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State Medicaid Integration Tracker©

NASUAD
National Association of States United for Aging and Disabilities

Welcome to the State Medicaid Integration Tracker©

The **State Medicaid Integration Tracker©** is published bimonthly by the National Association of States United for Aging and Disabilities (NASUAD). It is intended to provide a compilation of states' efforts to implement integrated care delivery-system models. Only publicly available and documented activities are included in this tracker.

This tracker includes new updates for each state that occurred during the most recent month. For comprehensive information on each state, as well as archived versions of the tracker, please visit: http://nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker

The **State Medicaid Integration Tracker©** focuses on the status of the following state actions:

1. Managed Long-Term Services and Supports (MLTSS)

2. State Demonstrations to Integrate Care for Dual Eligible Individuals and other Medicare-Medicaid Coordination Initiatives

3. Other LTSS Reform Activities, including:
   - Balancing Incentive Program
   - Medicaid State Plan Amendments under §1915(i)
   - Community First Choice Option under §1915(k)
   - Medicaid Health Homes

NASUAD uses many information sources to learn what is happening across the country in these areas. NASUAD's sources include: the CMS website on Managed Long Term Services and Supports (link), the CMS website on State Demonstrations to Integrate Care for Dual Eligible Individuals (link), the CMS Balancing Incentive Program website (link), the CMS website on Health Homes (link), the CMS list of Medicaid waivers (link), state Medicaid Agency websites, interviews with state officials, and presentations by state agencies. NASUAD lists sources for each update, as well as hyperlinks to related CMS and state documents and materials.

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Overview

Managed LTSS Programs:	AZ, CA, DE, FL, HI, IA, IL, KS, MA, MI, MN, NC, NJ, NM, NY, PA, RI, TN, TX, VA, WI
Medicare-Medicaid Care Coordination Initiatives: All states, except Minnesota, are operating a CMS-approved Financial Alignment (FA) demonstration program **: Pursuing alternative initiative	CA, IL, MA, MI, MN**, NY, OH, RI, SC, TX, WA
Other LTSS Reform Activities approved by CMS: **NOTE: Pending actions ONLY are noted with an asterisk. Otherwise, all states listed have approved programs.** *: Pending CMS approval	
o **Balancing Incentive Program:**	AR, CT, GA, IL, IN, IA, KY, LA, ME, MD, MA, MS, MO, NE, NV, NH, NJ, NY, OH, PA, TX
o **Medicaid State Plan Amendments under §1915(i):**	AR*, CA, CO, CT, DE*, DC*, ID, IN, IA, LA, MD, MI, MN*, MS, MT, NV, OR, SC*, WI
o **Community First Choice option under §1915(k):**	AR*, CA(2), CO*, CT, MD, MN*, MT, NY, OR, TX, WA, WI*
o **Medicaid Health Homes:**	AL, AZ*, AR*, CA*, CT, DE*, DC*, ID, IL*, IN*, IA(3), KS, KY*, ME(3), MD, MI, MN*, MS*, MO(2), NV*, NH*, NJ*, NM*, NY(3), NC, OH(2), OK, OR, RI(3), SD, VT(2), WA, WV*, WI(2)

State Updates

State	State Updates
California	**Medicare-Medicaid Coordination Initiatives** Cal MediConnect, a voluntary demonstration project for Medicare-Medicaid "Dual Eligibles" in seven counties—Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardina, and Santa Clara—released Performance Dashboard Metrics Summary in June 2018 for ten plans. The 2016-2017 enrollment and demographic data included 115,071 participants in September 2017. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. Quality "withhold" measures for eight Plans reported three plans that met all six measures and the average "withhold" amount received was 84% in 2014. Care coordination was evaluated by: (1) Completed individual care plans, obtained by 76% of the members; and (2) Follow-up visits after hospital discharge, provided to 77% of the members. CalOptima and IEHP had the highest number of appeals, with SCFHP, Molina, and IEHP having the highest number of grievances. For LTSS, Anthem, IEHP, HPSM, and SCFHP equaled or exceeded 300 members per 1,000 for the highest utilization of Long Term Services and Supports. The statewide LTSS average was approximately 280 per 1,000 members. (Source: California Department of Health Care Services, June 2018) California's Cal MediConnect Demonstration Year 2 (2016) continued with the ten Medicare-Medicaid plans from Year 1. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. All plans, with the exception of one, met 75% or better of performance measures. Two plans met 100%. In 2016, the percent of withheld funds "received," increased to an average of 83% compared to 65% in 2015. Four plans received 100% of withheld funds in 2016. (Source: CMS-California Medicare-Medicaid Plan Demo Year 1 and Demo Year 2 , 6-19-2018)
Florida	**Managed-Care Contracts** Florida requires re-bidding Medicaid managed care services every five years; these contracts will be comprehensive, including acute care, behavioral health and long-term services and supports. Initially, the contracts for two of the current MCOs, Prestige Health Choice and Molina Healthcare, were not renewed for the upcoming five-year term. However, after threatening legal action and subsequently reaching a settlement with the state, both plans were awarded additional Medicaid managed-care contracts. Now, Best Care Assurance, who was awarded a contract in April in Medicaid Region 8 and operates under the name of Horizon Health Plan, is legally challenging the decision to re-instate Molina Healthcare of Florida. At

