

# Improving Outcomes and Reducing Cost of Care for Complex Care Populations With Behavioral Health and Social Support Needs: Toolkit for Governors

## BACKGROUND

Governors play a critical role in reshaping the health system toward the three-part aim of improved health, high quality care, and reduced costs. As chief convener, regulator, administrator and purchaser of health care, a governor is uniquely positioned to establish statewide reforms by setting a unified vision, and pursuing needed policy, regulatory, payment and delivery innovations. Notably, increasing Medicaid expenditures are a significant driver of budgetary pressure in states and frequently spur health system reforms. Transformational effort often start by targeting populations with complex health and social needs. These individuals represent a small subset of the Medicaid beneficiaries but account for a large portion of a states' Medicaid costs. Nationally, approximately five percent of Medicaid enrollees account for more than 50 percent of total spending. They experience a disproportionate burden of mental illness, trauma histories, and/or substance use disorders (SUD) and are managing a host of social challenges, such as unemployment, homelessness and social isolation along with multiple chronic physical conditions. Evidence shows that they have frequent contact with emergency departments, hospitals, and jails and prisons, and that diversion from these costly settings through coordinated, community-based strategies can catalyze improved outcomes at reduced cost.

### Complex Care Programs: Select Resources for State Policy Makers

Since 2013, NGA's Center for Best Practices has joined the broader complex care community to support governors in building capacity for effective complex care programs. A host of relevant resources have been gathered and curated to support policy approaches and practical implementation.

#### NGA Resources

##### [Building Complex Care Programs: A Road Map for States](#)

- A detailed roadmap synthesizing lessons learned and best practices in: governance, stakeholder approach, data & evaluation, delivery and payment reforms and 10 state examples

##### [Housing as Health Care: A Roadmap for States to Leverage Housing Interventions that Improve Health Outcomes and Reduce Costs](#)

- An interactive webtool with detailed housing solutions for Medicaid beneficiaries with complex care needs

##### [Using Data to Better Serve the Most Complex Patients](#)

- Features lessons learned from work with seven states

Timely access to effective, community-based mental health and substance use interventions is successful but capacity needs to be scaled. Along with treatment, these interventions include safe and affordable housing, supported employment opportunities, reliable transportation, and care coordination supports. However, access to proven interventions is limited and exacerbated by historically fragmented health, behavioral health and social service systems. This is especially true for people with serious mental illness (SMI) and/or SUD, who comprise a large subset of the complex care population. Some state and local complex care programs, including the examples highlighted in this document, are successfully knitting together systems and achieving coordinated care. Governors may capitalize on lessons learned from those models and support complex care initiatives focused on this subset in their own states. Call out box #1 provides select resources to guide that effort.

### Key Partner Resources

#### [The Playbook: Better Care for People with Complex Needs](#) (

- Curated resources about promising approaches to improving care for people with complex needs

#### [Adults with Complex Needs](#) (Center for Health Care Strategies, Inc.)

- Resources and technical assistance tools for policy makers and providers

#### [National Center for Complex Health and Social Needs](#)

- An initiative of the Camden Coalition – to coalesce the emerging field of complex care across stakeholders. Includes numerous resources and an overarching Blueprint for Complex Care

#### [Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health](#) (National Academy of Medicine)

- Reports and reflects on key issues for improving care for high-needs patients – including policy actions and delivery reforms

#### [Leading Edge Practices in Medicaid for Addressing Social Factors that Affect Health](#) (State Health & Value Strategies)

- A state policy resource on “next generation” practices to address social factors using Medicaid 1115 waivers and leveraging managed care partnerships

#### [Medicaid Coverage of Social Interventions: A Roadmap for States](#) (Milbank Memorial Fund)

- A roadmap of legal authorities for policy makers for extending Medicaid coverage to social interventions

## BUILDING STATE CAPACITY TO ADDRESS BEHAVIORAL HEALTH AND SOCIAL SUPPORTS FOR COMPLEX CARE POPULATIONS: A LEARNING LABORATORY AND TOOLKIT

To assist governors in pursuing improved outcomes and reduced cost of care for complex care populations with behavioral health and social support needs, the NGA Center for Best Practices (NGA Center), in collaboration with the Robert Wood Johnson Foundation and the Commonwealth Fund, conducted an intensive, multi-state technical assistance project resulting in this toolkit. The toolkit features lessons learned from Arizona and Michigan, who served as models for the participating states, and supplements the NGA road map for [building complex care programs](#) and the [roadmap for a housing as health care](#) approach for this population – both offer step-by-step guides for governors and key lessons learned from successful programs.

