August 2, 2013

State Medicaid Integration Tracker©

July 2013 Edition

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). **New information presented each month is highlighted in purple.**

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

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

2. State Demonstrations to Integrate Care for Dual Eligible Individuals (Status Chart) 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 sources of information to find out what is happening across the country, including CMS website on Medicaid Managed Long Term Services and Supports, Centers for Medicare & Medicaid Services (CMS)' website on State Demonstrations to Integrate Care for Dual Eligible Individuals, CMS Balancing Incentive Program website, CMS website on Health Home, CMS list of Medicaid waivers, State Medicaid Agency websites, interview with state officials, and presentations by state agencies. Sources are listed for each item, and readers will find hyperlinks that direct to related documents and materials provided by CMS and states.

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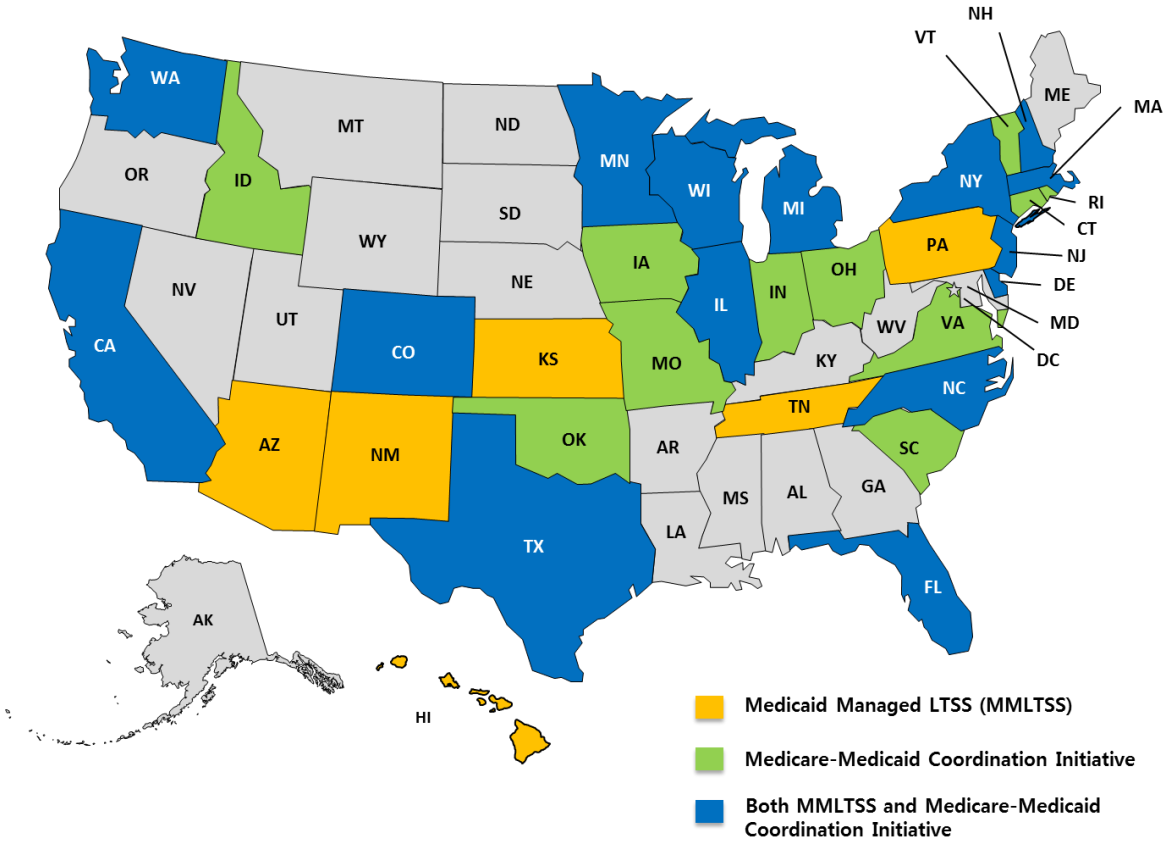
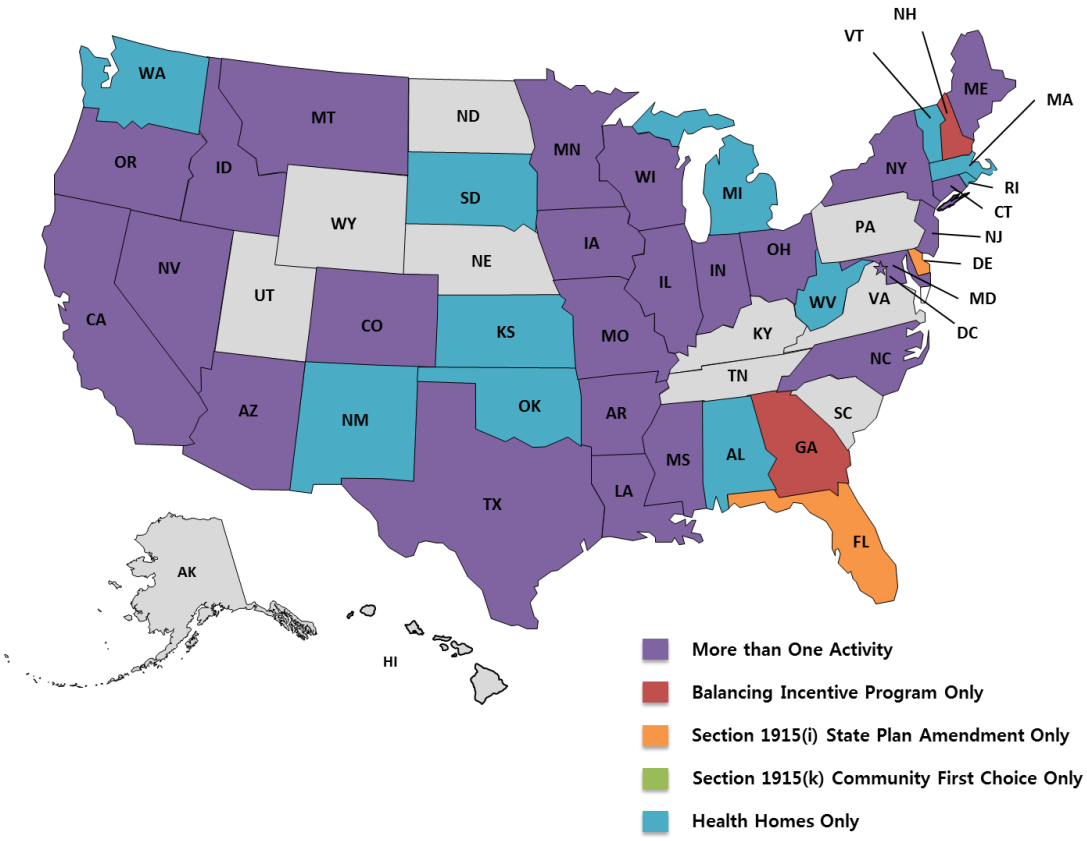
Summary



State Actions	
<u>Both</u> Medicaid Managed LTSS <u>and</u> Medicare-Medicaid Care Coordination Initiative	CA, DE, FL, IL, MA, MI, MN, NH, NJ, NY, NC, OH, TX, WA, WI
Medicaid Managed LTSS <u>Only</u>:	AZ, HI, KS, NM, PA, TN
Medicare-Medicaid Care Coordination Initiative: *: Financial Alignment (FA) demonstration proposal approved by CMS **: Initiatives other than FA demonstration W: No longer pursuing FA demonstration	~~AZ~~(W), CA*, CO, CT, DE, FL**, ~~HI~~(W), ID, IL*, IA, IN**, MA*, MI, MN(W)**, MO, NH**, NJ**, ~~NM~~(W), NY, NC, OH*, OK, ~~OR~~(W), RI, SC, ~~TN~~(W), TX, VA*, VT, WA*, WI (<u>Duals Demonstration Status Chart</u>)

Summary (Continued)



State Actions

Other LTSS Reform Activities (*Approved by CMS):

- **Balancing Incentive Program:** AR*, CT*, GA*, IA*, IL*, IN*, LA*, MD*, ME*, MO*, MS*, NH*, NJ*, NY*, OH*, TX*
- **Medicaid State Plan Amendments under §1915(i):** CA* (1 approved; 2 pending), CO*, CT*, DC, DE, FL*, IA*, ID*, IN, LA*, MD, MN, MT*, NC (2)*, NV*, OR*, ~~TX~~ (W), ~~WA~~, WI*
- **Community First Choice Option (CFCO) under §1915(k):** AZ, AR, CA* (1 approved; 1 pending), CO, LA, MD, MN, MT, NY, OR*, TX
- **Medicaid Health Homes:** AL*, AR, AZ, CA, DC, IA* (1 approved; 1 pending), ID*, IL, IN, KS, MA, MD, ME*, MI, MO (2)*, MS, NC*, NJ, NM, NV, NY*, OH*, OK, OR*, RI* (2 approved; 1 pending), SD, VT, WA, WI*, WV

State Updates

State	State Updates
Alabama	**Health Homes** CMS approved the Agency's request to implement its proposed health homes program. Under this program, the state will implement comprehensive care management in four networks. CMS approval allows the state to draw down 90% FMAP for a two-year period between July 1, 2012, and June 30, 2014. Target population includes individuals with two chronic conditions, one and at risk for another or SMI, i.e., all the conditions listed in §2703 of the ACA, except BMI over 25. Other chronic conditions include transplants, CVD, cancer, COPD, sickle cell anemia, HIV. (Source: Alabama Medicaid Agency News, May 7, 2013; Approved Health Homes State Plan Amendment (Approved 4/ 9/ 2013))
Arizona	**Currently Operating Medicaid Managed LTSS Program** Under Medicaid §1115 waiver authority, **Arizona Health Care Cost Containment System** (AHCCCS) provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid State Plan groups as well as demonstration expansion groups. The goal of the demonstration is to provide organized and coordinated health care for both acute and long-term care that includes pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. Beneficiaries receiving long-term care services receive additional benefits that would not otherwise be provided through the Medicaid State Plan. (Source: Medicaid.gov) State Website on AHCCCS Fact Sheet Current Approval Document (4/ 6/ 2012) Rate reductions were instituted for the 2011-2012 contract year for virtually all institutional and non-institutional services covered under AHCCCS. The state released (8/ 10/ 2012) final rule of the AHCCCS to maintain reimbursement reductions for inpatient and outpatient hospital services covered through the AHCCCS program that were instituted last contract year (October 1, 2011 through September 30, 2012) and to eliminate adjustments to those rates based on inflation. (Source: BNA Register, August 17, 2012) The state recently submitted (11/ 9/ 2012) amendment to its 1115 Waiver to extend the state authority (1) to provide Medicaid coverage to adults without dependent children with incomes between 0% and 100% of the Federal Poverty Level ("Childless Adults") for the entire period of its Demonstration, and (2) to obtain the enhanced federal medical assistance percentage (FMAP) for Childless Adults beginning January 1, 2014. No changes to the benefit package or to the current cost sharing requirements are being proposed through this amendment. Application for Amendment (11/ 9/ 2012) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** On April 10, AHCCCS Director Thomas Betlach submitted a letter withdrawing the state's proposal to participate in the CMS Capitated Financial Alignment Demonstration for members that have AHCCCS and Medicare. Arizona will continue to work with the CMS Medicare-Medicaid Coordination Office to improve the system for dually-eligible members through the current managed care model

State	State Updates
Arizona	by leveraging D-SNPs. (Source: State Website) Arizona Capitated Financial Alignment Demonstration Withdrawal Letter (4/ 10/ 2013) According to proposal submitted to CMS on May 31, 2012, the state's demonstration was to be statewide and would use a capitated payment model. Target population included full benefit Medicare dually-eligible enrollees with Medicare A and/ or B who are Medicaid-eligible through: (1) the Arizona Long-Term Care System Elderly and Physically Disabled (ALTCS E/ PD) program; (2) the acute care program or (3) as an acute care enrollee with Serious mental illness residing in Maricopa County, a subset of the acute care program. While the demonstration included almost the entire dually-eligible population in the state, persons with intellectual or developmental disabilities (I/ DD population) were fully carved out. Members who are eligible for ALTCS through the Department of Economic Security/ Division of Developmental Disabilities were not to be eligible for enrollment in the demonstration at this time. Covered benefits included Medicare Parts A, B, and D, Medicaid State Plan and 1115 Waiver (as applicable), and Medicare Supplemental benefits. Proposed implementation date was January 1, 2014. (Source: Demonstration Proposal) **Section 1915(k) Community First Choice (CFC) Option** In October 2012, Arizona submitted an application to CMS to implement the Community First Choice Option. AHCCCS proposes to utilize the authority of §1915(k) of the Social Security Act to adopt a new participant-directed alternative called "Agency with Choice." With this change, Arizona would offer a total of four participant-directed options in Arizona, including the new "Agency with Choice." Pending CMS approval, home-based ALTCS members could elect Agency with Choice beginning on January 1, 2013. State Website on ALTCS Member-Directed Options State Plan Amendment (10/5/2012) Presentation (10/29/2012) **Health Homes** The Arizona Department of Health Services/ Division of Behavioral Health Services (ADHS/ DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) were awarded (3/ 29/ 2011) a planning grant to explore the feasibility of a Regional Behavioral Health Authority (RBHA) model with expanded responsibility for Title XIX-eligible adults determined to have a Serious mental illness (SMI). This RBHA model is referred as "Recovery through Whole Health". This RBHA is funded for and fully responsible for coordinated and integrated behavioral healthcare and physical healthcare for Title XIX-eligible adults with SMI through the use of Health Homes Services. It is based on the goals, principles and concepts contained in the Health Home provisions in §2703 of the Affordable Care Act. (Source: State Website on Health Homes) **Arizona Health Care Cost Containment System (AHCCCS) Director Testifies before the U.S. Senate on Duals Demonstration** Overview Complete Testimony

State	State Updates
Arkansas	**Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (3/ 15/ 2013) that Arkansas will receive an estimated $ 61.2 million in enhanced Medicaid funds (2% enhanced FMAP rate). (Source: Balancing Incentive Program Award Letter) BIP Application (11/ 27/ 2012); BIP Award Letter (3/ 15/ 2013) **Health Homes** CMS approved planning request. (Source: Integrated Care Resource Center) **Section 1915(k) Community First Choice Option (CFCO)** The state plans to submit a §1915(k) State Plan Amendment to CMS to implement CFCO on July 1, 2013. (Source: CFCO 6th Meeting Minutes (5/30/2013)) The program would provide additional resources and a mechanism to address Arkansas' waiting list of over 2,000 people with developmental disabilities seeking services under the existing Alternative Community Services Waiver, offering long-awaited services to those who need them. The state estimates it could serve 20,294 clients under CFCO. (Source: Community First Choice Option Development and Implementation Council Presentation (11/20/2012)) State Website on CFCO Development & Implementation Council Meeting Documents
California	**Currently Operating Medicaid Managed LTSS Program** Under Medicaid §1915(a) authority, **SCAN Connections at Home** provides long-term services and supports (LTSS) to Medicare-Medicaid enrollees of age 65 and older at capitated rate. Services include nursing facility and HCBS waiver-like services, including homemaker, home delivered meals, personal care, transportation escort, custodial care, in-home respite, and adult day. The program operates in limited geographic area and enrollment is voluntary. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Website on SCAN Connections at Home **State Demonstration to Integrate Care for Dual Eligible Individuals** **Coordinated Care Initiative (CCI):** California submitted a revised demonstration proposal to CMS on May 31, 2012. On June 27, 2012, the governor approved a bill (SB 1008) to revise the existing law to require the Department of Health Care Services to establish demonstration sites in up to eight counties not sooner than March 1, 2013. (Source: Calduals.org, July 3, 2012) According to the demonstration proposal, target population includes all full benefit Medicare-Medicaid enrollees who are age 21 or over in eight counties with specified exceptions. Full benefit dually-eligible beneficiaries are those Medicare beneficiaries with Parts A, B, and D coverage and full Medi-Cal coverage. Medi-Cal covers Medicare premiums, co-insurance, copayments, and deductibles, as well as services that Medicare does not cover (primarily long-term services and supports). Beneficiaries with developmental disabilities who are receiving services from the Department of Developmental Services and regional centers are carved out from the demonstration, while some people with developmental disabilities receiving services through the state's in-home supportive services (IHSS) and community-based adult services (CBAS) will be included in the demonstration. Those enrolled in §1915(c) HCBS waiver programs are also excluded from the demonstration.

