



August 1, 2022

The Honorable Xavier Becerra
Secretary of U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Becerra,

The United States is facing a mental health and substance use crisis. The Centers for Disease Control and Prevention (CDC) estimate that [drug overdose deaths topped 100,000](#) last year, the highest number on record. [Nearly one in five U.S. adults](#) – over 50 million people – live with a mental health condition, and suicide is the [second leading cause of death](#) among young people. Addressing this crisis will require new partnerships, sustained investments, and creative thinking. As the nation's single largest payer for mental health and substance use services, Medicaid is uniquely positioned to help drive these solutions.

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is pleased to offer recommendations on how to improve our systems of care for mental health and substance use. Behavioral health needs and resources vary dramatically across states, and federal policies for Medicaid programs to strengthen behavioral health services should be crafted in a manner that meets states where they are and provides equitable opportunities for improvement.

As the Biden administration begins to implement its [national mental health strategy](#), we recommend that HHS act with four overarching principles in mind:

- **Drive collaboration across agencies**, including the Centers for Medicare & Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Education (DOE), the Department of Justice (DOJ), the Bureau of Prisons (BOP), the Department of Housing and Urban Development (HUD), and the Administration for Children and Families (ACF). This should include aligning strategic frameworks, guidance, and reporting requirements across agencies and funding streams.
- **Address racial disparities in care** by promoting equitable access to treatment and increasing the diversity of the behavioral health workforce.
- **Focus on upstream factors that lead to behavioral health challenges** by expanding access to prevention and early intervention services, outpatient treatment, and wrap-around supports.
- **Create solutions across payers** by expanding coverage of behavioral health services through Medicare, the Marketplace, and private insurers.

HHS should also focus on key areas of behavioral health policy. Importantly, initiatives in these spaces should be *options* to states, and not mandates. Behavioral health needs and resources – including the availability of providers – vary dramatically between states, and State Medicaid Directors should have the ability to tailor strategies to their local contexts.

- **Strengthen the behavioral health workforce** by building pathways into the profession, lowering barriers to participation in the Medicaid program, and supporting states in developing a non-licensed professional workforce.
- **Drive behavioral health integration** by providing technical assistance on provider coordination, funding electronic health records and other health information technology, and addressing regulatory barriers to data sharing.
- **Support children and young people** by addressing challenges with inpatient care, addressing the factors that lead to out-of-home placements, and coordinating across CMS, SAMHSA, ACF, and DOE.
- **Develop crisis response systems** by considering flexibilities around the 24/7 requirement for mobile crisis teams, developing sustainable funding mechanisms, and supporting states in providing follow-up care.
- **Address the substance use and overdose crisis** by allowing pre-release Medicaid coverage of incarcerated people, creating pathways to fund harm reduction services and naloxone, and increasing access to medications for opioid use disorder and innovative treatments for stimulant use.
- **Ensure access to inpatient and specialty care** by lifting the 15-day limit on managed care “in lieu of services” payments, addressing barriers to implementing 1115 waivers for inpatient care, and developing sustainable funding mechanisms for certified community behavioral health clinics (CCBHCs).

The National Association of Medicaid Directors stands ready to support these efforts. Mental health and substance use are top priorities for Medicaid directors, and we look forward to working with your Administration to develop solutions to these challenges. [Please reach out to Jack Rollins, NAMD’s Director of Federal Policy](#), if we can provide any additional information.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Sincerely,

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Core Principles for Action

Closing gaps in our systems of care for mental health and substance use will require a broad array of policy approaches. NAMD would like to offer four core principles to guide HHS’ work in this effort:

- **Cross-system collaboration:** Meeting mental health and substance use needs touches many systems, including the healthcare system, the justice system, and social services like housing. These services are funded through a variety of federal agencies, including the Centers for Medicare & Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Education (DOE), the Department of Justice (DOJ), the Bureau of Prisons (BOP), the Department of Housing and Urban Development (HUD), and the Administration for Children and Families (ACF). These agencies typically have separate funding streams with different regulations and reporting requirements, which can make it difficult for states to “braid” these funds into seamless, comprehensive services for individuals. To address these challenges, HHS should take a three-pronged approach:
 1. **Ensure cross-agency expertise.** CMS should have mental health and substance use experts on staff, and other federal agencies that work on behavioral health (including SAMHSA and ACF) should have Medicaid experts. This is important to ensuring that behavioral health initiatives (many of which are initially funded through grants) have pathways towards sustainability through Medicaid, and that CMS’ initiatives are building upon existing best practices. Deliberate partnerships between ACF and CMS are

also crucial for prevention and early intervention in childhood behavioral health issues, which may lead to more positive outcomes in adulthood.