States participating in the multi-state technical assistance project (Kentucky, North Carolina, North Dakota, and Utah) gained a firsthand understanding of innovative, evidence-based policies, programs, and practices through

a deep dive exchange of lesson learned with governors' senior advisors in Medicaid, behavioral health, and criminal justice from states leading in complex care work, **Arizona** and **Michigan**. The toolkit includes approaches from those states and resources from other pioneering states, and national and local efforts shared in this project. Five main areas of focus emerged throughout the project and are featured herein:

- **Integrating physical and behavioral health and needed social supports in Medicaid**
- **Care coordination: data-driven approaches**
- **Building a community-based crisis continuum of care**
- **Augmenting the workforce: building peer supports**
- **Coordinated reentry from corrections settings**

## INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH AND NEEDED SOCIAL SUPPORTS IN MEDICAID

**Arizona** serves as a model state for systematic and sustained physical, behavioral health and social services integration. Arizona's Medicaid Agency's, AHCCCS's (Arizona Health Care Cost Containment System), move towards integrated, whole person care was a decades-long effort relying on strong leadership and data to systematically integrate behavioral health, physical health, and long-term services and supports under managed care. Careful integration on the administrative level to provide aligned program management, oversight, and financing approaches was central to their success.

Prior to integration, behavioral health services were carved out and managed by Regional Behavioral Health Authorities (RBHAs), with physical health services managed by AHCCCS acute health plans[i]. Under the new, fully integrated managed care model referred to as Complete Care, recipients receive all services under one health plan. Individuals with serious mental illness receive behavioral health, physical health, and long-term care services through specialized health plans with behavioral health expertise. Administratively, Arizona merged the Division of Behavioral Health Services (DBHS) into AHCCCS, mirroring and supporting the integration happening at the health plan level. Statewide implementation of the Complete Care effort was complete on October 1, 2018. A detailed<sup>3</sup> review may be found [here](#). The state [AHCCCS website](#) describes the integration build in detail and [ongoing transition](#) of RHBA offered services into 2021.

**Phased Roll out:** AHCCCS credits the success of Complete Care implementation to their transparent, deliberate approach which involved multiple, phased roll-outs. In 2013, integration began with Children's Rehabilitative Services, followed closely by individuals with Serious Mental Illness (SMI) in Maricopa County. In 2015, integration for individuals with SMI rolled out across the state, and in 2016 integration for individuals dually eligible for Medicare and Medicaid with general mental health and substance use disorders was implemented. Finally, in October 2018, integrated managed care was implemented state wide for all managed care beneficiaries, under the name Complete Care. AHCCCS pursued a fully transparent, comprehensive stakeholder engagement strategy stretched across all stages of development and implementation.

**Stakeholder Engagement:** Robust external and internal stakeholder engagement was considered essential.

- *Development:* AHCCCS engaged stakeholders to garner input and support before developing the request for proposal (RFP) for the integrated health plans. Internal stakeholder engagement was also a critical component. When integrating DBHS, leadership intentionally elevated their agency processes and culture throughout the integration process.
- *Implementation:* AHCCCS gave hundreds of presentations to health plans, providers, and consumers; solicited extensive stakeholder feedback through focus groups and forums; and created a culture of collaboration amongst agencies, health plans and providers. AHCCCS also gave health plans as much information and as much data as quickly as possible so that Complete Care could be effective immediately upon the implementation date.
- *Post-Implementation:* AHCCCS engaged in daily meetings with managed care organizations (MCOs) and providers immediately post-implementation with a focus on ensuring continuity of care for beneficiaries. AHCCCS also maintained a 24-hour member transition line to assist with any problems and ensured that key staff were available on the weekend throughout the transition. AHCCCS trained all staff on Complete Care to ensure consistent communication and understanding.
- *Whole Person Care Initiative.* The state has initiated a stakeholder process to explore additional opportunities to address social determinants of health including: transitional housing for people leaving correctional facilities or psychiatric inpatient treatment and people experiencing chronic homelessness; non-medical transportation to access employment and health food options; and addressing social isolation among long-term care beneficiaries.

**Accountability and Oversight:** Important to the implementation of Complete Care was Arizona's strong oversight and compliance mechanism for their managed care program. Behavioral health integration began with clear requirements in early [managed care contracts](#) (pg. 88-89; 96) for physical health plans to coordinate with behavioral health plans for a small subset of high needs, high cost members. Throughout the transition to Complete Care, AHCCCS used a clear and transparent process for oversight and sanctions which included a graduated enforcement process progressing from a corrective action plan; to a notice to cure; and ending with sanctions that may be monetary or administrative. Decisions on moving from one step to the next were decided as a team and were implemented fairly across all health plans. All steps in the graduated enforcement process were publicly posted as part of the [public report cards](#).

