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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, 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 #: Planning to terminate FA in December 2017	CA, CO#, IL, MA, MI, MN**, NY, OH, RI, SC, TX, VA#, 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	
○ **Balancing Incentive Program:**	AR, CT, GA, IL, IN, IA, KY, LA, ME, MD, MA, MS, MO, NE, NV, NH, NJ, NY, OH, PA, TX
○ **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
○ **Community First Choice option under §1915(k):**	AR*, CA(2), CO*, CT, MD, MN*, MT, NY, OR, TX, WA, WI*
○ **Medicaid Health Homes:**	AL, AZ*, AR*, CA*, CT, DE*, DC*, ID, IL*, IN*, IA(3), KS, KY*, ME(2), 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
Arkansas	**Managed LTSS Program** Starting January 1, 2018, Arkansas will begin a new integrated and coordinated delivery system for eligible Medicaid beneficiaries with intellectual/developmental disabilities (I/DD) or behavioral health (BH). The program aims to serve those individuals with the highest level of need, which the state estimates to be approximately 30,000 individuals. Provider-led managed care organizations (MCOs) called Provider-Led Arkansas Shared Savings Entity, or PASSE, will be serving these individuals. PASSEs will provide all Medicaid state plan and waiver services for individuals using I/DD or BH services. Currently five PASSEs have been approved by the state: • Forevercare, Inc. Ownership of Forevercare breaks down as follows: 51 percent Arkansas provider groups, 49 percent Gateway Health Plan. • Arkansas Advanced Care (AAC). AAC is owned and operated by the following Arkansas-based entities: Baptist Health, the University of Arkansas for Medical Sciences, Arkansas Children's Hospital, and USAble Corporation. • Arkansas Total Care (ATC). ATC is a partnership between Mercy Health System, and two entities owned by Centene Corporation. • Empower Healthcare Solutions (EHS). EHS is owned by seven members, including Beacon Health Options, one of the largest national companies working on assessing addressing the needs of individuals with BH or I/DD. • APC PASSE, LLC (APCP). APCP is jointly owned by the Arkansas Providers Coalition, LLC, and Anthem. On September 1, 2017, individuals needing I/DD or BH services began to undergo an Independent Assessment (IA) to identify service needs. Individuals will be placed into 3 tiers of need: low-need, Tier I; intermediate need, Tier II; and high-need, Ter III. Tier II and III individuals meet an institutional level of care. Enrollees with an assessed level of need of Tier II or III will be automatically enrolled in PASSE; beginning in January 2019, Tier I enrollees will be able to opt-in to the program. The PASSE program will include two phases of implementation. ○ Phase one: In January 2018 PASSE organizations will assume care coordination for their attributed members. Beginning February 1, 2018, PASSE entities will begin receiving payments for care coordination and case management, but DHS will continue payments under a fee-for-service (FFS) model.

	○ Phase two: On January 1, 2019, DHS will commence making capitated global payments to PASSE organizations on a per-member per-month (PMPM) basis. (Source: Act 775 3/31/2017; PASSE Background Paper 6/27/2017; AR DHS PASSE Website; Insurance Department Release 12/18/2017; Insurance Department Release 10/23/2017)
Colorado	**State Demonstration to Integrate Care for Dual Eligible Individuals** On October 23, 2017, the Centers for Medicare & Medicaid Services (CMS) posted Colorado's Transition and Phase Out Plan for the state's managed FFS financial alignment demonstration, which expires December 31, 2017. The state intends to transition enrollees into its broader Accountable Care Collaborative (ACC) initiative, and will seek to take away promising practices from the demonstration and apply them to the ACC delivery system. (Source: CMS.gov 10/23/2017; Transition and Phase-Out Plan)
Illinos	**Managed LTSS Program** On November 29, 2017, Crain's Chicago Business reported that Illinois has completed contracts with the seven MCOs chosen to manage the state's Medicaid managed care program, HealthChoice, which expects to enroll approximately 80 percent of the state's Medicaid population into managed care. The state estimates that it will save between $200 and $300 million every year under the new contracts, largely through reduced rates paid to health plans. These estimates, however, have been questioned by some state lawmakers, as well as in a report by the Menges Group, which was commissioned by a stakeholder in Illinois that wants to see the program get into financial balance. The Menges Group report notes that current MCOs lost money in 2016 and 2017. (Source: Crain's Chicago Business 11/29/2017; the Menges Group 12/5/2017; Crain's Chicago Business 12/18/17)
Iowa	**Managed LTSS Program** On November 9, 2017, The Courier reported that six of the 13 candidates for Iowa governor who participated in a candidate forum, including four Democrats and two Republicans but not the current governor, Kim Reynolds, were in agreement that, if elected, they would seek to transition wholly or in part the state's Medicaid program back to FFS and away from managed care. (Source: The Courier 11/9/2017)

