October 3, 2014

State Medicaid Integration Tracker©

NASUAD
National Association of States
United for Aging and Disabilities

Welcome to the State Medicaid Integration Tracker©

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

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

1. Managed Long Term Services and Supports (MLTSS)

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

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

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

For more information, please contact **Damon Terzaghi** (dterzaghi@nasuad.org) or **Erin White** (ewhite@nasuad.org).

This Installment's Updates

Managed LTSS:

- **Kansas:** The three MCOs administering KanCare lost $72.6 million in the first half of 2014, after losing $110 million in 2013.
- **New Hampshire:** The state is delaying the second phase of its transition to managed care, which would have required LTSS recipients to enroll in managed care plans.
- **New York:** The state released a new timeline for transitioning to mandatory managed long-term care. The state also announced an updated timeline for the transition of behavioral health services to managed care. The state also delayed the nursing home benefit carve-in until January 2015.
- **North Carolina:** Two legislative oversight panels are meeting to examine the state's Medicaid reform/governance before the General Assembly reconvenes in January 2015.

Other Medicaid Developments of Interest:

- **Kentucky:** State lawmakers are working to improve access to HCBS waiver services for Kentucky's elderly to meet service demands; officials are trying to have regulations rewritten and approved by Spring 2015.
- **New York:** The state has partnered with Maximus to implement a Conflict-Free Evaluation and Enrollment Center to conduct initial evaluations to determine consumer eligibility for long-term community-based care.

Medicare-Medicaid Care Coordination Initiatives:

- **California:** Senior advocates filed a lawsuit seeking an injunction to halt the state's duals demonstration project (Cal MediConnect).
- **Colorado:** The state began enrolling duals into its Accountable Care Collaborative Medicare-Medicaid Program on September 1, 2014.
- **Massachusetts:** The state has cancelled the October 2014 round of OneCare passive enrollment.
- **Ohio:** The state released a MyCare Ohio Update.
- **Texas:** The state posted its Readiness Review Tool.
- **Virginia:** In September 2014, Virginia released a program update for Commonwealth Coordinated Care.
- **Washington:** The state delayed the HealthPathWashington implementation date until July 2015.

Balancing Incentive Program:

- **Massachusetts:** The state submitted a Structural Change Work Plan.
- **Nebraska:** CMS approved the state's BIP application.
- **Nevada:** The state submitted a Structural Change Work Plan.
- **Ohio:** The state surpassed the 50% spending target for HCBS one full year ahead of the federal deadline.

Community First Choice option under §1915(k):

- **Washington:** The state legislature has directed the state to implement CFCO; the Department of Social and Health Services intends to fully implement CFCO no later than August 2015.

Medicaid Health Homes:

- **New York:** The state plans to submit a proposed Health Home SPA to CMS on November 1 for Health Homes to Better Serve Children.

Overview

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

State Updates

State	State Updates
Alabama	**Regional Care Organizations** In June 2013, Alabama's governor signed Act 2013-261 into law, approving a strategy to develop risk-bearing Regional Care Organizations (RCOs) to manage a continuum of health care services for Medicaid beneficiaries under a single capitated rate. RCOs are organizations of health care providers that contract with the state Medicaid agency to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries within a defined region of the state. They will coordinate care for the majority of the Medicaid population and manage Medicaid benefits including physical, behavioral, and pharmacy services. The initiative aims to build on four existing regional pilots (Patient Care Networks of Alabama) that better enable primary medical providers to function as a medical or health home by providing care management and other health care services for chronically ill Medicaid enrollees. The State Medicaid Agency plans to establish geographic Medicaid regions and designate RCOs or alternate care providers to operate in each region. Subject to approval of the CMS, the Medicaid Agency shall enter into a contract in each Medicaid region for at least one fully certified RCO to provide medical care to the Medicaid beneficiaries. (Source: National Academy for State Health Policy, 11/2013). The State Medicaid Agency released an RCO Implementation Timeline establishing October 2016 as the date for RCOs to begin accepting capitation payments from Medicaid. (Source: State Medicaid website, 2/2014) Act 2013-261 1115 Waiver Concept Paper (5/17/2013) RCO Implementation Timeline On December 17, 2013, Alabama Medicaid filed five new rules to regulate the operation of Regional Care Organizations, outlining proposed state requirements that will be used to support the Agency's move to Regional Care Organizations and to comply with state law. The proposed rules include requirements for: RCO Governing Boards; RCO Citizens' Advisory Committees; receiving probationary certification as a RCO; contracting for specific case management services with probationary RCOs, and active supervision of probationarily-certified RCOs. (Source: State Medicaid Website, 1/10/2014). The original comment period for the RCO-related rules has been extended to March 2014. (Source: Alabama Medicaid Agency News, 1/10/2014; State Medicaid website) RCO Rules On June 13, 2014, the state submitted to CMS a §1115 Demonstration

