

November 15, 2013

State Medicaid Integration Tracker[©]

October-November 2013 Edition

Welcome to the State Medicaid Integration Tracker[®]

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

The **State Medicaid Integration Tracker[®]** focuses on the status of following state actions:

1. Medicaid Managed Long Term Services and Supports (MLTSS)
2. State Demonstrations to Integrate Care for Dual Eligible Individuals and other Medicare-Medicaid Coordination Initiatives
3. Other LTSS Reform Activities, including:
 - Balancing Incentive Program
 - Medicaid State Plan Amendments under §1915(i)
 - Community First Choice Option under §1915(k)
 - Medicaid Health Homes

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

For more information, please contact **John Michael Hall** (mhall@nasuad.org) or **Eunhee (Grace) Cho** (gcho@nasuad.org).

A Special Message from Eunhee (Grace) Cho

Thank you for subscribing to State Medicaid Integration Tracker. It has been a great pleasure and honor to be an author of the Integration Tracker since its birth on May 23, 2012. I would like to thank Diana Scully and Mike Hall, who were my advisors and editors on this important project. Working on the Integration Tracker was truly one of the most rewarding experiences. I hope you continue your interest in the Integration Tracker and enjoy future editions. Thank you.

Sincerely,
Eunhee (Grace) Cho

This Month's Updates

Medicaid Managed LTSS:

- CMS approved **New Mexico's** §1115 Medicaid demonstration proposal (entitled Centennial Care) in July 2013. The state plans to implement the demonstration in January 1, 2014.
- **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.

Medicare-Medicaid Care Coordination Initiatives:

- **South Carolina** has signed a Memorandum of Understanding with CMS to implement a dual eligible initiative called "Healthy Connections Prime".
- **Michigan** hopes to begin enrollment into their duals initiative beginning in July 2014. The state submitted a proposed Memorandum of Understanding to CMS in October 2013.

Community First Choice option under §1915(k):

- **Arkansas** projects implementation of the Community First Choice option in 2014.

Medicaid State Plan Amendments under §1915(i):

- **Indiana** has initiated the process of applying to CMS to secure federal funding for provision of Child Mental Health Wraparound (CMHW) services under §1915(i) of the Social Security Act.

Medicaid Health Home:

- **Kansas** will delay implementing Health Homes for people with Serious Mental Illness until July 1, 2014. (Previously, the state had intended to implement in January 1, 2014.) However, the state still anticipates implementing Health Homes for KanCare members who have other chronic conditions in July 2014 as planned.

Overview

| | |
|--|--|
| Medicaid Managed LTSS: | AZ, CA, DE, FL, HI, IL, KS, MA, MI, MN, NC, NE , NH, NJ, NM, NY, OH, PA, 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, DE, FL**, HI(W), ID, IL*, IA, MA*, MI, MN(W)**, MO, NH**, NJ**, NM (W), NY*, NC, OH*, OK, OR(W)**, RI, SC* , TN (W), TX, VA*, VT, WA*, WI** Duals Demonstration Status Chart |
| Other LTSS Reform Activities: (*Approved by CMS) | |
| <ul style="list-style-type: none"> Balancing Incentive Program: | AR*, CT*, GA*, IA*, IL*, IN*, LA*, MD*, ME*, MO*, MS*, NH*, NJ*, NY*, OH*, TX* |
| <ul style="list-style-type: none"> Medicaid State Plan Amendments under §1915(i): | CA* (1 approved; 2 pending), CO*, CT*, DE, FL*, IA*, ID*, IN, LA*, MD, MN, MT*, NC (2)*, NV*, OR*, TX (W), WA , WI* |
| <ul style="list-style-type: none"> Community First Choice option under §1915(k): | AZ(W), AR, CA*(1 approved; 1 pending), CO, LA, MD, MN, MT, NY, OR*, TX |
| <ul style="list-style-type: none"> Medicaid Health Homes: | AL*, AR, AZ, CA, DC, IA* (1 approved; 1 pending), ID*, IL, IN, KS, MA, MD, ME*, MI, MO (2)*, MS, NC*, NJ, NM, NV, NY*, OH*, OK, OR*, RI* (2 approved; 1 pending), SD, VT, WA, WI*, WV |

State Updates

| State | State Updates |
|-----------------------|--|
| <p>Alabama</p> | <p>Health Homes</p> <p>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))</p> |
| <p>Arizona</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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)</p> <p>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)</p> <p>The state recently submitted (11/9/2012) amendment to its 1115 Waiver to extend the state authority (1) to provide Medicaid coverage to adults without dependent children with incomes between 0% and 100% of the Federal Poverty Level (“Childless Adults”) for the entire period of its Demonstration, and (2) to obtain the enhanced federal medical assistance percentage (FMAP) for Childless Adults beginning January 1, 2014. No changes to the benefit package or to the current cost sharing requirements are being proposed through this amendment.</p> |

| State | State Updates |
|-----------------------|---|
| <p>Arizona</p> | <p><u>Application for Amendment</u> (11/9/2012)</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)</p> <p>On April 10, AHCCCS Director Thomas Betlach submitted a <u>letter</u> 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: <u>State Website</u>) <u>Arizona Capitated Financial Alignment Demonstration Withdrawal Letter</u> (4/10/2013)</p> <p>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: <u>Demonstration Proposal</u>)</p> <p>Section 1915(k) Community First Choice (CFC) Option</p> <p>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."</p> <p>In May 2013, CMS determined that CFC services could only be provided to individuals eligible under the State Plan. In Arizona, eligibility for LTSS is established under the state’s comprehensive §1115 waiver. On June 13, 2013, Arizona withdrew its application. Implementation of the "Agency with Choice" service model will continue under AZ’s §1115 waiver. (Source: National HCBS Conference Presentation, 9/11/2013) <u>State Website on ALTCS Member-Directed Options</u></p> |

| State | State Updates |
|------------------------|---|
| <p>Arizona</p> | <p>State Plan Amendment (10/5/2012) Presentation (10/29/2012)</p> <p>Health Homes</p> <p>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)</p> <p>Arizona Health Care Cost Containment System (AHCCCS) Director Testifies before the U.S. Senate on Duals Demonstration Overview Complete Testimony</p> |
| <p>Arkansas</p> | <p>Balancing Incentive Program</p> <p>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)</p> <p>Health Homes</p> <p>Planning request was approved by CMS. (Source: CMS Approval Letter, 02/04/2011) Letter of Request to CMS (01/31/2011)</p> <p>Section 1915(k) Community First Choice Option (CFCO)</p> <p>The state is projecting to implement 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</p> |

| State | State Updates |
|-------------------|--|
| Arkansas | <p><u>and Implementation Council Presentation (11/20/2012))</u> <u>Development & Implementation Council Meeting Documents</u></p> |
| California | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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, <u>The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update</u>, July 2012) <u>State Website on SCAN Connections at Home</u></p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>Coordinated Care Initiative (CCI): California submitted a revised <u>demonstration proposal</u> to CMS on May 31, 2012. On June 27, 2012, the governor approved a bill (<u>SB 1008</u>) to revise the existing law to require the Department of Health Care Services to establish demonstration sites in up to eight counties not sooner than March 1, 2013. (Source: CalDuals.org, July 3, 2012) According to the demonstration proposal, target population includes all full benefit Medicare-Medicaid enrollees who are age 21 or over in eight counties with specified exceptions. Full benefit dually-eligible beneficiaries are those Medicare beneficiaries with Parts A, B, and D coverage and full Medi-Cal coverage. Medi-Cal covers Medicare premiums, co-insurance, copayments, and deductibles, as well as services that Medicare does not cover (primarily long-term services and supports). Beneficiaries with developmental disabilities who are receiving services from the Department of Developmental Services and regional centers are carved out from the demonstration, while some people with developmental disabilities receiving services through the state’s in-home supportive services (IHSS) and community-based adult services (CBAS) will be included in the demonstration. Those enrolled in §1915(c) HCBS waiver programs are also excluded from the demonstration. Covered benefits include Medicare (Parts A, B and D) and Medicaid covered services. The demonstration will use a capitated payment model. (Source: <u>Demonstration Proposal; NASDDDS Managed Care Tracking Report</u>) State officials proposed (05/25/2012) a change in the implementation date, from March 2013 to June 2013. (Source: <u>www.californiahealthline.org</u>, May 30, 2012) <u>Demonstration Proposal</u> <u>State Website on Coordinated Care Initiative</u> <u>Timeline</u> <u>Coordinated Care Initiative Fact Sheets on CalDuals.org</u></p> <p>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</p> |

