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# Unlocking Transformation and Healing: Community-based Care Policy Options for Accessible Youth and Young Adult Mental Health Care

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## CLASP

Policy solutions that work for low-income people

## Unlocking Transformation and Healing: Background

The Center for Law and Social Policy's (CLASP) youth and young adult mental health framework calls for policies that increase access to healing, transformative mental health supports for this population.<sup>1</sup> Through our Policy Advancing Transformation and Healing (PATH) initiative, CLASP has collaborated with partners over 2019 and 2020 to test this framework, advancing systems and policy changes supporting well-being for transition-age youth (ages 16-17) and young adults (ages 18-25). **We identified a set of policy options with broad applicability and strong potential to increase access to transformation and healing for economically marginalized young people.**

***Today, too many young people can't get the mental health care they need.***

In 2018, nearly 1.1 million young people had trouble obtaining mental health services. These challenges are the result of decades of failed policymaking that has created barriers, rather than clearing pathways, to care. Ill-conceived policies have reduced access to convenient, comprehensive care by creating obstacles to community-based services and supports. As a result, seventy percent of adolescents with mental health needs do not receive needed care.<sup>2</sup> While cost and confidentiality concerns limit access to care, factors such as social stigma, provider shortages, and fragmented systems also act as hurdles. For example, nearly half of Generation Z and two in five millennials indicated they feared social stigma if they sought mental health services.<sup>3</sup> More than 15 million young people have a mental health disorder, but there are only 8,300 child psychiatrists.<sup>4</sup> By 2025, the shortage of mental health providers will be even more significant.<sup>5</sup> Access to care in community-based settings is cited by youth and young adults as essential to overcoming

stigma and responding to provider shortages in low-income communities.<sup>6</sup>

Evidence also illustrates the harm of keeping mental health separate from other medical services. In a survey conducted by the National Council for Behavioral Health, nearly one in three respondents wanted to access mental health care but didn't know where to go. This percentage is higher among individuals with low-incomes who are less likely to access services at a specialized mental health clinic.<sup>7</sup> The number is likely even greater for young adults with low-incomes, who often have the added barrier of navigating the health care system for the first time.

***States can clear a path for youth to access mental health services by adopting three effective solutions: advancing telehealth, investing in school-based care, and improving care integration.***

Providing services in settings that are familiar to young people can help reduce stigma, improve easy access, and integrate systems. This brief details several policy options to improve care access by increasing the availability of treatment in the settings that young people prefer. These environments can be virtual, as in telehealth, or physical, such as school-based mental health centers and integrated care settings. **The following policy solutions expand virtual and community-based access to care and are particularly effective for meeting the needs of youth and young adults.**

## Telehealth

### *What is Telehealth?*

Telementalhealth (TMH) is a broad term referring to the provision of mental health care at a distance. The distance involved can extend beyond geography to include:

- Temporal: Asynchronous services that are not provided in real time
- Economic: Expense associated with in-person services
- Cultural: Language, acceptability
- Psychological: Stigma, discomfort, or
- a combination of all these factors

TMH includes a wide range of applications, providers, and settings, and can incorporate mental health assessment, treatment, patient education, monitoring, and collaboration with primary care physicians.<sup>8</sup> As of early 2018, 95 percent of Americans had a cell phone. The widespread adoption of mobile technology has created opportunities to engage children and families in therapy and facilitate peer connections, extending the reach of services that were previously only available in person.<sup>9</sup>

***Telehealth has proven to boost youth and young adults' access to mental health care in a cost-effective way.***

Researchers have built a compelling body of evidence for the efficacy of telehealth for mental health service provision, particularly for youth and young adults. Studies document high feasibility and acceptance of TMH interventions,<sup>10</sup> improved help-seeking behavior in adolescents, and equal or better outcomes when compared with traditional, office-based therapies.<sup>11</sup> Nevada's TextToday pilot program was the nation's first crisis lines with the capacity to accept text messages. An evaluation of the text line noted both an increase in help-seeking behaviors by youth and a preference for this method of communication among their age cohort.<sup>12</sup> TMH improves access to care in rural areas, and can effectively

support other intervention strategies, such as school-based health centers and mobile crisis and stabilization services.

TMH is also cost-effective. With it, states can dramatically improve access to mental health care for youth and young adults at relatively low cost. App-based telehealth and telehealth by text are, at scale, significantly less expensive than traditional outpatient services and are responsive to several needs articulated by transition-age youth. Expanding access to these services can achieve a high impact with fewer financial resources than other means. TMH is a sound investment as conversations with youth stakeholders around the county indicate that young people overall view expanded access to app-based and text-capable telehealth as a high priority.

