April 1, 2014

State Medicaid Integration Tracker©

NASUAD
National Association of States
United for Aging and Disabilities

Welcome to the State Medicaid Integration Tracker©

The **State Medicaid Integration Tracker©** is published each month by the National Association of States United for Aging and Disabilities (NASUAD). **New information presented each month is highlighted in purple.**

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

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

2. State Demonstrations to Integrate Care for Dual Eligible Individuals and other Medicare-Medicaid Coordination Initiatives

3. Other LTSS Reform Activities, including:
   - Balancing Incentive Program
   - Community First Choice Option under §1915(k)
   - Medicaid Health Homes

NASUAD uses many information sources to learn what is happening across the country in these areas. NASUAD's sources include: the CMS website on Medicaid Managed Long Term Services and Supports (link), the CMS website on State Demonstrations to Integrate Care for Dual Eligible Individuals (link), the CMS Balancing Incentive Program website (link), the CMS website on Health Homes (link), the CMS list of Medicaid waivers (link), state Medicaid Agency websites, interviews with state officials, and presentations by state agencies. NASUAD lists sources for each update, as well as hyperlinks to related CMS and state documents and materials.

For more information, please contact **John Michael Hall** (mhall@nasuad.org) or **Erin White** (ewhite@nasuad.org).

This Installment's Updates

Medicaid Managed LTSS:

- **Alabama:** In December 2013, Alabama filed new rules to regulate its Regional Care Organizations (RCOs). The state plans to work with CMS to develop a §1115 Demonstration Waiver application to establish geographic Medicaid regions and designate RCOs to operate in each region.
- **Florida:** By March 2014, Florida will phase out its LTC Community Diversion Program and transition over to the Statewide Medicaid Managed Care LTC Program.
- **Georgia:** In October 2013, Georgia announced its intention to submit an SPA as part of a plan to implement a Medicaid Medical Coordination Program for Medicaid members who are aged, blind, or disabled.
- **Hawaii:** In January 2014, Hawaii announced awards in its RFP to integrate the QUEST and QUEST Expanded Access Medicaid managed care programs. The health plans will start provision of services to QUEST Integration members in January 2015.
- **Illinois:** In February 2014, Illinois submitted a §1115 waiver proposal for its "Path to Transformation" demonstration.
- **Kansas:** In January 2014, CMS approved the state's §1115 demonstration waiver amendment for HCBS-I/DD. In February 2014, Kansas began integrating I/DD waiver program participants into KanCare.
- **Michigan:** In December 2013, CMS approved Michigan's six-month extension request for its Michigan Specialty Services and Supports 1915(b) waiver; enabling the state to align its duals demonstration project with the effective date of the waiver.
- **Minnesota:** In October 2013, CMS enabled Minnesota to proceed with its Reform 2020 Initiative by approving federal financial participation in the Alternative Care Program.
- **Missouri:** The Missouri Senate Health Committee approved a bill to (a) shift more children and adults into managed care and (b) authorize a new model of coordinated care for many seniors and disabled patients.
- **Nebraska:** The state changed its MLTSS target implementation date from July 2015 to January 2017.
- **Nevada:** The state amended its State Plan to reflect updated processes and eligibility groups for its DHCFP Managed Care Programs.
- **New Hampshire:** In December 2013, New Hampshire launched its transition to Medicaid managed care.
- **New Jersey:** The state will move to a managed care system in July 2014, but existing nursing facility residents can remain under FFS for two years. MCOs will only be responsible for new nursing facility residents and HCBS for waiver populations currently enrolled in managed care.
- **New Mexico:** In January 2014, New Mexico implemented New Mexico Centennial Care as a replacement for the state's former Medicaid system.
- **New York:** The state submitted a request for a $10 billion §1115 waiver amendment to

its Partnership Plan. Additionally, in December 2013, the state began Phase IV of its mandatory MLTSS program. Subsequent phases will not occur before April 2014.

- **North Carolina:** The state's Medicaid department submitted a Medicaid reform proposal to the state legislature for a non-traditional Medicaid managed-care model known as the Partnership for a Healthy North Carolina. The legislature is expected to vote on the proposal as early as May 2014.
- **Ohio:** In February 2014, the state and CMS entered into a three-way contract establishing an integrated care delivery system plan to provide integrated care, including LTSS, to Medicare-Medicaid beneficiaries. The state will phase in enrollment from May through July, 2014.
- **Rhode Island:** In December 2013, CMS approved Rhode Island's Comprehensive §1115 Demonstration renewal request for Rhody Health Options, the LTSS aspect of the state's Integrated Care Initiative.
- **Texas:** In March 2014, CMS approved the state's §1115 waiver amendment request. The state moved cognitive rehabilitative services to managed care, effective March 2014. The state will expand STAR+PLUS in September 2014 and March 2015, which will include the addition of a STAR Kids program.

Medicare-Medicaid Care Coordination Initiatives:

- **California:** The state's Cal MediConnect passive enrollment will begin in April 2014.
- **Colorado:** In February 2014, Colorado signed an MOU for Colorado's managed fee-for-service demonstration model.
- **Idaho:** In February 2014, Idaho withdrew from the Dual Eligible Financial Alignment Initiative Demonstration.
- **Illinois:** In March 2014, the state's opt-in enrollment for dual eligibles became effective. Passive enrollment will be effective June 2014.
- **Massachusetts:** The state updated its "One Care" duals implementation timeline. The new three wave auto-assignment effective dates are January, April, and July 2014.
- **Michigan:** In April 2014, Michigan and CMS signed an MOU for the state's capitated demonstration model.
- **New York:** In October 2014, New York will begin opt-in enrollment for FIDA, its capitated duals demonstration program. The state will begin passive enrollment in January 2015.
- **North Carolina:** Community Care of North Carolina is expanding services to include dually eligible beneficiaries.
- **Ohio:** In February 2014, Ohio and CMS entered into a three-way contract establishing an integrated care delivery system plan to provide integrated care, including LTSS, to Medicare-Medicaid beneficiaries. The state will phase in enrollment May-July 2014.
- **Rhode Island:** In November 2013, Rhode Island implemented Phase I of the Integrated Care Initiative; the Phase II implementation start date is April 2015.
- **Texas:** The state plans to finalize contracts with MCOs by August 2014 and begin its dual eligible demonstration by January 2015.
- **Virginia:** In December 2013, Virginia and CMS entered into a three-way contract for

delivery of coordinated services and supports.

- **Washington:** In November 2013, Washington and CMS signed an MOU for the state's capitated demonstration model.
- **Wisconsin:** In December 2013, Wisconsin withdrew from the demonstration.

Balancing Incentive Program:

- **Indiana:** In October 2013, Indiana published a BIP Program Work Plan.
- **Kentucky:** CMS approved Kentucky's application for BIP funding.
- **Nevada:** In January 2014, Nevada submitted to CMS a BIP Program Application.
- **New Jersey:** In January 2014, the state submitted a Structural Change Work Plan.
- **New York:** In December 2013, New York submitted to CMS a BIP Structural Change Work Plan, which the state updated in January 2014.
- **Ohio:** In September 2013, Ohio submitted a Draft BIP Structural Change Work Plan.

Community First Choice option under §1915(k):

- **Maryland:** The state has submitted a §1915(k) SPA to CMS. Maryland converted to the new Community First Choice Option format in January 2014.

Medicaid Health Homes:

- **Indiana:** The state opted not to establish Health Homes; instead Indiana plans to develop Wellness Coordination services within its Community Integration and Habilitation Waiver.
- **Kansas:** The state released its Health Homes Preparedness and Planning Tool in February 2014. The state will begin utilizing Health Homes in July 2014.
- **Kentucky:** CMS approved Kentucky's State Health Home Planning Request.
- **Maine:** The state will implement Stage B of its Health Home Initiative in April 2014.
- **Maryland:** In September 2013, CMS approved Maryland's Health Home SPA; effective October 2013.
- **Minnesota:** CMS approved Minnesota's State Health Home Planning Request.
- **Mississippi:** CMS approved Mississippi's State Health Home Planning Request.
- **New Mexico:** CMS approved New Mexico's State Health Home Planning Request.
- **North Carolina:** The state's Health Home-eligible duals will transition to the managed fee-for-service model when the Health Homes SPA expires in October 2013.
- **Ohio:** The state decided to delay, but not withdraw, its Health Home rule packages.
- **Rhode Island:** In November 2013, CMS approved Rhode Island's third Health Home SPA, effective July 2013.
- **South Dakota:** In November 2013, CMS approved South Dakota's Health Home SPA, effective July 2013.
- **Vermont:** In March 2014, CMS approved Vermont's Health Home SPA, effective July 2013.
- **Washington:** In December 2013, CMS approved Washington's Health Home SPA, effective October 2013.
- **West Virginia:** CMS has approved **West Virginia's** Health Home Planning Request.