| State | State Updates |
|--------------------------|---|
| <p>California</p> | <p>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</p> <p>Section 1915(k) Community First Choice (CFC) Option</p> <p>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)</p> <p>In May 2013, the state submitted its second CFCO SPA (CFCO SPA #13-007) in order to update the Eligibility Language related to Medi-Cal’s Community First Choice Option, and received approval from CMS on July 31, 2013 (Approval Letter).</p> <p>State Website on CFCO</p> <p>Section 1915(i) State Plan Amendment</p> <ol style="list-style-type: none"> 1. Approved State Plan Amendment <p>California submitted an application to implement a §1915(i) Home and Community Based Services State Plan Option (SPA# 09-023A) in 2009 and received approval from CMS on April 25, 2013. The state’s SPA is the first in the nation approved by CMS under §1915(i) specifically for persons with developmental disabilities. The SPA approval allows the state to access federal funding for services, such as residential supports, day programs and respite, provided to individuals who do not meet the institutional level of care eligibility criteria of the current Medicaid HCBS Waiver. (Source: Press Release, May 1, 2013)</p> <ol style="list-style-type: none"> 2. Pending State Plan Amendments |

| State | State Updates |
|--------------------------|--|
| <p>California</p> | <p>California Department of Health Care Services (DHCS) submitted two additional §1915(i) State Plan Amendments in 2011. The <u>first one</u> (SPA# 11-041) proposed to target developmentally disabled individuals with a need for habilitation services. This SPA would extend Medi-Cal coverage for existing specialized health and other home and community-based services provided to Medi-Cal-eligible persons with developmental disabilities. Medi-Cal-eligible persons with developmental disabilities who do not meet the criteria for institutional long-term care services will be covered under this State Plan option. Services covered under the SPA would include community living arrangement services, respite care, and day services. The state anticipates serving 42,000 in the first year. The <u>second §1915(i)</u> (SPA# 11-040) proposed to target infants and toddlers with developmental delays and would provide a 1-day session with families to prepare the children for school or other appropriate facilities (currently funded with state-only funds). California anticipates serving 3,800 in the first year. (Source: California Department of Health Care Services Website)</p> <p>Health Homes</p> <p>CMS approved planning request. (Source: Integrated Care Resource Center)</p> |
| <p>Colorado</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>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</p> <p>Section 1915 (i) State Plan Amendment</p> <p>Colorado submitted a State Plan Amendment to implement §1915(i) State Plan Option in 2008 and received approval from CMS in 2009. To qualify for State Plan HCBS Services provided under the option, a physician must document that the individual’s health is at risk without appropriate supports due to a chronic condition and/or progressive disease as documented by a physician requires significant assistance with transferring mobility or supervision and assistance with at least one of the following Activities of Daily Living bathing dressing eating or toileting. (Source: State Plan Amendment)</p> <p>Accountable Care Collaborative (ACC)</p> |

| State | State Updates |
|---------------------------|---|
| <p>Colorado</p> | <p>A <u>bipartisan bill</u>, 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 <u>state website</u>, 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.</p> <p><u>Accountable Care Collaborative State Website</u> <u>Accountable Care Collaborative Fact Sheet</u></p> <p>Selected by the Center's for Medicare and Medicaid Services' (CMS') Innovation Center to participate in the <u>Comprehensive Primary Care (CPC)</u> 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: <u>Colorado Department of Health Care Policy and Financing</u>)</p> <p>Section 1915(k) Community First Choice Option</p> <p>The state is currently considering pursuing the option. In 2012, Colorado's <u>Long Term Services and Supports (LTSS) Strategic Planning Report</u> 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: <u>Colorado Community First Choice Council website</u>)</p> |
| <p>Connecticut</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>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: <u>NASDDDS Managed Care Tracking Report</u>) Covered benefits include</p> |

| State | State Updates |
|---------------------------|---|
| <p>Connecticut</p> | <p>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)</p> <p>Balancing Incentive Program</p> <p>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</p> <p>Section 1915(i) State Plan Amendment</p> <p>Connecticut's §1915(i) State Plan Amendment to CMS was submitted in 2011 and the option went effective in 2012. It is one of funding sources for Connecticut Home Care Program. Since February 2012, individuals with incomes up to 150% of the federal poverty level (FPL) have been able to get Medicaid-covered non-home health care community-based services under this option. (Source: OLR Research Report: Connecticut Home Care Program, February 2013) The state has identified elderly and disabled individuals, including older adults financially, but not functionally eligible for the state's HCBS elder waiver as the target populations. Services covered by the option would include adult day health, care management, homemaker, personal care assistant, respite, assisted living, assistive technology, chore services, companion, environmental accessibility adaptations, home delivered meals, mental health counseling, personal emergency response systems, and transportation. (Source: State Plan Amendment)</p> <p>Connecticut restructures the state's relationships with Medicaid managed care plans</p> <p>Starting January 1, 2012, Connecticut began directly reimbursing health care</p> |

| State | State Updates |
|---------------------------|---|
| <p>Connecticut</p> | <p>providers, while a non-profit organization, Community Health Network of Connecticut, Inc., provides care coordination and customer service for all of the state’s Medicaid and Children’s Health Insurance Program beneficiaries, plus members of a state-funded health programs for low-income adults — about 600,000 people in all. All services will be coordinated by the Department of Social Services’ single, statewide administrative services organization (ASO). (Source: Stateline; Community Health Network of Connecticut, Inc.) Press Release Request for Proposals (April 2011) HB06518. An Act Establishing An Administrative Services Organization</p> |
| <p>Delaware</p> | <p>Currently Operating Medicaid Managed LTSS Program & State Initiatives to Integrate Care for Dual Eligible Individuals</p> <p>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</p> <p>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)</p> <p>Section 1915(i) State Plan Amendment</p> <p>The state plans to implement the option in FY 2013 or FY 2014. (Source: Kaiser Family Foundation, June 2013)</p> |

| State | State Updates |
|-----------------------------|--|
| District of Columbia | <p>Health Homes</p> <p>CMS approved planning request. (Source: Integrated Care Resource Center)</p> |
| Florida | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>Florida Long-term Care Community Diversion Program operating under §1915(a) and §1915(c) Medicaid authorities serves Medicare-Medicaid dual eligibles of age 65 and older in 46 of 67 counties in the State. The state is currently processing applications for the remaining counties. Enrollment is voluntary with opt in. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Website on Long-term Care Community Diversion Program Approved Waiver</p> <p>Projected Medicaid Managed LTSS Program & State Initiatives to Integrate Care for Dual Eligible Individuals</p> <p>The Florida Agency for Health Care Administration (AHCA) recently (2/1/2013) received approval of its application for a §1915(b)(c) combination waiver from CMS to implement the long-term care component of the State Medicaid Managed Care (SMMC) Program. These simultaneous (b) & (c) waivers are effective beginning July 1, 2013, through June 30, 2016. The Agency had submitted (8/1/2011) initial §1915(b) waiver application and a concurrent initial §1915(c) waiver application to the CMS to implement the Florida Long Term Care Managed Care program as mandated by the 2011 Florida Legislature (House Bill 7107). The legislature required the agency to create a statewide long-term care managed care program for Medicaid recipients who are (a) 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability; and (b) determined to require nursing facility level of care. The specific authorities requested in the §1915(b) and (c) waiver applications will allow the state to require eligible Medicaid recipients to receive their nursing facility, hospice, and home and community based (HCB) 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, for the first region enrolling on August 1, 2013 and the final region enrolling on March 1, 2014. (Source: 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</p> |

| State | State Updates |
|-----------------------|--|
| <p>Florida</p> | <p>A Snapshot of the Florida Medicaid Long--term Care Program (6/30/2013)</p> <p>Florida Medicaid Reform—Section 1115 Demonstration Waiver (Approved 12/15/2011)</p> <p>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)</p> <p>Fact Sheet Current Approval Document Medicaid Reform waiver website Letter to CMS - Medicaid Managed Care Policies (10/13/2012)</p> <p>Section 1915(i) State Plan Amendment</p> <p>The state implemented §1915(i) State Plan Home and Community-Based Services (HCBS) benefit for delinquent youth with serious emotional disturbances and their families. The operating agency is the Department of Juvenile Justice. (Source: State Plan Amendment)</p> |
| <p>Georgia</p> | <p>Balancing Incentive Program</p> <p>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)</p> <p>CMS Award Announcement (6/13/2012) Balancing Incentive Program Grant Application (Submitted to CMS 3/3/2012) BIP Structural Change Work Plan</p> <p>Medicaid & CHIP Redesign Initiative</p> <p>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 enrollees into managed care plans, while still keeping</p> |

| State | State Updates |
|----------------|--|
| Georgia | <p>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)</p> <p>State Medicaid Redesign Initiative website</p> |
| Hawaii | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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)</p> <p>Approval Document (6/14/2012) Fact Sheet Additional information</p> <p>Department of Human Services (DHS) requested (05/29/2012) CMS for a three-year extension of the QUEST Expanded Section 1115 demonstration program, which otherwise would expire on June 30, 2013. DHS will submit a separate proposal, with a separate notice and opportunity for comment, to amend the Demonstration to reflect new requirements in the Affordable Care Act that take effect January 1, 2014. (Source: Hawaii State Med-QUEST Division)</p> <p>Governor signed a bill related to QUEST Expanded Section 1115 Demonstration Waiver</p> <p>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)</p> |

