

# STATE STRATEGIES TO OPTIMIZE MEDICAID

## The Role of Integrated Behavioral Health

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### Key Messages

**Medicaid**  
is the largest payer of behavioral health services in the United States



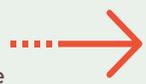
**51%** of adult Medicaid enrollees with any mental health condition did not receive treatment<sup>1</sup>



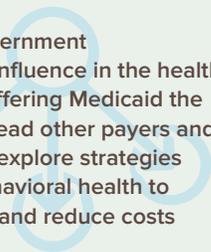
Integrating behavioral and physical health care improves health outcomes and saves money



State Medicaid programs have unique flexibility to advance behavioral health integration using a variety of purchasing, regulatory, and administrative strategies as well as delivery system reform



The federal government has significant influence in the health care industry, offering Medicaid the opportunity to lead other payers and health plans to explore strategies to integrate behavioral health to improve health and reduce costs



### Overview

States have the opportunity to improve the health of their Medicaid beneficiaries while realizing financial benefit by integrating mental health and substance use services (collectively referred to hereafter as behavioral health) into medical care. This brief presents a variety of purchasing, regulatory, and administrative strategies for delivery system reform that state policymakers, Medicaid agencies, and stewards of Medicaid services may implement as the mechanism by which to advance integrated behavioral health. This issue brief was developed following a rapid review to summarize evidence, a methodology that streamlines the usual processes for systematic reviews to synthesize relevant evidence in a timely manner for decision-makers in healthcare and policy. [Methods](#) are available in an online appendix.

### Integrated Behavioral Health Care

This brief describes the role of integrated behavioral health in state Medicaid programs. Behavioral health and primary care integration has been defined as patient-centered care that addresses mental health and substance use conditions, health behaviors, life stressors, and stress-related physical symptoms, provided by a team of primary care and behavioral health clinicians.<sup>2</sup> Addressing whole person health requires applying this concept of integration both within and outside of the traditional healthcare system. Therefore, behavioral health integration pertains to (1) the healthcare sector; and (2) cross sector collaborations between the healthcare sector and social services, employers, schools, and communities.

Ultimately, the underlying principle of behavioral health integration is that physical, behavioral, and social health are inextricably intertwined. Fragmented systems of care create barriers to achieving optimal whole person health. Integration of care is a solution to fragmentation. Understanding the physical, behavioral, and social determinants of health, and their relationship to one another, exposes the root causes of many health disparities. Policies advancing integration support sustainable change to achieve more equitable health outcomes.

### Medicaid Behavioral Health Needs and Access to Care

Medicaid is the largest government program for health care services in the United States, currently providing coverage to over 74.2 million individuals (as of October 2017).<sup>3</sup> Since the creation of the program in 1965, Medicaid has primarily been used to provide coverage to low-income families, pregnant women, those with disabilities, and children under 18 years of age. As of January, 2018, 33 states had adopted the Affordable Care Act (ACA) Medicaid expansion, which has consistently shown to increase coverage, access and utilization of care for low-income families.<sup>4</sup> Overall, Medicaid expansion has reduced rates of low-income individuals who are uninsured

## ADULTS WITH MEDICAID

**9.1 million**

have a mental illness

**3+ million**

have a substance use disorder

**1.8 million**

have both a mental illness and  
a substance use disorder<sup>10</sup>

## CHILDREN WITH MEDICAID

**54%**

with a behavioral health  
diagnoses are receiving  
treatment<sup>15</sup>

in the United States, thereby decreasing uncompensated care costs associated with this previously uninsured population.<sup>5</sup> This coverage gain has been particularly notable in vulnerable populations such as those living in rural areas, those who are often negatively affected by racial/ethnic health disparities, prescription drug users, those with HIV, young adults, mothers and parents, low-income workers, those with low educational achievement, veterans, childless adults with incomes under 100% of the FPL, and those with behavioral health needs.<sup>5</sup> Further, compared with non-expansion states, states that have adopted the Medicaid expansion have increased access to services and medications for behavioral health conditions.<sup>5,6</sup>

