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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.

For more information, please contact **Damon Terzaghi** (dterzaghi@nasuad.org)

Overview

Managed LTSS Programs:	AZ, CA, DE, FL, HI, IA, ID, 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

State Updates

State	State Updates
Alabama	**LTSS Reform Activities** Governor Kay Ivey announced on October 1, 2018 that the Centers for Medicare and Medicaid Services (CMS) approved the state's Integrated Care Network (ICN) program. This program is intended to offer more community options for Medicaid long-term care recipients. This includes both recipients who live in a nursing facility, and those who receive services in their homes through either Medicaid's Elderly and Disabled (E&D) waiver or the Alabama Community Transition (ACT) waiver. The program does not change any Medicaid benefits, but is intended to help recipients learn about and apply for services available to them. The state will now move forward with implementing a system of case management, outreach, and education, with the long-term goal of increasing the percentage of Medicaid recipients receiving in-home care. An RFP for the proposed Integrated Care Network was released on April 20, 2018, and Alabama Select Network was chosen to administer the program. (Source: Governor Ivey Press Release Announcing Approval of ICN 10-1-2018)
Arkansas	**Managed LTSS Program** The Arkansas Department of Human Services (DHS) announced on November 16, 2018 that they will be delaying the shift to managed care for about 40,000 individuals with mental illness or developmental disabilities. This shift to managed care is part of a two-part initiative aimed at reducing the cost of caring for certain Medicaid recipients. Earlier in 2018, DHS began part one of this initiative. During this initial stage, five companies known as Provider-led Arkansas Shared Savings Entities, or PASSEs, began coordinating recipients' care in exchange for monthly payments of $173.33 per recipient. During the second phase of this initiative, these companies will pay for all of the recipients' care in exchange for a higher monthly payment. This shift to managed care was originally scheduled to occur on January 1, 2019, but will now begin March 1, 2019 instead. This 60-day delay was implemented following discussions with stakeholders. The goal is to allow more time for the managed care companies to prepare and for the department to provide information to recipients and their families about this shift. (Source: The Arkansas Democrat Gazette, 11-18-2018)
California	**Medicare-Medicaid Coordination** CMS has recently released a new evaluation report describing the California Cal MediConnect demonstration's approach to integrating the Medicare and Medicaid programs. The report discusses the demonstration's approach to providing care coordination to enrollees, enrolling beneficiaries into the demonstration, and engaging stakeholders in the oversight of the

	demonstration. This report also provides information on financing, payment, and Medicare savings. The report states that those receiving care coordination under Cal MediConnect have offered positive feedback in a number of surveys and focus groups. Participants have said that both their access to care and quality of life have improved. This demonstration plan also participated in the Consumer Assessment of Healthcare Providers and Systems beneficiary survey, where results showed improvement from 2015 to 2016 in beneficiaries rating their health plans at the highest levels, a 9 or 10. The demonstration showed no significant savings according to gross Medicare Parts A & B cost analyses. CMS and DHCS have extended the California demonstration through 2019, which will provide further opportunities to evaluate the demonstration's overall performance. (Source: California Cal MediConnect: First Evaluation Report, 11-29-2018) **Summary of Best Practices Meeting Published** In the spring of 2018, the Cal MediConnect (CMC) plans participated in a best practices process to identify how plans can better connect members to home and community-based LTSS services and integrate these services with more traditional medical benefits. The best practices group also discussed ways to better serve members currently residing in long-term care facilities. A summary of the best practices meetings was published in September 2018. This summary spotlights key takeaways in the areas of identifying LTSS needs, connecting members to services, Care Coordination infrastructure, training and education, and working with LTSS partners. Highlights include: • Plans have accelerated the LTSS referral process and improved care coordination by implementing the new standardized LTSS referral questions into their Health Risk Assessments (HRA). • Technology such as care management software and the integration of the HRA into the electronic health record can support LTSS care coordination and increase data availability. • General principles from multiple models of care coordination were identified as best practices, including multiple follow-ups by different care managers. • It is necessary to train a wide variety of actors on LTSS services. • Many plans have built close relationships between plan care managers and LTSS program care managers in an effort to improve care delivery and care coordination. (Source: Findings from the Cal MediConnect Best Practices Meeting, September 2018)