| State | State Updates |
|----------------------|---|
| <p>Hawaii</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)</p> <p>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)</p> |
| <p>Idaho</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p><u>Idaho Demonstration to Integrate Care for Dual Eligibles</u> will replace the existing Medicare-Medicaid Coordinated Plan, which will continue to cover and coordinate Medicare and many Medicaid services through the end of 2013. Starting on January 1, 2014, the demonstration will enroll all full dual eligible ages 18 and older, including older persons, persons with physical disabilities, persons with developmental/intellectual disabilities, and persons with severe mental illness. The new program will utilize mandatory enrollment into health plans under concurrent §1915(b)/§1915(c) Social Security Act authority for Medicaid plan benefits, and passive enrollment with an opt-out provision for Medicare benefits. (Source: Demonstration Proposal)</p> <p>State Website on Integrating Care for Dual Eligibles Summary of the Idaho Initiative to Integrate Care for Dual Eligibles (10/10/2012)</p> <p>Health Homes</p> <p>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</p> |

| State | State Updates |
|------------------------|---|
| <p>Idaho</p> | <p><u>Eligibles</u>, 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: <u>Demonstration Proposal to Integrate Care for Dual Eligibles</u>)</p> <p><u>Approved Health Homes State Plan Amendment (11/21/2012)</u> <u>State Website on Health Homes</u></p> <p>Section 1915(i) State Plan Amendment</p> <p>CMS approved the state's §1915(i) State Plan Amendment in April 2011, and statewide implementation began July 1, 2011. Target populations include children with developmental disabilities and aged and disabled participants who meet eligibility requirements. Services include respite, habilitative supports, family education, community support services, support broker, and financial management services. (Source: <u>Approved State Plan Amendment</u>)</p> |
| <p>Illinois</p> | <p>Currently Operating Medicaid Managed LTSS Programs</p> <p>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.</p> <p>The Illinois Department of Healthcare and Family Services (HFS) implemented the state's first integrated health care program, known as Integrated Care Program (ICP) on May 1, 2011. The program is operated by two MCOs. Eligible populations are non-Medicare-eligible older adults and adults with disabilities receiving Medicaid including all Home and Community Based Waiver enrollees. The program is mandatory and operates in the pilot areas of suburban Cook, DuPage, Kane, Kankakee, Lake and Will Counties. Service package includes Phase I (primary, acute, behavioral health substance abuse services, and pharmacy), Phase II (long-term services and supports and waiver services excluding developmentally disabled waiver services), and Phase III (developmentally disabled waiver services). Phase III is delayed until Phase II becomes operational in October 2012. (Source: <u>State Website on Integrated Care Program</u>)</p> |

| State | State Updates |
|------------------------|---|
| <p>Illinois</p> | <p>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</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p><u>Illinois Medicare-Medicaid Alignment Initiative</u> proposes to enroll full benefit Medicare-Medicaid beneficiaries ages 21 and over in the Aged, Blind, and Disabled category of assistance in limited geographic area under capitated model. Institutional and HCBS waiver services for persons with developmental/intellectual disabilities are carved out. Enrollment is voluntary with opt out. (Source: Demonstration Proposal; State Website on Medicare-Medicaid Alignment Initiative)</p> <p>CMS announced on February 22, 2013 that Illinois would be the fourth state to enter into a Memorandum of Understanding (MOU) to test a new model for Medicare-Medicaid enrollees. This MOU will allow CMS and Illinois to implement the state’s Medicare-Medicaid Alignment Initiative to provide coordinated care to more than 135,000 Medicare-Medicaid enrollees in the Chicago and area and throughout central Illinois. According to the MOU, the state law requires moving 50% of all Medicaid beneficiaries from fee-for-service (FFS) to risk-based care coordination by January 2015, and the Demonstration will help support the transition. The Demonstration will begin on October 1, 2013. (Source: Centers for Medicare and Medicaid Services) Memorandum of Understanding State website on the demonstration</p> <p>Health Homes</p> <p>The state has submitted a draft State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013)</p> |

| State | State Updates |
|------------------------|---|
| <p>Illinois</p> | <p>Balancing Incentive Program</p> <p>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)</p> |
| <p>Indiana</p> | <p>Balancing Incentive Program</p> <p>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) Structural Change Work Plan</p> <p>Section 1915(i) State Plan Amendment</p> <p>The Family & Social Services Administration (FSSA), Office of Medicaid Policy & Planning (OMPP) and the Division of Mental Health & Addiction (DMHA) have commenced the process of applying to CMS for a State Plan Amendment to secure federal funding for provision of Child Mental Health Wraparound (CMHW) services under Section 1915(i) of the Social Security Act. The OMPP will reimburse DMHA-approved providers delivering CMHW services to children, ages six (6) through seventeen (17), who meet specific criteria for eligibility and level of need per the §1915(i) criteria. CMHW would include the following services: Wraparound Facilitation; Habilitation; Respite Care; and Family Support & Training for Unpaid Caregivers. DMHA believes CMHW services will allow the state to better accommodate the needs of children and youth with serious emotional disturbances (SED), resulting in improved patient outcomes and satisfaction, as well as a decrease in out-of-home placements. The state will not cover CMHW services until CMS approves the State Plan Amendment and the state completes the rule promulgation process. However, DMHA anticipates the program will begin before the end of the year. (Source: State website on CMHW Services) Notice of Intent Proposed Rule on Child Mental Health Wraparound Services</p> <p>Health Homes</p> <p>According to the state, Division of Disability and Rehabilitation Services (DDRS) is working on draft of Health Homes State Plan Amendment. The state is proposing a statewide implementation of health homes services for individuals with a co-occurring developmental disability (DD) who are at risk for developing another chronic health condition. Mental Health Stakeholders are currently developing a Health Homes proposal for SMI. (Source: State website on Health Homes) Health Homes Initiative Overview (5/18/2012) Provider Quarterly Update (1/22/2013) Draft State Plan Amendment (2/25/2013)</p> |

| State | State Updates |
|-------|---|
| Iowa | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>The demonstration will provide full benefit Medicare-Medicaid enrollees with access to comprehensive coordinated care management through a Health Homes model. Delivery system design includes the Health Homes model of care for members with chronic conditions; disease management targeting members with mental health and substance abuse service needs; and an ACO model. The demonstration will implement statewide, and reimbursement model is described as “Health Homes in a Fee-for-Service environment.” Proposed implementation date is January 1, 2013. (Source: Demonstration Proposal) Target population includes members with intellectual/developmental disabilities. (Source: NASDDDS Managed Care Tracking Report)</p> <p>Health Homes</p> <p>1. Health Homes for Individuals with Chronic Conditions</p> <p>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)</p> <p>2. Integrated Health Homes for Individuals with Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)</p> <p>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</p> |

| State | State Updates |
|----------------------|---|
| <p>Iowa</p> | <p>through a team of professionals including access to Family and Peer Support services.</p> <p>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)</p> <p>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)</p> <p>Section 1915(i) State Plan Amendment</p> <p>Habilitation Services is a program to provide Home and Community Based Services (HCBS) for Iowans with impairments typically associated with chronic mental illnesses. Services include case management, home-based habilitation, day habilitation, prevocational service, and supported employment. The program was approved in 2007. Program website State Plan Amendment (04/16/2007)</p> <p>Balancing Incentive Program</p> <p>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 Structural Change Work Plan</p> |
| <p>Kansas</p> | <p>Current Medicaid Managed LTSS Program</p> <p>The Kansas Department of Health and Environment resubmitted (8/6/2012) its</p> |

| State | State Updates |
|----------------------|--|
| <p>Kansas</p> | <p><u>application</u> 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) <u>Waiver Application</u> (Submitted 8/6/2012)</p> <p>Kansas awarded (6/27/2012) <u>contracts</u> 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: <u>Press Release</u>, 6/27/2012)</p> <p>Officials at the Kansas Department for Aging and Disability Services sent (8/15/2012) a <u>memo</u> 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: <u>Kansas Health Institute News</u>, 8/17/2012)</p> <p>CMS approved KanCare on December 27, 2012, and the implementation began on January 1, 2013. <u>Approved Application</u> (12/27/2012)</p> <p>Health Homes</p> <p>Health Homes for people with serious mental illness (SMI) or other chronic conditions is one of components built in KanCare §1115 demonstration waiver. The state originally expected to implement Health Homes for people with SMI on January 1, 2014, but has now delayed the implementation until July 1, 2014. However, the state still anticipates implementing Health Homes for KanCare members with other chronic conditions in July 2014, as planned. Kansas has submitted a health homes concept paper and request for funding from CMS to help plan and implement the health homes model in KanCare, as well as a formal health</p> |