**Strategic Investment:** In addition to system level integration, Arizona has focused on incentivizing integration and supports for complex care enrollees at the provider level. Under Arizona's 1115 Medicaid waiver, \$300 million over five years is included in the capitation rate (in the [Targeted Investments Program](#)) for managed care entities to incentivize providers to develop integrated systems of care. Incentive payments are based on meeting targets for performance improvement and increased integration of services. In order to support providers in these efforts, Arizona assisted providers in building peer relationships with one another as learning and support networks. A number of projects are underway including an [adult behavioral health integration project](#), a [pediatric behavioral health integration project](#), and an [adults transitioning from criminal justice system project](#). These projects improve coordination with social support services (such as housing and employment) and with the justice system (see more detail below).<sup>10</sup>



Staffing and coverage requirements have led to enhanced partnerships between the RBHAs and Complete Care health plans to ensure that their enrollees have access to the social support services they need. Arizona blended funds from federal block grants, state general funds, and county funds which are administered by RBHAs to provide housing subsidies. Additionally, each health plan is contractually required to have a housing specialist and an employment specialist. Supportive housing and supportive employment are included in health plan capitation payments through Medicaid funding. In addition, Arizona began suspending coverage for individuals who are incarcerated rather than disenrolling Medicaid beneficiaries, and require in-reach so that individuals are connected to care as soon as they are released. Finally, Arizona has implemented

forensic peer support to assist with system navigation, reducing stigma around accessing services, and reducing recidivism for enrollees who have been incarcerated.

Similarly, as part of **North Carolina's** move to [Medicaid managed care](#), the state is pursuing whole person care through integration of physical and behavioral health and pharmacy benefits. They are also pursuing cost-effective approaches to addressing non-medical drivers of health, including food security, safe and affordable housing, transportation, and interpersonal violence through their Healthy Opportunities Pilots. The [pilots](#) were authorized for up to \$650 million in Medicaid funding over five years and will operate in two to four geographic regions. Call out box #2 includes resources for physical, behavioral health, and social support integration.

## Sample National and State Resources: Integrating Physical, Behavioral Health and Social Supports through Medicaid

### Arizona

AHCCCS Integrated [Care Delivery System](#) org chart

- Delivery system organizational chart

Targeted Investments Program [Resources](#)

- Includes detailed descriptions of the programs and includes numerous tools such as core [components and milestones](#) and preapplication, self-assessment [tools](#) for providers

[Independent Evaluation](#) of Arizona's Medicaid Integration Efforts (2018)

### Michigan

Section 298 (Integration) Initiative

- [Pilot projects](#) on financially integrated Medicaid behavioral health and physical health benefits.

[Health Through Housing Initiative](#)

- To integrate health, behavioral health and housing supports for Medicaid beneficiaries experiencing chronic homelessness and with complex care needs

### North Carolina

[Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans](#)

- Medicaid Managed Care policy paper [Healthy Opportunities Pilots](#)
- Authority awarded as part of the state's 1115 demonstration waiver – allowing use of Medicaid funds to pay for specific non-medical services related to food, housing, transportation and interpersonal safety
- [Healthy Opportunities Pilots policy paper](#)
- [Buying Health, Not Just Health Care: North Carolina's Pilot Effort](#)
- Blog post providing overview of the state's Healthy
- [Healthy Opportunities Pilots fee schedule](#)
- [Healthy Opportunities Pilots Advisory Panel](#) on fee schedule
- North Carolina Medicaid Reform Demonstration [Special Terms and Conditions](#)

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## Sample National and State Resources, Continued:

### North Carolina

- [RFP](#) for Healthy Opportunities Lead Pilot Entities (on hold due to COVID-19 response)
  - Detailed description of the pilot [fee schedule](#)
- [Network adequacy for Standard Plans](#), which will be the basis for Tailored Plans

### Additional State Examples

#### California [Whole Person Care Pilots](#)

- Authorized through the state's 1115 Medicaid [waiver](#), the Whole Person Care Pilots are designed to coordinate health, behavioral health and social services in a cost-effective manner for complex care Medicaid beneficiaries

#### Rhode Island Health Homes

- One of the first states to implement [Medicaid Health Homes](#) across the care continuum including three types for: chronic conditions and [SMI, SMI and SUD](#).