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California	Covered benefits include Medicare (Parts A, B and D) and Medicaid covered services. The demonstration will use a capitated payment model. (Source: Demonstration Proposal; NASDDDS Managed Care Tracking Report) State officials proposed (05/ 25/ 2012) a change in the implementation date, from March 2013 to June 2013. (Source: www.californiahealthline.org, May 30, 2012) Demonstration Proposal State Website on Coordinated Care Initiative Timeline Coordinated Care Initiative Fact Sheets on CalDuals.org CMS announced on March 27, 2013 that California would be the fifth state to enter into a Memorandum of Understanding (MOU) to integrate care for dually-eligible beneficiaries as a component of California's Coordinate Care Initiative (CCI). According to the state's website, the project will be called the **Cal MediConnect** from now on. Through Cal MediConnect, eligible beneficiaries will have the opportunity to combine all their Medicare and Medi-Cal benefits into one health plan — and receive more coordinated and accountable care. Enrollment was initially expected to begin no sooner than October 1, 2013. On May 6, 2013, however, the Department of Health Care Services (DHCS) announced that Cal MediConnect would begin no earlier than January 2014. (Source: CalDuals, accessed 5/ 13/ 2013) Memorandum of Understanding **Section 1915(k) Community First Choice (CFC) Option** California submitted CFCO SPA #11-034 in December 2011 and received approval from CMS in August 2012. California is the first state to receive approval from CMS (9/ 4/ 2012) to enact the Community First Choice Option, which will provide the state an estimated $573 million in additional federal funds during the first two years of implementation. Community First Choice will enhance Medi-Cal's ability to provide community-based personal attendant services and support to seniors and persons with disabilities to certain enrollees who otherwise would need institutional care. California immediately will begin claiming the Community First Choice federal funding, which is retroactive for most In-Home Supportive Services (IHSS) program services provided since December 1, 2011. (Source: Press Release, 9/ 4/ 2012) In May 2013, the state submitted its second CFCO SPA (CFCO SPA #13-007), currently pending with CMS. (Source: State Website on CFCO) **Section 1915(i) State Plan Amendment** 1. Approved State Plan Amendment California submitted an application to implement a §1915(i) Home and Community Based Services State Plan Option (SPA# 09-023A) in 2009 and received approval from CMS on April 25, 2013. The state's SPA is the first in the nation approved by CMS under §1915(i) specifically for persons with developmental disabilities. The SPA approval allows the state to access federal funding for services, such as residential supports, day programs and respite, provided to individuals who do not meet the institutional level of care eligibility criteria of the current Medicaid HCBS Waiver. (Source: Press Release, May 1, 2013) 2. Pending State Plan Amendments California Department of Health Care Services (DHCS) submitted two additional

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California	§1915(i) State Plan Amendments in 2011. The first one (SPA# 11-041) proposed to target developmentally disabled individuals with a need for habilitation services. This SPA would extend Medi-Cal coverage for existing specialized health and other home and community-based services provided to Medi-Cal-eligible persons with developmental disabilities. Medi-Cal-eligible persons with developmental disabilities who do not meet the criteria for institutional long-term care services will be covered under this State Plan option. Services covered under the SPA would include community living arrangement services, respite care, and day services. The state anticipates serving 42,000 in the first year. The second §1915(i) (SPA# 11-040) proposed to target infants and toddlers with developmental delays and would provide a 1-day session with families to prepare the children for school or other appropriate facilities (currently funded with state-only funds). California anticipates serving 3,800 in the first year. (Source: California Department of Health Care Services Website) **Health Homes** CMS approved planning request. (Source: Integrated Care Resource Center)
Colorado	**State Demonstration to Integrate Care for Dual Eligible Individuals** Colorado's demonstration will include the state's entire dually-eligible population, including those with I/ DD, with enhanced coordination between acute and long-term care. (Source: NASDDDS Managed Care Tracking Report) The demonstration is statewide with managed fee-for-service as the payment model. Covered benefits include Medicare Parts A, B, and D, Medicaid State Plan, Behavioral Health Services available under an existing §1915(b) Medicaid waiver, and Home and Community-Based Services available under §1915(c) Medicaid waivers. Implementation date was not specified. (Source: Demonstration Proposal) State Website on Duals Demonstration **Section 1915 (i) State Plan Amendment** Colorado submitted a State Plan Amendment to implement §1915(i) State Plan Option in 2008 and received approval from CMS in 2009. To qualify for State Plan HCBS Services provided under the option, a physician must document that the individual's health is at risk without appropriate supports due to a chronic condition and/ or progressive disease as documented by a physician requires significant assistance with transferring mobility or supervision and assistance with at least one of the following Activities of Daily Living bathing dressing eating or toileting. (Source: State Plan Amendment) **Accountable Care Collaborative (ACC)** A bipartisan bill, which establishes a program to pilot-test Medicaid fee-for-service alternatives and **Regional Care Collaborative Organizations (RCCO)**, was signed into law by Governor John Hickenlooper (6/ 4/ 2012). (Source: ModernHealthcare.com; ModernPhysician.com) According to the state website, Medicaid clients in the **Accountable Care Collaborative (ACC)** will receive the regular Medicaid benefit package, and will also belong to a "Regional Care Collaborative Organization" (RCCO). The **Regional Care Collaborative Organization (**click here for state resource**)** connects Medicaid clients to Medicaid providers by helping Medicaid clients find community and social services in their area and providers communicate with Medicaid clients and with each other. A RCCO will also help Medicaid clients get the right care when they are returning home from the hospital or a

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Colorado	nursing facility, by providing the support needed for a quick recovery. A RCCO helps with other care transitions too, like moving from children's health services to adult health services, or moving from a hospital to nursing care. All clients enrolled in the ACC also have to choose Primary Care Medical Provider (PCMP). **Primary Care Medical Provider (**click here for state resource**)** is a Medicaid client's main health care provider. A PCMP is a Medicaid client's "medical home," where he or she will get most of their health care. When a Medicaid client needs specialist care, the PCMP will help him or her find the right specialist. Accountable Care Collaborative State Website Accountable Care Collaborative Fact Sheet Selected by the Center's for Medicare and Medicaid Services' (CMS') Innovation Center to participate in the Comprehensive Primary Care (CPC) Initiative, the state will implement this new primary care initiative through the existing ACC Program. The CPC Initiative is focused on strengthening primary care and fostering collaboration between health care systems. (Source: Colorado Department of Health Care Policy and Financing) **Section 1915(k) Community First Choice Option** The state is currently considering pursuing the option. In 2012, Colorado's Long Term Services and Supports (LTSS) Strategic Planning Report identified consumer direction/ Community First Choice as an important initiative within the strategy of LTSS. In accordance with the federal final rule on the option, Community First Choice Council has been formed. (Source: Colorado Community First Choice Council website)
Connecticut	**State Demonstration to Integrate Care for Dual Eligible Individuals** Connecticut's financial alignment demonstration proposes to serve dually-eligible (MMEs) age 18 to 64, and age 65 and older. The populations served will include individuals with Serious mental illness (SMI), and individuals with Intellectual and Developmental Disabilities, with increased coordination focused on acute health care. (Source: NASDDDS Managed Care Tracking Report) Covered benefits include Medicaid State Plan services (including §1915(i)), Medicaid waiver services, Medicare Parts A, B and D, and adjunct services and supports, such as Intensive Care Management, chronic disease self-management education, nutrition counseling, falls prevention, medication management services, and potentially also, peer support and recovery assistance. The demonstration will utilize a managed fee-for-service payment model. Participation of MMEs in the Administrative Services Organization (ASO) model will begin statewide effective January 1, 2013. Participation of MMEs in Health Neighborhoods (HN) model will be launched on a pilot basis in limited service areas starting April 1, 2013. The Department then plans to use the knowledge gained in this pilot period to expand the initiative to serve additional MMEs, and also potentially to expand the model to serve single-eligible Medicaid individuals (MEs) and convert risk-adjusted advanced payments to HNs (APM II) to a Health Homes coverage option. (Source: Demonstration Proposal) **Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (12/ 7/ 2012) that Connecticut will receive an estimated $72.8 million in enhanced Medicaid funds (2% enhancement of the state's FMAP rate). (Source: CMS Balancing Incentive Program website)

State	State Updates
Connecticut	CMS Award Announcement (12/ 7/ 2012) BIP Application (10/ 31/ 2012) **Section 1915(i) State Plan Amendment** Connecticut's §1915(i) State Plan Amendment to CMS was submitted in 2011 and the option went effective in 2012. It is one of funding sources for Connecticut Home Care Program. Since February 2012, individuals with incomes up to 150% of the federal poverty level (FPL) have been able to get Medicaid-covered non-home health care community-based services under this option. (Source: OLR Research Report: Connecticut Home Care Program, February 2013) The state has identified elderly and disabled individuals, including older adults financially, but not functionally eligible for the state's HCBS elder waiver as the target populations. Services covered by the option would include adult day health, care management, homemaker, personal care assistant, respite, assisted living, assistive technology, chore services, companion, environmental accessibility adaptations, home delivered meals, mental health counseling, personal emergency response systems, and transportation. (Source: State Plan Amendment) **Connecticut restructures the state's relationships with Medicaid managed care plans** Starting January 1, 2012, Connecticut began directly reimbursing health care providers, while a non-profit organization, Community Health Network of Connecticut, Inc., provides care coordination and customer service for all of the state's Medicaid and Children's Health Insurance Program beneficiaries, plus members of a state-funded health programs for low-income adults — about 600,000 people in all. All services will be coordinated by the Department of Social Services' single, statewide administrative services organization (ASO). (Source: Stateline; Community Health Network of Connecticut, Inc.) Press Release Request for Proposals (April 2011) HB06518. An Act Establishing An Administrative Services Organization
Delaware	**Currently Operating Medicaid Managed LTSS Program & State Initiatives to Integrate Care for Dual Eligible Individuals** Amendment to Diamond State Health Plan (DSHP) §1115 Medicaid managed care demonstration waiver (approved 3/ 22/ 2012) added **Diamond State Health Plan Plus (DSHP Plus)** in order to integrate Long Term Care Medicaid and other full-benefit dually eligible into the DSHP. DSHP Plus began on April 1, 2012. Services provided in capitated rate include primary, acute, and behavioral services, and LTSS. Prescription drugs are carved out of both DSHP and DSHP Plus. Target population includes older persons, persons with physical disabilities, persons with HIV/ AIDS, persons using Money Follows the Person services, workers with disabilities using Buy-in, Medicare-Medicaid enrollees, and all SSI-eligible children and adults except persons in ICF/ MRs and persons in DD/ MR §1915(c) waiver. The Amendment also consolidates Elderly/ Disabled, Acquired Brain Injury, and Assisted Living §1915(i) waivers into one Elderly and Disabled waiver program. Elderly and Disabled waiver program and AIDS/ HIV waiver will be incorporated into the long-term care managed care program. (Source: Medicaid.gov; DSHP Fact Sheet) Waiver Amendment Request Letter to CMS Current Approval Document Diamond State Health Plan website

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Delaware	Final rule of the Department of Health and Social Services, Division of Medicaid and Medical Assistance, amends and adopts regulations regarding the Diamond State Health Plan (DSHP) §1115 Medicaid managed care demonstration waiver. The rule expands the DSHP to include Long-Term Care Medicaid and other full-benefit dual eligible beneficiaries under the name Diamond State Health Plan Plus. The rule is effective June 10, 2012. For more information, please click here. (Source: BNA Register, 6/ 12/ 2012) **Section 1915(i) State Plan Amendment** The state plans to implement the option in FY 2013. (Source: Kaiser Commission on Medicaid and the Uninsured, April 2013)
District of Columbia	**Section 1915(i) State Plan Amendment** According to a DC official, the District is looking to develop and implement the §1915(i) State Plan option in the Affordable Care Act for its Day Treatment program, and is currently engaged in conversations with CMS technical assistance contractor to determine how the District can best use the §1915(i) option in its effort to bring Day Treatment service delivery into compliance. Target population will include older adults, adults with physical disabilities adults with mental illness, and adults with intellectual and developmental disabilities. (Source: NASUAD) **Health Homes** CMS approved planning request. (Source: Integrated Care Resource Center)
Florida	**Currently Operating Medicaid Managed LTSS Program** **Florida Long-term Care Community Diversion Program** operating under §1915(a) and §1915(c) Medicaid authorities serves Medicare-Medicaid dual eligibles of age 65 and older in 46 of 67 counties in the State. The state is currently processing applications for the remaining counties. Enrollment is voluntary with opt in. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Website on Long-term Care Community Diversion Program Approved Waiver **Projected Medicaid Managed LTSS Program & State Initiatives to Integrate Care for Dual Eligible Individuals** The Florida Agency for Health Care Administration (AHCA) recently (2/ 1/ 2013) received approval of its application for a §1915(b)(c) combination waiver from CMS to implement the long-term care component of the State Medicaid Managed Care (SMMC) Program. These simultaneous (b) & (c) waivers are effective beginning July 1, 2013, through June 30, 2016. The Agency had submitted (8/ 1/ 2011) initial §1915(b) waiver application and a concurrent initial §1915(c) waiver application to the CMS to implement the **Florida Long Term Care Managed Care program** as mandated by the 2011 Florida Legislature (House Bill 7107). The legislature required the agency to create a statewide long-term care managed care program for Medicaid recipients who are (a) 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability; and (b) determined to require nursing facility level of care. The specific authorities requested in the §1915(b) and (c) waiver applications will allow the state to require eligible Medicaid recipients to receive their nursing facility, hospice, and home and community based (HCB)

