundtable participants described existing and widening disparities among racial and ethnic groups, individuals with SMI, individuals with co-occurring mental health and SUD, and other populations. They said that the pandemic and increased use of telehealth is widening some of these disparities. Discussion group participants recommended statewide outreach and education about the widespread need for BH services, as well as more availability of mental health for communities of color and Medicaid members. Participants noted there may be gaps in members' awareness of BH services available through their individual health plans versus a county or other BH system plans.

Insights and Opportunities

- Promote linguistic and culturally responsive services and care, including for provider and patient-facing staff. In addition, conduct education and training around culturally responsive approaches, societal stigma, stigma among specific populations, and trauma-informed care.
- Ensure diversity of MCO staff, including hiring staff that is bilingual as well as representative of the makeup of MCO membership. Telehealth and remote work

opportunities, for example, offer the opportunity to hire staff beyond a physical office and from the communities that are being served.

- Strengthen outreach efforts for hard-to-reach populations, underserved racial and ethnic groups, and non-English speaking populations. MCOs have attempted to improve outreach to underserved racial and ethnic groups, for instance, using grants to fund outreach to Black and underserved communities to connect people to health care.
- Develop strong consumer advisory boards that can help MCOs understand the needs of and get timely feedback directly from members.
- Explore evidence-based practices around disciplinary action and juvenile justice involvement for children and adolescents, who instead need BH support services. In addition, expand preventive and early intervention strategies for children and adolescents in schools, particularly for children and adolescents from marginalized populations.

ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future Medicaid MCO Learning Hub work or programs you are working on to better serve your needs.

We want to hear from you. Please contact us at MCOLearningHub@norc.org to start the conversation or join our distribution list.

www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

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