Overview

Medicaid Managed LTSS:	AL, AZ, CA, DE, FL, GA, HI, IL, KS, MA, MI, MN, MO, NE, NV, NH, NJ, NM, NY, NC, OH, OR, PA, RI, TN, TX, WA, WI
Medicare-Medicaid Care Coordination Initiatives: *: Financial Alignment (FA) demonstration proposal approved by CMS **: Initiatives other than FA demonstration W: No longer pursuing FA demonstration	~~AZ~~(W), CA*, CO*, CT, FL**, ~~HI~~(W), ID(W), IL*, IA, MA*, MI*, MN(W)**, MO, NH**, NJ**, ~~NM~~(W), NY*, NC**, OH*, OK, OR(W)**, RI, SC*, ~~TN~~(W), TX, ~~VT~~(W), VA*, WA*, WI(W)**
Other LTSS Reform Activities: (*Approved by CMS)	
• **Balancing Incentive Program:**	AR*, CT*, GA*, IL*, IN*, IA*, KY*, LA*, ME*, MD*, MS*, MO*, NV*, NH*, NJ*, NY*, OH*, TX*
• **Community First Choice option under §1915(k):**	~~AZ~~, AR, CA*(2), ~~LA~~, MD, MN, MT, NY, OR*, TX
• **Medicaid Health Homes:**	AL*, AZ, AR, CA, DC, ID*, IL, IN, IA*(2), KS, KY, ME*, MD*, MA, MI, MN, MS, MO*(2), NV, NJ, NM, NY*, NC*, OH*, OK, OR*, RI* (3), SD*, VT*, WA*, WV, WI*

State Updates

State	State Updates
Alabama	**Regional Care Organizations** In June 2013, Alabama's governor signed Act 2013-261 into law, approving a strategy to develop risk-bearing Regional Care Organizations (RCOs) to manage a continuum of health care services for Medicaid beneficiaries under a single capitated rate. RCOs are organizations of health care providers that contract with the state Medicaid agency to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries within a defined region of the state. They will coordinate care for the majority of the Medicaid population and manage Medicaid benefits including physical, behavioral, and pharmacy services. The initiative aims to build on four existing regional pilots (Patient Care Networks of Alabama) that better enable primary medical providers to function as a medical or health home by providing care management and other health care services for chronically ill Medicaid enrollees. The State Medicaid Agency submitted an 1115 Waiver Concept Paper in early 2013 and has plans to work with CMS regarding the development of an application for a §1115 Demonstration Waiver. The State Medicaid Agency plans to establish geographic Medicaid regions and designate RCOs or alternate care providers to operate in each region. Subject to approval of the CMS, the Medicaid Agency shall enter into a contract in each Medicaid region for at least one fully certified RCO to provide medical care to the Medicaid beneficiaries. (Source: National Academy for State Health Policy, November 2013). The State Medicaid Agency released an RCO Implementation Timeline establishing October 2016 as the date for RCOs to begin accepting capitation payments from Medicaid. (Source: State Medicaid Website, February 2014) Act 2013-261 1115 Waiver Concept Paper (5/17/2013) RCO Implementation Timeline On December 17, 2013, Alabama Medicaid filed five new rules to regulate the operation of Regional Care Organizations, outlining proposed state requirements that will be used to support the Agency's move to Regional Care Organizations and to comply with state law. The proposed rules include requirements for: RCO Governing Boards; RCO Citizens' Advisory Committees; receiving probationary certification as a RCO; contracting for specific case management services with probationary RCOs, and active supervision of probationarily-certified RCOs. (Source: State Medicaid Website, January 10, 2014). The original comment period for the RCO-related rules has been extended to March 2014. (Source: Alabama Medicaid Agency News, January 10, 2014; State Medicaid Website) RCO Rules

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) an 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

State	State Updates
Arizona	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 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. The state proposed to utilize the state plan option 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." In May 2013, CMS determined that CFC services could only be provided to individuals eligible under the State Plan. In Arizona, the state's comprehensive §1115 waiver establishes eligibility for LTSS. On June 13, 2013, Arizona withdrew its 1915(k) application. Implementation of the

State	State Updates
Arizona	"Agency with Choice" service model will continue under AZ's §1115 waiver. (Source: National HCBS Conference Presentation, 9/11/2013) 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
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) BIP Structural Change Work Plan (Revised 6/28/2013) **Health Homes** On January 31, 2011, the state submitted to CMS a Health Home Planning Request for funding to create health homes for people with chronic conditions. On February 4, 2011, CMS approved the state's Planning Request. (Source: CMS Approval Letter, (02/04/2011); Letter of Request to CMS (01/31/2011)

State	State Updates
Arkansas	**Section 1915(k) Community First Choice Option (CFCO)** The state projects it will implement its Community First Choice option in 2014. (Source: State Website on CFCO) The state plans to submit a §1915(k) State Plan Amendment to CMS. (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)) 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

State	State Updates
California	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. 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 The state announced a Coordinated Care Initiative Update and LA Enrollment Strategy on February 4, 2014. The CCI Enrollment Update announcement revealed Cal MediConnect enrollment will begin in April 2014, with passive enrollment in San Mateo and "opt in" in Riverside, San Bernardino, San Diego, and Los Angeles counties. The update included a Revised Enrollment Chart outlining the CCI enrollment timeline by population and county. The LA Enrollment Strategy announcement revealed DHCS will offer beneficiaries a greater choice of Cal MediConnect plans in Los Angeles County to preserve its Two Plan Model while moving forward with Cal MediConnect. For Cal MediConnect beneficiaries in Los Angeles, California will passively enroll beneficiaries directly into Cal MediConnect eligible plans - CareMore, Care 1st, Molina, and Health Net - no sooner than July 2014. To be eligible, a plan must be a Medi-Cal participating plan, a Medicare participating plan, and have undergone Cal MediConnect plan readiness review. Once LA Care improves its Medicare quality rating, LA Care would be eligible to begin receiving passive enrollment. (Source: CalDuals, accessed 2/27/14)

State	State Updates
California	Revised Enrollment Chart Coordinated Care Initiative Update on CalDuals.org **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). The purpose of the CFCO SPA was to update the Eligibility Language related to Medi-Cal's Community First Choice Option. On July 31, 2013, CMS approved the CFCO SPA (Approval Letter). State Website on CFCO **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 On February 28, 2014, CMS and the state signed a Memorandum of Understanding for the state's managed fee-for-service demonstration model. (Source: CMS Demonstration Approvals website; CMS website; NSCLC Dual Eligible State Profiles website, April, 2014; Kaiser Family Foundation Duals

State	State Updates
Colorado	Demonstration Proposal Status Map, April 2014) Memorandum of Understanding (2/28/2014) **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 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)

State	State Updates
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) CMS Award Announcement (12/7/2012); BIP Application (10/31/2012) BIP Structural Change Work Plan **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

State	State Updates
Connecticut	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 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)
District of Columbia	**Health Homes** Prior to April 2013, the District of Columbia submitted a State Health Home Planning Request to CMS. Also prior to April 2013, CMS approved the state's Health Home Planning Request. (Source: Medicaid State Integrated Care Resource Center)
Florida	**Currently Operating Medicaid Managed LTSS Program** **Florida Long-term Care Community Diversion Program** The Florida Long-Term Care Community Diversion Program, operating

State	State Updates
Florida	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 From August 1, 2013 through March 1, 2014, the state will regionally phase out its LTC Community Diversion Program. The state will transition enrollees into its new Statewide Medicaid Managed Care Long-Term Care Program. (Source: Department of Elder Affairs Medicaid Waiver Programs Website) **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. On August 1, 2011, the state submitted an initial §1915(b) application and a concurrent initial §1915(c) waiver application to 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) 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. Mandatory enrollment populations include Medicare-Medicaid dual eligibles (fee-for-service). The Long-term Care program has been implemented on a regional basis. The first region will begin enrollment on August 1, 201; and the final region will begin enrollment on March 1, 2014. (Source: Florida

State	State Updates
Florida	Long-Term Care Managed Care Program Website; CMS and Truven Health Analytics, July 2012) Approval letter (2/1/2013) Florida Long-Term Care Managed Care Program Website A Snapshot of the Florida Medicaid Long-term Care Program (2/18/2014) **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)
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) BIP Structural Change Work Plan **Medicaid & CHIP Redesign Initiative** The state commissioned a report by a consultant that recommended moving all 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