	this time, Florida has contracted with thirteen managed care plans to provide comprehensive Medicaid services over the next five years at an expense of $90 billion. (CBS News 12 , 6-19-2018; Herald Tribune, 6-25-2018; Molina Healthcare, 6-18-2018)
Illinois	**Medicare-Medicaid Coordination Initiatives** On June 17, 2018, CMS published the "Financial Alignment Initiative" results for Demonstration Year 2 in the Illinois State-Specific Medicare-Medicaid plans. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. After dropping Health Alliance Connect from the Central Illinois Region in January 2017, the remaining seven plans received 50% or greater of their "withhold" in CY2016 with an average of 71%. One plan, Health Spring of Tennessee, Inc. received 100%. Previously, in Year 1 (CY 2015), the Illinois average for eight plans was 50%, with three plans receiving only 25%. (Source: CMS Illinois Medicare-Medicaid Plan Quality Withhold Analysis Results- Demonstration Year 1 and Demonstration Year 2, 06-19-2018; and Health Alliance Connect, 01-01-2017) Changes in the Illinois Medicare-Medicaid Alignment Initiative (MMAI) Demonstration Three-Way Contract (Illinois-US Department HHS-Plan Provider) included technical corrections and clarification of terms. • Aligned policies for notification when providers leave a MPP. • Revised credentialing process to require MMP's to use the state's IMPACT system and to align with the Medicaid program process in that state. • Added state law requirements for provider and pharmacy network directories. • Updated CMS reporting regulations • Updated state payment requirements for enrollees in Institutions of Mental Disease. • Updated "Medical Loss Ratio" (MLR) and calculation. • Added requirements for Medicare Reconciliation and Settlement (Source: Illinois and US Department HHS-Contract form, Summary of Contract Changes, 6-10-2018)
Iowa	**Managed LTSS Program** Iowa State Auditor, Mary Mosiman, plans to review the state's Medicaid managed-care program finances based on a request by a state senator, due to her concern regarding conflicting savings' estimates reported by various sources. In May 2018, Iowa Department of

	Human Services released an annual savings range of $140.9 million (fiscal year 2018) for Medicaid Managed Care. Previous savings estimates included: $47.1 million estimate for current budget year (which ends in June 2018) from DHS December quarterly report; and $232 million for this budget year from the former governor's preliminary estimate, released prior to Iowa Medicaid switching to a managed care system. (The Gazette (Des Moines) 6/7/2018)
Kansas	**Managed LTSS Program** On June 22, 2018 WIBW News reported that the Kansas Department of Health and Environment (KDHE) selected three MCOs to serve the state's Medicaid managed care population, which includes LTSS. The three MCOs selected are: o Sunflower State Health Plan (Centene); o United Healthcare, Midwest; and o Aetna Better Health of Kansas. Sunflower State Health Plan and United Healthcare are incumbent plans, while Aetna is newly selected. Amerigroup, as the third incumbent plan, was not awarded a contract but has stated that they intend to contest the loss of their contract through formal processes. According to the Kansas City Star, a law firm has filed an open-records request on behalf of Amerigroup, looking for additional information regarding the state's RFP process. (Source: WIBW News 6/22/2018; Kansas City Star 6/25/2018)
Maryland	**Community First Choice** Maryland's Medicaid Community First Choice (CFC) Program for dual-eligible beneficiaries, which covers personal care and care coordination, was evaluated for cost-effectiveness and sustainability to determine feasibility for a limited personal care and home and community-based service, "Help at Home," benefit in Medicare. The 3-year analysis used Maryland Medicaid claims data and assessment information, determining that CFC had stable per member per year (PMPY) cost of approximately $21,000 (2014-2016). Enrollment in CFC increased from 6,639 to 11,000 over this time. Eighty-seven percent of the expenses were for personal assistance services with only modest expenditures on administration. Average weekly hours of paid support per enrollee declined to 29 hours per member. This evaluation demonstrated that predictable supportive services with stable PMPY costs for HCBS/LTSS is possible. The CFC program also did not supplant unpaid informal care provided by family and friends. (Sources: The Commonwealth Fund, June 2018 and Health Payer Intelligence, 07-05-2018)

