

REPORT



October 2016

Implementing Coverage and Payment Initiatives

**Results from a 50-State Medicaid Budget Survey for
State Fiscal Years 2016 and 2017**

Prepared by:

Vernon K. Smith, Ph.D., Kathleen Gifford, Eileen Ellis and Barbara Edwards
Health Management Associates

and

Robin Rudowitz, Elizabeth Hinton, Larisa Antonisse and Allison Valentine
Kaiser Family Foundation

Executive Summary

Medicaid plays a significant role in the U.S. health care system, now providing health insurance coverage to more than one in five Americans and accounting for one-sixth of all U.S. health care expenditures.¹ The Medicaid program continues to evolve as state and federal policy makers respond to changes in the economy, the broader health system, state budgets, and policy priorities, and in recent years, to requirements and opportunities in the Affordable Care Act (ACA). This report provides an in-depth examination of the changes taking place in Medicaid programs across the country. The findings in this report are drawn from the 16th annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates (HMA), in collaboration with the National Association of Medicaid Directors. This report highlights policy changes implemented in state Medicaid programs in FY 2016 and those implemented or planned for FY 2017 based on information provided by the nation's state Medicaid directors. The District of Columbia is counted as a state for the purposes of this report. Key findings include the following:

Key Findings

Eligibility and enrollment. As of October 2016, 32 states had adopted the ACA Medicaid expansion. Two states (Alaska and Montana) implemented the expansion FY 2016 and Louisiana implemented in FY 2017. Beyond the ACA, states made few major eligibility changes. Some states have approval or are seeking approval to impose premiums or monthly contributions under Medicaid expansion waivers. Many states have initiatives to expand coverage to the criminal justice involved population.

Managed care and delivery system reforms. In 28 of the 39 MCO states, at least 75 percent of all Medicaid beneficiaries were enrolled in MCOs. Many states are implementing quality initiatives such as pay for performance, reporting MCO quality metrics, or collecting adult and child quality measures. States are using MCO arrangements to promote value based payment and increase attention to the social determinants of health. Twenty-nine (29) states are also adopting or expanding other delivery system reforms in FY 2016 or FY 2017, such as patient-centered medical homes (PCMHs), Health Homes, Accountable Care Organizations (ACOs), Delivery System Reform Incentive Payment (DSRIP) programs, and other efforts to better manage the care of high-need populations.

Long-term services and supports (LTSS). Nearly every state reported actions to expand the number of persons served in community settings in FY 2016 and FY 2017, primarily through increased enrollment in HCBS waivers and implementing new HCBS SPAs. Twenty-three (23) states provided some or all LTSS through a managed care arrangement as of July 1, 2016, with 15 states offering LTSS on a statewide basis for at least some LTSS populations.

Provider payment rates and taxes. In FY 2016, more states implemented provider rate increases than implemented restrictions; however, as economic conditions become more challenged, slightly fewer states are implementing rate increases (40 states) than restrictions (41 states) in FY 2017. All states (except Alaska) use at least one provider tax or fee to help finance Medicaid. Eight of the Medicaid expansion states reported plans to use provider taxes or fees to fund all or part of the costs of the ACA Medicaid expansion beginning in January 2017, when states must pay 5 percent of the costs of the expansion.

Benefits (including prescription drug policies). A total of 21 states expanded or enhanced covered benefits in FY 2016, and 20 states are planning expansions for FY 2017, most commonly for behavioral health and substance use disorder services. With rising drug costs, 31 states in FY 2016 and 23 in FY 2017 reported implementing or plans to implement pharmacy cost containment efforts, some targeted to high cost specialty drugs. As part of the battle to address the nation's opioid crisis, a majority of states have adopted, and many are expanding, pharmacy management strategies specifically targeted at opioids.

Looking ahead. Many states report administrative challenges in implementing the ACA, major delivery system reforms, new federal regulations, and new systems due to limited resources in terms of staff and funding for administration. Despite the administrative and fiscal challenges, Medicaid directors listed priorities for FY 2017 and beyond that focus on payment and delivery system initiatives designed to control costs, improve access to care, and achieve better health outcomes.

ELIGIBILITY AND ENROLLMENT

Medicaid expansion under the ACA continues to affect state policies for FY 2016 and FY 2017.

As of October 2016, 32 states had adopted the ACA Medicaid expansion. This includes 26 states that implemented the expansion in FY 2014, three states in FY 2015 (New Hampshire, Pennsylvania, and Indiana), two states in FY 2016 (Alaska and Montana), and Louisiana in FY 2017. Beyond eligibility changes tied to the ACA, in FY 2016 and FY 2017 states implemented or adopted only a few changes generally targeted to a limited number of beneficiaries. Medicaid policies related to beneficiary premiums and copayments changed little overall; most of the activity reported related to Medicaid waivers. In FY 2016, Montana implemented a Medicaid expansion waiver that included provisions to impose premiums or monthly contributions. At the time of the survey, Arkansas, Arizona, Kentucky, and Ohio had Medicaid waivers pending with premium provisions. HHS denied Ohio's pending waiver on September 9, 2016 and the Arizona waiver was approved on September 30, 2016.

Many states have initiatives to expand coverage to criminal justice involved populations. In states that implemented the ACA Medicaid expansion, a greater proportion of this population is now eligible for Medicaid. Key initiatives include efforts to enroll individuals in Medicaid prior to their release and policies that maintain Medicaid eligibility during incarceration by suspending rather than terminating Medicaid coverage.