State	State Updates
Georgia	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 On October 10, 2013, the State announced its intention to submit a Medicaid State Plan Amendment to CMS as part of its plan to implement a Medicaid Medical Coordination Program for Medicaid members who are aged, blind, or disabled. (Source: Georgia Department of Community Health Website) Public Notice, (10/10/2013) Medicaid State Plan Amendment, (10/10/2013)
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 §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)

State	State Updates
Hawaii	**Governor Signs 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) **Hawaii to Consolidate Medicaid Managed Care Contracts through QUEST Integration Program** On August 5, 2013, Hawaii submitted a Request for Proposals for its QUEST Integration (QI) program, which will consolidate the programs Hawaii operates independently under the QUEST Medicaid umbrella into a single Medicaid managed care program serving all of Hawaii's Medicaid population under §1115 Waiver authority. Hawaii's current separate Medicaid managed care programs – QUEST and QUEST Expanded Access (QExA) – are served by five managed care plans. These programs include several smaller Medicaid and non-Medicaid state-funded programs. The beneficiaries of all programs will be mandatorily enrolled in the plans awarded QI contracts under this RFP. The QI program will cover all Medicaid and state-funded non-Medicaid individuals under a unified contract with the awarded health plans. The only individuals excluded from the QI program are those who are: Medicare Special Savings Program Members; enrolled in the State of Hawaii Organ and Transplant Program (SHOTT); retroactively eligible only; and those eligible under non-ABD medically needy spend down. The state anticipates finalized capitation rates to be released on December 6, 2013, with contract awards following on January 6, 2014. The QUEST Integration program will launch with an enrollment effective date of January 1, 2015. (Source: Health Management Associates Weekly Roundup, 8/14/2013) QUEST Integration Procurement Information (2013) In January 2014, Hawaii's Department of Human Services Med-QUEST Division announced awards in its RFP to integrate the QUEST and QUEST Expanded Access (QExA) Medicaid managed care programs. The state has awarded contracts to the five incumbent health plans serving QUEST and QExA currently. According to the award announcement, all 5 health plans will be providing services to QUEST Integration members Statewide except for Kaiser Foundation Health Plan, which has chosen to focus their efforts on the islands of Oahu and Maui. The health plans will start provision of services to QUEST Integration members on January 1, 2015. (Source:

State	State Updates
Hawaii	Health Management Associates Weekly Roundup, 1/8/2014) **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** The State's Demonstration to Integrate Care for Dual Eligibles will replace the existing Medicare-Medicaid Coordinated Plan, which will continue to cover and coordinate Medicare with several 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

State	State Updates
Idaho	(10/10/2012) On February 26, 2014, the Idaho Department of Health and Welfare announced it will no longer participate in the Dual Eligible Financial Alignment Initiative Demonstration. Instead, Idaho will expand the benefits covered under its existing voluntary Medicare-Medicaid Coordinated Plan (MMCP). (Source: Idaho Department of Health and Welfare website; MLTSS Network Weekly Update (3/6/2014)) **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 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
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

State	State Updates
Illinois	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 **Section 1115 Reform Waiver** On February 10, 2014, Illinois submitted a §1115 waiver proposal for **"The Path to Transformation"** demonstration. Among other things, the waiver will provide flexibility to deliver appropriate and essential LTSS in a coordinated fashion through managed care entities and their provider networks. (Source: Illinois.gov website) Draft Waiver Concept Paper (11/7/13) §1115 Waiver Proposal (2/10/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals** **Illinois Medicare-Medicaid Alignment Initiative** The 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 areas under the capitated model. Institutional and HCBS waiver services for people with developmental/intellectual disabilities will be carved out and enrollment will be voluntary with an opt out option. (Source: Demonstration Proposal;

State	State Updates
Illinois	http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx; 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 (MMAI) 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 On March 1, 2014, opt-in enrollments became effective; and the earliest passive enrollments will become effective June 1, 2014. (Source: Illinois HFS website) **Health Homes** The state submitted a *draft* State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013) As of February 2014, Illinois had not submitted a Health Home State Plan Amendment to CMS. (Source: CMS State Health Home Proposal Status website, February 2014) **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) Structural Change Workplan (12/18/2013)
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)

State	State Updates
Indiana	Structural Change Work Plan In October 2013, the state published a Balancing Incentives Program Work Plan. (Source: Indiana FSSA website) State of Indiana Balancing Incentives Program Work Plan Table (10/10/2013) **Health Homes** The Division of Disability and Rehabilitation Services (DDRS) is drafting a Health Homes State Plan Amendment proposing statewide implementation of health homes services for individuals with a co-occurring developmental disability (DD) at risk for additional chronic health conditions. Mental Health Stakeholders are developing a Health Homes proposal for SMI. (Source: Indiana DDRS Provider Quarterly Update, 1/22/2013; Indiana DDRS Provider Quarterly Update, 4/24/2013) In its Community Integration and Habilitation Waiver Application, the state said DDRS explored the concept of Health Homes and developed a model for potential implementation, but stakeholder and advocate input led DDRS to redirect and develop Wellness Coordination services within its Community Integration and Habilitation Waiver. Wellness Coordination services provide a feasible and immediate response to the need for better coordination of waiver participants' health care issues. (Source: State Health Home CMS Proposal Status Website; Community Integration and Habilitation Waiver (Effective February 1, 2014)
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: NASDDS Managed Care Tracking Report Vol.1 No.2) **Health Homes** 1. **Health Homes for Individuals with Chronic Conditions**

State	State Updates
Iowa	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 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)

State	State Updates
Iowa	**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) 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 NASDDS Managed Care Tracking Report Vol.1 No.2)
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)

State	State Updates
Kansas	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) On December 27, 2013, the state announced the temporary postponement of its January 1, 2014 start date to incorporate intellectual and developmental disability waiver services into KanCare through a proposed amendment to its §1115 demonstration waiver. However, the state agreed to continue working with CMS to resolve issues related to the existing §1915(c) waiver for I/DD members by February 1, 2014. The state said it would determine the implementation timeline and any updates to the KanCare §1115 demonstration Special Terms and Conditions during its discussions with CMS (Source: KDHE News Release, 12/27/13) On January 17, 2014, the state announced it had made substantial progress in discussions with CMS and KanCare will include long-term services and supports for Kansans with I/DD beginning February 1, 2014. (Source: KDHE News Release, 1/17/14) On January 30, 2014, the state announced it had reached an agreement with CMS on the proposed amendment to the §1115 demonstration waiver for Home and Community-Based Services for individuals with Intellectual and/or Developmental Disabilities (HCBS-I/DD). Beginning February 1, 2014, both HCBS services and targeted case management for individuals in the Kansas I/DD waiver program will be integrated into KanCare. (Source: State Department for Aging and Disability Services Press Release, 1/30/14) Amendment Approval Letter (1/30/14) Amended Special Terms and Conditions (1/30/14) Waiver Authority Expenditure Authority **Health Homes** Health Homes for people with serious mental illness (SMI) or other chronic conditions is a component built into the KanCare §1115 demonstration waiver. The state originally expected to implement Health Homes for people with SMI on January 1, 2014, but delayed implementation until July 1, 2014. However, the state still plans to implement Health Homes for KanCare

State	State Updates
Kansas	members with other chronic conditions in July 2014, as planned. Kansas has submitted to CMS a health homes concept paper and request for funding to help plan and implement both the Health Homes model in KanCare and a formal Health Homes proposal with detailed information regarding the proposed SPA. (Source: State website on health homes) Concept Paper Kansas Letter of Request Approval Letter Health Home State Plan Amendment Proposal (9/12/2013) On February 24, 2014, the state announced health homes will begin July 1, 2014. (Source: KanCare Advisor, 2/24/14). In February 2014, the state announced its release of the Health Homes Preparedness and Planning Tool to assist providers in determining their ability to serve as a Health Home and developing a Health Home road map. (Source: Health Homes Herald, February 2014) Health Homes Preparedness and Planning Tool
Kentucky	**Balancing Incentive Program** On October 24, 2013, Kentucky submitted an application for BIP funding. CMS subsequently approved Kentucky's application for additional BIP funding. The state will receive an enhanced Federal matching rate of 2% for non-institutional long-term services and supports. (Source: CMS Balancing Incentive Program website; LeadingAge BIPP Update, 1//26/14) Kentucky's Balancing Incentive Program Application (10/24/2013) **Health Homes** Kentucky submitted a State Health Home Planning Request and CMS approved the Health Home Planning Request. (Source: State Health Home CMS Proposal Status website, February 2014)
Louisiana	**Section 1915(k) Community First Choice Option (Withdrawn)** The Department of Health and Hospitals Bureau of Health Services Financing and Office of Aging and Adult Services proposed 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 was to be terminated upon the Centers for Medicare and Medicaid Services' approval of the corresponding Community First Choice option (CFC) State Plan Amendment. (Source: Louisiana Register, Louisiana Register Vol. 38, No.6, June 20, 2012) Notice of Intent (Louisiana Register, 6/20/2012)

