

Medicaid Managed Care Strategies to Reduce Racial and Ethnic Health Disparities in Mental Healthcare for Adults

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Introduction

Many states are leveraging their Medicaid programs to confront structural racism¹ and implement strategies to promote health equity. Racism in healthcare, housing, food and nutrition, educational, and judicial systems contributes to health inequities—inequities that are well-documented, persistent, and lead to disparate health outcomes.² The combined impact of structural racism and a fragmented and underfunded mental healthcare system produces disparities in access to mental health services, diagnoses, and treatment of mental health conditions,³ quality of care, and health outcomes.

The experience of racism is correlated with higher risk of mental health conditions, including psychological and emotional distress, post-traumatic stress disorder, depression, anxiety, obsessive-compulsive symptoms, low self-esteem, and chronic stress, in addition to physical health symptoms.⁴ Discrimination, stereotyping, racial profiling, microaggressions, and biases, negatively impact mental health.⁵ The history of racism and discrimination in the United States (U.S.), “is a constant source of stress which can lead to feelings of invalidation, negation, dehumanization, disregard, and disenfranchisement.”⁵ When people experience racism daily, the cumulative impact of chronic stress has even more profound consequences.⁶

Medicaid programs have a significant role in promoting mental health equity. Medicaid is the single largest payer of mental health services, underscoring its influential position to improve mental healthcare and outcomes. Medicaid serves a disproportionate number of people of color and individuals with low incomes, subpopulations that also experience barriers to accessing mental healthcare. Untreated mental health conditions may lead to higher costs for Medicaid as worsening conditions may require more intensive care in higher-cost settings, such as hospitals.

In most states, individuals with Medicaid are enrolled in managed care. This issue brief highlights opportunities for Medicaid programs to implement managed care strategies that center equity in mental healthcare and improve mental health outcomes for adults.⁷ For additional information about steps Medicaid agencies can take to establish the internal building blocks to advance their equity goals, see *Promoting Health Equity in Medicaid Managed Care: A Guide for States*. (Strategies to address systemic physical health and mental healthcare payment disparities are outside of the scope of this issue brief.)

The mental healthcare system is one of many systems in the U.S. in which structural racism results in differential treatment and outcomes by race and ethnicity. Various other systems, including physical healthcare, housing, law enforcement, the judiciary, and education all connect in ways that influence mental health status and health disparities. The purpose of this brief is to identify ways in which states can leverage their Medicaid managed care (MMC) programs to advance their health equity goals. It focuses intentionally on mental health conditions, such as depression, anxiety, and schizophrenia, and not substance-use disorders. The authors acknowledge the intersection of mental health, substance-use disorders, physical health, and social conditions on outcomes and note that fragmented systems of care create significant barriers to access and poor outcomes. Where this brief focuses on integration, it is inclusive of mental health, substance-use disorder, physical health, and social needs.

State Medicaid Managed Care Approaches to Promoting Mental Health Equity

Most states contract with Medicaid managed care entities⁸ (MCE) to administer Medicaid services to enrollees. Medicaid programs can leverage their purchasing, payment, and delivery system reform strategies to improve mental health outcomes and confront inequities. Strategies to expand Medicaid coverage and benefits generally, and modify enrollment processes to promote continuity of care,⁹ are not within the scope of this brief but are equally important for states to consider as tools for promoting equity in mental healthcare and services.

There is limited research on the impact of mental healthcare initiatives on health equity. Studies find certain strategies and initiatives may improve mental health outcomes generally, but they do not examine the impact on racial and ethnic disparities. States can consider key features of the healthcare delivery system that hold the promise^{10,11,12} of reducing racial inequities in mental healthcare, including:

- Access to services in the community (i.e., community health centers, mobile clinics, community-organizations) or in the home.
- Promotion of whole-person care and provision of support and services to address social conditions that impact health and wellness.¹³
- Integration of behavioral healthcare with physical healthcare.
- A racially and ethnically diverse and representative workforce.
- Training in cultural humility and the impact of racism on healthcare.

Medicaid managed care strategies can thus focus on shoring up aspects of care delivery that align with the research and promote equity in mental healthcare. The four approaches outlined in this section of the issue brief describe requirements or incentives for MMC entities to:

- A. Direct quality improvement strategies to identify mental health disparities and successfully intervene to promote equity.
- B. Facilitate access to clinical and non-clinical mental healthcare services.
- C. Integrate mental health in primary care settings.
- D. Address the lack of a racially and ethnically diverse mental health workforce.

This issue brief elaborates on each of the above approaches, identifies specific purchasing, payment or delivery system reform steps Medicaid programs can take with MCEs, and provides state examples to further illustrate how an approach has been implemented.

