10 State Strategies for Improving Medicaid: Quality, Outcomes and The Bottom Line

By Kristine B. Goodwin

The National Conference of State Legislatures is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories. NCSL provides research, technical assistance and opportunities for policymakers to exchange ideas on the most pressing state issues, and is an effective and respected advocate for the interests of the states in the American federal system. Its objectives are:

• Improve the quality and effectiveness of state legislatures
• Promote policy innovation and communication among state legislatures
• Ensure state legislatures a strong, cohesive voice in the federal system

The conference operates from offices in Denver, Colorado and Washington, D.C.
Introduction

As Medicaid consumes a larger share of state budgets, policymakers seek ways to improve outcomes, reduce costs and make sure their state’s program is managed as efficiently and effectively as possible. While there is no silver bullet, states are adopting a wide array of strategies to reduce spending, improve care outcomes and quality, and provide states with a return on their health investments.

Over its 50-year history, Medicaid has represented an important and evolving issue for state policymakers. Approximately one in five, or 68 million, Americans received coverage through Medicaid in 2017, making it the largest source of coverage for low-income children, pregnant women, adults, seniors and people with disabilities. Although federal law sets Medicaid minimum standards related to eligible groups, required benefits and provider payments, it offers states latitude in decisions about program eligibility, optional benefits, premiums and cost-sharing, delivery system and provider payments. As a result, each state Medicaid program is unique, reflecting that states have options through their state plan amendments or by using Section 1115 waivers to design programs that better meet their needs and priorities. A state plan is an agreement between a state and the federal government describing how that state administers its Medicaid program; waivers give states latitude to deviate from those agreements.

States have adopted a wide range of innovations to improve Medicaid quality and results. States enacted more than 100 Medicaid laws in 2017 aimed at reducing costs and improving outcomes through a variety of delivery and payment reforms, eligibility expansions and Medicaid waivers. The following 10 questions highlight state strategies to address pressing health care challenges and deliver high-quality, cost-effective services to the millions of adults and children who rely on Medicaid for their coverage.

Top 10 Questions

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Overview of Medicaid Enrollment and Spending Trends

The graph in Figure 1 illustrates trends in Medicaid’s share of state budgets between 1989 and 2015. As of 2015, Medicaid accounted for greater than 28 percent of spending from all sources (federal and state funding), almost 20 percent of spending from state general funds, and nearly 16 percent of spending from all state funds (including other dedicated sources of revenue.)

According to a 2017 survey on Medicaid enrollment and spending trends, states projected a decreased rate of enrollment growth from the prior two years, yet a faster rate of spending growth, due to several factors. These include growth in the aged and disabled enrollment groups that account for a larger share of program spending, costly prescription drugs, and provider rate increases. Figure 2 demonstrates the trend in increased state Medicaid spending over time. Among the many challenges facing the program, Medicaid programs deliver complex and costly services for the growing number of Americans with an opioid addiction, described later in this report.
1. What Are States Doing to Introduce New Medicaid Payment Models?

Payment reform offers a powerful tool for controlling health care spending and often supports changes in the delivery system. Traditionally, health care providers have been reimbursed on a fee-for-service basis, which compensates for every service, test or procedure provided. Rather than reward volume, payment reform models seek to reward value and create financial incentives for health care providers. These models reward providers for focusing on primary and preventive care, improving access, and adopting more effective, efficient models of care delivery to improve quality and reduce costs.\(^3\)

The federal government has taken the lead in nudging the payment reform process along. Medicaid and Medicare, by testing different payment systems, including hybrid models that sometimes include fee-for-service, are exerting pressure and negotiating rates at a fraction of the levels used by private plans. The U.S. Department of Health and Human Services (HHS) has set targets of shifting 50 percent of fee-for-service Medicare payments to alternative quality or value payment models by 2018.

Overall, the new approaches typically include financial incentives designed to encourage collaboration and care coordination among different providers, reduce spending on unnecessary services, and reward providers for delivering higher-quality patient care.\(^4\) States can leverage their market power as large purchasers of health care services to create new payment models that may simultaneously contain costs and improve care.\(^4\) According to the National Association of Medicaid Directors (NAMD), some legislatures have required state Medicaid programs to implement payment reform. For example, in 2012, Massachusetts lawmakers passed legislation that required the state Medicaid agency to move 80 percent of its provider payments into alternative payment models by 2015.\(^5\)

State Actions

A 2016 NAMD survey of state Medicaid programs found that “states have committed significant resources to the implementation of alternative payment models.” And, “there is broad movement in Medicaid to transform payment at the provider level away from the traditional fee-for-service (FFS) system, which rewards volume, into alternative models that reward value.” Payment reform strategies are summarized below.

Managed care refers to health care systems that integrate financing and delivering health care services to covered individuals by arrangements with selected managed care organizations (MCOs). Such systems include a comprehensive set of health care services, standards for selecting health care providers, formal programs for ongoing quality assurance, and significant incentives for members to use providers and procedures associated with the plan. As of September 2017, 38 states and Washington, D.C., had Medicaid contracts with MCOs, and 13 states have over 90 percent of their Medicaid populations in MCOs. Nationally, close to 80 percent of the Medicaid population is in managed care, or approximately 62 million people.

Performance-based reimbursements, tied to quality and efficiency metrics, offer incentives for good health outcomes. They also pay for coordination of a patient’s care by a group of providers, such as physicians, nurses and social workers. According to a 2016 survey of state Medicaid directors, at least 12 states provided additional payments in exchange for meeting performance expectations. This model supports systems transformation and high-value services, such as care coordination, that typically are not reimbursed.

DELIVERY SYSTEM REFORM WAIVERS

According to the National Association of Medicaid Directors, several states use a Section 1115 waiver to create delivery system reform incentive payment (DSRIP) programs. The intent of DSRIP is to allow states to use Medicaid funds to support projects designed to transform the delivery system and thereby improve quality of care and patient outcomes, reduce the cost of care, and prepare providers for value-based purchasing. States with a DSRIP program include California, Kansas, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, Texas and Washington.

HEALTH HOMES

The Affordable Care Act established an optional Medicaid State Plan benefit for states to create “health homes” to coordinate care for people with chronic conditions. Health home providers “integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person,” according to the Centers for Medicare & Medicaid Services. With health homes, all of a person’s caregivers communicate with one another and share health records so that all of a patient’s needs are addressed in a comprehensive way. States receive a 90 percent enhanced federal match for health home services, which can include comprehensive care management, care coordination, transitional care, and referrals to community and social support services.

HOME- AND COMMUNITY-BASED SERVICES

Many states are taking steps to adopt Medicaid Home and Community Based Services (HCBS) payment reforms that provide incentives for providers that achieve quality and pro-
Home and community-based services (HCBS) enable people enrolled in Medicaid to receive services in their own home or community rather than in isolated settings or institutions. States can apply for HCBS Section 1915(c) waivers to support certain Medicaid populations, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illness. According to CMS, 47 states and the District of Columbia operate at least one Section 1915(c) waiver.

Bundled payments, also known as episode-based payments, provide a lump sum payment to a group of providers (such as hospitals and physicians) on the basis of expected costs for a clinically defined episode of care (e.g., knee replacement over a 90-day period). A group of providers can enter into a payment arrangement that includes financial and performance accountability for episodes of care. Bundled payments are increasingly used for high-cost procedures, such as cardiac bypass surgery. Less incentive exists to over-treat, since only a certain amount of money is allocated to meet patients’ needs, based on practice standards and other factors. Medicare is partnering with more than 500 hospitals and related health care organizations to make bundled payments for all the care associated with four dozen conditions and procedures, such as strokes and joint replacements.

Global payments are being tested to pay a single health care organization for providing all needed care for a specific population, such as the employees of a large company, or people living in a certain geographic area. Health care providers must meet certain quality criteria, such as offering timely preventive screenings and promptly following up on test results with patients. They receive bonuses if their patients stay healthy and avoid costly hospitalizations. For example, Oregon’s Coordinated Care Organizations are reimbursed for services by a global payment that includes physical health services, such as primary care visits and medical tests, as well as mental health and substance abuse services, dental services, and some long-term services and supports.

Accountable Care Organizations (ACOs) offer a way of both delivering and paying for patient care. Typically, ACOs are a partnership between a payer, such as a private or government insurer, and a network of doctors, hospitals and other providers that share responsibility for providing care to patients. ACOs create savings incentives by offering providers bonuses for efficiencies and quality care that results in keeping their patients healthy and out of the hospital, including focusing on prevention and managing patients with chronic diseases. States with ACOs are shown in Figure 3.

### Strategy State Options and Actions

| Payment and Delivery Reform | • Explore payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs. |
|• Examine the current payment and delivery system and identify opportunities for improving access, quality and efficiency. Some states have appointed commissions or task forces to make recommendations and guide implementation of new payment systems. |
2. What Can States Do to Improve Medicaid Performance and Quality?