State	State Updates
Louisiana	In August 2013, Louisiana withdrew its application to implement CFC. **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) Structural Change Work Plan
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) The MaineCare Health Home Initiative includes Stage A Health Homes for people with chronic conditions and Stage B Behavioral Health Homes for individuals with serious mental illness or serious emotional disturbance. (Source: MaineCare Services website) Maine previously implemented Stage A of its Health Home Initiative. On October 11, 2013, DHHS posted a Behavioral Health Home Request for Applications for Stage B of its Health Home Initiative. With an application deadline of January 24, 2014, the state will implement Stage B of its Health Home Initiative in April 2014. Practices may participate in both Stage A and Stage B of the Health Home Initiative beginning April 2014. (Source: MaineCare Services website) **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) Structural Change Work Plan
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 Health & Mental Hygiene $106.34 million through September 2015. Maryland's approved work plan is available here. (Source: CMS Balancing Incentive Program website)

State	State Updates
Maryland	BIP application (2/10/2012) Award Letter (3/20/2012) Structural Change Work Plan **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) Maryland submitted a §1915(k) State Plan Amendment to CMS, and the state converted to the new Community First Choice Option format on January 6, 2014. (Source: Kaiser Family Foundation website; CFC Council Meeting Minutes, 12/9/13) **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) Maryland Health Home SPA (Draft, 2/15/2013) Maryland Health Homes DRAFT Regulations (6/10/2013) Chronic Health Homes DRAFT Criteria (12/10/2012) On September 27, 2013, CMS approved Maryland's proposed Health Home State Plan Amendment. The State Plan Amendment became effective October 1, 2013. (Source: Medicaid.gov; State Health Home CMS Proposal Status website). Health Home State Plan Amendment (Approved 9/29/13)
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

State	State Updates
Massachusetts	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) Massachusetts' duals initiative, the State Demonstration to Integrate Care for Dual Eligibles, will 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), but will include acute and behavioral health for the I/DD population (Source: NASDDDS Managed Care Tracking Report). 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 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 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 A plan's participation in the duals demonstration formally begins once a contract is signed by all parties, and the plan has passed the readiness review. Consistent with guidance from CMMI and the MOUs cited in this Tracker, any health plan participating in a capitated duals demonstration must enter into three-way contract with CMS and the state. (Source: Center for Medicare and Medicaid Services) Massachusetts Contract The state has updated its "One Care" Duals Health Plan implementation timeline. The new effective dates for three waves of auto-assignment are January 1; April 1; and July 1, 2014. (Source: Massachusetts HHS website, March 2014)

State	State Updates
Massachusetts	**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) On November 25, 2013, the state submitted a request for a six-month waiver extension of the Michigan Specialty Services and Supports (MSS&S) 1915(b) waiver. The state requested the waiver extension in order to align Michigan's Medicare/Medicaid Demonstration project with the effective date of the waiver. (Source: Michigan.gov website) On December 17, 2013, CMS granted the six-month waiver extension through September 30, 2014. (Source: Michigan.gov website) CMS Approval Letter (12/17/2013) **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 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 demonstration will be launched in four regions of the state: the entire Upper Peninsula; a region in the Southwest part of the state consisting of the following counties: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St.

State	State Updates
Michigan	Joseph, and Van Buren; Macomb as a single county region; and Wayne as a single county region. Phased enrollment in the regions will commence in July 2014. (Source: Press Release, State of Michigan Department of Community Health, 9/17/2013) Michigan's submitted its proposed Memorandum of Understanding to CMS in October 2013. (Source: Stakeholder Forum PowerPoint Presentation, 10/23/2013) Program Website As the state and CMS prepare to finalize a Memorandum of Understanding and develop Medicare and Medicaid capitation rates for the ICOs and PIHPs, the state's focus shifts to the preparation of necessary waiver documents to implement the demonstration. (Source: HMA Weekly Roundup, 12/4/2013) In April 2014, CMS and the state signed a Memorandum of Understanding for the state's capitated demonstration model. (Source: NSCLC Dual Eligible State Profiles website, April, 2014; Kaiser Family Foundation Duals Demonstration Proposal Status Map, April 2014) Memorandum of Understanding (4/2014) **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 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 As of February 2014, Michigan had not submitted a Health Home State Plan Amendment to CMS. (Source: CMS State Health Home Proposal Status website, February 2014)
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

State	State Updates
Minnesota	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 to 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 §1115 Demonstration Application (Draft) Reform 2020 §1115 Demonstration Application (Resubmitted 11/21/2012) State Website on Reform 2020 §1115 Waiver **Reform 2020 Initiative: Alternative Care Program** On October 18, 2013, CMS granted approval for Minnesota to proceed with its Reform 2020 Initiative by approving federal financial participation in the Alternative Care Program – designed to provide home and community-based services -- *pre-Level-of-Care* -- to prevent and delay transitions to nursing facilities. This approval relates to the contingency items that were a part of Reform 2020. Federal approval for the state's Alternative Care Program will free up an additional $58 million over four years in state funds to reinvest in services that will keep more seniors and people with disabilities in their homes and communities. Those services include: • More employment opportunities – Investing in support services to help more Minnesotans with disabilities find and maintain employment in their communities. • More help in choosing quality care – Providing one-on-one support to help older adults, people with disabilities and their family

State	State Updates
Minnesota	members understand and choose the long term care services that best fit their individual needs. • More funding for community-based care – Reversing and partially restoring deep cuts in reimbursement rates for home and community based services that help people with disabilities stay in their homes. • One place to report abuse – Consolidating more than 160 separate phone services into one easy-to-reach hotline to report the abuse of seniors and other vulnerable adults. (Source: Minnesota DHS News website, November 2013) Alternative Care Program Fact Sheet (February 2014) DHS News Release (November 20, 2013) **Minnesota Long Term Care Realignment Section 1115 Demonstration Waiver** (Submitted 2/13/2012 and 11/21/2012; Pending as of 7/9/2013) 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 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. 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 §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

State	State Updates
Minnesota	demonstration model would result in a significantly lower payment than Minnesota receives for senior Medicare beneficiaries in current programs. However, the state will continue to consider that model in the future as it rolls out in other states. (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** On September 12, 2013, the state signed Memorandum of Understanding (MOU) with CMS on the Dual Demonstration for Seniors enrolled in Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) managed care programs. (Source: State Website) State Website on Demonstration to Integrate Care for Dual Eligibles Memorandum of Understanding (9/12/2013) Minnesota's Alternative Demonstration for People with Medicare and Medicaid (6/18/2013) Earlier in January 2013, 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)

State	State Updates
Minnesota	**Section 1915(k) State Plan Amendment** According to state officials, under Minnesota Long Term Care Realignment §1115 Waiver, the state proposes to implement Community First Choice under §1915(k). (Source: Waiver Application; NASUAD) The state plans to implement the option in FY 2014. (Source: Kaiser Commission on Medicaid and the Uninsured, April 2013) **Health Homes** CMS approved Minnesota's previously-submitted State Health Home Planning Request. However, as of February 2014, Michigan had not submitted a Health Home State Plan Amendment to CMS. (Source: CMS State Health Home Proposal Status website, February 2014)
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) Structural Change Work Plan **Health Homes** CMS approved Mississippi's previously-submitted State Health Home Planning Request. However, as of February 2014, Mississippi had not submitted a Health Home State Plan Amendment to CMS. (Source: CMS State Health Home Proposal Status website, February 2014)
Missouri	**Medicaid Managed LTSS** The Missouri Senate Health Committee approved a bill to shift more children and adults into managed care, while authorizing a new model of coordinated care for many seniors and disabled patients. The bill aims to improve coordination of care for patients and to reduce cost for services. The legislation does not include provisions to expand Medicaid as outlined by the Affordable Care Act. The bill will now move to the full Senate for debate. (Source: HMA Weekly Roundup, March 19, 2014) Missouri Senate Interim Committee on Medicaid Transformation and Reform Draft Report (12/15/2013)