A. Direct Quality Improvement Strategies to Identify Mental Health Disparities and Successfully Intervene to Promote Equity

MMC quality improvement strategies, including performance monitoring and accountability, offer one lever for states to pursue mental health equity. States should require their MMC entities to engage enrollees in the design and evaluation of quality improvement initiatives, including performance improvement projects, to ensure that programmatic changes reflect the input of those who stand to be most impacted.

Monitoring performance involves identifying where disparities exist, the magnitude of the disparities, and targeted performance improvement initiatives. States can stratify mental healthcare measures of quality, access and patient experience, among others, by race and ethnicity to confirm and/or identify disparities and measure the impact of efforts to reduce them. Importantly, states should include a focus on mental healthcare access measures to ensure quality improvement efforts do not unintentionally further limit access to services. States can then use the data to inform quality improvement initiatives or design performance improvement projects (PIPs).

State Medicaid agencies can **leverage their MCEs to monitor performance by:**

- a. Requiring MCEs to obtain enrollee-reported race and ethnicity information to improve the accuracy and completeness of demographic data.¹⁴
- b. Requiring MCEs to develop and implement quality improvement initiatives or performance improvement projects focused on racial and ethnic disparities in mental health access, quality, experience, and outcomes. Quality improvement activities should consider strategies for implementation of and adherence to standards for Culturally and Linguistically Appropriate Services (CLAS) in mental healthcare.¹⁵ MCEs should identify opportunities for improvement and incorporate a timeline for implementing changes that will target and reduce disparities in their PIPs.¹⁶
- c. Mandating that MCEs engage Medicaid enrollees to identify quality improvement opportunities to reduce racial and ethnic disparities in mental healthcare treatment and improve outcomes.¹⁷ For example, understanding enrollee experience with telehealth, including uptake, barriers to adoption, and experience can inform quality improvement strategies in this area.

States can use existing resources to identify mental health quality measures and equity-focused measures for inclusion in quality and performance improvement initiatives. The [National Inventory of Mental Health Quality Measures](#) is a searchable database that contains more than 300 behavioral health quality measures. In addition, states can reference the [State Health Equity Measure Set](#)¹⁸ for a curated set of existing equity-focused measures, the [Buying Value Measure Selection Tool](#) for mental healthcare measures that are in use in federal and state-specific programs, and the [Buying Value Repository](#) for modified Healthcare Effectiveness Data and Information Set (HEDIS) measures and non-HEDIS measures in use by state purchasers and regional health improvement collaboratives. (In addition, a March 2022 Health Affairs Forefront blog post identified four types of health equity measures which states can reference.¹⁹)

Beyond identifying and monitoring mental health and equity-focused quality, access, experience measures, **state Medicaid agencies can hold MCEs accountable for performance by:**

- a. Publicly reporting MCE performance on mental healthcare quality, access, and patient experience measures.
- b. Implementing financial or non-financial incentives to improve performance and achieve a target rate for subpopulations for which disparities have been identified.

Table 1 highlights how California and Oregon are targeting disparities in their quality improvement and measurement strategies.

| Table 1: State Examples of Quality and Performance Improvement Activities | |
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| • | California will require its Medicaid MCEs to develop a quality improvement plan focused on health equity that includes interventions to address utilization (over- or under-) of behavioral healthcare services. ²⁰ |
| • | Oregon's Medicaid program implemented the disparity-specific measure "Emergency Department Utilization for Individuals Experiencing Mental Illness" through the state's Coordinated Care Organization (CCO) program. The state incorporated a financial incentive for CCOs to improve performance. ²¹ |

B. Facilitate Access to Clinical and Non-Clinical Mental Healthcare Services

Through Medicaid procurement and contracting strategies, states can direct MCEs to cover specific mental healthcare services (e.g., crisis stabilization) and include clinical and non-clinical workers in their networks (e.g., peer specialists,²² family supports, health coaches, community health workers, navigators). MCEs should ensure that individuals can receive mental healthcare from a multi-disciplinary care team of clinical and non-clinical providers.

Community health centers generally provide a variety of early detection and treatment services, including for physical and mental health, and can assist individuals with needed social supports.¹¹ In addition, care that is delivered where people are most comfortable or "where they are" (e.g., in the home, on campus, outside of a traditional medical office) helps to increase access and sustain engagement. Traditional office-based medical care may alienate and deter people from seeking services, particularly individuals and population groups who have experienced racism within the healthcare system.

