National MLTSS Health Plan Association

Bridging the Divide: Integrating Long-Term Services and Supports and Behavioral Health Care

BACKGROUND: Defining Behavioral Health and Long-Term Services and Supports

Behavioral health (BH) encompasses mental health conditions such as anxiety, depression, and psychotic disorders, as well as substance use disorders (SUD) such as opioid addiction. In 2023, 84.7 million adults experienced a mental illness or substance use disorder (SUD) over the previous 12 months, totaling 33% of all American adults and 44% of adults who receive Medicaid.[1]

Medicaid plays a key role in financing BH care nationwide. People with behavioral health needs, and especially individuals with Serious Mental Illness, may qualify for Medicaid based on their disability status. In most states, if an individual qualifies for Supplemental Security Income (SSI) on the basis of mental illness they are automatically eligible for Medicaid. In 2020, almost 40% of the nonelderly adult Medicaid population had a mental health or substance use disorder (SUD).[2]

Long Term Services and Supports (LTSS) help individuals with functional support needs perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), either at home, in community-based settings, or in institutional care. LTSS includes the full spectrum of services that individuals with disabilities and older individuals need to thrive and live independently, including medical and non-medical services, such as bathing, dressing, and medication management. Individuals with behavioral health needs may also require Medicaid home and community-based services (HCBS), such as supported employment or supportive housing.

62% of Medicaid enrollees who utilize LTSS services are also enrolled in Medicare ("dually eligible beneficiaries").[3] People who are dually eligible are at higher risk of healthcare complications and institutionalization, therefore higher cost, due to the complex intersection of medical and socio-economic factors.

ISSUE: Many individuals who receive Medicaid-funded LTSS also have significant BH needs and limited BH treatment options.

Average annual Medicaid spending is twice as high for non-elderly adult enrollees with any mental health diagnoses compared to those without a mental health diagnosis (approximately $14,000 vs. $7,000 per enrollee per year).[4]

These substantial BH needs disproportionately affect certain Medicaid sub-populations, including:

- *Washington State (unpublished data):* Washington State found that **1 in 7 participants in their LTSS program has a diagnosis of a psychotic disorder**, compared to less than 1% of the national population. Of working-age beneficiaries receiving LTSS in 2018, 22% were diagnosed with mental illness and 14% with opioid use disorder. Among Medicare beneficiaries greater

[1] Medicaid's Role in Mental Health Care | Commonwealth Fund
[2] Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs | KFF
[3] Who Uses Medicaid Long-Term Services and Supports? | KFF
[4] 5 Key Facts About Medicaid Coverage for Adults with Mental Illness | KFF

than 65 years of age, entry into Medicaid LTSS recipiency was significantly correlated with depression, schizophrenic/psychotic disorders, and alcohol use disorder.

- *Dually eligible beneficiaries:* In 2022, **64% of dually eligible beneficiaries had at least one mental health diagnosis**.[5] Over 20% of dually eligible beneficiaries had an SMI diagnosis in 2019.[6]
- *Nursing home residents:* BH needs are a strong predictive factor of nursing home (NH) placement. Around **40% of long-term NH residents under 65 with Medicaid have a SMI**.[7] New NH admits are more likely to become long-term residents if they have a SMI.[8]

In 2020, mental health facility expenditures accounted for 5.6% of total institutional LTSS spending. National mental health facility spending increased by 18.5% between 2019 and 2020.[9] These significant expenditures underscore the need to better integrate BH services into Medicaid LTSS programs.

SOLUTION: Include LTSS in BH integration proposals

The vast majority (75%) of all Medicaid beneficiaries are enrolled in comprehensive managed care, making Medicaid managed care organizations (MCOs) an ideal structure for integrated care.[10] Over the last decade, states have been moving to integrate BH with other managed benefits—with the number of states providing integrated programs growing from only a handful to 16 states by 2016 and at least 31 states by 2023.[11,12]

States have seen success with a wide range of integration efforts, including provider-level data sharing, accountability for quality, and aligned incentives for care coordination. Integrated care products offer **opportunities for shared savings**, **improvements in clinical outcomes**, **and reduced health disparities**.[13,14,15,16] Many BH integration policy proposals - including establishing core service and quality standards, incentivizing integration through new and existing payment models, and expanding and training the workforce for integrated teams - are applicable to broader integration goals.[17] Any movement towards whole-person care must include the incorporation of both behavioral health care and LTSS to improve outcomes and quality of care.

