Medicaid & CHIP

Strengthening Coverage, Improving Health

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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
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Executive Summary

Medicaid provides vital health insurance coverage to over 70 million people, including more than 32 million low-income children, over 20 million non-elderly adults (including parents), nearly 7 million elderly adults, and more than 10 million Americans with disabilities. Since implementation of the Affordable Care Act (Affordable Care Act)'s Medicaid expansion, the number of people covered by Medicaid has grown by about 17 million, helping drive the nation's uninsured rate to the lowest level in history, below 9 percent. States, the federal government, and stakeholders have partnered to make Medicaid and the Children's Health Insurance Program (CHIP) the bedrock of the nation's system of health coverage by strengthening and expanding coverage, improving the delivery of care, enhancing quality, and fostering innovation.

For millions of children who need checkups or follow-up care, pregnant women who want their babies to get a healthy start in life, adults who need health coverage when they unexpectedly lose a job, or people with disabilities who want to live independently in their communities, Medicaid and CHIP have been there to provide comprehensive health coverage. Medicaid is the most efficient health coverage program we have, covering people at lower cost than commercial insurance coverage or even Medicare. At the same time, Medicaid has a proven track record of enabling access to care, improving health, and helping children succeed in life.

While Medicaid and CHIP have stayed true to their missions of providing comprehensive health care to low-income Americans, the programs have evolved in recent years through advancements in five key areas:

- **Connecting people to coverage –** Improving individuals' health starts with connecting to them to coverage. Not only have millions gained coverage thanks to the Affordable Care Act's Medicaid expansion, CMS and states have also established new, more streamlined and coordinated eligibility and enrollment pathways to enroll individuals into coverage, with particular benefits for children.
- **Strengthening benefits and access to care –** Working closely with states, CMS has taken steps to strengthen Medicaid benefits and ensure access to high-quality, cost-effective care. In recent years, CMS and states have improved coverage and care by promoting use of evidence-based preventive services as well as through innovations in the areas of substance use disorder treatment, mental health care, maternal and infant health and children's health. At the same time, Medicaid's core delivery system has continued to evolve: today, more than 75 percent of all Medicaid beneficiaries are enrolled in managed care, and most are served by private insurers that are financially responsible for improving access, quality and the health of their enrollees all while containing cost and ensuring value.
- **Serving as a platform for innovation** – From strengthening approaches to primary care, to coordinating care for people with chronic conditions like diabetes, to developing new models to promote efficient delivery of substance use treatment, CMS and states are supporting innovative efforts that lead to smarter spending and healthier people.
- **Providing care in the community –** Medicaid has driven major innovations in care delivery for seniors and people with disabilities. Two decades ago, 81 percent of Medicaid spending on long term services paid for institutional care. Today, more than half of all Medicaid spending on long term services and supports takes place in the community. States continue to make advances through new policies promoting community integration and testing the application of new payment models to community based care.
- **Strengthening program and financial integrity** – Through the first national quality measurement programs for Medicaid and CHIP, states are measuring and managing the quality of care for adults and children. CMS has also worked closely with states to strengthen program integrity, including in Medicaid managed care.

Working together, states and CMS continue to strengthen coverage, drive innovations in care delivery and change beneficiaries' lives by improving their access to care and overall health.

Background

Medicaid and CHIP provide health coverage for more than 70 million Americans, and are the cornerstone of health care coverage for low-income children, parents and other adults, individuals with disabilities, and seniors. Services provided range from pediatric and prenatal care to the provision of long term services and supports. Federal financial support and flexibilities in program rules, along with tools and options made available in recent years, including through the Affordable Care Act, have given states the platform to adopt a broad range of improvements and innovations in their Medicaid and CHIP programs.

Medicaid and CHIP are jointly funded by states and the federal government, and administered by states consistent with federal guidelines. The state role in administering the program means that no two state Medicaid and CHIP programs are alike. That variation reflects the flexibility that states have in designing their programs to meet their own state specific needs, including the flexibility to innovate through section 1115 demonstrations, as 37 states currently do. CMS works with states and other partners to advance state efforts to ensure access to affordable, quality health care, promote health, improve the quality of care, and lower health care costs.

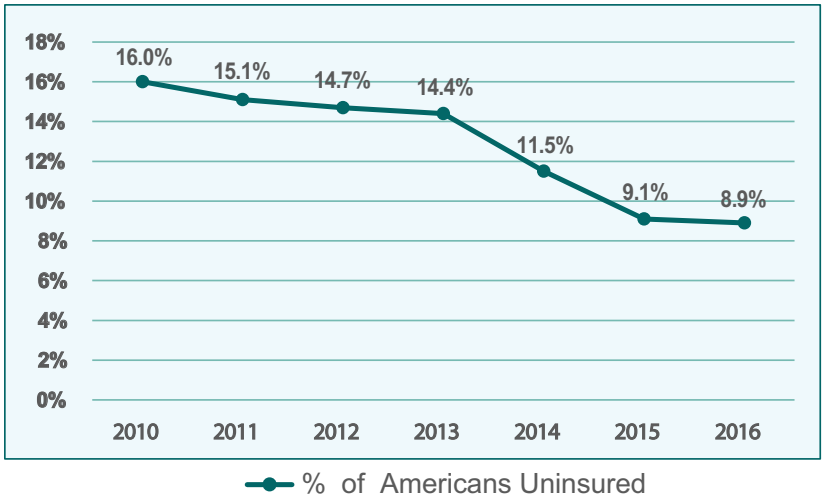
Connecting People to Coverage

Improving people's health and better managing health care costs begins with people having coverage and access to quality care so they can stay healthy and avoid more costly care. The Affordable Care Act created new pathways to coverage, and through CMS' collaboration with states, we have revamped how consumers apply for, and enroll in Medicaid, CHIP and the Basic Health Program (BHP), while maintaining rigorous eligibility checks.

Coverage Expansion

Medicaid and CHIP have long served the nation's most vulnerable populations of children and their parents, individuals with disabilities, and seniors. The Affordable Care Act established new coverage pathways, most notably for low-income adults, allowing Medicaid to serve as the solid foundation of coverage for low-income Americans. This coverage expansion, along with eligibility and enrollment simplifications, is contributing to historic declines in the rate of uninsurance in America. As of the first half of 2016, the uninsurance rate for all Americans is down to 8.9 percent, the lowest it has ever been.

Percent of Americans Uninsured from 2010-2016 *(Jan-June)*



Source: National Health Interview Survey

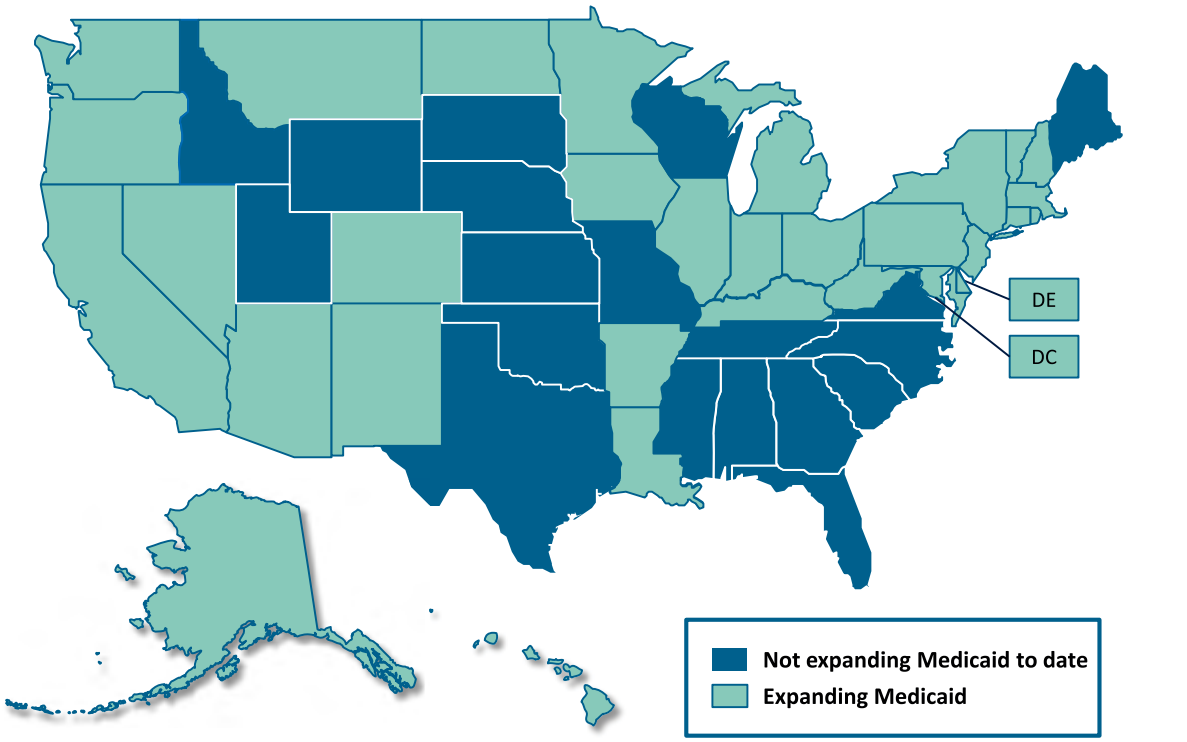
Monthly Reports Show Enrollment Increases

Since November 2013, CMS has published monthly reports on state Medicaid and CHIP data. States report these data to CMS as part of the Medicaid and CHIP Performance Indicator process. A recent report shows that, as of November 2016, nearly 17 million additional individuals were enrolled in Medicaid or CHIP compared to October 1, 2013.

Expanding Coverage to Low-Income Adults

Before the enactment of the Affordable Care Act, generally only very low income parents were eligible for Medicaid (in 2013, the median Medicaid eligibility level for working parents was 61 percent of the poverty level). By establishing Medicaid coverage for low-income adults with incomes up to 133 percent of the poverty level, the Affordable Care Act took a substantial step forward. It not only paved the way for more parents to get covered, but it also – for the first time in the program's history – allowed adults without dependent children to enroll in Medicaid under state plan authority and receive federal matching funds. Historically, Medicaid excluded these adults from state plan coverage; only a few states covered low income adults through section 1115 demonstrations or state-only funded programs. To date, 31 states and the District of Columbia have elected to expand Medicaid.

Map 1. Coverage Expansion, as of December 2016



Note: *In January 2017, the Governor of North Carolina expressed his intent to expand Medicaid.*

Thanks to Medicaid expansion, as of March 2016, over 11 million low-income adults are now receiving comprehensive, affordable, quality health care (see Appendix 1 for state-by-state numbers). The large majority of those gaining coverage under expansion are in working families, and many of them are parents. The Affordable Care Act supported states' ability to cover this population with an enhanced matching rate of 100 percent initially, 95 percent for 2017, 94 percent for 2018, 93 percent for 2019 and 90 percent for 2020 and beyond. While most of the states that have adopted the Medicaid expansion as of January 2017 have done so using state plan authority, some states have used the program's flexibility under section 1115 demonstration authority to support new, state-specific models of expansion, such as premium assistance and healthy behavior incentives. For example, adult Medicaid beneficiaries in Arkansas, Iowa, and New Hampshire (and starting in April 2018, Michigan) enroll in Qualified Health Plans offered in the Marketplace with the states providing "wrap-around" coverage/cost-sharing protections. Some states have also used section 1115 demonstrations to promote healthy behaviors and encourage health improvement activities such as obtaining an annual wellness exam.