## **Key Consideration: Medicaid Reimbursement**

### **Current reimbursement policy landscape**

Generally, state laws only permit Medicaid reimbursement for telehealth provided through real-time video. Until recently, fifty states and Washington, DC permitted Medicaid reimbursement for real-time video; fourteen states permitted Medicaid reimbursement for “store and forward,” which involves asynchronous (not in real time) capturing and secure sharing of information including digital medical records, photos, or videos. Twenty-two states permitted Medicaid reimbursement for remote patient monitoring. Thirty-four states had parity laws requiring private insurance coverage of TMH. While these laws help improve access to some kinds of TMH, they have also prevented Medicaid reimbursement for several modes of TMH, including telehealth by text, app, and phone.

### **Recent regulatory innovations are working for young people**

In response to the COVID-19 pandemic, the Center for Medicare and Medicaid Services (CMS) loosened restrictions on telehealth in Medicare. As a result, several states have enacted emergency waivers or passed legislation to increase access to TMH in both private insurance and Medicaid. Many states have relaxed licensing requirements to allow new professionals to operate by telehealth (i.e. peer support specialists), eased rules about use of technology that does not meet privacy standards, or both. Several states have also expanded access to reimbursement for app-based mental health care in the private insurance market. Although these changes have been driven by the pandemic, there are anecdotal signs that many youth and young adults view these options as their preferred treatment approach.

States that have already expanded access to telehealth in response to the COVID-19 pandemic should consider codifying the changes and making them permanent. In doing so, state policymakers should ensure that new laws and regulations support reimbursement parity and maximize flexibility in terms of:

- licensing requirements for telehealth providers to include peer support specialists;
- originating sites to include community-based locations; and
- currently available and future forms of technology.

### **State Spotlight: Maryland**

Maryland passed emergency legislation during the COVID-19 pandemic, the Telehealth Mental Health and Chronic Condition Management Services Coverage and Pilot Program. The legislation redefined telehealth as “the use of interactive audio, video, or other telecommunications or electronic technology,” opening up reimbursement for telehealth by phone, text, and app.<sup>13</sup> In making telehealth more flexible, more people enrolled in Medicaid will be able to access services. Maryland’s new definition of mental health telehealth is permanent; it does not expire when the pandemic ends.

## Youth and Young Adult Centered Implementation

To best meet the needs of youth and young adults, states should update their Medicaid telehealth reimbursement policies to ensure:

- Licensing requirements for telehealth providers include the full range of provider types that young people value, including peer support specialists.
- Telehealth definitions are broad enough to include both currently available and future forms of technology; relevant laws and regulations should follow Maryland’s model and allow for “other telecommunications and electronic technology.”
- The elimination of origination site requirements that dictate that providers must originate telehealth services from an “office.”
- Both synchronous and asynchronous care, as well as individual and group care are permissible by telehealth.
- Reimbursement schemes that create parity with in-person services and recognize the up-front costs of investing in appropriate technology infrastructure.

## School-Based Mental Health

### What is School-Based Mental Health?

School-based mental health encompasses both health services available at on-site centers and health supports integrated into the school’s programming. Young people are six times more likely to complete mental health treatment in schools than in community settings.<sup>14</sup> The National Center for School-based Mental Health (NCSMH) identified core features of comprehensive school mental health systems. The list includes: well-trained educators and specialized instructional support personnel, family-school-community collaboration and training, needs assessment and resource mapping, mental health screening, and funding.<sup>15</sup>

School-based health centers (SBHCS) represent a promising strategy to provide all individuals with necessary health care services. Recognizing this potential, lawmakers increased their funding under the Affordable Care Act (ACA). SBHCs can serve students at high risk of missing needed health services. An interdisciplinary team of health professionals, which can include both physical and behavioral health clinicians, provide young people with health care on-site.<sup>16</sup> Expanded school-based mental health care integrates mental health into multiple aspects of the school setting, generally through a three-tiered system. The first tier focuses on prevention and aims to reach all students.