State Medicaid programs can leverage their market power as large purchasers of health care services to create new payment models that may simultaneously contain costs and improve care. States have adopted a wide range of innovative strategies to improve the value of their Medicaid programs, from aligning incentives and provider payments with their desired patient outcomes to improving data capacity and transparency.

**DEFINING AND MEASURING QUALITY**

Quality touches all aspects of health care services, their delivery, and the systems through which services are delivered. The Centers for Medicare & Medicaid Services (CMS) define high-quality health care as “effective, safe, efficient, patient-centered, equitable, and timely care.”

As large purchasers of health care, states measure performance to assess value and assure accountability in public coverage programs. Quality measurement is a critical step to assuring access, improving quality, improving patient satisfaction, and reducing unnecessary spending or waste. CMS requires states that contract with managed care organizations to develop a quality measurement strategy, obtain input from enrollees and other key stakeholders, and make the quality strategy available to the public. In addition, CMS developed a voluntary adult and child core set of measures intended to provide a national and state-level snapshot of the quality of care provided to individuals using Medicaid and the Children’s Health Insurance Program (CHIP).

**State Actions**

**PAYMENT AND DELIVERY SYSTEM REFORMS**

To improve quality, states have aligned incentives with their desired outcomes and experimented with new payment models, such as attaching provider payments to patients’ health outcomes. For example, as part of Tennessee’s Health Care Innovation Initiative, TennCare—the state’s Medicaid program—adopted episode-based payment to align provider incentives with achieving a patient’s desired outcome during an episode of care. The payment is available for most procedures, hospitalizations, outpatient care, and some forms of chronic treatment. Some states provide care for Medicaid clients through accountable care organizations, which are designed to help states get the most value for their Medicaid dollars. ACOs create savings incentives by offering providers bonuses for efficiencies and quality care that results in keeping their patients healthy and out of the hospital, including focusing on prevention and managing patients with chronic diseases. (See Section 1 for more information on state payment models.)

Pay-for-performance is a system of payment that rewards health care plans and providers for achieving or exceeding benchmarks for quality of care, health results and/or efficiency. In 2017, Washington lawmakers passed S.B. 5815, which extended the Washington Safety Net Assessment Program. It authorized hospitals to earn a 1 percent incentive payment...
under the Medicaid Quality Incentive Program for providing data, such as infection prevention and percent of maternity patients with safe deliveries.14

SECTION 1115 DEMONSTRATION WAIVERS

A Medicaid waiver is a written approval from the federal government (reviewed and determined by CMS) that allows states to differ from the usual rules of the federal program. In other words, the state is allowed to “waive” some of the federal requirements. This means they can test and develop how to deliver services in their state-based program in a way that differs from federal guidelines. States use Section 1115 waivers to test policy changes that improve care and quality while not increasing costs. As of early 2018, 36 states had at least one approved Section 1115 waiver and 24 states had one or more waivers pending approval by the Centers for Medicare & Medicaid Services, according to the Kaiser Family Foundation.15 For example, the approval allowed California to extend its safety net care pool for five years and support alternative payment methods and better integration of care. (More information on Section 1115 demonstration waivers is available in NCSL’s recent Section 1115 Waivers: A Primer for State Legislators.)

REDUCING INEFFICIENCIES AND WASTE

Other innovations focus on reducing hospital visits (such as unnecessary trips to emergency rooms or premature hospital readmissions) by providing coordinated care with care managers who help patients with complex conditions navigate the health care system. (See Section 4 for more information on reducing unnecessary use of services, and Section 9 for reducing waste and fraud.)

IMPROVING DATA CAPACITY AND TRANSPARENCY

Because data collection and analysis are central to ensuring transparency and accountability, data mapping and other technological tools play a central role as states look to develop more efficient and effective Medicaid programs. A 2018 national survey published by the New Jersey Health Care Quality Institute found that lack of available data “inhibits state policymakers and researchers from seeing the impact of policy changes on the cost and use of Medicaid services.” To address the gaps, some states, including and Oklahoma and South Carolina, use Medicaid data to help state officials better allocate resources, according to the survey.16 If they see a spike in emergency room use in one area, for example, they can examine how to provide better access to primary care in that area.

Data collection and analysis also help policymakers see and examine the impact of policy changes on the cost and use of Medicaid services. For example, South Carolina Medicaid, in partnership with the University of South Carolina Birth Outcomes Initiative, uses cost and utilization data to improve the health of newborns in the Medicaid program. According to South Carolina Medicaid, the state reduced unnecessary early-elective deliveries by 50 percent, reduced neonatal intensive care unit admissions and saved the South Carolina Department of Health and Human Services more than $6 million in the first quarter of 2013.

Finally, policymakers, health care providers and other stakeholders recognize all-payer claims databases (APCDs) as a promising tool that can help achieve this objective. APCDs are designed to gather claims and eligibility data from medical, pharmacy, and dental payers to create a comprehensive collection of information on things like cost of care, utilization, patient demographics, and quality of health care. Requirements vary by state, but often include either voluntary or mandatory submissions from Medicaid, state employee health programs, commercial insurers and self-insured employer plans. As of early 2018, 25 states have established APCDs and other states have introduced legislation to create an APCD or to study the feasibility of creating a database.17

FEDERAL ROLE

In late 2017, CMS Administrator Seema Verma announced a new approach to quality measurement called “Meaningful Measures.” The initiative involves assessing the core issues that are most vital to providing high-quality care and improving patient outcomes, such as

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**Figure 4. Overall State Health System Performance Scorecard Rankings, 2018**

Source: The Commonwealth Fund, 2018
preventing and treating opioid and substance use disorders or addressing health-care-associated infections. According to CMS, Meaningful Measures “will move payment toward value through focusing everyone’s efforts on the same quality areas.” The purpose is to “improve outcomes for patients, their families and providers while also reducing burden on clinicians and providers.”

CMS encourages states to consider aligning their quality strategies with one of the following national quality strategies: the HHS National Quality Strategy or the CMS Quality Strategy. It also outlines five key steps states should take when creating their comprehensive quality strategy:

• Identify shared goals and aims.
• Select interventions that achieve these goals and aims.
• Measure and monitor progress toward these goals and aims.
• Define the starting point and targets for performance.
• Create feedback loops and transparency.

QUALITY TOOLS AND RESOURCES

States can turn to resources such as the 2017 Commonwealth Fund Scorecard on State Health System Performance, to assess overall health system performance. The scorecard ranks states on more than 40 measures in health care access, avoidable hospital use and costs, health outcomes, and health care equity. Figure 4 shows overall state health system performance in 2017.

The 2017 Scorecard on State Health System Performance highlights improvements for numerous indicators between 2013 and 2015. While it measures performance for all payers, and not just Medicaid, it can provide a useful snapshot of how a state is faring along a wide range of quality measures. The scorecard found that most improvements in health system performance occurred when policymakers and health system leaders created programs, incentives and/or collaborations to improve the overall quality, efficiency and accessibility of care.

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<tr>
<th>Strategy</th>
<th>State Options and Actions</th>
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<tbody>
<tr>
<td>Performance and Quality</td>
<td>• Develop and implement meaningful performance measures and outcomes.</td>
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<td>• Align incentives with desired outcomes and test new payment models, such as attaching provider payments to patients’ health outcomes.</td>
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<td></td>
<td>• Assess whether current data and measures are adequate to inform the public and policymakers about cost, use and performance.</td>
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<td></td>
<td>• Use nationally recognized data sets.</td>
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<td></td>
<td>• Encourage health organizations to publicly communicate exactly which benefits the services are providing to patients, employers and insurers for their money. Explore the status of state all claims payer databases at <a href="http://www.apcdcouncil.org/state/map">www.apcdcouncil.org/state/map</a>.</td>
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<td>• Examine the ability of health information technology to enhance patient-centered care; applications that strengthen patient- and family-centered care include systems for coordinated care, patient registries, performance reporting, referral tracking and electronic prescribing.</td>
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3. What Are State Medicaid Programs Doing to Address the Opioid Crisis?

The opioid epidemic touches every corner of the country. Responsible for about 116 deaths each day, the death rate from these drugs has increased more than five times since 1999, and continues to rise. More than 40 percent of these opioid-related deaths were caused by a prescription opioid. Across the country, more than 1.9 million non-elderly people have a prescription opioid addiction. Along with the tragic loss of life, opioid use and abuse has also resulted in huge financial costs. The White House Council of Economic Advisors estimated that total economic costs exceeded $500 billion in 2015, reflecting all costs associated with the opioid epidemic, including loss of life and productivity, and additional health care, substance abuse treatment, criminal justice and other associated costs. In 2017, the U.S. Department of Health and Human Services declared a public health emergency and announced a five-point national strategy to combat the epidemic.