Medicaid is the nation's largest payer of behavioral health services.<sup>7,8</sup> Although each state designs its programs based upon the attributes of the state and its population,<sup>9</sup> every state faces similar challenges regarding budgetary restraints and a high proportion of high-cost, high-need Medicaid enrollees who have behavioral health concerns. Approximately 9.1 million adults with Medicaid have a mental illness, over 3 million have a substance use disorder, and nearly 1.8 million have both a mental illness and a substance use disorder.<sup>10</sup> Further, while covering 14% of the general population, Medicaid covers 47% of adults with a mental illness or a serious mental illness, and 17% of adults with a substance use disorder.<sup>10</sup> Compared to private insurance enrollees and uninsured people, Medicaid enrollees are more likely to have had a major depressive episode and suicidal plans in the prior year.<sup>11</sup> Additionally, 51% of adult Medicaid enrollees with any mental health condition did not receive care in 2011.<sup>12</sup> Children are also highly reliant upon Medicaid and the Children's Health Insurance Program (CHIP) for behavioral health services. Together, Medicaid and CHIP cover 39% of the nation's children, and 44% of children with special care needs.<sup>13,14</sup> Of the approximately 32 million children covered by Medicaid, 11% utilize behavioral health care services, which accounts for over 36% (\$30.2 billion) of all costs for children in Medicaid. This is four times higher than Medicaid children who use only physical health care.<sup>15</sup> However, only 54% of all Medicaid covered children with a behavioral health diagnoses received treatment between 2005-2011.<sup>15</sup>

## Cost Burden of Comorbid Physical and Behavioral Health Conditions

Those with behavioral health needs often also have comorbid physical health needs.<sup>11</sup> Data from the 2001-2003 National Comorbidity Survey Replication state that more than 68% of adults with a behavioral health disorder reported having at least one physical disorder. Conversely, 29% of those with a physical disorder also had a comorbid behavioral health disorder.<sup>16,17</sup> National Medicaid claims data from 2002 reveal more than half of Medicaid enrollees with a behavioral health condition also had diabetes, cardiovascular disease, or pulmonary disease, which is a higher percentage of these physical disorders than found in persons without a comorbid behavioral health disorder.<sup>18</sup> There is also evidence that having either a physical health or behavioral health disorder is a risk factor for the other.<sup>19</sup>

Individuals with comorbid health needs inherently require more services, which typically equates with higher expenditures. Overall annual medical expenditures for chronic physical and behavioral health conditions combined cost 46% more than for those with just a physical medical condition.<sup>20,21</sup> Further, one study found that the addition of a behavioral health disorder to one or more chronic physical conditions resulted in a 60 to 75% increase in health care costs per individual.<sup>22</sup> Therefore, this population is often the costliest population to cover for Medicaid.<sup>23</sup> Although those with behavioral health conditions in 2011 accounted for 20% of Medicaid enrollees, they accounted for 48% of spending.<sup>11</sup> Average annual Medicaid spending

for enrollees with a behavioral health diagnosis compared to those without a behavioral health diagnosis is nearly 4 to 1 (\$13,303 vs. \$3,564).<sup>11</sup> This inflated cost, largely due to the proportion of institutionalized care and/or long-term services required for care,<sup>24</sup> reflects a need for more prevention-based and comprehensive behavioral health services to reduce overall healthcare costs and provide adequate care.

## Cost Savings and Improved Health

Meeting the behavioral health needs of a state's Medicaid population is a costly endeavor that requires prioritization in both the state's policy and budget. However, a growing body of evidence suggests that integrated behavioral health can reduce medical costs in both the short and long term.<sup>21,25</sup> Thus, increasing access to behavioral health care through integrated care could achieve significant savings.

Populations with behavioral health disorders have higher costs of care for several reasons, including their inherent need for behavioral health services, having higher rates of chronic medical conditions, challenges creating and sustaining connections and collaborative working relationships with their healthcare providers, difficulties with medical adherence, and perhaps due to all of the above, a higher reliance on emergency room and inpatient services.<sup>26</sup> However, initiatives designed to contain costs with behavioral health disorders are not complete if efforts are focused solely on the behavioral health service sector. Thus, integration and a whole person approach is essential to provide effective care and reduce costs of Medicaid enrollees with behavioral health concerns. Behavioral health disorders alone can affect medical costs at the same level as having multiple chronic medical conditions, suggesting they should be weighted at equal or greater value as medical conditions for forecasting and risk adjusting healthcare costs.