MANAGED CARE AND OTHER DELIVERY SYSTEM REFORMS

States continue to expand the use of MCOs and other delivery system reform efforts with goals to control costs, improve access to care and care outcomes, and ultimately improve population health (Figure ES-1). Many of these initiatives are targeted to high-need populations.

Reliance on risk-based managed care continues to grow as additional states use Managed Care Organizations (MCOs) to deliver care or enroll more populations. As of July 2016, 39 states contracted with risk-based managed care organizations (MCOs) to serve their Medicaid enrollees. (These states are referred to throughout the report as "MCO states.") In 28 of the 39 MCO states, at least 75 percent of all Medicaid beneficiaries were enrolled in MCOs (an increase from 21 of 39 states in July 2015). Three states (Iowa, Rhode Island, and West Virginia) terminated their Primary Care Case Management (PCCM) programs in either FY 2016 or FY 2017 and shifted those populations into risk-based managed care. Alabama plans to implement a new MCO program in FY 2017 and Missouri plans to expand its MCO program statewide in FY 2017.



States sometimes exclude special populations and/or some behavioral health services from MCO contracts. This survey asked about populations with special needs that may be included or excluded from acute care MCO enrollment. States reported that of the special populations noted in the survey, pregnant women were most likely to be enrolled on a mandatory basis into acute care MCOs (28 states) while persons with intellectual or developmental disabilities (ID/DD) were least likely to be enrolled on mandatory basis (10 states) and also most likely to be excluded from MCO enrollment (7 states).

Many states are implementing quality initiatives encouraging or requiring MCOs to implement alternative payment models or screen for social needs. Thirty-six (36) of the 39 MCO states reported one or more select MCO quality initiatives in place in FY 2015 and 17 states in each of the survey years (FY 2016 and FY 2017) implemented or adopted new quality initiatives such as pay for performance, reporting MCO quality metrics or collecting adult and child quality measures. In FY 2016, five states identified targets in MCO contracts for the use of alternative provider payment models; 10 additional states intend to do so in FY 2017. States are also using MCO arrangements to increase attention to the social determinants of health. Twenty-six (26) states reported requiring or encouraging MCOs to screen for social needs and provide referrals to other services in FY 2016 and four states intend to do so in FY 2017. States commonly require MCOs to perform a health needs/risk assessment that includes information on social determinants as well as medical needs. In addition, five states reported that they have policies in place to encourage or require MCOs to provide care coordination services to enrollees prior to release from incarceration (Arizona, Iowa, Kentucky, New Mexico, and Ohio), and 10 states intend to add such requirements in FY 2017.

Over two-thirds of all states (36) have at least one delivery system or payment reform initiative in place and the majority of states are expanding current programs or adopting new initiatives. Twenty-nine (29) states in either FY 2016 or FY 2017 reported adopting or expanding one or more initiatives including patient-centered medical homes (PCMHs), Health Homes, Accountable Care Organizations (ACOs), and other initiatives to better manage the care of persons with multiple chronic conditions. Interest in Episode of Care initiatives also ticked upward for FY 2017 (7 states). These initiatives may be implemented through fee-for-service or managed care. Seven states had Delivery System Reform Incentive Payment (DSRIP) programs in place in FY 2015. Four states reported new or expanded DSRIP programs in FY 2016 and five states reported new or expanded DSRIP programs in FY 2017.

LONG-TERM SERVICES AND SUPPORTS

Nearly every state reported actions to expand the number of persons served in community settings in FY 2016 and FY 2017, primarily through increased enrollment in HCBS waivers and implementing new HCBS SPAs. New PACE sites or expanded enrollment in existing PACE sites as well as including specific rebalancing incentives into managed care contracts that cover long-term services and supports (LTSS) were also strategies to increase community-based care.

Twenty-three (23) states provided some or all LTSS through a managed care arrangement as of July 1, 2016. Fifteen (15) states offered managed LTSS (MLTSS) on a statewide basis for at least some LTSS populations. The most common model combines both acute care and LTSS in a single plan, providing a comprehensive approach to service integration. Five states offer a prepaid health plan that covers only Medicaid LTSS. In FY 2016, four states implemented MLTSS or expanded MLTSS to new parts of the state, and four states expanded MLTSS to new populations. In FY 2017, two states anticipate geographic expansion in

MLTSS, while five states anticipate adding new populations to MLTSS. Enrollment into the MLTSS program is always mandatory for seniors in 13 of the 23 MLTSS states, for individuals who have full dual eligibility status in nine states, for nonelderly adults with physical disabilities in 12 states, and for individuals with I/DD in eight states. Thirteen (13) states with MCOs offering LTSS reported having LTSS quality measures in place in FY 2015. In FY 2016, a total of six states implemented new or expanded LTSS quality metrics; five states plan to expand quality measures for LTSS in FY 2017.