The costs to states are significant. As the country’s largest source of behavioral health services, Medicaid covered 38 percent of adults with an addiction in 2016. Adults enrolled in Medicaid have a higher rate of opioid use disorder than those who are privately insured. According to a 2017 Kaiser Family Foundation report, Medicaid spending on addiction treatment services and other related costs totaled $9.4 billion in 2013. Figure 5 outlines Medicaid enrollees with opioid addiction with the most recent data, which is from 2013.

State Actions

States take a multifaceted approach to combating the opioid epidemic through strategies to reduce and regulate opioid prescriptions, expand and expedite access to rescue drugs in the event of an overdose, and increase access to treatment and recovery services.

REDUCE AND REGULATE PRESCRIPTIONS

Many states have passed legislation to limit the quantity of opioids that can be prescribed, with some exceptions, such as for cancer or palliative care.

- In 2016 and 2017, more than 30 states considered at least 130 bills related to opioid prescribing. According to NCSL’s tracking, 32 states had enacted legislation with some type of limit, guidance or requirement related to opioid prescribing by May 2018.

- Twenty-two states have adopted the 2016 CDC-issued Guidelines for Prescribing Opioids for Chronic Pain in their Medicaid programs, a voluntary set of recommendations for providers intended to decrease the quantity of opioids being prescribed. These guidelines report that patients within certain groups, including women, can be at risk for inadequate pain treatment. Further prescribing recommendations for women are outlined by the Office of Women’s Health at HHS.

- Forty-nine states, the District of Columbia and Guam operate prescription drug monitoring programs (PDMPs), electronic databases that track prescriptions for controlled substances, including opioids. States vary in how quickly dispensers must submit data to the PDMP. At least 26 states and Guam require prescribers to check the Prescription Drug Monitoring Program (PDMP) before writing opioid prescriptions, sometimes

Figure 5. Medicaid Enrollees with Opioid Addiction, FY 2013

Note: Colorado data were unavailable. 2012 data were used in Rhode Island and Kansas, because of lack of data in 2013.
called mandated or universal use. A 2014 study found that state mandates to register with the PDPM were associated with a 9 percent to 10 percent reduction in the number of opioid prescriptions for Medicaid enrollees.

INCREASE ACCESS TO RESCUE DRUGS

States have been working to increase access to rescue drugs, such as naloxone, that can be used to reverse an overdose. In 2017, states enacted more than 40 bills to increase access to rescue drugs. States also addressed standing orders, permitting pharmacists to dispense naloxone without a prescription and allowing additional people—such as a family and friends, school personnel, law enforcement and emergency first responders—to carry or use it. Currently, 26 states list naloxone on their preferred drug lists or took actions to increase Medicaid enrollees’ access to the rescue drug.

TREATMENT AND RECOVERY

Several states, including California, Maryland, Massachusetts, Virginia and West Virginia, received approval from CMS to implement Section 1115 Substance Use Disorder (SUD) Demonstration waivers. These waivers are designed to help states provide effective care to Medicaid enrollees with a substance use disorder, including treatment services that were not previously paid for under Medicaid, such as residential treatment services.

- In 2016, Virginia amended its existing Section 1115 waiver to expand inpatient and residential treatment benefits and peer supports to all Medicaid enrollees, and increase provider payment for substance use disorder case management, counseling and treatment.

- In October 2017, CMS approved West Virginia’s request for the “Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders (SUD) Demonstration.” The demonstration authorizes West Virginia to strengthen its SUD delivery system to improve the care and health outcomes for West Virginia Medicaid beneficiaries with SUD through expanded coverage and new programs.

States are also taking steps to increase Medicaid enrollees’ access to evidence-based Medication Assisted Treatment (MAT), which combines medications such as Buprenorphine or methadone with counseling and other therapies. Every Medicaid program in the U.S. covers at least one of the MAT medications, and most states cover all three medications—methadone, Buprenorphine and Naltrexone. States with heavy abuse in rural area have increased use of telemedicine for MAT.

TREATMENT FOR EXPECTANT MOTHERS

A 2016 study found that opioid use among pregnant women had reached “epidemic proportions,” leading to an increase in adverse neonatal outcomes. These include neonatal abstinence syndrome, a set of problems that occur in a newborn who was exposed to addictive opiates drugs while in utero. State lawmakers have taken several approaches to assist or intervene when a woman is misusing substances while pregnant.

- Nineteen states have created or funded substance abuse treatment programs for pregnant women, and 17 states and the District of Columbia give pregnant women priority access to existing state-supported programs.

- In 2016, West Virginia lawmakers passed legislation requiring Medicaid providers to prioritize substance-abuse treatment for pregnant women. Ten states prohibit discrimination against pregnant women in publicly funded treatment programs. Alaska reaches out to mothers who are at a high risk of abusing opioids during pregnancy through the federal Women, Infants and Children (WIC) program, which provides supplemental food and nutritional education for low-income women who are pregnant or have young children. WIC staff are trained to screen expecting mothers for substance misuse or abuse. This type of cross-agency work helps the state address women’s health needs no matter how or where they receive services.

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| **Address Opioid Crisis** | • Consider legislation to address prescription drug misuse and overdose. State policies include: deterring people from obtaining multiple prescriptions inappropriately; providing immunity for people seeking medical assistance; ensuring appropriate prescribing of controlled substances; and using prescription drug monitoring programs that report all filled prescriptions for controlled substances.  
  • Consider increasing current access (or lowering the costs) of rescue drugs, such as naloxone, that can be used to reverse an overdose.  
  • Consider whether Medicaid Section 1115 Substance Use Disorder (SUD) Demonstration waivers could help the state provide effective care to Medicaid enrollees with a substance use disorder. |
4. What Are States Doing to Focus On High-Need, High-Cost Patients?

State governments, health systems, payers and providers increasingly focus on finding better ways to deliver care for high-cost patients. The Commonwealth Fund has studied this group, which accounts for a high proportion of health care spending, particularly for Medicaid programs. Adults with high needs are defined as people who have three or more chronic diseases and a functional limitation in their ability to care for themselves (such as bathing or dressing) or perform routine daily tasks (such as shopping or preparing food). Researchers found one of 20 adults (5 percent) in the U.S. population ages 18 and older, or about 12 million people, met this definition. The population of children with medical complexity represents 0.4 percent to 0.7 percent of all U.S. children (approximately 320,000 to 560,000 individuals), and account for 34 percent of all Medicaid spending on children. This is a growing population with substantial needs for coordinated health services.

The National Academy of Medicine recently released a publication that documents the challenges facing high-need, high-cost patients, as well as defining effective strategies for improving care, and outlining policy options to better meet their needs.

State Actions

Across the country, states fund and implement care coordination models, or care management programs that improve outcomes for people with complex needs. The programs...
Figure 6. Successful strategies in Care Coordination
People with multiple health problems—sometimes referred to as “high-need, high-cost” because of their intense use of medical care and behavioral health services—often need assistance with other things such as housing, or everyday tasks like walking or taking medications, to lead full, productive lives.

- **Target** the population most likely to benefit.

- **Monitor** progress.

- **Coordinate** care and facilitate communication among all care providers.

- **Connect** patients to appropriate follow-up and support services after hospital discharge.

- **Engage** patients and family members in managing care.

- **Develop** care plan centered around patients’ needs and preferences.

- **Assess** patients’ health-care related risks and needs.

What Works

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<tr>
<td><strong>High-Need, High-Cost Patients</strong></td>
<td>• Target high-need, high-cost patients to provide more appropriate and timely care and reduce high emergency room and hospital use</td>
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<td>• Expand care coordination programs to serve Medicaid clients with complex needs</td>
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<td>• Invest in evidence-based strategies that are shown to improve care and cut costs (e.g., the Program of All-Inclusive Care for the Elderly – PACE)</td>
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Several care coordination models have shown promise for high-cost, high-needs patients, including:39

- Integrated primary care (coordination of preventive, primary, acute and long-term care services)
- Enhancements to primary care (including care and case management, disease management, preventive home visits, geriatric evaluation and management, chronic disease self-management, and more)
- Transitional care (improved discharge transitions from hospital to home)
- Home- and community-based care (programs that substitute care in the patient’s home in lieu of a hospital stay)
- Medicaid health homes for individuals with complex and chronic conditions, such as mental illness, substance abuse, asthma and diabetes
- Team care in hospitals, nursing homes and outpatient settings
- Comprehensive care in hospitals

The evaluation of these models showed positive results in areas related to quality of care or a patient’s quality of life. Most models reduced hospital stays, though the evidence was mixed. Three models—interdisciplinary primary care for heart failure patients, transitional care from hospital to home, and “hospital-at-home” programs—showed evidence of lower costs.40

Many states have expanded use of the Program of All-Inclusive Care for the Elderly (PACE) as a strategy for helping frail, elderly patients with functional limitations stay in their homes. In 2017, there were 123 PACE Programs operating in 31 states.41

are designed to decrease costly and unnecessary treatments, avoiding preventable hospital and emergency room visits. While many of these programs offer the potential to reduce costs while improving patients’ health, evidence is scarce and few have demonstrated net cost savings to date. Cost savings analysis is difficult to demonstrate when the programs are embedded in a fee-for-service care system. Researchers state that “incentives created by accountable care and other value-based purchasing initiatives may strengthen the business case for adopting carefully designed and well-executed care coordination models.”38 Research shows that the most effective models include the elements outlined in Figure 6.
5. What Are Best Practices for Promoting Healthy Births?