State	State Updates
Alabama	Waiver Proposal to implement RCOs. RCOs are provider-based, community-led organizations that will, through an at-risk capitated payment model, manage State Plan benefits for the demonstration populations. However, long-term supports and services, hospice, and institutional and home and community-based services will not be managed by RCOs, because these services are excluded by statute. Beneficiaries will continue to receive these services through the fee-for-service delivery system. On October 1, 2015, the state Medicaid agency will submit a special study report to the Legislature and Governor, who will then determine whether these services will be included in the RCO benefit package or continue to be provided through the fee-for-service delivery system. (Source: State Medicaid website; §1115 Waiver Demonstration Proposal) §1115 Waiver Demonstration Proposal (6/13/2014) RCO Frequently Asked Questions (7/21/2014) As of July 3, 2014, seven groups representing all five regions of the state have filed official Notices of Intent with the state Medicaid agency to apply for probationary certification as a Regional Care Organization. (Source: State Medicaid website) **Health Homes** In April 2013, CMS approved the state's Health Homes State Plan Amendment. The state is implementing comprehensive care management in four networks over a two-year period from July 2013 to July 2014. The target population includes individuals with two chronic conditions, individuals with one chronic condition who are at risk for an additional chronic condition, and individuals with serious mental illness. (Source: Alabama Medicaid Agency News, 1/7/2013; Approved Health Homes State Plan Amendment, 4/9/2013)
Arizona	**Managed LTSS Program** Under Medicaid §1115 waiver authority, **Arizona Health Care Cost Containment System** (AHCCCS) provides health care services through a prepaid, capitated managed care delivery model that operates statewide for 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; payment arrangements; administrative and clinical systems; patient and provider services; and health services management. Long-term care service beneficiaries receive additional benefits not provided through the Medicaid State Plan. (Source: Medicaid.gov) State AHCCCS website Fact Sheet

State	State Updates
Arizona	Current Approval Document (4/6/2012) In August 2012, the state released a final ruling to maintain reimbursement reductions for inpatient and outpatient hospital services covered through the AHCCCS program as instituted in October 2011, and to eliminate inflation-based rate adjustments. (Source: BNA Register, August 17, 2012) In October 2012, the state submitted a §1115 waiver amendment seeking to extend state authority to provide Medicaid coverage to adults without dependent children with incomes between 0% and 100% of the Federal Poverty Level ("Childless Adults"); and to obtain the enhanced federal medical assistance percentage (FMAP) for Childless Adults beginning January 1, 2014. (Source: Application for Amendment, 11/9/2012) On July 19, 2014, Arizona submitted an application for CMS **State Innovation Model Funding** to accelerate the state's delivery system transformation towards a value-based integrated model focusing on whole person health in all settings and regardless of coverage source. The state will undertake transformation of the health care delivery system using three overarching strategies: 1) Facilitating Integration and Decreasing System Fragmentation; 2) Improving Care Coordination; 3) Driving Payment Reform. The **Arizona SIM Initiative** will begin by focusing on critical populations including individuals with serious mental illness (SMI) or other significant medical and behavioral health needs (super-utilizers); individuals dually eligible for Medicare and Medicaid; individuals transitioning from the justice system; members moving between Qualified Health Plans and Medicaid health plans; and the American Indian population. (Source: Arizona SIM Initiative website) CMS State Innovation Model Funding FAQs Arizona SIM Initiative Grant Application (7/19/14) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** In May 2012, the state submitted a proposal for a statewide participation in the Capitated Financial Alignment Demonstration model; the proposed implementation date was January 1, 2014. (Source: Demonstration Proposal) In April 2013, the state withdrew its proposal to participate in the Capitated Financial Alignment Demonstration for members that have AHCCCS and Medicare. The state said it would continue working with CMS to improve care for dual eligibles within its current managed care model. (Source: State

State	State Updates
Arizona	Medicaid website) Arizona Capitated Demonstration Withdrawal Letter (4/10/2013) **Section 1915(k) Community First Choice Option (Withdrawn)** In October 2012, Arizona submitted an application to CMS to implement the Community First Choice Option. In June 2013, Arizona withdrew its 1915(k) application, opting instead to implement its CFC service model under the state's §1115 waiver. (Source: National HCBS Conference Presentation, 9/11/2013; ALTCS Member-Directed Options website) State Plan Amendment (10/5/2012) **Health Homes** In March 2011, Arizona received a planning grant to explore the feasibility of a Regional Behavioral Health Authority (RBHA) model with expanded responsibility for Title XIX-eligible adults with SMI. This RBHA model is known as **Recovery through Whole Health**. (Source: State Health Homes website)
Arkansas	**Balancing Incentive Program** In March 2013, CMS awarded Arkansas 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 Revised Structural Change Work Plan (6/28/2013) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has not approved a §1915(i) HCBS State Plan Amendment for Arkansas; however, the state plans to participate in the HCBS State Plan Option in FY 2014. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option** The state plans to submit a §1915(k) State Plan Amendment to CMS and implement a CFCO program in 2014. The program will address the state's waiting list of people with DD seeking services under the existing Alternative Community Services Waiver. (Source: State CFCO website; CFCO Minutes; Development and Implementation Council Documents)

State	State Updates
Arkansas	**Health Homes** In February 2011, CMS approved the state's Health Home Planning Request for funding to create health homes for people with chronic conditions. (Source: CMS Approval Letter, 02/04/2011) As of June 2014, the state has not officially submitted a Proposed Health Home State Plan Amendment to CMS, but the state plans to participate in the Health Home State Plan Option in FY 2014. (Source: Kaiser Health Homes website, 6/2014)
California	**Managed LTSS Program** Under Medicaid §1915(a) authority, **SCAN Connections at Home** provides LTSS to Medicare-Medicaid enrollees age 65 and older at a 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 a limited geographic area under voluntary enrollment. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, 7/2012) **State Demonstration to Integrate Care for Dual Eligible Individuals** In May 2012, California submitted to CMS a capitated payment model demonstration proposal to integrate care for dual eligible beneficiaries known as the **Coordinated Care Initiative (CCI)**. The CCI mandates managed care enrollment for dual eligibles and makes changes to LTSS. The target population includes full benefit Medicare-Medicaid enrollees age 21 and over in 8 counties. Full benefit duals are Medicare beneficiaries with Parts A, B, and D coverage and full Medi-Cal coverage. (Medi-Cal covers: Medicare premiums; co-insurance; copayments; deductibles; and services not covered by Medicare such as LTSS). Beneficiaries enrolled in §1915(c) HCBS waiver programs and beneficiaries with DD receiving DDS services are excluded from the demonstration. Beneficiaries with DD receiving IHSS or CBAS services are included in the demonstration. Covered benefits include Medicare Parts A, B, and D; and Medicaid covered services. (Source: Demonstration Proposal; NASDDDS Managed Care Tracking Report) Demonstration Proposal State Website on Coordinated Care Initiative Timeline Coordinated Care Initiative Fact Sheets on CalDuals.org In March 2013, California and CMS entered into a Memorandum of Understanding (MOU) to integrate care for dual eligibles as a component of the state's Coordinate Care Initiative (CCI) through a project referred to as **Cal MediConnect**. Through Cal MediConnect, eligible beneficiaries can