#### TIER 1 SUPPORTS<sup>17</sup>

- Adopt K-12 social-emotional learning (SEL) standards
- Implement universal mental health screenings or wellbeing check-ups
- Institute mental health literacy for all programs
- Find funding streams to support intervention and prevention



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### State Spotlight: New Mexico<sup>18</sup>

New Mexico has a particularly robust SBHC system, administered in part by the New Mexico Alliance for School-Based Health Care (NMASBHC). NMASBHC defines SBHCs as providing “quality, integrated, youth-friendly, and culturally responsive health care services to keep children and adolescents healthy, in school, and ready to learn.” They further define the characteristics of an SBHC as follows<sup>19</sup>:

- Services are available to the broader community;
- Student privacy is protected through student-only hours and a separate waiting room;
- Strong partnerships with education, health, and youth serving agencies;
- Robust student engagement;
- Care is culturally responsive, confidential, and developmentally appropriate; and
- Have a robust sponsoring agency who provides funding and fiscal management, health infrastructure (medical oversight, health information technology, medical equipment, liability insurance), and sound business practices.

### Key Consideration: Financing School-based Health

Because school-based health aims to serve all students, regardless of insurance or ability to pay, it faces persistent funding and sustainability challenges. On average, an SBHC will bill four different patient revenue sources, which will cover one-third of program costs. Fee-for-service is the standard payment method for SBHCs, but some sites receive capitated payments (per person per month), or “pay for performance” supplements tied to population outcomes.

Comprehensive programming cannot rely on a fee-for-service model because many necessary services, including cultural healing practices and tier one preventative interventions, are not Medicaid reimbursable. For non-reimbursable educational and preventative services, school mental health systems can get funding through legislative earmarks, federal block and project grants, state or county funding, fee-for-service revenue from third-party payers, and private foundations.<sup>20</sup>

### **States can look to existing, creative approaches to ensure financial sustainability**

School-based health should be funded through a diverse donor base, including public and private insurers and foundation support. States should also consider developing state associations to help fund and manage school-based health and work to identify appropriate sponsors in the state.<sup>21</sup> For example, Wisconsin uses a braided funding model aligning large-scale investments from three federal sources to allow over 100 schools to receive mental health professional development, technical assistance, and coaching.<sup>22</sup>

## Youth and Young Adult Centered Implementation

For school-based health to have the most positive impact on transition-age youth, we have identified three key recommendations:

- **Access:** Services should be accessible to students, families, and communities. Centers should have weekend, evening, and summer hours or ensure students know where to access after-hour care.
- **Funding:** Services should be available to all, regardless of insurance coverage. To achieve this, SBHCs need diverse funding streams with a focus on expanding coverage and reimbursement when possible.
- **Partnerships:** SBHCs should have strong partnerships with Federally Qualified Health Centers (FQHCs), Behavioral Health Organizations (BHOs), providers, schools, students, and communities. SBHCs should also utilize national, state, and local resources to strengthen their infrastructure and array of services.

## Mental Health-Physical Health Integration

### What is Integration?

Mental Health and Physical Health integration is the delivery of services, whether mental, behavioral, or physical, so people receive a continuum of preventive and curative care according to their needs over time and across different levels of the health system.<sup>23</sup> This model contrasts to common practices that split our health needs into separate categories (medical, mental, dental), requiring we see a range of different providers at different times in different places.

**States can advance integrated care models to better meet young people's holistic needs while lowering costs**

Youth and young adults prefer integrated care,<sup>24</sup> which has been shown to meet Medicaid's "triple aim" or gold standard for services: it can improve patient outcomes, decrease cost, and increase the quality of care. Integrated physical and behavioral health care ensures that youth and young adults receive holistic care, so they can transition into adulthood in good health.

Integrating the physical and mental health care systems requires several state-level decisions. They include:

- determining effective regulatory and finance mechanisms;
- developing an integrated health care infrastructure, including cohesive information systems and adequate provider networks; and
- planning for successful implementation.

Each of these areas is examined below.

### Key Consideration: Authorization and Structure

#### Regulatory options to authorize integration

State-initiated integration efforts can be authorized using several regulatory mechanisms. These mechanisms include 1115 Medicaid Demonstration Waivers; Medicaid State Plan Amendments (SPAs); and newer options created by the Affordable Care Act (ACA), such as Health Home and Patient Centered

Medical Home SPAs.<sup>25</sup> Most states that have implemented state-initiated physical-behavioral health integration have done so using SPAs.