| State | State Updates |
|------------------|---|
| Kansas | <p>homes proposal with more detailed information regarding the proposed SPA. (Source: State website on health homes) Concept Paper Kansas Letter of Request Approval Letter Proposal Health Home State Plan Amendment (Draft, 8/29/2013)</p> |
| Louisiana | <p>Section 1915(k) Community First Choice Option</p> <p>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)</p> <p>In August 2013, Louisiana withdrew its application to implement CFC.</p> <p>Section 1915(i) State Plan Amendment</p> <p>The Department of Health and Hospitals submitted (3/10/2011) §1915(i) State Plan Amendment to the CMS with effective date of January 1, 2012. The covered service is Adult Behavioral Health Services concurrent with the Behavioral Health §1915(b) waiver under a capitated contract reimbursement methodology. The operating agency is Office of Behavioral Health (OBH) within Department of Health and Hospitals (DHH). The §1915(i) State Plan HCBS benefit targets the following populations: Persons with Acute Stabilization Needs (ASN), persons with serious mental illness (SMI) persons with major mental disorder (MMD), and persons who previously met any of the above and subsequently need medically necessary services for stabilization and maintenance. (Source: State Plan Amendment) State information on §1915 (i) program</p> <p>On March 2012, the fee-for-service mental health rehabilitation services program was transitioned to the Louisiana Behavioral Health Partnership managed by a Statewide Management Organization (SMO). (Source: State website) State Information on Louisiana Behavioral Health Partnership</p> <p>Balancing Incentive Program</p> <p>The Centers for Medicare & Medicaid Services (CMS) announced (3/15/2013) that Louisiana will receive an estimated \$69.25 million in enhanced Medicaid funds</p> |

| State | State Updates |
|------------------|--|
| Louisiana | <p>(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</p> |
| Maine | <p>Health Homes</p> <p>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)</p> <p>Balancing Incentive Program</p> <p>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)</p> |
| Maryland | <p>Balancing Incentive Program</p> <p>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) BIP application (2/10/2012) Award Letter (3/20/2012) Structural Change Work Plan</p> <p>Section 1915(k) Community First Choice Option</p> <p>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)</p> <p>Section 1915(i) State Plan Amendment</p> <p>Over the past several years, Maryland has operated a special CMS demonstration project known locally as the Residential Treatment Center (RTC) Waiver. This time limited demonstration project used a special authority granted by the federal</p> |

| State | State Updates |
|-----------------------------|---|
| <p>Maryland</p> | <p>government under Section 1915(c) of the Social Security Act to provide home and community-based services for children and youth with emotional disturbances and their families. The demonstration project has now effectively reached its statutory end.</p> <p>In order to sustain and refine the approach undertaken in the initial CMS Demonstration Project, Maryland intends to apply for a 1915(i) State Plan Amendment (SPA) to serve a similar, but not identical, population of youth and families as prescribed by the federal government. The service mix proposed is also similar to the initial demonstration, but has been refined and enriched, based on lessons learned from the process of implementing the original project.</p> <p>In addition to the full range of Medicaid somatic and behavioral health benefits available to all eligible individuals, participants enrolled in the proposed 1915(i) SPA will have access to a number of additional specialized services if they meet applicable medical necessity criteria. These specialized services and the proposed approach under which they will operate are described in the application. (Source: State website on 1915(i) State Plan Amendment for Children, Youth, and Families) 1915(i) State Plan Amendment (Draft, 9/17/2013)</p> <p>Health Homes</p> <p>The state has submitted a draft Health Homes State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013)</p> <p>Maryland Health Home SPA (Draft, 2/15/2013) Maryland Health Homes DRAFT Regulations (6/10/2013) Chronic Health Homes DRAFT Criteria (12/10/2012)</p> |
| <p>Massachusetts</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>Massachusetts Senior Care Options provides eligible adults of age 65 and older primary, acute, behavioral, prescription drugs, and LTSS in capitated rate. LTSS include nursing facility, adult foster care, group adult foster care, adult day health, and other community-based LTSS. Enrollment is voluntary, and the program covers most part of the state. The program operates under Medicaid §1915(a) and §1915(c) authorities. (Source: CMS and Truven Health Analytics, July 2012) State Website on Senior Care Options</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals (Approved 8/23/2012)</p> <p>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</p> |

| State | State Updates |
|-----------------------------|---|
| <p>Massachusetts</p> | <p>and Truven Health Analytics, July 2012), but will include acute and behavioral health for the I/DD population (Source: NASDDDS Managed Care Tracking Report).</p> <p>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)</p> <p>Memorandum of Understanding State website on the demonstration Duals Demonstration Timeline</p> <p>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</p> <p>Health Homes</p> <p>The state has submitted draft Health Homes State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated April 2013)</p> |
| <p>Michigan</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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)</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>Projected to begin in 2013, Michigan Integrated Care for People who are Medicare-</p> |

| State | State Updates |
|-------------------------|--|
| <p>Michigan</p> | <p>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. 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)</p> <p>Program Website</p> <p>Health Homes</p> <p>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)</p> <p>State Resource on Health Homes</p> |
| <p>Minnesota</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>Under Medicaid authority §1915(b) and §1915(c), Minnesota Senior Care Plus has provided primary, acute, behavioral, prescription drugs services and LTSS in capitated rate to older adults of age 65 and over. Enrollment is mandatory, while duals can choose Minnesota Senior Health Options (MSHO). Minnesota Senior Health Options (MSHO) provides the same services as Minnesota Senior Care Plus does to adults of age 65 and older who are eligible for both Medicaid and Medicare</p> |

| State | State Updates |
|-------------------------|---|
| <p>Minnesota</p> | <p>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</p> <p>Reform 2020 Draft Section 1115 Waiver Proposal</p> <p>The 2011 Minnesota Legislature directed the Department of Human Services (DHS) to develop a proposal to reform the Medical Assistance Program. Goals of the reform include: community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people’s needs. (Source: State Register notice, page 1580, June 18, 2012) According CMS, the state submitted (8/24/2012) the waiver application. After preliminary review of the application, however, CMS determined that the application did not meet the requirements for a complete application. The state recently resubmitted (11/21/2012) the application to CMS. (Source: Medicaid.gov) Reform 2020 Section 1115 Demonstration Application (Draft) Reform 2020 Section 1115 Demonstration Application (Resubmitted 11/21/2012) State Website on Reform 2020 Section 1115 Waiver</p> <p>Minnesota Long Term Care Realignment Section 1115 Demonstration Waiver (Pending as of 7/9/2013; Submitted 2/13/2012 and 11/21/2012)</p> <p>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)</p> <p>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 Section 1115 Waiver</p> |

| State | State Updates |
|-------------------------|--|
| <p>Minnesota</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)</p> <p>The state has decided (6/29/2012) not to pursue financial alignment demonstration, noting that Medicare financing under the financial alignment demonstration model would result in a significantly lower payment than Minnesota receives for senior Medicare beneficiaries in current programs. 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</p> <p>State Initiative to Integrate Care for Dual Eligible Individuals</p> <p>On September 12, 2013, the state signed Memorandum of Understanding (MOU) with the 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)</p> <p>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</p> |

| State | State Updates |
|---------------------------|---|
| <p>Minnesota</p> | <p>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)</p> <p>Section 1915(i) State Plan Amendment</p> <p>According to state officials, under Minnesota Long Term Care Realignment §1115 Waiver, the state proposes to implement §1915(i) State Plan Amendment and Community First Choice under §1915(k). Populations currently under consideration for inclusion in §1915(i) are persons with autism, adults with mental illness, and children with mental illness. (Source: Waiver Application; NASUAD) The state plans to implement the option in FY 2014. (Source: Kaiser Commission on Medicaid and the Uninsured, April 2013)</p> |
| <p>Mississippi</p> | <p>Balancing Incentive Program</p> <p>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</p> <p>Health Homes</p> <p>CMS approved planning request. (Source: Integrated Care Resource Center)</p> |
| <p>Missouri</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>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)</p> <p>Health Homes</p> <p>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)</p> |

| State | State Updates |
|------------------------|--|
| <p>Missouri</p> | <p>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)</p> <p>Balancing Incentive Program</p> <p>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</p> |
| <p>Montana</p> | <p>Section 1915(i) State Plan option</p> <p>The state’s Department of Public Health and Human Services submitted a §1915(i) Home and Community Based Service (HCBS) State Plan Amendment to CMS in 2012 in order to establish a §1915(i) HCBS State Plan program of Medicaid-funded home and community services for youth who have serious emotional disturbance. CMS approved the SPA effective January 1, 2013. The program is called “Montana i-home”. The purpose of this program is to provide mental health services to qualifying youth in the community setting. The §1915(i) HCBS State Plan option does not require eligible youth to meet the institutional level of care that is required under a §1915(c) HCBS waiver. The 1915(i) HCBS State Plan program is available statewide. (Source: i-Home Policy Manual (7/1/2013); Montana i-home website)</p> <p>Section 1915(k) Community First Choice</p> <p>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)</p> |

| State | State Updates |
|----------------------|---|
| Montana | <p>On August 29, 2013, Montana submitted a State Plan Amendment to CMS to implement to the Community First Choice option effective October 01, 2013. (Source: 2013 National HCBS Conference Presentation) Community First Choice Frequently Asked Questions</p> |
| Nebraska | <p>Medicaid Managed LTSS Program</p> <p>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)</p> |
| Nevada | <p>Section 1915(i) State Plan Amendment</p> <p>Home Based Habilitation Services (HBHS) is an optional Medicaid State Plan service authorized under State Plan authority titled Nevada §1915(i) State Plan Home and Community-Based Services (HCBS). The State Plan was amended in 2008 in response to the Deficit Reduction Act, Section 6086. Home Based Habilitation Services (HBHS) are medically prescribed treatment for improving or restoring functions, which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury. Services include Home and Community Based (HCBS) Adult Day Health Care, Habilitation, and Home and Community Based Services (HCBS) Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness. State Plan Amendment Medicaid Services Manual (updated 02/15/2012)</p> <p>Health Homes</p> <p>CMS approved planning request. (Source: Integrated Care Resource Center)</p> |
| New Hampshire | <p>Medicaid Managed LTSS Program (Approved 8/24/2012) & State Initiative to Integrate Care for Dual Eligible Individuals</p> <p>As required in Senate Bill 147 passed by the New Hampshire Legislature on June 2, 2011, the Department of Health and Human Services Department submitted (3/31/2012) State Plan Amendment to the CMS through the §1932(a) State Plan option for authorization of the implementation of a state wide managed care delivery system, called New Hampshire Medicaid Care Management Program. On May 9, 2012, members of the governor's Executive Council approved a \$2.3 billion contract establishing a managed care system for Medicaid recipients. CMS approved (8/24/2012) the State Plan Amendment.</p> |