State	State Updates
California	combine their Medicare and Medi-Cal benefits into one health plan and receive more coordinated and accountable care. The state initially proposed an enrollment start date of October 2013, but later changed the enrollment start date to January 2014. (Source: CalDuals, accessed 5/13/2013) Memorandum of Understanding On February 4, 2014, the state announced a Coordinated Care Initiative Update and LA Enrollment Strategy. Cal MediConnect enrollment will begin in April 2014, with passive enrollment in San Mateo and opt in enrollment in Riverside, San Bernardino, SanDiego, and Los Angeles counties. The update included a Revised Enrollment Chart outlining the CCI enrollment timeline by population and county. (Source: CalDuals, accessed 2/27/14) Revised Enrollment Chart Coordinated Care Initiative Update on CalDuals.org In March 2014, the state announced the following changes to its CCI timeline: **Cal MediConnect** and **Managed Medi-Cal Long-Term Services and Supports (MLTSS)** enrollment will be aligned so that beneficiaries will not transition to MLTSS ahead of passive enrollment into Cal MediConnect; the Medi-Cal fee-for-service population will transition to MLTSS starting in August 2014 rather than July 2014; and enrollment in Alameda and Orange counties will start no sooner than January 2015. (Source: HMA Weekly Roundup, 3/26/2014; CalDuals website) CCI Timeline (3/25/2014) In March 2014, CMS approved California's **§1115 Bridge to Reform waiver** amendment, authorizing the state to implement its Coordinated Care Initiative (CCI) on April 1, 2014. (Source: CalDuals website) On April 1, 2014, the state launched its duals demonstration, beginning passive enrollment in five counties. Passive enrollment for three additional counties will begin in May 2014. (Source: HMA Weekly Roundup, 4/9/14) San Diego County, one of the five counties that began passive enrollment in the demonstration on April 1, 2014, is developing a unique managed care initiative. The county's Aging and Independence Services (AIS), acting as the local AAA, is planning to collaborate with the Care1st managed care health plan to provide case management and other social services for dual eligible older adults. (Source: HealthyCal.org, 4/14/2014) On June 4, 2014, the state released an updated enrollment timeline for the demonstration. (Source: HMA Weekly Roundup, 6/11/2014) CCI Revised Timeline (6/4/2014) On July 1, 2014, the California duals demonstration began passive

State	State Updates
California	enrollment in Los Angeles County. (Source: HMA Weekly Roundup, 7/9/2014) On July 2, 2014, stakeholders filed a lawsuit in Superior Court against Cal MediConnect, claiming the duals demonstration enrollment process is misleading and confusing. Stakeholders asked the court for a preliminary injunction to halt the demonstration. (Source: California Healthline/Capitol Desk, 7/7/2014) On July 14, 2014, in response to stakeholder comments that the state's duals demonstration enrollment notices were unclear, the state revised its Cal MediConnect enrollment notices and will begin mailing the new notices to beneficiaries in July and August 2014. (Source: CalDuals website; HMA Weekly Roundup, 7/16/2014) Revised Enrollment Materials (July 2014) On July 18, 2014, the state released a set of initial concepts for the Medi-Cal §1115 Bridge to Reform waiver renewal. The state aims to submit the waiver renewal in early 2015 and is seeking stakeholder input. Waiver renewal concepts include a successor DSRIP program and Medicaid-funded shelter for vulnerable populations. (Source: HMA Weekly Roundup, 7/23/2014) §1115 Waiver Renewal Concepts (July 2014) On August 1, 2014, a California Superior Court judge ruled the state may continue its duals demonstration project to transition more duals into Medi-Cal managed care plans. The Medicaid Defense Fund intends to appeal the ruling as soon as possible. (Source: California Healthline/Capitol Desk, 8/4/2014) On August 1, 2014, the state announced a change to the Coordinated Care Initiative enrollment timeline for its duals demonstration and mandatory enrollment in MMLTSS. Enrollment in Alameda and Orange Counties will now begin in July 2015 to allow more time to achieve plan readiness. (Source: CalDuals website) CCI Revised Timeline (7/31/2014) On August 29, 2014, a group of advocates for seniors filed a lawsuit in the U.S. District Court in Los Angeles seeking an injunction to halt the Coordinated Care Initiative's duals demonstration project, known as Cal MediConnect. The lawsuit claimed passive enrollment into managed care puts frail and elderly duals at risk of a gap in care during the transition period. A previous lawsuit was judged in favor of continuing the duals project implementation. (Source: CaliforniaHealthline.org/Capitol Desk, 9/4/2014)