Massachusetts	**Medicare-Medicaid Coordination Initiatives and Managed LTSS** **OneCare and SCO Combined in Dual Demonstration 2**: The complex needs of Medicare-Medicaid dual-eligibles in Massachusetts have been served by integrated care plans offered by **One Care** (a 1115A Duals Demonstration for individuals who are 21-64 years old at time of enrollment and living with disabilities) and **SCO** (Senior Care Options--a Fully Integrated Dual Eligible Special Needs Plan for individual ages 65 and over). MassHealth seeks to move One Care and SCO to a combined "Duals Demonstration 2"--a new aligned 1115A Demonstration--while maintaining the distinct population focus, service package, eligibility, and competency requirements of the current programs. The goals of this newly combined demonstration include increased access to integrated care, improved member outcomes, and financial sustainability for MassHealth, CMS, participating plans, and providers through value-based purchasing, increased transparency, data-sharing, and aligning administrative processes. This would include allowing Medicare Advantage bidding applicable for Parts A, B, and D, for One Care beneficiaries and creating a "high-utilizer" stop loss mechanism. (Source: Commonwealth of Massachusetts-Duals Demonstration 2.0 Draft Document, June 2018) **Medicare-Medicaid Demonstration Year 3 Plan Analysis:** Massachusetts Demonstration Year 3 (Year 2016) for Massachusetts' One Care program included two providers—Commonwealth Care Alliance and Tufts Health Public Plans. An additional provider from 2015, Fallon Total Care, was no longer evaluated in the demonstration. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. In 2016, the two plans averaged 81% of performance measures met. The average percent of withholding "received" was 88%, with one plan receiving 100% and the other receiving 75% in 2016. (Source: MA Medicare-Medicaid Plan Demo Year 3, MA Year 2, 6-21-2018) **Medicare-Medicaid Coordination Initiatives** Changes in the Massachusetts Three-Way Contract, which was re-executed on June 11, 2018 included: • Date extension to December 31, 2019. • Technical corrections to the quality withhold measures. • Specification of 2019 financial parameters.

	(Source: Massachusetts Contract Amendment, MA Summary of Contract Changes, 6-25-2018)
Michigan	**Medicare-Medicaid Coordination Initiatives** Michigan's MI Health Link Demonstration Year 1 (Calendar Years 2015-2016) saw improvement in the two evaluated time periods. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. In 2016, six of the seven plans, met 71% or better of performance measures—for a state average of 80%. One plan met 100%. In 2016, the percent of withholding "received" increased to an average of 86% compared to 61% in 2015. Four plans received 100% of withholding in 2016. (Source: CMS Michigan Medicare Medicaid Plan Demo Year 1, 6-19-2018)
New Jersey	**Managed LTSS Program** In June 2018, the New Jersey legislature introduced Senate Bill 2761 to require home health and health care service providers to develop a plan of care for patients that includes coordinating services, collaborating with hospitals, and educating patients and families on care plans. This bill creates an incentive-based value payment (VBP) system that measures and rewards performance outcomes for Fully Integrated Dual Eligible Special Needs enrollees. Medicaid managed care organizations would administer the program by distributing incentive payments to providers. If the bill is passed, the governor will appoint eight new members, representing nursing, personal care assistants, hospice, home care administration, managed care organizations, and other organizations, to a Department of Human Services advisory board to develop regulations. (Sources: HMA Weekly Roundup, 6-27-2018; NJ Senate Bill 2761, 6-21-2018) **Managed-Care Contract** New Jersey's Department of Human Services, released January 2018 amendments to its Medicaid MCO contract. The changes from the July 2017 version include: caregiver definitions, transportation services descriptions, clarification of mental health and substance abuse disorder benefits, HEDIS and MCO Drug Utilization Review reporting requirements, and MLTSS Capitation Rates updates. (Source: HMA Weekly Roundup, 6-27-2018; NJ Contract, July 2018)

