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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 each month 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:	AZ, CA, DE, FL, HI, IA, ID, IL, KS, LA, MA, MI, MN, NC, NE, NH, NJ, NM, NY, OK, PA, RI, TN, TX, WA, WI
Medicare-Medicaid Care Coordination Initiatives: *: Financial Alignment (FA) demonstration proposal approved by CMS **: Pursuing alternative initiative	CA*, CO*, CT, FL**, IL*, MA*, MI*, MN**, NH**, NJ**, NY*, OH*, OK, RI, SC*, TX*, VA*, WA*
Other LTSS Reform Activities: *: Approved by CMS	
• **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):** SPA withdrawn:	AR, CA*, CO*, CT*, DE, DC, FL*, ID*, IN*, IA*, LA*, MD*, MI*, MN, MS*, MT*, NV*, OR*, SC, WI* TX, WA
• **Community First Choice option under §1915(k):** SPA withdrawn:	AR, CA*(2), CO, CT, MD*, MN, MT*, NY*, OR*, TX*, WA*, WI AZ, LA
• **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
California, Maryland, Montana, Oregon	**1915 (k) Community First Choice** On March 16, 2016, the Center for Medicaid and CHIP Services (CMCS) released a final Report to Congress (RTC) on the Section 1915(k) Community First Choice (CFC) benefit under the Affordable Care Act, which allows states to implement home and community-based attendant services and supports through their Medicaid State plan. Although currently eight states—California, Maryland, Montana, Oregon, Texas, Washington, and New York—have approved State Plan Amendments (SPA), this RTC focuses solely on the original four states that had been approved by December 31, 2014: California Maryland, Montana, and Oregon. The CFC benefit option gives states a 6 percentage point increase in their Federal Medical Assistance Percentage (FMAP) for HCBS services delivered to Medicaid enrollees requiring an institutional level of care. This program complements other federal policies aimed at "rebalancing" the long-term services and supports (LTSS) system away from institutional care and toward HCBS services. Since CFC is a state plan benefit, a state must ensure that services provided under CFC meet all of the traditional Medicaid requirements, including statewideness, comparability of services, and choice of providers. States can, however, control the amount, duration and scope of their services. Some of the key recommendations in the report, based on stakeholder feedback, include: • Developing strong communication strategies between organizations serving those with physical disabilities and entities serving individuals with developmental disabilities and also between different administrative levels—that is, at the federal, state and local levels; • Recognizing that one program is insufficient for serving all of a state's HCBS needs, and that a "patchwork" of initiatives and Medicaid expansion are needed to allow residents to live independently; • Early on in the process, developing a frequently asked questions (FAQs) document that is easily accessible for the public; • Extending the Development and Implementation Council meetings—which are required under the CFC—past the initial stages and well into the implementation phase; and In addition, the participating states strongly recommended that other states looking at implementing CFC calculate the fiscal and administrative impacts the program will have on their existing Medicaid system. The main impetus for states implementing CFC identified in the report—which may be applicable for future states looking at the program—were the amelioration or elimination of HCBS waitlists; increased access to HCBS

	for previously underserved populations; expansion of HCBS service options; and, the increased FMAP. (Source: CFC Final Report 3/16/2016)
Arkansas	**Managed LTSS Program** On March 30, 2016 the SWTimes reported that the Arkansas legislature was called to special session on April 6, 2016, to consider two gubernatorial proposals: the first of which would transfer management of parts of the Medicaid to managed care organizations (MCOs), and the other to extend the state's Medicaid expansion through what is referred to as the "private option." The Medicaid managed care proposal would include all behavioral health, services for individuals with developmental disabilities, and dental care. The second proposal would rename the private option to Arkansas Works, and would include work provisions, among other proposed changes. According to ArkansasOnline on Tuesday, April 5, the governor of Arkansas formally withdrew his proposal for the legislature to consider managed care in the special session beginning on April 6, after opposition from senior leadership in the legislature. (Source: SWTimes 3/30/2016; Arkansas Online 4/5/2016)
California	**State Demonstration to Integrate Dual Eligible Individuals** The California Department of Health Care Services (DHCS) released the Cal MediConnect Performance Dashboard, which looks at data for LTSS, health risk assessments (HRAs), case management, hospital use, and appeals among enrollees in California's dual eligible demonstration. Currently, Cal MediConnect has enrolled approximately 124,000 dual eligibles. Of these, in the third quarter of 2015 33,743 members were receiving LTSS. The vast majority of enrollees received LTSS in the community through In-home Supportive Services (IHSS), Community-based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP), while over 4,000 received services in a nursing facility. (Source: Performance Dashboard 3/2016; HMA Roundup 3/23/2016)
Massachusetts	**LTSS Program** On February 23, 2016, Sentinel & Enterprise News reported on new measures from the Massachusetts to increase state oversight of LTSS programs, which account for approximately $4.5 billion of the state's $15.4 billion Medicaid budget. Beginning March 1, 2016, the state will require prior approval for Medicaid LTSS expenditures, as well as establishing a conflict-free assessment for Medicaid patients. (Source: Sentinel & Enterprise 2/23/2016)
Michigan	**Medicaid Health Homes**