PROVIDER RATES AND TAXES

Changes in the economy continue to affect provider reimbursement rates, and states are also implementing reimbursement policies designed to promote quality. In FY 2016 more states implemented provider rate increases than implemented restrictions (45 and 38 states, respectively); however, as economic conditions become more challenged, slightly fewer states are implementing rate increases (40 states) than restrictions (41 states) in FY 2017. As part of efforts to improve the quality of health care and reduce costs, 21 states have or are adopting reimbursement policies in FY 2017 to reduce potentially preventable hospital readmissions in fee-for-service (FFS) and 11 of the 39 MCO states require or plan to require MCOs to adopt such incentives or penalties. Twenty (20) states have or are adopting reimbursement policies in FY 2017 designed to reduce the number of early elective deliveries in FFS and 14 states require or plan to require MCOs to adopt similar policies.

States continue to rely on provider taxes, with eight states using this financing mechanism to fund the state share of ACA expansion costs. All states except Alaska use at least one provider tax or fee to help finance Medicaid. In FY 2016 and FY 2017, 22 states increased or planned to increase one or more provider tax or fee and nine states are adding new provider taxes. Eight of the Medicaid expansion states (Arkansas, Arizona, Colorado, Illinois, Indiana, Louisiana, New Hampshire, and Ohio) reported plans to use provider taxes or fees to fund all or part of the costs of the ACA Medicaid expansion beginning in January 2017, when states must pay 5 percent of the costs of the expansion.

BENEFITS AND PRESCRIPTION DRUGS

A total of 21 states expanded or enhanced covered benefits in FY 2016, and 20 states planned benefit expansions in FY 2017. The most common benefit enhancements reported were for behavioral health and substance use disorder services, telemedicine and tele-monitoring services, and dental services for adults. Far fewer states reported benefit restrictions.

With rising drug costs, many states are focused on pharmacy cost containment efforts. The vast majority of states identified high cost and specialty drugs as a significant cost driver for state Medicaid programs, most pointing specifically to hepatitis C antivirals. Many states are focused on refining and enhancing their pharmacy programs, including actions related to new and emerging specialty and high-cost drug therapies. A total of 31 states in FY 2016 and 23 in FY 2017 reported implementing or plans to implement pharmacy cost containment efforts. Thirty-three (33) of the 39 states with MCO contracts as of July 1, 2016 reported that the pharmacy benefit was generally carved in, and another state reported plans to implement a full pharmacy carve-in in January 2017. States reported how they manage MCO pharmacy programs; in FY 2015, 13 states had uniform clinical protocols, 10 states had uniform prior authorization, and 10 states had

uniform PDL requirements across fee-for-service and MCO programs. Many states reported expansions of these strategies in FY 2016 and FY 2017.

As part of the battle to address the nation's opioid epidemic, a majority of states have adopted, and many are expanding, pharmacy management strategies specifically targeted at opioids. The CDC has developed and published recommendations for the prescribing of opioid pain medications for adults in primary care settings.² Twenty-one (21) states reported adoption or plans for adoption in FY 2017 for their FFS programs. Of the 39 states with MCO contracts, 11 are requiring MCOs to adopt the CDC guidelines or are planning to do so in FY 2017. Many other states indicated these policies were under review for FFS and MCOs. States were also adopting strategies to expand access to naloxone, a prescription opioid overdose antidote that prevents or reverses the life-threatening effects of opioids. Almost all states reported specific opioid-focused pharmacy management policies. Imposing a quantity limit was the most common pharmacy management approach, used by almost all states (46) in FY 2015 for their FFS programs. Use of prior authorization (45 states), clinical criteria (42 states), and step therapy (32 states) were also widespread in FY 2015 for FFS. Significantly fewer states (12) reported having a requirement in place in FFS in FY 2015 for Medicaid prescribers to check their states' Prescription Drug Monitoring Program before prescribing opioids to a Medicaid patient. Many states also reported MCO policies in place; however, it is unclear how many states require such policies.

ADMINISTRATION AND KEY PRIORITIES FOR 2017 AND BEYOND

Medicaid provides health coverage for over one-fifth of all Americans and accounts for one-sixth of national health expenditures.³ Its administration involves complex systems, rules, and requirements. States indicated their most significant administrative challenges related to implementing the ACA, major delivery system reforms, new federal regulations, and new eligibility and IT systems. Medicaid directors noted that limited resources in terms of staff and funding for administration make it difficult to balance competing priorities and implement multiple significant initiatives. Despite the administrative and fiscal challenges, Medicaid directors listed an array of priorities for FY 2017 and beyond that focus on payment and delivery system initiatives designed to control costs and achieve better health outcomes.

Introduction

Medicaid has become one of the nation's most important health care programs, now providing health insurance coverage to more than one in five Americans, and accounting for over one-sixth of all U.S. health care expenditures.⁴ The Medicaid program continues to change, as policy makers in each state seek to improve their program, responding to changes in the economy, the broader health system, state budgets and policy priorities, and in recent years, to requirements and opportunities in the Affordable Care Act (ACA) as well as new guidance and regulations. In many ways, state Medicaid programs are national leaders in delivery and payment system initiatives designed to improve health care and outcomes, and to control health care spending.

This report examines the reforms, policy changes and initiatives that occurred in FY 2016 and those adopted for implementation for FY 2017 (which began for most states on July 1, 2016⁵). The findings in this report are drawn from the annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA), in collaboration with the National Association of Medicaid Directors (NAMC). This was the sixteenth annual survey, which has been conducted at the beginning of each state fiscal year from FY 2002 through FY 2017.⁶ (Copies of previous reports are archived [here](#).)