Florida	**Managed LTSS Program** In October 2018, Lighthouse Health Plan filed a petition in state administrative court challenging the automatic assignment formula for Medicaid patients in Northwest Florida. Lighthouse was awarded a five-year contract this year to provide Medicaid "managed medical assistance" services in Medicaid regions 1 and 2, while Humana was awarded a "comprehensive" contract for managed medical-assistance services and long-term care. Lighthouse alleged that the state's method of automatic assignment for the regions unfairly benefited their competitor Humana. In November 2018, Lighthouse agreed to withdraw its administrative challenge after the state approved a series of changes to the five-year Medicaid managed care contract. These changes include the elimination of a clause in the contract that would have prevented the company from being sold to a Medicaid HMO for 20 months, and the return of a $10 million performance bond that was submitted to the state incorrectly in place of the intended $5 million bond. (Sources: WLRN, 10-03-2018 and Health News Florida, 11-20-2018)
Hawaii	**Managed LTSS Program** On October 2, 2018, AlohaCare and 'Ohana Health Plan announced that they will cover basic adult dental care for Medicaid members in Hawaii. The two managed care providers will include this coverage beginning January 1, 2019. LIBERTY Dental Plan will manage the dental network for both health plans, and coverage will include an annual exam, fluoride treatment, a cleaning every six months, one set of bitewing x-rays per year, and either a non-emergent tooth extraction or filling. Members with dual coverage (Medicaid and Medicare) will not qualify. Hawaii has not had basic dental coverage for adult enrollees in Medicaid since 2009. (Sources: AlohaCare and 'Ohana Health Plan Joint Press Release, 10-02-2018, and American Dental Association, 10-05-2018) **Revised 1115 Waiver Application Submitted** On September 14, 2018 Hawaii submitted its revised "Quest Integration" § 1115 Waiver Extension Application. Hawaii is seeking a five-year extension of this waiver. The QUEST Integration demonstration began in October 2013 and is currently effective through December 2018. The demonstration consolidates QUEST, QUEST-Net, QUEST-ACE, and QExA into a single QUEST Integration program and also integrates the demonstration's eligibility groups and benefits within the context of the Affordable Care Act. Hawaii's waiver extension application includes a summary of the comments received from stakeholders during the comment period. Several comments expressed support for this demonstration as an important effort to improve care coordination. Other comments

	specifically supported this demonstration due to its community based health reform initiatives and value-based purchasing model. Additionally, multiple stakeholders pointed out the importance of addressing the needs of high cost/high need utilizers of care and also emphasized the need for improved real-time availability and transparency of data, especially on the part of Medicaid MCOs. (Sources: State of Reform, 10-03-2018, and Hawaii QUEST Integration §1115 Waiver Extension Application, 09-14-2018)
Idaho	**Managed LTSS Program** Idaho currently operates an integrated Dual Special Needs Plan (D-SNP) model for dual eligible individuals. This program, known as the Medicare Medicaid Coordination Plan (MMCP) serves almost 30,000 individuals on a voluntary basis and includes LTSS supports in the managed care benefit, despite the state not having an existing MLTSS program outside of the dual eligible initiative. As part of its efforts to expand care coordination for dual eligible individuals, Idaho began rolling out a mandatory Medicaid-only managed care plan, known as Medicaid Plus, for dual eligible individuals who are not enrolled in MMCP. Medicaid Plus will incorporate all Medicaid services, including LTSS, into a managed care model for these individuals. Individuals who receive LTSS but are not eligible for Medicare, members of an American Indian Tribe, Pregnant women, and dual eligible individuals who receive services through the state's HCBS waiver for intellectual and developmental disabilities, are not required to enroll in Medicaid plus. Beginning November 1, 2018 dual eligible individuals in Twin Falls County were required to enroll in Medicaid Plus if they were not part of MMCP. The state plans to include additional counties, including Bonneville, Bannock, and Bingham counties on April 1, 2019. Sources: Idaho Stakeholder Engagement Presentation (11-19-2018); Idaho Medicaid Information Release (12-20-2018); Center for Health Care Strategies (12-12-2018)
Illinois	**Medicare – Medicaid Coordination** Effective October 1, 2018, the Illinois Department of Healthcare and Family Services will no longer automatically assign people to the Blue Cross Community Medicare-Medicaid Alignment Initiative plan. This practice has been terminated because the insurer has not completed health risk assessments and care plans for enrollees at a satisfactory rate. The state also expressed concern over appeals and grievance issues. The Illinois Department of Healthcare and Family Services and the Centers for Medicare & Medicaid Services wrote a letter to the insurer informing them that future enrollment practices will depend on