State	State Updates
California	**Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option** In September 2012, CMS approved the state's first CFCO SPA, making California the first state to receive CMS approval to enact the Community First Choice Option. The CFCO would provide the state an estimated $573 million in additional federal funds during the first two years of implementation; and the funding is retroactive for most in-home supportive services provided since December 2011. (Source: Press Release, 9/4/2012) CFCO SPA (8/31/2012) In May 2013, the state submitted its second CFCO SPA to update the eligibility language related to Medi-Cal's CFCO. In July 2013, CMS approved the state's second CFCO SPA. (Source: State CFCO website) CFCO SPA (7/31/2013) **Health Homes** As of March 2014, CMS has approved the state's Health Home Planning Request. (Source: CMS State Health Home Proposal Status, 3/2014)
Colorado	**Accountable Care Collaborative** In June 2012, the governor signed a bipartisan bill establishing an **Accountable Care Collaborative (ACC)** to pilot-test Medicaid fee-for-service alternatives and Regional Care Collaborative Organizations (RCCOs). (Source: ModernHealthcare.com; ModernPhysician.com) Medicaid clients in the ACC will not only receive regular Medicaid benefits but also belong to an RCCO that will connect them with Medicaid providers and assist them with care transitions. All clients enrolled in the ACC will be required to choose a Primary Care Medical Provider as their medical home. (Source: State RCCO website; State Accountable Care Collaborative website) Accountable Care Collaborative Fact Sheet CMS selected Colorado to participate in its **Comprehensive Primary Care (CPC) Initiative**, which Colorado implements through its existing ACC Program. The CPC Initiative strengthens primary care and fosters collaboration between health care systems. (Source: Colorado Department of Health Care Policy and Financing; CMS Comprehensive Primary Care Initiative website)

State	State Updates
Colorado	**State Demonstration to Integrate Care for Dual Eligible Individuals** **The Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees** builds on the infrastructure, resources and provider network found in the Accountable Care Collaborative (ACC) Program. The initiative will include the state's entire dually-eligible population, including its I/DD populations, in its managed fee-for-service duals demonstration. (Source: NASDDDS Managed Care Tracking Report) The demonstration will enhance coordination between acute and long-term care. Covered benefits will include: Medicare Parts A, B, and D; the 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. Colorado did not specify the proposed demonstration implementation date. (Source: Demonstration Proposal; State Duals Demonstration website) On February 28, 2014, CMS and the state signed a Memorandum of Understanding for the state's managed fee-for-service demonstration model. (Source: CMS Demonstration Approvals website; CMS website; NSCLC Dual Eligible State Profiles website, 4/2014; Kaiser Family Foundation Duals Demonstration Proposal Status Map (4/2014) Memorandum of Understanding (2/28/2014) On June 18, 2014, the state announced it received a $13.6 million grant from CMS to implement its duals demonstration; the grant will aid the state in implementing the ACC program to coordinate care for more than 50,000 dual eligibles. (Source: HMA Weekly Roundup, 6/18/2014) On July 16, 2014, Colorado and CMS signed a managed fee-for-service Financial Demonstration Agreement, establishing the terms and conditions for implementing the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees. (Source: CMS Colorado Demonstration website) The state will implement its duals demonstration on September 1, 2014. The program will integrate and coordinate physical, behavioral, and social health needs for full-benefit Medicare-Medicaid clients. Full benefit dual enrollees not already participating in an integrated system of care will be passively enrolled in the program with an option to opt-out. (Source: HMA Weekly Roundup, 8/6/2014) Financial Demonstration Agreement (7/22/2014) On September 1, 2014, the state began enrolling full benefit Medicare and Medicaid clients into the **Accountable Care Collaborative (ACC): Medicare-Medicaid Program**; and the state will continue to phase in enrollment over the next seven months. Full benefit Medicare-Medicaid enrollees that are not already participating in an integrated system of care

State	State Updates
Colorado	will be passively enrolled in the program with an opt-out option. Clients have the right to keep all their current benefits and use the same doctors. (Source: HMA Weekly Roundup, 9/3/2014) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option** The state is considering the Community First Choice Option. In 2012, Colorado's LTSS Strategic Planning Report identified CFC as an important LTSS initiative; and the state formed a CFC Council. (Source: Colorado CFC website; LTSS Strategic Planning Report) In May 2014, Colorado's Department of Health Care Policy and Financing held a CFC Council meeting, during which the Council stated its intent to continue moving CFC forward, as well as the need for additional funding to move CFC forward. (Source: CFC Council Minutes, 5/5/2014; Colorado CFC website)
Connecticut	**Nonprofit Oversight of Managed Care** In January 2012, Connecticut began directly reimbursing health care providers and the nonprofit Community Health Network of Connecticut, Inc. began providing care coordination and customer service for the state's Medicaid and Children's Health Insurance Program beneficiaries, plus members of a state-funded health program for low-income adults - about 600,000 people in all. All services are coordinated by the Department of Social Services' Administrative Services Organization (ASO). (Source: Stateline; Community Health Network of Connecticut, Inc.) Press Release Request for Proposals (4/2011) HB06518. An Act Establishing An Administrative Services Organization **State Demonstration to Integrate Care for Dual Eligible Individuals** Connecticut is proposing to contract with local Integrated Care Organizations (ICOs) featuring partnerships among multiple provider types facilitated by health information technology and electronic data gathering. The managed fee-for-service demonstration will serve dually Medicaid and Medicare eligibles (MMEs) 18 and older, including individuals with SMI and I/DD, with a primary focus on increasing acute health care service