The KCMU/HMA Medicaid survey on which this report is based was conducted from June through August 2016. The survey was sent to each state Medicaid director in June 2016. Directors and their staff provided data for this report in their written survey response and through a follow-up telephone interview. All 50 states and DC completed surveys and participated in telephone interview discussions between June and August 2016. The survey instrument is included as an appendix of this report.

The survey collects some data about Medicaid policies in place during a base year, but focuses on changes from year-to-year. For FY 2017, the survey includes policy changes implemented at the beginning of the year, or for which a definite decision has been made to implement during the fiscal year; it does not include policy changes under consideration but for which a definite decision on implementation has not been made. Medicaid policy makers know that policies adopted for the upcoming year are sometimes delayed or not implemented for reasons related to legal, fiscal, administrative, systems or political considerations, or due to delays in approval from CMS. The District of Columbia is counted as a state for the purposes of this report; the counts of state policies or policy actions that are interspersed throughout this report include survey responses from the 51 "states" (including DC). Key findings of this survey, along with state-by-state tables providing more detailed information, are described in the following sections of this report:

- Eligibility, Enrollment, Premiums and Copayments
- Managed Care Initiatives
- Emerging Delivery System and Payment Reforms
- Long-Term Services and Supports Reforms
- Provider Rates and Taxes
- Benefits and Pharmacy
- Administrative Challenges

Long-Term Services and Supports Reforms

Key Section Findings

- Nearly every state reported actions to expand the number of persons served in community settings in both years (46 states in FY 2016 and 47 states in FY 2017). Forty-two (42) states in FY 2016 and 41 states in FY 2017 increased or plan to increase the number of people served in community-based settings through existing or expanded Section 1915(c) HCBS waivers, new Section 1915(i) HCBS State Plan Options, or Section 1915(k) Community First Choice State Plan Amendments. Twenty-three (23) states in FY 2016 and 18 states in FY 2017 reported expanding PACE programs through new enrollment and/or new sites. Nineteen (19) states in FY 2016 and 18 states in FY 2017 report they include/will include specific rebalancing incentives in managed care contracts that cover LTSS. Fourteen (14) states in FY 2016 and nine states in FY 2017 expect to close or downsize a state institution and transition residents into community settings.
- In June 2015, CMS issued an Informational Bulletin to clarify when and how Medicaid reimburses for certain housing-related activities. Sixteen (16) states reported that they have or will implement or expand housing-related services as outlined in the Informational Bulletin in FY 2016 or FY 2017.
- Twenty-three (23) states provided some or all LTSS through a managed care arrangement as of July 1, 2016; 15 states offered MLTSS on a statewide basis for at least some LTSS populations. Twenty-one (21) states offered at least one MCO arrangement that covers both Medicaid acute and Medicaid LTSS (including dual eligible demonstration models), while five states offer a prepaid health plan that covers only Medicaid LTSS. In FY 2016, four states implemented MLTSS or expanded MLTSS to new parts of the state, and four states expanded MLTSS to new populations. In FY 2017, two states anticipate geographic expansion in MLTSS, while five states anticipate adding new populations to MLTSS.
- Enrollment into the MLTSS program is mandatory statewide for seniors in 13 of the 23 MLTSS states, for individuals with ID/DD in eight states, for non-elderly adults with physical disabilities in 12 states, and for individuals who have full dual eligibility status in nine states.

Additional information on LTSS expansions implemented in FY 2016 or planned for FY 2017 as well as state-level details on capitated MLTSS models can be found in Tables 12 and 13.

LTSS SYSTEM REBALANCING

Medicaid is the nation's primary payer for long-term services and supports (LTSS), covering a continuum of services ranging from home and community-based services (HCBS) that allow persons to live independently in their own homes or in other community settings to institutional care provided in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF-ID). In 2013, spending on HCBS (51 percent of total LTSS expenditures) surpassed spending on institutional LTSS (49 percent of total LTSS expenditures) for the first time in the history of the program. The trend toward spending for services in the community continues, with the percentage of spending for HCBS in 2014 growing to 53 percent of total LTSS spending.⁴⁴ This achievement represents a fundamental rebalancing of program expenditures over the last twenty years; in 1995, Medicaid reported that 82 percent of national expenditures on LTSS was in institutional settings, and that share is now less than half.⁴⁵

This year's survey shows, once again, that a large majority of states are employing a variety of tools and strategies to expand the number of people served in home and community-based settings for LTSS, including serving more people through existing or expanded Section 1915(c) HCBS waivers, new Section 1915(i) HCBS

State Plan Option or Section 1915(k) Community First Choice State Plan Amendments, PACE program growth,⁴⁶ and incentives to support system rebalancing through use of managed long-term services and supports (MLTSS). Expanding the numbers of individuals served through HCBS waivers and SPAs remains the most popular strategy, with 42 states in FY 2016 and 41 states in FY 2017 reporting they plan to increase the number of Section 1915(c) waiver slots, serve more individuals under existing Section 1915(c) waiver program caps, or are adding Section 1915(i) or Section 1915(k) state plan options to serve more individuals (Figure 7).