New York	**Medicare-Medicaid Coordination Initiatives** New York's Demonstration Year 2 (2016) for the NY Fully Integrated Duals Advantage (FIDA) included seventeen of the twenty-one plans from Year 1 (2015). All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. The average percent of performance measures met was 77%. Only one plan met less than 67% of the performance measures. Five plans met 100%. In 2016, the average percent of quality withholds "received" dropped to 82% compared to 93% in 2015. Six plans received 100% of withheld funds. Additionally, New York reported on another demonstration which provided services for people with Intellectual and Developmental Disabilities (I/DD) in FIDA-IDD Demonstration Year 1 (2016). This demonstration's sole MMP, Partners Health Plan, Inc., met 100% of its performance measures and received 100% of the quality withhold. (Source: NY FIDA Medicare-Medicaid Year 1, Year 2, NY FIDA-IDD-Calendar Year 2016, 6-19-2018)
Ohio	**Medicare-Medicaid Coordination Initiatives** Due to a temporary suspension of the Ohio-specific measures in the evaluation of their financial alignment demonstration, only CMS Core quality measures were used in evaluating Ohio's Demonstration Year 2 (2016) for MyCare Ohio plans. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. The five MyCare plans had an average performance measure of 83%, with two plans meeting 100%. In 2016, the average percent of quality withholds recaptured increased to 90%, compared to 75% in 2015. Three plans received 100% of withheld funds in 2016. The suspension of the Ohio-specific measures is expected to be temporary as new specifications for the measures are developed (Source: Ohio Medicare Medicaid Plan Demo Year 2 and Ohio Demo Year 1, 6-19-2018)
Pennsylvania	**Managed LTSS Program** On June 30, 2018, the six-month "continuity of care" period ended for the first phase of Pennsylvania's Community HealthChoices program – the state's new MLTSS program. For the first six months of operation in the Southwest Region (Pittsburgh and 13 surrounding counties), the MCOs--UPMC Community HealthChoices, AmeriHealth Caritas, and PA Health and Wellness--were barred from reducing authorized services and were required to maintain existing provider-client relationships. Beginning July 1, the MCOs are able to revise service plans for individuals receiving HCBS based on the individual's assessed need.

	The state will review each service reduction or denial. (Source: Pittsburgh Post-Gazette, 7-2-2018)
South Carolina	**Medicare-Medicaid Coordination Initiatives** South Carolina's Demonstration Year 1 (Calendar Years 2015-2016) for the South Carolina Healthy Connections Prime demonstration included four plans. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. Performance measures ranged from 75% (2015) to 79% (2016). In 2016, two plans met 100% of their performance measures, while another plan dropped to 33%. The average percent of quality withholds recaptured was 81%--with three of the plans receiving 100% and one plan receiving 25% of withheld funds for 2016. (Source: SC Medicare-Medicaid Plan Demo Year 1, 6-19-2018)
Texas	**Medicare-Medicaid Coordination Initiatives** Texas' Demonstration Year 1 (Calendar Years 2015-2016) for the Texas Dual Eligible Integrated Care Project included five plans. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. The average percent of performance measures meeting criteria ranged from 75% (2015) to 61% (2016). In 2016, none of the plans met 100% of the performance measures—with the plans ranging from 50%-83%. The average percent of quality withholds recaptured for the five plans was 65% in 2016—with three plans receiving only 50% of the withheld funds and one plan receiving 100%. This is a decline from earlier in the demonstration (2015) when the plans received an average of 75% of withheld funds. (Source: TX Medicare-Medicaid Plan Demo Year 1, 6-19-2018) **Managed LTSS Program** On July 23, 2018, Texas STAR+PLUS reposted the cancelled Request for Proposals (RFP) for Medicaid managed care services in its statewide procurement. The original RFP was cancelled on July 5, 2018. STAR+PLUS, a MLTSS program for older adults and people with disabilities, serves 529,966 members (2016) statewide with five plans—Amerigroup/Anthem, Cigna, Centene, Molina, and UnitedHealthcare. The proposals are solicited to expand the program and to ensure that at least two MCOs exist for each service area. (Sources: Texas Comptroller, 07-05-2019, Texas Comptroller, 7-31-2018 and HMA Weekly Roundup, 07-11-2018) Recently, a Dallas Morning News investigation reported that the Medicaid MCO system is failing the state's most vulnerable Texans. Subsequently, on June 27, 2018, the Texas House