State	State Updates
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) As of March 4, 2014, Missouri's State Demonstration Proposal is pending with CMS; and Missouri will still need to negotiate and sign a Memorandum of Understanding before the state can proceed with implementation. Source: NSCLC Duals Implementation Schedule; Kaiser Family Foundation State Demonstration website). **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) Structural Change Work Plan

State	State Updates
Montana	**Section 1915(k) Community First Choice** The Governor's budget proposal included 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 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) According to Montana's 2013 Draft CFC Timeline, the state planned to submit a State Plan Amendment to CMS on August 29, 2013 and implement the Community First Choice option effective October 01, 2013. (Source: 2013 National HCBS Conference Presentation) Community First Choice Frequently Asked Questions
Nebraska	**Medicaid Managed LTSS Program** Nebraska Medicaid has started the process of developing a statewide Medicaid managed care program for the delivery of long-term services and supports, with a targeted implementation date in July 2015. Examples of long-term services and supports include nursing facility services, Personal Assistance Service (PAS), home health services, and home and community-based waiver services such as Assisted Living; Home Care/Chore; Home-Delivered Meals; Personal Emergency Response Systems; and Respite Care. In addition to long-term services and supports, the benefits package for MLTSS will include physical and behavioral health care, dental care, and pharmacy. (Source: State Website on Medicaid MLTSS) Nebraska Medicaid changed the target implementation date for MLTSS from July 2015 to January 2017. The state will update the Project Chart and Concept and Design documents to reflect the revised implementation date. (Source: State Website on Medicaid MLTSS)
Nevada	**Medicaid Managed LTSS Program** Nevada has amended its State Plan to reflect updated processes and eligibility groups as they relate to the DHCFP's Managed Care Programs. (Source: Medicaid State Resource Center website) Approved State Plan Amendment (Effective 10/1/2013) **Balancing Incentive Program** On January 7, 2014, Nevada submitted to CMS a Balancing Incentive

State	State Updates
Nevada	Payment Program application. Subsequently, CMS approved the BIP application. (Source: Medicaid.gov website) Balancing Incentive Payment Program application (1/7/2014) **Health Homes** CMS approved Nevada's Health Home Planning Request. (Source: Integrated Care Resource Center)
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 & Human Services submitted (3/31/2012) a State Plan Amendment to CMS through the §1932(a) State Plan option for authorization of a statewide 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 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 regarding 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; CMA 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 Managed Care Info Meeting Final Report (August 2012) January 2013 Update on Medicaid Care Management (1/24/2013)

State	State Updates
New Hampshire	On December 1, 2013, the state launched its transition to Medicaid managed care. (Source: HMA Weekly Roundup, December 19, 2013) **Balancing Incentive Program** New Hampshire was the first state to apply for and to receive CMS approval under the Balancing Incentive Program. CMS 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) BIP Structural Change Work Plan (10/23/2012)
New Jersey	**Medicaid Managed LTSS Program** (Approved 10/2/2012) & **State Initiative to Integrate Care for Dual Eligible Individuals** **New Jersey §1115 Comprehensive Waiver** (Submitted 9/9/2011; Approved 10/2/2012) New Jersey's §1115 Comprehensive Waiver seeks to provide State Plan benefits, as well as long-term care services & 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)

State	State Updates
New Jersey	According to a Press Release (10/4/2012) from the New Jersey Department of Human Services, some of the 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) The New Jersey Division of Medical Assistance and Health Services (DMAHS) delayed its New Jersey §1115 Comprehensive Medicaid Waiver implementation date until July 1, 2014. The revised implementation schedule will shift both HCBS and custodial care in nursing facilities to managed care effective July 1, 2014. (Source: HMA Weekly Roundup, January 8, 2014) In March 2014, the state said it will ***not*** enroll existing nursing facility residents into managed care on July 1, 2014, as previously planned under the New Jersey Comprehensive Medicaid Waiver. Instead, when the state switches over to a managed care system on July 1, 2014, existing nursing facility residents can remain under the Medicaid fee-for-service system for at least two more years; and MCOs will only be responsible for new nursing facility residents and home and community services for waiver populations currently enrolled in managed care. (Source: MLTSS Weekly Update, March 14, 2014; HMA Weekly Roundup, March 19, 2014). **Balancing Incentive Program** On March 15, 2013, CMS approved New Jersey's Balancing Incentive Program Application. The grant program is funded through September 30, 2015. (Source: CMS website; New Jersey DHS website) BIP Application (12/20/2012) In January 2014, New Jersey submitted to CMS a Structural Change Work Plan. (Source: CMS website) Structural Change Work Plan (1/16/2014) **Health Homes** CMS has approved the state's Heath Home Planning Request. (Source: Integrated Care Resource Center)

State	State Updates
New Mexico	**Currently Operating Medicaid Managed LTSS Program** Since 2008, **Coordination of Long-Term Services** (CoLTS) has provided managed 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. (Source: CMS and Truven Health Analytics, July 2012) Services include doctor visits, hospital services, home and community-based services and long-term care services. Examples of long-term care services include medical care, home health services, personal care & support, meal preparation and physical therapy. Long-term care services can be provided at home, in the community, in assisted living facilities, or nursing homes. (Source: State CoLTS Final Report (6/28/2013) Effective January 1, 2014, Centennial Care replaces New Mexico's previous Medicaid managed care programs, CoLTS and Salud!. The state will send out information beginning in October 2013 to Medicaid managed care members with instructions on how to choose a Centennial Care MCO. (Source: Centennial Care CoLTS FAQs 7/2/2013) **(See below)** **Projected Medicaid Managed LTSS Program (Approved)** In August 2012, New Mexico submitted a new §1115 Medicaid demonstration proposal entitled Centennial Care, and the proposal was approved by the CMS in July 2013. The demonstration will be implemented from January 1, 2014, through December 31, 2018. Under this demonstration, New Mexico will consolidate its existing §§1915(b) and 1915(c) waivers to create a comprehensive managed care delivery system. Centennial Care's contracted health plans will offer the full array of current Medicaid services, including acute, behavioral health, institutional, and community-based long term services and supports. Other features of Centennial Care will include expanded care coordination for all beneficiaries and a beneficiary reward program, offered through managed care organizations, to provide incentives for beneficiaries to pursue healthy behaviors. Centennial Care also creates a Safety Net Care Pool made up of two sub-pools: an Uncompensated Care (UC) Pool and a Hospital Quality Improvement Incentive (HQII) Pool. The approval of this demonstration does not impose any new requirements for Native Americans to enroll in managed care. Native American Medicaid beneficiaries will have the opportunity to voluntarily opt-in to managed care. The state will still enroll dually-eligible Native American beneficiaries or those meeting nursing facility level-of-care in managed care, as was the case under the CoLTS §1915(b)(c) combo waiver. (Source: Approval Letter,

State	State Updates
New Mexico	7/12/2013) Waiver application (Submitted 8/17/2012) State Website on Centennial Care Centennial Care general FAQs 6-19-13 On January 1, 2014, the state implemented New Mexico Centennial Care as a replacement for the New Mexico Medicaid system. (Source: State website on Centennial Care) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** 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 under a §2703 planning grant to design its first SPA to establish health homes throughout the state that address recipients with a behavioral health condition. The state intends to develop health homes in Core Service Agencies (CSAs) statewide, designed in conjunction with the MCOs under Centennial Care. Once a recipient enrolls in a BHH, MCOs will delegate responsibility for both care management and care coordination to the BHH. Over time, the state intends to establish health homes for other chronic conditions through the SPA process. The state plans to coordinate the health homes model(s) with Centennial Care to ensure integration of care is achieved at all levels. (Source: Centennial Care §1115 Demonstration Waiver Application) CMS approved the state's Heath Home Planning Request. (Source: CMS State Health Home Proposal Status website, February 2014)

State	State Updates
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. **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 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

State	State Updates
New York	of the Partnership Plan. New York has submitted an amendment to its §1115 Waiver, the Partnership Plan. The state and CMS are negotiating the $10 billion waiver request, which includes a large Delivery System Reform Incentive Payment (DSRIP) program. (Source: HMA Weekly Roundup, January 29, 2014) **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 **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-

State	State Updates
New York	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, September 2012) State Website on Managed Long Term Care/Care Coordination Model **Additional Projected Medicaid Managed LTSS Program** **New York People First Waiver** (Pending as of 10/26/2013)**:** 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) On December 1, 2013, Phase IV of New York's mandatory Medicaid long-term care program began in four upstate counties. Subsequent phases will not occur before April 2014. The state plans to implement mandatory managed long-term care for Medicaid beneficiaries requiring more than 120 days of community-based long-term care in every county by the end of 2014. (Source: MLTSS Network Weekly Update, January 23, 2014; HMA Weekly Roundup, December 4, 2013)