Medicaid programs should collaborate with other state agencies and advocacy organizations to facilitate partnerships and introductions between MCEs and organizations that have established trusted relationships with people in their communities including educational, cultural, and faith-based organizations.¹⁷

States can leverage authorities to offer a more flexible and broader set of mental healthcare services or require coverage of specific provider types. **States can require MCEs to contract with certain covered service providers or provide flexibility in the mental healthcare services offered.** Specifically, states can:

- a. Permit and identify in lieu of services (ILOS) to provide medically appropriate, cost-effective substitutes for Medicaid state plan-covered mental health services or settings that include community-based care settings and non-clinical workers. ILOS can be used to assess and address social needs and risk factors, which may alleviate symptoms of mental illness in some circumstances. (See *Addressing Health-Related Social Needs Through Medicaid Managed Care* for additional information on state approaches to measure and incentivize Medicaid managed care entities to address unmet social needs.)
- b. Require MCEs to contract with crisis response service providers for crisis stabilization services that include, at a minimum, 24/7 mobile crisis care, peer support services, and community crisis stabilization units, and support MCEs and providers with contracting to ensure first line crisis responders are mental healthcare providers.

States can **support providers' transition to the Medicaid managed care network and ensure that MCEs are educating providers about billing practices and codes to facilitate reimbursement.** This is especially important for non-clinical providers who are shown to improve outcomes (such as peer specialists, health navigators, community health workers, and others), but who may be less familiar with Medicaid managed care operations.²³ Specifically, states can:

- a. Require that MCEs develop and implement trainings to support the transition to managed care, inclusive of topics that cover Medicaid billing and coding processes.
- b. Issue guidance to MCEs on the scope of the roles of non-clinical workers to ensure clarity and consistency across plans for mental healthcare providers.²⁴

Federal rules under [42 CFR 438.6\(c\)](#) govern and limit states' abilities to direct certain types or levels of MCE payments to specific classes of providers.²⁵ **Within federal requirements, state Medicaid programs can direct and/or incentivize MCEs to:**

- a. Increase payment rates to community-based providers to support investment and maintenance of a range of mental health services (e.g., require MCEs to increase payment per service provided by a mental healthcare provider, inclusive of non-clinical providers, by a certain percentage or dollar amount).
- b. Implement directed payments to MCE community-based providers to cover the costs of outreach and education to communities experiencing disparities in mental healthcare.
- c. Adopt value-based payment models designed to improve the quality of mental health services and reward higher performing providers. Value-based payment models could include total cost of care payment arrangements with accountable care organizations that include a spectrum of healthcare services, including mental healthcare. Entities in total cost of care payment arrangements have a financial incentive to deliver high-quality, coordinated, and cost-effective care. Pay-for-performance is another payment model that can encourage quality improvements.
- d. Require MCEs to implement a specific alternative payment model to support a predictable source of funding for certain providers such as crisis stabilization service providers.²⁶

Table 2 summarizes steps California, Florida, and Massachusetts are taking to facilitate access to clinical and non-clinical services for mental health, including through a mix of state and federal Medicaid authorities.

Table 2: State Examples to Facilitate Access to Clinical and Non-Clinical Mental Healthcare Services

- California's** Advancing and Innovating Medi-Cal (CalAIM), the state's Medicaid managed care transformation effort, seeks more equitable, coordinated, and person-centered care. CMS approved the state's request to finance health-related services statewide, primarily under Medicaid managed care ILOS authority defined in federal rules.²⁷ Under this ILOS authority, CalAIM covers "Community Supports" including housing transition navigation supports, housing deposits, medical respite, home modifications, and medically tailored meals for eligible managed care members.²⁸ These Community Supports covered by MCEs target social conditions and structural factors that impact mental health and contribute to health inequities. In addition, as part of CalAIM, the state provides financial incentive payments to Medicaid plans to build appropriate care management and ILOS capacity to effectively implement these approaches to improve care for Medicaid managed care enrollees with specific needs, including mental health needs.
- Florida's** Medicaid managed care program includes crisis stabilization units and Class III and Class IV freestanding psychiatric hospital care as a state-defined ILOS.²⁹ In addition, managed care plans in Florida may request state approval for other ILOS. Examples of other ILOS offered by Florida Medicaid plans include community-based wrap-around services, intensive outpatient mental health services, partial hospitalization programs, self-help, and peer services.³⁰
- With funding from the American Rescue Plan and Medicaid, **Massachusetts** directed MCEs to increase rates for specific behavioral healthcare services, including certain in-home therapy services that support diversion of inpatient hospitalization, behavioral health urgent care centers, and mobile crisis intervention services. Massachusetts directed MCEs to ensure that providers receiving the time-limited rate increases use 90% of the funds to support home and community-based services and behavioral health direct care and support staff. The state identified "frontline workers who provide care, services, or support to families and individuals in home and community-based and behavioral health outpatient and diversionary settings" as an example of the staff eligible for the rate increase.