One example of cost-savings related to integrated care details the cost-effectiveness of including behavioral health treatment in overall medical care for patients with type 2 diabetes.<sup>27</sup> Depression and diabetes are often comorbid and bidirectional, and the combined presentation in patients is associated with 4.5 times higher healthcare expenditures as compared to patients without depression.<sup>28</sup>

Results from Medicaid claims spanning multiple years indicated that total healthcare expenditures were reduced by 28% when both antidepressants and psychotherapy treatment was included in the patients' care as compared to no behavioral health treatment. The reduction of healthcare expenses was likely related to effectively treating the depression, improving adherence to their medical regimen, improving their overall self-care, and thereby reducing overall healthcare utilization.<sup>27</sup>

Youth with complex needs and behavioral health disorders are a high-risk, high-cost population. An integrated medical, mental health, and social services intervention was evaluated for youth with serious behavioral health disorders at risk for frequent psychiatric hospitalizations or long-term out of home placement (both heavy contributors to high costs).<sup>29</sup> Overall, the youth who received integrated care for a year had lower claims expense (32% lower for emergency room, 74% lower for inpatient psychiatry services) as compared to the matched usual care group. The intervention youth also showed improved functioning and 88% of days were spent at home over the course of the year (as compared to psychiatric hospitals or locked detention centers). Thus, integrated care improved both health and cost outcomes for at-risk youth with behavioral health disorders.

It is important for states to consider that cost savings related to integrated behavioral health will emerge differently depending upon the structure of their state's Medicaid budget. If behavioral health is part of the larger Medicaid budget, then cost savings will be apparent within the overall budget. Unfortunately, the majority of healthcare systems, including most state Medicaid agencies, treat physical and behavioral health services separately in terms of billing codes and mechanisms by which reporting and reimbursement occur.<sup>30</sup> If behavioral health is indeed separate (as a carve-out), cost-savings may not be apparent in the behavioral health carve-out budget as savings accrued from improving behavioral health are often due to decreases in medical or other high cost services. Therefore, cost-savings related to integrated behavioral health will likely emerge in the overall Medicaid budget due to the nature of cost-savings related to behavioral health (i.e., ways in which behavioral health treatment improves physical health adherence and health

## INTEGRATING BEHAVIORAL AND PHYSICAL HEALTH CARE NOT ONLY IMPROVES HEALTH BUT ALSO SAVES MONEY

### 28% decrease

in costs for patients with diabetes when both antidepressants and psychotherapy treatment was included in the patients' care<sup>27</sup>

### 32% reduction

in emergency room claims expenses and 74% reduction in psychiatry inpatient service claims expenses for youth with complex needs who received integrated care for a year<sup>29</sup>

outcomes, decreases use of emergency room and inpatient treatment centers, saves physicians time and allows them to see more patients, etc.), and may not be initially apparent to state Medicaid agencies.<sup>25</sup>

## **Integrated Behavioral Health as a Solution to Fragmentation**

States have the opportunity to fundamentally change the overall health of their Medicaid beneficiaries by integrating behavioral health. The evidence provides a compelling case for state Medicaid programs to pursue integrated behavioral health as a cost-effective solution to fragmentation and sub-optimal care. In many ways, behavioral health integration has become the hallmark for comprehensive healthcare<sup>21,23</sup> and is a promising solution for many problems that Medicaid faces, including rising costs and unmet behavioral health needs. State Medicaid agencies may use a variety of purchasing, administrative, and regulatory strategies to help overcome common problems associated with the delivery of integrated behavioral health services. Additionally, state Medicaid agencies may change policy to overcome common problems to integrated care delivery including: state Medicaid restrictions on payments for same-day billing; lack of reimbursement for collaborative care or case management; lack of reimbursement for non-physician providers; lack of reimbursement for “only” a mental health diagnosis or requiring a “covered” mental health diagnosis; lack of reimbursement incentives for screening and preventative services; limits on mental but not physical health annual visits, and low provider-participation rates.<sup>23,30-34</sup>