Research has shown that Medicaid expansion has helped improve quality, access and affordability of care. The Department of Health and Human Services' Assistant Secretary for Planning and Evaluation (ASPE) reported in January 2017 that Medicaid expansion has increased access to primary care, expanded the use of prescription medications, and increased rates of diagnosis of chronic conditions for new enrollees. It also found that Medicaid expansion has improved the affordability of care, with the number of low-income adults reporting problems paying medical bills down by 10.5 percentage points. Because Medicaid expansion provides low-income individuals with affordable, quality health care, ASPE also found that:

- Unmet health care needs among low-income adults also declined 10.5 percentage points;
- Nearly two-thirds (61 percent) of adults with Medicaid expansion coverage consider themselves to be better off now than they were before enrolling in Medicaid;
- For those adults enrolled in managed care, 93 percent are very or somewhat satisfied with their Medicaid health plans and 92 percent are very or somewhat satisfied with their plan doctors; and
- The use of recommended preventive services increased by more in expansion states than non-expansion states since 2013.

Impact of Medicaid Expansion on States

In-depth studies of the impact of Medicaid expansion in particular states have shown clear improvements in access to care, health, and financial security. For example:

- Medicaid expansion in Kentucky and Arkansas led to a 60 percent decline in the share of low-income adults relying on the emergency room as a primary source of care, a 50 percent decline in the share delaying needed care due to cost, an almost 40 percent increase in the share reporting that they are in excellent health, and a roughly one third decline in the share having trouble paying medical bills.
- In Michigan, studies have shown that Medicaid expansion improved access to care for low-income adults.
- An Ohio Medicaid agency study of individuals gaining coverage found that high fractions reported improved access to care, better health, and reduced medical debt.
- In Louisiana, the state reports high take-up of preventive services among those gaining coverage through expansion. Between July 2016 when the state expanded and January 9, 2017, over 450,000 women have been screened for breast cancer, and nearly 4,500 adults have been screened for colon cancer.
- Studies of pre-Affordable Care Act Medicaid expansions covering low-income adults in Massachusetts and in Arizona, New York, and Maine found that they increased access to care, improved health, and saved lives

Additional Coverage Options for States

The Affordable Care Act also created a new eligibility group for family planning services, an option that was previously only available to states under a section 1115 demonstration. To date, 14 states (CA, CT, IN, LA, ME, NC, NH, NM, NY, OK, PA, SC, VA, and WI) have taken up this option. Medicaid eligibility was also extended for children who have aged-out of the foster care system and had previously received Medicaid while in foster care, until they turn 26. States also have the option, under a section 1115 demonstration, to provide coverage to former foster care youth who aged out of foster care under the responsibility of another state (and were enrolled in Medicaid while in foster care), and are now applying for Medicaid in the state in which they live. To date, 14 states (CA, GA, KY, LA, MA, MI, MT, NM, NY, PA, SD, UT, VA, and WI) have provided such coverage to these former foster youth. Finally, states interested in extending Medicaid eligibility for adults above 133 percent of the poverty level can do so without using section 1115 authority, as the District of Columbia did in 2016 by extending eligibility to 200 percent of the poverty level.

Basic Health Program (BHP)

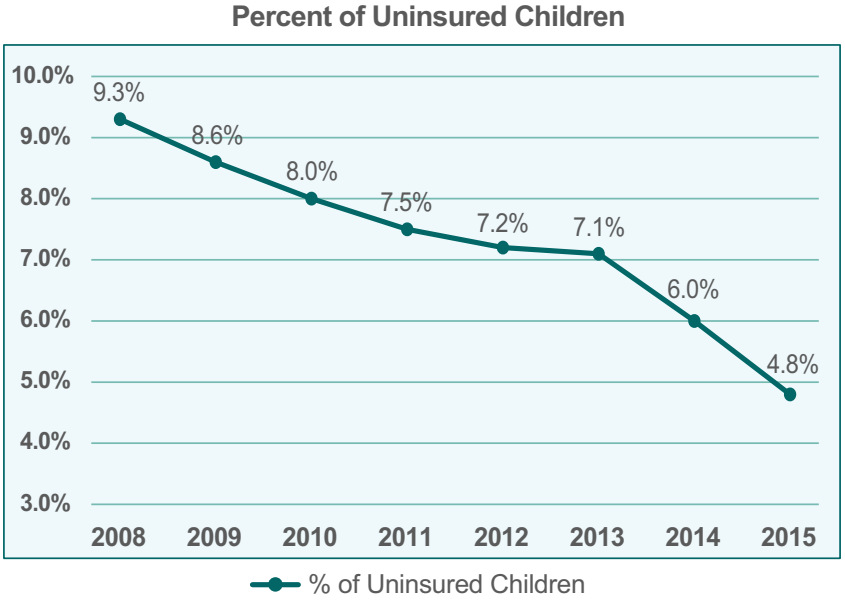
In an effort to help states improve continuity of care by creating a bridge between Medicaid, CHIP and coverage through the Marketplace, section 1331 of the Affordable Care Act gives states the option of creating a BHP, a health benefits coverage program for low-income residents who would otherwise be eligible to purchase subsidized coverage through the Marketplace. So far, New York and Minnesota have established BHPs, which are providing coverage to more than 700,000 individuals combined.

Connecting Children to Covergae

Uninsured rates for children have also fallen under the Affordable Care Act, and about 95 percent of children now have health insurance. The uninsured rate for children has been cut nearly in half since 2008, translating into more than 3 million children gaining coverage, as the Children's Health Insurance Program Reauthorization Act of 2009, described below, and the Affordable Care Act took effect. All groups of children – including black, Asian, and Hispanic children – experienced coverage gains in the last decade.

CHIPRA and Children's Coverage

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) contributed to significant progress in children's coverage by streamlining eligibility and administrative processes, expanding CHIP eligibility to low-income uninsured pregnant women, giving states the option to provide health insurance to immigrant children and pregnant women who are legal residents of the United States but had previously been excluded from coverage, and enhancing CHIP benefits by requiring states to cover pediatric dental. In addition, CHIPRA established performance bonuses to give states an incentive to support the enrollment and retention of eligible children in Medicaid and CHIP and to help defray the costs associated with increasing enrollment of the lowest income children. Finally, CHIPRA authorized the Connecting Kids to Coverage national campaign to raise awareness of the availability of coverage and connect children and their families to enrollment in their communities by providing outreach training, support, and materials. Through four Connecting Kids to Coverage outreach and enrollment grant cycles, CMS has awarded a total of $158 million to 187 organizations and 51 tribal entities across the nation in outreach and enrollment funding. CHIP was reauthorized again in 2015, through legislation that continued many of these improvements.



Source: Children's Health Coverage Rate Now at Historic High of 95 Percent. Joan Alker and Alisa Chester; Georgetown University Center for Children and Families, October 2016.

The Affordable Care Act and Children's Coverage

The Affordable Care Act has also had a major impact on coverage for children and young adults. Between 2013 and 2015, children's uninsured levels experienced the largest two- year decline on record, coinciding with the implementation of the major coverage provisions of the Affordable Care Act. Growing Medicaid and CHIP enrollment contributed significantly to these gains. Although low- and moderate-income children were generally Medicaid or CHIP eligible before the Affordable Care Act, low- and moderate-income parents generally were not. Research has demonstrated that extending coverage to parents promotes enrollment of eligible children. The Affordable Care Act also simplified eligibility and enrollment processes (described below), which contributed to children's coverage gains.

Long-term Gains from Children's Coverage

These coverage gains are likely having a significant impact not only on children's health, but also on their educational attainment and earnings. Researchers have found that getting covered makes children more likely to complete college and leads to higher earnings and better health, including fewer hospitalizations, as adults. On top of the direct benefits to individuals and the economy, higher earnings and better health means investing in Medicaid coverage pays off in higher tax revenues and lower costs decades later.

Simplifying Eligibility and Enrollment

The Affordable Care Act enabled states to implement streamlined system of eligibility determination and enrollment that are coordinated across insurance affordability programs including Medicaid, CHIP, BHP and coverage through the Marketplace.

Simplified Eligibility and Enrollment Rules and Processes

The Affordable Care Act replaced complex income counting rules to determine eligibility across all insurance programs with a new financial methodology, Modified Adjusted Gross Income (MAGI), for most children, parents, pregnant women, and nondisabled adults under age 65. These simpler rules, as well as the use of a single application to collect consumer information and the shift to a streamlined coordinated eligibility and enrollment system that maximizes technology, electronic information and data has created a "no-wrong-door" approach to applying and enrolling in coverage. It has also enabled consumers – for the first time – to receive a final eligibility decision for Medicaid and CHIP in real time, without compromising accuracy.

These changes are helping to connect eligible individuals to coverage quickly, easily and accurately, and to keep people enrolled for as long as they are eligible. They have also created administrative efficiencies for states and decreased burden for consumers by moving away from time and labor intensive paper-driven processes. As of January 2017, over three quarters of states reported that they can make real-time Medicaid eligibility determinations (defined as less than 24 hours) for children, pregnant women, and non-disabled adults. Another example of administrative efficiencies is the option for states to implement targeted enrollment strategies made available in 2013 and 2015 that help identify and enroll eligible individuals in Medicaid, or to facilitate their renewal, with less paperwork for the individual and the state. To date, eleven states have taken up these strategies (AK, AR, IL, LA, MI, NJ, NY, OR, PA, VA, and WV).

States are also focusing on streamlining eligibility determination and enrollment for additional populations, and implementing multi-benefit applications, through which people can apply for several different low-income programs simultaneously, such as Medicaid, CHIP, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Low Income Home Energy Assistance Program (LIHEAP). Currently, there are 25 states that use multi-benefit applications, and CMS continues to work closely with other states to develop multi-benefit applications and other integrated consumer-facing processes.

These improvements in eligibility and enrollment were supported with investments in technology and significantly modernized eligibility systems, such as automating the application and renewal process and enhancing program reporting and data analytics. In 2011, CMS notified states that the available match rate for the development and implementation of modernized eligibility systems from 50 percent to 90 percent for five years and in 2015, finalized a rule that extends this enhanced funding for the design, development, installation, or enhancement of Medicaid eligibility and enrollment systems on an ongoing basis.

Strengthening Benefits and Access to Care

Working closely with states, CMS has taken steps to strengthen Medicaid benefits and ensure access to high-quality, cost-effective care. CMS has been collaborating with states to strengthen coverage, for example by expanding preventive services and developing innovative approaches to help address emerging public health crises, such as Zika, the lead crisis in Flint, Michigan and the opioid epidemic.

Preventive Services

Preventing disease before it starts or becomes severe is critical to helping people live longer, healthier lives. Medicaid and CHIP promote prevention by helping millions of beneficiaries access preventive healthcare services, such as immunizations, screenings for common chronic and infectious diseases and cancers, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease.

