Medicaid Strategies for People with Specialized Needs

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Part of a series of briefs developed by the Technical Assistance Collaborative, Inc. (TAC) to assist policy makers, providers, and advocates to understand and capitalize upon opportunities in the Affordable Care Act (ACA) to help improve the lives of people with disabilities.

The passage of the Affordable Care Act (ACA) presents state Medicaid programs with an opportunity to improve access to needed supports and services for people with specialized needs whose unique issues have not always been considered in the design and development of enrollment systems, services, and provider networks. People that require customized approaches include people with mental and/or substance use disorders who are: experiencing homelessness; exiting the criminal justice system; involved with the child welfare or juvenile justice systems; and/or are members of underserved racial, ethnic, and cultural groups. Members of these groups often face significant barriers to enrolling in and maintaining Medicaid benefits. They also face challenges in accessing effective services that meet their needs based on the nature of their condition, their status and/or involvement in other systems, and/or their race, ethnicity or culture.

To more effectively serve these populations, Medicaid programs need to consider the unique social, familial, cultural, linguistic, financial and/or environmental issues that need to be factored into the design and implementation of the Medicaid program. Areas requiring particular attention include:

- Enrollment and outreach practices;
- Benefit design and service array;
- Provider qualifications and network issues; and
- Monitoring of access to and quality of mental health and substance use care.

Without attention to these areas, people with specialized needs are at risk for receiving poor quality, sub-optimal care (or at risk for no care at all) – which only serves to drive Medicaid and other system costs upward. Health care reform – with its focus on improving outcomes and quality of care as well as lowering costs – presents many new opportunities that can be leveraged to better meet the needs of people with specialized needs. This brief will highlight what is known about effective Medicaid design strategies for people with specialized needs and will describe current opportunities, as well as those available (or required) under the ACA, to improve care for these populations.

Why Consider People with Specialized Needs?

People with mental and substance use disorders often face significant stigma and discrimination related to their conditions. These issues are influenced by racial, ethnic or cultural identity and social factors such as homelessness or involvement in the justice system. These populations also tend to have poor access to primary and behavioral health services as a result of significant structural barriers related to obtaining and maintaining Medicaid benefits, the availability of effective outreach and service interventions, and the lack of culturally and linguistically competent mental health and substance use providers capable of meeting their unique needs.

Members of these populations have high rates of mental and substance use disorders as compared to the general population as well as significant unmet needs related to these conditions. Specific issues facing these populations include:

- Among **people experiencing homelessness**, 64% reported alcohol or drug use problems, 39% reported mental health problems, and 66% reported two or more of these problems.[1] Estimates are that

[1] Burt, M., Aron, L., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). *Homelessness: programs and the people they serve.* Summary report. Findings of the National Survey of Homeless Assistance Providers and Clients. Washington, DC: The Urban Institute.

70% of homeless individuals are uninsured,[2] and approximately 50% of those presumed eligible are not receiving Medicaid.[3] One national study found that 21% of homeless individuals reported unmet need for mental health care, and that being uninsured was a predictor of the inability to access needed care.[4]

- In 2009, it was estimated that approximately 20.9 million **people with a substance use disorder** (SUD) needed but did not receive specialized treatment.[5] While many of these individuals did not feel as if they needed treatment or did not attempt to seek treatment, of those who did attempt to seek treatment, 37% cited that lack of health insurance coverage was a barrier to receiving treatment, with another 9% indicating that they did have insurance but it did not cover the cost of SUD treatment.[6]

- National estimates are that 65% of **adults in the corrections system** have drug and/or alcohol use disorders,[7] 14.5% of men and 31% of women entering jail have a serious mental illness (SMI),[8] and among those, 72% have co-occurring mental and substance use disorders.[9] Recent results of the National Survey on Drug Use and Health (NSDUH) indicated that about half of women between 19 and 49 who were on probation or parole experienced any mental illness, and that rates of serious mental illness were three times higher among women who had been on probation or parole than those who were not.[10]