Integrated behavioral health is considered an innovative strategy to care delivery, as the traditional separation of physical and behavioral health care delivery persists. Mainstream efforts to scale and sustain integrated care are necessary for the benefits to be achieved across the country and for the cultural shift for behavioral and physical health care delivery to be integrated to meet the whole person health needs. Scaling of integrated behavioral health is likely dependent on integrated payment models for behavioral and physical health, a trained workforce for care delivery, and infrastructure and operational transformations to support integrated care.<sup>25,35</sup>

As the largest single payer of health care, the amount of revenue provided by the U.S. government gives Medicaid significant influence in the health care industry. A variety of health policy trends have demonstrated the government’s role in encouraging businesses to serve as test cases for government preferred payment models like bundled payments and Accountable Care Organizations (ACO), driving reimbursement rates to providers (most notably through Medicare), and shaping innovation adoption like telehealth.<sup>36,37</sup> The federal government’s ability to shape and shift the health care industry provides the opportunity for Medicaid to lead other payers and health plans to prioritize integrated behavioral health. States have an imperative to use one or more of the available strategies to catalyze integration efforts within their state.

## **State Strategies to Optimize Medicaid to Advance Integrated Behavioral Health**

The flexibility of state Medicaid programs to catalyze integration efforts is allowable through two mechanisms. Beyond the program requirements and mandated coverage for certain populations and benefits set by the federal Medicaid law, states make the operational and policy decisions, such as enrollment eligibility,

covered services, and payments through their state plan. The state plan must be approved by The Centers for Medicare & Medicaid Services (CMS), under the authority of the Secretary of the U. S. Department of Health and Human Services, for the state to access federal Medicaid funds. The first mechanism for changing a state Medicaid program is through a State Plan Amendment (SPA). States can change administrative aspects of their Medicaid program, such as provider payment rates or prescription benefits structures. SPAs do not require meeting any budgetary targets, although states are required to indicate any expected financial impact.<sup>38, 39</sup>

States seeking additional flexibility can apply for formal waivers of some of the federal requirement of Medicaid. Every state has at least one Medicaid waiver agreement in place; the extensive use of waivers contributes to the great variations in Medicaid programs among states. Waiver applications must meet certain federal budget requirements (depending on the waiver type) and if approved, renewal is typically required every three to five years.<sup>39,40</sup> Section waivers offer considerable flexibility to advance behavioral health integration.

States have a variety of existing levers available within Medicaid, as well as opportunities enabled by the ACA, including new payment policies, Medicaid demonstrations, and accountable care organizations. States may leverage purchasing strategies, administrative structures, regulatory options, and delivery system reform through SPAs and section waivers to advance behavioral health integration.

### Purchasing Strategies

Managed care is a Medicaid program structure whereby a state contracts with an organization to provide services to Medicaid consumers through its own network of providers.<sup>10</sup> In contrast to fee-for-service, in this purchasing strategy Medicaid pays for some or all services at a prepaid rate and often based on enrollment.<sup>41</sup> The state contracts with a managed care organization (MCO) to provide managed care services to their enrollees. MCOs often accept a set per number per month payment for services. However, mental health and psychiatric prescription benefits within Medicaid managed care can either be integrated (managed the same as other medical benefits), subcontracted (managed care is responsible for mental health benefits but subcontract this management out to a specialized outside mental health entity), or a carve-out, where mental health benefits are provided on a fee-for-service basis or by another managed care plan not responsible for other medical benefits).<sup>41</sup>

As of 2012, nearly two thirds of Medicaid enrollees receive most or all of their benefits via managed care.<sup>42</sup> Two possible sources of saving from this Medicaid strategy are reducing hospital use and costly procedures, and lower per unit prices as compared to fee-for-service payment rates.<sup>42</sup> Thus, in states with relatively high fee-for-service rates, managed care may be a particularly good option to improve patient care and reduce costs. As of January, 2016, sixteen states provide or are planning to offer behavioral health services through an integrated managed care benefit to centralize accountability for costs and quality within one organization.<sup>43</sup>