C. Integrate Mental Healthcare and Physical Healthcare in Primary Care³¹

Many individuals who seek mental healthcare services do so through their primary care provider; yet the primary care infrastructure is largely organized around prevention and management of physical healthcare needs—and without recognition that some physical symptoms may be related to mental health conditions. Treatment for depression, including medication prescriptions, is largely provided in primary care in the U.S.³² Integrating mental healthcare where individuals are accessing primary care services and reimbursing mental health and physical healthcare services provided on the same day can support early identification and initiation of treatment for mental health conditions.³³ Furthermore, accessing a range of services at a single location reduces other barriers to care, including transportation, time off work, or child care. Evidence suggests an association between integration and improved symptoms of depression, better patient experience of care, and reductions in racial and ethnic disparities.³⁴

There are many models of integration, which range from coordinating care to full integration of clinical care or systems. Integrated care is not a new model, and early efforts offer lessons for states to initiate or further expand on their behavioral health integration strategies.

States can **direct MCEs to create integrated care capacity in their networks**. States may begin with integrating mental healthcare into primary care, leveraging the broad existing primary care delivery system, but should also explore ways to incorporate primary care services into new or expanding mental health clinics to avoid further system fragmentation. States can promote integration by:

- a. Defining integrated care and requiring that MCEs demonstrate adherence to the underlying features of integrated care, inclusive of physical healthcare, oral healthcare, mental healthcare, trauma-informed care, person-centered care, and culturally appropriate care.
- b. Establishing standards for implementing an integrated model of care that includes promoting health equity and monitoring MCE performance against those standards.³⁵
- c. Incorporating training requirements to ensure primary care providers, nurses, medical assistants, mental health clinicians, peer support service providers, and other members of the multi-disciplinary care team and practice are working together to support fully integrated and efficient care delivery.
- d. Requiring that MCEs can demonstrate their provider network includes integrated care settings.

States can **support and direct implementation of payment models that ensure sufficient reimbursement and flexibility for the range of activities and staff necessary to build and sustain integration activities**. States can develop their own models and require MCEs to implement them with primary care providers or require MCEs to design and implement payment models. States can also provide guidance on the billing codes to providers. Specifically, actions include:

- a. Changing same day billing limitations, to the extent they currently exist, to permit billing of multiple services during a single patient visit.³⁶
- b. Expanding billing codes to support models of integrated and collaborative care, including permitting billing of physical and behavioral health services during a single patient visit.
- c. Directing or encouraging implementation of value-based payment models that provide flexibility to fully integrate care.
 - i. For example, capitating or bundling payments to primary care providers gives practices flexibility to invest in the staff (clinical and non-clinical) and non-staff (e.g., technical infrastructure) supports to effectively integrate physical and mental healthcare and collaborate with community-based organizations. Prospective payment, like the current payment structure for Certified Community Behavioral Health Clinics (CCBHC) model, provides a predictable and advanced financing stream that enables clinics to expand their workforce to bring on new clinicians (e.g., psychiatrists), expand services, and more fully integrate primary care into operations.

Table 3 identifies actions California, Massachusetts, and Rhode Island are taking to support integration of physical and mental healthcare in primary care.

| Table 3: State Examples of Promoting Integration of Physical and Mental Healthcare in Primary Care |
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| <ul style="list-style-type: none"> • California identified specific reimbursement codes for providers to support implementation of the Psychiatric Collaborative Care Model, an evidence-based model of integrating physical and behavioral healthcare in the primary care setting.^{37,38} |
| <ul style="list-style-type: none"> • Accountable care organizations (ACOs) in Massachusetts that serve MassHealth enrollees are required to achieve and maintain certification, which is administered by the state's Health Policy Commission (HPC). The HPC updated the ACO certification standards in 2022 to focus attention on health equity and care integration. ACOs must show an intentional activity or initiative to improve health equity and describe steps to integrate behavioral healthcare into primary care settings. ACOs must set and measure progress on increasing integration over time.³⁹ |
| <ul style="list-style-type: none"> • Rhode Island will require Medicaid MCEs to develop a Behavioral Health Innovation Plan subject to approval by the state's Executive Office of Health and Human Services. The state will require MCEs to identify strategies and timelines for promoting evidence-based integrated care delivery models and implement processes to "identify specific populations (i.e., racial/ethnic, geographic, etc.) that have experienced disproportionately poor health outcomes." MCEs will also need to identify approaches to improving health equity, including staff and network provider training on cultural competency and implicit bias. MCEs will be required to submit quarterly update reports on the innovation plan activities and outcomes and are subject to financial penalties for failing to report on or meet targets or activities specified in the plans. In addition, the state will require MCEs to participate in an ongoing workgroup with the state's health, youth and family, and behavioral health agencies, accountable entities, advocates, and other stakeholders "to identify practices and protocols to promote health equity and access to integrated and coordinated physical health, behavioral health, substance use disorder, and social determinants of health services." |