- Some studies have noted prevalence of mental and other behavioral and developmental disorders among **youth in foster care** to be as high as 80%.[11, 12, 13] Due in part to these special health care needs, Medicaid agencies spend more money on youth in foster care than on all other non-disabled children.[14]

- Rates of mental and substance use disorders among **youth involved with the juvenile justice system** are significant as well, with the prevalence of mental health problems among the juvenile justice population estimated to be as high as 70%.[15]

- In 2010, Blacks between the ages of 12-17 had the highest percentage for receiving mental health services in restrictive settings such as inpatient psychiatric units or residential treatment settings, but the second lowest percentage (after Asians) for receipt of care in outpatient settings.[16] In 2008 and 2009 **Blacks and Hispanics** were less likely to receive treatment for depression than Whites.[17] Between 2005 and 2008, Blacks who were treated for substance use problems were significantly less likely than Whites to complete treatment.[18] In 2009, suicide was the second leading cause of death for

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[2] National Health Care for the Homeless Council. (2010). *Policy Brief: Reducing Medicaid Enrollment Barriers for Individuals Who are Homeless.* Nashville, TN: National Health Care for the Homeless Council.
[3] Technical Assistance Collaborative, Policy Research Associates, the Corporation for Supported Housing (2006). *Assessment of Continuum of Care Progress in Assisting Homeless People to Access Mainstream Resources.*
[4] Baggett, T.P., O'Connell, J.J., Singer, D.E., Rigotti, N.A. (2010). The Unmet Health Care Needs of Homeless Adults: A National Study. *American Journal of Public Health*; 100(7).
[5] Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4856Findings). Rockville, MD.
[6] Ibid.
[7] The National Center on Addiction and Substance Use (CASA) at Columbia University. (2010*). Behind Bars II: Substance Use and America's Prison Population.* New York, NY: Columbia University.
[8] Steadman, H.J., Osher, F.C., Robbins, P.C., et al. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6).
[9] National GAINS Center. *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails.* Retrieved from: http://www.gainscenter.samhsa.gov/pdfs/disorders/gainsjailprev.pdf
[9] Davis, L.M., et al. (2009). *Understanding the Public Health Implications of Prisoner Reentry in California: Phase I Report.* Santa Monica, CA: The RAND Corporation.
[10] Substance Abuse and Mental Health Services Administration. (2012). Half of Women on Probation or Parole Experience Mental Illness. *Data Spotlight from the National Survey on Drug Use and Health.* Rockville, MD: Author.
[11] Clausen, J.M. et.al. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies*, 7(3).
[12] Chernoff, R., et. al. (1994). Assessing the health status of children entering foster care. *Pediatrics*, 93(4).
[13] Geen, R., Sommers, A., & Cohen, M. (2005). *Medicaid Spending on Foster Children.* Washington, D.C.: The Urban Institute.
[14]Geen, R., Sommers, A., & Cohen, M. Op. cit.
[15] Shufelt, J.L. & Cocozza, J.J. (2006). *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study.* Delmar, NY: National Center for Mental Health and Juvenile Justice.
[16] Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2010.
[17] Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2008-2009.
[18] Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set, Discharge Data Set, 2005-2008.

American Indian/Alaska Natives (AI/AN) between the ages of 10 and 34.[19]

- While reliable information on the size of the **lesbian, gay, bi-sexual, transgender, and questioning, (LGBTQ) population** is difficult to obtain, a recent study of disparities in California found that the rate of mental health need for the LGBTQ population was more than double the statewide rate.[20]

An estimated 16-22 million new individuals across the country will become eligible for Medicaid as a result of the expansion of the program as part of the ACA.[21] People with complex needs and circumstances are expected to compose a fairly significant portion of that group. For example:

- Between 185,000 to 380,000 uninsured American Indian/Alaska Natives (AI/AN) who receive care from the Indian Health Service (IHS) are estimated to become eligible for Medicaid coverage as part of the expansion.[22]

- Of the estimated 26.3 million uninsured adults between the ages of 18-64 with incomes below 138% of the FPL in 2010, 35% were Hispanic, 18% were Black, 4% were Asian, and 1% were AI/AN.[23]

- In 2010, 708,677 people were released from federal and state prisons.[24] While not all inmates being released into the community will be eligible for Medicaid due to not meeting citizenship or financial requirements, many people exiting prison will qualify based on having incomes less than 138% of the FPL.