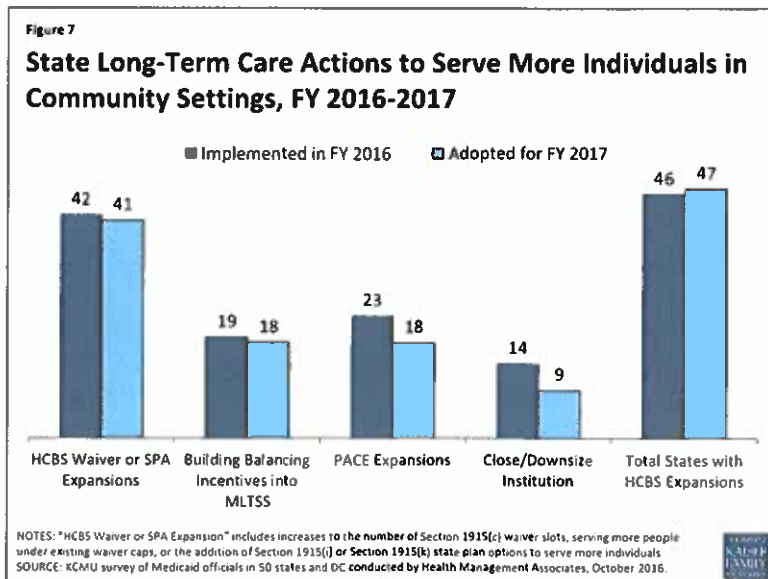
Four states reported implementing a new Section 1915(i) state plan option for targeted populations in FY 2016, with five states intending to implement a Section 1915(i) state plan option for targeted populations in FY 2017. Three states implemented a new Section 1915(k) state plan option in FY 2016 (Connecticut, New York and Washington), while one state intends to implement Section 1915(k) in FY 2017 (Wyoming).

Several states are also using MLTSS strategies intended to serve more individuals in home and community-based settings. Nineteen (19) states in FY 2016 and 18 states in FY 2017 report they include or will include specific rebalancing incentives (performance targets and/or financial incentives) in managed care contracts to encourage MCOs that cover LTSS to expand access to HCBS. This includes a number of states that provide HCBS for some or all populations under Section 1115 waivers, in connection with MLTSS, instead of through Section 1915(c).⁴⁷ For example, Tennessee, which transferred its Section 1915(c) waiver services for several LTSS populations to a Section 1115 waiver with its expansion to MLTSS in 2010 (TennCare CHOICES), reported that it expects to convert its remaining Section 1915(c) waiver for persons with intellectual and developmental disabilities to Section 1115 authority in FY 2017. The state anticipates significant expansion in HCBS capacity for this population under its managed care approach. See the MLTSS section below for more detail on the use of MLTSS in state Medicaid programs.

PACE continues to be reported as a rebalancing tool, with 23 states in FY 2016 and 18 states in FY 2017 expecting growth in these programs. For most of these states, growth will come within existing PACE sites; however, Florida, New Jersey, Rhode Island, Texas, and Maryland reported that they expect to add at least one new PACE site.

Further, 14 states in FY 2016 and nine states in FY 2017 expect to close or downsize a state institution and transition residents into community settings. This strategy is still an important tool of rebalancing. In addition, both Indiana and Massachusetts imposed a moratorium on new nursing facility beds in FY 2016.

States were also asked if they have adopted or plan to adopt new restrictions on the number of people served in the community in FY 2016 or FY 2017. Two states (Missouri and North Carolina) reported that they were acting to restrict PACE programs. Missouri terminated its PACE site in FY 2016, and North Carolina, citing concern over the rate of growth in the program, placed a limit on the number of individuals each PACE site can enroll



each month. Virginia reported that it intends to cap enrollment in its Alzheimer's Assisted Living Section 1915(c) waiver, which currently serves 56 people and cannot meet the new CMS regulatory standards for home and community-based settings; a stakeholder group is meeting to formulate plans for individuals who are currently served under the waiver. While New Jersey is expanding HCBS through other initiatives, the state also increased the number of institutional LTSS beds in FY 2016; 60 additional long-term care beds for individuals who have Huntington Disease were approved by the New Jersey Department of Health in FY 2016.

Table 12 shows state use of LTSS rebalancing tools in FY 2016 and FY 2017.

HOUSING SUPPORTS

In June 2015, CMS issued an [Informational Bulletin](#) to clarify when and how Medicaid reimburses for certain housing-related activities, including individual housing transition services, individual housing and tenancy sustaining services, and state-level housing related collaborative activities.⁴⁸ CMS's intent was to assist states in designing benefits that support community integration for seniors, individuals with disabilities, and individuals experiencing chronic homelessness.

Many of the services outlined in CMS's Informational Bulletin were developed under the auspices of federal grant programs, including the Money Follows the Person (MFP) rebalancing demonstration. MFP is a federal grant program, enacted under the Deficit Reduction Act of 2005 and extended through September 2016 by the Affordable Care Act, which operates in 44 states. Enhanced federal funding under MFP has supported the transition of over 52,000 individuals from institutional to home and community-based settings of LTSS as of mid-2015.⁴⁹ Under MFP, states identified the lack of affordable and accessible housing as a major barrier to assisting individuals to leave institutional settings of care. With MFP resources, many states have offered new housing related services, incorporated housing expertise within the Medicaid program to increase the likelihood of successful community living for persons who need supports, and engaged in strategic activities to assist in identifying and securing housing resources for individuals who choose HCBS.