Prematurity and other birth-related problems, such as low birth weight and birth defects, have profound and lasting effects on individuals, families and society. Preterm birth, defined as those that occur at least three weeks before their due date, is a leading cause of infant mortality and disability. Moreover, an increasing number of babies born with neonatal abstinence syndrome—a drug withdrawal syndrome resulting from maternal drug use—is associated with poor outcomes for infants and moms alike.45

In addition to the human toll, poor birth outcomes are costly to states. Today, one baby in 10 babies is born prematurely, resulting in long-term medical, early intervention and special education costs of more than $26 billion annually.46 Because Medicaid finances about 45 percent of all births in the United States, and because the rate of preterm birth is 25 percent higher for the Medicaid population than for the privately insured, 46 state efforts to improve birth outcomes within the Medicaid population offer a powerful opportunity to improve health care quality, achieve better outcomes on a large scale, and save costs.

ADDRESSING CHALLENGES

After several years of declining rates of preterm births, the U.S. preterm birth rate increased for two consecutive years in 2015 and 2016. As shown in Figure 7, preterm birth rates range from a low of 7.8 percent in New Hampshire to a high of 13.7 percent in Mississippi. Babies born with a low birth weight, or under 5.5 pounds,45 are more likely to experience health problems and longer-term developmental problems or disabilities.45

The Centers for Disease Control and Prevention (CDC) recommends several strategies for reducing preterm birth. They include providing access to care before and between pregnancies, identifying women at risk for preterm delivery and offering treatments to prevent early births, discouraging deliveries before 39 weeks without a medical need, and preventing unintended pregnancies. In addition to state actions outlined below, CMS has implemented several initiatives to help states improve health outcomes and reduce the cost of care for women and infants in Medicaid and CHIP, including the Maternal and Infant Health Initiative (MIHI) and the Medicaid Innovation Accelerator Program’s MIHI Value-Based Payment Technical Support Initiative.

State Actions

IMPROVE ACCESS TO EARLY, HIGH-QUALITY PRENATAL AND POSTPARTUM CARE

Infants born to women who receive late or no prenatal care are twice as likely to have low birth weights as infants born to women who receive prenatal care in the first trimester.

Timely prenatal care reduces unhealthy behaviors that can harm infants and connects pregnant women with appropriate services. States have taken various steps to facilitate access to prenatal care for Medicaid enrollees, including through changes to eligibility and enrollment procedures, as described below.

- **Medicaid Eligibility.** States are required to provide Medicaid coverage to pregnant women with incomes up to 133 percent of federal poverty guidelines and they have the option of extending it to pregnant women with higher incomes. According to a 2017 Kaiser Family Foundation report, as of January 2017, 34 states covered pregnant women with incomes up to 200 percent of the poverty limit (or an annual income of $50,200 for a household of four in 2018). Five states covered pregnant women through CHIP, and 16 states used the unborn child option to cover income-eligible pregnant women under CHIP.47
Enrollment Procedures. As of January 2017, 30 states had adopted “presumptive eligibility” under Medicaid that allows immediate access to prenatal care services for pregnant women while their eligibility is determined.

States are required to cover pregnancy-related services for women enrolled in Medicaid, and they have the option (with waiver approval) to cover specialized or enhanced prenatal services for high-risk expectant mothers. For example, Colorado’s Prenatal Plus Program targets high-risk pregnant women enrolled in Medicaid with early and comprehensive services, such as nutrition counseling, mental health services and care coordination. New York’s Community Health Worker program provides outreach, education and home visiting to uninsured and underinsured pregnant women at risk for poor health outcomes.

Reduce Early Elective Deliveries

Between 10 percent and 15 percent of all U.S. births occur early, without a medical reason, according to a 2012 report by the Centers for Medicare & Medicaid Services. Early elective deliveries are associated with increased risks of neonatal morbidity, breathing and feeding problems, blood infections and other complications that may require costlier hospital stays and cause long-term health problems. The U.S. Department of Health and Human Services estimates that just a 10 percent reduction in deliveries before 39 weeks of gestation would lead to more than $75 million in annual Medicaid savings for associated complications.

According to a 2016 Kaiser Family Foundation survey of states, 19 states had adopted a limited fee-for-service reimbursement policy to reduce early elective deliveries, and 12 states require such a policy for Medicaid managed care plans. A 2017 study published in Health Affairs found that early elective deliveries dropped by 14 percent in Texas following the Medicaid change required in a 2011 law that denied reimbursement for non-medically necessary early elective deliveries.

Promote Screening and Early Intervention for Medicaid-Enrolled Pregnant Women and Children

Identifying developmental disorders early can prevent more costly problems later and help infants and toddlers learn skills and meet developmental milestones during their early years. Legislators can play an important role in assuring that Medicaid providers incorporate evidence-based screening guidelines. Medicaid’s Early Periodic Screening, Diagnosis, and Treatment Program benefit package for children covers the costs of periodic, comprehensive screenings, including vision, dental and hearing. In Maine, providers who incorporate the American Academy of Pediatrics’ Bright Futures standards receive enhanced reimbursement under MaineCare, the state’s public health insurance program.

Screening for pregnant and postpartum women offers another way to promote healthy birth outcomes and child development. According to the American Academy of Pediatrics, untreated maternal depression can have a long-term impact on child health and well-being. Maternal depression screening and treatment helps protect the child from the potentially negative physical and developmental effects. A 2016 federal informational bulletin clarified that, if a state chooses to do so, it can incentivize health care providers to bill Medicaid for maternal depression screening provided during pediatric well-child visits, as well as related treatment services where the child is present. As of 2017, 13 state Medicaid programs provided coverage for maternal depression screenings.

Invest in Evidence-Based Home Visitation

Home visits by a trained provider, such as a nurse or early childhood educator, support expectant and new parents to promote infant and child health, foster healthy child development and improve school readiness. Well-designed programs achieve a wide array of benefits for children and families, while creating long-term savings for states on avoidable emergency room visits, child protective services and special education, and increased parental earnings.

States support home-visiting programs through a combination of federal, state, local and private funds. The federal Maternal, Infant and Early Childhood Home Visiting Program, authorized in February 2018, funds states to develop and implement evidence-based and voluntary programs for at-risk pregnant women and parents with infants or young children. In 2016, the state grantee programs served over 160,000 parents and children in all 50 states, the District of Columbia, and five U.S. territories. Many states rely on Medicaid financing mechanisms to support several home visiting services, including targeted case management and enhanced prenatal benefits under both managed care and traditional medical assistance services. As described in a 2016 federal bulletin, states can cover services for pregnant women or children with home visiting through Medicaid mechanisms, including the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid’s benefit program for children, as well as through Section 1115 and other Medicaid waivers.

A 2017 survey of states by the Kaiser Family Foundation found that at least 30 states use Medicaid to cover prenatal and postpartum home visits. State legislatures play a key role by financing programs and advancing legislation that helps coordinate the variety of state home visiting programs as well as strengthening the quality and accountability of those programs.

Arkansas lawmakers passed SB 491 (2013) that required the state to implement state-wide, voluntary home visiting services to promote prenatal care and healthy births; to use at least 90 percent of funding toward evidence-based and promising practice models; and to develop protocols for sharing and reporting program data and a uniform contract for providers.
• In 2017, New Jersey lawmakers passed SB 1475, establishing a three-year Medicaid home visitation demonstration project to provide ongoing health and parenting information, parent and family support, and links to essential health and social services during pregnancy, infancy, and early childhood.

• During the 2016 legislative session Rhode Island lawmakers passed the Rhode Island Home Visiting Act (HB 7034). It requires the Department of Health to coordinate the system of early childhood home visiting services; implement a statewide home visiting system that uses evidence-based models proven to improve child and family outcomes; and implement a system to identify and refer families before the child is born or as early after the birth of a child as possible.