State	State Updates
Connecticut	coordination. (Source: NASDDDS Managed Care Tracking Report; NSCLC website; Demonstration Proposal) **Balancing Incentive Program** In December 2012, CMS announced Connecticut will receive an estimated $72.8 million in enhanced Medicaid funds (a 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 **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Health Homes** As of June 2014, the state has not officially submitted a Proposed Health Home State Plan Amendment to CMS, but the state plans to participate in the Health Home State Plan Option in FY 2014. (Source: CMS Health Home Proposal Status website, 6/2014; Kaiser Health Home website, 6/2014)
Delaware	**Managed LTSS Program & State Demonstration to Integrate Care for Dual Eligible Individuals** In 1996, through its **Diamond State Health Plan (DSHP)** §1115 managed care demonstration waiver, the state began mandatorily enrolling most Medicaid recipients into **managed care organizations (MCOs)** to create efficiencies in the Medicaid program and expand Medicaid coverage. (Source: DSHP Fact Sheet) Diamond State Health Plan website In June 2012, through an amendment to its DSHP §1115 managed care demonstration waiver, the state began providing LTSS to eligible individuals, including dual eligibles, through a mandated managed care delivery system entitled **Diamond State Health Plan Plus (DSHP-Plus).** (Source: BNA Register, 6/12/2012; DSHP Fact Sheet) Waiver Amendment Request Letter to CMS Current Approval Document

State	State Updates
Delaware	**Balancing Incentive Program** Delaware is planning to participate in the Balancing Incentive Program in FY 2014. However, the state has not yet submitted a BIP Application to CMS. (Source: Kaiser BIP website, 6/2014) **Section 1915(i) HCBS State Plan Option** As of June 2014, Delaware has submitted to CMS a proposed §1915(i) HCBS State Plan Amendment known as **Pathways to Employment**. The proposed program will target youth aged 14 to 25 in certain disability groups and offer an array of employment-related services including: Employment Navigator; career exploration and assessment; supported employment (individual and small group); benefits counseling; financial coaching; non-medical transportation; personal care (including a self-directed component); and orientation, mobility, and assistive technology. The program will seek to ensure more seamless transitions from school to work, and across the array of employment options and supports. (Source: Kaiser HCBS State Plan Option website, 5/2014; State Medicaid website; Pathways to Employment website) Proposed State Plan Amendment **Health Homes** As of June 2014, the state has not officially submitted a Proposed Health Home State Plan Amendment to CMS, but the state plans to participate in the Health Home State Plan Option in FY 2014. (Source: CMS Health Home Proposal Status website, 6/2014; Kaiser Health Home website, 6/2014)
District of Columbia	**Section 1915(i) HCBS State Plan Option** As of August 2014, CMS has not approved a §1915(i) HCBS State Plan Amendment for the District of Columbia; but the District of Columbia plans to participate in the §1915(i) HCBS State Plan Option in FY 2014. (Source: Kaiser HCBS State Plan Option website, 8/2014) **Health Homes** CMS has approved the District of Columbia's Health Home Planning Request. As of June 2014, the District of Columbia has not officially submitted a Proposed Health Home State Plan Amendment to CMS, but the District of Columbia plans to participate in the Health Home State Plan Option in FY 2014. (Source: CMS Health Home Proposal Status website, 6/2014; Kaiser Health Home website, 6/2014)

State	State Updates
Florida	**Section 1115 Demonstration Waiver** On July 31, 2014, CMS approved Florida to continue its **§1115 Managed Medical Assistance (MMA) demonstration** waiver through June 30, 2017. The waiver was initially approved in 2005. Under the demonstration, managed care participation is mandatory for TANF-related populations and the Aged and Disabled group, as well as individuals eligible for both Medicare and Medicaid. The following populations may choose to be participants in the managed care demonstration: Individuals who have other creditable health care coverage, excluding Medicare; individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility; individuals in an intermediate care facility for ID; individuals with DD enrolled in the HCBS waiver pursuant to state law; and Medicaid recipients waiting for waiver services. (Source: Medicaid.gov) Approval Letter (7/31/2014) Fact Sheet (7/31/2014) **Managed LTSS Program & State Initiative to Integrate Care for Dual Eligible Individuals** The **Florida Long-Term Care Community Diversion Program**, operating under §1915(a) and §1915(c) waiver authorities, provided community-based services to people who would otherwise qualify for Medicaid nursing home placement. The LTC Community Diversion Program was phased out in 2014. (Source: LTC Community Diversion Program website; Department of Elder Affairs Medicaid Waiver Programs Website) Approved Waiver The 2011 Florida Legislature passed HB 7107 which directed the state to restructure its Medicaid program into an integrated managed care program requiring almost all Medicaid recipients (including TANF, SSI and duals) to receive covered services through the Statewide Medicaid Managed Care (SMMC) program. In August 2011, in accordance with this legislation, the state submitted to CMS concurrent §1915(b) and §1915(c) waiver applications to implement the **Florida Long Term Care Managed Care Program.** (Source: Florida Long-Term Care Managed Care Program Website; CMS and Truven Health Analytics, 7/2012; HMA Weekly Roundup, 6/4/2014) §1915(b) waiver application §1915(c) waiver application In February 2013, CMS approved the state's concurrent §1915(b)/(c) Florida Long Term Care Managed Care Program waiver, effective July 1, 2013 through June 30, 2016. From August 2013 through March 2014, the