	General Investigating and Ethics Committee convened a hearing where patients, advocates, and executives of five health plans reported on the status of the state's Medicaid managed care program. (Texas Tribune, 06-27-2018, Dallas Morning News, 06-03-2018, and HMA Weekly Roundup, 07-11-2018)
Virginia	**Medicare-Medicaid Coordination Initiatives** Virginia's Demonstration Year 2 (Calendar Year 2016) for the Virginia Commonwealth Coordinated Care Demonstration included three plans. All Financial Alignment Demonstrations include a provision to 'withhold' a portion of the Medicare-Medicaid Plans' capitation rate that can be recaptured if the MMPs meet quality measures. In 2016, none of the plans met 100% of the performance measures—with the plans averaging 58%-75%. The average percent of withholding "received" stayed constant at 67% between 2016 and 2015. Two plans received 75% and one plan received 50% of withheld funds in 2016. (Source: Virginia Medicare-Medicaid Plan Demo Year 2, and Virginia Year 1, 6-19-2018)

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 5/22/2018)

	States	Proposed Financing Model	Submitted to CMS	Status	Implementation Date[1]	Anticipated End Date
1	**California**	Capitated	5/31/2012	**MOU Signed** 3/27/2013	Fully implemented in 7 counties	12/31/2019
2	**Colorado**	Managed FFS	5/2012	**TERMINATED on** 12/31/2017		N/A
3	**Illinois**	Capitated	4/6/2012	**MOU Signed** 2/22/2013	Fully implemented in greater Chicago and central Illinois areas	12/31/2019
4	**Massachusetts**	Capitated	2/16/2012	**MOU Signed** 8/23/2012	Fully implemented statewide	12/31/2018
5	**Michigan**	Capitated	4/26/2012	**MOU Signed** 4/2014	Fully implemented in 10 counties and the Upper Peninsula	12/31/2020
6	**Minnesota**	Admin. Alignment	4/26/2012	**Admin. Alignment MOU Signed** (9/12/2013)	Fully implemented	12/31/2018
7	**New York**	Capitated[2]	5/25/2012	**MOU Signed** 8/26/2013; 11/5/2015	Fully implemented in NYC, Nassau, Westchester and Suffolk counties	12/31/2019; 12/31/2020
8	**Ohio**	Capitated	4/2/2012	**MOU Signed** 12/12/2012	Fully implemented in 29 counties	12/31/2019
9	**Rhode Island**	Capitated	5/31/2012	**MOU Signed**	Three phases of opt-in enrollment:	12/31/2018

[1] Implementation dates are based on demonstration proposals submitted to CMS, Memoranda of Understanding, and Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS, 1/6/2016.

[2] New York initially submitted demonstration proposal for both financial models, but later withdrew its Managed FFS model. Please refer to text in New York section.

	States	Proposed Financing Model	Submitted to CMS	Status	Implementation Date[1]	Anticipated End Date
					7/2016; 8/2016; and 9/2016	
10	**S. Carolina**	Capitated	5/25/2012	**MOU Signed**	Fully implemented	12/31/2018
11	**Texas**	Capitated	5/2012	**MOU Signed**	Fully implemented in 6 counties	12/31/2018
12	**Virginia**	Capitated	5/31/2012	**TERMINATED on 12/31/17**		N/A
13	**Washington**	Managed FFS	4/26/2012	**MOU Signed** 10/25/2012	Fully implemented in 36 counties	12/31/2018

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