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

| State | State Updates |
|--------------------------|---|
| <p>New Jersey</p> | <p><u>Comprehensive Medicaid Waiver Website</u> <u>Waiver Application</u> (9/9/2011) <u>Approval Letter</u> (10/2/2012) <u>Recommendations by workgroup</u></p> <p>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)</p> <p>According to <u>Press Release</u> (10/4/2012) from the state Department of Human Services, some of reform proposals in the application were denied by CMS, including the following: the State’s request to no longer provide retroactive Medicaid eligibility for applicants; consolidation of all nine state waivers into one, and the state’s appeal for an estimated \$107 million in Medicare Part B retro payment for Medicare services erroneously billed to Medicaid. The federal government also determined that approval of future programmatic changes and that the Community Care Waiver will remain outside the comprehensive waiver. (Source: <u>Press Release</u>, State of New Jersey Department of Human Services, 10/4/2012)</p> <p>Balancing Incentive Program</p> <p>The Centers for Medicare & Medicaid Services (CMS) recently approved (3/15/2013) New Jersey’s Balancing Incentive Program Application. (Source: <u>CMS Website</u>) <u>BIP Application</u> (12/20/2012)</p> <p>Health Homes</p> <p>CMS approved planning request. (Source: Integrated Care Resource Center)</p> |
| <p>New Mexico</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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) <u>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 Website on CoLTS)</u></p> <p><u>Effective January 1, 2014, Centennial Care will replace current Medicaid managed</u></p> |

| State | State Updates |
|--------------------------|--|
| <p>New Mexico</p> | <p>care programs such as 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 7-2-13)</p> <p>Projected Medicaid Managed LTSS Program (Approved)</p> <p>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.</p> <p>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.</p> <p>The approval of this demonstration will not include 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 is the case today under the CoLTS §1915(b)(c) combo waiver. (Source: Approval Letter, 07/12/2013) Waiver application (Submitted 8/17/2012) State Website on Centennial Care Centennial Care general FAQs 6-19-13</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)</p> <p>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)</p> |

| State | State Updates |
|--------------------------|--|
| <p>New Mexico</p> | <p>Health Homes</p> <p>New Mexico seeks to establish health homes as an integral step in the integration of care under the §1115 demonstration waiver. The state is currently working with a 2703 planning grant to design its first SPA to establish health homes throughout the state that address recipients with a behavioral health condition. It is the state’s intent to develop health homes in Core Service Agencies (CSAs) statewide. This model for behavioral health homes (BHH) is being designed in conjunction with the MCOs under Centennial Care. Once a recipient is enrolled in a BHH, the responsibility for both care management and care coordination is delegated by the MCO to the BHH. Over time, the state intends to establish health homes for other chronic conditions through the SPA process. The state will work to closely coordinate the health homes model(s) with Centennial Care to ensure the integration of care is achieved at all levels. (Source: Centennial Care Section 1115 Demonstration Waiver Application)</p> |
| <p>New York</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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)</p> <p>Partnership Plan Waiver & Federal-State Health Reform Partnership (F-SHRP) waiver</p> <p>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.</p> |

| State | State Updates |
|------------------------|---|
| <p>New York</p> | <p>New York Federal-State Health Reform Partnership (F-SHRP) was the state’s second demonstration waiver approved by CMS. The demonstration provides federal financial support for a health reform program in New York that addresses the state’s need to modernize its acute and long-term care infrastructure, increase capacity in primary and ambulatory care, and make investments in health information technology. The demonstration also allows the state to enroll certain Medicaid populations into managed care on a mandatory basis: aged, blind and disabled individuals statewide, and children, caretaker relatives, and pregnant women in selected counties. (Source: Medicaid.gov) State Website on Partnership Plan Waiver (corrected link) State Website on Federal-State Health Reform Partnership Fact Sheet on F-SHRP</p> <p>CMS approved (8/31/2012) the state’s recent application for Amendments to Partnership Plan and F-SHRP. Click here to see approval letter. The state requested (10/31/2012) the federal government for extension of Partnership Plan beyond its current 12/31/2014 expiration date to 12/31/2017. The application for extension includes an interim evaluation of the Partnership Plan.</p> <p>Medicaid Redesign Team (MRT) Waiver</p> <p>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</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>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</p> |

| State | State Updates |
|------------------------|---|
| <p>New York</p> | <p>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)</p> <p>Memorandum of Understanding State Website on the demonstration</p> <p>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.</p> <p>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).</p> <p>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, Nassau, New York, Queens, Richmond, Suffolk, and Westchester.</p> <p>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)</p> <p>Health Homes</p> <p>New York Health Homes State Plan Amendment for Individuals with Chronic</p> |

| State | State Updates |
|------------------------|---|
| <p>New York</p> | <p><u>Behavioral and Mental Health Conditions</u> (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: <u>State Website on Health Homes</u>)</p> <p><u>Approved State Plan Amendment</u> (2/3/2012)</p> <p><u>State Website on Medicaid Health Homes</u> (April 2012)</p> <p><u>State Website on Medicaid Health Homes</u> (November 2012)</p> <p>New York State Medicaid Director Testified before the U.S. Senate on its Medicaid Redesign and Duals Demonstration (7/18/2012) <u>Complete Testimony</u></p> <p>Projected Medicaid Managed LTSS Program</p> <p>Medicaid Redesign Team Proposal #90 and 2011 budget legislation requires the transition and enrollment of certain community-based long term care services recipients into Managed Long-Term Care Plans (MLTCPs) or Care Coordination Models (CCMs). New York State currently operates three models of MLTCP: the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Advantage Plus (MAP); and partially capitated managed long-term care plans. Currently there are no CCMs established. All models provide community-based long term care services, nursing home care and many ancillary services, including individualized care management. During July 2012, the Department received verbal approval from the Centers for Medicare and Medicaid Services (CMS) to initiate mail distribution of mandatory enrollment notifications. These notifications, alerting current members that they must choose a plan to continue receiving community based long-term care services, are being rolled out in New York City using a phased approach by borough and zip code. On August 31, 2012, the Department received written approval from CMS to proceed with auto-assignment of members into partial capitated managed long term care plans in New York City. The mandatory enrollment initiative will continue within the five boroughs of New York City until all eligible cases are transitioned. In January 2013, the initiative will move to Nassau, Suffolk and Westchester counties. (Source: <u>State Medicaid Update</u>, September 2012)</p> <p><u>State Website on Managed Long Term Care/Care Coordination Model</u></p> <p>Projected Medicaid Managed LTSS Program</p> <p>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</p> |

| State | State Updates |
|------------------------------|---|
| <p>New York</p> | <p>achieve improved health outcomes and quality of care while lowering health care costs for the developmentally disabled population. (Source: Medicaid.gov)</p> <p>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)</p> <p>Balancing Incentive Program</p> <p>The Centers for Medicare & Medicaid Services (CMS) announced (3/15/2013) that New York will receive an estimated \$598.7 million in enhanced Medicaid funds (2% enhanced FMAP rate). (Source: State Website) BIP Application (12/20/2012) Revised BIP Application (2/26/2013) BIP Award Letter (3/15/2013)</p> <p>Section 1915(k) Community First Choice Option</p> <p>The state’s Community First Choice Options Development and Implementation Council has been holding meetings to discuss the state’s proposed application / implementation of the option. (Source: State Website on CFCO)</p> |
| <p>North Carolina</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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)</p> |