2. **Align strategic frameworks and guidance across funding streams.** HHS should work across agencies and with other departments to build towards one shared vision for mental health and substance use care. Aligning policy and guidance across agencies (for example, aligning definitions of mobile crisis teams) is important to ensuring that providers can deliver uninterrupted care, even if their funding stream changes. HHS could create these strategic frameworks by convening departments and agencies to align funding, technical assistance opportunities, guidance, and timely action on state requests. States report an urgent need for shared strategic frameworks around housing: CMS should work with HUD to develop a more deliberate way to fund supportive housing, given that Medicaid cannot pay for room and board. Similarly, HHS should drive strategic frameworks for supportive employment and prevention services.
 3. **Align reporting requirements across and within funding streams.** Many behavioral providers may receive funds from both Medicaid and SAMHSA block grants, for example. Reporting requirements are different across federal funding streams, which leads to increased administrative burden for providers. CMS, SAMHSA, and other federal agencies should work to find common metrics.
- **Promoting health equity:** Closing racial disparities in behavioral health should be a core aim of the administration's approach. Although the overdose crisis is often thought of as primarily impacting White people, in recent years [the most dramatic increases in overdose rates have been among Black people](#), due in part to increases in stimulant use and polysubstance use. Providing states with authorities to promote equitable access to medications for opioid use disorder is crucial to addressing these disparities, as is ensuring access to evidence-based treatments for stimulant use (e.g. contingency management). Efforts to expand the workforce should also aim to increase the diversity and cultural competence of Medicaid providers. Nationally, [approximately 20 percent of Medicaid members are Black and 29.3 percent are Latino](#), so equipping state Medicaid programs with the tools they need to improve their mental health and substance use care is an important strategy in advancing health equity. CMS should also seek to close disparities for Indigenous Peoples; this should include focused work with tribal entities.
 - **Addressing upstream factors:** Policymakers often turn their attention to the most acute behavioral health needs, including workforce shortages, long wait times to access treatment, and our country's lack of robust crisis response systems. The administration's mental health strategy must address these immediate challenges, but NAMD also urges HHS to invest in the community-based supports that prevent mental health and substance use concerns from starting or escalating. This could include enhancing funding for primary prevention, expanding access to outpatient

treatment and wrap-around services, integrating treatment and screening into primary care and schools, and providing flexible funding aimed at addressing the [situational factors](#) (like poverty, trauma, and housing instability) that may increase the risk of mental health and substance use issues.

- **Creating solutions across payers:** Although Medicaid plays an outsized role in the behavioral healthcare system, Medicare and private insurers must also be part of the solution. Currently, [Medicare does not cover](#) most intermediate levels of substance use treatment and many types of treatment providers, including licensed counselors, certified addiction counselors, and peer counselors. Similarly, many private insurers do not cover clinically indicated mental health and substance use services, despite federal parity laws. This limited coverage exacerbates workforce shortages and access challenges. To create real solutions to the nation's behavioral health crisis, CMS should expand coverage through Medicare and the Marketplace – including seeking additional authority from Congress to provide such coverage where necessary.

Building a Strong Workforce

States report that workforce shortages and distribution issues are one of the biggest challenges – if not the biggest challenge – facing their mental health and substance use treatment systems. Although these issues span the continuum of care, states identified acute shortages among specific provider types (including psychiatrists, social workers, and psychiatric nurse practitioners), multilingual providers, and Black/Latino providers.