D. Address the Lack of a Racially and Ethnically Diverse Mental Health Workforce

The Agency for Healthcare Research and Quality's 2021 National Healthcare Quality and Disparities Report underscored the need for a more racially and ethnically representative mental healthcare workforce, citing the lack of diversity as a "significant contributor" to the barriers in mental healthcare treatment for people or communities of color.⁴⁰ Expanding the network of providers who speak languages other than English and share or represent diverse identities⁴¹ can improve patient engagement and effectiveness of treatment, and mitigate bias. States can think beyond the traditional workforce and contemplate strategies for bolstering the workforce from within communities to connect people with mental healthcare services and encourage discussion of mental health as part of overall health to reduce stigma.⁴²

States can leverage Medicaid and MCE leadership meetings, and enrollee engagement opportunities, to discuss strategies for identifying and training trusted community members (for example religious and spiritual leaders, community health workers, and barbers and stylists). Training could include talking with people about mental health services available in the community and how to access them, evidence-based interventions, low-intensity interventions, or other topics. As an example, the Confess Project of America supports training of barbers and stylists to increase mental health awareness and reduce stigma around mental health within Black communities.⁴³

Expanding the workforce will take time. While states invest in longer-term efforts to bolster the workforce to ensure it is more racially and ethnically diverse, training the existing workforce and focusing on provider networking strategies represent more immediate opportunities.^{44,45}

States can **promote a racially and ethnically diverse network of mental healthcare providers by creating standards of network adequacy** that focus on expanding the racial and ethnic composition of MCE networks.⁴⁶ States can:

- a. Require MCEs to demonstrate how they are recruiting and retaining a network of racially and ethnically diverse mental healthcare providers to ensure access to and continuity of care.
- b. Require that MCEs indicate providers' cultural and linguistic capabilities (e.g., languages spoken, medical interpreter services available) in their provider directories.

States can **require that Medicaid MCEs foster a culture of care and staff that is inclusive, responsive, and representative of the enrolled population.** States can do this by:

- a. Requiring MCEs to implement the national CLAS standards, which are intended to advance health equity, improve quality, and help eliminate healthcare disparities.⁴⁷ The Substance Abuse and Mental Health Services Administration (SAMHSA) has collaborated with the Office of Minority Health to create a guide to implementing CLAS within behavioral health settings.⁴⁸
- b. Mandating that MCEs receive the National Committee for Quality Assurance's (NCQA) Health Equity or Health Equity Plus accreditation within a certain timeframe.⁴⁹ In order to obtain these health equity accreditations, among other criteria, MCEs will need to document to NCQA's standards that:
 - i. The MCE's "internal culture supports the health equity work it performs externally, beginning with the training it provides to staff and its practices for recruitment and hiring."
 - ii. Its practitioner network "is capable of serving its diverse membership and is responsive to individual needs and preferences."
 - iii. CLAS programs include "measurable goals for continuous improvement of the cultural and linguistic appropriateness of the services" provided.⁵⁰

Table 4 identifies examples of workforce initiatives in California, Massachusetts, Mississippi, and Oregon.

| Table 4: State Examples of Workforce and Provider Network Initiatives |
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| <ul style="list-style-type: none"> The California Department of Public Health's Office of Health Equity and the state's Medicaid Behavioral Health Division are partnering to reduce disparities within a Community Mental Health Equity Project which includes development of guidance on cultural competency plans that align with CLAS standards, contracting strategies, and stakeholder engagement.⁵¹ |
| <ul style="list-style-type: none"> Massachusetts is leveraging funds received through the Delivery System Reform Incentive Payment program to support community mental health centers with recruiting psychiatrists and nurse practitioners. The state will prioritize funding for community mental health centers that "address a particular cultural competency need."⁵² |
| <ul style="list-style-type: none"> Provider directories for MCEs in Mississippi must include providers' cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training.⁵³ |
| <ul style="list-style-type: none"> In Oregon, CCOs, which manage care for individuals with Medicaid, are required to develop a plan to provide cultural responsiveness and implicit bias training, which must be informed by trauma-informed care practices.⁵⁴ CareOregon, one of the Oregon CCOs, created a Health Resiliency Program in which case workers trained in trauma-informed care work in clinical settings. Case workers support patients who have experienced trauma and educate other clinic providers about the impact of trauma.⁵⁵ In addition, Oregon requires CCOs to increase their assertive community treatment network if 10 or more individuals eligible for assertive community treatment face wait times of more than 30 days. |