| State | State Updates |
|------------------------------|--|
| <p>North Carolina</p> | <p><u>State Website on MH/DD/SAS Health Plan Waiver</u></p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>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: <u>Demonstration Proposal</u>; <u>State Website on Duals Demonstration</u>)</p> <p>Section 1915(i) State Plan Amendment</p> <p>The state has submitted two §1915 (i) State Plan Amendments. The first program proposes to provide Personal Assistance Services, which consists of assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for three distinct target populations: individuals with physical disabilities; adults with a diagnosis of mental illness, mental retardation/developmental disability, or dementia; and elderly individuals with functional disabilities. The Consolidated Personal Care Services (PCS) program is designed to provide personal care services to individuals residing in a private living arrangement, or a residential facility licensed by the State of North Carolina as an adult care home, or a combination home as defined in G.S. 131E-101(1a).G.S. 131E-101(1a); or resides in a group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency. Effective date is January 1, 2013. (Source: North Carolina Department of Health and Human Services) <u>State Plan Amendment</u> (Submitted 04/30/2012) <u>Consolidated Personal Care Services (PCS) state website</u></p> <p>The second program, titled “Alzheimer’s and Dementia Services,” proposes to target Medicaid eligible individuals of 21 years or older with one of the following primary diagnoses: Alzheimer’s Disease, Vascular Dementia, Dementia with Lewy Bodies, Pick’s Disease, Parkinson’s Disease, Creutzfeldt-Jakob Disease, or Huntington’s Disease. The benefit consists of hands-on, supervision, set-up, and cueing assistance with qualifying ADLs and associated IADLs; medication assistance; medical monitoring; assistance with durable medical equipment and adaptive and assistive devices; and safety monitoring and supervision. Activities of daily living, for the purposes of this benefit, are bathing, dressing, mobility, toileting, and eating. Instrumental activities of daily living are basic home management tasks that are directly related to the qualifying ADLs and essential to the beneficiary’s care at home. (Source: <u>State Plan Amendment</u>, Submitted 9/17/2012)</p> |

| State | State Updates |
|------------------------------|--|
| <p>North Carolina</p> | <p>Health Homes</p> <p><u>North Carolina Health Homes State Plan Amendment</u> (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, <u>State-by-State Health Homes State Plan Amendment Matrix: Summary Overview</u>, Updated June 2012; Kaiser Commission on Medicaid and the Uninsured, <u>Medicaid Health Homes for Beneficiaries with Chronic Conditions</u>, August 2012) The SPA will expire in October 2013. (Source: <u>Demonstration Proposal</u>)</p> |
| <p>Ohio</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals & Medicaid Managed LTSS Program</p> <p>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; <u>State Website</u>) According to an updated timeline posted on the State website, voluntary enrollment in the plans will begin September 1, 2013. (Source: <u>State Website</u>) The demonstration will implement in seven regions composed of three to five counties each, and will use a capitated financial alignment model. (Source: <u>Demonstration Proposal</u>) <u>State Website on Integrated Care Delivery System</u> <u>Notice of delay in implementation</u> (10/5/2012) <u>CMS Press Release</u> (12/12/2012) <u>Memorandum of Understanding</u></p> <p>Health Homes</p> <p>Ohio's Health Homes State Plan Amendment was approved on September 17, 2012. According to <u>duals demonstration proposal</u>, Ohio State Medicaid agency has been working with CMS on the State Plan Amendment to create Health Homes for Medicaid beneficiaries who meet the state's definition of serious and persistent mental illness, or SPMI (including adults with serious mental illness, or SMI, and children with serious emotional disturbance, or SED) in five sites (Butler County,</p> |

| State | State Updates |
|------------------------|--|
| <p>Ohio</p> | <p>Adams County, Scioto County, Lawrence County, and Lucas County), effective October 1, 2012. (Source: CMS Approval Letter) The state will expand the services statewide next Spring. (Source: NASUAD) The SPA is expected to enhance the traditional patient-centered medical home to better coordinate physical and behavioral health services. Community behavioral health centers (CBHCs) will be eligible to apply to become Medicaid health homes for individuals with SPMI. At a later date, Ohio Medicaid will implement Medicaid Health Homes focusing on individuals with qualifying chronic physical health conditions. (Source: Duals demonstration proposal) Approved Health Homes State Plan Amendment (9/17/2012) Approval Letter (9/17/2012) State Medicaid Health Homes Website</p> <p>Balancing Incentive Program</p> <p>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)</p> |
| <p>Oklahoma</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>The demonstration will cover all full benefit Medicare-Medicaid enrollees including those with intellectual/developmental disabilities statewide, starting July 2013. Under this demonstration, Oklahoma is pursuing a three-pronged approach to integrating care for the state’s dually-eligible population. The first concept, SoonerCare Silver care coordination program will cover dually-eligible members residing in all of Oklahoma’s counties (with limited exceptions) utilizing a fee-for-service payment model. Individuals receiving care coordination through other programs such as Tulsa’s Health Innovation Zone (THIZ), PACE and the ICS will be excluded from the SoonerCare Silver care coordination program. All other dually-eligible individuals who are not receiving care coordination services through their current benefit program will be eligible to receive care coordination through the SoonerCare Silver program. The second concept, Tulsa Health Innovation Zone covers those Medicare-Medicaid members who receive primary care services through participating practices in Tulsa and the surrounding region with a per-member-per-month payment model. The third concept, ICS Demonstration Model covers all full benefit Medicare-Medicaid enrollees age 45 and older living in the Oklahoma City or Lawton metropolitan areas and rural areas of the state under a capitated payment model. (Source: Demonstration Proposal)</p> <p>Health Homes</p> <p>Oklahoma has submitted draft State Plan Amendment to CMS. (Source: CMS State Health Home CMS Proposal Status, updated May2013) According to the state’s</p> |

| State | State Updates |
|------------------------|--|
| <p>Oklahoma</p> | <p><u>duals demonstration proposal</u>, Oklahoma Health Care Authority (OHCA) is currently partnering with the State Mental Health Authority (SMHA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to implement the health homes model. Health homes are designed to serve people with chronic mental illnesses. Children diagnosed as Serious Emotional Disturbance (SED) - the term used to describe children who qualify, and Seriously Mentally Ill (SMI) - the term for qualifying adults are served by a nurse care manager, who coordinates a team of professionals that determine the best services for the member. Health homes will be hosted by ODMHSAS through the statewide network of community mental health centers (CMHCs) and their satellite locations, which have historically provided community-based mental health services. The CMHCs provide screening, assessment and referral services, emergency services, therapy, psychiatric rehabilitation, case management, and other community support services designed to assist adult mental health consumers with living as independently as possible and to provide therapeutic services for children who are demonstrating symptoms of emotional disturbance. All CMHCs provide services to both adults and children. (Source: <u>Duals Demonstration Proposal</u>)</p> |
| <p>Oregon</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)</p> <p>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: <u>State website on the demonstration</u>) <u>Demonstration Proposal</u> <u>State website on the demonstration</u> <u>Letter to Coordinated Care Organizations and Stakeholders (10/30/2012)</u></p> <p>Amendment to Oregon Health Plan Section 1115 Demonstration Waiver (Approved 7/5/2012; Submitted to CMS 3/1/2012)</p> <p>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)</p> <p>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</p> |

| State | State Updates |
|----------------------|---|
| <p>Oregon</p> | <p>methodologies to reimburse providers on the basis of outcomes and quality through shared savings and incentives; (2) Ability to reimburse non-traditional health care workers such as community health workers, peer wellness specialists, Duals, and personal health navigators; (3) Flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State Plan service but help keep people living in the community; (4) Developing an alternative payment methodology to allow a unique prospective payment system/alternative payment methodology for Federal Qualified Health Centers. (Source: Oregon Division of Medical Assistance Programs Update) Application for Amendment and Renewal (3/1/2012)</p> <p>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</p> <p>Coordinated Care Organizations</p> <p>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 State resource on Coordinated Care Organization 2 Senate Bill 1580 (2012 CCO Implementation) HB 3650 (2011 CCO Creation)</p> <p>Health Homes</p> <p>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) Approved Health Homes State Plan Amendment (3/13/2012)</p> |

| State | State Updates |
|----------------------------|---|
| <p>Oregon</p> | <p>Section 1915(i) State Plan Amendment</p> <p>§1915(i) State Plan option was approved on February 14th, 2012. Covered services include Home Based Habilitation, HCBS Behavioral Habilitation, HCBS Psychosocial Rehabilitation for persons with Chronic Mental Illness (Source: DMAP Update) Introduction to Oregon’s §1915(i) Plan Policy Option Package for §1915(i) State Plan Option Amendment</p> <p>Section 1915(k) Community First Choice Option</p> <p>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</p> |
| <p>Pennsylvania</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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</p> |
| <p>Rhode Island</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>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)</p> <p>Health Homes</p> <p>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).</p> |