State	State Updates
Florida	services through long term care (LTC) plans selected by the state through a competitive procurement process. With the implementation of Florida Long Term Care Managed Care, five of Florida's current HCBS waivers will be phased out, and eligible recipients (older persons or adults with physical disability who meet nursing facility level of care) will receive HCBS through a the new §1915(c) Florida Long Term Care Managed Care Program waiver that will operate concurrently with the §1915(b) Florida Long Term Care Managed Care Program. The Agency has begun implementation, and must complete statewide implementation by October 1, 2013. Mandatory enrollment populations include Medicare-Medicaid dual eligibles (fee-for-service). (Source: Florida Long-term Care Managed Care Program Website; CMS and Truven Health Analytics, July 2012) Approval letter (2/ 1/ 2013) Section 1915(b) waiver application Section 1915(c) waiver application Florida Long-term Care Managed Care Program website Florida Long-Term Care Managed Care Program Overview Florida AHCA Long-term Care (LTC) Managed Care Invitation to Negotiate (ITN) Attachment D (12/ 28/ 2012) Technical Advisory Workgroup Final Report (8/ 21/ 2012) **Florida Medicaid Reform—Section 1115 Demonstration Waiver** (Approved 12/ 15/ 2011) Under Florida Medicaid Reform waiver, most Medicaid beneficiaries in five counties are required to enroll in a managed care plan (either a capitated health plan or a fee-for-service Provider Service Network plan) as a condition of eligibility for Medicaid. Participation is mandatory for TANF-related populations. Voluntary participants include individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD; dually-eligible individuals; and individuals with developmental disabilities. (Source: Medicaid.gov, Fact Sheet) Fact Sheet Current Approval Document Medicaid Reform waiver website Letter to CMS - Medicaid Managed Care Policies (10/ 13/ 2012) **Section 1915(i) State Plan Amendment** The state implemented §1915(i) State Plan Home and Community-Based Services (HCBS) benefit for delinquent youth with serious emotional disturbances and their families. The operating agency is the Department of Juvenile Justice. (Source: State Plan Amendment)
Georgia	**Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (6/ 13/ 2012) that Georgia will receive estimated $64.4 million of enhanced Medicaid funds (2% enhanced rate). Approved work plan is available here. (Source: CMS Balancing Incentive Program website) CMS Award Announcement (6/ 13/ 2012) Balancing Incentive Program Grant Application (Submitted to CMS 3/ 3/ 2012) **Medicaid & CHIP Redesign Initiative** The state commissioned a report by a consultant that recommended moving all

State	State Updates
Georgia	people in Medicaid into managed care. That would include those in nursing homes and people with disabilities, currently in a traditional fee-for-service system. The Department of Community Health, which runs Medicaid and PeachCare, expressed interest in protecting UPL in a manner similar to Texas and California, should the program be changed to "full-risk" managed care. Under UPL, the state is able to get a higher reimbursement rate (at the Medicare level) for delivering Medicaid services. Texas received a five-year waiver from the CMS to move almost one million additional Medicaid enrollees into managed care plans, while still keeping federal matching funds for hospitals. The waiver requires hospitals to increase primary care access and health quality. (Source: Kaiser Daily Health Policy Report, May 31, 2012) The full implementation of the Georgia Medicaid changes was set to start in January 2014. (Source: GeorgiaHealthNews.com, March 29, 2012). The state's Medicaid agency recently announced (6/ 4/ 2012) an updated timeline for its decision on how the health program will be restructured. Officials plan to award the vendor contract(s) in early 2013, with a projected implementation roll-out starting in the first half of 2014. (Source: Georgia Department of Community Health) State Medicaid Redesign Initiative website
Hawaii	**Currently Operating Medicaid Managed LTSS Program** The state's **QUEST Expanded (QEx) program** is a statewide §1115 demonstration waiver (approved 6/ 14/ 2012). The demonstration enables the state to operate QUEST, which provides Medicaid coverage for medical, dental, and behavioral health services through competitive managed care delivery systems. The four programs included in QEx (QUEST; QUEST-Net; QUEST-ACE; QExA) use capitated managed care as a delivery system unless otherwise noted. The **QUEST Expanded Access (QExA)** component provide acute and primary care using managed care, as well as institutional and home and community-based long-term-care services through comprehensive and specialized managed care plans to individuals eligible as ABD under the Medicaid State Plan. Enrollment is mandatory regardless of need for LTSS. (Source: Medicaid.gov; CMS and Truven Health Analytics, July 2012) Approval Document (6/ 14/ 2012) Fact Sheet Additional information Department of Human Services (DHS) requested (05/ 29/ 2012) CMS for a three-year extension of the QUEST Expanded Section 1115 demonstration program, which otherwise would expire on June 30, 2013. DHS will submit a separate proposal, with a separate notice and opportunity for comment, to amend the Demonstration to reflect new requirements in the Affordable Care Act that take effect January 1, 2014. (Source: Hawaii State Med-QUEST Division) **Governor signed a bill related to QUEST Expanded Section 1115 Demonstration Waiver** Governor Neil Abercrombie signed (7/ 3/ 2012) H.B. 2275 into law. The legislation establishes a hospital sustainability fee and the hospital sustainability program special fund to receive Medicaid matching funds under the QUEST Expanded Medicaid §1115 Demonstration Waiver. It requires the Department of Human Services (DHS) to charge and collect a provider fee on health care items or services provided by private hospitals. The law will be effective on July 1, 2012. Press Release (7/ 6/ 2012)

State	State Updates
Hawaii	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** According to a state official, the state has decided not to pursue the demonstration at least in calendar year 2014. (Source: NASUAD) Hawaii's proposed **QExA Integrated with Medicare (QExA-IM) Program** was based upon leveraging the existing QExA program model to deliver integrated care to dual eligibles (MMEs). The target population would have included the eligible MME portion of the existing QExA population, including children and adults with disabilities and the elderly, but excluding individuals enrolled in the DD/ ID §1915(c) home & community-based services (HCBS) waiver program. Adults with serious mental illness (SMI) would also have been included in the demonstration as originally proposed to CMS, but specialized behavioral health services would have remained carved out. Individuals receiving HCBS under the state's approved §1115 demonstration waiver would also have been included. Under Hawaii's original proposal, covered benefits would have included Medicaid State Plan services; Medicaid waiver services; Medicare Parts A, B & D; behavioral health; and "community-based services". Hawaii had proposed to implement the demonstration on a statewide basis utilizing passive enrollment with an opt-out. QExA health plans would receive a capitation payment for the combined Medicare and Medicaid benefit package for members enrolled in the QExA-IM. QExA health plans would also have received different capitation rates for those individuals enrolled and those not enrolled in the QExA-IM demonstration. Hawaii had originally proposed a January 2014 implementation date, but the state has now decided to withdraw that proposal and reevaluate its options. (Source: Demonstration Proposal)
Idaho	**State Demonstration to Integrate Care for Dual Eligible Individuals** **Idaho Demonstration to Integrate Care for Dual Eligibles** will replace the existing Medicare-Medicaid Coordinated Plan, which will continue to cover and coordinate Medicare and many Medicaid services through the end of 2013. Starting on January 1, 2014, the demonstration will enroll all full dual eligible ages 18 and older, including older persons, persons with physical disabilities, persons with developmental/ intellectual disabilities, and persons with severe mental illness. The new program will utilize mandatory enrollment into health plans under concurrent §1915(b)/ §1915(c) Social Security Act authority for Medicaid plan benefits, and passive enrollment with an opt-out provision for Medicare benefits. (Source: Demonstration Proposal) State Website on Integrating Care for Dual Eligibles Summary of the Idaho Initiative to Integrate Care for Dual Eligibles (10/ 10/ 2012) **Health Homes** According to the state's website on Health Homes, CMS approved the state's Health Homes State Plan Amendment, and implementation began on January 1, 2013. According to the state's Demonstration Proposal to Integrate Care for Dual Eligibles, the state has been working to create a Medicaid State Plan option to offer health homes for individuals with the following conditions: 1) A serious, persistent mental illness, or; 2) Diabetes and an additional condition, or; 3) Asthma and an additional condition. The new coordinated plans for dual eligibles will need to contract with the health homes to ensure that those benefits will be made available to all qualifying dually-eligible individuals, as they will become required Medicaid State Plan benefits. The health homes model will provide care for an individual's physical condition, and it will also provide links to long-term community care services and supports, social services, and family services. The health homes will

State	State Updates
Idaho	receive Fee for Service payments from the health plan for services rendered. The health homes will also receive per member per month payment for the coordinating and managing the Medicaid services of individuals who qualify for health homes. (Source: Demonstration Proposal to Integrate Care for Dual Eligibles) Approved Health Homes State Plan Amendment (11/ 21/ 2012) State Website on Health Homes **Section 1915(i) State Plan Amendment** CMS approved the state's §1915(i) State Plan Amendment in April 2011, and statewide implementation began July 1, 2011. Target populations include children with developmental disabilities and aged and disabled participants who meet eligibility requirements. Services include respite, habilitative supports, family education, community support services, support broker, and financial management services. (Source: Approved State Plan Amendment)
Illinois	**Currently Operating Medicaid Managed LTSS Programs** The Medicaid reform law adopted by the Illinois General Assembly in 2011, P.A. 96-1501, mandates that 50 percent of all Illinois Medicaid recipients be in coordinated care by January 1, 2015. Currently, Illinois Medicaid has two managed care programs that provide long term services and supports. The Illinois Department of Healthcare and Family Services (HFS) implemented the state's first integrated health care program, known as **Integrated Care Program (ICP)** on May 1, 2011. The program is operated by two MCOs. Eligible populations are non-Medicare-eligible older adults and adults with disabilities receiving Medicaid including all Home and Community Based Waiver enrollees. The program is mandatory and operates in the pilot areas of suburban Cook, DuPage, Kane, Kankakee, Lake and Will Counties. Service package includes Phase I (primary, acute, behavioral health substance abuse services, and pharmacy), Phase II (long-term services and supports and waiver services excluding developmentally disabled waiver services), and Phase III (developmentally disabled waiver services). Phase III is delayed until Phase II becomes operational in October 2012. (Source: State Website on Integrated Care Program) The state's second managed care program is called **Care Coordination Innovations Project**, which is projected to begin operation in January 2013 for older adults and adults with physical disabilities, and in April 2013 for children with complex needs. Managed care entity will include **Care Coordination Entity (CCE) and Managed Care Community Network (MCCN).** A **CCE** is a collaboration of providers that develop and implement a Care Coordination model that meets the state's guidelines. CCE project collaborators must include participation from hospital(s), Primary Care Providers, and mental health and substance abuse providers. CCEs use a shared-risk model for care coordination. A **Managed Care Community Network (MCCN)** is a provider sponsored organization that contracts to provide Medicaid covered services through a risk-based capitation fee. Participation in a CCE or MCCN is voluntary. (Source: State Presentation on Innovations Project, 10/ 31/ 2011) For more information on the two managed care programs, such as rollout schedule, click here. State Website on Care Coordination initiative **State Demonstration to Integrate Care for Dual Eligible Individuals**

State	State Updates
Illinois	**Illinois Medicare-Medicaid Alignment Initiative** proposes to enroll full benefit Medicare-Medicaid beneficiaries ages 21 and over in the Aged, Blind, and Disabled category of assistance in limited geographic area under capitated model. Institutional and HCBS waiver services for persons with developmental/ intellectual disabilities are carved out. Enrollment is voluntary with opt out. (Source: Demonstration Proposal; State Website on Medicare-Medicaid Alignment Initiative) CMS announced on February 22, 2013 that Illinois would be the fourth state to enter into a Memorandum of Understanding (MOU) to test a new model for Medicare-Medicaid enrollees. This MOU will allow CMS and Illinois to implement the state's Medicare-Medicaid Alignment Initiative to provide coordinated care to more than 135,000 Medicare-Medicaid enrollees in the Chicago and area and throughout central Illinois. According to the MOU, the state law requires moving 50% of all Medicaid beneficiaries from fee-for-service (FFS) to risk-based care coordination by January 2015, and the Demonstration will help support the transition. The Demonstration will begin on October 1, 2013. (Source: Centers for Medicare and Medicaid Services) Memorandum of Understanding State website on the demonstration **Health Homes** The state has submitted a draft State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013) **Balancing Incentive Program** CMS announced on June 12, 2012 that Illinois will receive an estimated $90 million in enhanced Medicaid funds (2% enhanced FMAP rate) from July 1, 2013 through September 30, 2015. (Source: CMS Balancing Incentive Program Website) BIP Application (Submitted 3/ 27/ 2013)
Indiana	**Program Initiative for Indiana Dually-Eligible Members** According to the state website on the initiative, as of August 2011 Indiana had over 125,000 fully-eligible dual members being served under traditional Fee-For-Service Medicaid. This population is not currently served within the Hoosier Healthwise and *Care Select* programs. Although Indiana has withdrawn its letter of intent for CMS Duals Demonstration, the state has been actively working to develop a program specifically designed to meet the needs of its dual population. A robust care coordination or case management component will be a fundamental part of the program. (Source: State website) According to stakeholder meeting presentation by the Office of Medicaid Policy & Planning, the demonstration is likely to be risk-based managed care model inclusive of long term care services. It is undecided whether the program will be statewide or will be pilot program in select areas, and/ or will be phase in regionally over time. At this time, the demonstration is not anticipated to include individuals enrolled in nursing homes at the time of open enrollment for the demonstration. It is also likely that Medicaid beneficiaries currently in nursing homes or being served under HCBS waivers will be not be included in the demonstration. Beneficiary Outreach begins for enrollment by December 31, 2012. The time frame to begin implementation of the new initiative is July-October, 2013. (Source: State stakeholder meeting presentation)

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Indiana	**Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (9/ 4/ 2012) that Indiana will receive estimated $78.2 million of enhanced Medicaid funds. Balancing Incentive Program application (Submitted 7/ 5/ 2012) **Section 1915(i) State Plan Amendment** In May 2012, Indiana submitted a §1915(i) State Plan Amendment aimed at assisting individuals with Serious Mental Illness (SMI) who have reached their recovery goals, yet are in need of services to continue living in the community. (Source: Balancing Incentive Program application) The state plans to implement the option in FY 2014. (Source: Kaiser Commission on Medicaid and the Uninsured, April 2013) **Health Homes** According to the state, Division of Disability and Rehabilitation Services (DDRS) is working on draft of Health Homes State Plan Amendment. The state is proposing a statewide implementation of health homes services for individuals with a co-occurring developmental disability (DD) who are at risk for developing another chronic health condition. Mental Health Stakeholders are currently developing a Health Homes proposal for SMI. (Source: State website on Health Homes) Health Homes Initiative Overview (5/ 18/ 2012) Provider Quarterly Update (1/ 22/ 2013) Draft State Plan Amendment (2/ 25/ 2013)
Iowa	**State Demonstration to Integrate Care for Dual Eligible Individuals** The demonstration will provide full benefit Medicare-Medicaid enrollees with access to comprehensive coordinated care management through a Health Homes model. Delivery system design includes the Health Homes model of care for members with chronic conditions; disease management targeting members with mental health and substance abuse service needs; and an ACO model. The demonstration will implement statewide, and reimbursement model is described as "Health Homes in a Fee-for-Service environment." Proposed implementation date is January 1, 2013. (Source: Demonstration Proposal) Target population includes members with intellectual/ developmental disabilities. (Source: NASDDDS Managed Care Tracking Report) **Health Homes** **1. Health Homes for Individuals with Chronic Conditions** The Centers for Medicare and Medicaid Services (CMS) approved (6/ 8/ 2012) Iowa's State Plan Amendment (SPA) to implement Health Homes services for members with chronic conditions. Effective July 1, 2012, qualified providers will begin to offer advanced services to members with two chronic conditions or one chronic condition and the risk of developing another. Services will include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. (Source: Integrated Care Resource Center, State-by-State Health Homes State Plan Amendment Matrix: Summary Overview, Updated June 2012; Kaiser Commission on Medicaid and the