Fully addressing provider shortages and geographic distribution will require a long-term federal strategy. However, there are actions that CMS, SAMHSA, the Health Resources and Services Administration (HRSA), and other agencies could take to help address these challenges:

- **Create funding mechanisms to expand training and technical assistance programs.** CMS could address workforce shortages by creating a model (similar to the Graduate Medical Education model in Medicare) to fund behavioral health education, fund teaching Community Mental Health Clinics directly, or create scholarships. Alternatively, CMS could approve 1115 demonstration waiver pathways or other mechanisms for state Medicaid programs to fund training and technical assistance; currently, state Medicaid programs cannot directly use federal funds for continuing education or advanced training, limiting their ability to address workforce issues. Training components may be embedded into a rate structure tied to a specific service, but this type of career-advancing training cannot be billed standalone and generate federal Medicaid match. HRSA could also help address workforce challenges by creating grant programs that specifically support workforce development and distribution efforts targeted at increasing the number of Medicaid-enrolled behavioral health providers. These efforts are crucial to accomplishing

CMS' aim of moving "[the vast majority](#)" of Medicaid members into value-based care relationships by 2030.

- **Provide technical assistance on developing a non-licensed professional workforce.** Peer support workers, community health workers, and other non-licensed professionals are a crucial part of the behavioral health workforce. CMS and SAMHSA could provide states with technical assistance on certification, coverage, and reimbursement of the peer support and non-licensed professional workforce, including mapping different types of non-licensed professionals (e.g. peer recovery coaches, youth and family peers, recovery specialists, community health workers) to potential Medicaid reimbursement pathways. These efforts could build on [existing state-level initiatives](#) to define and map different categories of non-licensed workers. CMS should also provide clarity on how [criminal records may influence the ability](#) of peer support workers to enroll as Medicaid providers. Substance use-related charges should not necessarily be considered disqualifying, as peer support workers are often effective providers *because* of their lived experience with substance use or mental health conditions.
- **Support behavioral health providers in participating in the Medicaid program.** Many behavioral health providers [do not accept Medicaid or even private insurance](#), exacerbating workforce shortages. CMS could provide technical assistance on the Medicaid enrollment and reimbursement process, along with resources to implement electronic health records and other health IT, to support provider enrollment. Separately, HHS should encourage medical schools to include behavioral health (including the use of medications for opioid use disorder) in their curricula.
- **Remove administrative barriers to ensuring adequate reimbursement for behavioral providers, including state efforts to promote value-based and/or outcomes-based payments.** Most Medicaid members receive all or some of their benefits through managed care. States have reported that the review process for state-directed payments in managed care is administratively burdensome. Securing approval for minimum fee schedules for behavioral health providers can take many months, with much longer timelines for approval of value-based or outcome-based payment methodologies. CMS should consider simplifying this review process to support states in implementing innovative reimbursement methodologies, particularly when such methodologies are tied to adoption of an existing state fee schedule.

Driving Behavioral Health Integration

Our country's healthcare system is fragmented, with physical health services, mental health services, and substance use services delivered by different providers in different locations, and often covered by different payers. Behavioral healthcare integration works to streamline access by having medical, mental health, and substance use providers collaborate to ensure the best possible outcomes for their patients. [This often includes](#) providing assessments, treatment, and care coordination in primary care

settings. Integrated care models can also include coordination with social service providers to connect patients to housing, nutrition programs, and other wrap-around services. To support state Medicaid programs in integrating care, HHS should:

- **Work towards a comprehensive model of integration.** Comprehensive behavioral health integration in Medicaid [operates at three levels](#): 1) policy and systems integration, such that Medicaid and behavioral health agencies work towards one shared vision; 2) payment integration, such that funding from Medicaid, SAMHSA block grants, and other payers are braided; and 3) provider integration, such that behavioral health services are integrated into primary care, and community mental health centers and opioid treatment programs have co-located primary care. HHS should create technical assistance and other opportunities at each of these levels, including identifying reimbursement codes for coordination across providers.
- **Create funding for EHRs and other systems work.** Interoperable electronic health records (EHRs), health information exchanges, closed loop referral systems, and other health IT systems are essential for integrating behavioral health at the provider level. Behavioral health providers were [initially excluded](#) from HITECH (Health Information Technology for Economic and Clinical Health Act) funding and often lack robust administrative infrastructure, limiting the uptake of EHRs and other IT. HHS should examine opportunities to support providers in implementing health IT, including through federal financial resources like an enhanced federal match or grant funding.
- **Examine federal policy barriers to integration, including 42 CFR Part 2.** 42 CFR Part 2 includes restrictions on sharing substance use-related patient data; these restrictions [are stricter than HIPAA](#) and prevent providers from sharing information that would be useful for coordinating care. Additionally, designing EHRs that are interoperable between physical and behavioral health providers and comply with 42 CFR Part 2 is [technically extremely challenging](#). The Coronavirus Aid, Relief, and Economic Security (CARES) Act included data sharing provisions that aim to better align 42 CFR Part 2 with HIPAA. HHS is [still developing](#) the final rule, however, so it is unclear how these changes will impact data sharing, and states report that many providers lack a strong understanding of what data sharing is allowable under current law. HHS should provide clear guidance to providers on how to integrate care in the context of 42 CFR Part 2. Additionally, Congress should address regulatory barriers in Medicaid reimbursement policy – including restrictions on reimbursements for electronic consultations or “eConsults” to Federally Qualified Health Centers and Indian Health Programs– that may restrict integration.