| State | State Updates |
|------------------------------|---|
| <p>Rhode Island</p> | <p><u>Rhode Island CEDARR Family Center Health Homes State Plan Amendment</u> (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: <u>Integrated Care Resource Center, State-by-State Health Homes State Plan Amendment Matrix: Summary Overview</u>, Updated June 2012; Kaiser Commission on Medicaid and the Uninsured, <u>Medicaid Health Homes for Beneficiaries with Chronic Conditions</u>, August 2012)</p> <p>The state has submitted another draft Health Homes State Plan Amendment to CMS. (Source: <u>CMS State Health Home CMS Proposal Status</u>, updated April 2013)</p> |
| <p>South Carolina</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>South Carolina recently signed <u>Memorandum of Understanding</u> with the CMS/CMMI to implement a dual eligible initiative called "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.</p> <p><u>Demonstration Proposal</u> <u>Memorandum of Understanding</u> <u>State Website on Duals Demonstration</u></p> <p>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: <u>South Carolina Memorandum of Understanding; Integrated Care Workgroup Session</u>, 10/17/2013)</p> <p>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: <u>SCDuE Weekly Update</u>, July 3, 2013)</p> |
| <p>South Dakota</p> | <p>Health Homes</p> <p>The state has submitted draft Health Homes State Plan Amendment to CMS. (Source: <u>CMS State Health Home CMS Proposal Status</u>, updated April 2013)</p> |

| State | State Updates |
|-------------------------|--|
| <p>Tennessee</p> | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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, <u>The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update</u>, July 2012) <u>State Website on TennCare CHOICES</u></p> <p>Amendment to TennCare II Section 1115 Demonstration Waiver (Approved 6/15/2012; Extension request submitted 6/29/2012)</p> <p>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) <u>Application for Amendment</u></p> <p>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 <i>Interim</i> 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) <u>Current Approval Document</u> <u>Three-year Extension Request Document</u></p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)</p> <p>Tennessee recently submitted (12/21/2012) a <u>letter</u> to Medicare-Medicaid Coordination Office requesting to withdraw its financial alignment demonstration</p> |

| State | State Updates |
|------------------|---|
| Tennessee | <p>proposal. In the letter, the state expressed its concerns pertaining to the reimbursement methodology. (Source: Letter to Medicare-Medicaid Coordination Office) Tennessee's dual demonstration TennCare PLUS proposed to enroll full benefit dual eligibles, except PACE participants, starting January 1, 2014, statewide. The demonstration will not include LTSS for persons with intellectual disabilities (including ICF/MR and §1915(c) waiver services), but dually-eligible members receiving these services will be part of the demonstration for all other Medicare and Medicaid services. The demonstration will operate under a capitated payment model. For more information, click here. (Source: Demonstration Proposal)</p> |
| Texas | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>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</p> <p>Under Healthcare Transformation and Quality Improvement Program Section 1115 demonstration waiver (Approved 12/12/2011), Texas is expanding STAR and STAR+PLUS (MMLTC) statewide and using savings from the expansion of managed care and the discontinuation of supplemental provider payments to finance new funding pools to assist hospitals and other providers with uncompensated care costs and to promote delivery system transformation and improvement. The Texas Health & Human Services Commission submitted a request for Amendment on 5/3/2012, wherein it proposes to add Day Activity Health Services to the existing STAR+PLUS waiver, effective September 1, 2012. The service targets individuals who are eligible for the STAR+PLUS waiver and exceed the financial requirements for Day Activity and Health Services under the §1915(i) authority. Services include nursing and personal care, physical rehabilitation, noon meal and snacks, social, educational and recreational activities, and transportation. (Source: Medicaid.gov) Current Approval Document Request for Amendment (submitted 5/3/2012)</p> <p>The Texas Health and Human Services Commission (HHSC) is adopting new permanent payment rules that implement the provider eligibility requirements and payment methodologies approved by CMS under Healthcare Transformation</p> |

| State | State Updates |
|---------------------|--|
| <p>Texas</p> | <p>and Quality Improvement Program waiver. (Source: Texas Register, June 22, 2012) State information on the adopted rules</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>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)</p> <p>Cost-sharing methodology for Dual Eligibles</p> <p>HHSC also amends regulations regarding the coordination of Medicaid with Medicare Parts A, B, and C. The rule authorizes the commission to make higher cost-sharing payments for dual eligibles for certain services if the commission determines that a higher payment amount is necessary to ensure adequate access to care or would be more cost-effective to the state. HHSC will have to request and receive approval for a Medicaid State Plan Amendment from the Centers for Medicare and Medicaid Services in order to implement specific adjustments to the Medicare Equalization policy. The changes will implement to coincide with the effective date of the State Plan Amendment. (Source: Texas Register, June 22, 2012) State information on the adopted rules</p> <p>Section 1915(i) State Plan Amendment</p> <p>According to a draft of the state’s §1915(i) State Plan Amendment (the link to the SPA has been disconnected), Texas planned to cover Day Activity and Health Services (DAHS) under §1915(i) State Plan HCBS benefit. Target population was to include aged and disabled individuals living in the community, unless they qualify for nursing facility §1915(c) waiver services or are individuals with Intellectual Disabilities. For Year 1 (9/1/2012 – 8/31/2013), projected number of participants was 14,493 in STAR+PLUS (managed care) Service Areas, and 1,845 outside the managed care service areas. In the STAR+PLUS Service Areas, the SMA conducts annual desk and on-site reviews of each contracted managed care organization (MCO). Outside the STAR+PLUS Service Areas, the Department of Aging and Disability Services (DADS) reviews a statistically valid randomly selected sample, proportionate to consumer enrollment in each long term services and support</p> |

| State | State Updates |
|-----------------------|---|
| <p>Texas</p> | <p>region. All Day Activity and Health Services (DAHS) consumers were subject to random selection. (Source: Draft State Plan Amendment) According to a state official, Texas withdrew the Amendment in 2012 and has no plans at the current time to implement it. (Source: State official) Information on the 1915(i) SPA 1 (House Bill 2725 Report) (October 2012) Information on the 1915(i) SPA 2 (May 2012)</p> <p>Balancing Incentive Program</p> <p>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)</p> <p>Section 1915(k) Community First Choice Option</p> <p>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)</p> <p>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)</p> |
| <p>Vermont</p> | <p>Vermont Choices for Care—Section 1115 Demonstration Waiver</p> <p>The Vermont long-term care §1115 demonstration, known as “Choices for Care,” is a statewide initiative to rebalance long-term care services through managing nursing facility admissions and increasing community-based options. The demonstration does not include children or individuals receiving institutional</p> |

| State | State Updates |
|------------------------|--|
| <p>Vermont</p> | <p>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)</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>The demonstration includes full benefit dual eligibles, including those with intellectual/developmental disabilities. It will implement statewide under a capitated payment model starting January 1, 2014. PACE Vermont participants (approximately 120 people) are not included. (Source: Demonstration Proposal) State website on the demonstration</p> <p>Health Homes</p> <p>The state has submitted its Health Homes State Plan Amendment (SPA 13-021, draft), with July 1, 2013 as 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)</p> |
| <p>Virginia</p> | <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>The demonstration is projected to cover full benefit Medicare-Medicaid enrollees (age 21 and older), older persons and persons with physical disabilities, nursing facility residents, and persons who receive services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver. Persons with intellectual/developmental disabilities who are not in the EDCD Waiver are excluded from the program. Assisted living services, intellectual/developmental disability services, and PACE programs will be carved out. The program will initially start in four regions in January 2014, with voluntary enrollment with opt out. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Demonstration Proposal State Website on Duals Demonstration</p> <p>On May 21, 2013, Governor Bob McDonnell announced that Virginia has signed a Memorandum of Understanding (MOU) with CMS to implement Medicare-</p> |

| State | State Updates |
|-------------------|--|
| Virginia | <p>Medicaid Enrollee Financial Alignment Demonstration aimed at coordinating care for more than 78,000 Virginians currently enrolled in Medicare and Medicaid. Under this initiative, recently branded as Commonwealth Coordinated Care, Virginia and CMS will enter into a contract with health plans for the delivery of coordinated services and supports to enrollees. Eligible individuals include older adults and individuals with disabilities, including those receiving long-term services and supports, and who live in designated regions around the Commonwealth. The regions include the areas surrounding: Central Virginia/Richmond, Charlottesville, Tidewater, Roanoke and Northern Virginia. (Source: Press Release, May 21, 2013) Memorandum of Understanding</p> |
| Washington | <p>Currently Operating Medicaid Managed LTSS Program</p> <p>After inception in 2005, LTSS component was added to Washington Medicaid Integration Partnership (WMIP). Under the program, primary, acute, behavioral, prescription drugs, and LTSS (nursing facilities and community-based services) are provided in capitated rate. Groups enrolled include adults age 21-64 with SSI or SSI-related Medicaid and adults age 65 and older. Enrollment is voluntary, and very limited geographic area is covered. (Source: CMS and Truven Health Analytics, July 2012) State Resource on WMIP (December 2010)</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals (Managed Fee-For-Service Model & Capitated Model)</p> <p>HealthPath Washington (formerly Pathways to Health), the Washington State’s Medicare and Medicaid Integration Project, proposes to realign and integrate care through three strategies: 1. Health Homes (managed fee-for-service financial model); 2. Full Financial Integration Capitation (three-way capitation financial model); and 3. Modernized and Consolidated Service Delivery with Shared Outcomes and Aligned Financial Incentives (capitation and fee-for-service). The project’s target population is full benefit Medicare-Medicaid enrollees of all ages.</p> <p>1. Strategy 1: Health Homes (Managed Fee-For-Service Model) – Approved (10/25/2012)</p> <p>On October 25, 2012, CMS approved the first strategy in the State’s Financial Alignment demonstration proposal. According to the Memorandum of Understanding, CMS initially planned to begin this Managed Fee-for-Service Financial Alignment Demonstration on April 1, 2013. However, in February 2013, Health Care Authority Department of Social and Health Services notified stakeholders that the state will introduce Health Homes on July 1, 2013. (Source: Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: California, Illinois, Massachusetts, Ohio, and Washington, Kaiser Commission on Medicaid and the Uninsured, May 2013; Washington Health Care Authority</p> |