	improvement of completion rates and improved practices related to appeals and grievances. (Source: Chicago Tribune, 08-28-2018) **CMS Evaluation** CMS has recently released a new evaluation report describing the launch of the Medicare-Medicaid Alignment Initiative (MMAI) demonstration in March 2014. This demonstration integrated care for Medicare-Medicaid beneficiaries in two regions. This first Evaluation Report describes implementation of the MMAI demonstration and provides early analysis of the demonstration's impacts. Utilization analysis showed a 15% decrease in inpatient utilization. This demonstration also showed significant reductions in skilled nursing facility (SNF) admissions, with a reduction of nearly 9%. However, despite this reduction, the Illinois demonstration did show a nearly 3% increase in long-stay nursing facility use. Comments from State officials, focus group participants, and enrollee and provider representatives suggest that enrollees' care coordination experiences have varied. The plan did participate in the Consumer Assessment of Healthcare Providers and Systems beneficiary survey, where results showed improvement from 2015 to 2016 in beneficiaries rating their health plans at the highest levels, a 9 or 10. There was also significant savings associated with this demonstration, with savings rates of 5% each year from year three through five. (Source: Illinois Medicare-Medicaid Alignment Initiative: First Evaluation Report, 11-29-2018) **Managed LTSS Programs** Two of Illinois' managed care insurers have consolidated into one health plan. Effective January 1, 2019, Harmony Health Plan is becoming part of Meridian Health Plan. Members of Harmony will automatically be enrolled with Meridian at this time, unless they opt out. Harmony was previously under sanctions because it did not have enough doctors and hospitals in its network to ensure adequate access, according to the state. It is unclear what will now happen with these sanctions following Harmony's acquisition. There will be a total of six managed care companies in Illinois following this consolidation. (Source: Modern Healthcare, 11-06-2018)
Iowa	**Managed LTSS Programs** Iowa's Department of Human Services published the SFY 18 Quarter 4 Managed Care Performance Data on September 25, 2018. Data from this report shows that UnitedHealthcare had 18,145 critical incidents as of June, while Amerigroup had 5,655 critical incidents. During a recent meeting, Iowa Department of Human Services officials and council members expressed concern over the number of critical incidents reported to the managed-care organizations this