- In FY 2010, 23,983 youth between the ages of 18 and 20 exited the foster care system.[25] The ACA extends Medicaid eligibility to youth who have “aged-out” of the foster care system up to age 26.

- People with a sole substance use disorder are not considered disabled for the purposes of determining eligibility for Supplemental Security Income (SSI), a common pathway to Medicaid enrollment. With the ACA expanding coverage to people at or below 138% of the FPL, many people with substance use disorders will now become eligible for Medicaid.

Identification of strategies to engage these populations and address their special health care needs is an important component of current and future health reform planning efforts.

State of the Art in Medicaid Strategies for People with Specialized Needs

This section highlights aspects of enrollment and outreach systems, covered services, quality monitoring, and provider qualifications/network design that need attention given the unique circumstances of these populations.

Outreach, enrollment, and retention strategies

Increasing access to and retention of Medicaid benefits for people with specialized needs who are un-enrolled or uninsured is a critical first step to accessing the treatment and supports necessary to an individual’s recovery from mental and/or substance use disorders. These people often require specific strategies to facilitate their enrollment in the Medicaid program. This might be due to problems such as lack of proper documentation to substantiate citizenship or finances/ assets, misinformation about how enrollment in Medicaid

[19] Centers for Disease Control and Prevention National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS).
[20] Grant, D., Padilla-Frausto, M., Streja, L., Aguilar-Gaxiola, S., Caldwell, J. (2011). *Adult Mental Health in California: Findings from the 2007 California Health Interview Survey.* Los Angeles: UCLA Center for Health Policy Research.
[21] Holahan, J., Headen, I. (2010, May). Medicaid coverage and spending in health reform: National and state by state results for adults at or below 133% FPL (Kaiser Commission on Medicaid and the Uninsured Report No. 8076). Washington, DC: Henry J. Kaiser Family Foundation.
[22] National Indian Health Board. (2011). Medicaid Expansion Under ACA for American Indians and Alaska Natives. Washington, D.C.; Author. Retrieved from: http://www.nihb.org/docs/05212011/NIHB%20Issue%20Paper%20-%20Medicaid%20Expansion%20under%20ACA%20for%20AI-AN%20FINAL%202011-04-14.pdf
[23] Henry J. Kaiser Family Foundation. (2012). Distribution of non-elderly uninsured below 138% of FPL. Washington, DC: Author. Retrieved from: http://facts.kff.org/chart.aspx?ch=2422
[24] Guerino, P.M., P.M. Harrison, and W. Sabol. (2011). *Prisoners in 2010.* NCJ 236096. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics. Retrieved from: http://www.bjs.gov/content/pub/pdf/p10.pdf
[25] Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2010 data (October 1, 2009 through September 30, 2010).

might impact other benefits they receive, lack of a permanent address, or limited availability of transportation to get to an enrollment center. Because of the numerous challenges many people with specialized needs have experienced enrolling in Medicaid, the ACA requires states to establish procedures for conducting outreach to and enrolling vulnerable and un-served/underserved populations including children, unaccompanied homeless youth, certain racial and ethnic groups, and individuals with mental and/or substance use disorders.

The ACA makes important changes to Medicaid enrollment and outreach requirements that will make it easier for states to comply with this requirement. This includes several provisions intended to simplify Medicaid enrollment and minimize administrative barriers that in the past have made the Medicaid enrollment and redetermination process difficult for many people with specialized needs. For example, states must implement a “user-friendly” application form that will allow people to apply for all available health insurance programs offered by a state (e.g., Medicaid, CHIP, etc.) in person, via phone, online, or via mail. States must also use technology to simplify and reduce the need for documentation required to establish eligibility, and adhere to rules making the counting of income easier, which reduces historical barriers to enrollment for several of these populations, including people experiencing homelessness and those exiting the corrections system.