State	State Updates
New York	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn: Managed Fee-For-Service Model)** (Proposal Pending: Capitated Managed Care Model) On August 26, 2013, CMS announced that it will partner with the State of New York to test a new model for providing Medicare-Medicaid enrollees with a more coordinated, person-centered care experience. The federal-state partnership will include a three-way contract with Fully-Integrated Duals Advantage (FIDA) plans, Medicare-Medicaid Plans (MMPs) that will provide integrated benefits to those Medicare-Medicaid Enrollees residing in the targeted geographic area and who choose to participate in the demonstration. The demonstration will begin no earlier than July 1, 2014 and continue until December 31, 2017. The population eligible to participate in the FIDA demonstration is limited to "Full Benefit" Medicare-Medicaid Enrollees age 21 or older meeting the eligibility criteria outlined above. CMS will implement this initiative under Medicare Parts C and D and demonstration authority for Medicare, and State Plan, demonstration, and waiver authority for Medicaid. (Source: CMS Press Release, 8/26/2013) Memorandum of Understanding State Website on the demonstration 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-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,

State	State Updates
New York	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) New York's duals demonstration program will establish FIDA plans in eight downstate counties. Voluntary enrollment for community-based and nursing home populations begins October 1, 2014, and passive enrollment for both populations begins January 1, 2015. The state intends to have final three-way contracts signed by July 2014. (Source: HMA Weekly Roundup, January 15, 2014; HMA Weekly Roundup, January 22, 2014; MLTSS Network Weekly Update, February 20, 2014) **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 **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)

State	State Updates
New York	BIP Award Letter (3/15/2013) On December 20, 2013, the state submitted to CMS a BIP Structural Change Work Plan. On January 9, 2014, the state published a BIP Work Plan Update (Source: CMS website; New York State Medicaid website) BIP Structural Change Work Plan (12/20/2013) BIP Work Plan Update (1/9/2014) On March 21, 2014, the state issued a Request for Applications for BIP funding grants. The application deadline is May 7, 2014. (Source: New York State Medicaid website) Request for Applications (3/21/2014) **Section 1915(k) Community First Choice Option** The Commissioner's Advisory Group has been holding meetings to discuss the state's proposed application / implementation of the option. (Source: State Website on CFCO)
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) State Website on MH/DD/SAS Health Plan Waiver North Carolina's Medicaid department recently submitted a Medicaid reform proposal to the state legislature. On March 17, 2014, the state released a detailed report of the proposed Medicaid reform proposal plan, known as the **Partnership for a Healthy North Carolina**. The proposed plan does not pursue a traditional risk-based Medicaid managed care model. Instead, the reforms detailed in this proposal would: 1. Establish provider-led Medicaid accountable care organizations (ACOs) for the management of physical health; 2. Continue the consolidation and strengthening of the Local Management Entity Managed Care Organizations (LME-MCOs) providing services for the mental health, substance abuse, and intellectual and developmental disabilities (I/DD) populations; and 3. Streamline and

State	State Updates
North Carolina	strengthen the coordination of Medicaid long-term services & supports (LTSS). The legislature is expected to vote on the proposal as early as May 2014. (Source: HMA Weekly Roundup, March 19, 2014) **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) As of March 2014, North Carolina's Demonstration Proposal is still pending with CMS. (Source: Kaiser Family Foundation website) Community Care of North Carolina (CCNC) is expanding services beyond Medicaid enrollees. The state received a §646 waiver that expanded CCNC's reach to include dually eligible (Medicare and Medicaid) beneficiaries, thereby covering Medicare patients in 26 counties. CMS also awarded the state a Multi-Payer Advanced Primary Care Practice demonstration grant. Under this demonstration, certain CCNC networks coordinate the care and improvement for patients covered by Medicaid, Medicare, Blue Cross Blue Shield of North Carolina, and State Health Plan (which together represent about 80 percent of covered lives). (Source: National Academy for State Health Policy, November 2013) National Academy for State Health Policy Brief (11/2013) **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: 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) Health Home-eligible duals will transition to the managed fee-for-service model when the Health Homes SPA expires in October 2013. (Source: NC Response to CMS Questions on Duals Demonstration, November, 2012)

State	State Updates
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 The state's three-year duals coordination demonstration – named **MyCare Ohio** – will use a managed care approach to coordinate benefits for residents covered by both Medicare and Medicaid. (Source: State Medicaid website) On February 11, 2014, CMS, the Ohio Department of Medicaid, and the MyCare Ohio Plan entered into a three-way contract, establishing an integrated care delivery system plan to provide integrated care, including LTSS, to Ohio's Medicare-Medicaid beneficiaries. (Source: State Medicaid website) On May 1, 2014, individuals in Northeastern Ohio will begin enrolling in a MyCare Ohio managed care program. Enrollment will be phased in through June and July, until all eligible individuals are enrolled. (Source: MLTSS Weekly Update, March 6, 2014; State Medicaid website; MyCare Ohio Enrollment Update) Three-Way Contract (2/11/2014) MyCare Ohio Enrollment Update (1/2014)

State	State Updates
Ohio	**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) On September 30, 2013, the Ohio Department of Medicaid submitted to CMS a Draft BIP Structural Change Work Plan. On January 31, 2014, Ohio submitted to CMS a revised Structural Change Work Plan. Structural Change Work Plan (1/31/2014) **Health Homes** Ohio's Health Homes State Plan Amendment was approved on September 17, 2012. According to the state's duals demonstration proposal, the Ohio State Medicaid agency engaged in discussions with CMS regarding a proposed 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 planned to expand the services statewide in Spring 2013. (Source: NASUAD) Designed to enhance the traditional patient-centered medical home, the SPA will allow better coordination of 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 On August 14, 2013, the Ohio Department of Medicaid and the Ohio Department of Mental Health and Addiction Services announced they had decided to delay the Health Home rule packages in order to change the originally proposed rule filings and guarantee program sustainability. The state delayed, but did not withdraw the rule packages (Source: State Medicaid Health Homes Website) Health Home Packages Delay Notice (8/14/2013)

State	State Updates
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 would pursue 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 would be excluded from the SoonerCare Silver care coordination program. All other dually-eligible individuals not receiving care coordination services through their current benefit program would 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) As of March 2014, Oklahoma's Demonstration Proposal is still pending with CMS. (Source: Kaiser Family Foundation website) **Health Homes** Oklahoma has submitted a draft State Plan Amendment to CMS. (Source: State Health Home CMS Proposal Status, updated May 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

State	State Updates
Oklahoma	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) As of February 2014, Oklahoma has not officially submitted a Proposed Health Home State Plan Amendment to CMS. (Source: State Health Home CMS Proposal Status, updated February 2014)
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 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

State	State Updates
Oregon	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 resource on Coordinated Care Organization 1 Senate Bill 1580 (2012 CCO Implementation) HB 3650 (2011 CCO Creation) **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 **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 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)

State	State Updates
Oregon	Approved Health Homes State Plan Amendment (3/13/2012)
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	**Medicaid Managed LTSS Program** On December 23, 2013, CMS approved the state's Comprehensive §1115 Demonstration renewal request. In its March 28, 2014 Draft Comprehensive Quality Strategy for the §1115 Demonstration, Rhode Island described **Rhody Health Options (RHO)** as the LTSS aspect of its Integrated Care Initiative. RHO represents the integration of Medicaid LTSS services into a managed care delivery system. (Source: Rhode Island HHS website) Rhode Island Comprehensive Demonstration (Approved 12/23/2013) Stakeholder Notice (3/28/2014) **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) In November 2013, the state implemented Phase I of the Integrated Care Initiative. In February 2014, the final group of Medicare/Medicaid recipients and Medicaid-only recipients to enroll (adults with I/DD and Adults with Serious and Persistent Mental Illness (SPMI)) received voluntary enrollment letters. The following services will remain the same during Phase I: Long-term Services & Supports for adults with IDD; and Intensive Behavioral Health Services for adults with SPMI.