State	State Updates
Iowa	Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, August 2012) Approved Health Homes State Plan Amendment (6/ 8/ 2012) State Website on Health Homes (for providers) **2. Integrated Health Homes for Individuals with Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)** Iowa has submitted its second Health Homes State Plan Amendment to CMS. An Integrated Health Home (IHH) is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). The Integrated Health Home will be administered by the Medicaid Behavioral Health Care Managed care Organization (Magellan Behavioral Care of Iowa) and provided by community-based Integrated Health Homes. Compared to Health Homes for Individuals with Chronic Conditions, where targeted case management provides an individual staff person to help coordinate care while an individual is receiving community-based services, an Integrated Health Home provides care coordination through a team of professionals including access to Family and Peer Support services. Adults who meet the criteria for an SMI or children who meet the criteria for an SED will be eligible for IHH. Individuals who receive both Habilitation and services through another HCBS Waiver (e.g. Intellectual Disabilities, Physical Disabilities, Brain Injury, etc.) will not be eligible and will continue to receive Targeted Case Management services. Effective July 1, 2013, the program will cover five Iowa counties, Linn, Polk, Warren, Woodbury and Dubuque (adults in Dubuque will begin IHH January 1, 2014), and the remaining Iowa counties will be phased in over the next 12 to 18 months. (Source: Integrated Health Home FAQs, Revised April 30, 2013) Integrated Health Home Informational Flyer (Revised April 18, 2013) PowerPoint Presentation "Integrated Health Homes for Medicaid Members with a Serious & Persistent Mental Illness" (April 9, 2013) **Section 1915(i) State Plan Amendment** Habilitation Services is a program to provide Home and Community Based Services (HCBS) for Iowans with impairments typically associated with chronic mental illnesses. Services include case management, home-based habilitation, day habilitation, prevocational service, and supported employment. The program was approved in 2007. Program website State Plan Amendment (04/ 16/ 2007) **Balancing Incentive Program** CMS announced (6/ 13/ 2012) that Iowa will receive estimated $61.8 million of enhanced Medicaid funds (2% enhanced rate). When approved, the state must have finalized a work plan submitted by January 1, 2013. The finalized work plan will have detailed descriptions of how the key components – NWD/ SEP, CSA, and conflict-free case management – will be operationalized through October 11, 2015. During this time, the state must also demonstrate rebalancing of community LTSS expenditures to equal or exceed the expenditures spent for institutional LTSS. (Source: Iowa Medicaid Enterprise Endeavors Update)

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Iowa	BIP application (Submitted to CMS: 4/ 30/ 2012) CMS Award Announcement (6/ 13/ 2012) IME Bureau of Long Term Care Revised Work Plan (January 2013) State Website on Balancing Incentive Program
Kansas	**Current Medicaid Managed LTSS Program** The Kansas Department of Health and Environment resubmitted (8/ 6/ 2012) its application for the **KanCare** §1115 demonstration waiver to CMS. The resubmitted application revises and builds upon the demonstration project proposal initially submitted on April 26, 2012. According to the resubmitted application, the waiver will proceed on two separate tracks. In the first track, the state will work with CMS to develop and implement by 2013 an integrated care system, "KanCare," to provide Medicaid and Children's Health Insurance Program (CHIP) services, including long term services and supports (LTSS), through managed care to all beneficiaries. In the second track, the state will begin discussions with CMS to implement a global waiver that will administer an outcome-based Medicaid and CHIP program under a per-capita block grant. Groups to be included in the program are children with disabilities, adults with physical disabilities, adults with developmental/ intellectual disabilities, and older persons ages 65 and older. Waiver authority is being sought to move all Medicaid populations into a person-centered integrated care system by January 1, 2013. (Source: Medicaid.gov; CMS and Truven Health Analytics, July 2012) Waiver Application (Submitted 8/ 6/ 2012) Kansas awarded (6/ 27/ 2012) contracts to three health insurance companies to manage its Medicaid program. KanCare will cover the medical, behavioral health, and long-term care services for all Medicaid consumers beginning January 1, 2013. Long-term services for people with developmental disabilities will be launched January 1, 2014, while pilot programs will be allowed. (Source: Press Release, 6/ 27/ 2012) Officials at the Kansas Department for Aging and Disability Services sent (8/ 15/ 2012) a memo to managers of local agencies that provide Medicaid case management services to encourage workers currently employed as case managers for physically disabled and elderly Medicaid enrollees to apply for similar jobs with the three insurance companies chosen to implement KanCare. (Source: Kansas Health Institute News, 8/ 17/ 2012) CMS approved KanCare on December 27, 2012, and the implementation began on January 1, 2013. Approved Application (12/ 27/ 2012) **Health Homes** Health Homes is one of components built in KanCare §1115 demonstration waiver. According to the waiver application, the state intends to implement health homes through managed care companies by the end of 2013 for people with severe and persistent mental illness, diabetes, or both, and by the end of 2014, all beneficiaries with complex needs will have a health homes. The state will work with the CMS Health Homes team to prepare a related State Plan Amendment, which is expected to be submitted in July 2013. The state plans to implement health homes starting January 1, 2014. For more information, please visit state website on health homes. (Source: KanCare Section 1115 demonstration waiver application; state website on health homes)

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Louisiana	**Section 1915(k) Community First Choice Option** The Department of Health and Hospitals Bureau of Health Services Financing and Office of Aging and Adult Services propose to replace the current Long-Term Personal Care Services (LT-PCS) Program by adopting provisions to establish Community First Choice Option services as a covered service under the Medicaid State Plan. The LT-PCS Program shall be terminated upon the Centers for Medicare and Medicaid Services' approval of the corresponding Community First Choice Option (CFCO) State Plan Amendment. (Source: Louisiana Register, Louisiana Register Vol. 38, No.6, June 20, 2012) Notice of Intent (Louisiana Register, 6/ 20/ 2012) **Section 1915(i) State Plan Amendment** The Department of Health and Hospitals submitted (3/ 10/ 2011) §1915(i) State Plan Amendment to the CMS with effective date of January 1, 2012. The covered service is Adult Behavioral Health Services concurrent with the Behavioral Health §1915(b) waiver under a capitated contract reimbursement methodology. The operating agency is Office of Behavioral Health (OBH) within Department of Health and Hospitals (DHH). The §1915(i) State Plan HCBS benefit targets the following populations: Persons with **Acute Stabilization Needs** (ASN), persons with **serious mental illness** (SMI) persons with **major mental disorder** (MMD), and persons who previously met any of the above and subsequently need medically necessary services for stabilization and maintenance. (Source: State Plan Amendment) State information on §1915 (i) program On March 2012, the fee-for-service mental health rehabilitation services program was transitioned to the Louisiana Behavioral Health Partnership managed by a Statewide Management Organization (SMO). (Source: State website) State Information on Louisiana Behavioral Health Partnership **Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (3/ 15/ 2013) that Louisiana will receive an estimated $69.25 million in enhanced Medicaid funds (2% enhanced FMAP rate). (Source: Balancing Incentive Program Award Letter, 3/ 15/ 2013) BIP Application (2/ 8/ 2013) BIP Award Letter (3/ 15/ 2013)
Maine	**Health Homes** The state's Health Homes State Plan Amendment has received approval from CMS. (Source: CMS Website) Approved Health Homes State Plan Amendment (1/ 22/ 2013) **Balancing Incentive Program** CMS announced on June 12, 2012 that Maine will receive an estimated $21 million in enhanced Medicaid funds. (Source: CMS Balancing Incentive Program Website) BIP Application (Submitted 5/ 1/ 2013)
Maryland **Maryland**	**Balancing Incentive Program** Maryland is the second state (after New Hampshire) to be awarded Balancing Incentive Program (BIP) funding. CMS has awarded the Maryland Department of

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	Health & Mental Hygiene $106.34 million through September 2015. Maryland's approved work plan is available here. (Source: CMS Balancing Incentive Program website) BIP application (2/ 10/ 2012) Award Letter (3/ 20/ 2012) **Section 1915(k) Community First Choice Option** According to information provided by the state, the Department of Health and Mental Hygiene plans to include all required and optional services allowed under proposed federal regulations. These services are Personal/ Attendant Care, Personal Emergency Response Systems (PERS), Voluntary training for participants, Transition Services, and Services that increase independence or substitute for human assistance. Following approval from CMS, the state would implement CFCO in January 2014. (Source: CFC Meeting Notes, 1/10/2013) State Website on Community First Choice Option Presentation by CFC Implementation Council Meeting (January 2012) **Section 1915(i) State Plan Amendment** The state's §1915(i) State Plan Amendment targets community Medicaid-eligible children (youth must continue to meet community Medicaid eligibility while enrolled in the 1915(i)). The state submitted the application in 2012. The state plans to implement the option in FY 2013. (Source: Maryland's Development of a §1915(i) State Plan Amendment for Children (6/ 13/ 2012); Kaiser Commission on Medicaid and the Uninsured, April 2013) **Health Homes** The state has submitted a draft Health Homes State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013)
Massachusetts	**Currently Operating Medicaid Managed LTSS Program** **Massachusetts Senior Care Options** provides eligible adults of age 65 and older primary, acute, behavioral, prescription drugs, and LTSS in capitated rate. LTSS include nursing facility, adult foster care, group adult foster care, adult day health, and other community-based LTSS. Enrollment is voluntary, and the program covers most part of the state. The program operates under Medicaid §1915(a) and §1915(c) authorities. (Source: CMS and Truven Health Analytics, July 2012) State Website on Senior Care Options **State Demonstration to Integrate Care for Dual Eligible Individuals** (Approved 8/ 23/ 2012) State Demonstration to Integrate Care for Dual Eligible Individuals is projected to cover full dual eligibles of ages 21-64. The proposal currently carves out ICF/ MR services, HCBS waiver services for persons with developmental disabilities, and HCBS waiver services for persons with brain injury. (Source: CMS and Truven Health Analytics, July 2012) There will be intersection of the I/ DD population with acute and behavioral health care needs. (Source: NASDDDS Managed Care Tracking Report)
Massachusetts	CMS announced on August 23, 2012 that Massachusetts would be the first state to enter into a Memorandum of Understanding (MOU) to test a new model for

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	Medicare-Medicaid enrollees. This MOU will allow CMS and Massachusetts to contract with an integrated care organization to oversee the care of 110,000 Massachusetts residents who are enrolled in both Medicare and Medicaid. (Source: Centers for Medicare and Medicaid Services) The state and CMS initially planned to implement the demonstration statewide beginning April 1, 2013; however, the state and CMS subsequently agreed to postpone the implementation until July 1, 2013. (Source: CMS Press Release, 8/ 23/ 2012; Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: California, Illinois, Massachusetts, Ohio, and Washington, Kaiser Commission on Medicaid and the Uninsured, May 2013) Memorandum of Understanding State website on the demonstration Duals Demonstration Timeline **Health Homes** The state has submitted draft Health Homes State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013)
Michigan	**Currently Operating Medicaid Managed LTSS Program** Under §1915(b) and §1915(c), **Medicaid Managed Specialty Support & Services Program** provides behavioral service and LTSS in capitated rate to adults with intellectual/ developmental disabilities, adults with serious mental illness (SMI), children with intellectual/ developmental disabilities, as well as children with serious emotional disturbance. LTSS includes nursing facility, ICF/ MR, personal care services, targeted case management, and HCBS waiver services for persons with developmental disabilities. Enrollment is mandatory. (Source: CMS and Truven Health Analytics, July 2012) **State Demonstration to Integrate Care for Dual Eligible Individuals** Projected to begin in 2013, **Michigan Integrated Care for People who are Medicare-Medicaid-Eligible** will cover all dual eligibles, including children with disabilities, adults with physical disabilities, adults with developmental/ intellectual disabilities, adults with serious mental illness (SMI), and older persons of age 65 and older. Enrollment is voluntary with opt out. (Source: CMS and Truven Health Analytics, July 2012) While already existing pre-paid inpatient health plans (PIHPs) will remain in place, if individuals with I/ DD opt out of the demonstration, they will not receive the enhanced care coordination and linkages with acute care envisioned in the demonstration. (Source: NASDDDS Managed Care Tracking Report) The demonstration will use a capitated payment model. (Source: Demonstration Proposal) Although Michigan's original plan was to implement the program statewide, the state has decided to go with a regionalized approach instead. The state aims to implement the program in January 2014 in four selected regions, with outreach, education, and enrollment starting in October 2013. (Source: Press Release, State of Michigan Department of Community Health, 1/17/2013) Program Website **Health Homes** According to the state's proposal for duals demonstration, the state is working to develop the health homes concept with Prepaid Inpatient Health Plans (PIHPs), the entities that currently deliver Medicaid behavioral health and developmental disabilities benefit in the state. The state anticipates that health homes will be part
Michigan	

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	of the services delivery model. For persons who have an intellectual/ developmental disability and those with serious mental illness or substance use disorder, the supports coordinator within the PIHP will be responsible for leading other members of the participant's care team across the delivery system to ensure integration of physical and behavioral health care. PIHPs will be required to deliver all supports and services in the least restrictive setting, to use person-centered planning and to make self-determination arrangements readily available. (Source: Demonstration Proposal) State Resource on Health Homes
Minnesota	**Currently Operating Medicaid Managed LTSS Program** Under Medicaid authority §1915(b) and §1915(c), **Minnesota Senior Care Plus** has provided primary, acute, behavioral, prescription drugs services and LTSS in capitated rate to older adults of age 65 and over. Enrollment is mandatory, while duals can choose **Minnesota Senior Health Options** (MSHO). **Minnesota Senior Health Options** (MSHO) provides the same services as Minnesota Senior Care Plus does to adults of age 65 and older who are eligible for both Medicaid and Medicare Parts A and B. Enrollment is voluntary with opt in. MSHO operates under §1915(a) and §1915(c). (Source: CMS and Truven Health Analytics, July 2012) State Website on Senior Care Plus State Website on Senior Health Options **Reform 2020 Draft Section 1115 Waiver Proposal** The 2011 Minnesota Legislature directed the Department of Human Services (DHS) to develop a proposal to reform the Medical Assistance Program. Goals of the reform include: community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs. (Source: State Register notice, page 1580, June 18, 2012) According CMS, the state submitted (8/ 24/ 2012) the waiver application. After preliminary review of the application, however, CMS determined that the application did not meet the requirements for a complete application. The state recently resubmitted (11/ 21/ 2012) the application to CMS. (Source: Medicaid.gov) Reform 2020 Section 1115 Demonstration Application (Draft) Reform 2020 Section 1115 Demonstration Application (Resubmitted 11/ 21/ 2012) State Website on Reform 2020 Section 1115 Waiver **Minnesota Long Term Care Realignment Section 1115 Demonstration Waiver** (Pending as of 7/ 9/ 2013; Submitted 2/ 13/ 2012 and 11/ 21/ 2012) Minnesota has proposed to Minnesota Long Term Care Realignment §1115 Waiver to revise its nursing facility level of care criteria (LOC) up from its current minimum of one ADL or IADL, with additional changes to LOC criteria regarding clinical need, cognition/ behavior and frailty/ vulnerability. This will impact not only eligibility for nursing facilities, but also for three of the state's §1915(c) Home and Community-Based Services (HCBS) waivers: Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), and Elderly Waiver (EW). The state is also requesting Federal Financial Participation (FFP) for two limited benefit HCBS programs: Alternative Care Program (AC) and Essential Community Supports (ECS). AC serves individuals age 65 and older who meet the LOC criteria but whose income exceeds Medicaid standards, while ECS will serve individuals who do not meet the revised LOC criteria regardless of whether or not their income
Minnesota	