	Following the exit of one of Iowa's three MCOs, AmeriHealth Caritas, Medicaid enrollees currently under AmeriHealth were offered to switch to one of Iowa's other two MCOs, Amerigroup or UnitedHealthcare. However, in a reversal from this earlier decision, the state announced that members who had chosen to switch to Amerigroup would now be covered under Medicaid FFS, after Amerigroup informed the state that they do not have the capacity to take on any new members. Iowa remains in the process of seeking a third MCO to replace AmeriHealth Caritas. (Source: Globe Gazette 11/27/2017) A new report from Iowa's Medicaid Managed Care Ombudsman indicates that the leading complaint from Iowa Medicaid managed care members is denial, reduction or termination of services. A significant number of these complaints are coming from individuals that receive home and community-based services (HCBS) through Medicaid. Close to half of the 4,000-plus calls over the period of October 2016 – September 2017 were regarding denial, reduction, or cessation of services. (Source: Managed Care Ombudsman Program Quarterly Report; RadioIowa 12/19/2017)
Kansas	**Managed LTSS Program** On November 20, 2017, KCUR reported on a series of public hearings to solicit feedback, suggestions, and concerns regarding the next iteration of Kansas' comprehensive 1115 demonstration waiver, KanCare 2.0, which covers nearly all of the state's Medicaid population, including LTSS. The state aims to make some improvements to the existing KanCare program. Kansas hopes to implement KanCare 2.0 beginning January 1, 2019, which will immediately precede a state gubernatorial election; some candidates have criticized the KanCare system and have expressed openness to moving the state back to a FFS or nonprofit system. (Source: KCUR 11/20/2017)
Massachusetts	**Managed LTSS Program** On November 10, 2017, WBUR reported that the Massachusetts Senate passed a significant health care bill aimed at a variety of reforms for both the state's Medicaid program and the commercial market. The bill retained proposed changes to the state's Senior Care Options program—one of the state's MLTSS programs—that were detailed in the November edition of the State Medicaid Integration Tracker©. The new version of the bill added specificity around opt-out procedures and protections for beneficiaries. (Source: WBUR 11/10/2017; Senate Bill)

New Jersey	**Managed LTSS Program** The New Jersey Department of Human Services has expanded the list of covered health benefits to certain individuals enrolled in Medicaid managed care in the state. The move aims to align behavioral health coverage for New Jersey Medicaid beneficiaries enrolled in MLTSS, Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), and Division of Developmentally Disabled (DDD) MCO members. New Jersey is also expanding access to substance use disorder (SUD) services for individuals enrolled in MLTSS, FIDE SNPs, and DDD managed care. (Source: NJ DHS 11/2017)
New York	**Managed LTSS Program** The New York Department of Health (DOH) recently released its Medicaid Global Spending Cap Report, which runs through August 2017. New York's global spending cap increased from $18.6 billion in FY17 to $19.5 billion in FY18, a growth of 5.2 percent. Areas of growth include price and utilization increases. Specifically: o Increases for mainstream Medicaid managed care totaling $411 million, and managed long-term care (MLTC) rates equaling $101 million; o Utilization increases included annualization of FY17 new enrollees, and new enrollment for FY18 that included 8,100 nursing home (NH) and 13,000 community-based eligibles. MLTC enrollment continues to grow in New York—driven by mandatory enrollment, and the expansion into NH eligibles. In March 2017, New York had 201,610 enrollees in MLTC, but it projects that by March 2018 it will have nearly 224,000. (Source: Medicaid Global Spending Cap Report 8/2017) New York released its value-based payment (VBP) reporting requirements, which details the quality measures for MCOs participating in the state's Medicaid VBP initiative. There are five different VBP arrangements that are available under the program, including one for MLTC. The set of measures are based on an analysis of their validity and reliability, and classified under either pay for reporting (P4R) or pay for performance (P4P). The vast majority of the measures address clinical outcomes, with only 4 addressing quality of life or service satisfaction (Source: MLTC VBP Measure Set 11/2017) **Medicaid Health Homes**