A return on investment analysis of nurse home visiting has shown an estimated $6.40 return on investment for every dollar invested in the Nurse-Family Partnership, resulting from potential gains in wages, employment and quality of life.54

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<tr>
<td>Promote Healthy Births</td>
<td>• Educate women about healthy pregnancies by supporting education and outreach.</td>
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<td>• Reduce early elective induction and Caesarian deliveries by restricting Medicaid reimbursement for them, educating patients and providers, monitoring performance and reporting, and coordinating efforts to disseminate best practices to perinatal providers.</td>
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<tr>
<td></td>
<td>• Inform families about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services through home visiting, Women’s Infants and Children Food and Nutrition Service (WIC) and other programs.</td>
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</tbody>
</table>
6. How Are Medicaid Programs Encouraging Personal Responsibility Through Incentives and Work Requirements?

To reduce costs and improve health and well-being for Medicaid enrollees, states are adopting a variety of measures aimed at promoting health and encouraging employment among able-bodied adult enrollees. In January 2018, the Centers for Medicare & Medicaid Services (CMS) issued guidance that allows states to test “incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries.” Although current law does not allow states to implement such requirements as a condition of eligibility, CMS signaled its support of Section 1115 waiver requests containing such provisions. The new policy excludes adults with a disability, pregnant women and elderly Medicaid enrollees. It also gives states the flexibility to identify community service, caregiving, education, job training, substance use disorder treatment, or other activities that meet their eligibility requirements.

According to the guidance, the new flexibility allows states to design programs that improve Medicaid enrollee health and well-being while promoting the Medicaid program’s objectives. Citing evidence that work, volunteering and other forms of community engagement can lead to better health outcomes, CMS began allowing states to determine if the policies help enrollees obtain steady employment and improved health status.

State Actions

As of March 2018, three states—Arkansas, Indiana and Kentucky—received CMS approval for waivers that contained work requirement provisions, and seven states had submitted such proposals (Figure 8). While state waivers vary, they share common features, such as exemptions for certain people (e.g., full-time students, family caregivers, pregnant women, or individuals receiving substance use treatment) and a requirement that non-exempt enrollees verify their compliance. Concerns have been raised about the additional burden (and costs) to the states to verify compliance with work requirements, as well as the burden on Medicaid enrollees in documenting and verifying compliance with the new rules. Job training and placement activities cannot be paid by Medicaid, but instead, must be covered by other state and federal funds. In response to these concerns, Arkansas is working to develop an online system that will be both simple to use and potentially inexpensive to maintain. Arkansas will implement an outreach strategy to inform enrollees about the process for reporting their compliance with the new requirements.

The potential impact of these policies to states and enrollees is not yet known. In 2016, 60 percent of adult Medicaid enrollees were employed, and 32 percent reported they were not employed because of caregiving, school, illness or disability—leaving a small share of people who may be affected by new work or community engagement requirements. Other concerns challenge the effectiveness of work requirements. These include potential loss of Medicaid eligibility for individuals who may no longer qualify based on their income, increased administrative burdens for individuals, lock-out periods from Medicaid coverage, and barriers to coverage for those who are navigating the new rules and procedures. State experiences and evaluations will shed light on the impact these approaches have on improving health and well-being.
HEALTHY BEHAVIOR INCENTIVES AND PROMOTION

To improve Medicaid enrollee health and reduce health care costs, several Medicaid programs offer incentives or rewards to encourage healthy behaviors. These include actions such as taking prescriptions as directed, attending primary care visits, exercising and maintaining a healthy diet, and quitting smoking. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), as of December 2015, 15 states operated healthy behavior incentive programs for certain populations. They vary across states and can include direct financial incentives, health savings account contributions, credits that can be used to pay for health-related products, or expanded access to services, such as dental care. For example:

- Florida’s current Section 1115 demonstration allows the state to operate a capitated Medicaid managed care program. Participating enrollees have access to healthy behaviors programs that provide incentives and rewards for healthy behaviors, such as losing weight or quitting tobacco use.

- Indiana’s consumer-driven health care program for Medicaid-eligible low-income individuals uses Personal Wellness and Responsibility (POWER) accounts to promote the efficient use of health care, encourage preventive care and discourage unnecessary care through care coordination and the use of preventive services.

- Kentucky’s recently approved “Helping to Engage and Achieve Long Term Health” (HEALTH) waiver includes consumer-driven tools, such as awards accounts, which provides incentives for healthy behaviors that enrollees can use to obtain enhanced benefits. A deductible health savings account is intended to educate beneficiaries about the cost of health care.

- Michigan House Bill No. 4714, Michigan Public Act 107 of 2013, directed the Department of Community Health to seek a federal waiver and authorized the Healthy Michigan Plan. The legislation encourages healthy behaviors and use of preventive services, while discouraging “low-value services,” such as non-urgent emergency room visits, using care coordination and other models to intervene before a crisis. CMS approved the Michigan Healthy Michigan §1115 waiver and the waiver includes a healthy behaviors program.

Research on whether healthy behavior incentives improve health outcomes is mixed. According to a 2017 study by the Vanderbilt University School of Medicine, financial incentives and rewards are effective for one-time or short-term activities, such as filling a prescription, receiving a recommended vaccine or attending a follow-up visit. The incentives are less effective at changing behaviors that require ongoing maintenance, such as weight loss or tobacco cessation, which researchers noted “often are the behaviors that influence health care costs the most.” Low levels of participation, lack of awareness about the programs, challenges monitoring progress and environmental barriers, such as lack of transportation, may hinder the effectiveness of such efforts.

To address these challenges, Vanderbilt researchers point out the following best practices for healthy behavior initiatives:

- Ensure that enrollees are aware of and understand how incentives work.
- Create positive incentives for one-time or short-term activities that have evidence showing they improve patient health.
- Make incentives worthwhile, timely and simple.
- Evaluate program effectiveness.

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<tr>
<td>Encourage Healthy Behaviors and Use of Health Care Services</td>
<td>• Explore investments in health infrastructure that support the patient’s responsibility for his or her own care, and the efforts of patients, families and their clinicians to work together in a coordinated way.</td>
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<td>• Assess employment barriers and consider opportunities to promote healthy behaviors and community engagement.</td>
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<td>• Consider expanding the role of peer support specialists, who use formal training and personal experience with a mental illness or substance use disorder to provide education, support and connections to other services for their peers.</td>
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<td>• Incorporate incentives such as cost-sharing reductions for healthy behaviors (quitting smoking).</td>
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7. What Are States Doing Related to Enrollment, Eligibility and Cost-Sharing?

As Medicaid costs consume a larger share of state budgets, policymakers continually seek ways to improve outcomes, control costs, reduce growth in Medicaid, and make sure their state’s program is managed as efficiently and effectively as possible. When states approach coverage and eligibility, there is no one-size-fits-all approach. As described below, state actions impact both eligibility and enrollment decisions on the one hand, and decisions about benefits on the other. This is especially true for high-needs populations that account for a large share of Medicaid spending, such as coverage for mental health and opioid addiction services.

HOW STATES ENACT ELIGIBILITY AND ENROLLMENT CHANGES

Although federal law sets Medicaid minimum standards related to eligible groups, required benefits and provider standards, states have latitude to make decisions about program eligibility, optional benefits, premiums and cost-sharing, delivery system and provider payments. This is done either through a state plan amendment process or through a Medicaid waiver process.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid program.

A Medicaid waiver is a written approval from the federal government (reviewed and determined by CMS) that allows states to differ from the usual rules of the federal program. In other words, the state is allowed to “waive” some of the federal requirements. This means that they can test and develop how to deliver services in their state-based program in a way that differs from federal guidelines.

States can make many changes to their Medicaid programs without a federal waiver. They can choose to cover optional benefits, expand eligibility to people with higher incomes, define which providers can provide optional services, or make certain changes to their program’s delivery system. These changes require a state to submit a state plan amendment to CMS for review and approval. Beyond this existing flexibility, states can apply for Section 1115 waivers to make many types of changes to their Medicaid programs that otherwise would not be allowed under law. The Affordable Care Act expanded both Medicaid eligibility and federal funding to allow all low-income adults with incomes up to 133 percent of federal poverty guidelines to participate. Given this choice, many states have been weighing the costs and savings associated with expanding Medicaid to this non-traditional adult population. As of March 2018, 32 states and the District of Columbia had expanded Medicaid, with several variations negotiated by waivers or state plan amendments. Additionally, Maine voters approved Medicaid expansion through a ballot initiative, though the state has not yet officially expanded coverage.