Enhanced Match for Preventive Services

To expand access to preventive services, the Affordable Care Act required private insurance and Medicare to cover without cost-sharing preventive services recommended by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA) as well as vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP). This same requirement applies to coverage for adults covered under Medicaid expansion. To incentivize states to extend such coverage to all their Medicaid beneficiaries without cost-sharing, the Affordable Care Act established a one percentage point increase in the federal match that applies to expenditures for specified preventive services assigned a grade of A or B by the USPSTF and HRSA as well as approved vaccines and their administration, recommended by the ACIP. To date, at least 12 states (CA, CO, DE, HI, KY, NV, NH, NJ, NY, OH, WA and WI) have applied for and receive the enhanced match for preventive services.

Beneficiary Incentives for Chronic Disease Prevention

The Affordable Care Act authorized grants to states to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. In September 2011, CMS awarded 10 states (CA, CT, HI, MN, MT, NV, NH, NY, TX and WI) demonstration grants to implement chronic disease prevention approaches for their Medicaid enrollees to test the use of incentives to encourage behavior change. A few states are also experimenting with incentives for healthy behaviors as part of 1115 demonstrations.

Innovating Through Evidence-Based Approaches

CMS has worked with states to incorporate new practices based on a review of research and evidence about outcomes and clinical effectiveness. Examples of guidance described in other places in this report are:

- Early Intervention Services for First Episode Psychosis
- Long-Acting Reversible Contraception
- Maternal Depression Screening and Treatment
- Home Visiting Services
- Best Practices for Addressing Opioid Addiction
- Medication Assisted Treatment for Substance Use Disorder
- Behavioral Health Services for Youth with Substance Use Disorder
- Tri-Agency letter on Trauma-informed Treatment

Montana's Diabetes Prevention Program

Montana implemented a program modeled off of the National Diabetes Prevention Program for adults at high-risk for developing cardiovascular disease and type 2 diabetes (including adults enrolled in Medicaid) with the goal of encouraging weight loss among program participants. Montana found that 50 percent of the participants lost at least 5 percent of their body weight at 4 months and 33 percent of the participants lost at least 7 percent of their body weight at 4 months. As a result of what they found, the state added group nutrition counseling and physical activity coaching to prevent diabetes and cardiovascular disease to the services provided by licensed providers to all eligible beneficiaries.

Tobacco cessation

Cigarette smoking is one of the greatest drivers of adverse health outcomes and costs for state Medicaid programs. Yet, while 70 percent of U.S. smokers report that they want to quit, few who try to quit use evidence-based treatments that can significantly increase their odds of success. States can reduce smoking rates and health care costs and improve health outcomes by investing in comprehensive smoking cessation programs. Tobacco dependence treatment is one of the most cost-effective preventive services with as much as a $2-$3 return on every dollar invested, a substantial return on investment in both the short and long term. To help states reach their tobacco cessation goals, Medicaid provides several tools, such as mandatory coverage of tobacco cessation counseling for pregnant women, the provision of cessation services for all other Medicaid beneficiaries, and coverage of all FDA-approved tobacco cessation medications.

Mental Health and Substance Use Disorder

Medicaid is the single largest payer for mental health services in the United States and plays a large role in financing substance use disorder services. CMS has worked closely with states on initiatives to support their efforts in addressing mental illness and substance use disorder.

Mental Health and Medicaid

Approximately one in four individuals with incomes low enough to qualify for Medicaid has a mental health or substance use disorder condition. Individuals with a behavioral health disorder utilize significant health care services—approximately one in eight visits to emergency departments (EDs) in the United States involves mental health and substance use disorders.

Mental Health Parity

Congress has enacted several laws designed to improve access to mental health and substance use disorder services, including the Mental Health Parity and Addiction Equity Act, which is critical for improving access to treatment for these conditions as it ensures that restrictions on mental health and substance use disorder benefits are no greater than those on medical benefits. In 2016, CMS issued a final rule requiring that mental health and substance use disorder benefits for beneficiaries who receive services through managed care organizations, ABPs, or CHIP, including long term services and supports, must comply with parity standards. This rule also aligns Medicaid and CHIP requirements to those in the commercial market.

New Opportunity to Address Substance Use Disorders

As of January 2017, four states (CA, MA, MD and VA) have taken advantage of a new opportunity for states to transform substance use delivery systems under section 1115 demonstrations. Announced in July 2015, this new opportunity provides federal support for states to develop comprehensive strategies to ensure a full continuum of services, focusing on integrating primary care and mental health treatment and delivering services that are rooted in evidence-based models consistent with industry standards. While there is considerable flexibility available to states under current Medicaid authorities to provide substance use disorder services, this section 1115 demonstration initiative provides additional flexibility for states to address some of the most significant barriers to providing effective care to individuals.

Addressing the Opioid Epidemic

Since January 2016, over one-third of states have adopted or plan to adopt the CDC opioid prescribing guidelines in their Medicaid programs; some require their MCOs to adopt them as well. Half of states have made naloxone available without prior authorization or added it to their preferred drug list. In addition, a number of states have implemented innovative ways to improve access to treatment. For example, Vermont's Hub and Spoke initiative includes regional addiction treatment centers that act as "hubs" providing integrated SUD treatment and rehabilitative services while patients with less complex needs can receive less intensive care through "spokes," which consist of primary care health homes and federally qualified health centers (FQHCs).

Best Practices for Addressing Prescription Opioid Overdoses, Misuse, and Addiction

The opioid epidemic is a public health crisis that affects the lives of millions of Americans. According to the Center for Disease Control (CDC), since 1999, the number of deaths in the U.S. due to overdoses of prescription opioid pain medication and heroin have quadrupled. A primary driver of the spike in opioid overdose deaths has been the increased number of prescriptions for opioid pain medications. To help address this epidemic, CMS issued an Informational Bulletin in January 2016 highlighting strategies available to state Medicaid programs in order to combat the epidemic, such as encouraging safer opioid alternatives for pain relief, working with other state agencies to educate Medicaid providers on best practices for opioid prescribing, employing pharmacy management practices, and working to increase access to naloxone, an overdose antidote.

Medication Assisted Treatment for Substance Use Disorder

Millions of Americans are affected by substance use disorders. Medication Assisted Treatment (MAT) is an effective practice for treating substance use disorders, which combines the use of FDA-approved medications with evidence-based behavioral therapies to provide a whole-patient approach to treating substance use disorders such as alcohol use and opioid use disorders. CMS released an Informational Bulletin in July 2014 in partnership with the Substance Abuse Mental Health Services Administration (SAMHSA), CDC and National Institutes of Health (NIH) to help promote delivery of these services in Medicaid programs. As the 2014 guidance highlights, there is strong evidence that the use of MAT in managing substance use disorders results in substantial cost savings as well as fewer inpatient admissions.

Maternal and Infant Health

Medicaid covers nearly 50 percent of U.S. births. Medicaid coverage helps keep pregnant women healthy and ensures that infants get off to a good start in life. In collaboration with our state partners and providers, CMS is improving the quality of maternity care and birth outcomes.

Maternal and Infant Health Initiative

In 2014, CMS launched a Maternal and Infant Health Initiative (MIHI) to build on strategies identified by maternal and infant health experts and stakeholders to drive improvements in the care provided postpartum and between pregnancies as well as to substantially improve the short- and long-term health outcomes of Medicaid/CHIP enrollees. Twenty-nine states participate in the various MIHI initiatives.

Strong Start for Mothers and Newborns

Led by the CMS Innovation Center (CMMI), Strong Start aims to improve maternal and infant outcomes for pregnancies covered by Medicaid and CHIP. The initiative funds three enhanced prenatal care approaches—group prenatal care, maternity care homes, and birth centers—and is currently supporting service delivery through 27 awardees and 199 provider sites across 30 states, the District of Columbia, and Puerto Rico, with a proposed target of serving up to 50,000 women.

CMS Text4baby Pilot Project

This project was launched in 2014 as a three-year collaborative effort between CMS and four states (CA, LA, OH and OK) to customize interactive mobile text messages to provide expecting and new mothers with targeted information and information about local resources. One pilot state, Oklahoma, used Text4baby to identify 470 pregnant women at risk for preterm birth, 74 percent of whom were in their first trimester of pregnancy, giving the state time to target additional services and resources to reduce the risk.

Ensuring Access to Family Planning Services and Supplies

Medicaid plays a significant role in the provision of family planning services, providing more than 70 percent of such services for low-income Americans. CMS is committed to working with states and women's health groups on ways to better ensure access to family planning services and supplies. CMS issued guidance in April and June 2016 to ensure Medicaid beneficiaries' choice of family planning providers, and to help states improve the delivery of, and timely access to, family planning services, including contraception. Effective contraception helps improve maternal and infant health by preventing unplanned pregnancies, improving birth spacing and reducing the risk of low-weight and premature births. CDC has identified long-acting reversible contraception (LARC) methods – intrauterine devices and contraceptive implants – as among the most effective family planning methods. Based on information collected from experts and state officials, CMS released an Informational Bulletin in April 2016 sharing emerging LARC reimbursement strategies. In partnership with CDC and Office of Population Affairs, CMS is working with 28 states to improve access to effective methods of contraceptive, especially LARC.

Maternal Depression Screening and Treatment

Maternal depression is a serious and widespread condition that affects the mother's health and can also have a lasting detrimental effect on a child's health and development. Low-income mothers are more likely to experience some form of depression than the general population. Medicaid plays a critical role in screening mothers for maternal depression and connecting mothers and children with treatment resources. In a May 2016 Informational Bulletin, CMS shared the American Affordable Care Actdemy of Pediatrics (AAP) best practices related to maternal depression screening and treatment. The bulletin also highlights and clarifies state Medicaid programs' ability to cover such screenings and medically necessary treatment for children.

Treating Maternal Depression in Virginia

In Virginia, Medicaid covers the administration of the Behavioral Health Risks Screening Tool for pregnant and non-pregnant women of child-bearing age. The state encourages practitioners to use the screening tool and provides information about treatment services available for women who screen positive.

Home Visiting Services

In March 2016, CMS jointly released an Informational Bulletin with HRSA on coverage for home visiting services. Home visiting programs, which deliver services such as screening, case management, family support, counseling, and skills training for pregnant women and parents with young children, have a strong record of improving child outcomes. The Informational Bulletin lays out the various Medicaid services and existing authorities available to states to use in developing their home visiting programs. For example, Michigan operates the Michigan Maternal Infant Health Program (MIHP) to encourage and educate women about family planning and well-women care between pregnancies. Participation in MIHP is associated with reduced risk of adverse outcomes such as low birth weight and premature birth.

Benefits for Children

As discussed above, researchers have found that access to Medicaid and CHIP coverage during childhood results in long-term gains in children's health and economic well-being. To further improve the quality of Medicaid coverage for children, CMS has undertaken a number of pediatric initiatives.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Medicaid's EPSDT benefit ensures that over 35 million eligible children and youth under age 21 receive a comprehensive array of preventive, diagnostic, and treatment services. This pediatric benefit is designed to meet the full range of children's health and developmental needs. EPSDT covers age-appropriate medical, dental,

vision and hearing screening services at specified times, as well as when health problems arise or are suspected. In addition to screening, EPSDT covers diagnostic and treatment services described in section 1905(a) of the Social Security Act to correct or ameliorate identified conditions. In 2014, CMS published a guidebook intended to help states, plans, providers and others realize the promise of EPSDT.