| State | State Updates |
|--------------------------|---|
| <p>Washington</p> | <p><u>Stakeholder Notice, February 4, 2013</u>)</p> <p>Under the demonstration, eligible Medicare-Medicaid enrollees will elect to receive health home services from Health Home Care Coordinators, supplemented by multidisciplinary teams that coordinate across disciplines, including primary, acute, prescription drugs, behavioral health, and long-term services and supports (LTSS). Health home services will include: comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family supports; referral to community and social support services; and the use of a web-based clinical decision support tool (PRISM) and other health information technology to improve communication and coordination of services. The geographic area for this Demonstration is all counties in the state, with the exception of any counties in which the state receives approval from CMS to implement a capitated Financial Alignment Demonstration (Strategy 2). At this moment, the exceptions include King, Snohomish, and Whatcom counties. If the state no longer seeks to implement a capitated model in any of the three counties, Washington may expand this Demonstration to those additional counties beginning by November 1, 2013, at the latest. (Source: <u>Memorandum of Understanding</u>)</p> <p style="text-align: center;">2. Strategy 2: Full Integration Capitation (Three Way Contracts between Health Plan/State/CMS) – <i>Pending</i></p> <p>HealthPath Washington Strategy 2 Financial Alignment Demonstration will use a full-risk managed care model of health delivery that coordinates Medicare and Medicaid medical services, behavioral health services, and long-term services and supports. The Demonstration will be available to adults and children of King County and Snohomish County who are eligible for both Medicare and Medicaid, and for whom the state has a responsibility for payment of cost sharing obligations under the Washington State Plan. Beneficiaries may not be concurrently enrolled in the Demonstration and a Medicare Advantage Plan, the Program of All-inclusive Care for the Elderly (PACE), or a Medicare Hospice Program. Beneficiaries may participate in and are eligible for enrollment in the Demonstration if they voluntarily disenroll from their existing programs. Beneficiaries who are on the Medicaid Fee-for-Service delivery system and the Medicare Fee-for-Service delivery system and are receiving Medicare ESRD benefits may also voluntarily enroll in the Demonstration. At a future date, subject to additional discussions with CMS and other interested parties, Washington may also include beneficiaries receiving developmental disabilities §1915(c) home and community-based waiver services. If this population is included, the Medicare-Medicaid Integrated (MMI) Plans (managed care plans) will be responsible for services specified in the negotiated 3-way contract. The demonstration will begin on April 1, 2014. (Source: <u>Washington State Health Care Authority Request For Application (RFA) NO. 2013-003</u>, revised April 17, 2013)</p> |

| State | State Updates |
|-----------------------------|--|
| <p>Washington</p> | <p>Strategy 3 will be provided in counties where full capitation is not available. It will include Medicaid services for individuals with intellectual or developmental disabilities (I/DD) through a fee-for-service model. (Source: Demonstration Proposal; NASDDDS Managed Care Tracking Report) HealthPath Washington project website (Corrected link) HealthPath Washington Medicaid Health Homes Website HealthPath Washington Medicaid Health Homes Presentation (6/21/2012)</p> <p>Health Homes</p> <p>The state submitted draft Health Homes 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 Fact Sheet (10/1/2012) Washington Health Home State Plan Amendment (5/4/2013)</p> <p>Section 1915(i) State Plan Amendment (Closed)</p> <p>Washington State's State Plan Amendment for the Washington Adult Day Health (§1915(i) of the Social Security Act) was approved in December 2009, and went effective January 1, 2010. (Source: Approval Letter, 12/21/2009). However, the 2011-13 Washington State budget directed the Department of Social and Health Services (DSHS) to remove the Adult Day Health (ADH) program from the §1915(i) State Plan option and to add it to the Community Options Program Entry System (COPES) Waiver. The ADH service under the §1915(i) State Plan option permanently closed effective October 1, 2011. (Source: Adult Day Health Client Notification Letter) State Resources on Adult Day Health program</p> |
| <p>West Virginia</p> | <p>Health Homes</p> <p>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</p> |

| State | State Updates |
|---------------|--|
| West Virginia | Health Homes Webinar Presentation (6/13/2013) |
| Wisconsin | <p>Currently Operating Medicaid Managed LTSS Programs</p> <p>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)</p> <p>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</p> <p>State Demonstration to Integrate Care for Dual Eligible Individuals</p> <p>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</p> <p>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</p> |

| State | State Updates |
|------------------|--|
| Wisconsin | <p>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 (draft) (8/12/2013)</p> <p>Section 1915(i) State Plan Amendment</p> <p>Wisconsin's Medicaid State Plan Amendment (SPA) under §1915(i) State Plan Home and Community-Based Services is called Community Recovery Services, and provides three specific services – Community Living Supportive Services, Supported Employment, and Peer Supports – under the umbrella of psychosocial rehabilitation. Populations covered are elderly and disabled individuals. The SPA was approved June 3, 2010. (Source: Program website)</p> <p>Health Homes</p> <p>The state’s Health Homes State Plan Amendment received approval from CMS (10/1/2012). The service targets Medicaid and BadgerCare Plus members with a diagnosis of HIV/AIDS and who have at least one other diagnosed chronic condition or is at risk of developing another chronic condition. (Source: Approved Health Homes State Plan Amendment) Approved Health Homes State Plan Amendment (10/1/2012)</p> |

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 11/15/2013)

| | States | Proposed Financing Model | Submitted to CMS | Status | Target Implementation Date ¹ |
|----|----------------|--------------------------|------------------|--|---|
| 1 | Arizona | Capitated | 5/31/2012 | Formally withdrew | Jan 2014 |
| 2 | California | Both | 5/31/2012 | MOU Signed 3/27/2013 | April 2014 |
| 3 | Colorado | Managed FFS | 5/2012 | | N/A |
| 4 | Connecticut | Managed FFS | 5/31/2012 | | Dec 2012 |
| 5 | Hawaii | Capitated | 5/25/2012 | Withdrew; may reconsider | Jan 2014 |
| 6 | Idaho | Capitated | 5/2012 | | Jan 2014 |
| 7 | Illinois | Capitated | 4/6/2012 | MOU Signed 2/22/2013 | January 2014 (opt-in); April 2014 (passive) |
| 8 | Iowa | Managed FFS | 5/29/2012 | | Jan 2013 |
| 9 | Massachusetts | Capitated | 2/16/2012 | MOU Signed 8/23/2012 | October 2013 (opt-in); January 2014 (passive) |
| 10 | Michigan | Capitated | 4/26/2012 | | July 2014 |
| 11 | Minnesota | Capitated | 4/26/2012 | Withdrew; signed MOU with CMS on other duals initiative | Dec 2012 |
| 12 | Missouri | Managed FFS | 5/31/2012 | | Oct 2012 |
| 13 | New Mexico | Capitated | 5/31/2012 | Formally withdrew | Jan 2014 |
| 14 | New York | Capitated ² | 5/25/2012 | MOU Signed 8/26/2013 | July 2014 |
| 15 | North Carolina | Managed FFS | 5/2/2012 | | Jan 2013 |
| 16 | Ohio | Capitated | 4/2/2012 | MOU Signed 12/12/2012 | March 2014 (opt-in); April 2013 (passive phase-in) |
| 17 | Oklahoma | Correction: Both | 5/31/2012 | | July 2013 |
| 18 | Oregon | Capitated | 5/11/2012 | Withdrew; working with CMS through other initiative | Jan 2013 |
| 19 | Rhode Island | Capitated | 5/31/2012 | | Jan 2013 |
| 20 | South Carolina | Correction: Capitated | 5/25/2012 | MOU Signed | Jan 2014 |

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](#).

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.

| | States | Proposed Financing Model | Submitted to CMS | Status | Target Implementation Date ¹ |
|----|------------|--------------------------|------------------|--|---|
| 21 | Tennessee | Capitated | 5/17/2012 | Formally withdrew | Jan 2014 |
| 22 | Texas | Capitated | 5/2012 | | Jan 2014 |
| 23 | Vermont | Capitated | 5/10/2012 | | Jan 2014 |
| 24 | Virginia | Capitated | 5/31/2012 | MOU Signed 5/21/2013 | March 2014 (opt-in); July 2014 (passive) |
| 25 | Washington | Both | 4/26/2012 | MOU Signed Managed FFS (10/25/2012); Capitated (pending) | Managed FFS model (July 2013) |
| 26 | Wisconsin | Both | 4/26/2012 | Working with CMS through modified demonstration | Jan 2013 |



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