Meeting the Needs of Children and Youth

Children and young people face unique behavioral health challenges. Even prior to the COVID-19 pandemic, [up to 20 percent of children](#) ages three to 17 were reported to have a mental, emotional, developmental, or behavioral disorder. The COVID-19 pandemic has led to even more acute challenges, as young people experience increased isolation, disruptions to routines, financial instability, and trauma. In October 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children’s Hospital Association [declared a national emergency](#) in child and adolescent mental health, citing “dramatic increases in Emergency Department visits for all mental health emergencies.” Addressing this emergency will require urgent action from policymakers, providers, school systems, and other stakeholders.

[Almost half](#) of all Medicaid and CHIP members are children, so state Medicaid programs play an outsized role in connecting young people to mental health services. To support states in this work, NAMD recommends that HHS:

- **Address capacity, quality, and safety concerns around psychiatric residential treatment facilities.** Psychiatric residential treatment facilities (PRTFs) provide inpatient psychiatric care to children and young people under the age of 21. There are steps CMS could take to promote safety and quality within these facilities, including:
 - **Launch quality improvement projects.** The Center for Medicaid & CHIP Services (CMCS) or the Center for Medicare & Medicaid Innovation (CMMI) could develop models for delivering high-quality care to young people with complex behavioral health needs who require high-acuity care. CMS could also work with states to develop optional quality measures that states could adopt to promote better care within PRTFs. CMS should also provide technical assistance on specialized services for Reactive Attachment Disorder, Oppositional Defiance Disorder, Conduct Disorder, sexual behavior problems, traumatic brain injuries, autism, and intellectual or developmental disabilities. States report particularly acute challenges finding placements for young people with these diagnoses.
 - **Provide guidance on out-of-state placements.** When a child obtains PRTF services out-of-state, state Medicaid agencies must navigate issues surrounding the Interstate Compact on the Placement of Children (ICPC) and the Interstate Compact on Adoption and Medical Assistance (ICAMA). There is currently confusion over which state’s Medicaid program covers coordination and discharge services (including non-emergency medical transportation), which can impact efforts to stepdown children into community-based options.
 - **Provide technical assistance on “no reject, no eject” policies.** States report that PRTFs sometimes refuse to accept young people with higher-

acuity needs or inappropriately discharge these patients from their services. In response, some states have instituted “no reject, no eject” policies which require PRTFs to accept all eligible young people and not discharge patients without first consulting with the state. HHS should provide technical assistance to states on how to develop these policies.

- **Provide flexibility on eligibility for initiating waiver services.** States report challenges providing streamlined services to help young people transition from PRTFs back into their communities. CMS could provide flexibility on waiver eligibility so that state Medicaid agencies could begin covering community-based services (which are typically covered by waivers) while the child is still transitioning out of a PRTF.
- **Work to address the upstream factors that increase the likelihood of out-of-home placements, including foster care and inpatient placements.** Addressing capacity and quality issues with PRTFs is a major priority for state Medicaid Directors, but the administration’s strategy should also focus on prevention and early intervention. HHS should support states interested in providing services to children and their caregivers in their homes, schools, and communities; this could include home visiting, mental health/SUD counseling, parent education, and social services (peer supports, housing supports, transportation, etc.) that help young people safely remain with their families or next-of-kin caregivers. As part of this strategy, it is crucial to ensure that young people with emerging mental health or substance use-related needs have access to less acute forms of care, including behavioral health education and prevention services (youth wellness programming, coaching supports), early intervention services, outpatient treatment, partial hospitalization programs. HHS could also consider developing specialized respite care or short-term treatment in community-based settings to provide caregivers with needed breaks; these providers would need high levels of expertise in caring for young people with complex behavioral health needs. Finally, HHS should consider ways to enhance the availability of supportive services for young people transitioning out of foster care or inpatient placements due to their age.
- **Require SAMHSA, CMS, ACF, the DOE, and other federal agencies that impact children and youth to coordinate funding and guidance.** Children and young people with mental health challenges interact with a variety of systems, including the educational systems, the treatment system, the juvenile justice system, child welfare services, and child care services. HHS should require that the federal agencies that fund these systems – including CMS, SAMHSA, ACF, and DOE – support state Medicaid programs’ efforts to better coordinate care. This could include ensuring cross-agency expertise, aligning guidance, oversight, and reporting requirements across programs, and launching initiatives to develop more streamlined models of care.