	On November 13, 2017, Politico published an article on some the successes and challenges of New York's Medicaid Health Homes program. New York's Health Homes program has reduced inpatient costs by 8 percent per month, and utilization has decreased by 6 percent. Enrollment, however, has lagged projections—it was estimated that as many as close to a million individuals would be eligible, but currently there are 163,000 enrolled in the program in 35 health homes across New York. The state aims to increase program effectiveness by submitting altered rates and new rules to align incentives across the program, which will have to be approved by CMS. (Source: Politico New York 11/13/2017)
North Carolina	**Managed LTSS Program** On November 20, 2017, the North Carolina Department of Health and Human Services (DHHS) submitted an amendment to its section 1115 waiver, originally submitted to CMS in June 2016, which seeks to implement managed care for large portions of its Medicaid population, including Medicaid LTSS. DHHS' tentative timeline for implementation is as follows: o Request for proposals (RFP) for prepaid health plans (PHPs) – April 2018; o PHP proposals due – June 2018; o PHP awards – October 2018; o Commencement of managed care – July 2019; o Launch of behavioral health (BH) and I/DD tailored plan, and phase-in of Innovations and TBI waivers – July 2021. Under the demonstration, all LTSS services, other than PACE and behavioral health and I/DD services provided by LME/MCOs, will be the responsibility of PHPs. Dual eligibles will be excluded. North Carolina intends to operate its 1915(c) waivers concurrently with the 1115 demonstration—that is, coverage for these services will be authorized under 1915(c) and the 1115 waiver will allow for delivery of these services via PHPs. As detailed in the September edition of the State Medicaid Integration Tracker, however, the state proposes an extended phase-in timeline for both institutional and community-based LTSS under the plan. (Source: Press Release 11/20/2017; 1115 Demonstration Waiver Amendment 11/20/2017; Behavioral Health and I/DD Tailored Plan Concept Paper 11/9/2017)
South Carolina	**State Demonstration to Integrate Care for Dual Eligible Individuals** On November 21, 2017, CMS announced on its website that South Carolina officially re-executed its three-way contract for its dual eligible demonstration, Healthy

	Connections Prime, which gave the program a new end date of December 31, 2018—an extension of a year. As of November 2017, South Carolina had an estimated 11,500 dual eligibles enrolled in Healthy Connections Prime. (Source: CMS.gov 11/21/2017; HMA Weekly Roundup 12/13/2017)
Texas	**Managed LTSS Program** Texas has cancelled a planned I/DD Medicaid managed care pilot, which was discussed at a Health and Human Services Commission (HHSC) I/DD System Redesign Advisory Committee meeting on October 3, 2017. Instead, HHSC will include parameters in the upcoming STAR+PLUS request for proposals (RFP) for MCOs to be prepared for the addition of this population into Medicaid managed care and MLTSS. (Source: HHSC Website 10/3/2017) On December 4, 2017, the Texas HHSC released its RFP to re-procure the STAR+PLUS Medicaid managed care program, which provides acute and LTSS services to approximately 529,966 adults 65 and older, and those that are blind or have a disability. The procurement is statewide, and includes the following service areas (SAs): Bexar; Central Texas; Dallas; El Paso; Harris; Hidalgo; Jefferson; Lubbock; Northeast Texas; Nueces; Tarrant; Travis; and West Texas. HHSC will award contracts to a minimum of two MCOs per each SA. HHSC notes that service coordination will be a key component of the re-procured program, including adequate levels of personnel to manage the everyday service needs of beneficiaries, including those with I/DD and dual eligibles. MCOs must demonstrate readiness to serve the I/DD population and provide LTSS in the event that HHSC adds this population to STAR+PLUS. Populations included in the STAR+PLUS program where participation is mandatory include: o Supplemental Security Income (SSA) eligibles age 21 and above; o Individuals 21 and older who are eligible for Medicaid due to being in a Social Security Exclusion Program; o Beneficiaries who quality for the STAR+PLUS HCBS program; o Medicaid residents of licensed nursing facilities (NFs); o Dual eligibles who are 21 and older; o Beneficiaries eligible for the Medicaid for Breast and Cervical Cancer program; o Individuals enrolled in certain 1915(c) waiver programs will receive acute care services from an MCO:

	○ Community Living Assistance and Support Services (CLASS); ○ Home and Community-based Services (HCS); ○ Deaf-Blind Multiple Disability waiver (DBMD); and ○ Texas Home Living (TxHml). ○ Residents of community-based intermediate care facilities for individuals with I/DD or related conditions (ICF/IIDs) will receive acute services from an MCO. Populations excluded from STAR+PLUS are: ○ Residents of state supported living centers (SSLCs), institutions of mental disease, individuals residing in a pediatric care facility class of NFs, or any State Veterans Home; ○ Participants in the states' dual eligible demonstration, PACE program, or dual eligibles not eligible for full Medicaid benefits. Responses to the RFP are due March 5, 2018. HHSC expects contracts to begin October 2018, with an operational start date of January 1, 2020. HHSC expects enrollment to reach 530,000. (Source: RFP 12/4/2017)

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 12/20/2017)

	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	**MOU Signed** 2/28/2014	Fully implemented statewide	12/31/2017
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	Fully implemented in NYC, Nassau, Westchester and Suffolk counties	12/31/2019
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	**MOU Signed** 5/21/2013	Fully implemented in 104 localities	12/31/2017
13	**Washington**	Managed FFS	4/26/2012	**MOU Signed** 10/25/2012	Fully implemented in 36 counties	12/31/2018

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