State Actions

ELIGIBILITY, ENROLLMENT AND COST-SHARING

Many states considered or implemented changes to cost-sharing, including adding premiums and increasing copayments and other out-of-pocket costs for which enrollees are...
responsible. In addition, states deliberated eligibility changes as ways to reduce state costs, increase enrollee responsibility, and reduce unnecessary or inappropriate use of health care services. A March 2018 Kaiser Family Foundation report found that eligibility, enrollment and benefit restrictions, as well as copayments, were among the major areas of focus for approved state Section 1115 waivers. (Other focus areas included work requirements, delivery system reforms, and behavioral and physical health integration—topics that are discussed elsewhere in this report.)

While requiring patients to pay more for their health care may reduce spending in the near term, it can increase health spending in the long term, especially for patients with chronic conditions who avoid necessary care due to their out-of-pocket costs. Among the best practices for cost-sharing, researchers at the Vanderbilt University School of Medicine suggest targeting copayments to overused services and regularly evaluating the effect of cost-sharing on enrollees’ access to needed care and long-term program costs.66

As of March 2018, eight states had received federal approval for Section 1115 waivers that restricted eligibility and enrollment, and seven states received approval for waivers that restricted benefits, assessed copayments or provided incentives for healthy behaviors. Several states have sought or received CMS’ approval for Section 1115 waivers that contain eligibility- and enrollment-related provisions for both expansion and traditional Medicaid populations.

To date, CMS has approved waivers allowing a number of states to implement premium surcharges, six states to eliminate retroactive eligibility, and three states to unenroll or “lock out” individuals for a period of time due to unpaid premiums.

Other pending proposals include lifetime limits on Medicaid coverage for able-bodied people, drug screening and testing, and limiting eligibility for the expansion population to those living at 100 percent of the federal poverty level.

**COVERED BENEFITS FOR MEDICAID ENROLLEES**

States also have considered and implemented changes to covered benefits. While state actions vary, a 2017 state survey found more states added benefits than reduced them (Figure 9). More than half of the states (26) expanded or enhanced benefits in 2017 and 17 states reported that they planned to add or enhance benefits in 2018—most often for behavioral health and substance use disorder services and dental services.

As of March 2018, three states—Kentucky, Iowa and Indiana—received approval to eliminate non-emergency medical transportation for their childless adult expansion populations. Kentucky received approval to collect copayments above statutory limits for non-urgent emergency room use, and several other states—including Maine, New Mexico, Utah and Wisconsin—have submitted similar proposals to CMS. Massachusetts submitted a proposal to adopt a closed prescription drug formulary.

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<tr>
<td>Eligibility and Cost-Sharing</td>
<td>• Assess current cost-sharing and eligibility requirements.</td>
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<td>• Consider targeting copayments to overused services and regularly evaluating the effect of cost-sharing on enrollees’ access to care and program costs.</td>
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8. What Are States Doing to Integrate Behavioral Health and Primary Care?

As the largest payer of behavioral health services, Medicaid plays an important role in covering and paying for a broad array of behavioral health services to address mental illness and substance use disorders. One in five Medicaid enrollees has a behavioral health diagnosis and account for about half of total Medicaid expenditures. Total Medicaid spending for enrollees with a behavioral health diagnosis was nearly four times higher than for those without a diagnosis, reflecting the array of physical conditions, such as asthma or diabetes, that often accompany a behavioral health diagnosis.

As policymakers consider how to control Medicaid costs and improve health outcomes for the 9 million enrollees with a behavioral health diagnosis and the 3 million with a substance use disorder, many are taking steps to integrate primary medical care and behavioral health delivery systems. States adopt various strategies to address the traditionally fragmented system of care and to integrate behavioral and physical health. These include using comprehensive managed care that combines physical and behavioral health services, health homes, and accountable care organizations (ACOs). As shown at right, integration offers a key opportunity to improve care and reduce costs for Medicaid enrollees. For example:

- Medicaid covered 21 percent of U.S. adults with a mental illness, 26 percent of adults with a serious mental illness, and 17 percent of adults with a substance use disorder.

- People with complex conditions disproportionately affect Medicaid budgets. According to the Centers for Medicare & Medicaid Services (CMS), 5 percent of Medicaid beneficiaries account for 54 percent of total Medicaid expenditures, and just 1 percent account for 25 percent of total expenditures.

- About 14 percent of children under age 21 who were enrolled in Medicaid, or 4 million of the 29 million enrolled children, had a behavioral health diagnosis. Those may include attention deficit disorder or attention-deficit hyperactivity disorder (ADD/ADHD), depression, behavioral problems, anxiety, autism spectrum disorders and substance use disorders. A 2017 report by the Milbank Memorial Fund found that only 15 percent to 25 percent of children with psychiatric disorders receive needed care.

- While children in foster care represent only 3 percent of children in Medicaid, they account for 15 percent of youth using behavioral health services and 13 percent receiving psychotropic medications. Increasingly, these children are enrolled in Medicaid managed care programs, where there is an opportunity to improve monitoring psychotropic medication use and increase access to home- and community-based services.

Key Reasons to Integrate Physical and Behavioral Health Services in Medicaid

- 20% of beneficiaries have a behavioral health diagnosis.
- 26% of all behavioral health spending nationally is paid by Medicaid.
- 48% of beneficiaries with a behavioral health diagnosis account for almost half of total Medicaid expenditures.
- 75% spending can increase up to 75 percent when beneficiaries with a chronic physical condition also have a mental illness.

Sources: Report to Congress on Medicaid and CHIP, Medicaid and CHIP Payment and Access Commission, June 2015; Clarifying Multimorbidity Patterns to Improve Targeting and Delivery on Clinical Services for Medicaid Populations, Center for Health Care Strategies, December 2010.

HOW INTEGRATION HELPS TO ADDRESS BARRIERS, IMPROVE CARE AND REDUCE COSTS.

Historically, the health care system has cared for a person’s physical needs separately from his or her behavioral needs, often charging more and providing less coverage in both inpatient and outpatient visits. When care is fragmented and physical needs are separated from behavioral ones, it ultimately leads to higher costs and less effective outcomes. An estimated 60 percent to 70 percent of patients with behavioral health conditions who seek care in emergency rooms or primary care clinics leave these settings without receiving treatment for their mental health or substance abuse needs. This increases the chances they will have difficulty recovering from those conditions.
INTEGRATION CAN HELP ADDRESS THESE CHALLENGES

According to CMS, “Given the prevalence of mental health conditions in the Medicaid population, the high level of Medicaid spending on behavioral health care, and the adverse impact that uncoordinated care can have on people’s health, initiatives to integrate physical and mental health are a top priority for Medicaid agencies.” Effective, integrated care offers better access to individualized treatments, increased collaboration among providers, a decrease in unnecessary emergency services, greater adherence to treatment, and increased mental and physical health. The American Psychiatric Association found that integrated behavioral health care can save between 9 percent and 16 percent of the additional costs incurred by patients with behavioral health issues.

State Actions

States, the federal government and health care providers have made significant investments and enacted a wide range of strategies to integrate services. State actions that address integration include:

- Expanding and diversifying the types of mental health providers for different levels of services or treatment, and providing both commercial and Medicaid reimbursement for a variety of mental health providers. In 2011, CMS approved Missouri’s State Plan Amendment to create Community Mental Health Center (CMHC) Healthcare Homes for enrollees with serious mental illness. CMHC homes provide community psychiatric rehabilitation services and help individuals access needed physical and behavioral health care and social services and supports. They also help participants manage their mental illness and other chronic conditions.

- Integrating mental health and substance abuse into primary care visits. For example, in 2015, Iowa lawmakers passed legislation to establish patient-centered medical homes, accountable care organizations and other integrated care models to improve quality and health, while reducing health care costs. Legislators required the Department of Public Health to collaborate with Iowa Medicaid and child health specialty clinics to integrate the “1st Five” initiative. The program supports health providers in efforts to detect social-emotional and developmental delays in children from birth to age five, and coordinates referrals, interventions and follow-up.

- Adopting reimbursement and portable licensure policies to remove practice barriers for health care providers who provide telehealth services. For example, Mississippi and New Mexico are among the states using telehealth programs to build provider capacity and increase access for both behavioral and physical health services. The Massachusetts Child Psychiatry Access Program addresses behavioral health access barriers by delivering telephone child psychiatry consultations and specialized care coordination support to pediatric primary care providers.

- Ensuring payment for outpatient mental health services in state programs (for example through foster care, ensuring that state mental health outpatient programs are eligible for Medicaid reimbursement).

- Expanding the role of peer support specialists, who use formal training and personal experience with a mental illness or substance use disorder to provide education, support and connections to other services for their peers.

States design and improve their Medicaid programs working within the flexibility allowed under existing federal Medicaid law, using longstanding tools such as Section 1115 waivers to best meet their state’s unique needs. Legislators play an important role by enacting legislation related to Medicaid waivers, engaging with federal partners during waiver development, implementation and oversight.