School Based Health Services

Medicaid helps ensure that children receive needed health care so they can be successful in school. CMS has worked closely with states by providing technical assistance and clarifying guidance on the availability of federal Medicaid funding for school based health services. In 2014, CMS issued guidance clarifying the availability of federal Medicaid funding to support access to health care in schools and other settings.

Oral Health

Tooth decay continues to be one of the most prevalent chronic diseases of childhood, despite the abundance of scientific evidence demonstrating that it can be prevented. CMS is committed to improving access to dental and oral health services for children enrolled in Medicaid and CHIP. Together, CMS and states have made considerable progress in this area as the percentage of Medicaid-enrolled children (ages 1 and older) who receive dental care continues to increase nationwide. To ensure this progress continues, we are working closely with states through our Oral Health Initiative 2.0. We have also launched a children's oral health delivery system reform project through CMS' Medicaid Innovation Accelerator Program, described further below.

Improvements in Oral Health

Using data from the 2011–12 National Survey of Children's Health, and after adjusting for demographic and parent characteristics, the authors found no difference between publicly and privately insured children in parent-reported use of dental care by children.

Behavioral Health Services for Youth

About 5 percent of adolescents (1.2 million) between the ages of 12 and 17 had substance use disorders in 2015. For young adults aged 18-25, the rate in 2015 was 15.3 percent. In January 2015, CMS jointly released an Informational Bulletin with SAMSHA on how states can develop a benefit tailored to youth with substance use disorder. In addition to substance use disorder, complex trauma is common and serious concern for children, especially for those in foster care. Nine out of 10 foster care children are exposed to trauma. To address complex trauma and improve social-emotional health among children known to child welfare systems, CMS, ACF, SAMHSA joined together to issue a State Medicaid Director Letter in 2013 encouraging the use of trauma-focused screening, functional assessments and evidence-based practices in appropriate settings.

Adolescence or early adulthood is when a majority of people with severe mental illness experience their first psychotic symptoms. Left untreated, psychosis increases a person's risk of suicide, involuntary emergency care and poor clinical outcomes. Early intervention with evidence-based services can alter this illness trajectory by lessening the severity of first episode psychotic symptoms and enable individuals to stay in school or at work, live in community settings, participate fully in family and community life, and put them on a path to better health. An October 2015 Informational Bulletin jointly released by CMS, the National Institute of Mental Health (NIMH) and SAMHSA highlighted the effectiveness of coordinated specialty care programs to deliver early intervention services for treating first episode psychosis in real-world settings.

Benefits for Targeted Populations

CMS has worked closely with states in implementing innovative approaches to strengthen coverage for targeted populations, such as individuals living with HIV. To help states better design benefit packages for people living with HIV, CMS, CDC and HRSA jointly issued an Informational Bulletin on World AIDS Day 2016 highlighting opportunities available to states to drive improvements in the accessibility, quality, cost, and population-level impact of HIV prevention and care services available to Medicaid beneficiaries.

Another targeted Medicaid population CMS has worked closely with states on is individuals re-entering the community from the criminal justice system. This population has high incidences of mental illness and substance use disorder and often faces other health challenges. In April 2016, CMS issued guidance to promote access to care and support re-entry policies that promote health and well-being, including ensuring the continuity of care while individuals are in a transition period from confinement to full release into the community.

Ensuring Access to Care

CMS is committed to ensuring that beneficiaries have access to affordable, quality health care. Using different tools and mechanisms, CMS has worked with states over the past several years to promote access to care.

Methods to Ensure Access

CMS issued a final rule in 2015 establishing processes for states and CMS to make better informed, data-driven decisions when considering proposed changes to Medicaid fee-for-service payment rates and the potential effect on access to services. The final rule requires states to analyze access to care, institute new transparency procedures and receive real-time information from stakeholders so that CMS can better monitor, measure, and ensure Medicaid access to care within fee-for-service reimbursement methodologies. These new policies parallel access improvements included in the final managed care rule, such as strengthened network adequacy standards. For example, states are implementing new procedures to consider public input when proposing rate reductions as well as analyze the potential effect of rate reductions on beneficiary access to care, including monitoring access for three years after such reductions take effect. States are also conducting ongoing access to care reviews of a core set of five services: primary care, physician specialists, behavioral health, pre- and post-natal obstetrics (including labor and delivery), and home health services. Finally, states are implementing mechanisms, such as through hotlines, surveys or ombudsman's offices, to solicit ongoing beneficiary and provider feedback to identify access issues:

Promoting Access to Care

The Affordable Care Act temporarily increased primary care payments for certain primary care services to equal Medicare Part B payments in calendar years 2013 and 2014 to help providers serve the millions of newly Medicaid eligible. States received 100 percent federal matching funds for the increase in payments in both fee-for-service and managed care settings. A number of states elected to continue these higher payment rates in full or in part after the enhanced federal funding expired in 2014.

Strengthening Access in Indian Country

In 2015, CMS received proposals from Alaska and South Dakota to improve access for the American Indian and Alaska Native (AI/AN) populations in their respective states. After consideration of their proposals, in 2016, CMS issued new guidance related to the availability of the enhanced federal match for services "received through" an Indian Health Service (IHS) or Tribal facility. The guidance offers states, the IHS, and Tribes a new option to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health. CMS has also supported the provision of services to AI/AN individuals though a number of section 1115 demonstrations (AZ, CA and OR). CMS has also worked with states to implement statutory provisions mandating lower premium and cost-sharing as well as other protections for AI/ANs.

Strengthening Medicaid's Purchasing of Prescription Drugs

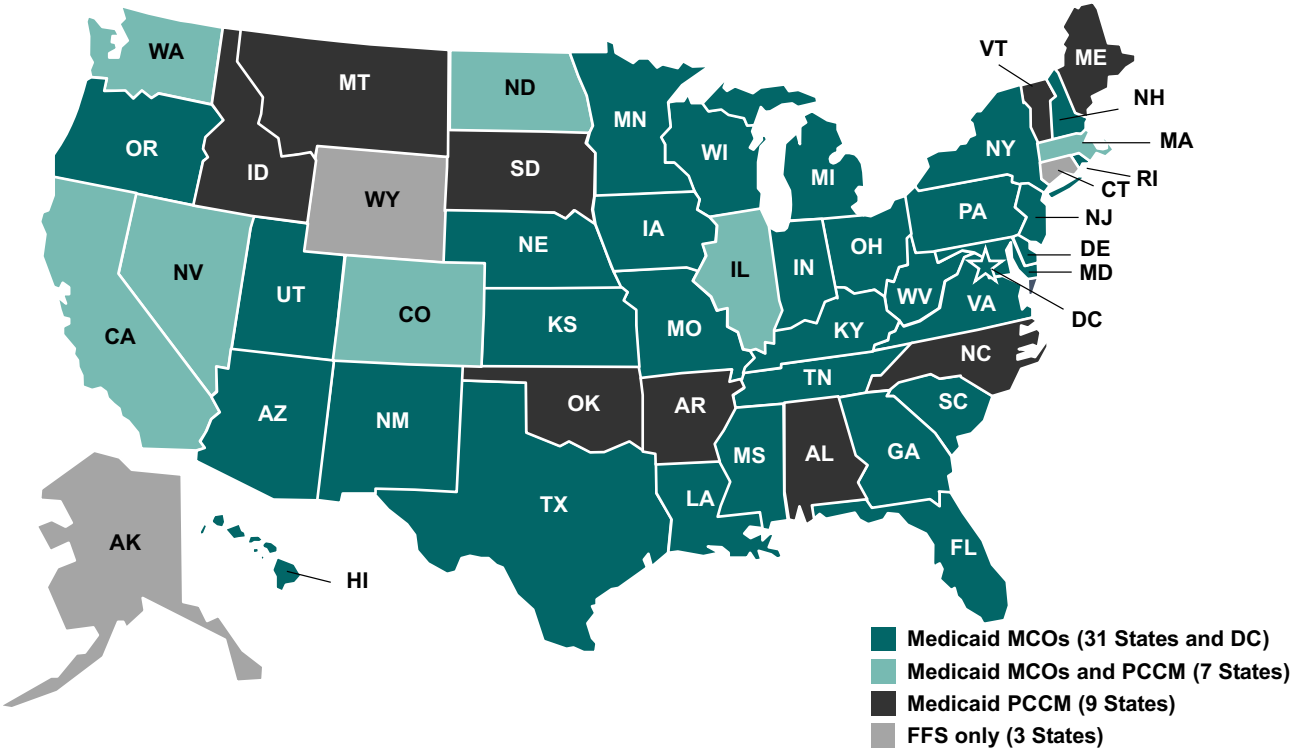
Over the past several years, CMS has partnered with states to achieve better health and improved care at lower cost. CMS and states have strengthened Medicaid's role as an effective purchaser of prescription drugs in the following ways:

- **The Medicaid Drug Rebate Program** – The Medicaid Drug Rebate Program is a program that includes CMS, State Medicaid Agencies, and participating drug manufacturers that helps to offset the Federal and State costs of most outpatient prescription drugs dispensed to Medicaid patients. These offsets take the form of rebates paid by manufacturers; the rebates vary in amount depending on the classification of the drug (e.g., brand name, authorized generic, or generic), and whether the manufacturer has increased the price of a drug faster than the rate of inflation. In early 2016, CMS issued the final Covered Outpatient Drug Rule which, among other things, clarifies many of the changes made to the MDRP by the Affordable Care Act and provides drug manufacturers with enhanced regulatory guidance to ensure proper calculation and reporting of drug product and pricing information.
- **Pharmacy Survey to Aid States in Efficiently Pricing Prescription Drugs** – In an effort to increase transparency in drug pricing and help states determine appropriate payments to pharmacies, CMS finalized a national Medicaid drug survey of retail community pharmacy invoice prices in late 2013. This voluntary monthly survey gathers invoice pricing information on covered outpatient drugs purchased by retail community pharmacies. The resulting pricing files, termed the National Average Drug Acquisition Cost, represent a national pricing benchmark that states can consider when setting their reimbursement methodology.
- **Assuring Medicaid Beneficiary Access to Hepatitis C Drug** - Modern medicine delivers tremendous benefits for patients, including new therapies that can cure or help combat life threatening diseases, such as the Hepatitis C Virus (HCV). Before rebates, while these innovative medicines have the potential to improve quality of life and health outcomes, their high prices affect patients, businesses, taxpayers. Medicaid (state and federal) spent approximately $57 billion on pharmaceuticals in 2015, and 34 percent of covered drugs cost more than $1,000 per fill, before rebates. In late 2015, CMS issued a letter reminding states of the shared commitment to provide beneficiaries with chronic HCV access to effective, clinically appropriate, and medically necessary treatments. CMS continues to work with states to remove restrictions that limit coverage. In recognition of the role manufacturers play in ensuring access and affordability to these medications, CMS also sent a letter in late 2015 asking them to provide information regarding any value-based purchasing arrangements they offer for these drugs so that states might be able to participate in such arrangements.

Modernizing Managed Care

There has been a fundamental shift in how Medicaid services are delivered and paid for. When Medicaid was first established in 1965, it, like Medicare, was primarily a claims-paying fee-for-service program Today, more than 75 percent of all Medicaid beneficiaries are enrolled in managed care, and most are served by private insurers that are financially responsible for improving access, quality and the health of their enrollees all while containing costs and ensuring value. To help advance these goals, CMS updated its Medicaid and CHIP managed care regulations in 2016, representing a major overhaul of rules that were in place in 2002 and establishing CHIP managed care standards that align with those of Medicaid and the Marketplace.