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Minnesota	meets Medicaid standards. (Source: Medicaid.gov) According to state officials, under Minnesota Long Term Care Realignment §1115 Waiver, the state proposes to implement §1915(i) State Plan Amendment ~~and Community First Choice under Section 1915(k)~~. Populations currently under consideration for inclusion in §1915(i) are persons with autism, adults with mental illness, and children with mental illness. (Source: Waiver Application,11/ 21/ 2012) State Website on Long-Term Care Realignment Section 1115 Waiver **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** The state has decided (6/ 29/ 2012) not to pursue financial alignment demonstration, noting that Medicare financing under the financial alignment demonstration model would result in a significantly lower payment than Minnesota receives for senior Medicare beneficiaries in current programs. (Source: State Website on the demonstration) In the demonstration proposal, the first phase of the demonstration was going to include all full benefit dually-eligible seniors 65 and over who qualify for Medicaid managed care enrollment and are enrolled in or choose to enroll in Minnesota Senior Health Options (MSHO) and Minnesota SeniorCare Plus (MSC+). The second phase of the demonstration would include dually-eligible people with disabilities of age 18-64 now enrolled in Special Needs BasicCare (SNBC). Implementation would be statewide for seniors, and statewide contingent on further negotiations with CMS for people with disabilities. Seniors would receive LTSS including Elderly Waiver, §1915 (c) and all Medicaid PCA and Home Health under capitated model. Partial nursing facility (NF) services would also be included. People with disabilities would receive partial NF and LTSS (Personal Care Assistance, Private Duty Nursing, Community Alternative Care, Community Alternatives for Disabled Individuals, Brain Injury, Intellectual and Developmental Disabilities §1915(c) waivers under fee-for-service model. (Source: Demonstration Proposal) State website on the demonstration **State Initiative to Integrate Care for Dual Eligible Individuals** Minnesota Department of Human Services, Health Care and Continuing Care Administrations recently released (1/ 22/ 2013) Notice of Request for Public Input on its website for Demonstration to Integrate Care for Dual Eligibles. The purpose is to identify best practices for development of Integrated Care System Partnerships (ICSPs) between managed care organizations and primary, acute, long-term care and mental health providers serving seniors and people with disabilities under managed care programs. The ICSPs are especially for seniors and people with disabilities eligible for Medicare and Medicaid (dual eligible), including Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs BasicCare (SNBC). (Source: State Website) State Register, Vol. 37, No. 30 (1/ 22/ 2013) **Section 1915(i) State Plan Amendment** According to state officials, under Minnesota Long Term Care Realignment §1115 Waiver, the state proposes to implement §1915(i) State Plan Amendment and Community First Choice under §1915(k). Populations currently under consideration for inclusion in §1915(i) are persons with autism, adults with mental illness, and children with mental illness. (Source: Waiver Application; NASUAD) The state plans to implement the option in FY 2014. (Source: Kaiser Commission on Medicaid and the Uninsured, April 2013)

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Mississippi	**Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (6/ 13/ 2012) that Mississippi will receive an estimated $68.5 million in enhanced Medicaid funds (5% enhanced FMAP rate). (Source: CMS Balancing Incentive Program website) The state's work plan has been approved. (Source: Mission Analytics Group, The Balancing Incentive Program Newsletter, Issue No.4., 2/ 4/ 2013) CMS Award Announcement (6/ 13/ 2012) BIP application (Submitted to CMS 5/ 1/ 2012) **Health Homes** CMS approved planning request. (Source: Integrated Care Resource Center)
Missouri	**State Demonstration to Integrate Care for Dual Eligible Individuals** Under this demonstration, Missouri proposes that Medicare agree to share with the state savings that Medicare realizes from Missouri's two Health Homes programs. For more information on Health Homes, see below. Proposed financing model is managed fee-for-service. (Source: Demonstration Proposal) **Health Homes** The State of Missouri MO HealthNet Division (MHD) received approval from the CMS to implement two Health Homes programs under §2703 of the Affordable Care Act (ACA). Implemented in January 2012 statewide, the Health Homes programs provide care coordination services to eligible Medicaid beneficiaries that meet the program criteria, including those beneficiaries who are dually-eligible for Medicare and Medicaid. The first approved program, Missouri Community Mental Health Center Health Homes State Plan Amendment (approved 10/ 20/ 2011) program targets Medicaid beneficiaries with (1) serious and persistent mental health condition, or (2) a mental health or substance abuse condition and another chronic condition or a risk of developing another due to tobacco use. The second approved program, Missouri Primary Care Practice Health Homes (PCP-HH) Clinic – State Plan Amendment (approved 12/ 22/ 2011) program targets Medicaid beneficiaries who have two or more chronic physical conditions or with one chronic condition and are at risk of developing another. (Source: Demonstration Proposal) Missouri Community Mental Health Center Health Homes SPA (approved) Missouri Primary Care Practice Health Homes (PCP-HH) Clinic SPA (approved) **Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (6/ 13/ 2012) that Missouri will receive an estimated $100.9 million of enhanced Medicaid funds (2% enhanced FMAP rate). Approved work plan is available here. (Source: CMS Balancing Incentive Program website) CMS Award Announcement (6/ 13/ 2012) BIP application (Submitted to CMS 3/ 28/ 2012)
Montana **Montana**	**Section 1915(i) State Plan option** The state's Department of Public Health and Human Services submitted a §1915(i) Home and Community Based Service (HCBS) State Plan Amendment to CMS in

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	2012 in order to establish a §1915(i) HCBS State Plan program of Medicaid-funded home and community services for **youth who have serious emotional disturbance**. CMS approved the SPA effective January 1, 2013. The program is called "Montana i-home". The purpose of this program is to provide mental health services to qualifying youth in the community setting. The §1915(i) HCBS State Plan option does not require eligible youth to meet the institutional level of care that is required under a §1915(c) HCBS waiver. (Source: §1915(i) HCBS State Plan Program Policy Manual (1/ 1/ 2013); Montana i-home website) Montana Health Care Programs Notice (1/ 11/ 2013) **Section 1915(k) Community First Choice** The state is currently considering pursuing the option. The Governor's budget proposal includes a request from Senior & Long Term Care Division (NP 22222) for $17 million in federal spending authority to be used to refinance and enhance Montana's system of Medicaid-funded in-home personal assistance services. Pursuing the option was also discussed recently at the Senior & Long Term Care budget hearing. (Source: Montana Department of Public Health & Human Services, January 2013 Minutes, 1/ 29/ 2013) Community First Choice: A Federal Initiative to Support Community Based Services, 1/ 10/ 2013 (Webinar)
Nevada	**Section 1915(i) State Plan Amendment** Home Based Habilitation Services (HBHS) is an optional Medicaid State Plan service authorized under State Plan authority titled Nevada §1915(i) State Plan Home and Community-Based Services (HCBS). The State Plan was amended in 2008 in response to the Deficit Reduction Act, Section 6086. Home Based Habilitation Services (HBHS) are medically prescribed treatment for improving or restoring functions, which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury. Services include Home and Community Based (HCBS) Adult Day Health Care, Habilitation, and Home and Community Based Services (HCBS) Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness. State Plan Amendment Medicaid Services Manual (updated 02/ 15/ 2012) **Health Homes** CMS approved planning request. (Source: Integrated Care Resource Center)
New Hampshire **New Hampshire**	**Medicaid Managed LTSS Program** (Approved 8/ 24/ 2012) & **State Initiative to Integrate Care for Dual Eligible Individuals** As required in Senate Bill 147 passed by the New Hampshire Legislature on June 2, 2011, the Department of Health and Human Services Department submitted (3/ 31/ 2012) State Plan Amendment to the CMS through the §1932(a) State Plan option for authorization of the implementation of a state wide managed care delivery system, called **New Hampshire Medicaid Care Management Program.** On May 9, 2012, members of the governor's Executive Council approved a $2.3 billion contract establishing a managed care system for Medicaid recipients. CMS approved (8/ 24/ 2012) the State Plan Amendment. The state plans to launch the new care management system in three phases over the

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	course of three years. In Phase 1, all Medicaid patients in the state would be required to enroll in one of the new care management plans offered by the MCOs. Beneficiaries eligible for both Medicare and Medicaid would have the option to opt out during Phase 1. For more information for populations served by the program, click here. LTSS would be added in Phase 2, currently estimated to begin January, 2014. Groups that the state proposes to enroll by January 1, 2014 include children with physical, cognitive, or behavioral disabilities, adults with physical disabilities, adults with developmental/ intellectual disabilities, and older persons. Enrollment would be mandatory. In the last phase, the program would include those newly eligible for Medicaid benefits by virtue of the Affordable Care Act. One percent of each Medicaid enrollee's capitated payment would be withheld by the state and repaid to the MCOs only if they satisfy performance measures. (Source: Care Management Program Website; CMS and Truven Health Analytics, July 2012) Care Management Program Website Care Management State Plan Amendment (3/ 30/ 2012) Approval Letter from CMS (8/ 24/ 2012) DHHS Medicaid Care Management Info Meeting Final Report (August 2012) January 2013 Update on Care Management (1/ 24/ 2013) **Balancing Incentive Program** New Hampshire is the first state to apply for and to receive CMS approval for Balancing Incentive Program. CMS has awarded the state $26.5 million in enhanced Medicaid funds. (Source: Award Letter, 3/ 1/ 2012) Approved work plan is available here. (Source: CMS Balancing Incentive Program website) BIP application (12/ 30/ 2011)
New Jersey	**Medicaid Managed LTSS Program** (Approved 10/ 2/ 2012) & **State Initiative to Integrate Care for Dual Eligible Individuals** **New Jersey 1115 Comprehensive Waiver** (Approved 10/ 2/ 2012; Submitted 9/ 9/ 2011) seeks to provide State Plan benefits as well as long-term care services and supports to Medicaid and CHIP beneficiaries. The §1115 demonstration waiver combines authority for several existing Medicaid and CHIP waiver and demonstration programs, including two §1915(b) managed care waiver programs; a Title XIX Medicaid and a Title XXI CHIP §1115 demonstration waiver and four §1915(c) HCBS waiver programs. **The first phase** includes the non-dual population of aged, blind and disabled Medicaid beneficiaries, populations served by the Department of Developmental Disabilities (DDD) including Community Care Waiver clients, clients already covered by a commercial or Medicare HMO, and breast or cervical cancer clients. **The second stage** includes all dual eligibles, an increased range of waiver clients, clients with traumatic brain injury, and those clients participating in the AIDS Community Care Alternatives Program and Community Resources for People with Disabilities. (Source: Waiver Application) Comprehensive Medicaid Waiver Website Waiver Application (9/ 9/ 2011) Approval Letter (10/ 2/ 2012) Recommendations by workgroup According to a state official, the state proposed to add nursing home and HCBS to Managed Care contracts for Medicaid-eligible individuals who meet a NF level of care. The state also worked with CMS on Special Terms and Conditions and Budget Neutrality. (Source: NASUAD Membership Meeting, 9/ 9/ 2012)
New Jersey	According to Press Release (10/ 4/ 2012) from the state Department of Human

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	Services, some of reform proposals in the application were denied by CMS, including the following: the State's request to no longer provide retroactive Medicaid eligibility for applicants; consolidation of all nine state waivers into one, and the state's appeal for an estimated $107 million in Medicare Part B retro payment for Medicare services erroneously billed to Medicaid. The federal government also determined that approval of future programmatic changes and that the Community Care Waiver will remain outside the comprehensive waiver. (Source: Press Release, State of New Jersey Department of Human Services, 10/ 4/ 2012) **Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) recently approved (3/ 15/ 2013) New Jersey's Balancing Incentive Program Application. (Source: CMS Website) BIP Application (12/ 20/ 2012) **Health Homes** CMS approved planning request. (Source: Integrated Care Resource Center)
New Mexico	**Currently Operating Medicaid Managed LTSS Program** Since 2008, **Coordination of Long-Term Services** (CoLTS) has provided LTSS to children with LTSS needs, adults less than age 65 with physical disabilities, and adults of age 65 and older through State Plan Personal Care Options and §1915(c) HCBS waivers. The state is currently seeking to merge CoLTS with Salud! (Medicaid managed care for other populations) and the state's behavioral health carve out plan via a §1115 demonstration waiver. (Source: CMS and Truven Health Analytics, July 2012) State Resource on Coordination of Long-Term Services (CoLTS) **Projected Medicaid Managed LTSS Program** New Mexico submitted (8/ 17/ 2012) a §1115 Medicaid demonstration proposal entitled **Centennial Care**. According to information provided by the state, Centennial Care proposes to create a comprehensive managed care delivery system in New Mexico under which contracted health plans will offer the full array of current Medicaid services, including acute, behavioral health, home and community based and long term institutional care. This proposal would combine existing §1915(b), §1915(c), and §1115 waivers under a comprehensive demonstration project. Waiver application (Submitted 8/ 17/ 2012) State Website on Centennial Care Centennial Care Concept Paper Proposed rule of the Human Services Department, Medical Assistance Division, amends regulations to align the Behavioral Health Collaborative standards with the health services delivery model of New Mexico Centennial Care. The rule allows for multiple providers of behavioral health services instead of a single statewide behavioral health provider. For more information, please click here. (Source: BNA's State Health Care Regulatory Developments, 9/ 18/ 2012) To check on the program's most recent progress, click here.
New Mexico	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)**

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	Department of Human Services submitted (8/ 7/ 2012) a letter to CMS withdrawing the state's previous proposal seeking permission to conduct this demonstration. In the demonstration proposal submitted on May 31, 2012, the state had proposed that dually-eligible individuals receiving services through the New Mexico Developmental Disabilities waiver would receive their regular medical benefits through the demonstration, but that their long-term care services would remain carved out of managed care and paid through a fee-for-service arrangement. Demonstration Proposal Letter to CMS to notify withdrawal (8/ 17/ 2012) **Health Homes** New Mexico seeks to establish health homes as an integral step in the integration of care under the §1115 demonstration waiver. The state is currently working with a 2703 planning grant to design its first SPA to establish health homes throughout the state that address recipients with a behavioral health condition. It is the state's intent to develop health homes in Core Service Agencies (CSAs) statewide. This model for behavioral health homes (BHH) is being designed in conjunction with the MCOs under Centennial Care. Once a recipient is enrolled in a BHH, the responsibility for both care management and care coordination is delegated by the MCO to the BHH. Over time, the state intends to establish health homes for other chronic conditions through the SPA process. The state will work to closely coordinate the health homes model(s) with Centennial Care to ensure the integration of care is achieved at all levels. (Source: Centennical Care Section 1115 Demonstration Waiver Application)
New York	**Currently Operating Medicaid Managed LTSS Program** **New York Medicaid Advantage Plus (MAP)**, operating under Medicaid § 1915(a), provides LTSS in capitated rate to adults age 18-64 with physical disabilities and adults of age 65 and older. Enrollment is voluntary with opt in. (Source: CMS and Truven Health Analytics, July 2012) **Partnership Plan Waiver & Federal-State Health Reform Partnership (F-SHRP) waiver** In 1997, the state received approval from the federal government of its first § 1115 demonstration waiver known as the **Partnership Plan**. Since the original approval and subsequent Amendments, the Partnership Plan Demonstration currently consists of four major program components: **1. Medicaid Managed Care** providing Medicaid State Plan benefits through comprehensive MCOs to most recipients eligible under the State Medicaid Plan; **2. Family Health Plus** providing a more limited benefit package, with cost-sharing imposed, for adults with and without children with specified income; **3. Family Planning Benefit Program** serves men and women who are otherwise not eligible for Medicaid but are in need of family planning services who have net incomes at or below 200 percent of the federal poverty level (FPL) and to women who lose Medicaid eligibility at the end of their 60-day postpartum period; and **4. Home and Community-Based Services Expansion** providing an expansion of three §1915(c) waiver programs by eliminating a barrier to financial eligibility to receive care at home. The Partnership Plan Demonstration operates separately from, and complements, New York's Federal-State Health Reform Partnership (F-SHRP) §1115 Demonstration.