After September 2016, states can continue to transition individuals under MFP through 2018 (with CMS approval) and have through 2020 to use their remaining funding.⁵⁰ As of July 2016, 23 states reported that they currently offer housing-related services under a state plan, Section 1915(c), or 1115 waiver authority that the state intends to continue after the expiration of the MFP grant program. Most of these states are using current Section 1915(c) waivers that provide community transition services and environmental modifications for seniors, individuals with physical disabilities and/or individuals with intellectual or developmental disabilities. Other states, including Alabama, Kansas, Massachusetts, Michigan, and Ohio, plan to continue to offer housing coordinators or other search services to assist waiver beneficiaries. States have noted that some demonstration services and program supports will terminate when [MFP funding expires](#).

Beyond MFP, 16 states reported that they have or will implement or expand housing-related services, as outlined in the Informational Bulletin, in FY 2016 or FY 2017; one state has done so in 2016, eight states plan to do so in 2017, and seven states plan to implement or expand housing-related services in both years (Exhibit 7). States report planning to use an array of authorities, in addition to Section 1915(c) waivers, for offering housing related services. For example, the District of Columbia proposes to offer health home services that support links to housing, and California proposes to offer housing-related services using a health home-based Whole Person Care Pilot under a Section 1115 waiver. New Jersey plans to use a Section 1115 waiver to offer a

supported housing benefit to a wide range of Medicaid beneficiaries, including people who are homeless, at-risk of homelessness, residing in nursing facilities, are jail involved, or have a behavioral health diagnosis. Connecticut proposes to provide transition supports and tenancy sustaining supports using a Section 1915(i) State Plan Amendment. Under its Section 1115 waiver, Washington plans to provide supportive housing services (including individual housing transition services and individual tenancy sustaining services) to Medicaid beneficiaries age 18 or older who meet HUD’s definition of “chronically homeless” *or* have frequent or lengthy institutional contacts *or* adult residential care stays *or* have frequent in-home caregiver/provider turnover *or* meet specific risk criteria.⁵¹

Exhibit 7: States Implementing or Expanding Housing-related Services Outlined in the CMS Informational Bulletin		
FY 2016 only	FY 2017 only	both FY 2016 and FY 2017
OH	CT, DC, DE, FL, HI, NJ, RI, VT	CA, LA, MA, NC, OK, TN, WA

HCBS BENEFIT CHANGES

Ten (10) states in FY 2016 and 14 states in FY 2017 reported a wide variety of HCBS benefit additions or expansions. HCBS benefits include those in Section 1915(c) waivers, Section 1915(i) authority, Section 1915(k) authority (known as “Community First Choice” or “CFC”), and State Plan personal care services, home health services and private duty nursing (Exhibit 8).⁵² For example, three states in FY 2016 (Connecticut, New York, and Washington) and one in FY 2017 (Wyoming) reported implementing or planning to implement CFC and one state (Texas) reported enhancing its CFC benefit in FY 2016 to add transportation and respite services for persons with intellectual and developmental disabilities; one state in FY 2016 (Texas) and two in FY 2017 (Florida and South Carolina) reported behavioral health-related HCBS service additions; two states (Colorado and DC) reported increasing access to consumer directed service options in FY 2016; two states (Pennsylvania and Tennessee) reported employment services expansions in FY 2017 and one state (Wisconsin) reported adding consultative and therapeutic services for caregivers and training services for unpaid caregivers in FY 2016.

HCBS benefit restrictions reflect the elimination of a covered benefit or the application of utilization controls for existing benefits. For FY 2016, West Virginia applied service limitations in its home and community-based services waiver serving persons with intellectual and developmental disabilities and eliminated a benefit in two other HCBS waivers. For FY 2017, Tennessee is limiting coverage for facility-based day services (Exhibit 8).

Exhibit 8: HCBS Benefit Enhancements or Additions and Restrictions or Eliminations		
Benefit	FY 2016	FY 2017
HCBS Enhancements or Additions	CA, CO, CT, DC, MS, MT, NY, TX, WA, WI	CT, DC, FL, ID, IN, KY, MA, MN, MT, PA, SC, SD, TN, WY
HCBS Restrictions or Eliminations	WV	TN

CAPITATED MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)

As of July 1, 2016, almost half of states (23 states) covered LTSS through one or more of three types of capitated managed care arrangements: a Medicaid MCO (covering Medicaid acute care and LTSS), a PHP (covering only Medicaid LTSS), or an MCO arrangement for dually eligible beneficiaries (covering Medicaid and Medicare acute care and Medicaid LTSS services in a single contract, under the financial alignment demonstration for dual eligibles). Of the 23 states that reported using one or more of these MLTSS models, eight states reported using two models, and one state (New York) reported using all three. Among states with MLTSS arrangements, 18 states offer a Medicaid MCO that covers both Medicaid acute services and Medicaid LTSS. (Michigan, South Carolina, and Virginia are not among these 18 states; however, they use Medicaid MCOs that cover Medicaid acute and Medicaid LTSS (as well as Medicare acute care) in financial alignment demonstration (FAD) initiatives for duals.) Just five states reported offering a Medicaid LTSS PHP. Of the states with capitated MLTSS, 15 offered some form of managed care plan on a statewide basis for at least some LTSS populations as of July 1, 2016.