- **Address ongoing challenges associated with implementing Qualified Residential Treatment Programs (QRTPs).** QRTPs, which were created by the Family First Act, are a type of setting that provides behavioral health services to young people in foster care. States face challenges implementing this care model due to the Institutions for Mental Diseases (IMD) exclusion, which prohibits states from using federal Medicaid funds for mental health facilities with more than 16 beds. CMS has created an 1115 pathway to allow states to receive federal match on QRTPs with more than 16 beds, but states must meet an average length of stay of 30 days or less. States report that this is challenging, as the average length of stay in a QRTP is typically over 30 days. Although Congressional action may be needed to create a long-term solution, HHS could work across agencies to develop technical assistance for states on QRTP-related issues.

Developing Crisis Response Systems

Our country lacks a dedicated system for responding to behavioral health crises, which leads to unnecessary encounters with the justice system and child welfare system, and inappropriate utilization of emergency rooms. Approximately [one in five police calls](#) and [one in eight visits to the emergency room](#) involve mental health or substance use. Crisis response systems represent an alternative approach.

These systems include [three core components](#): call centers, which provide remote crisis interventions, assess risk, and dispatch crisis teams or emergency services; mobile crisis teams, which quickly respond to crises in homes, workplaces, or the community; and crisis stabilization centers, which provide short-term interventions and connections to care in non-hospital settings. Together, these services can help ensure that a person experiencing a mental health or substance use-related crisis is connected to behavioral health care. To help states build out their crisis response systems, HHS should:

- **Consider flexibilities around the 24/7 requirement in the American Rescue Plan’s mobile crisis option.** The American Rescue Plan Act created a state option to provide community-based mobile crisis, with a corresponding 85 percent federal match rate. [CMS’ guidance on the option](#) outlines specific criteria for qualifying services: mobile crisis services must be available 24/7, and must be staffed by two people, including one licensed behavioral health provider. States have reported that the 24/7 requirement is difficult to operationalize, especially in rural areas and other areas with workforce shortages. To increase uptake of the option, CMS could consider providing flexibilities around the 24/7 requirement, such that states can use telehealth or other strategies to ensure overnight access.
- **Address barriers to implementing crisis stabilization centers.** Crisis stabilization centers (including crisis residential facilities) offer short-term stabilization, observation, treatment, case management, and/or connections to care following a crisis. The “institutions for mental diseases” (IMD) exclusion,

which prevents Medicaid from covering most inpatient behavioral health services, limits the scalability of crisis stabilization centers; the IMD exclusion's 16-bed limit may be particularly challenging in rural communities with limited provider networks. Although Congressional action may be needed to address this challenge, HHS should consider pathways to exempt crisis centers – which, by definition, provide short-term stays – from the IMD exclusion. States also note that transportation can present a barrier to accessing these services: non-emergency medical transportation often needs to be scheduled in advance, rendering it useless during a crisis, and patients often do not require the higher level of care (and cost) associated with emergency medical services. An intermediate transportation option would be helpful for ensuring that patients can be brought from the scene of the crisis to a crisis stabilization center.