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New York	**New York Federal-State Health Reform Partnership (F-SHRP)** was the state's second demonstration waiver approved by CMS. The demonstration provides federal financial support for a health reform program in New York that addresses the state's need to modernize its acute and long-term care infrastructure, increase capacity in primary and ambulatory care, and make investments in health information technology. The demonstration also allows the state to enroll certain Medicaid populations into managed care on a mandatory basis: aged, blind and disabled individuals statewide, and children, caretaker relatives, and pregnant women in selected counties. (Source: Medicaid.gov) State Website on Partnership Plan Waiver (corrected link) State Website on Federal-State Health Reform Partnership Fact Sheet on F-SHRP CMS approved (8/ 31/ 2012) the state's recent application for Amendments to Partnership Plan and F-SHRP. Click here to see approval letter. The state requested (10/ 31/ 2012) the federal government for extension of Partnership Plan beyond its current 12/ 31/ 2014 expiration date to 12/ 31/ 2017. The application for extension includes an interim evaluation of the Partnership Plan. **Medicaid Redesign Team (MRT) Waiver** The MRT waiver is an Amendment to the state's existing §1115 Demonstration waiver, Partnership Plan. The state recently submitted (8/ 6/ 2012) Medicaid Redesign Team (MRT) waiver, which will allow the state to invest up to $10 billion of $17.1 billion in federal savings generated by the Medicaid Redesign Team (MRT) reforms over a five-year period. The MRT waiver Amendment will be restricted to the portion of the Medicaid program controlled by the Department of Health. Specifically excluded from the 1115 waiver Amendment are those Medicaid services provided through waivers administered by the Office for People with Developmental Disabilities (OPWDD). The state is currently pursuing a different waiver agreement that will encompass services/ waivers that relate to people with developmental disabilities. Both this waiver and the OPWDD waiver will rely on care management as the primary method for driving change and innovation. More information on the Medicaid 1115 waiver is available at State Website on Medicaid Redesign. (Source: Medicaid Redesign Team (MRT) waiver application) Medicaid Redesign Multi-year Action Plan **State Demonstration to Integrate Care for Dual Eligible Individuals** The state initially proposed to integrate care for the dually-eligible population through two models: (1) Managed Care Model (Fully-Integrated Duals Advantage; FIDA), and (2) Managed Fee-for-Service Model (Health Homes). However, in a letter sent on March 21, 2013, the state notified CMS of its withdrawal of the Managed Fee-for-Service model. According to the state's original demonstration proposal, the now withdrawn Managed Fee-for-Service (FFS) Health Homes program would have provided care coordination for a dually-eligible population with complex medical, behavioral, social service and long term care needs requiring less than 120 days of long term care services. According to the letter to CMS, the state will keep its commitment to enroll qualifying dually-eligible members in its health home program (Please refer to Health Homes section for more information). Such change does not affect the Managed Care financial model in the demonstration. Built off the State's **Medicaid Advantage Plus** program, **Fully-**
New York	

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New York	**Integrated Duals Advantage (FIDA)** program would cover full dual eligibles (age 21 or older) who require 120 or more days of Long-Term Supports and Services (LTSS). Starting January 2014, these individuals would be provided the entire range of Medicare and Medicaid services as well as an extensive list of LTSS many of which were previously only available in New York State's Home and Community-Based Services Waiver programs. The FIDA program would serve eight NY counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. Full dual eligibles (age 21 or older) who are receiving services through the Office of Persons with Developmental Disabilities (OPWDD) system will be served under **FIDA OPWDD** statewide. The FIDA OPWDD program will include only developmental disabilities waiver services and ICF/ MR services. (Source: CMS and Truven Health Analytics, July 2012; New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals) **Health Homes** New York Health Homes State Plan Amendment for Individuals with Chronic Behavioral and Mental Health Conditions (approved 2/ 3/ 2012) targets Medicaid enrollees with two or more chronic conditions; or HIV/ AIDS and a risk of developing another chronic condition; or one serious mental illness. The initiative does not include those receiving long-term care and those with intellectual disabilities, and the state intends to seek approval of a separate health homes SPA that will specifically target these populations. Enrollment began in February 2012. (Source: State Website on Health Homes) Approved State Plan Amendment (2/ 3/ 2012) State Website on Medicaid Health Homes (April 2012) State Website on Medicaid Health Homes (November 2012) **New York State Medicaid Director Testified before the U.S. Senate on its Medicaid Redesign and Duals Demonstration** (7/ 18/ 2012) Complete Testimony **Projected Medicaid Managed LTSS Program** Medicaid Redesign Team Proposal #90 and 2011 budget legislation requires the transition and enrollment of certain community-based long term care services recipients into **Managed Long-Term Care Plans (MLTCPs) or Care Coordination Models (CCMs)**. New York State currently operates three models of MLTCP: the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Advantage Plus (MAP); and partially capitated managed long-term care plans. Currently there are no CCMs established. All models provide community-based long term care services, nursing home care and many ancillary services, including individualized care management. During July 2012, the Department received verbal approval from the Centers for Medicare and Medicaid Services (CMS) to initiate mail distribution of mandatory enrollment notifications. These notifications, alerting current members that they must choose a plan to continue receiving community based long-term care services, are being rolled out in New York City using a phased approach by borough and zip code. On August 31, 2012, the Department received written approval from CMS to proceed with auto-assignment of members into partial capitated managed long term care plans in New York City. The mandatory enrollment initiative will continue within the five boroughs of New York City until all eligible cases are transitioned. In January 2013, the initiative will move to Nassau, Suffolk and Westchester counties. (Source: State Medicaid Update,

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	September 2012) State Website on Managed Long Term Care/ Care Coordination Model **Projected Medicaid Managed LTSS Program** **New York People First Waiver** (Pending as of 7/ 9/ 2013)**:** The target population for the People First Waiver is Medicaid enrollees of all ages with developmental disabilities. The state proposes to develop and implement creative service delivery and payment models that integrate acute and long-term care to achieve improved health outcomes and quality of care while lowering health care costs for the developmentally disabled population. (Source: Medicaid.gov) Mandatory services provided in capitation rate will include (1) family and individual support, integration and community habilitation, flexible goods and services, home and community-based clinical and behavioral supports; (2) Adult Day Health Care; (3) Assisted Living Facility; (4) Home Care (Nursing, Home Health Aide, PT, OT, SP, Medical Social Services); (5) ICF/ MR; and (6) Skilled Nursing Facility. Pilot projects are projected to begin in October 1, 2012. Statewide launch of partial and fully capitated DISCOs begins in Summer 2015. (Source: New York's Response to Centers for Medicare & Medicaid Services' Request for Additional Information, April 2012) Enrollment is voluntary in pilot phase, and becomes mandatory when fully implemented. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Website on New York People First Waiver New York's Response to CMS' Request for Additional Information (April 2012) **Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (3/ 15/ 2013) that New York will receive an estimated $598.7 million in enhanced Medicaid funds (2% enhanced FMAP rate). (Source: State Website) BIP Application (12/ 20/ 2012) Revised BIP Application (2/ 26/ 2013) BIP Award Letter (3/ 15/ 2013) **Section 1915(k) Community First Choice Option** The state's Community First Choice Options Development and Implementation Council has been holding meetings to discuss the state's proposed application / implementation of the option. (Source: State Website on CFCO)
North Carolina **North Carolina**	**Currently Operating Medicaid Managed LTSS Program** **MH/DD/SAS Health Plan Waiver** (formerly Piedmont Cardinal Health Plan – Innovations (PCHP)), under §1915(a) authority, began operating in 2005 as a five-county pilot, and is scheduled to become statewide in 2013. The program targets Children and adults of all ages with serious emotional disturbance, developmental disabilities, mental illness, or substance abuse disorders. Services provided in capitated rate are inpatient and outpatient behavioral health (mental health and substance abuse), including enhanced community services, Psychiatric Residential Treatment Facilities (PRTFs), Emergency Room visits for behavioral health treatment, and LTSS (ICF/ MR, HCBS waiver services for persons with developmental and intellectual disabilities, Therapeutic Foster Care (TFC), Residential Child Care). (Source: CMS and Truven Health Analytics, July 2012)

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North Carolina	State Website on MH/ DD/ SAS Health Plan Waiver **State Demonstration to Integrate Care for Dual Eligible Individuals** The state's demonstration targets full benefit dually-eligible beneficiaries, age 21 and older. It does not include individuals with mental health, intellectual/ developmental disabilities, and substance abuse needs receiving services under Medicaid Prepaid Inpatient Health Plan (PHIP)/ §1915(b)/ (c) Medicaid Waiver. It will implement statewide using a managed fee-for-service reimbursement model. (Source: Demonstration Proposal; State Website on Duals Demonstration) **Section 1915(i) State Plan Amendment** The state has submitted two §1915 (i) State Plan Amendments. The first program proposes to provide Personal Assistance Services, which consists of assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for three distinct target populations: individuals with physical disabilities; adults with a diagnosis of mental illness, mental retardation/ developmental disability, or dementia; and elderly individuals with functional disabilities. The Consolidated Personal Care Services (PCS) program is designed to provide personal care services to individuals residing in a private living arrangement, or a residential facility licensed by the State of North Carolina as an adult care home, or a combination home as defined in G.S. 131E-101(1a).G.S. 131E-101(1a); or resides in a group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency. Effective date is January 1, 2013. (Source: North Carolina Department of Health and Human Services) State Plan Amendment (Submitted 04/ 30/ 2012) Consolidated Personal Care Services (PCS) state website The second program, titled "Alzheimer's and Dementia Services," proposes to target Medicaid eligible individuals of 21 years or older with one of the following primary diagnoses: Alzheimer's Disease, Vascular Dementia, Dementia with Lewy Bodies, Pick's Disease, Parkinson's Disease, Creutzfeldt-Jakob Disease, or Huntington's Disease. The benefit consists of hands-on, supervision, set-up, and cueing assistance with qualifying ADLs and associated IADLs; medication assistance; medical monitoring; assistance with durable medical equipment and adaptive and assistive devices; and safety monitoring and supervision. Activities of daily living, for the purposes of this benefit, are bathing, dressing, mobility, toileting, and eating. Instrumental activities of daily living are basic home management tasks that are directly related to the qualifying ADLs and essential to the beneficiary's care at home. (Source: State Plan Amendment, Submitted 9/ 17/ 2012) **Health Homes** North Carolina Health Homes State Plan Amendment (approved 5/ 24/ 2012) targets beneficiaries with two chronic medical conditions or one and at risk of another condition. The state also adds ten qualifying conditions to the list, including blindness, congenital anomalies, and chronic neurological diseases. Enrollment in the program is voluntary through Community Care of North Carolina (CCNC), which will provide health homes services. (Source: Integrated Care Resource Center, State-by-State Health Homes State Plan Amendment Matrix:

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	Summary Overview, Updated June 2012; Kaiser Commission on Medicaid and the Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, August 2012) The SPA will expire in October 2013. (Source: Demonstration Proposal)
Ohio	**State Demonstration to Integrate Care for Dual Eligible Individuals & Medicaid Managed LTSS Program** CMS announced on December 12, 2012 that Ohio would be the third state to enter into a Memorandum of Understanding (MOU) to test a new model for Medicare-Medicaid enrollees. Ohio and CMS will contract with **Integrated Care Delivery System** (ICDS) plans that will oversee and be accountable for the delivery of covered Medicare and Medicaid services for approximately 115,000 Medicare-Medicaid enrollees in seven regions of the state. (Source: Centers for Medicare and Medicaid Services) The plans will serve most dual eligibles age 18 and older in 29 targeted counties (out of a total 88 counties statewide), and will not include persons with intellectual or developmental disabilities who are otherwise served in §1915(c) HCBS waiver programs or in ICF/ MR facilities. (Source: CMS and Truven Health Analytics, July 2012; State Website) According to an updated timeline posted on the State website, voluntary enrollment in the plans will begin September 1, 2013. (Source: State Website) The demonstration will implement in seven regions composed of three to five counties each, and will use a capitated financial alignment model. (Source: Demonstration Proposal) State Website on Integrated Care Delivery System Notice of delay in implementation (10/ 5/ 2012) CMS Press Release (12/ 12/ 2012) Memorandum of Understanding **Health Homes** Ohio's Health Homes State Plan Amendment was approved on September 17, 2012. According to duals demonstration proposal, Ohio State Medicaid agency has been working with CMS on the State Plan Amendment to create Health Homes for Medicaid beneficiaries who meet the state's definition of serious and persistent mental illness, or SPMI (including adults with serious mental illness, or SMI, and children with serious emotional disturbance, or SED) in five sites (Butler County, Adams County, Scioto County, Lawrence County, and Lucas County), effective October 1, 2012. (Source: CMS Approval Letter) The state will expand the services statewide next Spring. (Source: NASUAD) The SPA is expected to enhance the traditional patient-centered medical home to better coordinate physical and behavioral health services. Community behavioral health centers (CBHCs) will be eligible to apply to become Medicaid health homes for individuals with SPMI. At a later date, Ohio Medicaid will implement Medicaid Health Homes focusing on individuals with qualifying chronic physical health conditions. (Source: Duals demonstration proposal) Approved Health Homes State Plan Amendment (9/ 17/ 2012) Approval Letter (9/ 17/ 2012) State Medicaid Health Homes Website **Balancing Incentive Program** CMS announced June 12, 2012 that Ohio will receive an estimated $169 million in enhanced Medicaid funds (2% enhanced FMAP rate). (Source: CMS Balancing Incentive Program Website) BIP Application (Submitted 3/ 28/ 2013)
Ohio	

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Oklahoma	**State Demonstration to Integrate Care for Dual Eligible Individuals** The demonstration will cover all full benefit Medicare-Medicaid enrollees including those with intellectual/ developmental disabilities statewide, starting July 2013. Under this demonstration, Oklahoma is pursuing a three-pronged approach to integrating care for the state's dually-eligible population. The first concept, **SoonerCare Silver** care coordination **program** will cover dually-eligible members residing in all of Oklahoma's counties (with limited exceptions) utilizing a fee-for-service payment model. Individuals receiving care coordination through other programs such as Tulsa's Health Innovation Zone (THIZ), PACE and the ICS will be excluded from the SoonerCare Silver care coordination program. All other dually-eligible individuals who are not receiving care coordination services through their current benefit program will be eligible to receive care coordination through the SoonerCare Silver program. The second concept, **Tulsa Health Innovation Zone** covers those Medicare-Medicaid members who receive primary care services through participating practices in Tulsa and the surrounding region with a per-member-per-month payment model. The third concept, **ICS Demonstration Model** covers all full benefit Medicare-Medicaid enrollees age 45 and older living in the Oklahoma City or Lawton metropolitan areas and rural areas of the state under a capitated payment model. (Source: Demonstration Proposal) **Health Homes** Oklahoma has submitted draft State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013) According to the state's duals demonstration proposal, Oklahoma Health Care Authority **(**OHCA) is currently partnering with the State Mental Health Authority (SMHA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to implement the health homes model. Health homes are designed to serve people with chronic mental illnesses. Children diagnosed as Serious Emotional Disturbance (SED) - the term used to describe children who qualify, and Seriously Mentally Ill (SMI) - the term for qualifying adults are served by a nurse care manager, who coordinates a team of professionals that determine the best services for the member. Health homes will be hosted by ODMHSAS through the statewide network of community mental health centers (CMHCs) and their satellite locations, which have historically provided community-based mental health services. The CMHCs provide screening, assessment and referral services, emergency services, therapy, psychiatric rehabilitation, case management, and other community support services designed to assist adult mental health consumers with living as independently as possible and to provide therapeutic services for children who are demonstrating symptoms of emotional disturbance. All CMHCs provide services to both adults and children. (Source: Duals Demonstration Proposal)
Oregon **Oregon**	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** Oregon submitted its proposal to CMS on May 11, 2012, but decided not to pursue the demonstration as currently described, which would have relied on a capitated payment model. Oregon Health Authority (OHA) has determined that the demonstration is not likely to be financially viable for Oregon's **Coordinated Care Organizations** (CCOs) and their affiliated Medicare Advantage plans. OHA will explore the feasibility of a modified demonstration with CMS, focusing on delivery system reforms underway in CCOs, paired with Medicare/ Medicaid administrative alignments, without the proposed financial component of the