	On March 4, 2016, CMS formally approved a second state plan amendment (SPA) for Michigan that will cover beneficiaries with certain chronic conditions, as well as depression and anxiety, that are to be served by federally qualified health centers (FQHCs) and tribal health centers. Qualified providers will receive a one-time start up payment to cover the costs of an initial health assessment and care plan development, and thereafter will receive monthly payments for providing the basic health home services. The new health home program will be effective July 1, 2016. (Source: SPA 3/4/2016; NASHP 3/23/2016)
Nebraska	**Managed LTSS Program** On March 8, 2016, the Nebraska Department of Health & Human Services (DHHS) announced a change to the awardees for the three managed care organizations set to administer the state's Heritage Health Program. Previously, the three MCOs chosen were United HealthCare Community Plan, Nebraska Total Care (Centene), and Aetna Better Health of Nebraska. After a limited re-evaluation, however, the Division of Medicaid and Long-Term Care replaced Aetna with WellCare, due to a scoring error in the evaluation process. (Source: Press Release 3/8/2016)
New Hampshire	**Managed LTSS Program** On March 24, 2016, the New Hampshire Senate passed a bill that would delay implementation of the second phase of Medicaid managed care in the state, which would impact nursing homes, homecare services, and developmentally disabled and acquired brain disorder in-home supports. Implementation of Medicaid managed care will not be allowed before July 1, 2017, and upon approval by the joint legislative fiscal committee. (Source: Senate Bill 553 3/24/2016; NH Union Leader 3/24/2016)
New Jersey	**Medicaid Health Homes** On April 8, 2016, the Cape May County Herald reported that New Jersey is set to expand its behavioral health home model, which treats physical and mental health, as well as substance use disorders, with integrated, coordinated care. There are currently four behavioral health homes statewide, with seven organizations pursuing certification. New Jersey's behavioral health home model began in 2014 with the state's Comprehensive Medicaid Waiver. The state intends to raise reimbursement rates and increase access for substance use and behavioral health, which will channel an additional $127 million to providers. (Source: Cape May County Herald 4/8/2016)
New Mexico	**Medicaid Health Homes**

	On March 21, 2016, CMS formally approved New Mexico's Medicaid health home state plan amendment (SPA), which became effective April 1, 2016. The health home initiative will be known as CareLink NM, and will serve adults with serious persistent mental illness, and children with serious emotional disturbance in San Juan County and Curry County. Health homes receive an enhanced per-member per-month (PMPM) payment in order to cover the costs of health home services. (Source: SPA 3/21/2016; NASHP 4/12/2016)
New York	**State Demonstration to Integrate Dual Eligible Individuals** New York's dual eligible demonstration for individuals 21 and older that receive long-term care and developmental disability services, FIDA-IDD, officially commenced enrollment in March, with services beginning as early as April 1, 2016. Individuals residing in Rockland, Westchester, Long island and NYC counties are eligible for the demonstration. Individuals can choose to enroll or opt-out at any time. (Source: HMA Roundup 3/9/2016)
North Carolina	**Managed LTSS Program** On March 1, 2016, the North Carolina Department of Health and Human Services (DHHS) released a draft version of its Section 1115 Waiver Application which aims to improve the state's Medicaid program in terms of access, quality, and cost control. The waiver has four major goals, including: • Greater budget predictability for the state; • Improved quality, satisfaction and financial metrics; • Increased efficiency and cost-effectiveness; and • Delivery system reform through the creation of two new prepaid health plans (PHPs)—provider-led entities (PLEs) and commercial plans (CPs). North Carolina's Section 1115 Waiver will allow PHPs to provide long-term services and supports (LTSS) to Medicaid-only beneficiates, which will include all state plan LTSS services, institutional care, and waiver services available through the states two section 1915(c) waivers. The enabling legislation for the 1115 Waiver, SL 2015-245, instructs DHHS to establish a Dual Eligibles Advisory Committee to formulate long-term strategies to cover dual eligible individuals through capitated PHP plans. DHHS' hypothetical timeline for the application is as follows: • Submission of waiver application to CMS—June 1, 2016; • Draft RFP and contract—October 2016-January 2017;