### Common ways to structure integrated models of care

The Center for Medicare and Medicaid Services (CMS) has identified several options to structure integrated physical and behavioral health. Strategies include having either the Managed Care Organizations (MCOs), Primary Care/Physical Health entities, or Behavioral Health Organizations (BHOs) as the lead or developing an equal partnership among these partners.<sup>27</sup>

Each model has strengths and weaknesses. When state-level integration efforts focus on people who have serious mental illness (SMI) or children with serious emotional disturbance (SED), integration is usually structured with the behavioral health organizations as lead. When integration efforts target broader populations of people enrolled in Medicaid, the other structures are more typical. The most common arrangement for broad populations designates MCOs as the lead; integrating behavioral health into primary care (promising from a prevention standpoint) is less common and equal partnership arrangements least common.

#### State Spotlight: Vermont

The Vermont Blueprint for Health<sup>27</sup> is a statewide multi-payer initiative with dual goals: It aims to turn primary care practices into patient centered medical homes (PCMHs) that provide mental health services. It also seeks to support community health teams (CHTs) in offering multidisciplinary care coordination and support services. The Blueprint is increasing the primary care system's capacity to treat people facing mild to moderate behavioral health issues such as depression and anxiety. For individuals with greater needs, the initiative is enabling better collaboration between the primary care and specialty mental health systems. Vermont pooled funding across multiple agencies/sectors. It has supported a broad and flexible array of services, particularly to address the social determinants of health — community conditions that are often decisive for health outcomes.

### Cornerstones of effective integration

CMS has identified 5 cornerstones of effective behavioral-physical health integration.<sup>28</sup> They include:

1. Aligned financial incentives across physical and behavioral health systems: Historically, payment has been one of the biggest barriers to effective physical-behavioral health integration.<sup>29</sup> States have adopted a number of approaches to improve financial alignment, including carving-in behavioral health in the context of managed care (where the same managed care entity is responsible, either directly or through contracts, for physical and behavioral health), per member per month capitated payments instead of fee for service (FFS) (sometimes with a risk adjustment/enhanced payment for individuals with serious mental illness), parity enforcement, and same-day billing policies. Aligning financial incentives across physical and behavioral health systems is critical to comprehensive integration.
2. Real-time information sharing across systems: Many states have identified data collection and the

use of information systems as critical components of their integration efforts.<sup>30</sup> When done effectively, these efforts can ensure that relevant information is available to all members of a care team.

3. Multidisciplinary care teams that are accountable for coordinating the full range of medical, behavioral, and long-term supports and services as needed: A consistent theme among states with established integration efforts is the importance of peer support, care managers, and navigators.<sup>31</sup> Several states, such as Arizona, Florida, and Iowa, explicitly built peer support into their range of integrated services to address wellness, recovery, and prevention goals.
4. Competent provider networks: States with existing integration initiatives have emphasized the value of allowing time to develop a comprehensive provider oversight system. For example, to monitor the quality of services provided, Kansas' comprehensive oversight methodology requires on-site reviews, internal systems validation and survey work, performance improvement plan monitoring, and review of submitted reports. In addition, to help ensure there are enough providers offering services in the community, Texas requires monthly reports from health plans on the number of network providers who offer mental health rehabilitative and targeted case management services.
5. Mechanisms for assessing and rewarding high quality care: States that have established physical-behavioral health integration initiatives typically identify a set of measures across both health domains to track health results, behavior changes, and costs. Some of the commonly tracked outcomes, such as emergency room visits, Body Mass Index (BMI), and outpatient visits are highly relevant for transition age youth. Others, such as high blood pressure and chronic condition hospital admissions may be less relevant for youth and young adults. In order to effectively reward high quality integrated care for youth and young adults, states need to identify outcome assessments with relevance to transition age youth. In Iowa, the state documented demonstrated improvements in the Quality Caregiver Survey (QCS), which tracks medical, school, family, economic, psychological, and legal issues.<sup>32</sup> As another example, Kansas has used selected metrics from the National Outcomes Measurement System (NOMS) to assess certain social determinants of health, such as employment status and housing.<sup>33</sup>





## Youth and Young Adult Centered Implementation

To maximize the strengths of state-level physical-behavioral health integration for youth and young adults, and to address potential challenges, state policymakers should address these additional decisions:

- **Should our integration initiative focus on young people with serious mental illness/serious emotional disturbance, or serve transition age youth broadly?:** A key decision point that state leaders face is whether to develop a single integrated system or multiple, specialized systems of care for subsets of people in need.<sup>34</sup> Although many MCO-led integration efforts focus on SMI/SED, Hennepin County in Minnesota, and statewide services in Massachusetts, Tennessee, and New York serve broad populations of people who are enrolled in Medicaid.
- **Should our state advance full integration immediately, or phase-in integration efforts across the integration continuum?:** Before implementing full-scale integration, some states first have phased-in integration efforts. Such early steps may focus on increasing care coordination or expanding co-location of services.
- **Should our state implement integration statewide or pilot in select regions?:** Larger states, and those with larger populations, such as New York, Arizona, or Texas, often started their integration efforts in select regions, expanding statewide over time. Other states with smaller populations, like Kansas, or a longer history of managed care, as with Tennessee, have gone straight to statewide implementation.
- **Should our state's integration program requirements be highly prescriptive or more flexible?:** State partners have indicated that initial program requirements should clearly reflect the state's policy goals, and allow plans the space to develop innovative approaches. At the same time, plans can be very prescriptive in a few key areas that include: providing continuity of care requirements to safeguard beneficiaries during program transitions; having clear rules for sub-contracting Behavioral Health Organizations (BHOs) that foster coordination; and specifying regulations for care coordination and administrative data collection.
- **How can our state ensure stakeholder buy-in?:** State and health plan leaders have noted that they often underestimated how much work it would take to create buy-in for a program that merges two (or more) systems into one. They recommend that states develop a comprehensive, overarching approach to stakeholder engagement. To be successful, states should focus targeted engagement efforts on specific providers as needed during the program design and early implementation phases.<sup>35</sup>
- **How will our state support necessary infrastructure and technical assistance?:** Providers in different systems can have widely varying levels of familiarity with Medicaid billing, electronic health records, and shared data systems. Some state partners have observed that they sometimes misjudged the learning curve for providers, particularly community based and social services providers.<sup>36</sup> States must develop a strategy to assess the existing provider network's readiness for integration and use this information to inform on-going planning and technical assistance.

## Policy Recommendations: Community-based Care

State policymakers can ensure young people access the community-based mental health care they need by adopting the strategies outlined above: expanding telehealth, investing in school-based health, and ensuring the effective integration of mental and behavioral health services. The following are specific policy solutions to expand youth access to care:

- Expand telehealth access and codify regulations that expanded telehealth for mental health services in many states in response to the COVID-19 pandemic to ensure that this expanded access becomes permanent.
- Follow the lead of employers and private insurers that are incorporating app-based mental health into their services so that young adults enrolled in Medicaid are not left behind.
- Work with school systems to ensure school-based services are available to the broader community, including out-of-school youth and young parents.
- Expand hours of SBHCs to include youth friendly after-school, weekend, and summer hours. Ensure students and community members know how they can access services if the school is closed.
- Partner with a strong and supportive sponsoring agency, such as FQHCs, BHOs, universities, or other qualified entities to maximize Medicaid reimbursement. These partnerships free up limited county and philanthropic dollars to serve uninsured students.
- Ensure the school system maximizes access to federal dollars. Schools can do so by becoming a Medicaid provider that can bill the agency directly, or by participating in the Medicaid School-Based Services program. This program covers care for students with an Individualized Education Program (IEP) but can also help cover administrative costs for all students.
- Leverage national and state-level resources and trainings that are offered through organizations like NCSMH, School Based Health Association (SBHA), among others, to expand school-wide tier-one level supports.
- Develop strategies to successfully integrate mental and behavioral health services with physical health care. Planning should include taking care to effectively engage stakeholders; to assess how prepared the existing provider network is for integration; and to make decisions about integration models and strategies. Policymakers can use this information to inform on-going planning and technical assistance.

## Conclusion

State and local policy makers can reshape the mental health policy landscape for youth and young adults, to one that advances their transformation and healing. The goal in such a system is to change young people's lives by acknowledging the threats they experience and taking action to reduce them. **Policy choices must facilitate access to life-changing supports, or risk perpetuating further harm.**

Community-based care represents a key policy area where changes can make a meaningful difference for youth and young adults. Equitable access to care requires taking steps to maximize youth and young adults' access to convenient, comprehensive care in the settings they prefer. By exercising the options outlined in this brief, state and local policymakers can ensure that virtual, school-based, and integrated care settings are widely available and accessible.

As documented throughout this brief, some states have exercised each of these options, but none are universal. State and local leaders can immediately review their existing policies in these areas and look for

opportunities to strengthen them to increase equitable access to care for youth and young adults. Adopting the recommendations outlined in this brief will help ensure that state and local mental health policies create pathways to transformative, healing experiences for young people who need them most. In doing so, we can advance a future that supports youth and young adults' mental health, well-being, and healing on a national scale.

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