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Oregon	financial alignment demonstration. (Source: State website on the demonstration) Demonstration Proposal State website on the demonstration Letter to Coordinated Care Organizations and Stakeholders (10/ 30/ 2012) **Amendment to Oregon Health Plan Section 1115 Demonstration Waiver** (Approved 7/ 5/ 2012; Submitted to CMS 3/ 1/ 2012) Oregon Health Plan 2 §1115 Demonstration provides coverage to mandatory and optional State Plan populations through the OHP Plus benefits package, and expands populations with a limited benefits package through OHP Standard. Medicaid eligibles may also elect to receive benefits through a premium assistance program which allows individuals to purchase coverage through the commercial insurance market. (Source: Medicaid.gov) The state (3/ 1/ 2012) submitted a Request for Amended Waiver to CMS to seek federal flexibility in several areas including the following: (1) Alternative payment methodologies to reimburse providers on the basis of outcomes and quality through shared savings and incentives; (2) Ability to reimburse non-traditional health care workers such as community health workers, peer wellness specialists, Duals, and personal health navigators; (3) Flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State Plan service but help keep people living in the community; (4) Developing an alternative payment methodology to allow a unique prospective payment system/ alternative payment methodology for Federal Qualified Health Centers. (Source: Oregon Division of Medical Assistance Programs Update) Application for Amendment and Renewal (3/ 1/ 2012) The Amendment was approved (7/ 5/ 2012) by CMS. The demonstration has been extended through June 30, 2017. Under the demonstration, Oregon will launch new **Coordinated Care Organizations** (CCOs), which are managed care entities that will operate on a regional basis, with enhanced local governance and provider payment structures that promote transparency and accountability. CCOs will replace the specialized managed care entities currently contracted through the Oregon Health Plan. (Source: Current Approval Document, 7/ 5/ 2012) Program Website **Coordinated Care Organizations** On May 3, 2012, the U.S. Department of Health and Human Services (HHS) has given the state preliminary approval of a five-year, $1.9 billion demonstration program to create Coordinated Care Organizations (CCOs) in the state's Medicaid program, which Oregon estimates will save $11 billion over coming years by setting a "global budget" for the state's Medicaid program and lowering the percentage it will grow each year. Press Release (5/ 3/ 2012) State information on Coordinated Care Organization 1 State information on Coordinated Care Organization 2 Senate Bill 1580 (2012 CCO Implementation) HB 3650 (2011 CCO Creation) **Health Homes** Oregon's Health Homes State Plan Amendment was approved by CMS on 3/ 13/ 2012. Oregon's Health Homes targets individuals with two chronic

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	conditions, one chronic condition and a risk of developing another, or one serious mental illness. Services are offered statewide. (Source: Kaiser Commission on Medicaid and the Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, August 2012) Approved Health Homes State Plan Amendment (3/ 13/ 2012) **Section 1915(i) State Plan Amendment** §1915(i) State Plan option was approved on February 14th, 2012. Covered services include Home Based Habilitation, HCBS Behavioral Habilitation, HCBS Psychosocial Rehabilitation for persons with Chronic Mental Illness (Source: DMAP Update) Introduction to Oregon's §1915(i) Plan Policy Option Package for §1915(i) State Plan Option Amendment **Section 1915(k) Community First Choice Option** Oregon is the second state to receive approval from CMS to implement §1915(k) Community First Choice Option. The approval of Oregon's Community First Choice Option, or K Plan, will provide the State approximately $100 million to expand person-centered and community-based services for eligible individuals, effective July 1, 2013. (Source: Press Release, July 1, 2013) State Plan Amendment and other resources
Pennsylvania	**Currently Operating Medicaid Managed LTSS Program** Since 2009, Pennsylvania has provided **Adult Community Autism Program** to adults of age 21 or higher with diagnosis of Autism Spectrum Disorder under the authority of Medicaid §1915(a). Services included in the capitation rate are primary, behavioral, dental, ICF/ MR, targeted case management, adult day, and occupational therapy/ physical therapy/ speech therapy (OT/ PT/ ST). The program is operating in four (out of 67) counties, and enrollment is voluntary. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Program Website
Rhode Island **Rhode Island**	**State Demonstration to Integrate Care for Dual Eligible Individuals** Under the demonstration titled **Integrated Care for Medicare and Medicaid Beneficiaries,** Rhode Island proposes to enroll approximately 12,000 Medicaid-only enrollees and 23,000 Medicare-Medicaid enrollees. Services for persons with Intellectual/ developmental disabilities and persons with serious mental illness are carved out in 2013, with possibility of being included in 2014. (Source: CMS and Truven Health Analytics, July 2012) Demonstration Proposal State Presentation on Duals Demonstration (7/ 23/ 2012) **Health Homes** Rhode Island has two approved health homes State Plan Amendments implemented statewide, effective October 1, 2011. Rhode Island Community Mental Health Organization Health Homes State Plan Amendment (approved 11/ 23/ 2011) targets individuals with a serious and persistent illness (SPMI). Rhode Island CEDARR Family Center Health Homes State Plan Amendment (approved 11/ 23/ 2011) is for children and youth under age 21 with diagnosis of severe mental

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	illness or serious emotional disturbance, or with two of the following chronic conditions, or have one and at risk of developing another: mental health condition, asthma, diabetes, DD, Down syndrome, mental retardation, or seizure disorder. (Source: Integrated Care Resource Center, State-by-State Health Homes State Plan Amendment Matrix: Summary Overview, Updated June 2012; Kaiser Commission on Medicaid and the Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, August 2012) The state has submitted another draft Health Homes State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013)
South Carolina	**State Demonstration to Integrate Care for Dual Eligible Individuals** **South Carolina Dual Eligible Demonstration** (SCDuE) is projected to enroll full benefit Medicare-Medicaid enrollees who are 65 years of age and older, not living in institutions at time of enrollment, and not enrolled in a PACE program by January 1, 2014. Enrollment is voluntary with opt out, and there will be no exclusions based on diagnosis or condition(s). The state initially had HCBS waiver services carved out. However, as of April 12, 2013, the proposed model has been changed to reflect a carve-in of home and community based services (HCBS). The program will operate statewide by July 2014. (Source: State Website on Duals Demonstration; Demonstration Proposal; CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Individuals with intellectual/ developmental disabilities are not included in the demonstration. (Source: NASDDDS Managed Care Tracking Report) Demonstration Proposal State Website on Duals Demonstration
South Dakota	**Health Homes** The state has submitted draft Health Homes State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013)
Tennessee	**Currently Operating Medicaid Managed LTSS Program** Under TennCare II §1115 Demonstration Waiver, **TennCare CHOICES** provides primary, acute, behavioral, nursing facility, and HCBS waiver-type services to eligible persons of all ages residing in nursing homes, adults under age 65 with physical disabilities, and adults age 65 and higher. At inception in 2010, LTSS was added to the existing TennCare managed care demonstration. The program is operating statewide, and enrollment is mandatory. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Website on TennCare CHOICES **Amendment to TennCare II Section 1115 Demonstration Waiver** (Approved 6/ 15/ 2012; Extension request submitted 6/ 29/ 2012)
Tennessee	Under this demonstration, all Medicaid State Plan-eligibles (except those eligible only for Medicare premiums) are enrolled in TennCare Medicaid and receive most of the State Plan services through the demonstration's managed care delivery system. The recently submitted amendment pertains to the CHOICES program, which is Tennessee's Medicaid managed long-term care program. CHOICES serve three groups: CHOICES 1 serves nursing facility residents; CHOICES 2 serves elderly adults or adults with physical disabilities who meet nursing facility level of

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	care, but who have elected to receive home and community based services; CHOICES 3 serves elderly adults or adults with physical disabilities who do not meet nursing facility level of care, but are "at risk" for institutionalization. The amendment seeks to increase the enrollment target for CHOICES 2, effective July 1, 2012. (Source: Medicaid.gov & application to CMS) Application for Amendment Amendments #14 and #16 for the demonstration were approved by CMS (6/ 15/ 2012). Amendment #14, effective as of July 1, 2012, authorizes an increase to the enrollment targets for the CHOICES 2 program and approves the rebalancing of the CHOICES managed long-term care program and the creation of *Interim* CHOICES 3. Amendment #16 pertains to Disproportionate Share Hospital allotment. The Department of Finance and Administration submitted a three-year extension request to CMS on 6/ 29/ 2012. (Source: Centers for Medicare & Medicaid Services) Current Approval Document Three-year Extension Request Document **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** Tennessee recently submitted (12/ 21/ 2012) a letter to Medicare-Mediciad Coordination Office requesting to withdraw its financial alignment demonstration proposal. In the letter, the state expressed its concerns pertaining to the reimbursement methodology. (Source: Letter to Medicare-Mediciad Coordination Office) Tennessee's duals demonstration **TennCare PLUS** proposed to enroll full benefit dual eligibles, except PACE participants, starting January 1, 2014, statewide. The demonstration will not include LTSS for persons with intellectual disabilities (including ICF/ MR and §1915(c) waiver services), but dually-eligible members receiving these services will be part of the demonstration for all other Medicare and Medicaid services. The demonstration will operate under a capitated payment model. For more information, click here. (Source: Demonstration Proposal)
Texas	**Currently Operating Medicaid Managed LTSS Program** Through Medicaid §1115 authority, **Texas STAR+PLUS** (inception: 1998) provides primary, acute, behavioral, and LTSS (Personal Attendant, Assisted Living, PERS, nursing, Adult Foster Care, dental, respite, home-delivered meals, OT/ PT/ ST, consumer directed services, home mods, medical supplies) to eligible adults age 21 and older with disability (SSI), adults age 21 and older in Community-based alternatives HCBS waiver, adults age 65 and older, and full-benefit Medicare-Medicaid enrollees. Certain groups are excluded, such as people living in nursing facilities, ICFs-MR, and in HCBS waivers other than the community-based alternatives waiver. Enrollment is mandatory for full-benefit Medicare-Medicaid enrollees. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Program Website
Texas	Under **Healthcare Transformation and Quality Improvement Program Section 1115 demonstration waiver** (Approved 12/ 12/ 2011), Texas is expanding STAR and STAR+PLUS (MMLTC) statewide and using savings from the expansion of managed care and the discontinuation of supplemental provider payments to finance new funding pools to assist hospitals and other providers with uncompensated care costs and to promote delivery system transformation and improvement. The Texas Health & Human Services Commission submitted a request for Amendment on 5/ 3/ 2012, wherein it proposes to add Day Activity

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Texas	Health Services to the existing STAR+PLUS waiver, effective September 1, 2012. The service targets individuals who are eligible for the STAR+PLUS waiver and exceed the financial requirements for Day Activity and Health Services under the §1915(i) authority. Services include nursing and personal care, physical rehabilitation, noon meal and snacks, social, educational and recreational activities, and transportation. (Source: Medicaid.gov) Current Approval Document Request for Amendment (submitted 5/ 3/ 2012) The Texas Health and Human Services Commission (HHSC) is adopting new permanent payment rules that implement the provider eligibility requirements and payment methodologies approved by CMS under Healthcare Transformation and Quality Improvement Program waiver. (Source: Texas Register, June 22, 2012) State information on the adopted rules **State Demonstration to Integrate Care for Dual Eligible Individuals** Texas' **Dual Eligible Integrated Care Model** targets full dually-eligible adults, who are required to participate in STAR+PLUS. Capitated Medicaid Managed Care Organizations will offer a full array of Medicaid and Medicare services for the targeted population. Starting January 1, 2014, the demonstration was originally planned to be implemented statewide, with the possibility of phase-in implementation beginning with the most populous counties. (Source: Demonstration Proposal) A Texas state official, however, confirmed that the demonstration would be implemented in limited geographic areas, i.e., 19 counties with the largest number of dually-eligible beneficiaries. (Source: NASUAD) Individuals with intellectual/ developmental disabilities are fully carved out of this demonstration. (Source: NASDDDS Managed Care Tracking Report) **Cost-sharing methodology for Dual Eligibles** HHSC also amends regulations regarding the coordination of Medicaid with Medicare Parts A, B, and C. The rule authorizes the commission to make higher cost-sharing payments for dual eligibles for certain services if the commission determines that a higher payment amount is necessary to ensure adequate access to care or would be more cost-effective to the state. HHSC will have to request and receive approval for a Medicaid State Plan Amendment from the Centers for Medicare and Medicaid Services in order to implement specific adjustments to the Medicare Equalization policy. The changes will implement to coincide with the effective date of the State Plan Amendment. (Source: Texas Register, June 22, 2012) State information on the adopted rules **Section 1915(i) State Plan Amendment** According to a draft of the state's §1915(i) State Plan Amendment (the link to the SPA has been disconnected), Texas planned to cover Day Activity and Health Services (DAHS) under §1915(i) State Plan HCBS benefit. Target population was to include aged and disabled individuals living in the community, unless they qualify for nursing facility §1915(c) waiver services or are individuals with Intellectual Disabilities. For Year 1 (9/ 1/ 2012 – 8/ 31/ 2013), projected number of participants was 14,493 in STAR+PLUS (managed care) Service Areas, and 1,845 outside the managed care service areas. In the STAR+PLUS Service Areas, the SMA conducts annual desk and on-site reviews of each contracted managed care organization (MCO). Outside the STAR+PLUS Service Areas, the Department of Aging and Disability Services (DADS) reviews a statistically valid randomly selected sample,