As part of the ACA reforms to Medicaid, hospitals that are qualified Medicaid providers will be allowed to make presumptive Medicaid eligibility determinations. Presumptive eligibility has been an effective strategy for facilitating enrollment in Medicaid for pregnant women and children for many years. This provision however, allows for a broader group of people to be made ‘temporarily’ eligible for Medicaid. This temporary eligibility determination would be in place for a certain period of time and would follow the person. For example, if a person who is homeless visits a hospital emergency department (ED), the hospital could make a presumptive eligibility determination. If the person is then referred for follow-up care to a mental health clinic that accepts Medicaid, they would be able to get care at the clinic, and the clinic would be able to bill for the cost of the services. This will be an important strategy to help many individuals who frequently encounter barriers to gain longer-term coverage. Readying hospitals for this change and ensuring systems are in place for hospitals to facilitate enrollment should be an important component of a state’s eligibility and enrollment plan.

Of course, enrolling people in Medicaid *prior* to their seeking care at a hospital is preferable. For some people, particularly those without transportation, with limited English proficiency, or who need assistance in completing the application, use of community-based organizations as enrollment and outreach brokers can be particularly helpful. For example, co-locating eligibility specialists at homeless shelters, Federally Qualified Health Centers (FQHCs), community centers, drop-in centers for transition age youth, and other community-based organizations, can be an effective strategy for enrolling many of these populations . Attention to the development of written materials and use of other media (billboards, flyers, website materials, social media, etc.) that is targeted to specific populations is also critical for effective outreach and enrollment efforts.

Providers with expertise in working with people with specialized needs can also be important allies in outreach and enrollment efforts. In particular, transition age youth workers, family partners, former foster youth, and members of particular racial and ethnic groups can be some of the most effective partners in outreaching and engaging underserved populations. FQHCs have particular expertise in reaching out to culturally diverse populations. With many people experiencing homelessness expected to be among the Medicaid expansion population, Healthcare for the Homeless programs, are particularly well-suited to facilitating health insurance enrollment among this population. In addition, Health Resources and Services Administration (HRSA) designated outpatient health programs/facilities operated by tribal organizations or urban Indian organizations can also be important partners in reaching out to and enrolling Native Americans in health insurance.

Some states such as Massachusetts and New York offer grants to community-based organizations so they can hire staff members that are reflective of the community

served to conduct Medicaid outreach and enrollment activities. Other states, like Oklahoma, offer free trainings and technical assistance to community organizations who can then participate as "SoonerEnroll" partners. As most community-based providers have little familiarity with enrollment policies and procedures, training this workforce in these procedures can be helpful in increasing enrollment among many of these populations. While training for community providers on the enrollment process is important, so is training state or county eligibility workers about working with people with mental and substance use disorders.

People exiting the adult criminal justice and the juvenile justice systems have particular issues related to their enrollment or eligibility for Medicaid. Under federal law, states cannot receive federal reimbursement for services provided to individuals while they are "inmates of a public institution." While federal financial participation (FFP) is not available for services provided to individuals who meet this criteria, states do not have to terminate their Medicaid eligibility. Suspending rather than terminating eligibility while an individual is incarcerated can help avoid complicated re-instatement processes which delay access to community-based treatment upon release and/or interrupt recovery. Policies that allow for suspension rather than termination facilitate a smoother transition to the community and can help avoid recidivism. Additionally, Medicaid enrollment strategies that promote enrollment prior to or at the time of release for previously ineligible individuals is also important. Making information regarding eligibility available to prisoners pre-release and allowing them to apply for Medicaid benefits before they return to the community is crucial.