	• Hypothetical CMS approval—January 1, 2018; • Issue RFP—March 2018; • PHP proposals due—June 2018; • PHP awards—September 2018; • Readiness reviews—November 2018-June 2019; and • PHP begin date—July 1, 2019. DHHS notes that this timeline is tentative, and is based off an assumed approval date of January 1, 2018 by CMS. (Source: Draft Waiver Application 3/1/2016)
Pennsylvania	**Managed LTSS Program** On March 16, 2016, Pennsylvania held a pre-proposal conference for its procurement of the Community HealthChoices program that will use managed care organizations to manage physical and LTSS services for eligible Medicaid beneficiaries. The potential bidders present were: United; Gateway Health; Molina; Health Partners; WellCare; AmeriHealth Caritas; Aetna; Magellan; UPMC; Atelier Health; Geisinger; and Accenda Health. The Pennsylvania Department of Human Services released a Q&A following the conference, as well as Addendum #5 and a revised draft agreement. (Source: : HMA Roundup 3/16/2016; PA E Marketplace 4/12/2016)
Virginia	**Managed LTSS Program** According to HMA Weekly Roundup, Virginia is set to reprocure its Medicaid managed care program, which is called Medallion 3.0, in 2016. Medallion 3.0 covers approximately 740,000 beneficiaries, including pregnant mothers, children, parents up to 52 percent of the FPL, waiver recipients needing acute care services, as well as the aged, blind, and disabled (ABD) population. As a component of the new procurement, however, the ABD population will be shifted into the state's proposed MLTSS program. (Source: HMA Roundup 4/6/2016)
Wisconsin	**Managed LTSS Program** The Wisconsin Department of Health Services (DHS) released a concept paper outlining forthcoming changes, as mandated under the State's 2017 State Budget Act, to the Family Care and IRIS (Include, Respect, I Self-direct) programs. Family Care is the state's MLTSS program, and IRIS allows self-direction of LTSS services. Family Care/IRIS 2.0, as the changes have been labeled, will integrate acute, behavioral, and LTSS for 55,000 Medicaid enrollees across the state through contracts with integrated health agencies (IHAs).

	• Populations covered: adults with physical disabilities, adults with intellectual/developmental disabilities, and elderly individual. Dual eligibles may enroll in Family Care/IRIS 2.0 or may choose to remain enrolled in the Family Partnership program. • Areas served: the concept paper proposes splitting the state into three regions, each of which will be served by three IHAs. • Payment structure: IHAs managing care for Family Care/IRIS 2.0 beneficiaries will be paid a monthly capitated payment. (Source: Concept Paper 3/2016)

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 4/13/2016)

	States	Proposed Financing Model	Submitted to CMS	Status	Target Implementation Date[1]
2	**California**	Capitated	5/31/2012	**MOU Signed** 3/27/2013	4/2014, 7/2015 (opt-in); 8/2014, 10/2014, 1/2015, 8/2015 (passive), Org. Cnty. LTC after 11/2015
3	**Colorado**	Managed FFS	5/2012	**MOU Signed** 2/28/2014	9/2014 (passive)
4	**Connecticut**	Managed FFS	5/31/2012		N/A
7	**Illinois**	Capitated	4/6/2012	**MOU Signed** 2/22/2013	3/2014 (opt-in); 6/2014 (passive)
9	**Massachusetts**	Capitated	2/16/2012	**MOU Signed** 8/23/2012	10/2013 (opt-in); 1/2014, 4/2014, & 7/2014 (passive)
10	**Michigan**	Capitated	4/26/2012	**MOU Signed** 4/2014	3/2015 (opt-in); 7/2015 (passive)
14	**New York**	Capitated[2]	5/25/2012	**MOU Signed** 8/26/2013	1/2015 (opt-in); 4/2015 (passive)
16	**Ohio**	Capitated	4/2/2012	**MOU Signed** 12/12/2012	5/2014 (opt-in); 1/2015(passive)
17	**Oklahoma**	Both	5/31/2012		N/A
19	**Rhode Island**	Capitated	5/31/2012	**MOU Signed**	12/2015(opt-in); (passive TBD)

[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	Target Implementation Date[1]
20	**S. Carolina**	Capitated	5/25/2012	**MOU Signed**	1/2015 (opt-in); 4/2015 (passive)
22	**Texas**	Capitated	5/2012	**MOU Signed**	3/2015 (opt-in); 4/2015 (passive)
24	**Virginia**	Capitated	5/31/2012	**MOU Signed** 5/21/2013	5/2014 (opt-in); 8/2014 (passive)
[3]					

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[3] AZ, HI, ID, IA, MO, NM, NC, OR, TN, VT, and WI withdrew their sole application to the Medicare-Medicaid Coordination Office (MMCO). MN and WA withdrew their capitated demonstration application to CMS. The applications of CT and OK remain pending with MMCO.

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