Given that the vast majority of individuals who use LTSS are also dually eligible beneficiaries with complex health care needs, Medicare-Medicaid integration proposals also have implications for

[5] A Profile of Medicare-Medicaid Dual Beneficiaries | ATI Advisory
[6] A Profile of Medicare-Medicaid Dual Beneficiaries | ATI Advisory
[7] Quality Concerns in Nursing Homes That Serve Large Proportions of Residents With Serious Mental Illness | *The Gerontologist*
[8] Predictors of Nursing Facility Entry by Medicaid-Only Older Adults and Persons With Disabilities in California | INQUIRY
[9] Medicaid Long Term Services and Supports Annual Expenditures Report, Federal Fiscal Year 2020 | CMS
[10] 10 Things to Know About Medicaid Managed Care | KFF
[11] Integrating Behavioral Health into Medicaid Managed Care: Lessons from State Innovators | Center for Health Care Strategies
[12] Increasing Access to Behavioral Health Services: Opportunities at the State and Federal Level | NASHP
[13] Impacts of an Integrated Medicaid Managed Care Program for Adults with Behavioral Health Conditions: The Experience of Illinois | Administration and Policy in Mental Health and Mental Health Services Research
[14] Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration | Bipartisan Policy Center
[15] Medicaid Managed Care Strategies to Reduce Racial and Ethnic Health Disparities in Mental Healthcare for Adults | Robert Wood Johnson Foundation
[16] Use of behavioral health care in Medicaid managed care carve-out versus carve-in arrangements | Health Services Research
[17] Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration | Bipartisan Policy Center

improved BH care. FIDE-SNPs offer the highest level of integration for these members with more intensive care and support needs.

POLICY RECOMMENDATIONS: Charting a path towards BH-LTSS integration

Promote Medicaid Integration of LTSS and Behavioral Health in Managed Care Contracts	Problem: Medicaid beneficiaries with complex behavioral health and LTSS needs are often subjected to fragmented care, lack of behavioral health services, inflating costs and worsening health outcomes. There are opportunities for improvement both in states that already integrate their LTSS and behavioral health services, and especially in the remaining states that do not. Opportunities: • Through 42 CFR §438, incentivize states to include integration requirements in managed care contracts. Mechanisms could include tying rate add-ons or achievable, actuarily-sound quality withholds to shared BH-LTSS care planning and metrics, as well as mandating interdisciplinary care teams and data-sharing capabilities in MCO performance requirements. • Issue a sub-regulatory guidance clarifying how states can use 1915(i), 1915(c), or 1115 authorities to blend BH and LTSS funding. ○ State Example: Washington State received CMS approval for a 1915(i) State Plan Amendment (SPA WA-24-0001), effective July 1, 2024, establishing Community Behavioral Health Supports (CBHS) under its HCBS benefit. This new program enables supplemental behavioral health staffing, such as supportive supervision, within LTSS/HCBS residential settings, blending behavioral health funds with traditional LTSS/HCBS payments but keeping them separate for accountability – a structure known as “braided funding." Although Washington currently operates this model outside of managed LTSS, integrating CBHS into its MLTSS framework (i.e., by incorporating it into managed care contracts) could enhance care coordination, accountability, and outcomes by aligning funding streams, care planning, and provider oversight. Expected Impact: Shifting care coordination incentives and braiding BH and LTSS funding within MCO contracts could reduce costs associated with hospitalization and nursing home stays, building upon CMS’ commitment to administrative efficiency and cost containment.

Launch Joint Workforce Development Initiative and Address Shortages	Problem: As of 2025, 123 million Americans live in areas designated as Mental Health Professional Shortage Areas (HPSAs).[18] Mental Health HPSAs are designated based on: low provider-to-population ratios (often less than 1 provider per 30,000 people), the percent of individuals under 100% of the poverty level, and average travel time to the nearest provider, among other criteria.[19] Concurrently, the LTSS direct care workforce is also experiencing significant shortages. The direct care workforce is estimated to grow by 860,000 new jobs between 2022 and 2032, and demand for LTSS and direct care workers only continues to rise. Opportunities: • Develop shared certification pathways and competency standards through HRSA and SAMHSA for cross-training direct care/LTSS and BH providers. • Revisit dated policies that hinder providers' ability to practice across state lines. • Make pandemic-era telehealth and remote controlled-substance prescribing permanent within Medicaid. • Issue guidance for Medicaid reimbursement for integrated BH-LTSS roles. Expected Impact: Amplified provider availability across BH and direct care sectors, allowing for greater care coordination and career ladders with upper-level certification options.
Strengthen Data Integration and Sharing	Problem: CMS interoperability regulations do not require states to connect LTSS and BH care providers. LTSS and BH data systems remain siloed, particularly among community-based providers, who often lack certified EHRs or technical infrastructure. These data gaps impede care coordination and the proactive identification of individuals with co-occurring LTSS and BH needs, resulting in fragmented care and inefficient use of Medicaid resources. Opportunities: • Require states to expand their interoperability strategies to explicitly include BH and LTSS provider networks, particularly those in home- and community-based settings. • Leverage HITECH and Medicaid IT funding to incentivize integration across sectors. • Establish minimum data-sharing expectations for BH and LTSS providers in Medicaid MCO networks, with aligned incentives for data exchanges.