### General Resources to Inform State Policy and Medicaid Approach

#### SAMHSA-HRSA [Center for Integrated Health Solutions](#)

- Multiple behavioral health integration resources organized in three content areas:
  - Assessing Organizational Readiness (e.g., [Standard Framework for Levels of Integrated Care](#))
  - Building the Business Case (e.g., [Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home](#))
  - Workforce Development (e.g., [Core Competencies for Integrated Behavioral Health and Primary Care](#))

#### [Certified Community Behavioral Health Centers](#) (The National Council for Behavioral Health)

- Impact report on Medicaid demonstration to establish a new provider type to provide comprehensive services to people with SMI/SUD and other underserved populations

#### [Integration of Behavioral and Physical Health Services in Medicaid](#) (MACPAC)

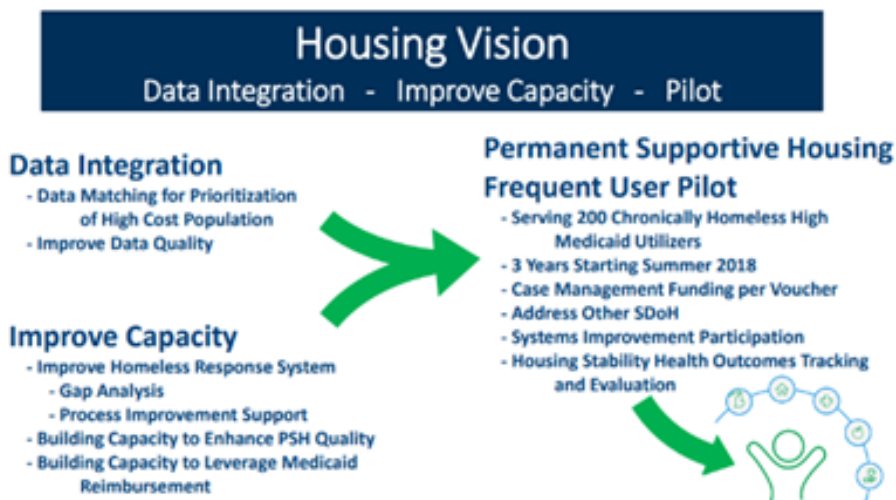
- Overview of Medicaid approached to behavioral and physical health services, including mechanisms for integration, common barriers, and state examples

## CARE COORDINATION: DATA-DRIVEN APPROACHES

**Michigan** served as a model state for administratively-driven integration efforts. In Michigan, behavioral health services for the SMI/SUD population are carved out of Medicaid and offered through separate plans (Pre-paid Inpatient Health Plans). To assist with coordination across plans, the state employs a number of data sharing and analytics tools, including CareConnect360 (CC360). CC360 is a web-based tool hosted by DHHS that facilitates care coordination across programs and payment systems. It allows detailed understandings of specific individuals' care needs as well as broader population health information. Using a shared data system has allowed Michigan to streamline and coordinate programs and services around specific strategies and goals. Linking Medicaid and homelessness information through CC360 has also supported Michigan's housing first strategies.

Michigan saw an opportunity to use these data to improve outcomes for complex care populations. They identified 2,700 Medicaid enrollees with 20 or more ED visits in the previous 12 months. About 57% of those were eligible to receive services from an FQHC health home and about 83% of those had a psychiatric admission, residential SUD intervention or a serious mental illness diagnosis. Michigan was then able to link 60% of Homeless Management

Information System (HMIS) data with Medicaid claims and found that 16% of the of the 2,700 identified ED high utilizers were homeless. This information, coupled with the strong evidence base demonstrating housing as a cost-effective intervention, particularly for homeless individuals, led Michigan to pursue strengthening their Housing First approach in the state. More detail on the approach can be found in the [NGA complex care roadmap](#).



## CareConnect360 and NC 360

CareConnect360 (CC360) is Michigan's Department of Health and Human Services-hosted, web portal that facilitates coordination of care across programs and payment systems in the context of a Medicaid behavioral health carve-out. It was originally developed to increase shared accountability for whole person outcomes among managed care plans separately providing for physical health services (Medicaid Health Plans) and behavioral health services (Pre-paid Inpatient Health Plans). It is accessed by plans, behavioral health providers, and authorized foster care professionals, to facilitate coordination of care across physical, behavioral and other human services needs and is jointly funded by the state and Optum, the state's technology partner. More information can be found [here](#). CC360 can be used to identify and analyze aggregated health trends in Medicaid, draw comparisons with the entire state population, and provides geographic visuals to inform policy and target

interventions. CC360 is part of to the state's broader coordination of care infrastructure.