Nine states offered an MCO-based FAD (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia) as of July 1, 2016.⁵³ The FAD model involves a three-way contract between an MCO, Medicare and the state Medicaid program.^{54,55} Two states reported new FAD initiatives: in FY 2016, New York launched a second FAD initiative, contracting with a managed care plan to serve dual eligibles with ID/DD, and Rhode Island is launching a FAD initiative in FY 2017. Massachusetts *also* operates an administrative alignment demonstration (without financial alignment) for dually eligible beneficiaries (Senior Care Options (SCO) program). Minnesota *only* operates an administrative alignment demonstration (without financial alignment) for dually eligible beneficiaries (Minnesota Senior Health Options program).

Other states not participating in a formal demonstration have taken action to encourage improved coordination and integration of services for the dually eligible population under MCO arrangements. Five states (Arizona, Hawaii, Minnesota, Tennessee, and Wisconsin) reported that they require Medicaid-contracting MCOs to also offer a Medicare Dual Eligible Special Needs Plan (D-SNP)⁵⁶ to allow a beneficiary to choose to receive Medicare as well as Medicaid benefits from the same plan (though not through a single contract). Florida contracts for MLTSS with MCOs that are chronic disease SNPs⁵⁷ for dually eligible beneficiaries. New Jersey and Idaho reported that at least one plan in each state is a Fully Integrated Dual Eligible (FIDE) SNP,⁵⁸ which allows beneficiaries to choose a single MCO to offer both Medicare and Medicaid benefits, creating an opportunity for improved coordination and integration.

Table 13 provides state-level details on MLTSS models.

MLTSS ENROLLMENT

This year's survey also asked states with capitated MLTSS arrangements whether, as of July 1, 2016, certain populations were enrolled on a mandatory or voluntary basis or were always excluded. On the survey, states selected from "always mandatory," "always voluntary," "varies (by geography or other factor)," or "always excluded" for the following populations: seniors, persons with ID/DD, non-elderly adults with physical disabilities, and full-benefit dually eligible beneficiaries. As shown in Exhibit 9 below, seniors were most likely to be enrolled on a mandatory basis statewide (13 states), while persons with ID/DD were least likely to be enrolled on a mandatory basis (8 states) and also most likely to be excluded from MLTSS enrollment (4 states).

No state with a MLTSS program always excludes individuals who have full dual eligibility status from enrollment.

**Exhibit 9: MLTSS Enrollment by Populations, July 1, 2016
(# of States)**

	Seniors	Persons with ID/DD	Nonelderly Adults with Physical Disabilities	Full Benefit Dual Eligibles
Always mandatory	13	8	12	9
Always voluntary	5	6	4	7
Varies (by geography or other factor)	4	5	4	7
Always excluded	1	4	3	0

MLTSS BENEFITS

Almost every MLTSS state (22 states) includes both institutional and HCBS in the same contractual arrangement, though this sometimes varies within a state across populations. For example, Minnesota offers both institutional and HCBS in the same MCO for seniors, but only institutional LTSS are included in an MCO for individuals with disabilities who are under the age of 65. One state (North Carolina) reported covering only HCBS in its MLTSS program for persons with intellectual and developmental disabilities.

MLTSS POPULATION CHANGES

The growth in the use of MLTSS has continued since the prior survey reporting period. In FY 2015, six states (California, Michigan, New Jersey, New York, South Carolina, and Texas) implemented MCO arrangements for LTSS for at least some populations, some of these in conjunction with implementing a FAD. In FY 2016, four states implemented or expanded MLTSS to new parts of the state, while four states expanded MLTSS to new populations. South Carolina and Wisconsin anticipate geographic expansion in MLTSS in FY 2017, while five states anticipate adding populations to MLTSS in FY 2017 (Exhibit 10).

Exhibit 10: MLTSS Population Expansions, FY 2016 and FY 2017

	FY 2016	FY 2017
Geographic Expansions	IA, ID, SC, WI	SC, WI
New Population Groups Added	IA, NJ, NY, SC	IL, NY, SC, TN, TX

Only two states reported any reduction in the use of MLTSS. Massachusetts imposed a temporary cap on enrollment in OneCare (its FAD model) in FY 2016, but that cap was subsequently lifted. Idaho noted that its one MLTSS PHP is expected to reduce its service plan area in FY 2017.

MLTSS QUALITY

Most states with MCO programs track state-identified quality measures and require other health plan quality-related activities to improve health care outcomes and plan performance under MLTSS. Thirteen (13) states with MCOs offering LTSS reported having LTSS quality measures in place in FY 2015. In FY 2016, a total of six states implemented new or expanded MLTSS quality measures, bringing the total to 15 states. Five of these 15 states plan to expand quality measures for LTSS in FY 2017. See Exhibit 11 for information on states with quality measures for MLTSS.