For youth involved in the juvenile justice system, the inmate payment exception can contribute to delays in youth accessing health care services upon their release. Similar to adults, suspension rather than termination of Medicaid can help reduce coverage gaps and promote access to needed services for youth. States such as Oregon, Arizona, California, and North Carolina suspend rather than terminate benefits. Massachusetts does not terminate or suspend eligibility bur rather keeps youth enrolled in MassHealth (the state's Medicaid program) but does not submit for federal reimbursement for services provided to youth at the time they are considered "inmates of a public institution." Other strategies that have been identified to help connect juvenile justice involved youth to Medicaid and promote access to Medicaid covered treatment services include allowing juvenile justice staff to make presumptive eligibility determinations, conducting screening for Medicaid eligibility prior to release, and training (and requiring) juvenile justice case workers to assist eligible youth and their families with completing Medicaid applications prior to release.[26]

Foster children in all states are eligible for enrollment in Medicaid; however they are at risk of losing their eligibility when returning to their families. In fiscal year 2010, approximately 254,114 children across the country exited foster care.[27] Ensuring that these youth retain access to some type of health insurance coverage after they leave the foster care system helps promote stability for these youth during a critical transition period in their lives. For foster youth who are reuniting with their families, care must be taken to ensure that these youth do not lose health insurance coverage during this period. Strategies that have been proposed to assist families in retaining coverage for their children include: [28]

- Providing for 12 months of continuous eligibility;
- Using information from Medicaid files or other benefits programs to renew eligibility; and
- Allowing families a "grace period" of additional time to complete necessary paperwork before terminating the child's Medicaid coverage.

Twenty-three states allow for 12 months of continuous Medicaid eligibility for children.[29] This policy reduces gaps in coverage for these youth and allows for

[26] Zemel, S. & Kaye, N. (2009). *Medicaid Eligibility, Enrollment, and Retention Policies: Findings from a survey of juvenile justice and Medicaid policies affecting children in the juvenile justice system.* Washington, DC: National Academy of State Health Policy.
[27] US Department of Health and Human Services, Administration for Children and Families. (2010, June). *Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2010 data (October 1, 2009 through September 30, 2010).* Washington, DC: Author.
[28] Redmond, P. (2003). *Children Discharged from Foster Care: Strategies to prevent the loss of health coverage at a critical transition.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.
[29] Kaiser Family Foundation. State Health Facts. Retrieved on December 5, 2011 from: http://www.statehealthfacts.org/profileind.jsp?ind=233&cat=4&rgn=6&cmprgn=1

continuity of care during what can be a stressful period for youth and their families. It can also help ease the youth's transition home by ensuring that they will not lose coverage immediately upon leaving foster care. Section 1413 of the ACA which calls for streamlined procedures for enrollment (and reenrollment) in Medicaid and other state health programs, including use of existing data should help make renewal of Medicaid eligibility easier, reducing a common problem, the temporary loss of coverage for youth and families who fail to complete necessary renewal paperwork.

Changes made by the ACA also provide important coverage improvements for foster youth who are "aging out" of the system by permitting them to remain on Medicaid until they reach their 26th birthday. Medicaid programs will need to develop systems to make these youth aware of the benefits of continued enrollment in Medicaid and develop systems to make their enrollment as streamlined as possible. The state of California has been noted for its simple enrollment procedures that eliminate loss of coverage for youth who are aging out of the foster care system; youth are notified by the county that they will be automatically enrolled in Medi-Cal three months prior to their 18th birthday, no forms or additional documentation is required.[30]

Putting systems in place to assist the populations discussed above in the timely completion of eligibility re-determinations are as important as promoting first-time enrollment. The ACA simplifies some of the re-determination process, but there may continue to be individuals who lose Medicaid coverage because re-determination paperwork was not completed correctly or on time. This is particularly true for people who are homeless because they lack a permanent address making it difficult to receive and retain administrative documents. Having a designated third party representative may assist with this. Adding a data field to the Medicaid application for housing status will also allow for targeted outreach to facilitate the re-enrollment process for homeless individuals.[31]

Consideration of the issues facing people with specialized needs will help states meet the ACA requirements to establish procedures for conducting outreach to and enrolling vulnerable and underserved populations in the Medicaid program. Policies and procedures that effectively target people with specialized needs for enrollment will help decrease the number of people who are uninsured and the amount of uncompensated care that is provided in the state. Absent this type of strategic outreach and enrollment approach, existing health care disparities for these people are likely to continue to widen.