State	State Updates
Rhode Island	April 2015 has been set as the tentative start date for Phase II of the Integrated Care Initiative. Phase II will fully integrate Medicaid and Medicare services delivered by a health plan. (Source: State Integrated Care Initiative Update, February 2014) Integrated Care Initiative Update (2/18/2014) Integrated Care Initiative Phase II Draft Timeline (3/26/2014) As of March 2014, the state's Demonstration Proposal is pending with CMS. (Source: Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014) **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 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) Approved CEDARR Health Home State Plan Amendment (Effective 10/1/2011) Approved Community Mental Health Organization Health Home State Plan Amendment (Effective 10/1/2011) The state submitted to CMS a draft Health Homes State Plan Amendment for a third health home. (Source: CMS State Health Home CMS Proposal Status, updated April 2013) On November 6, 2013, CMS approved the state's third Health Home State Plan Amendment, with an effective date of July 1, 2013. The Health Home will target opioid-dependent Medicaid recipients who currently receive or meet the criteria for Medication Assisted Treatment. (Source: CMS Health Home SPA Matrix, March 2014; State Health Home CMS Proposal Status, February 2014; Medicaid.gov website) Approved Opioid Treatment Health Home State Plan Amendment (Effective 7/1/2013)

State	State Updates
South Carolina	**State Demonstration to Integrate Care for Dual Eligible Individuals** South Carolina recently signed a Memorandum of Understanding with CMS/CMMI to implement a dual-eligible initiative titled **Healthy Connections Prime**. The South Carolina demonstration will employ a three-way contract with Coordinated & Integrated Care Organizations (CICOs) to provide benefits to dual-eligibles statewide under a capitated model of financing. The state indicates that the demonstration will begin no sooner than July 1, 2014 and continue until December 31, 2017. Demonstration Proposal Memorandum of Understanding State Website on Duals Demonstration South Carolina has defined the individuals eligible to participate in the demonstration as persons 65 and over: (1) living in the community at the time of enrollment, (2) receiving full Medicaid benefits, (3) entitled to benefits under Medicare Part A, and (4) enrolled under Medicare Parts B and D. Individuals receiving HCBS services (e.g. HIV, Vent, and Community Choices) are also eligible for the demonstration. The state will not include individuals with intellectual or developmental disabilities in the demonstration. Enrollment includes an opt-in period followed by passive enrollment, but beneficiaries can opt-out, as well as change plans at any time. (Source: South Carolina Memorandum of Understanding; Integrated Care Workgroup Session, 10/17/2013) The state initially planned to carve HCBS waiver services out of the demonstration, but recently revised the proposed model to carve-in home- and community-based services. (Source: SCDuE Weekly Update, 7/3/2013)
South Dakota	**Health Homes** The state submitted a draft Health Homes State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013) On November 22, 2013, CMS approved the state's Health Home State Plan Amendment, with an effective date of July 2, 2013. The Health Home will target Medicaid recipients with two or more chronic conditions, one chronic condition and the risk of developing another, or one serious and persistent mental health condition. (Source: CMS Health Home SPA Matrix, March 2014; State Health Home CMS Proposal Status, February 2014; Medicaid.gov website) CMS Approval Letter (11/22/2013) Approved Health Home State Plan Amendment (Effective 7/2/2013)

State	State Updates
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) 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 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	State Updates
Tennessee	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** Tennessee submitted (12/21/2012) a letter to Medicare-Medicaid 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-Medicaid Coordination Office) (Prior to Tennessee's decision to withdraw from the duals demonstration, the State had proposed, via **TennCare PLUS,** to enroll full benefit dual eligibles, except PACE participants, starting January 1, 2014, statewide. The demonstration would not have included LTSS for persons with intellectual disabilities (including ICF/MR and §1915(c) waiver services), but dually-eligible members receiving these services would have been included in the demonstration for all other Medicare and Medicaid services. The now-withdrawn demonstration would have operated 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 Under **Healthcare Transformation and Quality Improvement Program §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 proposed amendment to the §1115 on 5/3/2012, proposing to add Day Activity 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

State	State Updates
Texas	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) CMS Approval Letter (12/12/2011) Approval Document (Effective 12/12/2011) The Texas Health and Human Services Commission (HHSC) promulgated new permanent payment rules that implement the provider eligibility requirements and payment methodologies approved by CMS under the §1115 Healthcare Transformation and Quality Improvement Program waiver. (Source: Texas Register, June 22, 2012) State information on the adopted rules On June 19, 2013, the state submitted a further amendment to its §1115 demonstration waiver; and CMS approved the amendment on March 6, 2014. The amendment allows the state to make several managed care changes to the §1115 waiver, including carving nursing facility services into managed care and adding additional mental health services and HCBS to managed care. The addition of cognitive rehabilitative services is effective March 6, 2014; all other amendment changes are effective September 1, 2014. (Source: CMS.gov) Request for Amendment (Submitted 6/19/2013) Approval Document (Effective 3/6/2014 and 9/1/2014) In a March 2014 information session, Texas HHS verified it will expand STAR+PLUS statewide on September 1, 2014. On this date, the state will implement the Behavioral Health carve-in to managed care and I/DD acute care service carve-ins to managed care. People living in nursing facilities will get full Medicaid coverage through STAR+PLUS on March 1, 2015. (Source: HMA Weekly Update, January 29, 2014; Texas HHS Managed Care Informational PowerPoint, March 2014; State Health and Human Services website) Texas HHS Managed Care Informational PowerPoint (3/2014) **STAR Kids** Beginning September 1, 2015, most children and young adults under the age of 21 who get SSI Medicaid or HCBS will receive some or all of their Medicaid services through a new program known as **STAR Kids**. This program is a Medicaid managed care model designed specifically for children and young adults with special needs. Enrollees will receive comprehensive service coordination. Children and youth enrolled in the Medically Dependent Children Program and children enrolled in the Youth Empowerment Services mental health and substance abuse waiver will

State	State Updates
Texas	receive all of their services (LTSS and acute care) through STAR Kids. Individuals who receive services through other home and community-based programs administered by DADS will continue to receive LTSS through that program, but will receive acute care through STAR Kids. (Source: Texas HHS Managed Care Informational PowerPoint, March 2014; HMA Weekly Update, January 29, 2014) **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, October 2012) As of March 2014, the state's Demonstration Proposal is pending with CMS. (Source: Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014) On March 24, 2014, the state provided an update on its dual eligible demonstration, indicating it is close to entering into three-way contracts with CMS and STAR+PLUS health plans in six counties. The state plans to finalize contracts with MCOs by August 2014 and begin the project by January 15, 2015. Duals can opt out of the demonstration. (Source: HMA Weekly Roundup, January 29, 2014; HMA Weekly Roundup, March 26, 2014) **Cost-sharing methodology for Dual Eligibles** HHSC also amended 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 & Medicaid Services in order to implement specific adjustments to the Medicare Equalization policy. The

State	State Updates
Texas	changes will implement coincident with the effective date of the State Plan Amendment. (Source: Texas Register, June 22, 2012) State information on the adopted rules **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) BIP Structural Change Work Plan **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 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

State	State Updates
Vermont	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) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** The proposed demonstration would have included full benefit dual-eligibles, including those with intellectual/developmental disabilities. The now-withdrawn proposal originally would have implemented statewide under a capitated payment model starting January 1, 2014. Vermont's duals demo would not have included PACE participants (approximately 120 people). (Source: Demonstration Proposal) State website on the demonstration As of March 2014, the state has withdrawn its Demonstration Proposal and no longer plans to participate in the demonstration. (Source: Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014) **Health Homes** The state has submitted its Health Homes State Plan Amendment (SPA 13-021, draft), with July 1, 2013 as the proposed effective date. Under the SPA, Vermont would establish the Health Homes for Beneficiaries Receiving Medication Assisted Therapy for Opioid Dependence, i.e., MAT for the chronic condition of opioid dependence. Vermont's Health Home services build on existing MAT resources and the infrastructure created by Vermont's Blueprint for Health Patient-Centered Medical Home (PCMH) and multidisciplinary Community Health Team (CHT) model. (Source: Draft State Plan Amendment) On March 4, 2014, CMS approved the state's Health Home State Plan Amendment, with an effective date of July 1, 2013. (Source: State Health Home CMS Proposal Status, March 2014; Medicaid.gov website) Approved Health Home State Plan Amendment (Effective 7/2/2013)

State	State Updates
Virginia	**State Demonstration to Integrate Care for Dual Eligible Individuals** Virginia's duals demonstration proposes 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 state targeted January 2014 for initial implementation in four regions, utilizing 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, then-Governor Bob McDonnell announced that Virginia has signed a Memorandum of Understanding (MOU) with CMS to implement its 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, 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 On December 4, 2013, the state and CMS entered into a three-way contract with health plans for the delivery of coordinated services and supports to enrollees. (Source: NSCLC Dual Eligible State Profiles website, March 2014) Three-Way Contract (12/4/2013)
Washington	**Currently Operating Medicaid Managed LTSS Program** After inception in 2005, an LTSS component was added to **Washington Medicaid Integration Partnership** (WMIP). Under the program, WMIP covers primary, acute, behavioral, prescription drugs, and LTSS (nursing facilities and community-based services) at a 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 a very limited geographic area is covered. (Source: CMS and Truven Health Analytics, July 2012)