State Medicaid programs may change regulatory policies that impede integrated behavioral health care delivery or enhance behavioral health integration. A broad spectrum of regulatory changes could include: expanding professional credentialing to allow for services provided by community health workers, patient navigators, or peer counselors to be covered by Medicaid; allowing for same day billing for behavioral and physical health services; increasing reimbursement rates for evidence-based services in integrated care settings; supporting information exchange through education on privacy laws with agency guidance; and streamlining privacy standards with a single set of requirements for all protected information and standardized, multi-provider consent forms.<sup>45,46</sup>

“The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy, and the handicapped.”

– Hubert Humphrey, vice president under Lyndon Johnson when Medicaid was first enacted



## STATE SPOTLIGHT

### texas

Health plans have the option to provide services themselves or to contract with a behavioral health organization. Texas has “carved in” behavioral health rehabilitation and case management services into 20 managed care plans as mandated by 2013 Senate Bill 58. Prior to Senate Bill 58, behavioral health services were provided by Local Mental Health Authorities (LMHAs; the network of community mental health centers in Texas), via fee-for-service (FFS) payment models. Managed care plans and behavioral health organizations now contract directly with LMHAs and other entities to provide behavioral health services.<sup>43</sup> Although the framework for the Medicaid managed care program is based on a FFS model, the program does not restrict to operating on FFS policies or rates, and allows greater flexibility to meet the needs of its members. Financing of behavioral health services depends on the care delivery setting with federally qualified health centers (FQHCs) having access to additional billing options through federal payment structures. This results in FQHCs having access to funds designed to cover the complete cost of care for a patient with Medicaid coverage.<sup>44</sup>

## Administrative Structures

Administrative responsibilities for physical and behavioral health services have historically been bifurcated between multiple state agencies, resulting in different leadership, policies, expertise, programs, and visions for care delivery. Agency alignment, agency consolidation, or consolidated contract oversight are options to better integrate systems and policies, leading to better integrated care delivery.<sup>45</sup>



## STATE SPOTLIGHT

### arizona

In 2015, Arizona gave the state’s Medicaid director responsibility for both physical and behavioral health services after it merged its Medicaid agency, named the Arizona Health Care Cost Containment System (AHCCCS) and its Department of Health Services’ Division of Behavioral Health Services (DBHS). The merging into one agency resulted in the services and expertise necessary to address the physical and behavioral health services of Medicaid enrollees. The Medicaid agency assumed a new level of leadership in integration resulting in increased attention to behavioral health integration across the state, strategic purchasing of both physical and behavioral health services, and streamlined regulation, consistent policy, enhanced communication, and increased cross sector collaboration.<sup>47</sup>

## Delivery System Reform

### Accountable Care Organizations

An accountable care organizations (ACO) is a group or network of providers and hospitals that work together to coordinate care for the patients it serves.<sup>10</sup> This often encourages the participating doctors, hospitals, and other health care providers to coordinate care, as they are often eligible for shared savings when they deliver quality care while limiting unnecessary spending. By focusing on prevention and effectively working with patients with chronic diseases, ACOs are often successful at preventing hospitalizations and unnecessary and costly procedures that benefit all of the participating stakeholders in the long run. However, patients are not required to go to a participating ACO provider or hospital at any time.

ACOs were first adopted in Medicare under the ACA, and unlike the Medicare ACO programs, there are no uniform national standards for Medicaid ACO programs, leading to flexibility in how states design their programs. With guidance from the Centers for Medicare and Medicaid, states have designed their ACO programs to improve care coordination and hold providers financially accountable for their patient population by implementing value-based payment structures, measuring quality improvement, and collecting and analyzing data.<sup>48,49</sup> Value-based payment structures typically used by Medicaid ACOs include shared savings arrangements or global budget models.<sup>49</sup> As of October, 2017, thirteen states report having active ACO programs.<sup>50</sup>

Among these states, some are developing programs to integrate behavioral health to improve healthcare quality and target healthcare costs. State Medicaid ACO programs that have integrated behavioral health use several strategies to coordinate behavioral health and physical health services. The four strategies most commonly used are:

1. including behavioral health services in payment models
2. requiring behavioral health quality metrics to be reported and tying some metrics to payment
3. including behavioral health providers in ACO or in ACO governance mode
4. providing support to ACOs to integrate behavioral health services.<sup>51</sup>



## STATE SPOTLIGHT

### minnesota

Minnesota's Integrated Health Partnership (IHP) program, its Medicaid accountable care model, is implemented alongside other transformation efforts to improve managed care organizations and the state's fee-for-service model. Minnesota has experienced overall savings of \$1 billion through these healthcare reform efforts, with more than \$213 million of this savings occurring in the last four years due to the success of the IHP program. IHPs across the state have served 460,000 Minnesotans, improved health care access and outcomes for those served, and reduced hospital admissions by 14% and emergency room visits by 7%.<sup>52</sup> Features of Minnesota's IHPs include: behavioral health services are accounted for in total cost of care calculations; depression remission at six months is used as a quality metric and is tied to payment; encouragement of incentives and distribution of shared savings with behavioral health providers; provision of support for integration by using State Innovation Model (SIM) funding to build data-sharing capacity, train providers, and host learning collaboratives to facilitate implementation of data sharing tools within behavioral health practices; and prioritization within SIM grant infrastructure funding for behavioral health providers who have partnered with an IHP.<sup>51</sup> Based on the success of the IHP programs, Minnesota is in the process of planning for the expansion of the demonstration project in 2019. This will ensure enrollees have a meaningful choice in providers and provider networks, encourage networks to value providers who coordinate care and work with communities to improve outcomes, move providers towards accountability for health care costs and quality, and create a similar experience for providers and enrollees across programs through common administrative practices.<sup>52</sup>



## STATE SPOTLIGHT

### missouri

In 2012, Missouri implemented a statewide health home system, the Community Mental Health Centers Healthcare Home (CMHC HCH), designed to integrate care for individuals with severe mental illness or serious emotional disturbances. Historically, many of the individuals with the highest expenditures in Missouri Medicaid had co-occurring mental and chronic health conditions. The aim of CMHC HCH is to improve patient experience of care, improve population health outcomes, and reduce the cost of care. The CMHC HCH has met or exceeded goals for disease management of physical health conditions among individuals with severe mental illness including: increased metabolic syndrome screening rates (from 12% in 2012 to 88% in 2015); increased percentage of enrollees with diabetes who had controlled blood pressure (27% to 72%), good cholesterol levels (22% to 54%), and controlled blood glucose levels (18% to 61%); increased percentage of enrollees with hypertension and cardiovascular disease who had controlled blood pressure (24% to 67%) and good cholesterol levels (21% to 56%); increased 72 hour hospitalization follow-up rates (35% to 49%); and reduced the average number of hospitalizations by 14% and emergency room visits by 19%.<sup>56,57</sup> Additionally, the program has demonstrated continued cost savings for \$20.7 million for all enrollees for the first year of services.<sup>56,57</sup> Missouri has identified areas of opportunity to continue to improve population health through the CMCH HCH program, including: increase percentage of enrollees who are tobacco free and decrease obesity and extreme obesity within the population; continue to improve data technology and to facilitate population health management and care coordination; evaluate organizations' transformation to integrated care and the impact on their individual organization outcomes; and develop a child-focused Healthcare Home model to address the unique needs and existing gaps in care for children.<sup>56,57</sup>



## STATE SPOTLIGHT

### missouri

In addition to Community Mental Health Centers Healthcare Homes, Missouri also has an initiative to increase health homes in primary care by integrating behavioral health. Original qualifying conditions included a combination of any two: diabetes, heart