Benefit design and service array

Ensuring coverage of and access to the types of mental health and substance use services these people need is also critical to improving individual and system-level outcomes. People with specialized needs are often not considered in the planning of services to meet their health care needs. Thus, the types of services which may be effective for the general population needing mental health and substance use services are often not adequate to meet the needs of certain subgroups of individuals. Many of the populations discussed here have more intensive and protracted service needs due to the following factors:

- They are frequently involved with multiple service systems and providers (e.g., child welfare, special education, mental health, juvenile justice, etc.).

- They often have multiple chronic physical and mental health conditions. Among chronically homeless individuals, which nationally comprise an estimated 17% of the homeless population, at least 30% have SMI, over 60% have SUDs, and high rates of co-occurring chronic health conditions are common. Youth in foster care have similarly high rates of multiple chronic conditions. The UCLA Center for Healthier Children, Families, and Communities, found that approximately 60% of youth in foster care have a chronic condition, while 25% have three or more chronic conditions.[32]

[30] Redmond, P. (2003). *Children Discharged from Foster Care: Strategies to prevent the loss of health coverage at a critical transition*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.
[31] National Health Care for the Homeless Council. (2010). *Policy Brief: Reducing Medicaid Enrollment Barriers for Individuals Who are Homeless.* Nashville, TN: National Health Care for the Homeless Council.

[32] Inkelas, M. & Halfon, N. (2002). *Medicaid and Financing of Health Care for Children in Foster Care: Findings from a National Survey.* Policy Brief from the Study of Health Services for Children in Foster Care. UCLA Center

- They have higher rates of certain risk factors for mental, emotional, and behavioral problems, including poverty, exposure to traumatic events, domestic violence, child abuse and neglect, prenatal drug and alcohol exposure, and discrimination.

As a result of these and other issues, coverage of specific evidence-based and best practices found effective for these populations such as Assertive Community Treatment (ACT), Permanent Supportive Housing (PSH), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Supported Employment, Integrated Treatment for Co-Occurring Disorders, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and peer and family support services are important components of a “good and modern” mental health and addictions treatment system that is inclusive of the treatment needs of people with specialized needs.[33] States such as Massachusetts, Pennsylvania, Oklahoma, Texas, Georgia, Wyoming, Connecticut, and Minnesota cover peer or family support services which can help promote engagement in mental health and substance use services, prevent hospital readmissions, and offer critical social support to individuals and families with mental health and addiction issues. North Carolina, Connecticut, Maine, Arizona, Louisiana, New Mexico, and the District of Columbia cover MST which has proved to be an effective treatment of youth with mental health needs involved with juvenile justice. Numerous states cover ACT including North Carolina, New Jersey, Indiana, Oklahoma, Rhode Island, Illinois, Massachusetts and Maryland which can be effective in serving people with SMI experiencing homelessness. Increasingly, evidence-based practices (EBPs) have been viewed as prudent investments by public purchasers due to their success at reducing spending on high-cost/poor-outcome interventions such as residential treatment or emergency department use.

Several provisions within the ACA also present opportunities for coverage of some of the aforementioned EBPs as well as other services that can help many of the populations discussed here to be successful in the community. For example, Section 2703 of the ACA affords states the option through a state plan amendment (SPA), to provide for “health homes” for enrollees with chronic conditions. Given the complex physical and behavioral health needs of these populations, this option offers a great opportunity to access comprehensive care that is coordinated across providers and promotes integration of physical and behavioral health. The ACA also makes several changes to the 1915(i) home and community-based services (HCBS) state plan option which presents states with the opportunity to provide many of the populations discussed here with a broader array of HCBS, such as supported employment, non-medical transportation, respite care, and services designed to help people transition from an institution to the community. These new options may also assist states in meeting their obligations under *Olmstead* by facilitating access to home and community-based services that can decrease reliance on institutional or out-of-home care for these populations many of whom are at particularly high risk of institutionalization. Certain provisions also offer an enhanced federal matching rate to support the implementation of new services.