State	State Updates
Washington	State Resource on WMIP (December 2010) **State Demonstration to Integrate Care for Dual Eligible Individuals** (Managed Fee-For-Service Model & Capitated Model) **HealthPath Washington** (formerly Pathways to Health), Washington State's Medicare & 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. **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, the state would implement this Managed Fee-for-Service Financial Alignment Demonstration on April 1, 2013. The Washington Health Care Authority Department of Social and Health Services later said 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 Pilot Program website) Under the demonstration, eligible Medicare-Medicaid enrollees 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 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 encompasses 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 time, 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:

State	State Updates
Washington	Memorandum of Understanding) Memorandum of Understanding (10/24/2012) Addendum to Demonstration Proposal Washington Managed FFS Model Final Demonstration Agreement (6/28/13) **Strategy 2: Full Integration Capitation (Three Way Contract between Health Plan/State/CMS)** MOU Signed (11/25/2013) **HealthPath Washington** is Strategy 2 Financial Alignment Demonstration; this strategy 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 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 dis-enroll 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, October 2012) HealthPath Washington project website HealthPath Washington Medicaid Health Homes Website HealthPath Washington Medicaid Health Homes Presentation (6/21/2012) In November 2013, CMS and the state signed a Memorandum of Understanding for the state's capitated model demonstration proposal. (Source: CMS Demonstration Approvals website; Kaiser Family Foundation

State	State Updates
Washington	Duals Demonstration Proposal Status Map, March 2014; NSCLC Dual Eligible State Profiles website, March 2014) Memorandum of Understanding (11/25/2013) Washington Capitation Readiness Review Tool (12/27/2013) Washington Health Care Innovation Plan (12/2013) **Health Homes** The state submitted a draft Health Home State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013) Following CMS approval of the SPA, implementation of Health Homes started on July 1, 2013. The initial strategy focuses on all Medicaid clients in 37 of 39 counties who have select chronic conditions and at greater risk for costly and poorly coordinated health care services. The state plans a second strategic approach for the remaining two counties (Snohomish and King), but that phase won't begin until next year. (Source: Health Homes News Release, June 28, 2013) State Website on Health Homes Health Homes Updated Fact Sheet (6/8/2013) Washington Health Home State Plan Amendment (Effective 7/1/2013) On September 17, 2013, the state submitted an additional proposed Health Home State Plan Amendment to CMS. On December 11, 2013, CMS approved the state's Health Home State Plan Amendment, with an effective date of October 1, 2013. The Health Home will target Medicaid recipients with two or more chronic conditions, one chronic condition and the risk of developing another, or one serious and persistent mental health condition. (Source: State Health Home CMS Proposal Status, February 2014; Medicaid.gov website) CMS Approval Letter (12/11/2013) Approved Health Home State Plan Amendment (Effective 10/1/2013)
West Virginia	**Health Homes** According to the most current version of West Virginia's Draft State Plan Amendment, the state will implement Health Homes in a limited geographic area. Individuals eligible for health home services will have a diagnosis of bipolar disorder, with specific attention being given to risk for Hepatitis B and/or C. (Source: State Website on Health Homes) Draft State Plan Amendment (11/29/2012) Draft State Plan Amendment (8/24/2012) West Virginia Health Improvement Institute Website on Health Homes Guidance Letter from CMS (11/16/2010) Health Homes Updated Webinar Presentation (6/2013)

State	State Updates
West Virginia	As of March 2014, CMS has approved the state's Health Home Planning Request, but West Virginia has not officially submitted a Health Home State Plan Amendment to CMS for approval. (Source: State Health Home CMS Proposal Status, March 2014)
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 (4/5/2011) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** 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

State	State Updates
Wisconsin	Wisconsin Department of Health Services (DHS) submitted a revised draft Memorandum of Understanding (MOU) to CMS on August 12, 2013. This state drafted version reflects the design proposal of Wisconsin's Integrated Demonstration, with updates from versions previously submitted to CMS. While CMS considers the proposed MOU, DHS is working to leverage the innovative ideas and investments in building more integrated systems by applying the "lessons learned" to current Wisconsin-administered Medicaid programs while awaiting CMS' response. (Source: State website on the demonstration) DHS letter to CMS (8/12/2013) DHS Memorandum of Understanding (revised draft) (8/12/2013) On November 22, 2013, CMS informed Wisconsin DHS it was unable to approve the state's MOU as currently proposed. In response, the state withdrew from the Demonstration to Integrate Care for Dual Eligible Individuals on December 19, 2013. (Source: Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014; NSCLC Dual Eligible State Profiles website, March 2014) CMS Letter to Wisconsin DHS (11/22/2013) State Demonstration Withdrawal Letter (12/19/2013) **Health Homes** 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 (Effective 10/1/2012)

State Medicaid Integration Tracker©

NASUAD National Association of States United for Aging and Disabilities

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 4/1/2014)

	States	Proposed Financing Model	Submitted to CMS	Status	Target Implementation Date[1]
1	**Arizona**	~~Capitated~~	~~5/31/2012~~	**Withdrew**	~~1/2014~~
2	**California**	Capitated	5/31/2012	**MOU Signed** 3/27/2013	4/2014
3	**Colorado**	Managed FFS	5/2012	**MOU Signed** 2/28/2014	N/A
4	**Connecticut**	Managed FFS	5/31/2012		12/2012
5	**Hawaii**	~~Capitated~~	~~5/25/2012~~	**Withdrew**	~~1/2014~~
6	**Idaho**	Capitated	5/2012	**Withdrew**	1/2014
7	**Illinois**	Capitated	4/6/2012	**MOU Signed** 2/22/2013	3/2014 (opt-in); 6/2014 (passive)
8	**Iowa**	Managed FFS	5/29/2012		1/2013
9	**Massachusetts**	Capitated	2/16/2012	**MOU Signed** 8/23/2012	1/2014; 4/2014; 7/2014
10	**Michigan**	Capitated	4/26/2012	**MOU Signed** 4/2014	
11	**Minnesota**	Admin. Alignment ~~Capitated~~	~~4/26/2012~~	**Admin. Alignment MOU Signed** (9/12/2013) **Withdrew Capit.**	~~12/2012~~

[1] Implementation dates are based on demonstration proposals submitted to CMS, Memorandum of Understanding, and CMS financial alignment demonstration for dual-eligible beneficiaries: status report, 9/13/2013.

	States	Proposed Financing Model	Submitted to CMS	Status	Target Implementation Date[1]
12	**Missouri**	Managed FFS	5/31/2012		10/2012
13	**New Mexico**	~~Capitated~~	~~5/31/2012~~	**Withdrew**	~~1/2014~~
14	**New York**	Capitated[2]	5/25/2012	**MOU Signed** 8/26/2013	10/2014 (opt-in); 1/2015 (passive)
15	**North Carolina**	Managed FFS	5/2/2012		1/2013
16	**Ohio**	Capitated	4/2/2012	**MOU Signed** 12/12/2012	5/2014-7/2014 (passive phase-in)
17	**Oklahoma**	Both	5/31/2012		7/2013
18	**Oregon**	~~Capitated~~	~~5/11/2012~~	**Withdrew**	~~1/2013~~
19	**Rhode Island**	Capitated	5/31/2012		11/2013 & 2/2014 (opt-in); 4/2015 (passive)
20	**S. Carolina**	Capitated	5/25/2012	**MOU Signed**	7/2014
21	**Tennessee**	~~Capitated~~	~~5/17/2012~~	**Withdrew**	~~1/2014~~
22	**Texas**	Capitated	5/2012		1/2014
23	**Vermont**	~~Capitated~~	~~5/10/2012~~	**Withdrew**	~~Jan 2014~~
24	**Virginia**	Capitated	5/31/2012	**MOU Signed** 5/21/2013	3/2014 (opt-in); 7/2014 (passive)
25	**Washington**	Both	4/26/2012	**2 MOUs Signed** MFFS (10/25/2012) Capit. (11/25/2013)	MFFS (7/2013) Capit. (7/2014)
26	**Wisconsin**	~~Both~~	~~4/26/2012~~	**Withdrew**	~~1/2013~~

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

National Association of States

United for Aging and Disabilities

1201 15th Street NW, Suite 350

Washington, DC 20005

Phone: 202-898-2578

www.nasuad.org