[18] Health Workforce Shortage Areas | HRSA

[19] PCO Guidelines for Creating Health Professional Shortage Area Applications for Mental Health | CT General Assembly

	• Encourage use of shared care planning tools and care coordination platforms that connect LTSS and BH providers through existing state HIE infrastructure. Expected Impact: Enhanced BH-LTSS data integration would contribute to improved care coordination, earlier identification of at-risk individuals, and a more efficient allocation of resources across health systems.
Aligning County- and State-Based Services	Problem: States frequently decentralize LTSS and BH administration to county or regional levels, resulting in inconsistent eligibility standards, fragmented assessments, and duplicative processes across jurisdictions. Although some states have taken action to unify administration across jurisdictions, federal guidance is needed. Opportunities: • Issue guidance to states stipulating that managed LTSS plans and BH authorities must implement consistent eligibility, assessment, and data-sharing protocols across jurisdictions. • Disseminate best practices based on states' experiences. Expected Impact: Standardizing LTSS and BH administration could reduce service disruptions, enhance cost-efficient integrated care, and encourage the development of unified assessment, care coordination, and billing protocols across jurisdictions.
Promote Levels of Care that Allow Individuals to Stay in their Community, such as Intensive Outpatient Services (IOP)	Problem: Individuals with behavioral health needs, including dually eligible individuals, frequently end up in hospitals, long-term institutions, or receive no care at all due to limited community-based supports and gaps in Medicare coverage for behavioral health services. This disrupts their daily lives, separates them from their support networks, and drives up overall health care costs. Opportunities: • 42 CFR 422.116 requires D-SNPs to meet network adequacy standards for behavioral health providers offering IOP and other outpatient services. CMS could require states to embed these standards into their SMAC to ensure timely access to care. • Expand Medicare telehealth flexibilities to include IOP services. Under current law, Medicare coverage of IOP is limited to in-person care, potentially excluding individuals in rural areas or those facing barriers to accessing in-person treatment. • Require states to use SMACs to collect and share IOP utilization data with MCOs and providers, reducing care fragmentation and improving coordination with LTSS providers. • Issue guidance encouraging state HCBS programs to use lower-cost, less intensive services like IOP before moving to partial or full inpatient hospitalization, aligning with LTSS goals of maintaining community living.

	Expected Impact: Outpatient services such as IOP play a crucial role in supporting individuals with SMI and SUD. By providing structured, community-based care, these services help individuals maintain stability, preserve independence, and stay connected to their communities. This approach not only enhances the quality of life for individuals but also contributes to healthcare cost savings by reducing the need for more intensive, inpatient treatments.

CONCLUSION

BH and LTSS needs are inextricably linked. States are seeking opportunities to integrate their LTSS delivery and Medicare and Medicaid services through managed care contracts due to the efficacy of these products. As Congress continues to explore integrating BH, it is important to acknowledge that the driving force for this initiative also has implications for the value and urgency of LTSS integration, as well as integrated care products for dually eligible beneficiaries.

For individuals with complex medical, non-medical, and behavioral health needs, the fragmentation of LTSS and BH care contributes to costly and avoidable harm. A growing number of states are leveraging Medicaid managed care contracts to align LTSS and BH delivery systems, recognizing that fragmented care contributes to preventable hospitalizations, institutionalization, and inefficient spending. However, without clear federal support, these efforts remain uneven and limited in scale. Federal guidance is needed to facilitate LTSS-BH integration and support models that advance both quality and fiscal sustainability. Scalable integration will require investment in the healthcare workforce, interoperable data systems, and consistent administrative processes across jurisdictions. With thoughtful Federal leadership, states can build on existing momentum to deliver truly integrated, person-centered care that improves care for individuals with significant care and support needs.