While the ACA provides new opportunities for coverage of new Medicaid services that can help people with specialized needs receive appropriate treatment for their mental and substance use disorders, Medicaid funding alone is not adequate for achieving broad-based adoption of evidence-based and promising practices. A creative financing approach that blends and braids dollars from different funding streams together is often required. This is because use of Medicaid dollars for certain purposes such as training, child care, transportation, or room and board, is either restricted or not allowable. This type of financial collaboration however requires leadership and a commitment from both state and county officials in order to ensure its success. Child welfare, juvenile justice, housing, education, vocational rehabilitation, county mental health and substance use systems, early childhood, and corrections systems all have access to funding that in

for Healthier Children, Families, and Communities. Retrieved on December 6, 2011 from: http://www.healthychild.ucla.edu/PUBLICATIONS/ChildrenFosterCare/Documents/Financing%20brief%20final%20for%20distribution.pdf

[33] SAMHSA (2011). Description of a modern addictions and mental health service system (draft). Retrieved on May 7, 2012 from: http://www.samhsa.gov/healthreform/docs/good_and_modern_4_18_2011_508.pdf

many cases can be used more flexibly, and when combined with Medicaid funding can be used to promote greater adoption of EBPs.

Provider network and qualifications

Successful engagement in services of high need populations requires providers who are knowledgeable of and sensitive to the culture, worldview, background and life experiences of their clients, particularly as it relates to behavioral health, who are linguistically competent, and who are knowledgeable of and skilled in the delivery of best practice service modalities.

Some people with specialized needs will require inclusion of providers with highly specialized skills and expertise. For example, people who have experienced homelessness or incarceration as well as people with SUDs often respond best to engagement and treatment by providers who have had those same experiences themselves. This is similarly the case for underserved racial and ethnic groups and people who are LGBTQ, where providers that reflect the diversity of those being served can positively improve treatment engagement and outcomes. Youth in foster care and juvenile justice often need access to providers and practitioners with skills in working with transition age youth, children with sexual offending or acting-out behaviors, and histories of trauma. Given the increased demand for services among diverse populations that can be expected in 2014, the need exists to support providers who currently serve these populations in becoming Medicaid providers. Once people are enrolled in Medicaid, inadequate access to providers can be a significant barrier for people with specialized needs in receiving the care they need.

Many people with specialized needs receive mental health and substance use services from other systems (e.g., housing, child welfare, juvenile justice, etc.) that have provider networks which possess a great deal of experience working with these populations. Many of these providers have not traditionally sought to be or been accepted as Medicaid providers; often because they do not have the infrastructure or overhead to meet requirements that larger organizations can meet such as having a Medical Director; or are low-volume “niche” providers who serve certain neighborhoods or communities. Inclusion of these providers in a Medicaid network can offer opportunities to enhance engagement of populations; as well as provide a range of services to often underserved communities.
However, for some providers the transition from grants and state contracts to billing Medicaid is a substantial shift. Mental health, substance use, child welfare, homeless services, and other providers of services to these populations will need technical assistance with this transition process to ensure they are incorporated into the provider networks and medical homes serving these populations. Helping them identify strategies for leveraging Medicaid, including developing partnerships with FQHCs, is vital to the long-term sustainability of these valuable services.

There is also a need for training in services needs, cultural competency and sensitivity, and effective engagement and service practices for non-specialized providers who will increasingly come in contact with people with specialized needs. Providers may not always know when they are serving someone with a specialized need unless that information is disclosed, which makes training in culturally sensitive and competent service delivery for all of these populations even more critical. Investing in initial and ongoing training, coaching, as well as fidelity and outcomes monitoring are equally critical to developing and implementing the EBPs and community-defined promising practices proven so effective for these populations. Use of enhanced rates, particularly during start-up phases, as well as tapping into resources available through state general fund or grant dollars to pay for training and evaluation of these services, can encourage more widespread adoption of these practices.