Conclusion

Medicaid programs are uniquely positioned to promote equity in mental healthcare. Medicaid plays an outsized role in the financing and delivery of mental healthcare. In addition, Medicaid serves a disproportionate number of people of color. Together, structural racism and an underfunded and fragmented mental healthcare system contribute to persistent racial and ethnic disparities in mental healthcare. This issue brief identifies specific Medicaid managed care strategies to improve mental health outcomes and reduce inequities. It describes how states can leverage Medicaid managed care quality improvement initiatives to identify racial and ethnic mental health disparities and inform intervention strategies. It also identifies how Medicaid managed care programs can facilitate access to clinical and non-clinical mental healthcare services, integrate mental healthcare in primary care settings, and promote a racially and ethnically diverse mental healthcare workforce. These strategies highlight opportunities Medicaid programs have to leverage their purchasing, payment, and delivery system reform strategies within managed care to improve health and promote health equity.

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ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have.

Health is more than an absence of disease. It is a state of physical, mental, and emotional wellbeing. It reflects what takes place in our communities, where we live and work, where our children learn and play, and where we gather to worship. That is why RWJF focuses on identifying, illuminating, and addressing the barriers to health caused by structural racism and other forms of discrimination, including sexism, ableism, and prejudice based on sexual orientation.

We lean on evidence to advance health equity. We cultivate leaders who work individually and collectively across sectors to address health equity. We promote policies, practices, and systems-change to dismantle the structural barriers to wellbeing created by racism. And we work to amplify voices to shift national conversations and attitudes about health and health equity.

Through our efforts, and the efforts of others, we will continue to strive toward a Culture of Health that benefits all. It is our legacy, it is our calling, and it is our honor.

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ABOUT BAILIT HEALTH

This brief was prepared by Erin Taylor, Rachel Isaacson, and Mary Beth Dyer. Michael Bailit served as reviewer of the brief. Bailit Health is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.