Based on lesson learned about the CC360 tool, North Carolina developed a statewide coordinated care network to defragment care and electronically connect people to needed community services and supports (e.g. food pantries). [NCCARE360](#) is a technology platform shared by health care and human services organizations to facilitate person-centered, community-oriented, care coordination. Providers in all 100 counties can electronically connect people with services and resources in the community and evaluate the outcome of referrals made. The tool results from a public-private partnership between the North Carolina Department of Health and Human Services and the Foundation for Health Leadership and Innovation and relies on a seasoned implementation team including: United Way of NC/2-1-1, Expound Decision Systems.

## Integration Resources: Data-Driven Care Coordination

### Michigan

#### [CareConnect360](#)

- Overview of the CC360 model

#### [Building Michigan's Coordination of Care Infrastructure](#)

- Findings form the coordinating the care coordinators workshop series 2017 – provides a comprehensive view of care coordination across the state

#### [Behavioral Health Standard Consent Form](#)

### North Carolina

#### [NCCARE360](#)

- Comprehensive website with overview of the tool and resources and support for users
- [NCCARE360 Inclusion Criteria](#)
- [NCCARE360 FAQ](#)
- [Standardized Social Determinants of Health Screening Questions](#)

## Integration Resources: Data-Driven Care Coordination

### Other State Examples:

**Washington** [PRISM](#) – data integration and predictive risk modeling tool, managed by Medicaid and used by managed care plans

**New York** Psychiatric Services and Clinical Knowledge Enhancement System ([PSYCKES](#))

- Developed by the NY State Office of Mental Health (with MOU with Department of Health), PSYCKES is a HIPAA-compliant web-based portfolio of tools to support quality improvement and clinical decision-making in the NY Medicaid population through claims data

## BUILDING A COMMUNITY-BASED CRISIS CONTINUUM OF CARE

A comprehensive and integrated crisis network is central to reducing unnecessary use of acute and institutional care settings. When effectively employed it is both [cost-effective](#) and person-centered, and also relieves overburdened law enforcement and psychiatric systems by providing an easily accessible alternative for recovery-oriented supports. A true crisis continuum includes four core elements (reproduced from [crisis now](#)).

National Guidelines promulgated by SAMHSA provide detailed information on the core services, funding, implementation tips, continuous quality improvement and unique challenges in rural and frontier areas. **Arizona**, **Georgia** and **Colorado** have built robust crisis continua where individuals in crisis and first responders have clear options. New Jersey has developed a [model program](#) for mobile crisis response and stabilization services for children and youth that wraps into the state's overarching System of Care. Detailed descriptions, tools and resources are provided in the call out box #4.

## FOUR CORE ELEMENTS FOR TRANSFORMING CRISIS SERVICES



### HIGH-TECH CRISIS CALL CENTERS

These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems. At the same time, they provide high-touch support for individuals and family in crisis.



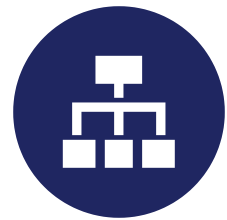
### 24/7 MOBILE CRISIS

Mobile crisis offers outreach and support where people in crisis are. Programs should include contractually required response times and medical backup.



### CRISIS STABILIZATION PROGRAMS

These programs offer short-term "sub-acute" care for individuals who need support and observation, but not ED holds or medical inpatient stay, at lower costs and without the overhead of hospital-based acute care.



### ESSENTIAL PRINCIPLES & PRACTICES

These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.



Based on lessons learned from these states and their own success in urban parts of the state, **North Dakota** built capacity for a crisis continuum in rural and frontier parts of the state. They took a measured, phased approach starting with a self-assessment of current capacity, leveraging partnerships to address gaps in the crisis continuum (short-term housing challenges, workforce shortages and managing transitions), and scaling solutions across two rural areas of the state. The figure below depicts the planned transformation.

Notably, in the [2019-2021 Executive Budget](#), Governor Burgum included as a major budget priority shoring up the behavioral health system across the continuum of care, including more than 20% of those funds dedicated to eliminating regional gaps and improving quality of crisis response services statewide.