- **Ensure that states can provide follow-up care after a crisis.** [As stated in CMS' guidance on the mobile crisis option](#), effective models of crisis care provide follow-up care to ensure that individuals are connected to continuing behavioral health supports. However, scheduling follow-up visits with a community-based provider may be extremely difficult, when the patient is in active crisis. Some states report that it would be helpful to create a defined service bundle that includes a small number (e.g. up to three) of follow-up visits or a window of time (e.g. up to 30 days) to receive crisis-related services after the initial crisis intervention. CMS should expand their guidance to allow the enhanced federal match for these treatment bundles; even though the individual may be past the most acute phase of their crisis, ensuring appropriate screenings and connections to continuing care is crucial for reducing the risk of future crises.
- **Develop sustainable funding mechanisms for crisis response systems.** States report serious concerns about funding 988 crisis line call centers, mobile crisis teams, and crisis stabilization centers. These services use a “fire house” model of 24/7 staffing, as opposed to Medicaid's model of reimbursement for specific Medicaid services or capitation payments for Medicaid enrollees. Although state Medicaid programs can fund some amount of these services (typically the portion that was estimated to be used by Medicaid members), individuals with private insurance or who are uninsured will also utilize crisis response systems. States report that many crisis response providers (including crisis stabilization centers) are having serious difficulties obtaining reimbursements from private payers. 988 call centers will likely also not receive reimbursement from private payers. HHS should examine ways to create more sustainable multi-payer funding models for these services, including mechanisms that incorporate the private sector.

Addressing Substance Use and Overdose

In 2021, [over 100,000 Americans died](#) from overdose, largely due to increases in fentanyl and stimulant use. These deaths represent a fraction of the [2.7 million Americans](#) who receive treatment for substance use disorder, and the [over 41 million Americans](#) who may benefit from treatment. Strengthening the workforce, increasing access to integration and specialty care, and building crisis care continuums are all essential to meeting the needs of people with a substance use disorder. However, there are additional steps HHS could take to reduce the risk of overdose and other negative health outcomes (including the transmission of HIV) associated with substance use:

- **Allow state Medicaid programs to cover incarcerated people up to 90 days before their release.** Re-entry from incarceration is a vulnerable time; one study found that, during the two weeks immediately post-release, individuals were [129 times more likely](#) to experience a fatal overdose than the general population. CMS should create a pathway to allow states to provide Medicaid coverage up to 90 days pre-release. This option would prevent gaps in care – for chronic physical health and mental health conditions, in addition to substance use – and support care coordination efforts. HHS should also provide planning and implementation grants to support state Medicaid agencies, prisons, and jails in building data exchanges and other shared processes to facilitate pre-release coverage.
- **Create pathways allowing states to fund harm reduction services.** Harm reduction services reduce the health risks associated with substance use, including overdose, HIV and other infectious disease, and myocarditis. This can include providing access to clean syringes, naloxone, fentanyl testing, HIV and other STI testing, pre-exposure and post-exposure prophylaxis to prevent HIV transmission, counseling, and peer support. Most harm reduction programs are not funded through Medicaid [for a variety of reasons](#): many programs lack the administrative infrastructure to bill Medicaid, many harm reduction clients are not comfortable providing their name and other information needed to bill Medicaid, and some harm reduction supplies (like syringes and smoking supplies) [cannot be purchased with federal funds](#). CMS should consider creating optional reimbursement pathways and demonstration models that account for these challenges, along with technical assistance on braiding State Opioid Response funds with Medicaid funds.
- **Develop a cost allocation methodology for naloxone.** Naloxone is a medication that reverses the effects of opioid overdoses. [Statistical modeling has suggested](#) that approximately 21 percent of opioid overdoses could be prevented if naloxone were highly distributed among laypersons and emergency personnel. Although Medicaid can cover naloxone when it is prescribed to an individual, many states have implemented low-barrier naloxone distribution programs where it is difficult to gather insurance information. CMS should provide states with technical assistance on developing cost allocation methodologies to allow for

reimbursement of naloxone in situations where individual insurance information cannot be collected. Alternatively, the federal government could explore bulk purchasing naloxone and distributing it to states.