State	State Updates
Florida	state regionally phased out five of its current HCBS waivers and transitioned eligible recipients from its LTC Community Diversion Program into its new Statewide Medicaid Managed Care Long-Term Care Program. Mandatory enrollment populations include dual eligibles (under fee-for-service). (Source: LTC Community Diversion Program website; Department of Elder Affairs Medicaid Waiver Programs Website; Florida Long-Term Care Managed Care Program Website) Approval Letter (2/1/2013) A Snapshot of the Florida Medicaid Long-term Care Program (2/18/2014) On July 1, 2014, Florida began offering a Medicaid managed health plan designed exclusively for people with serious mental illness. The plan, offered by Magellan Complete Care, is part of a wave of state experimentation to coordinate physical and mental health care for those enrolled in Medicaid. About 140,000 low-income Floridians are likely to be eligible, and Magellan predicts about 20,000 will participate voluntarily in the first year. Medicaid recipients who meet the plan's criteria will automatically be assigned to it by the state, with the option to opt into a different managed care plan within 90 days of enrollment. Coverage began July 1 in Miami-Dade and Broward counties and will roll out to other regions by September 2014. (Source: Pensacola News Journal, 7/5/2014; HMA Weekly Roundup, 7/9/2014) On July 14, 2014, the state announced all individuals with critical needs who have been on the Agency for Persons with Disabilities (APD) waiting list as of July 1, 2014 will be offered enrollment in the HCBS Medicaid Waiver. (Source: State APD News Release, 7/14/2014) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014)
Georgia	**Medicaid & CHIP Redesign Initiative** In 2012, a state-commissioned report of a comprehensive assessment of Georgia's Medicaid Program and Children's Health Insurance Program (CHIP/PeachCare for Kids) recommended moving state Medicaid recipients into managed care. As a result, the state is planning to implement a Medicaid Medical Coordination Program for aged, blind or disabled (ABD) Medicaid recipients. (Source: State Medicaid Redesign Initiative website) Navigant 2012 Report In October 2013, the state announced its intention to submit a Medicaid SPA

State	State Updates
Georgia	to CMS as part of its plan to implement a Medicaid Medical Coordination Program for ABD Medicaid recipients. (Source: State DCH website; Public Notice, 10/10/2013) Medicaid State Plan Amendment, (10/10/2013) In June 2014, the state cancelled its RFP to establish a contract with a vendor to provide managed care to ABD beneficiaries because contract proposals were over budget. The RFP would have allowed enrollees access to a nurse phone line and case management services in order to better coordinate their care. For now, services provided to ABD Medicaid beneficiaries will continue to be paid for using the traditional fee-for-service model; and a revised RFP will be issued on July 11, 2014. (Georgia Health News, 6/9/2014; HMA Weekly Roundup, 6/11/2014; HMA Weekly Roundup, 6/18/2014) **Balancing Incentive Program** In June 2012, CMS awarded the state an estimated $64.4 million of enhanced Medicaid funds (a 2% enhanced rate). (Source: CMS BIP website) CMS Award Announcement (6/13/2012) BIP Grant Application (3/3/2012) BIP Structural Change Work Plan
Hawaii	**Managed LTSS Program** In June 2012, CMS approved the state's **QUEST Expanded (QEx)** program, a statewide §1115 demonstration waiver. The four programs included in QEx **(QUEST; QUEST-Net; QUEST-ACE; and QExA)** use capitated managed care as a delivery system unless otherwise noted. 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 **QUEST Expanded Access (QExA)** component provides acute and primary care using managed care, as well as institutional and home and community-based long-term-care services through comprehensive and specialized managed care plans to individuals eligible as ABD under the Medicaid State Plan. Enrollment is mandatory regardless of need for LTSS. (Source: Medicaid.gov; CMS and Truven Health Analytics, July 2012) Approval Document (6/14/2012) Fact Sheet Additional information In May 2012, the state requested a three-year extension of the QEx §1115 demonstration program, set to expire on June 30, 2013. The state would submit a separate proposal to amend the demonstration to reflect new

State	State Updates
Hawaii	Affordable Care Act requirements. (Source: Hawaii State Med-QUEST Division) In July 2012, the governor signed H.B. 2275 into law, establishing a hospital sustainability fee and hospital sustainability program fund to receive Medicaid matching funds under the QEx §1115 demonstration. The legislation required the state to charge and collect a provider fee on health care items or services provided by private hospitals. (Source: Press Release, 7/6/2012) In August 2013, Hawaii submitted an RFA for its **QUEST Integration (QI)** program, which will consolidate the Managed Care programs Hawaii operates independently under the QUEST Medicaid umbrella into a single managed care program serving all of Hawaii's Medicaid population under §1115 Waiver authority. Hawaii's current separate managed care programs – QUEST and QExA – are served by five managed care plans. These programs include several smaller Medicaid and non-Medicaid state-funded programs. The beneficiaries of all programs will be mandatorily enrolled in the plans awarded QI contracts under this RFP. The QI program will cover all Medicaid and state-funded non-Medicaid individuals under a unified contract with the awarded health plans. The only individuals excluded from the QI program are those who are Medicare Special Savings Program Members; enrolled in the State of Hawaii Organ and Transplant Program (SHOTT); retroactively eligible only; and those eligible under non-ABD medically needy spend down. The state anticipates finalized capitation rates to be released in December 2013 and contract awards following in January 6, 2014. (Source: HMA Weekly Roundup, 8/14/2013) Request for Proposals QUEST Integration Procurement Information (2013) In January 2014, the state announced awards in its RFP to integrate the QUEST and QUEST Expanded Access (QExA) managed care programs. The state awarded contracts to the five incumbent health plans currently serving QUEST and QExA. According to the award announcement, all 5 health plans will provide QI services statewide except for the Kaiser Foundation Health Plan, which will focus on the islands of Oahu and Maui. The QI program will launch enrollment on January 1, 2015, and the health plans will start provision of services to QI members on January 1, 2015. (Source: HMA Weekly Roundup, 1/8/2014) On July 25, 2014, Hawaii announced it is on track to implement its QUEST Integration health plan on January 1, 2015; QI will create a single managed care program for the state. (Source: State Human Services News website) Press Release, 7/25/2014