## STANDARDIZED CRISIS RESPONSE



## Resources to Support Building a Crisis Response Continuum

### General Resources

#### [National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#) (SAMHSA)

- A comprehensive resource with guidelines for program design, development, implementation, communications, and continuous quality improvement including notes on rural and frontier challenges
- Crisis System State/Regional [Self-Assessment Tool](#)
- [Making the Business Case: Crisis Now Model](#)
- "It's Been a Bad Day: 911 in a Mental Health vs. Medical Crisis" [video](#)
- 988 – Nationwide number for mental health and suicide crisis ([designated](#) by the FCC – required to be implemented by all carriers July 2022)

#### [Making the Case for Comprehensive Children's Crisis Continuum of Care](#)

- Technical report from the National Association of State Mental Health Program Directors provides a detailed guide and state examples

#### [A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness](#) (National Association of State Mental Health Program Directors)

- Risk assessment tool to facilitate evidence-based, structured professional case formulation about certain risk factors
- [HCR-20 Violence Risk Assessment Tool](#)
- [Rating Sheet - 1](#)
- [Rating Sheet - 2](#)

### Arizona

- [AHCCCS Complete Care Crisis Intervention Services](#)
- [AHCCCS Comprehensive FAQ](#) on Complete Care Crisis Services for all population served
- [Regional Behavioral Health Providers Crisis Contract Language](#)
- [Complete history of Case Study #1](#)
- SAMHSA Webinar: [Creating and Sustaining High Quality Crisis Services: Lessons from Arizona](#)

# Resources to Support Building a Crisis Response Continuum

## Other State Examples:

### Colorado

[Colorado Crisis Services Overview](#)

[Colorado Crisis Services Statewide Crisis Line RFP](#)

[Mobile Crisis, Walk-In Crisis, Crisis Stabilization, Crisis Respite Services RFP](#)

[Crisis Services Regional Contractors RFP](#)

Communications and Outreach Tools

- [Colorado Crisis Services toolkit](#)
- [Youth outreach tools](#) – “Below the Surface”
- [Colorado Crisis Steering Committee Final Report & Recommendations](#)

### New Jersey

- [Mobile Response Service Guidelines – Initial 72 hours](#)
- [Mobile Response Stabilization Service Guidelines – \(Up to 8 Weeks\)](#)
- [Request for Proposals for Crisis Stabilization and Assessment Services for Youth with Intellectual and Developmental Disabilities](#)
- [Youth and Family Guide to NJ's System of Care](#)
- [Making the Case for a Comprehensive Children's Crisis Continuum of Care](#) (National Association of State Mental Health Program Directors)
- [Children's System of Care Training & Technical Assistance](#)

### Georgia

[Georgia's Mobile Services](#)

- [Guide to Mobile Crisis Services](#)

[Crisis Access and Mobile Services](#)

- [Community Medicaid Provider Standards](#) – Behavioral Health Services
- [Comprehensive Community Provider Standards](#) – Behavioral Health Safety Net

[Mobile Crisis Dispatch Guidelines](#)

## AUGMENTING THE WORKFORCE: BUILDING PEER SUPPORTS

Catalyzed by the inaugural [Surgeon General's Report on Mental Health](#) and the [President's New Freedom Commission on Mental Health](#) findings, consumer-informed recovery has been the goal of behavioral health system transformation. Peer-delivered health and wellness services are successfully incorporated into the behavioral health services in a number of states – especially for people with SMI and/or SUD.

Certified peer specialists are now considered a critical part of the behavioral health workforce and key to achieving true person-centered care. [Early adopters](#) with notable success include **Georgia**, **New Jersey** and **Michigan**. Key lessons learned from these states are [described in detail](#) and include:

- clearly defining the model of peer support to be disseminated,
- providing the necessary training for the peer workforce,
- financing the implementation, and
- establishing
- with funders clear expectation regarding quality and staffing supports.

**Georgia** is a pioneer in establishing a certified peer-specialist program that bring consumer influence to policy, service provision and advocacy.<sup>13</sup> The state was the first to receive Medicaid fee-for-service reimbursement for peer support (in 1999). Since, it has developed over 2000 certified peer specialists, in partnership with the [Georgia Mental Health Consumer Network](#). Their model has been replicated across the country.

Most recently, in **North Carolina's** move to Medicaid managed care, peer service providers were deemed essential to effective behavioral health integration efforts. Their [Medicaid State Plan Amendment for Peer Support Services](#) (informed by lessons learned in Georgia) was approved by the Centers for Medicare & Medicaid Services on Oct. 23, 2019. Call out box #5 includes additional peer support resources for states.

# Resources for building capacity for whole person care for people with SMI and/or SUD through enhancing a peer-support workforce.