- **Create pathways for states to fund contingency management and other innovative treatment modalities.** Methamphetamine use (along with other stimulant use) has [sharply increased](#) in recent years. Contingency management – a treatment modality in which individuals are given money, vouchers, or other rewards if they meet treatment goals – has been shown to be [highly effective](#) for treating stimulant use. There may be [federal barriers](#) to Medicaid reimbursing for these types of incentives, as payments to Medicaid members may violate federal anti-kickback statutes. CMS should clarify these legal questions and create optional pathways for states to reimburse for contingency management and other innovative therapies.
- **Increase access to buprenorphine, methadone, and other medications for opioid use disorder (MOUD).** At the start of the COVID-19 pandemic, the Drug Enforcement Administration and SAMHSA [enacted flexibilities](#) around methadone and buprenorphine prescribing to ensure access and reduce the risk of COVID-19 transmission. These flexibilities, which expanded the ability of providers to use telehealth for treatment initiation and follow-up visits and allowed for longer “take-home” doses of methadone, should be preserved long-term.

Ensuring Access to Inpatient Care and Specialty Care

Although integrating behavioral healthcare into primary care settings is essential, there are also times when specialty care or inpatient care are clinically indicated. Ensuring access to a full continuum of care – including inpatient care – is crucial to addressing our country’s behavioral health needs. To help meet the full spectrum of behavioral health needs, HHS should:

- **Lift the 15-day monthly limit on managed care “in lieu of services” payments for IMDs.** Due to the IMD exclusion, Medicaid programs generally cannot receive federal match for Medicaid services provided to patients in inpatient or residential behavioral health facilities with more than 16 beds. The 2016 CMS final managed care rule [included an exemption](#) that allows capitated managed care organizations to cover IMDs through the “in lieu of services” authority. However, there is a 15-day limit per calendar month on this authority, resulting in administrative maneuvering for patients who need longer stays, including delaying admission so that the stay spans multiple months or prorating managed care payments. CMS should consider pathways to extend or waive this monthly limit, allowing clinicians to make appropriate decisions about medically necessary lengths of stay.

- Address barriers to 1115 waiver uptake for serious mental illness (SMI).** CMS has created 1115 waiver pathways to provide inpatient services for substance use disorder (SUD) and serious mental illness (SMI). Although most states ([33 states approved; 4 states pending](#)) have taken up the substance use option, a much smaller number ([8 states approved, 8 states pending](#)) have taken up the SMI option, potentially limiting access to care. CMS should examine the reasons for this disparity and address barriers to state uptake, including complex administrative requirements and budget neutrality rules. States also report that the reporting protocols for the SUD and SMI 1115 waivers are administratively burdensome; CMS could instead leverage T-MSIS or the Behavioral Health Core Set. Some states note that their SMI waiver special terms and conditions (STCs) include a lack of availability of federal match for stays over 60 days, without a parallel requirement for their SUD waiver. CMS should make federal match available for SMI stays over 60 days, which are sometimes clinically necessary.
- Address challenges implementing certified community behavioral health clinics (CCBHCs).** Certified Community Behavioral Health Clinics (CCBHCs) are one model of specialty care that provide timely access to services and robust coordination with social services and the justice system. CCBHCs are required to use a [prospective payment system](#), such that clinics are paid a daily or monthly reimbursement rate intended to cover the full cost of care. States have reported that the prospective payment system (including challenges accurately determining appropriate rates) and challenges accessing quality data can limit uptake by state Medicaid programs. Additionally, the lack of a sustainable funding mechanism presents serious concerns for state Medicaid programs; Medicaid will face a “fiscal cliff” when SAMHSA grants that support CCBHCs expire. CMS should also explore providing guidance on payment methodologies for value-based behavioral health models beyond CCBHCs.
- Develop an assessment and decision support tool for mental health.** The American Society of Addiction Medicine (ASAM) has developed a [patient assessment and treatment recommendation guide](#) for substance use disorder that presents clear guidelines on the levels of care comprising the continuum of addiction treatment, standards for each level of care, treatment placement, length of stay, and transfers or discharges. This guide is widely used by payers, but no similar national tool exists for mental health treatment decisions. In the absence of a national tool, some states have developed their own mechanisms to determine level of care, but other states report challenges accurately defining levels of treatment and placement needs, especially for patient with mild to moderate symptoms. HHS should work with external partners, including clinical associations, to explore the development of a national tool to address these gaps. In the absence of a clear clinical consensus on appropriate levels of care and treatment placements, HHS should work with researchers, including those at the National Institutes of Health. As with the ASAM criteria, the use of any

resulting mental health patient assessment and treatment recommendation guides should be optional for payers, including Medicaid.