CMS has identified a gap in the national availability of tested, reliable and valid quality measures for HCBS. A variety of efforts are underway to address this gap. The US Department of Health and Human Services has contracted with the National Quality Forum to create a conceptual framework for HCBS quality measurement; to synthesize existing evidence, measures, and measure concepts; to identify gaps in HCBS measures based on the framework; and to make recommendations for HCBS measure development efforts.^{59 60}

Exhibit 11: MLTSS Quality Measures, FY 2015, FY 2016, and FY 2017		
In Place FY 2015	New/Expanded FY 2016	New/Expanded FY 2017
AZ, CA, DE, FL, IL, KS, MA, MN, NM, OH, TN, TX, VA	AZ, CA, DE, IA, NJ, VA	AZ, CA, DE, TX, VA

TABLE 12: LONG-TERM CARE EXPANSIONS IN ALL 50 STATES AND DC, FY 2016 AND FY 2017

States	Waiver or SPA Expansions		Building Balancing Incentives in MLTSS		PACE Expansions		Downsize/Close Institution		Total States with HCBS Expansions	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Alabama	X	X							X	X
Alaska										
Arizona			X	X					X	X
Arkansas	X	X			X	X			X	X
California	X	X	X	X	X	X	X	X	X	X
Colorado	X	X			X	X			X	X
Connecticut	X	X					X	X	X	X
Delaware	X	X	X	X	X	X	X		X	X
DC	X	X							X	X
Florida	X	X	X	X	X	X			X	X
Georgia		X								X
Hawaii			X	X					X	X
Idaho	X	X							X	X
Illinois	X	X	X	X					X	X
Indiana	X	X			X	X			X	X
Iowa	X	X	X		X		X		X	X
Kansas	X		X	X	X				X	X
Kentucky	X								X	
Louisiana										
Maine	X	X							X	X
Maryland	X	X							X	X
Massachusetts	X	X	X	X	X	X			X	X
Michigan	X	X	X	X	X	X			X	X
Minnesota	X	X							X	X
Mississippi	X	X			X		X	X	X	X
Missouri	X	X							X	X
Montana	X	X					X	X	X	X
Nebraska	X	X							X	X
Nevada	X	X							X	X
New Hampshire	X	X							X	X
New Jersey			X	X	X				X	X
New Mexico			X	X					X	X
New York	X	X	X	X	X	X	X		X	X
North Carolina		X				X				X
North Dakota	X				X	X			X	X
Ohio	X	X					X	X	X	X
Oklahoma	X	X			X		X		X	X
Oregon	X	X			X	X			X	X
Pennsylvania	X	X	X	X	X	X	X		X	X
Rhode Island	X	X	X	X	X	X			X	X
South Carolina	X	X			X		X	X	X	X
South Dakota	X	X							X	X
Tennessee	X	X	X	X			X	X	X	X
Texas	X	X	X	X	X	X	X	X	X	X
Utah	X	X							X	X
Vermont										
Virginia	X	X	X	X	X	X	X	X	X	X
Washington	X	X			X	X			X	X
West Virginia	X	X							X	X
Wisconsin	X	X	X	X					X	X
Wyoming	X	X			X	X			X	X
Totals	42	41	19	18	23	18	14	9	46	47

NOTES: "HCBS Waiver or SPA Expansions" include increases to the number of Section 1915(c) waiver slots, serving more people under existing waiver caps, or the addition of Section 1915(l) or Section 1915(k) state plan options to serve more individuals. In addition to the actions reported here, two states (IN and MA) also reported imposing a moratorium on construction of new nursing facility beds in FY 2016.

SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2016.

TABLE 13: CAPITATED MLTSS MODELS IN ALL 50 STATES AND DC, AS OF JULY 1, 2016

States	Medicaid MCO	PHP	Medicare + Medicaid Demonstration	Any MLTSS	Statewide
Alabama					
Alaska					
Arizona	X			X	X
Arkansas					
California	X		X	X	
Colorado					
Connecticut					
Delaware	X			X	X
DC					
Florida	X			X	X
Georgia					
Hawaii	X			X	X
Idaho		X		X	
Illinois	X		X	X	
Indiana					
Iowa	X			X	X
Kansas	X			X	X
Kentucky					
Louisiana					
Maine					
Maryland					
Massachusetts	X		X*	X	
Michigan		X	X	X	X
Minnesota	X		X*	X	X
Mississippi					
Missouri					
Montana					
Nebraska					
Nevada					
New Hampshire					
New Jersey	X			X	X
New Mexico	X			X	X
New York	X	X	X	X	X
North Carolina		X		X	X
North Dakota					
Ohio*	X		X	X	
Oklahoma					
Oregon					
Pennsylvania					
Rhode Island*	X			X	X
South Carolina			X	X	
South Dakota					
Tennessee	X			X	X
Texas	X		X	X	X
Utah					
Vermont					
Virginia			X	X	
Washington					
West Virginia					
Wisconsin	X	X		X	
Wyoming					
Totals	18	5	10	23	15

NOTES: States were asked whether they cover long-term services supports through any of the following managed care (capitated) arrangements as of July 1, 2016: Medicaid MCO (MCO covers Medicaid acute + Medicaid LTSS); PHP (covers only Medicaid LTSS); or Medicare + Medicaid Demonstration (Medicaid MCO covers Medicaid and Medicare acute + Medicaid LTSS). "Medicare + Medicaid Demonstration" - these states use Medicaid MCOs in Financial Alignment Demonstration (FAD) initiatives which involve care coordination for dually eligible beneficiaries. States were also asked whether MLTSS plans were operating in all regions of the state as of July 1, 2015 (statewide). *MA operates a FAD and another administrative alignment demonstration for dually eligible beneficiaries. *MN operates an administrative alignment demonstration (without financial alignment) for dually eligible beneficiaries. *RI is launching a FAD initiative in FY 2017. *OH offers a Medicaid MCO (MCO offers Medicaid acute + Medicaid LTSS) only in those counties where the FAD is offered; dually eligible seniors who opt out of the FAD must enroll in this Medicaid MCO model for Medicaid services.

SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2016.