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ENDNOTES

1. For the purposes of this issue brief, the definition of structural racism is: “A complex system, rooted in historical and current realities of differential access to power and opportunity for different racial groups. This system is embedded within and across laws, structures, and institutions in a society or organization. This includes laws, inherited disadvantages (e.g., the intergenerational impact of trauma) and advantages (e.g., intergenerational transfers of wealth), and standards and norms rooted in racism.” Dwan Everette T, Sathasivam D, Siegel K. *Health Equity Language Guide for State Officials, Part 1: Discussing Racism*. NJ: State Health & Value Strategies; 2021. <https://www.shvs.org/wp-content/uploads/2021/08/Talking-About-Anti-Racism-Health-Equity-1-of-3.pdf>. Accessed August 23, 2022.
2. Office of Health Equity. Racism and Health. Centers for Disease Control and Prevention website. <https://www.cdc.gov/minorityhealth/racism-disparities/index.html>. Accessed April 17, 2023.
3. This may include misdiagnosis. For example, Black men are more likely than other groups to receive a misdiagnosis of schizophrenia when expressing symptoms related to other mood disorders or post-traumatic stress disorder. See for example, Gara, MA, Minsky S, Silverstein, SM, Miskimen, T, Strakowski, SM. A naturalistic study of racial disparities in diagnoses at an outpatient behavioral health clinic. *Psychiatric Services*. 2019; 70(2):130–134. <https://doi.org/10.1176/appi.ps.201800223>. Accessed September 14, 2022.
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5. Other forms of discrimination include bigotry, heterosexism, transphobia, and ageism. See *California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities*. CA: California Pan-Ethnic Health Network; 2018. https://cpehn.org/assets/uploads/archive/resource_files/crdp_strategic_plan.pdf. Accessed September 14, 2022.
6. Geronimus AT, Hicken M, Keene D, Bound J. “Weathering” and age patterns of allostatic load scores among blacks and whites in the United States. *American Journal of Public Health*. 2006; 96(5), 826–833. <https://doi.org/10.2105/AJPH.2004.060749>. Accessed February 2, 2023.
7. This brief focuses intentionally on mental health conditions, such as depression, anxiety, and schizophrenia, and not substance use disorders. The authors acknowledge the intersection of mental health, substance use disorders, physical health, and social conditions on outcomes and note that fragmented systems of care create significant barriers to access and poor outcomes. Where this brief focused on integration, it is inclusive of mental health, substance use disorder, physical health, and social needs. This brief also focuses on the adult population only.
8. Medicaid Managed Care Entities (MCEs) include managed care organizations (MCOs), managed behavioral health organizations (MBHOs), managed long term services and supports (MLTSS) organizations, managed dental plans (MDPs) and accountable care organizations (ACOs).
9. For example, temporary loss of Medicaid coverage due to changes in economic circumstances that impact eligibility or not meeting renewal / re-enrollment process requirements, disrupt continuity of care and treatment plans. This loss of coverage, even if re-established, is especially challenging for individuals with severe and persistent mental illness.
10. “Components of an effective strategy to achieve mental health equity include increasing population-based care; increasing community-based healthcare services; addressing the social determinants of health; engaging the community; enhancing the pipeline; and supporting a diverse, structurally competent workforce.” Alves-Bradford JM, Trinh NH, Bath E, Coombs A, Mangurian C. Mental Health Equity in the Twenty-First Century: Setting the Stage. *The Psychiatric Clinics of North America*. 2020; 43(3), 415–428. <https://doi.org/10.1016/j.psc.2020.05.001>. Accessed September 14, 2022.
11. Alegría M, Frank RG, Hansen HB, Sharfstein JM, Shim RS, Tierney M. Transforming Mental Health And Addiction Services. *Health Affairs*. 2021; 40(2), 226–234. <https://doi.org/10.1377/hlthaff.2020.01472>. Accessed September 15, 2022.
12. One example of a model that has been studied is New York’s program to provide supportive housing to certain individuals with Medicaid, 66% of whom had a serious mental illness diagnosis. An evaluation of the program found that overall Medicaid health expenditures decreased by 15% in one year and were accompanied by a 40% reduction in inpatient days and a 27% reduction in patients with inpatient psychiatric admissions. A statistically significant reduction in utilization of inpatient and emergency care was observed for Latino/a individuals. Non-Hispanic Black individuals experienced a smaller but still significant reduction in emergency department visits. McGinnis S, Polvere L, Gullick M, Rees CE, Mahmud M. *Medicaid Redesign Team Supportive Housing Evaluation Outcomes Report 2 Volume 1: Pre-Post Analysis*. NY: New York State Department of Health & Center for Human Services Research, University at Albany, State University of New York; 2020. https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing/docs/2020-06_final_outcomes_v1.pdf. Accessed September 15, 2022.
13. In addition to the traditional Medicaid mental healthcare services, strategies to address social needs, for example, employment, housing and food, can improve mental health outcomes. See McCarthy D, Shah T, Lewis C. *Making the Business Case for Social Needs Interventions — An Update*. NY: Commonwealth Fund; 2022. <https://doi.org/10.26099/mxma-a912>. Accessed February 2, 2023.
14. States are simultaneously focused on improving the collection of race, ethnicity, language, and disability status (RELD) data as well as sexual orientation, gender identity and sex (SOGIS) data by state agencies, health plans, and providers to ensure the data are complete, accurate, and self-identified. The Massachusetts Quality Measure Alignment Taskforce, for example, has a health equity-focused advisory group that is developing statewide standard categories to collect RELD and SOGIS data for use with Medicaid and commercial payers. Kanneganti D, Mar J, Bailit M. *State Health Equity Measure Set*. NJ: State Health and Value Strategies; 2023. <https://www.shvs.org/resource/state-health-equity-measure-set/>. Accessed June 27, 2023.
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21. Bazinsky KR, Bailit M. *How States Can Use Measurement as a Foundation for Tackling Health Disparities in Medicaid Managed Care*. NJ: State Health and Value Strategies; 2019. <https://www.shvs.org/resource/how-states-can-use-measurement-as-a-foundation-for-tackling-health-disparities-in-medicaid-managed-care/>. Accessed September 15, 2022.
22. In the context of mental health, peer support and education means getting information and support from another person who has been diagnosed with a mental health condition, received mental health services, or has had experiences that are typically labeled as mental health symptoms. Source: National Alliance on Mental Illness (NAMI) Massachusetts. Peer Support & Education. NAMI Massachusetts website. <https://namimass.org/peer-support/>. Accessed September 15, 2022.
23. As a pre-requisite to this, Medicaid programs should engage in a process with community members, advocacy organizations, MCEs, providers, and others to understand who is currently serving populations that experience inequities and identify opportunities to leverage existing relationships and networks.
24. Ideally, Medicaid agencies would align the roles with operational practices that other state agencies, advocacy organizations, or reputable programs have instituted. Finally, states can require MCEs to adopt those definitions in credentialing of the non-clinical workforce.
25. 42 C.F.R. § 438.6 (2022). <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6>. Accessed September 15, 2022.
26. The American Rescue Plan includes grant funding for state Medicaid agencies to develop mobile crisis response programs like CAHOOTS (Crisis Assistance Helping Out On The Streets) in Oregon. States that receive grant funding will also be eligible for enhanced federal Medicaid matching of 85% for qualifying services.
27. Two of California's enhanced care management (ECM) services are authorized under 1115 waiver authority. The remaining 10 ECM services are authorized within managed care authorities available to all state Medicaid programs. Manatt Health. (2022, February 15). *Centering Health Equity in Medicaid Section 1115 Demonstrations*. [Webinar]. State Health and Value Strategies. <https://vimeo.com/677862243>. Accessed September 15, 2022.
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31. The scope of this brief is mental healthcare. The authors acknowledge that integration includes an array of services (e.g., physical, mental health, substance use disorder, social supports) that treat the whole person, including social risk factors that may impede access, delay treatment, and increase risk of poor outcomes. Integration efforts generally encompass mental health and substance use disorder services, together under the umbrella term "behavioral health."
32. Barkil-Oteo A. Collaborative care for depression in primary care: how psychiatry could "troubleshoot" current treatments and practices. *The Yale Journal of Biology and Medicine*. 2013; 86(2), 139–146. PMID: [23766735](https://pubmed.ncbi.nlm.nih.gov/23766735/), PMCID: [PMC3670434](https://pubmed.ncbi.nlm.nih.gov/PMC3670434/).
33. Historically, the inability to bill for more than one service during the same visit has been a barrier to providing integrated care.
34. Fradkin D, Germack HD, Gonnella K, Doell C, Martsolf GM. *Policies to Improve Implementation and Sustainability of Behavioral Health Integration*. DC: Health Affairs Forefront; 2021. <https://www.healthaffairs.org/doi/10.1377/forefront.20210514.181346/full/>. Accessed September 15, 2022.
35. States can do this by defining the core competencies of integrated care, defining health equity, ensuring a focus on health equity in mental healthcare specifically, and mandating that governing and clinical leadership committees include multiple mental healthcare providers. This could apply to MCOs and also to states that certify accountable care organizations (ACOs).
36. In some states, if a patient receives care from a medical provider and a mental health specialist on the same day, only one treatment is reimbursed as a visit. In many states, a patient who, for instance, needs treatment for a substance use disorder and oral healthcare, cannot receive treatments for both conditions in the same day.