## Health Homes

Health homes (HH) consist of a team of providers who provide patient-centered, integrated physical and behavioral health care.<sup>10</sup> HHs focus on specific populations with chronic conditions (including serious mental illness, substance abuse, and chronic medical diseases) and are often the most beneficial for high-cost patients who require broad, coordinated, and whole person care.<sup>53</sup> Section 2703 of the ACA established a HH option for states to reduce costs of high-need populations. The ACA incentive provided by the federal government is 90% federal match for the first two years of HH operation when the following services are included: comprehensive care management, care coordination and health promotion, comprehensive transition care from inpatient to other settings including appropriate follow-up, individual and family support, referral to community and social support settings, and the use of health information technology to link services.<sup>54</sup> To be eligible, Medicaid beneficiaries must have at least two chronic conditions or at least one serious and persistent mental health condition. States are given a great amount of freedom in deciding how to implement and coordinate HHs including delivery methods, payment methods, and organization of staff.<sup>53</sup> This flexibility allows states to target their unique high-risk Medicaid users, or implement a HH in a more generic primary care setting. HH can operate as a fee-for-service or managed care program. The most common form of payment is a per member per month (PMPM) rate paid by the state to the HH, based on the acuity of population needs.<sup>54</sup> Coordinating and integrating care for HH beneficiaries allows patients to receive the best care and for the HH to maximize their incoming funds or to advocate for value-based payment. As of May, 2017, 21 states and the District of Columbia were serving over 1.3 million Medicaid enrollees through 32 approved Medicaid HH models. Of these, 18 states and the District of Columbia were targeted to a specific mental health or substance use population.<sup>55</sup>

## Patient-Centered Medical Homes

A patient-centered medical home (PCMH) is similar to the health home model but is specific to primary care, and the care team is typically led by a primary care provider.<sup>58</sup> PCMHs are responsible for medical and behavioral health services, as well as preventive, acute, chronic, and transitional care.<sup>53</sup> Reimbursement under the ACA is typically fee-for-service and is often offset by member-per-month payments and pay-for-performance bonuses. Under this structure, 44% of programs have received shared savings reimbursements.<sup>53</sup> Given the structure of PCMH, the ideal setting to implement a PCMH is a large and organized health care system that has the resources (personnel and infrastructure) to successfully integrate and implement services.<sup>53</sup>

## Waivers

A waiver is a contractual agreement between the federal and state government that allows a state to be exempted from certain federal Medicaid requirements codified in the Social Security Act. Commonly pursued waivers include: Section 1115 research and demonstration waiver, 1915(b) managed care waiver, and 1915(c) or 1915(i) home and community-based services waiver.<sup>10</sup> The waiver is named for the section of the Social Security Act being waived and allows state Medicaid programs to serve people who would not otherwise be eligible or to provide services that are not otherwise offered in the state's Medicaid benefit package.

States have commonly used Section 1915(c) waivers to address behavioral health issues in home or community, exemplifying an integrated approach to care. The Section 1915(c) provides an option for states to offer services to people impaired by either a developmental or intellectual disability, including autism spectrum disorders. Fifty current or former waivers across 29 states that included children with autism spectrum disorder included the target populations have been identified.<sup>60</sup> Waivers varied significantly across states in the population covered, estimated cost of services, cost control method employed, and services offered to children with autism spectrum disorder.

Section 1115 waivers employ research and demonstration projects to explore novel Medicaid programs to achieve greater quality, access or cost savings. There is high interest among states in Section 1115 to expand behavioral health services. As of February 2018, 16 states were using Section 1115 waivers to fund delivery system reforms such as behavioral health integration, expanding community-based behavioral health benefits, paying for services in “institutions for mental disease” and expanding Medicaid benefits to additional populations with behavioral health needs (including those recently released from jail or prison). Additionally, 13 states have pending 1115 waivers related to behavioral health.<sup>14,61</sup> Four states have approved Section 1115 Waivers to finance behavioral health delivery system reforms to advance the integration of behavioral healthcare. Three states have pending waivers seeking funding to support behavioral health integration with applications focused on funding for alternative payment models and workforce development initiatives.<sup>14,61</sup> States seeking to address the challenge of mounting costs related to behavioral health, including substance use related to the opioid epidemic, have considerable flexibility to innovate with Section 1115 waivers.