State	State Updates
Hawaii	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** The state'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. The target population would have included the dual eligible portion of the existing QExA population, including children and adults with disabilities, adults with SMI, and the elderly. Individuals receiving HCBS under the state's approved §1115 demonstration waiver would also have been included. Persons enrolled in the I/DD §1915(c) HCBS waiver program would be excluded, and specialized behavioral health services would be carved out. The state proposed a January 2014 implementation date, but later decided to withdraw its demonstration proposal and reevaluate its options. (Source: Demonstration Proposal; NSCLC Dual Eligibles website)
Idaho	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** The state planned to replace its existing voluntary Medicare-Medicaid Coordinated Plan (MMCP) with a **Demonstration to Integrate Care for Dual Eligibles**, effective January 1, 2014. (Source: Demonstration Proposal) State Website on Integrating Care for Dual Eligibles Summary of Idaho Initiative to Integrate Care for Dual Eligibles, 10/2012) On February 26, 2014, the state announced it will no longer participate in the Dual Eligible Financial Alignment Initiative Demonstration. Instead, Idaho will expand benefits under the existing voluntary **Medicare-Medicaid Coordinated Plan (MMCP)**. (Source: Idaho Department of Health and Welfare website; MLTSS Network Weekly Roundup, 3/6/2014) The state implemented dual eligible benefits under its MMCP on July 1, 2014. All persons age 21 and over who are eligible for Medicare and Medicaid can enroll in the MMCP. (Source: Idaho Medicaid website) Medicare-Medicaid Coordinated Plan Stakeholder Update, 6/24/2014) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Health Homes** CMS approved the state's Health Home State Plan Amendment, and Idaho

State	State Updates
Idaho	began implementing the SPA in January 2013. The Health Homes target individuals with serious mental illness; diabetes and an additional condition; or asthma and an additional condition. (Source: Demonstration Proposal to Integrate Care for Dual Eligibles; State Health Homes website) Approved Health Home State Plan Amendment (11/21/2012)
Illinois	**Managed LTSS Programs** In 2011, the Illinois General Assembly adopted a Medicaid reform law (P.A. 96-1501) mandating the state to move 50% of Illinois Medicaid recipients from fee-for-service to risk-based care coordination by January 2015. Currently, the state has two managed LTSS programs. (Source: State Website on Integrated Care Program) In May 2011, the state implemented its first integrated health care program, a mandatory managed care program for the non-dual ABD population known as the **Integrated Care Program (ICP)**, in 5 pilot counties. (Source: State Integrated Care Program website) In February 2013, health plans began covering LTSS benefits for ICP enrollees. In mid- 2013, the state began its ICP enrollment expansion. In March 2014, the state began ICP enrollment expansion in the City of Chicago, the state's final region for ICP expansion. (Source: HMA Weekly Roundup, 4/2/2014) In early 2013, the state implemented its second managed care program, known as the **Care Coordination Innovations Project**. Eligible populations include older adults, adults with physical disabilities, and children with complex needs. The managed care entities include **Care Coordination Entities (CCEs)** and **Managed Care Community Networks (MCCNs)**. CCEs are provider-organized networks providing care coordination for risk- and performance-based fees; medical and other services are paid on a fee-for-service basis. Some CCEs have already begun serving beneficiaries, while others will go live later in 2014. MCCNs are provider-sponsored organizations that contract Medicaid covered services through a risk-based capitated fee model. Participation in a CCE or MCCN is voluntary. (Source: State Presentation on Innovations Project, 10/31/2011; HMA Weekly Roundup, 4/23/2014) Care Coordination Information and Fact Sheet State Website on Care Coordination initiative In early June 2014, the state postponed the July 1, 2014 launch date for its managed care programs, in order to finalize contracts and mail out patient information packages. On June 17, 2014, the state updated its care coordination rollout map. (Source: Chicago Tribune, 6/10/2014; HMA Weekly Roundup, 6/11/2014; HMA Weekly Roundup, 6/18/2014). Care Coordination Expansion Map (6/25/2014)

State	State Updates
Illinois	Care Coordination Webcast Presentation (6/30/2014) On June 4, 2014, Illinois submitted to CMS a **§1115 Waiver for its Path to Transformation demonstration**. The waiver proposes comprehensive reforms to the state's Medicaid program that will impact all Medicaid eligible populations, including seniors and people with disabilities. The waiver proposes significant changes to Medicaid LTSS, including consolidating the nine existing waivers into a single §1115 waiver; reducing waiting lists; moving individuals from sheltered workshops into integrated employment; and expanding availability of behavioral health services. The waiver also proposes to create a fund to reimburse institutions that close or reduce capacity, and to establish an assessment of HCBS providers. Lastly, the waiver suggests that Illinois may examine institutional eligibility criteria to ensure that policies prioritize services in other settings. (Source: Illinois.gov website; Draft Waiver Concept Paper, 11/7/13) §1115 Waiver Proposal (6/4/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals** In April 2012, the state submitted a **Medicare-Medicaid Alignment Initiative (MAAI)** proposal for a demonstration to provide coordinated care under a capitated model in limited geographic areas to full benefit dual eligibles age 21 and over who are aged, blind, or disabled. Persons with I/DD are carved out, and enrollment is voluntary with an opt out option. (Source: Demonstration Proposal; Illinois Care Coordination website; Illinois Medicare-Medicaid Alignment Initiative website) Illinois Medicare-Medicaid Alignment Initiative Proposal In February 2013, the state and CMS signed a Memorandum of Understanding to provide coordinated care to more than 135,000 dual eligibles in the Chicago area and throughout central Illinois under the MMAI demonstration, beginning on October 1, 2013. (Source: Centers for Medicare and Medicaid Services) Opt in enrollment began on April 1, 2014. Passive enrollment began on June 1, 2014. (Source: Illinois HFS website; HMA Weekly Roundup, 5/7/2014) Memorandum of Understanding **Balancing Incentive Program** In June 2012, CMS awarded the state an estimated $90 million in enhanced Medicaid funds (a 2% enhanced FMAP rate) from July 1, 2013 through September 30, 2015. (Source: CMS Balancing Incentive Program website) BIP Application (3/27/2013) Structural Change Work Plan (12/18/2013)