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38. “The collaborative care model is a systematic approach to the treatment of depression and anxiety in primary care settings that involves the integration of care managers and consultant psychiatrists, with primary care physician oversight, to more proactively manage mental disorders as chronic diseases, rather than treating acute symptoms.” Eghaneyan BH, Sanchez K, Mitschke DB. Implementation of a collaborative care model for the treatment of depression and anxiety in a community health center: results from a qualitative case study. *Journal of Multidisciplinary Healthcare*. 2014; 7: 503–513. <https://doi.org/10.2147/JMDH.S69821>.
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41. This includes race / ethnicity, gender, sexual orientation, and disability status, for example.
42. Miller BF, Burgos A. *Enhancing the Capacity of the Mental Health and Addiction Workforce: A Framework*. PA: Think Bigger Do Good; 2021. <https://thinkbiggerdogood.org/enhancing-the-capacity-of-the-mental-health-and-addiction-workforce-a-framework/>. Accessed September 19, 2022.
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45. States can use other policy levers beyond Medicaid managed care to implement training programs, including by requiring anti-racist and implicit bias training of providers as a condition of licensure. California, Connecticut, Massachusetts, Michigan, New Jersey, and Oregon have implemented requirements that healthcare providers complete training on implicit bias or cultural competency.
46. The authors acknowledge that creating and applying standards of network adequacy that focus on expanding racial and ethnic composition of MCE networks will take time, particularly in a landscape of general mental health workforce shortages and challenges.
47. California, Indiana, Louisiana, Michigan, Ohio, Oregon, and Washington have such requirements. See Bailit Health. *Compendium of Medicaid Managed Care Contracting Strategies to Promote Health Equity*. NJ: State Health and Value Strategies; 2023. <https://www.shvs.org/resource/medicaid-managed-care-contract-language-health-disparities-and-health-equity/>. Accessed September 19, 2022.
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49. An evaluation commissioned by Covered California found that health insurers were more intentional about directing efforts and funds to reducing health disparities with the distinction. The final report indicated that “the main benefit of requiring ...Distinction in Multicultural Healthcare is to support the creation of a necessary and consistent infrastructure for improving CLAS and narrowing disparities...” As a result of the findings, Covered California will require all plans to obtain the distinction by 2024. Health Management Associates. *NCQA Distinction in Multicultural Health Care: Assessment of the Benefits and Recommendation to Require that Issuers Achieve this Distinction*. CA: Covered California; 2020. <https://www.healthmanagement.com/insights/briefs-reports/hma-prepares-ncqa-distinction-in-multicultural-health-care-report/>. Accessed September 19, 2022. (Since the time of the evaluation, NCQA has transitioned from a Distinction in Multicultural Healthcare to Health Equity Accreditation.)
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