Service access for people with specialized needs is also largely dependent on the availability of a service in a community setting versus office-based care. Meeting people where they are in the community is a key tenet of effective outreach and service delivery for people with specialized needs. The same is true for certain racial and ethnic groups for whom stigma related to mental health and substance use treatment may prevent them coming into an office setting to seek treatment. Transportation can also be major barrier to accessing services for some populations. Ensuring that rates

incentivize provider travel or co-location in easily accessible community locations can create a shift from office-based to community and home-based models that are often more effective in treating people with specialized needs.

Attention to provider/practitioner qualification and credentialing issues is also important in thinking about how to ensure that people's needs are met. Provider qualifications play an important role in the quality of the overall system by ensuring that providers serving these populations actually posses the requisite skills and competencies to address their needs. However, care must be taken not to rely only on traditional "proxies" for practitioner qualifications such as licensure or level of education, as they may inadvertently eliminate whole categories of providers such as people with lived experience, who could otherwise be qualified if different proxies or measures were used.

Setting provisional qualifications that include meeting/exceeding specified process and outcome targets for providers, offering technical assistance and training, and crediting lived experience in lieu of formal education are all effective strategies for developing an inclusive provider network. Also, inclusion of people with specialized needs on credentialing committees and workgroups involved in setting provider qualifications is critical to establishing a well-rounded provider network. Obviously provider qualifications are not the only component driving provider quality, but it is an important piece of an overall strategy for ensuring that these vulnerable populations have access to high quality care.

Monitoring access and quality of care

As discussed earlier, many of the populations discussed here, have had historically low service penetration rates and use a disproportionate share of high-cost, poor-outcome services. People with specialized needs typically have higher rates of unmet service needs compared to other groups as well. Specific attention to monitoring access and quality of care for these populations plays an important role in addressing the significant behavioral health disparities they experience. For example, monitoring penetration rates is a specific strategy that can be used to inform how well particular populations are being served by the system. Analyzing and reporting utilization data for populations of interest such as certain racial and ethnic groups, youth in foster care, or people with co-occurring disorders, can help identify disparities in service use and can be an important strategy for targeting patient and provider interventions and quality improvement efforts. Ensuring that Medicaid data such as claims and utilization for the populations they serve is made available to providers can play an important role in helping them to better target interventions and engage and outreach underserved populations. Use of health information technology (HIT) to promote sharing of health information such as inpatient admissions, pharmacy data, and ED use is important to have access to across providers in order to serve these populations.

Provider contracting and reimbursement strategies can also be used to address quality of care and disparity issues for these populations. For example, states and Medicaid managed care organizations could consider development of performance improvement projects that include financial incentives for providers to more effectively engage and treat people with specialized needs and reduce disparities in care received by these populations. Interventions that use people with specialized needs such as transition age youth, people with lived experience, or former foster youth, to provide education and conduct outreach and engagement activities can be particularly effective in reducing disparities for these populations.

Of course these strategies are dependent on having data collection mechanisms that can track provider performance as well as identifying the populations in question. This often requires adding particular data fields to current data collection systems or adding modifiers on claim codes in order to properly monitor system/provider performance. Given that many of these populations are served by multiple agencies (e.g., housing, child welfare, juvenile justice, corrections) data sharing and collaboration agreements among the various agencies are also important to having a complete picture of how well the system is performing. Additionally, efforts to collect information about these populations that is standardized across these entities, such as common race, ethnicity and language categories can also help

provide useful information for reporting on outcomes of service use.

Conclusion

Many of the groups discussed here, such as people experiencing homelessness, people with SUDs, and people exiting the corrections systems will comprise a significant portion of the Medicaid expansion population. The ACA presents many opportunities (and requirements) that can improve both access to and quality of the mental health and substance use services these populations receive. However without specific attention to the needs of these populations in the design of outreach and enrollment strategies, services, provider qualifications and networks, as well as quality monitoring and improvement activities, these populations could continue to experience barriers to service access, poor treatment outcomes, and high utilization of costly services such as EDs and inpatient care.

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