	past quarter, describing the figures as, "higher than what anyone would want." The quarterly report also found that the trend of increasing grievances continued over the past quarter. Amerigroup's complaints increased from 276 to 297, while UnitedHealthcare's number of complaints rose from 471 last quarter to 745. The report identified most of these grievances as resulting from an unfulfilled request to enroll in or change a benefit plan during an open enrollment period and noted that the vast majority of these grievances were resolved within 30 days. (Sources: The Gazette 10-10-2018 and Iowa Medicaid Managed Care Q4 Report 9-25-18)
Kansas	**Managed LTSS Programs** On August 13, 2018, Shawnee County District Judge Franklin Theis denied Amerigroup's request for a temporary injunction to block Kansas from implementing newly awarded Medicaid managed care contracts. Amerigroup sued the state after losing the state's RFP for the new KanCare contract, alleging unfair treatment and lack of equal consideration. Although he denied the request for an injunction, Judge Theis did order a hearing to consider flaws in the bidding process. Following this hearing, on October 12, 2018, the judge ruled that there was no evidence to support accusations of misconduct in the bidding process and that KanCare's new contracts could go forward as planned. KanCare will move forward with three contracts: Aetna, Sunflower State Health Plan (a division of Centene) and UnitedHealthCare. (Sources: Kansas City Star 10-12-2018 and HMA Weekly Roundup, 8-22-2018)
Massachusetts	**Medicare-Medicaid Coordination** The Massachusetts Executive Office of Health and Human Services (EOHHS) has submitted to CMS the Final Concept Paper for its proposed Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0. This demonstration would include both the One Care demonstration for dually eligible individuals under age 65, and the Senior Care Options Dual Eligible Special Needs Plan (D-SNP) program for dually eligible individuals ages 65 and older. The proposed Demonstration would provide federal authorities and flexibilities for MassHealth's integrated care programs for dual eligible members. The final concept paper incorporates feedback from various stakeholder meetings and responses from Massachusetts' RFI. The CMS public comment period for the proposal ended October 17, 2018. CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. (Sources: Massachusetts Duals Demonstration 2.0 Final Concept Paper, 8-20-2018; Integrated Care Resource Center, September 2018)

	LTSS Reform Activities In October 2018, CMS approved MassHealth's Flexible Services Program as a component of the DSRIP program. This $149 million dollar program allows Accountable Care Organizations (ACOs) to pay for health-related nutrition and housing supports for certain eligible members. Eligible members must: • Be enrolled in one of MassHealth's Accountable Care Organizations (ACOs); • Meet at least one of the Health Needs Based Criteria defined in the Flexible Services Protocol. This includes having a behavioral health need, a complex physical health need, needing assistance with one or more documented Activities of Daily Living or Independent Activities of Daily Living, having repeated Emergency Department use within a certain timeframe, or being pregnant or having high-risk complications due to pregnancy); and • Meet at least one of the Risk Factors defined in the Flexible Services Protocol (which include being homeless, being at risk of homelessness, or being at risk for a nutritional deficiency). Eligible members can receive services including pre-tenancy and tenancy sustaining assistance, help completing home modifications needed for health and safety, and help obtaining nutritional benefits and/or home-delivered meals. The Flexible Services Program supports the broader MassHealth goal of addressing the health-related social needs of its members as part of the ACO program. The program is expected to begin in January 2020. (Source: MassHealth Flexibile Services Program, November 2018)
Minnesota	**Medicare-Medicaid Coordination** On September 9, 2018 CMS and Minnesota signed a second Memorandum of Understanding (MOU) extension. The original MOU was signed on September 12, 2013 in order to test new ways of improving care for Medicare-Medicaid enrollees. This partnership builds on the Minnesota Senior Health Options (MSHO) program, which serves approximately 36,000 older adults through eight different health plans that contract with the State as Medicaid managed care organizations and with CMS as D-SNPs. The Demonstration will be extended under this MOU until December 31, 2020. The main goals of this MOU extension are to more fully align Medicare and Medicaid within MSHO, improve beneficiary experiences, and address administrative efficiencies. (Source: MN Second MOU Extension) CMS has recently released a new evaluation report analyzing the Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience. This