Although federal law sets Medicaid minimum standards related to eligible groups and required benefits, states have latitude to make decisions about program eligibility, optional benefits, premiums and cost-sharing, delivery system and provider payments. This is done either through a state plan and amendment process or through a Medicaid waiver process.

According to tracking by the Kaiser Family Foundation, as of March 2018, 19 states were using Section 1115 waivers to provide enhanced behavioral health services to targeted groups, expand Medicaid eligibility to additional populations with behavioral health needs, and fund physical and behavioral health integration and other delivery system reforms. Thirteen states had pending waiver proposals that included behavioral health provisions.
For example:

- Arizona’s Health Care Cost Containment System Section 1115 waiver provides health care services through a statewide, capitated managed care delivery system for both mandatory and optional Medicaid groups. CMS approved Arizona’s waiver in September 2016 to integrate physical and behavioral health care through regional behavioral health authorities and children’s rehabilitative services plans. In January 2017, CMS approved an amendment to establish the Targeted Investments Program, which provides incentive payments to providers for increasing physical and behavioral health integration and coordination for enrollees with behavioral health needs.

- Delaware’s Section 1115 waiver implemented the Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), a voluntary program that provides enhanced behavioral health services and supports for targeted Medicaid beneficiaries.

- Massachusetts’ Section 1115 waiver implemented a statewide Accountable Care Organization (ACO) program aimed at improving integration of care and coordination among providers to reduce the rate of growth in spending and avoidable use of services, while maintaining access and quality.81, 82

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| Integrate Primary Care and Behavioral Health | • Integrate mental health and behavioral health into primary care visits.  
   • Adopt reimbursement and portable licensure policies to remove practice barriers for health care providers who provide telehealth services  
   • Consider using Medicaid Section 1115 waivers to provide enhanced behavioral health services to targeted groups, expand Medicaid eligibility to additional populations with behavioral health needs, and fund physical and behavioral health integration and other delivery system reforms. |
9. How Can Medicaid Programs Decrease Fraud, Abuse and Waste?

Fraud, abuse and waste in Medicaid cost states billions of dollars every year, diverting funds that could otherwise be used for legitimate health care services. According to a 2018 review by the U.S. Government Accountability Office, improper payments—which include things like payment for non-covered services or for services that were billed but not provided—are a “significant and growing cost to the Medicaid program.” They increased from $29 billion of federal Medicaid expenditures in 2015 to $36 billion in 2016.

Not only do improper payments and fraudulent practices increase the cost of Medicaid without adding value, they increase risk and potential harm to patients who are exposed to unnecessary procedures. In her 2017 congressional testimony, Assistant Inspector General Ann Maxwell asserted that “protecting Medicaid from fraud, waste and abuse is an urgent priority because of its impact on the health of vulnerable individuals and its fiscal impacts on federal and state spending.”

Every state Medicaid program is required by federal rules to have an investigative and audit unit in order to receive Medicaid funds. Arizona, New York and New Jersey all have an office of Inspector General, while other states have a Program Integrity Division. For example, Florida statute directs all Medicaid managed care plans to adopt an anti-fraud plan to detect and prevent overpayments, abuse and fraud; managed care plans then submit it to the Office of Medicaid Program Integrity.

Although Medicaid fraud involves knowingly misrepresenting the truth to obtain unauthorized benefit, abuse includes any practice that is inconsistent with acceptable fiscal, business or medical practices that unnecessarily increase costs. Waste encompasses overutilization of resources and inaccurate payments for services, such as unintentional duplicate payments. The Centers for Medicare & Medicaid Services (CMS) has broad oversight responsibilities, but the 2017 GAO report finds that states have “primary responsibility for ensuring the integrity of the Medicaid program by preventing, identifying, and correcting improper payments. They therefore remain the first line of defense against Medicaid improper payments.”

ADDRESSING THE PROBLEM

The federal government and states have adopted a variety of steps to combat Medicaid fraud, waste and abuse and to ensure that public funds are used to promote Medicaid enrollees’ health. Although fraud and abuse can be committed by both Medicaid providers and patients, CMS found in a review of federal data that most state strategies focus on investigating providers. There are three primary ways to reduce fraud and abuse among providers: 1) screen them before and after they are accepted into the program, 2) review claims before they are paid, and 3) review claims after they are paid and recover improper payments, also called “pay and chase.”

Such program integrity strategies ensure that federal and state funds are “spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse from taking place,” says the Medicaid and CHIP Payment Access Commission (MACPAC). These include data mining and analytics, claims databases, audits, investigations, enforcement actions, technical assistance to help state agencies detect fraud and abuse, and provider and enrollee outreach and education. Well-designed program integrity initiatives ensure that:

- Eligibility decisions are made correctly
- Prospective and enrolled providers meet federal and state participation requirements
• Delivered services are medically necessary and appropriate
• Provider payments are made in the right amount and for appropriate services.

A 2013 Pew Charitable Trusts’ report found that states used three types of Medicaid fraud prevention strategies, including provider screening, prior authorization and prepayment reviews, and post-payment review and recovery.84 While states have traditionally relied upon the latter “pay and chase” model in which they pay Medicaid claims and then try to recover improper payments, they increasingly focus on preventing and detecting fraudulent activities early on. New York, for example has integrated targeted data mining and risk analysis to uncover and reduce fraud. In Texas, a few simple process changes and new pattern analysis and recognition efforts moved the state closer to real-time analysis and significantly increased the amount of fraud identified.

State Actions

All-payer claims databases (APCD) are another way to combat Medicaid fraud, as they can help identify wasteful spending and assist payers, providers and patients in making better-informed spending decisions. In a new report, the Washington Health Alliance (WHA) explains how it implemented a cost calculator within its APCD to identify wasteful health care services. The analysis revealed about $282 million was spent on wasteful health care for 622,000 Washington residents. Utah’s All Payer Claims Database allows the state to analyze complete episodes of care, from initial diagnosis through treatment and follow-up. It also enables the state to study disparities within the 50 million to 65 million claims submissions received annually.

Working in partnership with state agencies and other states is also an effective way to fight Medicaid fraud. During its CMS review, Louisiana shared how various state agencies worked together to identify problems surrounding services provided by unqualified staff or without documentation, as well as for billings for noncovered services. Officials overseeing Medicaid program integrity worked in partnership with the staff in the state’s Mental Health Rehabilitation program to review 131 providers. As a result, the state saved about $65 million through cost avoidance and recovered $586,000 between 2005 to 2007.85

States are working both individually and together to address issues around disparate data collection. Most states have already agreed to submit their Medicaid transaction data to a national database. California, Massachusetts, New York and Utah have all announced or implemented their intention to implement data analytics programs.

In 2013, Colorado lawmakers passed legislation that created a Medicaid fraud detection system “for the purpose of detecting and preventing Medicaid provider and client fraud, waste, and abuse.” It also required an annual legislative report detailing total savings, total costs, and cost-effectiveness of fraud detection efforts.

Florida’s Bureau of Medicaid Data Analytics within the Agency for Healthcare Administration monitors, evaluates and reports on plan performance for the statewide Medicaid managed care program and assesses cost-effectiveness, among other functions.

FEDERAL MEDICAID INTEGRITY PROVISIONS

The Affordable Care Act (ACA) introduced various requirements aimed at improving Medicaid program integrity. For example, the law created a web-based portal, enabling states to compare information on providers that have been terminated (and whose billing privileges have been revoked). An overview of the law’s provisions related to improving Medicaid program integrity is available here.

The CMS Center for Program Integrity reviews states’ efforts to reduce improper Medicaid payments, and encourages states to use collaborative audits conducted by CMS contractors and states to review payments for accuracy. GAO’s 2017 review found that the burden on staff and other barriers prevented or hindered state participation in these audits. As shown in Figure 10, states’ use of audits varied significantly. Between 2012 and 2016, 41 states conducted at least one audit, while 11 states had conducted none.

The federal Department of Health and Human Services (HHS) works with the Office of the Inspector General (OIG) to oversee Medicaid Fraud Control Units, which operate in 49 states and D.C. These are an important part of efforts to decrease waste, fraud and abuse in Medicaid.

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<td>Reduce Waste and Inefficiencies</td>
<td>• Consider using collaborative audits conducted by CMS contractors and states to review payments for accuracy.</td>
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<td>• Consider using data analytics to monitor, evaluate and report on plan performance.</td>
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10. How Are States Improving and Managing Long-Term Services and Supports?

Millions of Americans of all ages need long-term services and supports (LTSS) that result from disabling conditions and chronic illnesses. Long-term services and supports include a broad range of day-to-day assistance needed by people with chronic health conditions and challenges with daily living activities—for example, dressing, bathing, housework, managing medications or finances, and transportation. Services are provided in the home or in institutional settings such as nursing homes, supportive housing or assisted living facilities.