Map 2. States with Medicaid Managed Care



NOTES: Medicaid MCOs refers to risk-based managed care, which includes full-risk, PIHPs and PAHPs; Medicaid PCCM refers to primary care case management. Data do not reflect Idaho's Medicaid-Medicare Coordination Plan, which is secondary to Medicare. Some states (e.g. South Carolina, Texas and Wyoming) use PCCM authority to provide select services or make PCMH payments that are not reflected here. Colorado's PCCM program refers to the state's Accountable Care Collaboratives. MCO enrollees in Oregon include those enrolled in the state's Coordination Care Organizations. California's PCCM program operates in Los Angeles County for those with HIV. Connecticut terminated its MCO contracts in 2012 and now operates its program on a fee-for-service basis using four Administrative Services Only entities.

Improving the Beneficiary Experience

The managed care rule seeks to strengthen communication between the managed care plans and their enrollees by expanding their ability to communicate through a range of electronic communications and ensuring that important information such as provider directories and drug formularies are posted on managed care plans' websites. To strengthen access to services in a managed care network, states will establish specific time and distance network adequacy standards and assess, on an annual basis, the adequacy of a managed care plan's provider network. The final rule also strengthens standards for care coordination, assessments and treatment plans especially for those individuals using long term services and supports. The final rule also enhances the enrollment process by making sure enrollees have access to unbiased information on available managed care plans or provider options.

Strengthening Delivery System Reform Efforts

The rule strengthens states' delivery system reform efforts and ability to support local priorities and advance initiatives, such as establishing patient-centered medical homes, while ensuring quality of care for Medicaid beneficiaries. For example, the final rule engages states and plans in establishing value based payment models for providers and developing approaches to support timely access to care and improving quality.

Aligning with the Marketplace and Medicare

The rule aligns Medicaid and CHIP managed care standards with the Marketplace and Medicare to improve operational efficiencies for states and health plans and to promote smooth transitions for individuals whose circumstances may change and who move between health care coverage options. For example, the rule establishes a medical loss ratio consistent with the standards applied by the Marketplace and Medicare, aligns appeals processes with the Marketplace and Medicare, and aligns processes for providing information to beneficiaries, like posting provider directories and drug formularies to a public website in a manner similar to the Marketplace and Medicare.

Improving the Delivery of Managed Long Term Services and Supports (MLTSS)

As states have moved towards MLTSS, CMS has strengthened expectations for MLTSS programs and beneficiary protections, while allowing states flexibility in program design and administration. The rule promotes stakeholder engagement, planning and readiness review, community person-centered planning and MLTSS network adequacy.

MLTSS

Currently, twenty three states use a managed care delivery system to provide long term services and supports to some or all of their Medicaid population.

Strengthening Quality in Managed Care

The managed care rule also advances quality measurement and reporting. With state and stakeholder input, CMS is developing the first Medicaid and CHIP quality rating system (QRS), similar to the QRS that exists for the Marketplace, allowing states to develop and implement their own QRS as long as it is substantially comparable to the QRS developed by CMS. This will help consumers shop for plans and states better measure and manage the quality of care. The final rule also strengthens the external quality review process, promotes transparency of information, and ensures that key quality processes support reducing health disparities and ensure quality for MLTSS and for people with special health care needs.

Section 1115 Delivery System Demonstrations

Section 1115 demonstration authority provides state flexibility in a number of areas of the Medicaid program, and states have increasingly been using them as a tool to advance delivery system reform. Some states have used this authority to design new and innovative approaches to delivering care in their Medicaid programs, in ways that target state specific priorities. Thirty-seven states (*see Appendix 2*) – operate section 1115 demonstrations that serve a variety of objectives. States are increasingly using this authority to design transformation efforts that move toward paying for value, improving outcomes, and aligning with other payers to make system-wide reforms. The most commonly used structure is a Delivery System Reform Incentive Payment ("DSRIP") program that offer providers incentives that are contingent on achieving performance improvement goals. DSRIP programs represent a significant investment in improvements to care delivery in the nation's safety net; since 2010, 9 states have received approval for DSRIP waivers totaling $39.1 billion. An additional 4 states have received approval for smaller federal delivery system reform investments, totaling approximately $1 billion. These amounts represent spending over several years of the states' demonstrations. As Table 1 shows, states are taking different approaches under section 1115 demonstration authority to significantly transform how Medicaid pays for and delivers health care services to beneficiaries. (The table lists the delivery system reform model and approach each state is using in its section 1115 demonstration).

Table 1. Innovative 1115 Demonstrations		
State	**Delivery System Reform Model Used**	**Approach under the Demonstration**
AZ **Approved January 2017**	*Program Integration*	Integrates behavioral and physical health care and better coordinates care for individuals with behavioral health needs, individuals who reenter the community from the justice system, and American Indians who enroll in medical homes. Managed care plans will support providers who demonstrate improved performance and implement projects that increase integration and reduce fragmentation between acute care and behavioral health care, creating efficiencies in service delivery and improving health outcomes.
OR **Renewed January 2017**	*Provider Based Managed Care*	Utilizes community driven, innovative practices through the establishment of Coordinated Care Organizations aimed at promoting evidence-based, coordinated, and integrated care to improve health outcomes, data and measurement while restraining costs.
WA **Approved January 2017**	*Alternative Payment Model* *DSRIP*	Adopts Alternative Payment Models (APMs) in state managed care contracting by converting 90 percent of Medicaid provider payments to reward outcomes rather than volume by 2021. Also forms regional multi-stakeholder organizations, Accountable Communities of Health (ACH), to improve health and transform care delivery for the populations that live within their region. ACHs will also administer a DSRIP, which outlines a series of health care projects with associated performance metrics to promote integration and coordination across provider specialties and care settings.
MA **Approved November 2016**	*Accountable Care Organization* *DSRIP*	Establishes an ACO model as the primary system of care delivery and payment across medical, long-term care and behavioral services to improve integration, coordination, and beneficiary experience while reducing cost and maintaining clinical quality and access. A DSRIP incentivizes providers to form and join ACOs to integrate care delivery, with a portion of overall DSRIP funding at risk to incentivize specific quality improvement goals,
RI **Approved December 2016**	*DSRIP*	Establishes Accountable Entities (AEs), or integrated provider organizations, to improve the quality of care, beneficiary experience, and total cost of care for an attributed population of plan enrollees· Through value-based contracts, health plans and AEs will enter into shared savings agreements, with a portion of each year's AE incentive being at risk for performance.
NY **Renewed December 2016**	Alternative Payment Model *DSRIP*	Promotes community-level collaboration to reduce health care costs while financially stabilizing the state's safety net system. A total of 25 statewide Performing Provider Systems implement innovative projects focused on system transformation, clinical improvement and population health improvement. A DSRIP promotes achieving performance goals and project milestones, including establishing goals for statewide adoption of APMs in managed care contracting by 2019 with funding contingent on achieving APM adoption.

State	Delivery System Reform Model Used	Approach under the Demonstration
VT **Approved December 2016**	*Accountable Care Organization*	Provides authority and start up investment for Medicaid to participate in an All Payer ACO Model, testing an APM in which the most significant payers within the state – Medicare, Medicaid, and commercial health care payers – work together to incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the care delivery system.
AL **Approved February 2016**	*Provider Based Managed Care*	Moves from a fee-for-service (FFS) delivery system to managed care under locally-run, provider-based Regional Care Organizations (RCOs), which will provide care coordination and other interventions aimed at improving health. A time-limited transition pool will reward RCOs and providers who meet operational and quality targets.[1]
NH **Approved January 2016**	Alternative Payment Model *DSRIP*	Establishes regionally-based behavioral and physical health care providers to improve access to and quality of behavioral health services through an integrated delivery system. Over the next 5 years, the state will also move to value-based purchasing in its managed care contracts.
CA **Renewed December 2015**	*DSRIP* *Alternative Payment Model*	Tests a new global payment methodology for Public Health Systems to deliver more coordinated care for the uninsured population, including new incentives to promote stronger care delivery and more integrated care focused on APMs that align with HHS delivery system reform goals. A portion of funding for the DSRIP will be conditional on achievement of APM goals.
NM **Approved November 2014**	*DSRIP*	Incentivizes hospitals to improve the health and quality of care for the Medicaid and uninsured individuals that they serve.
KS **Approved December 2012**	*DSRIP*	Incentivizes hospitals to improve the health and quality of care for the Medicaid and uninsured individuals that they serve.
NJ **Approved October 2012**	*DSRIP*	Supports projects that emphasize outpatient care, incentivizing collaborations between hospitals and outpatient settings.
TX **Approved December 2011**	*DSRIP*	Expands managed care and establishes a funding pool to provide incentive payments to participating hospitals that implement and operate delivery system reforms.

[1] As of the date of this report, the state has yet to implement the demonstration.

Medicaid as a Platform for Innovation

Just as Medicare and private payers are shifting their payment arrangements from reimbursement based only on volume to reimbursement based on value, Medicaid is rapidly evolving the way in which it delivers and purchases the care it provides. States, plans, and providers are developing innovative approaches to promote smarter spending and healthier people. These range from far-reaching Accountable Care Organizations (ACOs) to more targeted approaches that strengthen primary care and care coordination. At the same time, CMS and states are working together to spread best practices on payment and delivery system reform through the Medicaid Innovation Accelerator Program. In addition, electronic health records are playing a major role in improving efficiency and coordination.

State Innovation Model

The State Innovation Models (SIM) Initiative provides financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models, with an aim to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and CHIP beneficiaries—and for all residents of participating states. In 2013, Round One of the SIM Initiative was awarded to 25 states to design or test innovative health care payment and service delivery models in the form of Model Design, Model Pre-Test, and Model Test awards. In 2014, Round Two moved some states from design to test status and funded 28 states, three territories, and the District of Columbia. When combining both Round One and Two awardees, over half of states representing 61 percent of the U.S. population are supporting comprehensive state-based innovation in health system transformation.

Comprehensive Primary Care

Since the Comprehensive Primary Care (CPC) initiative, an advanced multi-payer primary care model, initially launched in October 2012, five state Medicaid agencies joined Medicare and private payers to strengthen primary care. In 2016, CPC+ added three more states to the CPC initiative for a total of eight state Medicaid agencies (AR, CO, OH, OK, OR, MT, RI and TN) joining Medicare and private payers and hundreds of primary care practices to further advance primary care. To date, the CPC initiative has shown promise in reducing costs, lowering hospital admission and readmission rates, and improving patient experience. Over the next five years, CPC+ will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization.

Health Homes

Established by the Affordable Care Act, the health home state plan option provides states an opportunity to improve care coordination and care management for Medicaid beneficiaries with chronic conditions, supported on a temporary basis by enhanced federal match. As of January 2017, there are 29 approved health home programs in 20 states plus the District of Columbia, serving over 1 million Medicaid beneficiaries with multiple chronic conditions, including severe mental illness (*see Appendix 3*). Three states (MD, RI and VT) have targeted populations with substance use disorders such as opioid dependency. These models are showing promise for reducing costs and improving quality of care: a number of states have already seen an impact on health care utilization, such as increases in primary care visits and reductions in emergency room visits.