	demonstration authorizes a set of administrative activities designed to better align the Medicare and Medicaid policies and processes involved in the MSHO program. It also formalizes certain prior informal agreements between CMS and Minnesota that allowed flexibility for the Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) participating in MSHO. Analysis of this demonstration is challenging due to its technical and operational nature. However, several positive behind-the-scenes outcomes have been reported. For example, this demonstration has helped the state establish a more reliable communication channel with CMS. It has also addressed aspects of Medicare and Medicaid alignment in the MSHO program, such as integrated processes for grievances and appeals, for claims adjudication, and for program enrollment. The upcoming third Evaluation Report on this demonstration will take into account qualitative information gained from site visits. (Source: Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience: Second Evaluation Report, 11-29-2018)
Mississippi	**Managed Care Program** Mississippi Senate Bill 2836 directed the state to establish a commission that would study and develop recommendations regarding whether the state should include additional categories of Medicaid-eligible beneficiaries in managed care, as well as to study the feasibility of developing an alternative managed care payment model for medically complex children. The final report was delivered to the Governor and Legislature on December 1, 2018, and included the following recommendations: • Mississippi Medicaid should study and implement an alternative managed care payment model pilot program for Children with Complex Medical Conditions receiving services from the University of Mississippi Medical Center; • The Medicaid agency should study the feasibility regarding a pilot program for individuals with behavioral health needs who receive services through the state's regional mental health/intellectual disability commission system; and • The Medical Care Advisory Committee within the state's Medicaid agency should have the responsibility of continually monitoring the feasibility of adding additional populations to managed care and to make recommendations for other changes to the state's MCO payment model. Source: Mississippi Commission on Expansion of Medicaid Managed Care Report (12-1-2018) **1915(i) and Managed LTSS** Mississippi submitted an amendment to CMS, effective October 1, 2018, that includes Psychiatric Residential Treatment Facility (PRTF) services within the state's Coordinated Care

	Organizations (CCOs) benefit package. In the same amendment, Mississippi also excluded the state's 1915(i) Community Support Program (CSP) from inclusion in the CCOs. Source: Mississippi State Plan Amendment Public Notice (9-28-2018)
New Mexico	**Managed LTSS** On November 21st, a District Court Judge ruled in favor of the State of New Mexico in a court battle regarding award of the state's Centennial Care managed care contracts. In December 2017, New Mexico awarded contracts for Centennial Care, which includes MLTSS, to three companies: Presbyterian Health, Blue Cross and Blue Shield, and Western Sky Community Care (Centene). Incumbents Molina and UnitedHealth Care did not receive contracts under the new procurement. Molina filed suit alleging that there were challenges and inconsistencies in the procurement and award process. The ruling rejected these claims, but Molina indicated intent to appeal the decision. The state has indicated they intend to move forward with implementation on January 1, 2019 barring any further court actions. Sources: HMA Weekly Roundup (11-28-2018); Albuquerque Journal (11-21-2018); and Santa Fe New Mexican (11-21-2018).
New York	**Medicare-Medicaid Coordination** On December 17th, the New York State Department of Health held a stakeholder update regarding its Medicare-Medicaid Coordination activities, with an emphasis on the state's Fully Integrated Duals Advantage (FIDA) program. Notable information from this update includes: • FIDA enrollment was estimated at 3,800 in October 2018, down from a peak of 8,900 individuals enrolled; • Four FIDA plans will leave the market after the end of 2018, leaving six plans in operation during 2019; • The FIDA demonstration will end on December 31, 2019, except for the intellectual/developmental FIDA, which will end on December 31, 2020; • New York is exploring using default enrollment to promote integration between Medicare and Medicaid once FIDA ends. Source: New York Stakeholder Update Presentation (12-17-2018).
North Carolina	On October 24th, North Carolina announced that CMS had approved its 1115 waiver application for Medicaid managed care. The waiver approval will allow the state to move forward with implementation of its managed care initiative, including managed long-term services and supports. The approval includes authority for the state to begin implementation

	of the base managed care program, known as the "standard plans," in 2019 and then to tentatively begin implementing specialty "tailored plans" in 2021. Tailored plans are intended for individuals with a serious mental illness, serious emotional disturbance, severe substance use disorder, intellectual/ developmental disability or a traumatic brain injury. In the interim period before tailored plans are implemented, qualified beneficiaries will continue to be served through the state's fee-for-service system for primary and acute services and through the existing county-based behavioral health and ID/DD system. Once the tailored plans are implemented, participants will have the choice to be in a tailored or standard plan. Separately, North Carolina announced that eight vendors submitted applications for the RFP issued in August. The list of entities that submitted applications includes: Aetna, AmeriHealth Caritas North Carolina, BCBSNC – Healthy Blue, Carolina Complete Health, My Health by Health Providers, Optima Health, United Health Care, and WellCare Health Plans. North Carolina indicated that they intend to issue contracts with plans in February 2019 and to begin enrollment on a staggered basis starting November 2019. This procurement is only for standard plans. The state tentatively intends to issue a separate RFP for tailored plans in early 2020. Sources: North Carolina 1115 Approval Announcement (10-24-2018); CMS Approval Letter (10-19-2018); North Carolina DHHS Stakeholder Update (11-28-2018); List of Offerors (10-19-2018).
Ohio	**Medicare Medicaid Integration** In November, CMS released the first evaluation of Ohio's financial alignment demonstration. The evaluation touches upon the characteristics of the demonstration as well as some outcomes associated with the program. Some highlights from the demonstration include: • Roughly 69,000 of the over 100,000 individuals eligible for the demonstration had enrolled in it by December 2016; • An analysis of the Medicare data indicates statistically significant savings over the initial demonstration period of May 1, 2014–December 31, 2015. Medicaid data was not analyzed as it was not yet available; • Inpatient admissions and nursing facility admissions were lower for the demonstration population vs a comparison group. In contrast, preventable