## General Resources

MACPAC [issue brief](#) on Recovery Support Services for Medicaid Beneficiaries with Substance Use Disorder

- Details Medicaid's role and how states are using state plan authority to cover services

National Association of State Mental Health

Program Directors: [Enhancing the Peer](#)

[Provider Workforce: Recruitment, Supervision and Retention](#)

[Promoting Health and Wellness Through Peer-Delivered Services: Three Innovative State Examples](#)

- Peer reviewed journal article detailing three state approaches including: start-up processes, interventions and program models, peer provider training, and funding for sustainability

## Select State Initiatives and Tools

### Georgia

[Georgia's Forensic Peer Mentoring Program](#)

- Partnership among the state Department of Behavioral Health and Developmental Disabilities, Department of Corrections, and the Georgia Mental Health Consumer Network
- Peers need to obtain certified peer specialist and certified addiction

recovery empowerment specialist credential and training

- Support transition/release planning and obtaining stable housing, employment and linkage to services and recovery supports

[Georgia's Medicaid State Plan Amendment including Peer Specialists](#)

### North Carolina

[Health Improvement Peer Program: Peer Support Specialist Facilitator's Manual](#)

- Curriculum for peer specialist training informed by Georgia's approach

[North Carolina State Funded Peer Support Services](#)

- Provides detailed description of requirements for covered services

[Reimbursement for other state-funded mental health, developmental disabilities and substance abuse services](#)

### Michigan

[Peer Recovery Services and Supports](#)

- Site includes a variety of information about the state approach and associated tools – including for certified peer support specialists, peer recovery coaches, and veteran peers.

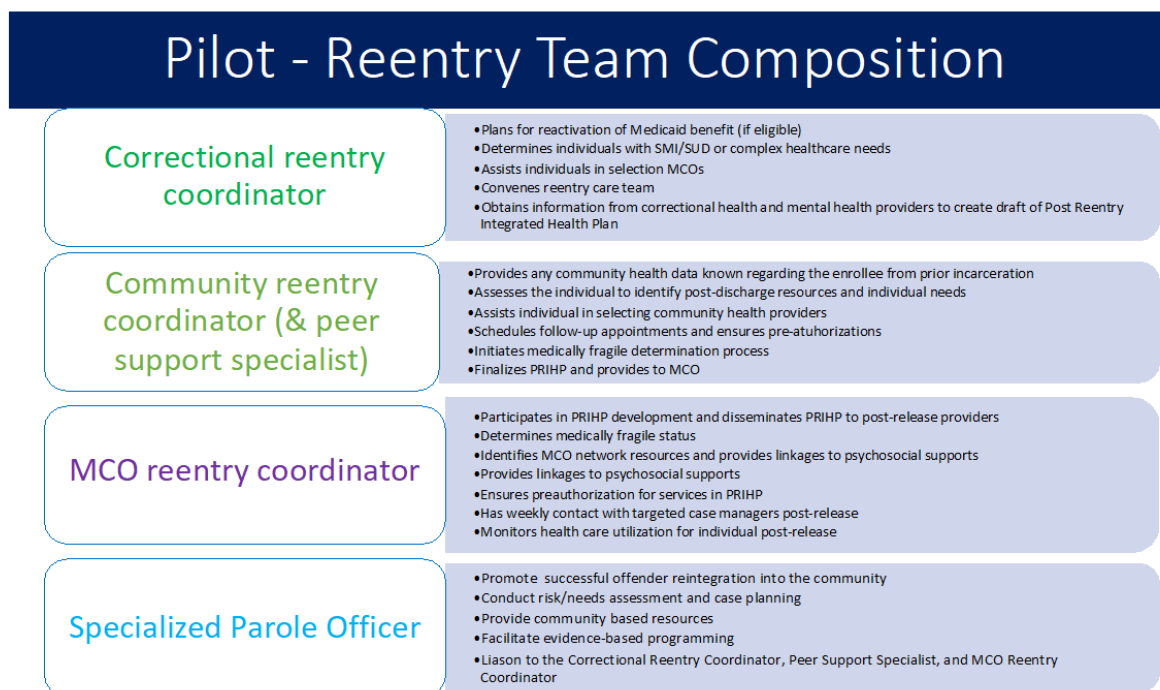
## COORDINATED REENTRY FROM CORRECTIONS SETTINGS

**Arizona** is a leader in strongly aligned corrections and health care policy, programming, and financing designed to reduce recidivism and improve outcomes for people with behavioral health challenges transitioning out of justice systems. Arizona shared this insight with participating states during NGA's learning collaborative. Through the AHCCCS [Justice Initiatives](#), the state works with Medicaid Managed Care Organization partners and community providers to prepare for and provide strong coordination of care and linkages to services and supports upon reentry.