Health Homes Success in Missouri

Missouri's Community Mental Health Homes have increased 72 hour hospitalization follow-up rates from 35 to 49 percent and reduced the average number of hospitalizations by 14 percent and emergency room visits by 19 percent for enrollees.

Integrated Care Models

Using other flexible Medicaid authorities, a number of states are also rewarding Medicaid plans and providers for improved health outcomes, increased quality of care and lower program costs. CMS established guidance in 2013 through a series of State Medicaid Director Letters on Integrated Care Models. These models include shared savings and primary care case management. Shared savings models, which five states (AR, LA, ME, MI and VT) have implemented, incentivize states, health plans and providers to invest in delivery system reforms by enabling them to share savings that the reforms generate. To help improve quality and lower the cost of care, primary care case management allows states to offer additional payment through contracts with primary care managers who coordinate, locate, and monitor health care services beyond what is expected from FFS primary care providers. Three states (ME, MI and VT) have used this authority to implement various initiatives, including the CPC+ and the Medicare-Medicaid ACO demonstration.

Medicaid Innovation Accelerator Program

In 2014, CMS launched the Medicaid Innovation Accelerator Program (IAP) to further advance state delivery system and payment reform efforts. IAP works closely with state Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development, and cross-state learning opportunities. As of January 2017, IAP has provided direct technical support to 27 Medicaid programs (see "Appendix 4-IAP Program Support Activity") through one or more of its programmatic or functional area. In addition, IAP has disseminated information to Medicaid officials from all 50 states and the District of Columbia. IAP's focus areas are:

Episodes of Care and Payment Bundles for MAT

The Medicaid Innovation Accelerator Program is developing new tools for states to use to design episodes of care and payment bundles for medication-assisted treatment (MAT) services delivered to individuals with opioid dependence. In late January 2017, IAP will be posting three MAT tools:

- an office-based opioid treatment program model based on Vermont's "Hub and Spoke" program;
- an office-based opioid treatment program model in operation in Massachusetts; and
- a model that uses specialty providers to begin MAT and transfers patients to primary care practices for continuing care, based on the "Baltimore Buprenorphine Initiative."

- **Reducing Substance Use Disorders (SUD)** – IAP has provided support to states to develop SUD policy, program and payment reforms, such as expanding coverage for effective SUD treatment and enhancing SUD care delivery. For example, IAP has supported six states (KY, LA, MI, PA, TX and WA) in designing, planning and implementing strategies to improve their SUD delivery systems as well as supporting a number of other states in the development of their section 1115 SUD demonstration proposals. In addition, IAP hosted a learning series that covered a wide range of topics including increasing provider capacity, incorporating SUD into managed care contracts, and best practices and strategies for MAT.
- **Improving Care for Medicaid Beneficiaries with Complex Care Needs & High Costs (BCN)** – In 2013, CMS issued an Informational Bulletin offering states strategies on how to improve care and manage costs for Medicaid beneficiaries ("super-utilizers") who, because of their complex health and/or social conditions, are likely to experience high levels of costly but preventable service utilization. To complement this guidance, IAP is working with five states to enhance data analytic capacity, design program elements, and develop payment approaches that support changes in how care is structured and delivered to this population.
- **Promoting Community Integration through Long Term Services and Support (CI-LTSS)** – IAP is working with 18 states to expand community-based LTSS programs, including increasing state adoption of strategies that tie together quality, cost and outcomes in support of community-based LTSS programs. Nine states are developing ways to incentivize quality and outcomes, four states are implementing such activities, and eight states are building Medicaid Agency and Housing Agency Partnerships in an effort to improve community-based LTSS.
- **Supporting Physical and Mental Health Integration (PMH)** – IAP is working with nine states and one territory to develop physical and mental health integration strategies and payment approaches. This effort focuses on identifying appropriate measures for integration, administrative alignment strategies and promising practices of value-based purchasing.

- **Building additional state DSR capacity** – IAP is also building state capacity in a few key areas. Specifically, IAP is providing technical support to states on Medicaid data analytics. For example, four states (AL, NH, NJ and PA) and District of Columbia have received technical support to integrate Medicare-Medicaid data to improve care coordination for their dual eligible populations. In addition, IAP is working to improve states' quality measurement capacity related to their Medicaid delivery system reforms as well as support state efforts to design, develop, or implement value-based payment approaches and financial simulations. Finally, IAP is working with states to improve performance training and support by helping states set goals and determine the aims and "drivers" of change.

Value-Based Purchasing in Medicaid

In March 2016, the National Association of Medicaid Director's (NAMD) released a report describing the design and implementation of Value Based Purchasing in Medicaid. States are tailoring VBP models to reflect their state-specific needs, but the state models generally fall into 3 main categories:

- **Additional payments to providers** in exchange for meeting performance measures;
- **Episode-based payments** whereby one provider is held accountable for costs and quality of services over a period of time; and
- **Population-based payments** whereby one or more providers are held accountable for costs and quality of care for a broader range of services delivered to an attributed population.

Electronic Health Records (EHR)/Health Information Exchange (HIE)

To help improve efficiency and facilitate delivery system reform, CMS has worked to advance state adoption of EHRs and investment in HIE through implementation of the 2009 Health Information Technology for Economic and Clinical Health Act, helping connect nearly 200 hospitals and 50,000 providers to state systems, focused on acute care hospitals and primary care clinicians. CMS released guidance in February 2016 to support interoperability between a range of Medicaid providers. Five states are taking advantage of this opportunity

Integrating Medicare and Medicaid Service Delivery and Financing

Over 11 million individuals are jointly enrolled in Medicaid and Medicare, and CMS and states have moved forward with stronger approaches to integrate financing and service delivery for this population. Between 2011 and 2016, the estimated number of Medicare-Medicaid enrollees served by integrated programs that align Medicare and Medicaid benefits rose from approximately 162,000 to more than 698,000. Notably, enrollment in the Programs of All-Inclusive Care for the Elderly (PACE), which provide integrated Medicare and Medicaid benefits for individuals age 55 and older with nursing facility level of care needs, rose by three-quarters, from just under 20,000 in 2011 to more than 35,000 in 2016. Over the same period, enrollment in those Medicare Advantage Special Needs Plans (SNPs) that also offered most or all Medicaid services nearly doubled to more than 240,000 enrollees.

In addition to these alignment initiatives, CMS launched the Medicare-Medicaid Financial Alignment Initiative in 2011 to address the financial misalignment between Medicare and Medicaid and to integrate primary, acute, behavioral health, and long-term services and supports for Medicare-Medicaid enrollees. Through this initiative and related work, CMS is partnering with states to test models intended to achieve those goals, including a capitated model and a managed fee-for-service model. Although the approaches differ in each demonstration, beneficiaries in every version of the model receive all the services and benefits they historically received from Medicare and Medicaid, with added care coordination, beneficiary protections, and access to enhanced services.

To date, there are 14 operational demonstrations in 13 states to test new models. Eleven of these demonstrations, including two in New York, are testing the capitated model, implemented through Medicare-Medicaid Plans serving approximately 364,000 beneficiaries as of October 1, 2016. Two demonstrations, in Colorado and Washington, are testing the managed fee-for-service model, serving approximately 49,000 beneficiaries as of September 1, 2016. CMS has partnered with Minnesota to implement an alternative model testing Medicare and Medicaid administrative alignment activities, building on the longstanding Minnesota Senior Health Options program serving 36,669 Medicare-Medicaid enrollees as of October 1, 2016.

to support interoperability among Medicaid providers, with another fourteen states in the process of securing funding to implement their interoperability activities.

Providing Long Term Services and Supports in the Community

State HIE Projects

Nebraska is modernizing a statewide electronic prescription drug monitoring system to help combat opioid abuse; Colorado is building an Advanced Directive registry to improve end-of-life care; and Florida is on-boarding long- term care providers to the existing Health Information Exchange to better facilitate transitions of care.

Long term services and supports are an important Medicaid function: Medicaid provides half the nation's long-term care. Over the decades, states, CMS, providers and consumers have worked to broaden access to care in home and community based settings, where many seniors and people with disabilities would prefer to live. Although the provision of long term care services had long been focused on institutional care, enormous progress has been made in achieving greater access to home and community based services. In 2013, the Medicaid program reached a major milestone: for the first time, the majority of Medicaid spending on long term services and supports (LTSS) was for home and community based services (HCBS) rather than for institutional care. And since then, the share of Medicaid spending that takes place in HCBS settings has increased steadily. HCBS, which include services like case management, home health aide services, and adult day health, are a critical component of the Medicaid program. The movement toward HCBS in Medicaid is both part of and reflective of progress toward community integration taking place across the federal government and in states (see Graph 1). To continue the HCBS progress CMS and our state partners have made, CMS issued a Request for Information in November 2016 seeking public input on ways to accelerate access to HCBS and continue protecting quality of care.

Defining Home and Community Based Services and Settings

In 2014, CMS published final rules on HCBS to establish final requirements for home and community-based settings in Medicaid HCBS programs, while giving states five years to fully implement the new requirements. The rule defines home and community-based settings across several factors, including the quality of the individual's experiences to ensure that HCBS are truly home and community based. The final rules also establishes person-centered planning as the foundation of service provision across authorities, and by providing states with the option to streamline administration by combining different populations into one 1915(c) waiver. The rule also address conflict of interest in person-centered planning while clarifying the timing of amendments and public input requirements for proposed modifications of HCBS waiver programs and service rates.

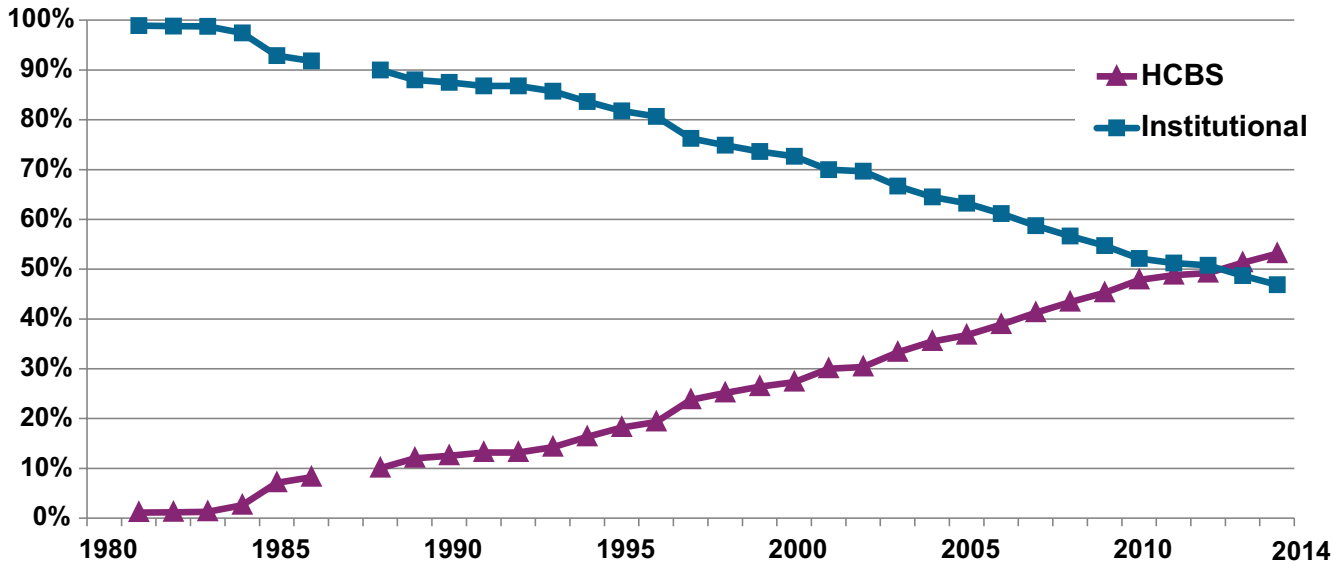
1915(c) Home and Community-Based Waivers

Under section 1915(c) of the Social Security Act, CMS may waive certain provisions of Medicaid law to provide states flexibility to offer HCBS to meet the needs of people who prefer to receive LTSS in their home or community, rather than in an institutional setting. Using this flexibility, states can tailor services to meet the needs of a particular target population, including by establishing specific eligibility criteria to target specific groups within a population (e.g., individuals with HIV/AIDS, traumatic brain injury, etc.). States also have the option to tailor the benefits, including by providing a combination of standard medical services, such as case management and personal care, and non-standard medical services that help transition individuals from institutions into their homes and community. Currently, more than one million individuals are receiving services under HCBS waivers. Nearly all states and DC offer services through HCBS Waivers. States can operate as many HCBS waivers as they want — currently, more than 275 HCBS waiver programs are active nationwide.