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	proportionate to consumer enrollment in each long term services and support region. All Day Activity and Health Services (DAHS) consumers were subject to random selection. (Source: Draft State Plan Amendment) According to a state official, Texas withdrew the Amendment in 2012 and has no plans at the current time to implement it. (Source: State official) **Balancing Incentive Program** On September 4, 2012, CMS approved the state's BIP application, awarding $301.5 million of enhanced Medicaid funds. Texas must implement the required structural changes and achieve a 50 percent benchmark of Medicaid community-based LTSS expenditures by October 2015. HHSC has delegated coordination of BIP activities to DADS. (Source: State website) BIP application (Submitted 6/ 29/ 2012) **Section 1915(k) Community First Choice Option** Senate Bill 7 calls for implementation of the Community First Choice Option for individuals with intellectual/ developmental disabilities in STAR+PLUS. For more information on the bill, click here. If enacted, the option would allow managed care organizations to provide basic attendant and habilitation service to 11,902 people with intellectual/ developmental disabilities. (Source: Texas Legislature Key Features of SB7, April 29, 2013) The state currently provides these services to certain elderly or disabled Medicaid enrollees who would otherwise be eligible for nursing facility care. The bill sponsor projects that implementing Community First Choice would expand services to Medicaid enrollees with a disability who might otherwise be eligible for care in an ICF/ IID. The 6% enhanced match would apply to certain existing services and those provided to the expanded population. According to a timeline contained in the Fiscal Note attached to the Senate bill, implementation of CFC would begin by September 1, 2014. (Source: Fiscal Note, 83rd Legislative Regular Session, February 25, 2013) Cost projections in the Fiscal Note attached to the legislation indicate that wages for those that provide habilitation services would be about 25% less than current HCS habilitation wages. IDD Local Authorities would coordinate the new CFC service, but would not provide the CFC service. Current CLASS, HCS and TxHmL providers would be eligible to provide the new IDD service. (Source: Texas Legislature Key Features of SB7, April 29, 2013)
Vermont **Vermont**	**Vermont Choices for Care—Section 1115 Demonstration Waiver** The Vermont long-term care §1115 demonstration, known as "Choices for Care," is a statewide initiative to rebalance long-term care services through managing nursing facility admissions and increasing community-based options. The demonstration does not include children or individuals receiving institutional services through Intermediate Care Facilities for persons with Mental Retardation (ICF/ MR). Choices for Care created an entitlement to Home and Community-Based Services (HCBS) for individuals with the highest need for services and also implemented a person-centered assessment and options counseling process to identify what services would be needed to enable individuals to remain in their own homes. The state also implemented the Program of All-inclusive Care for the Elderly (PACE) in two locations, one of which is rural. (Source: Medicaid.gov) Fact Sheet Current Approval Document (9/ 21/ 2010)

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	State Demonstration to Integrate Care for Dual Eligible Individuals The demonstration includes full benefit dual eligibles, including those with intellectual/ developmental disabilities. It will implement statewide under a capitated payment model starting January 1, 2014. PACE Vermont participants (approximately 120 people) are not included. (Source: Demonstration Proposal) State website on the demonstration **Health Homes** The Department of Vermont Health Access (DVHA) has submitted its Health Homes State Plan Amendment, effective 1/ 1/ 2013 (Source: CMS State Health Home CMS Proposal Status, updated April 2013) Beneficiaries targeted are those with chronic opioid dependence, as defined by the DSM-IV-TR criteria for "Diagnosis of Opioid Dependence" and receiving Medication Assisted Therapy (MAT) for this condition. (Source: Draft State Plan Amendment)
Virginia	**State Demonstration to Integrate Care for Dual Eligible Individuals** The demonstration is projected to cover full benefit Medicare-Medicaid enrollees (age 21 and older), older persons and persons with physical disabilities, nursing facility residents, and persons who receive services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver. Persons with intellectual/ developmental disabilities who are not in the EDCD Waiver are excluded from the program. Assisted living services, intellectual/ developmental disability services, and PACE programs will be carved out. The program will initially start in four regions in January 2014, with voluntary enrollment with opt out. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Demonstration Proposal State Website on Duals Demonstration On May 21, 2013, Governor Bob McDonnell announced that Virginia has signed a Memorandum of Understanding (MOU) with CMS to implement Medicare-Medicaid Enrollee Financial Alignment Demonstration aimed at coordinating care for more than 78,000 Virginians currently enrolled in Medicare and Medicaid. Under this initiative, recently branded as Commonwealth Coordinated Care, Virginia and CMS will enter into a contract with health plans for the delivery of coordinated services and supports to enrollees. Eligible individuals include older adults and individuals with disabilities, including those receiving long-term services and supports, and who live in designated regions around the Commonwealth. The regions include the areas surrounding: Central Virginia/ Richmond, Charlottesville, Tidewater, Roanoke and Northern Virginia. (Source: Press Release, May 21, 2013) Memorandum of Understanding
Washington **Washington**	**Currently Operating Medicaid Managed LTSS Program** After inception in 2005, LTSS component was added to **Washington Medicaid Integration Partnership** (WMIP). Under the program, primary, acute, behavioral, prescription drugs, and LTSS (nursing facilities and community-based services) are provided in capitated rate. Groups enrolled include adults age 21-64 with SSI or SSI-related Medicaid and adults age 65 and older. Enrollment is voluntary, and very limited geographic area is covered. (Source: CMS and Truven Health Analytics, July 2012) State Resource on WMIP (December 2010)

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Washington	**State Demonstration to Integrate Care for Dual Eligible Individuals** (Managed Fee-For-Service Model & Capitated Model) **HealthPath Washington** (formerly Pathways to Health), the Washington State's Medicare and Medicaid Integration Project, proposes to realign and integrate care through three strategies: 1. Health Homes (managed fee-for-service financial model); 2. Full Financial Integration Capitation (three-way capitation financial model); and 3. Modernized and Consolidated Service Delivery with Shared Outcomes and Aligned Financial Incentives (capitation and fee-for-service). The project's target population is full benefit Medicare-Medicaid enrollees of all ages. 1. **Strategy 1: Health Homes (Managed Fee-For-Service Model)** – *Approved (10/25/2012)* On October 25, 2012, CMS approved the first strategy in the State's Financial Alignment demonstration proposal. According to the Memorandum of Understanding, CMS initially planned to begin this Managed Fee-for-Service Financial Alignment Demonstration on April 1, 2013. However, in February 2013, Health Care Authority Department of Social and Health Services notified stakeholders that the state will introduce Health Homes on July 1, 2013. (Source: Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: California, Illinois, Massachusetts, Ohio, and Washington, Kaiser Commission on Medicaid and the Uninsured, May 2013; Washington Health Care Authority Stakeholder Notice, February 4, 2013) Under the demonstration, eligible Medicare-Medicaid enrollees will elect to receive health home services from Health Home Care Coordinators, supplemented by multidisciplinary teams that coordinate across disciplines, including primary, acute, prescription drugs, behavioral health, and long-term services and supports (LTSS). Health home services will include: comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family supports; referral to community and social support services; and the use of a web-based clinical decision support tool (PRISM) and other health information technology to improve communication and coordination of services. The geographic area for this Demonstration is all counties in the state, with the exception of any counties in which the state receives approval from CMS to implement a capitated Financial Alignment Demonstration (Strategy 2). At this moment, the exceptions include King, Snohomish, and Whatcom counties. If the state no longer seeks to implement a capitated model in any of the three counties, Washington may expand this Demonstration to those additional counties beginning by November 1, 2013, at the latest. (Source: Memorandum of Understanding) 2. **Strategy 2: Full Integration Capitation** (Three Way Contracts between Health Plan/ State/ CMS) – *Pending* HealthPath Washington Strategy 2 Financial Alignment Demonstration will use a full-risk managed care model of health delivery that coordinates Medicare and Medicaid medical services, behavioral health services, and long-term services and supports. The Demonstration will be available to adults and children of King County and Snohomish County who are eligible for both Medicare and Medicaid, and for whom the state has a responsibility for payment of cost sharing obligations under the Washington State Plan. Beneficiaries may not be concurrently enrolled in the Demonstration and a Medicare Advantage Plan, the Program of All-inclusive

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	Care for the Elderly (PACE), or a Medicare Hospice Program. Beneficiaries may participate in and are eligible for enrollment in the Demonstration if they voluntarily disenroll from their existing programs. Beneficiaries who are on the Medicaid Fee-for-Service delivery system and the Medicare Fee-for-Service delivery system and are receiving Medicare ESRD benefits may also voluntarily enroll in the Demonstration. At a future date, subject to additional discussions with CMS and other interested parties, Washington may also include beneficiaries receiving developmental disabilities §1915(c) home and community-based waiver services. If this population is included, the Medicare-Medicaid Integrated (MMI) Plans (managed care plans) will be responsible for services specified in the negotiated 3-way contract. The demonstration will begin on April 1, 2014. (Source: Washington State Health Care Authority Request For Application (RFA) NO. 2013-003, revised April 17, 2013) Strategy 3 will be provided in counties where full capitation is not available. It will include Medicaid services for individuals with intellectual or developmental disabilities (I/ DD) through a fee-for-service model. (Source: Demonstration Proposal; NASDDDS Managed Care Tracking Report) HealthPath Washington project website (Corrected link) HealthPath Washington Medicaid Health Homes Website HealthPath Washington Medicaid Health Homes Presentation (6/ 21/ 2012) **Health Homes** The state submitted draft Health Homes State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013) Please refer to State Demonstration to Integrate Care for Dual Eligible Individuals (previous section) for more information regarding the Washington State's Health Homes program. State Website on Health Homes (Corrected link) Draft Health Homes Proposal, 2nd Revised (5/ 8/ 2012) Health Homes Fact Sheet (10/ 1/ 2012) Washington Health Home State Plan Amendment (5/ 4/ 2013) – *Pending* **Section 1915(i) State Plan Amendment** (Closed) Washington State's State Plan Amendment for the Washington Adult Day Health (§1915(i) of the Social Security Act) was approved in December 2009, and went effective January 1, 2010. (Source: Approval Letter, 12/ 21/ 2009). However, the 2011-13 Washington State budget directed the Department of Social and Health Services (DSHS) to remove the Adult Day Health (ADH) program from the §1915(i) State Plan option and to add it to the Community Options Program Entry System (COPES) Waiver. The ADH service under the §1915(i) State Plan option permanently closed effective October 1, 2011. (Source: Adult Day Health Client Notification Letter) State Resources on Adult Day Health program
West Virginia	**Health Homes** The West Virginia Bureau for Medical Services (BMS), the state Medicaid agency, has submitted its State Plan Amendment for Health Homes. (Source: CMS State Health Home CMS Proposal Status, updated April 2013) Draft of the State Plan Amendment is available here. According to the draft, Health Homes will be provided in limited geographic area in the state, starting January 1, 2013. Eligibility

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	will be limited to those individuals who have one condition and at risk for a second: 1. Bipolar disorder; 2. At risk for Hepatitis B and/ or C. (Source: State Website) Draft State Plan Amendment (8/ 24/ 2012) West Virginia Health Improvement Institute Website on Health Homes Guidance Letter from CMS
Wisconsin	**Currently Operating Medicaid Managed LTSS Programs** Wisconsin has two MLTSS programs. **Wisconsin Family Care** (under §1915(b) and §1915(c)) provides LTSS to adults under age 65 with physical disabilities, adults under age 65 with intellectual/ developmental disabilities, and adults of age 65 and older. HCBS waiver services are only available to members who are a nursing home level of care, and primary, acute, and prescription drugs services are excluded from capitation rate. Enrollment is voluntary (choice of Family Care, Family Care Partnership, PACE, or IRIS depending on what is offered in the county and individual's functional level of care) with opt in. The program covers 57 counties in the state (out of 72 counties). Effective April 3, 2012, temporary caps on enrollment in the Family Care or IRIS programs were lifted. More information on Family Care is available here and here. (Source: dhs.wisconsin.gov) **Wisconsin Family Care Partnership** (FC-P) (under §1932(a) and §1915(c)) provides Medicare cost-sharing, behavioral health (not covered by Medicare), prescription drugs (not covered by Medicare), LTSS (HCBS and institutional), and other services including case management, dental, hospital, hospice, and therapies. Groups enrolled are adults under age 65 with physical disabilities, adults under age 65 with developmental disabilities, and frail adults of age 65 and older. Enrollment is voluntary with opt in. The program covers 19 counties in the state (out of 72 counties). (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Program Website Waiver Application NASUAD & n4a presentation **State Demonstration to Integrate Care for Dual Eligible Individuals** Wisconsin's proposed demonstration, Virtual PACE, will include all people who are full dual eligible members over the age of 18 residing in a Nursing Home (NH) on a long-term basis and receiving Medicaid services via the fee-for-service system at the time of enrollment. On January 1, 2013, Wisconsin will implement Virtual PACE in the Southeastern region, and then statewide in 2015. The demonstration will use a capitated payment model. (Source: Demonstration Proposal) State website on the demonstration **Section 1915(i) State Plan Amendment** Wisconsin's Medicaid State Plan Amendment (SPA) under §1915(i) State Plan Home and Community-Based Services is called **Community Recovery Services**, and provides three specific services – Community Living Supportive Services, Supported Employment, and Peer Supports – under the umbrella of **psychosocial rehabilitation**. Populations covered are elderly and disabled individuals. The SPA was approved June 3, 2010. (Source: Program website) **Health Homes**
Wisconsin	

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	The state's Health Homes State Plan Amendment received approval from CMS (10/ 1/ 2012). The service targets Medicaid and BadgerCare Plus members with a diagnosis of HIV/ AIDS and who have at least one other diagnosed chronic condition or is at risk of developing another chronic condition. (Source: Approved Health Homes State Plan Amendment) Approved Health Homes State Plan Amendment (10/ 1/ 2012)

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 8/2/2013)

	States	Proposed Financing Model[1]	Submitted to CMS[2]	MOU Signed	Target Implementation Date[3]
1	**Arizona (Withdrawn; W)**	~~Capitated~~	~~5/31/2012~~		~~Jan 2014~~
2	**California**	Both	5/31/2012	3/27/2013	No earlier than January 2014
3	**Colorado**	Managed FFS	5/2012		2013
4	**Connecticut**	Managed FFS	5/31/2012		Dec 2012
5	**Hawaii (W)**	~~Capitated~~	~~5/25/2012~~		~~Jan 2014~~
6	**Idaho**	Capitated	5/2012		Jan 2014
7	**Illinois**	Capitated	4/6/2012	2/22/2013	Oct 2013
8	**Iowa**	Managed FFS	5/29/2012		Jan 2013
9	**Massachusetts**	Capitated	2/16/2012	8/23/2012	July 2013
10	**Michigan**	Capitated	4/26/2012		July 2013
11	**Minnesota (W)**	~~Capitated~~	~~4/26/2012~~		~~Dec 2012~~
12	**Missouri**	Managed FFS	5/31/2012		Oct 2012
13	**New Mexico (W)**	~~Capitated~~	~~5/31/2012~~		~~Jan 2014~~
14	**New York**	Capitated[4]	5/25/2012		Jan 2013
15	**North Carolina**	Managed FFS	5/2/2012		Jan 2013
16	**Ohio**	Capitated	4/2/2012	12/12/2012	Sept 2013
17	**Oklahoma**	Correction: Both	5/31/2012		July 2013
18	**Oregon (W)**	~~Capitated~~	~~5/11/2012~~		~~Jan 2013~~
19	**Rhode Island**	Capitated	5/31/2012		Jan 2013
20	**South Carolina**	Correction: Capitated	5/25/2012		Jan 2014
21	**Tennessee (W)**	~~Capitated~~	~~5/17/2012~~		~~Jan 2014~~
22	**Texas**	Capitated	5/2012		Jan 2014
23	**Vermont**	Capitated	5/10/2012		Jan 2014
24	**Virginia**	Capitated	5/31/2012	5/21/2013	Jan 2014
25	**Washington**	Both	4/26/2012	Managed FFS (10/25/2012); Capitated (pending)	Managed FFS model (July 2013)
26	**Wisconsin**	Both	4/26/2012		Jan 2013

[1] CMS provided two potential Medicare-Medicaid financial alignment models: 1. Capitated model where the state & CMS would enter into a 3 way contract with a health plan to provide coordinated care; and 2. Managed Fee-for-Service where the state would share in any savings as a result of an initiative designed to reduce costs. On chart, models are listed as Capitated, FFS (Fee for Service) or both.

[2] Under CMS's Transparency regulation, CMS posted the proposed plans for 30 days. At this point, all of the comment periods have closed. (See http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4284).

[3] For states doing a phased approach, the implementation date listed is for the earliest phase.

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

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