Prisons and jails submit [Medicaid applications](#) 30 days prior to inmate release for individuals not previously connected to Medicaid through contracted “reach in” efforts by [health plans](#). In reach involves providers with lived experience including with the criminal justice system, SMI, and/or SUD. Through daily file transfers, [Medicaid is suspended](#) and reinstated efficiently for individuals that were already enrolled in Medicaid. Careful oversight of suspension and reinstatement of Medicaid benefits as people prepare for community reentry has resulted in estimated \$42.4 million in saving in 2018 alone. To address data privacy issues, the state uses a universal release of [information form](#) to facilitate health care data sharing.

Most recently, the state has stood up 13 probation/parole sites with co-located treatment for behavioral health (including onsite Medication Assisted Treatment for opioid use disorder), physical health care, and wrap-around services that keep people productive and healthier in the community (including support for housing, employment and food security, and supports for families). [See participant testimonials.](#)

In the course of the project, **Kentucky** developed and began implementing a prison reentry pilot developing cross-sector collaboration to streamline the reentry process for justice-involved people with SMI/SUD. Leadership from the Kentucky Department of Corrections (DOC), Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID), the state Medicaid agency, and the state opioids task force within the Office of Drug Control Policy (ODCP) collaborated with Medicaid managed care partners and community providers in pilot design and implementation. Specialized reentry care teams connected to two state prisons were tasked with securing in-reach to the target population while incarcerated to facilitate Medicaid enrollment ensuring care coordination in and out of prison and a seamless transition between correctional and community-based providers. The team consists of the following members:



Coordinated reentry plans were supported through the following funding sources: DOC general funds and personnel through the Division of Reentry Services (with 50 FTEs dedicated to community reentry), MH/SUD block grant dollars, federal Opioids STR and OTR funds, Medicaid personnel, Medicaid managed Care personnel and federal grant applications. Additional detail can be found [here](#).



# Resources to Support State Policymakers, Medicaid Directors, Behavioral Health leads, and Departments of Correction in collaboratively supporting effective transitions to the community.

[Strategies for Connecting Justice-involved Populations to Health Coverage and Care](#) (Urban Institute and Manatt Health)

- Policy guide with state examples and concrete strategies for: Medicaid enrollment, coordinated care across settings, sustainable funding approaches

[State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid](#) (Manatt Health and the Commonwealth Fund)

- Issue brief describing the latest developments in comprehensive primary care delivery models for people leaving jail or prison and Medicaid's role in financing and supporting

[Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need](#) (The National Reentry Resource Center)

- Brief for policymakers with concrete strategies, state and local examples including Medicaid's role improving care delivery to reduce recidivism/improve outcomes

[SAMHSA's Gains Center for Behavioral Health and Justice Transformation](#)

- [Sequential Intercept Model](#) – details how individuals with SMI and SUD move through the criminal justice system and potential points of diversion

[Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12](#)

- Special report from the Bureau of Justice Statistics with latest summarized statistics

## Select State Initiatives and Tools

### Arizona

Support for Individuals Transitioning out of the Criminal Justice System

- [A complete set of resource](#): targeted investments, enrollment/suspension template, pre-release applications and [reach-in resources](#) and AHCCCS [contracts](#) with health plans describing reentry

- [Targeted Investments Program Core Components and Milestones: Justice](#)

### Kentucky

[Kentucky Prison Reentry Pilot Reentry Services and regional maps](#)

## Other State Examples

### Ohio

[Returning Home Ohio – Corporation for Supportive Housing brief overview](#)

- Department of Rehabilitation and Correction [reentry resource guide](#) featuring [relink.org](#) and [Auntbertha](#) – online tools to connect people with community-based programs and services across the continuum of care
- Department of Mental Health and Addiction Services (OhioMHAS) [Community Linkage Program](#) as part of OhioMHAS Prison Pre-Release Project
- OhioMHAS encourages behavioral agencies to offer [Supported Employment](#) (SE) services, including the evidence-based practice of SE, Individual Placement and Support (IPS)
- [SOR Employment Services Gap Funding Checklist](#)

### Massachusetts

FY2020 budget includes \$3.1 for an expanded [behavioral health pilot](#) in two counties (with the goal to expand statewide in 2021) funded by MassHealth (the state's Medicaid program). The pilot, developed with law enforcement and people with lived experience, provides individualized services and supports for criminal justice-involved people with SMI/SUD at high risk for recidivism or hospitalization who are returning to the community.

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## **Endnotes**

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