	emergency room use increased while there was no change to overall emergency room visits; • The plans' lack of experience with LTSS and behavioral health led to challenges in the demonstration's first year; and • Most enrollees who responded gave their plans high ratings on the CAHPS survey. Source: First Evaluation Report for the Ohio Demonstration (11-15-2018).
Pennsylvania	**Managed LTSS** Pennsylvania will expand its Community HealthChoices program, which includes MLTSS, on January 1, 2019 into Philadelphia and its surrounding counties. Participants had until November 14, 2018 to select a plan, after which the state automatically assigned individuals to a MCO. Although participants can switch plans at any time, they must select a different plan by December 21st for it to be effective on January 1. Source: Pennsylvania Department of Human Services Press Release (12-3-2018)
Texas	**Managed LTSS** Texas released a comprehensive report, known as the "Rider 61 Report," that assesses the state's managed care system. The report includes information about the state's STAR+PLUS program, which includes MLTSS. Notably, the report included an audit examining ways to reduce costs through administrative efficiencies. The report cited the STAR+PLUS program as having high aggregate administrative expenses. Sources: State of Reform (10-11-2018); Texas HHSC (8-17-2018). On October 2nd, the Dallas Morning News reported that the Texas Health and Human Services Commission cancelled its procurement for Medicaid managed care, including MLTSS, and would re-issue the RFP after finding flaws in the procurement process specifically related to rules around minority owned businesses. Texas reopened the procurement for STAR+PLUS and required all bidders to resubmit as if no previous procurement had taken place. The new deadline was November 15, 2018. Sources: Dallas Morning News (10-2-2018); Texas Online Procurement System (10-1-2018).
Washington State	**Medicare Medicaid Integration** CMS recently published a report summarizing the final Medicare Parts A & B savings estimates from the Washington health home managed fee-for-service (MFFS) demonstration. The report includes final analysis from 2015 and a preliminary analysis of savings for 2016. The

	Washington Health Home MFFS demonstration leverages Medicaid health homes, established under Section 2703 of the Affordable Care Act, to integrate care for full-benefit Medicare-Medicaid beneficiaries. This demonstration aims to improve service quality and integration while reducing costs of care for high-risk, high-cost dually eligible beneficiaries. In 2015, Washington demonstrated a final gross Medicare savings of $30 million. The preliminary gross Medicare savings for 2016 are $42 million. Sources: Full Analysis of Washington's Demonstration (11-16-2018); CMS Blog Post (11-16-2018)

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 12/21/2018)

	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	12/31/2019; Duals Demo 2.0 pending
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	12/31/2020
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 for FIDA; 12/31/2020 for ID/DD
8	**Ohio**	Capitated	4/2/2012	**MOU Signed** 12/12/2012	Fully implemented in 29 counties	12/31/2019; Seeking three-year extension
9	**Rhode Island**	Capitated	5/31/2012	**MOU Signed**	Three phases of opt-in enrollment:	12/31/2020

[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	12/31/2020
11	**Texas**	Capitated	5/2012	**MOU Signed**	Fully implemented in 6 counties	12/31/2020
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; Extension to 12/31/2020 has been approved

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