People who require LTSS represent a diverse group, including those over age 65 and younger adults with different types of physical, cognitive and mental disabilities, as well as children with complex health care needs. Demand for these services is projected to grow in the coming years—as are the associated costs, which are often paid for by public dollars. Medicaid, the largest single payer of long-term services and supports across age groups, accounts for about half of all LTSS spending.

Studies suggest that home- and community-based services (HCBS) are cost-effective compared to institutional care. Medicaid spending on HCBS outpaced spending on institutional long-term care for the first time in 2013 and continues to increase. In fact, 55 percent of Medicaid spending on LTSS was for home- and community-based services in 2015. Home- and community-based services are less expensive than institution-based care but may still represent a major financial burden for individuals, their families and states. In 2015, the median cost for one year of home health aide services (at $20 per hour, 44 hours per week) was almost $45,800 and adult day care (at $69 per day, five days per week) totaled almost $18,000.

Home- and community-based services are an optional Medicaid benefit (unlike nursing home care) and states vary on the specific HCBS they offer and the authority they use to establish these programs. Some home- and community-based services are offered within a Medicaid state plan, while other HCBS programs operate under 1915(c) or 1115 waivers. Under these waiver programs, states have the flexibility to target services to specific populations, like seniors with dementia or children with developmental disabilities.

MANAGED LONG-TERM SERVICES AND SUPPORTS

State policymakers are taking steps to ensure that affordable and high-quality long-term services and supports are accessible to the growing population in need of such services (particularly low-income people), and to manage the impact on state budgets. State legislators can play a key role in reforming their LTSS systems by shifting services to home settings and to capitated, managed care plans.

HOME- AND COMMUNITY-BASED SERVICES

Many states have been reforming their Medicaid-funded long-term care systems by moving away from costly institutional care toward home- and community-based services (HCBS), which are often less costly and more popular. Various studies suggest that home- and community-based services are cost-effective. According to the Kaiser Family Foundation, in 2015, the median annual cost for nursing facility care was $91,250. Generally, home- and community-based services are less expensive than institution-based care but may still represent a major financial burden for individuals, their families and states. In 2015, the median cost for one year of home health aide services (at $20 per hour, 44 hours per week) was almost $45,800 and adult day care (at $69 per day, five days per week) totaled almost $18,000.

State Medicaid agencies increasingly are providing LTSS through capitated contracts with managed care organizations, known as managed long-term services and supports (MLTSS). In 2017, about 1.2 million people were covered through MLTSS.

As of 2017, 22 states had MLTSS programs and Pennsylvania planned to implement MLTSS (Figure 11). States adopt MLTSS for a variety of reasons, including to integrate primary care, behavioral health and LTSS. Managed LTSS encourages health care providers to deliver coordinated, patient-centered care. It also can improve outcomes through care management, coordinated care teams and value-based purchasing. According to a 2018 Truven Health Analytics report, as of 2017, 11 states included children with disabilities in MLTSS programs.

States use different Medicaid managed care authorities to establish these programs, including through federal waivers (e.g., Section 1115, Section 1915(a), or Section 1915 (b)/(c) waivers, or through state plan authority. As of 2016, 11 states used Section 1115 waivers to provide capitated MLTSS, according to the Kaiser Family Foundation. For example:

- Vermont delivers long-term services and supports through its Choices for Care program under the authority of an 1115 Medicaid demonstration waiver. The program provides LTSS in a variety of settings (e.g., home, family member’s home or nursing facility) to Medicaid-eligible older adults and younger adults with physical disabilities who need the level of care provided in nursing homes.
• Wisconsin supports consumer choice through several innovative programs, including the Family Care and IRIS (Include, Respect, I Self-Direct) programs. These Medicaid waiver programs provide eligible individuals with HCBS in an effort to avoid using costly institutions.

Quality Improvement. The LTSS State Scorecard—a tool created by AARP, The Commonwealth Fund and The SCAN Foundation—aims to “pick up the pace” of improving LTSS by providing comparable state data to benchmark performance, measure progress and identify areas for improvement. The scorecard measures 25 indicators across five dimensions: affordability and access; choice of setting and provider; quality of life and quality of care; support for family caregivers; and effective transitions between care settings or providers. Figure 12 shows the rankings from the LTSS State Scorecard.  

**Figure 12: Long-Term Services And Supports Scorecard**

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<th>Strategy</th>
<th>State Options and Actions</th>
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| Managed Long-Term Services and Supports | • Explore the relative cost benefit of high-quality home- and community-based services. Access to home-based care can encompass a wide array of funding, workforce, informational or other strategies designed to meet local and state needs.  

• Track progress toward achieving quality, funding and other state-defined goals. State policymakers can require the lead state agency to submit performance and quality data that demonstrate progress toward benchmarks and goals. |
Conclusion and Policymaker Considerations

The strategies highlighted in this report suggest myriad options and considerations for policymakers who want to examine their own systems to build on what works and address areas where the system could be improved. The examples highlighted in the report suggest several considerations and areas of inquiry that might lead to further improvements. The table highlights select actions that states have taken in each of the 10 areas.

Table 1. Summary of Select State Actions to Improve Quality and Control Spending

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<th>Strategy</th>
<th>State Options and Actions</th>
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| **Payment and Delivery Reform** | • Explore payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs.  
                                | • Examine the current payment and delivery system and identify opportunities for improving access, quality and efficiency. Some states have appointed commissions or task forces to make recommendations and guide implementation of new payment systems. |
| **Performance and Quality** | • Develop and implement meaningful performance measures and outcomes.  
                                | • Align incentives with desired outcomes and test new payment models, such as attaching provider payments to patients’ health outcomes.  
                                | • Assess whether current data and measures are adequate to inform the public and policymakers about cost, use and performance.  
                                | • Use nationally recognized data sets.  
                                | • Encourage health organizations to publicly communicate exactly which benefits the services are providing to patients, employers and insurers for their money. Explore the status of state all claims payer databases at www.apcdcouncil.org/state/map.  
                                | • Examine the ability of health information technology to enhance patient-centered care; applications that strengthen patient- and family-centered care include systems for coordinated care, patient registries, performance reporting, referral tracking and electronic prescribing. |
| **Address Opioid Crisis**  | • Consider legislation to address prescription drug misuse and overdose. State policies include: deterring people from obtaining multiple prescriptions inappropriately; providing immunity for people seeking medical assistance; ensuring appropriate prescribing of controlled substances; and using prescription drug monitoring programs that report all filled prescriptions for controlled substances.  
                                | • Consider increasing current access (or lowering the costs) of rescue drugs, such as naloxone, that can be used to reverse an overdose.  
<pre><code>                            | • Consider whether Medicaid Section 1115 Substance Use Disorder (SUD) Demonstration waivers could help the state provide effective care to Medicaid enrollees with a substance use disorder. |
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<tr>
<th>Strategy</th>
<th>State Options and Actions</th>
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| High-Need, High-Cost Patients | • Target high-need, high-cost patients to provide more appropriate and timely care and reduce high emergency room and hospital use  
  • Expand care coordination programs to serve Medicaid clients with complex needs  
  • Invest in evidence based strategies that are shown to improve care and cut costs (e.g. the Program of All-Inclusive Care for the Elderly – PACE)                                                                                                                                                                                                                                                                                                                                                      |
| Promote Healthy Births        | • Educate women about healthy pregnancies by supporting education and outreach.  
  • Reduce early elective induction and Caesarian deliveries by restricting Medicaid reimbursement for them, educating patients and providers, monitoring performance and reporting, and coordinating efforts to disseminate best practices to perinatal providers.  
  • Inform families about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services through home visiting, Women’s Infants and Children Food and Nutrition Service (WIC) and other programs.                                                                                                                                                                                                                       |
| Encourage Healthy Behaviors   | • Explore investments in health infrastructure that support the patient’s responsibility for his or her own care, and the efforts of patients, families and their clinicians to work together in a coordinated way.  
  • Assess employment barriers and consider opportunities to promote healthy behaviors and community engagement.  
  • Consider expanding the role of peer support specialists, who use formal training and personal experience with a mental illness or substance use disorder to provide education, support and connections to other services for their peers.  
  • Incorporate incentives such as cost-sharing reductions for healthy behaviors (quitting smoking).                                                                                                                                                                                                                                                                                                                                 |

States continue to innovate to improve their health systems, motivated by rising costs, inefficiencies and consumer demands for better care. Overall, new payment designs are driving innovation in how states pay for and deliver health care, improving the chances that smart investments in health will move the overall system toward better outcomes, lower costs and better access to care. While there is no silver bullet, the examples profiled here illustrate the wide array of strategies to reduce spending, improve care outcomes and quality, and provide states with a return on their health investments.
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