disease, asthma, overweight, tobacco use, or developmental disabilities. In 2016, the state updated qualifying conditions to include anxiety, depression, and substance use, and two single conditions: pediatric asthma and obesity. Currently there are over 38 participating organizations, with the majority being FQHCs or hospital affiliated. An evaluation summary for July 2012 to June, 2013, demonstrated that both hospital admissions and emergency room utilizations decreased in the year following enrollment (nearly 6% and 10% per 1000, respectively) resulting in a total savings of \$5.68 million for this period. Per-member per-month payments for the year totaled \$8.03 million, leading to a net result of nearly 71% of the total PMPM payments being saved through the primary care health home initiative.<sup>59</sup>



### STATE SPOTLIGHT

## oregon

Oregon has had a Section 1115 Medicaid Demonstration waiver since 1994, allowing the state to deliver Medicaid services in flexible and unique ways to meet its healthcare needs. With the waiver, Oregon established Coordinated Care Organizations (CCO): geographically defined, multi-sector partnerships that accept upside and downside risk for both health care costs and quality for their Medicaid population.<sup>62</sup> As of February, 2018, there are 15 CCOs. Since 2013, CCO coverage has increased by 65%, totaling more than one million individuals.<sup>63</sup> Key elements of Oregon's CCO include using evidence-based practices to manage and coordinate care; sharing responsibility among providers, payers, and consumers; transparency in price and quality; performance measures that are consistent across health systems; innovative payment methods, such as population and episode-based payments and incentives for quality outcomes; and a sustainable rate of growth. CCOs continue to transform how healthcare is delivered and promote integration with performance measures related to the integration of physical, behavioral, and oral health care. CCO integration incentive measures that increased in 2017 include: follow up after hospitalization for mental illness; mental, physical, and dental health assessment within 60 days for children in Department of Human Services custody; and screening for clinical depression with a

follow up plan. Approximately 60% of primary care practices are recognized as a Patient-Centered Primary Care Home.<sup>63</sup> The Medicaid Demonstration waiver was renewed in January, 2017 for another five years, through June, 2022.<sup>64</sup>



## STATE SPOTLIGHT

### virginia

In April of 2017, the Virginia Medicaid program began implementing an enhanced substance use disorder treatment benefit, Addiction and Recovery Treatment Services (ARTS). The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in CHIP and Medicaid programs, including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.<sup>65</sup> A Section 1115 Demonstration waiver allows Virginia Medicaid to pay for substance use services in residential treatment facilities with more than 16 beds, which significantly increases substance use disorder treatment capacity and requires Medicaid health plans and providers to use American Society of Addiction Medicine criteria in all substance use assessment and treatment services. The waiver does not change Medicaid eligibility and requires an independent evaluation.<sup>66</sup> Policy goals of ARTS include increasing the number of physicians serving Medicaid members, additional service coverage, and increased coordination with behavioral and physical health.<sup>67</sup> Evaluation results from the first three months of the program include: a 50% increase in treatment rates among Medicaid members with substance use disorders compared to a similar period in 2016; the number of outpatient providers delivering opioid use disorder services to Medicaid members more than doubled (300 to 691 providers), and rates of psychotherapy for Medicaid members with opioid use disorder in the eastern region of the state increased by 79%.<sup>68</sup>

## Conclusion

In conclusion, there is a growing body of evidence on the improved outcomes and cost savings of integrating behavioral and physical health care at the system, payment, and delivery levels. States can optimize Medicaid to advance integrated behavioral health. Medicaid allows for the flexibility to improve whole person care and obtain cost savings realized with integrated care by carving in behavioral health services in payment models, designing accountable care organizations and health homes, and leveraging waivers to flexibly meet behavioral health needs. States must develop, implement, and evaluate new payment models and delivery systems to sustain integrated care in practice and to better understand cost outcomes. Although all states are facing similar difficulties in meeting the behavioral health needs of their population, additional evidence is needed to understand which Medicaid policy levers are best suited to meet the unique needs of each state. Nonetheless, current evidence demonstrates that taking an overall whole person approach to healthcare is a way to address fragmentation, rising costs, and sub-optimal care. By prioritizing integration, state Medicaid programs have the opportunity to lower costs and significantly improve the whole health of their beneficiaries, while also leading other payers and health plans to implement payment and delivery models to integrate behavioral health.

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