State Plan Home and Community-Based Services Benefit

States now have the option to provide HCBS (such as extended state plan services, respite, case management, supported employment, and environmental modifications) under the state plan to individuals who meet state specified needs-based criteria. States also have the option to target such services to specific populations. As of 2017, CMS had approved 18 state plan HCBS benefits in 15 states (CA, CO, CT, FL, ID, IN, IA, LA, MI, MS, MT, NV, OH, OR and WI).

Graph 1. Medicaid Home and Community Based Services (HCBS) and Institutional Expenditures as a Percentage of Total Medicaid Long Term Services and Supports Expenditures, FY 1981–2014



* Data for FY 1987 are excluded

Note: Data for FY 1987 are excluded

Affordable Care Act's Initiatives to Rebalance from Institutions to Community-Based Care

The Affordable Care Act created three initiatives to help states rebalance their LTSS programs from institutions to community-based care. The first initiative, the Balancing Incentive Program, provided financial incentives to states from October 2011 to September 2015 to increase access to non-institutional LTSS and promote community integration by authorizing grants to serve more people in home and community-based settings. Twenty-one states participated in the program in its first four years (AR, CT, GA, IN, IA, IL, KY, LA, MA, MD, ME, MO, MS, NE, NH, NJ, NY, NV, OH, PA and TX)[2], and thirteen states (CT, GA, IL, MA, MD, ME, MS, NH, NJ, NY, NV, PA and TX) continue to participate in the program by spending the grant funds to increase access to new or expanded services and infrastructure. The second rebalancing initiative, Money Follows the Person (MFP), helped transition over 63,000 individuals from institutional settings into the community by December 2015, with forty-three states participating. In addition, the MFP Tribal Initiative provided five existing MFP state grantees (MN, ND, OK, WA and WI) with financial support to work with tribal partners in their states to build sustainable community-based LTSS specifically for Indian country. Finally, the Affordable Care Act established the Community First Choice (CFC) option, allowing states to provide home and community-based attendant services and supports to Medicaid enrollees with disabilities under a state plan amendment rather than a waiver. As of January 2017, CMS has approved this option in eight states (CA, CT, MD, MT, NY, OR, TX and WA). CMS is currently providing technical assistance to several additional states that are considering adopting the CFC benefit.

Strengthening Home Health Services

In February 2016, CMS issued a final rule strengthening the provision and integrity of home health services, including defining the medical supplies covered under the home health benefit. It requires physicians to document face-to-face encounters with Medicaid beneficiaries for the authorization of home health services and supplies. The final rule also aligns with Medicare to help streamline beneficiaries' access to needed items and maximize consistency in service delivery, as well as reduce administrative burden on the provider community.

Strengthening Quality and Accountability

Through the first national quality measurement programs for Medicaid and CHIP, states are measuring and managing the quality of care for adults and children. CMS has also worked closely with states to strengthen program integrity, including in Medicaid managed care.

Improving Outcome Measurement

Through the first national quality measurement programs for Medicaid and CHIP, CMS is working with state and federal partners to promote uniform reporting of quality measures across the entire Medicaid program and to align these measures with ones used by other payers. States are actively focused on improving outcomes in key areas like maternal and infant health and HCBS as well as strengthening approaches to quality in managed care programs.

Examples of State Core Measure Quality Reporting for Federal Fiscal Year 2015

Access to Primary Care for Children 12-24 months of age (percentage with a PCP visit in the past year):

- 45 states reporting
- Median performance rate* of 95.2

Timeliness of Prenatal Care (percentage with a prenatal visit in the first trimester or within 42 days of Medicaid or CHIP enrollment):

- 37 states reporting
- Median performance rate* of 82.0

Comprehensive Diabetes Care (percentage with diabetes -Type 1 or Type 2 - who had a Hemoglobin A1c Test)

- 37 states reporting
- Median performance rate* of 81.9

**Median performance rate represents the middle performance result of all states reporting on that measure.*

CMS has now identified core sets of health care quality measures to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP. The goals of this effort are to encourage national reporting by states on a uniform set of measures and support states in using these measures to drive quality improvement. CMS and states continue to make progress in building a national, cross-state voluntary quality measurement program for children in Medicaid and CHIP.

Development of HCBS CAHPS survey

CMS is developing the tools and infrastructure supports needed to create and sustain a person-driven, community-based, long term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life. Most recently, we have released an experience of care survey for use by states and providers. The Consumer Assessment of Healthcare Providers and Systems® (CAHPS) Home- and Community-Based Services Survey makes it possible for HCBS programs to gauge the experiences of beneficiaries with the services that matter the most to them.

Provider Screening and Enrollment

The Affordable Care Act requires that all providers be screened prior to enrollment in Medicaid and every five years thereafter, with the level of screening varying with the risk the provider presents to the program (the Medicare program uses a parallel process). Implementation of these screening and enrollment requirements began in March 2011 for providers in fee-for-service Medicaid, and will be extended to providers participating in managed care plan provider networks beginning in January 2018. CMS' Center for Program Integrity (CPI) has conducted trainings for state program integrity staff on the screening and enrollment requirements at

the Medicaid Integrity Institute. CPI has also improved state access to Medicare provider enrollment database (PECOS), to reduce administrative burden on both providers and state Medicaid agencies.

Suspension of Payments to Fraudulent Providers

To limit program and beneficiary risk, the Affordable Care Act requires state Medicaid programs to refer providers who are the subject of credible allegations of fraud to law enforcement for investigation and, during the investigation, to suspend payment to the provider unless there is good cause not to do so. CMS began implementing these requirements in 2011 for fee-for-service Medicaid. Beginning in July 2017, Medicaid managed care plans will be required to suspend payments to network providers if the state determines there is a credible allegation of fraud.

Accountability for Managed Care Plans

CMS' May 2016 managed care rule contains a number of provisions to protect federal and state Medicaid funds paid to plans, and by plans to subcontractors and network providers, from fraud. As noted above, the final rule extends a number of program protections that now apply to fee-for-service providers to managed care network providers. The final rule also requires plans and subcontractors to disclose information on ownership and control and attest to its accuracy. Similarly, plans will be required to submit financial and encounter data to state Medicaid agencies; plan management will be required to certify to the accuracy, completeness, and truthfulness of the data submitted; and states will be required to audit the accuracy, completeness, and truthfulness of the encounter and financial data. These and other similar provisions, which will improve accountability and transparency of managed care plans and their subcontractors, take effect beginning July 1, 2017.

Strengthening Financial Accountability

To help ensure appropriate use of state and federal Medicaid dollars, CMS has taken a number of steps to further strengthen financial accountability. For example, a 2013 State Medicaid Director letter implemented a requirement that states submit upper payment limit demonstrations for designated services on an annual basis. The new process

Improving Data Collection and Modernizing Systems

CMS is working with states to improve data systems, strengthen accountability, and evaluate innovations being implemented through section 1115 demonstrations. For example:

- **T-MSIS –** Transformed Medicaid Statistical Information System, is an expansion and improvement of previous Medicaid data systems. CMS began the T-MSIS effort in 2011 to modernize Medicaid and CHIP data by making available more robust, timely, and accurate data to ensure the highest financial and program performance. In addition, these changes will better support policy analysis and ongoing improvement, identify potential fraud or waste, and enable data-driving decision making. This ongoing initiative is also intended to streamline state reporting of data to CMS.
- **Standard Data, or Performance Indicators** – CMS, in consultation with states, developed a series of Performance Indicators for Medicaid and CHIP business functions. The goal is to have a common set of indicators, with standardized data across all state Medicaid and CHIP programs, to provide information to support program management and policy-making at both the federal and state level. Starting in 2014, CMS made public timely standardized data across all state Medicaid and CHIP programs. The data allows states to compare themselves to their peers, and allows stakeholders to analyze larger trends within the program.
- **Strengthening Section 1115 Demonstration Monitoring and Evaluation** - As described earlier, section 1115 demonstrations support a wide array of innovations in Medicaid and CHIP that may have significant impacts on beneficiaries, providers and other stakeholders. In September 2014, CMS initiated a national, cross-state evaluation of several different types of Medicaid section 1115 demonstrations, (including an evaluation of MLTSS that addresses programs beyond section 1115 demonstrations). This evaluation effort will be ongoing through federal fiscal year 2019.

provides CMS with better and more frequent information with which to manage and monitor states' payments for services. A 2014 State Medicaid Director letter clarified what constitutes a health care-related tax.

CMS also enhanced states' financial reporting by modifying the Medicaid Budget and Expenditure System to accommodate more detailed reporting of expenditures, including those related to supplemental payments for services and payments made under demonstration authority.

In addition, CMS modified policies with respect to uncompensated care pools authorized in section 1115 demonstrations to ensure that Medicaid payments support Medicaid coverage and services provided to Medicaid and low income uninsured individuals. Similarly, the Medicaid managed care regulation transitions some states from using "pass-through payments," or contractually required payments managed care plans must make to providers that are not directly linked to services, into payments for delivered services, such as value-based payment structures or enhanced fee schedules.

Improving Communication and Transparency with Beneficiaries and States

To make sure beneficiaries, stakeholders and states have the most up-to-date information, CMS has made significant changes to improve how we communicate and disseminate information. These improvements include:

- **Medicaid.gov** – In December 2011, CMS launched a website – Medicaid.gov – to provide transparency and access to Medicaid information to the public, including Medicaid topic pages (e.g., Medicaid eligibility, managed care, benefits, etc.), federal guidance, and Medicaid waivers (e.g., section 1115 demonstrations, section 1915(b) and (c) waivers, etc.). Each year, Medicaid.gov is visited more than 10 million times and has more than 8 million users. And in 2016, Medicaid.gov made another leap forward by joining Twitter – make sure to follow us @MedicaidGov!
- **Section 1115 Demonstration Transparency** –To assure meaningful public input on section 1115 demonstration projects, CMS issued a final rule and supporting guidance in 2012 outlining transparency requirements and a standardized application and review process. This process, which applies to states requesting new demonstration projects or renewing existing ones, establishes public input processes at the state and federal levels.
- **State Operational and Technical Assistance (SOTA)** – CMS created the SOTA initiative in the spring of 2012 to work closely with states on policy and operational changes required in Medicaid by the Affordable Care Act. Through SOTA emails and all-state SOTA calls, CMS reaches over 3,300 people via weekly email updates and an average of 289 callers on the all-state calls. CMS enhanced this initiative by creating SOTA 2.0 which provides each state with a central point of contact to coordinate and track Medicaid issues across CMS.
- **Tribal Consultation** – To strengthen our government-to-government relationship with Indian Tribes, CMS issued its first Tribal consultation policy on November 17, 2011, establishing a clear, concise and mutually acceptable process through which consultation can take place between CMS and Tribes. CMS issued a revised CMS Tribal Consultation Policy effective December 10, 2015 adding a new section incorporating requirements for states obtain the advice and input from Indian health care providers and Tribes prior to changes to state Medicaid programs that affect Tribes

Conclusion

Medicaid has a proven track record of helping our nation's most vulnerable populations access the care they need to improve their health and help them succeed in life. Medicaid and CHIP have stayed true to their missions of providing comprehensive health care to low-income Americans and have made significant progress in improving access to coverage and key services. At the same time, Medicaid is a full partner in broader health system changes aimed at improving care, while lowering costs. CMS values our partnerships with states, beneficiaries, consumer groups and health care providers in this important work.

Appendix 1: ACA Medicaid Expansion Enrollment (as of March 2016)			
	ACA Medicaid Expansion Effective Date	Total Medicaid Enrollment	Total ACA Medicaid Expansion Enrollment
Alaska	9/1/2015	137,596	14,428
Arizona	1/1/2014	1,868,223	416,349
Arkansas	1/1/2014	767,011	303,944
California	1/1/2014	12,837,936	3,535,354
Colorado	1/1/2014	1,321,725	425,513
Connecticut	1/1/2014	856,088	207,625
Delaware	1/1/2014	217,499	66,730
District of Columbia	1/1/2014	233,298	61,993
Hawaii	1/1/2014	311,062	108,072
Illinois	1/1/2014	2,869,889	664,124
Indiana	2/1/2015	1,269,041	381,631
Iowa	1/1/2014	591,421	148,896
Kentucky	1/1/2014	1,281,542	443,200
Maryland	1/1/2014	1,103,730	248,237
Massachusetts	1/1/2014	1,845,531	394,943
Michigan	4/1/2014	2,321,077	633,013
Minnesota	1/1/2014	1,134,287	187,060
Montana	1/1/2016	201,305	46,688
Nevada	1/1/2014	592,375	203,929
New Hampshire	8/15/2015	192,134	52,892
New Jersey	1/1/2014	1,638,319	536,741
New Mexico	1/1/2014	855,781	243,110
New York	1/1/2014	4,874,096	2,094,895
North Dakota*	1/1/2014	-	-
Ohio	1/1/2014	2,965,703	677,540
Oregon	1/1/2014	1,102,098	550,610
Pennsylvania	1/1/2015	2,747,730	702,758
Rhode Island	1/1/2014	281,565	60,455
Vermont	1/1/2014	208,655	63,281
Washington	1/1/2014	1,811,835	592,910
West Virginia	1/1/2014	510,175	179,972
30 States and the District of Columbia		48,948,727	14,246,893

Notes: Data reflect Medicaid enrollment in states that had implemented the ACA Medicaid expansion as of March 2016; Louisiana has since implemented the ACA Medicaid expansion effective July 1, 2016. Also excluded are enrollment data for the territories. In addition, North Dakota has not currently entered its enrollment data. Total Medicaid enrollment reflects all enrollment under Title XIX programs in these states. The ACA Medicaid Expansion Enrollment reflect those enrolled under Group VIII – newly eligible and those not newly eligible.

Source: Medicaid Budget and Expenditure System (MBES) Enrollment Report, January – March 2016, posted December 2016. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/enrollment-mbes/index.html.

Appendix 2. 1115 Demonstrations by State, as of January 2017				
State	Comprehensive	Family Planning	Targeted Special Needs	CHIP Only
Alabama	X	X		
Arkansas	X		X	
Arizona	X			
California	X			
Colorado				X
Delaware	X			
Florida	X	X	X	
Georgia		X		
Hawaii	X			
Iowa	X	X		
Indiana	X			
Kansas	X			
Massachusetts	X			
Maryland	X	X		
Maine			X	
Michigan			X	
Minnesota	X			
Missouri	X	X		
Mississippi		X	X	
Montana	X	X		
New Hampshire	X			
New Jersey	X			
New Mexico	X			
Nevada	X			
New York	X	X		
Oklahoma	X			
Oregon	X	X		
Pennsylvania	X			
Rhode Island	X	X		
Tennessee	X			
Texas	X			
Utah	X			
Virginia			X	X
Vermont	X			
Washington		X		
Wisconsin	X			
Wyoming		X		

Appendix 3: State Spending on Medicaid Home and Community Based Services *(as of FY 2014)*	
State	Percentage of HCBS Expenditures as a % of total Medicaid expenditures
Alabama	41.5
Alaska	69.7
Arizona	70.4
Arkansas	49.9
California	64.4
Colorado	63.0
Connecticut	47.6
Delaware	42.2
District of Columbia	53.0
Florida	33.3
Georgia	48.1
Hawaii	41.7
Idaho	53.4
Illinois	43.7
Indiana	31.1
Iowa	50.2
Kansas	52.9
Kentucky	40.7
Louisiana	39.3
Maine	54.9
Maryland	55.5
Massachusetts	56.9
Michigan	35.0
Minnesota	74.8
Mississippi	27.2
Missouri	55.3
Montana	56.5
Nebraska	48.5
Nevada	48.9
New Hampshire	50.0
New Jersey	40.6
New Mexico	73.6
New York	58.1
North Carolina*	
North Dakota	40.5
Ohio	52.4
Oklahoma	43.5
Oregon	79.2
Pennsylvania	43.7
Rhode Island	57.8
South Carolina	42.7
South Dakota	47.2
Texas	57.1
Tennessee	53.2
Utah	47.6
Vermont	68.2
Virginia	54.6
Washington	65.8
West Virginia	47.7
Wisconsin	64.0
Wyoming	49.8
National	**53.1**

Note: North Carolina was excluded from the analysis due to lack of data.

Source: Medicaid Budget and Expenditure System (MBES)

Appendix 4: States with Health Home Programs (As of January 2017)			
	Active Health Home SPAs	Medicaid Populations Targeted	Number Served
Alabama	1	Beneficiaries with multiple chronic conditions and SMI (expanded statewide and added Hepatitis C)	220,253
Connecticut	1	Beneficiaries with SMI (statewide)	6,700
District of Columbia	1	Beneficiaries with SMI (District -wide)	1,267
Iowa	2	Beneficiaries with multiple chronic conditions (statewide) Beneficiaries with SMI (expanded statewide)	12,942 24,585
Maine	2	Medicaid beneficiaries with multiple chronic conditions (statewide) Medicaid beneficiaries with SMI (statewide)	51,794 5,095
Maryland	1	Medicaid beneficiaries with SMI and substance use treatment (statewide)	4,668
Michigan	2	Medicaid beneficiaries with SMI (3 counties) Medicaid beneficiaries with multiple chronic conditions (21 counties)	681
Minnesota	1	Medicaid adult beneficiaries with SMI and Medicaid children/youth experiencing SED (statewide)	1,500
Missouri	2	Medicaid beneficiaries with multiple chronic conditions (statewide, added mental health and substance use disorder) Medicaid beneficiaries with SMI (statewide)	19,507 25,036
New Jersey	2	Medicaid adult beneficiaries with SMI (5 counties) Medicaid children/youth experiencing SED (5 counties)	500 250
New Mexico	1	Medicaid beneficiaries with SMI and experiencing SED (2 counties)	
New York	1	Medicaid beneficiaries with multiple chronic conditions and SMI (expanded statewide and expanded eligibility to children)	231,543
North Carolina	1	Medicaid beneficiaries with multiple chronic conditions (statewide)	540,841
Ohio	1	Medicaid beneficiaries with SMI (5 counties)	12,341
Oklahoma	2	Medicaid adult beneficiaries with SMI (statewide) Medicaid children/youth experiencing SED (statewide)	4,991 4,214
Rhode Island	3	Medicaid children and youth with special health care needs (statewide) Medicaid adult beneficiaries with SMI (statewide) Medicaid beneficiaries with opioid use disorder (statewide)	1,530 8,007 2,851
South Dakota	1	Medicaid beneficiaries with multiple chronic conditions and SMI (statewide)	5,851
Vermont	1	Medicaid beneficiaries with opioid use disorder (14 counties)	5,499
Washington	1	Medicaid beneficiaries with multiple chronic conditions (37 counties)	68,688
West Virginia	1	Medicaid beneficiaries with SMI (6 counties)	693
Wisconsin	1	Medicaid beneficiaries with HIV/AIDS (4 counties)	283
20 States and the District of Columbia	**29 active SPAs**		**1,307,359 Beneficiaries**

The table reflects states with active and approved state plan amendments to implement health homes; additional states have submitted health home SPAs but these have not yet been approved. Additionally, ID, KS and OR had health home SPAs but have since terminated them. Enrollment data are as of May 2016 except for the following: health home enrollment for IA, MD, NY, RI's chronic conditions health home are as of March 2016; health home enrollment for DC, MI, MO's chronic condition health home, NJ, OH and SD are as of April 2016; health home enrollment for WI reflect December 2015.

Appendix 5: IAP Program Support Activity (as of January 2017)				
	Reducing Substance Use Disorders (SUD)	Improving Care of Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN)	Promoting Community Integration through Long-term Services and Supports	Supporting Physical and Mental Health Integration (PMH)
1. Alabama				
2. Alaska				
3. Arizona				
4. Arkansas				
5. California			X	
6. Colorado				
7. Connecticut			X	
8. Delaware				
9. District of Columbia		X		
10. Florida				
11. Georgia				
12. Hawaii			X	X
13. Idaho				X
14. Illinois			X	X
15. Indiana			X	
16. Iowa				
17. Kansas				
18. Kentucky	X		X	
19. Louisiana	X			
20. Maine				
21. Maryland			X	
22. Massachusetts			X	X
23. Michigan	X			
24. Minnesota	X			
25. Missouri				
26. Montana				
27. Mississippi			X	
28. Nebraska			X	
29. Nevada			X	X
30. New Hampshire				X
31. New Jersey		X	X	X
32. New Mexico				
33. New York				
34. North Carolina			X	
35. North Dakota				
36. Ohio			X	
37. Oklahoma				
38. Oregon		X	X	
39. Pennsylvania	X			
40. Puerto Rico				X
41. Rhode Island				
42. South Carolina				
43. South Dakota				
44. Tennessee				
45. Texas	X	X		
46. Utah				
47. Vermont				
48. Virginia		X	X	
49. Washington	X		X	X
50. Wisconsin				
51. West Virginia				
52. Wyoming				

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Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244
www.cms.gov
www.medicaid.gov

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