State	State Updates
Illinois	**Health Homes** In 2013, the state submitted a draft Health Home State Plan Amendment to CMS. (Source: CMS Health Home Proposal Status website, 4/2013) As of June 2014, the state has not officially submitted a Proposed Health Home State Plan Amendment to CMS, but the state plans to participate in the Health Home State Plan Option in FY 2014. (Source: CMS Health Home Proposal Status website, 6/2014; Kaiser Health Home website, 6/2014)
Indiana	**Balancing Incentive Program** In September 2012, CMS awarded Indiana an estimated $78.2 million of enhanced Medicaid funds. (Source: Approved BIP Application) Approved BIP Application Structural Change Work Plan BIP Work Plan Table (10/2013) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Health Homes** In 2013, the state considered Health Homes for persons with SMI or a co-occurring developmental disability at risk for additional chronic health conditions. (Source: Indiana DDRS Provider Quarterly Update, 4/24/2013) In 2014, however, the state decided to develop Wellness Coordination services within its Community Integration and Habilitation Waiver as a feasible and immediate response to the need for better coordination of waiver participants' health care issues. (Source: CMS Health Home Proposal Status website, 2/2014; Community Integration and Habilitation Waiver, 2/1/2014)
Iowa	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** In May 2012, the state submitted to CMS a Financial Alignment Demonstration Proposal to provide full benefit dual eligible access to comprehensive coordinated care management through a Health Homes model. The target population is persons with I/DD, and the proposed reimbursement model is a "Health Homes in a Fee-for-Service environment". The originally proposed implementation date was January 1, 2013, but the MOU is still pending. (Source: Demonstration Proposal;

State	State Updates
Iowa	NASDDS Managed Care Tracking Report Vol.1 No.2; NSCLC Duals website) As of July 2014, the state has withdrawn from the Financial Alignment Demonstration. (Source: Kaiser Duals Demonstration Proposal Status Map, 7/2014) **Balancing Incentive Program** In June 2012, CMS awarded the state an estimated $61.8 million of enhanced Medicaid funds (a 2% enhanced rate). (Source: Iowa Medicaid Enterprise Endeavors Update; State BIP website) BIP Application (4/30/2012) CMS Award Announcement (6/13/2012) IME Bureau of LTC Revised Work Plan (1/2013) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Health Homes** In June 2012, CMS approved Iowa's first Health Home State Plan Amendment to implement Health Homes for individuals with two chronic conditions or one chronic condition with the risk of developing another chronic condition. (Source: CMS Health Homes Matrix, 6/2014; State Health Homes website) Approved Health Homes State Plan Amendment (6/2012) In June 2013, CMS approved Iowa's second Health Home State Plan Amendment to implement Integrated Health Homes (IHH) for adults and children with SPMI. (Source: CMS Health Homes Matrix, 6/2014) On June 23, 2014, CMS approved Iowa's third Health Home SPA, for the Phase III expansion of the state's SPMI Health Home Program for Medicaid eligible individuals as authorized under Section 2703 of the Patient Protection and Affordable Care Act. (Source: Medicaid State Resource Center website; CMS Health Home Proposal Status website, 6/2014) Approved Health Home SPA, 6/23/2014
Kansas	**Managed LTSS Program** In August 2012, the state resubmitted to CMS its **KanCare** §1115 demonstration waiver application, seeking waiver authority to move all

State	State Updates
Kansas	Medicaid populations into a person-centered integrated care system by January 1, 2013. (Source: Medicaid.gov; CMS and Truven Health Analytics, 7/2012) Waiver Application (Submitted 8/6/2012) In December 2012, CMS approved KanCare and the state began implementing KanCare on January 1, 2013. Approved Application (12/27/2012) In December 2013, the state announced temporary postponement of its January 1, 2014 start date to incorporate I/DD waiver services into KanCare through a proposed §1115 demonstration waiver amendment. However, the state agreed to continue working with CMS to resolve issues related to the existing §1915(c) waiver for I/DD members by February 1, 2014. The state said it would determine the implementation timeline and any updates to the KanCare §1115 demonstration Special Terms and Conditions during its discussions with CMS (Source: KDHE News Release, 12/27/13) In January 2014, the state announced it had reached an agreement with CMS on the proposed amendment to the §1115 demonstration waiver for HCBS for individuals with I/DD (HCBS-I/DD). Beginning February 1, 2014, HCBS-I/DD will be integrated into KanCare. (Source: State Press Release, 1/30/14; KDHE News Release, 1/17/14) Amendment Approval Letter (1/30/14) Amended Special Terms and Conditions (1/30/14) Waiver Authority Expenditure Authority On September 9, 2014, the Kansas Health Institute reported that the three managed care organizations administering KanCare lost $72.6 million in the first half of 2014, after losing $110 million in 2013. On September 7, Representative Jim Ward, who is a member of a KanCare oversight committee, questioned how long the three companies can sustain such losses. (Source: Kansas Health Institute, 9/9/2014) **Health Homes** In September 2013, Kansas submitted to CMS an official Health Home SPA for Health Homes targeting people with SMI or other chronic conditions as a component of the KanCare §1115 demonstration waiver. (Source: Kansas Health Homes website; CMS Health Home Proposal Status website, 6/2014) Health Home SPA Proposal (9/12/2013) On February 24, 2014, the state announced it will begin implementing Health Homes on July 1, 2014. (Source: KanCare Advisor, 2/24/14). As of

State	State Updates
Kansas	June 2014, the state was planning to implement Health Homes in July 2014. (State Health Homes Herald, 6/2014) On July 1, 2014, the Kansas Health Institute reported that the state has chosen to indefinitely delay much of the implementation of the new Health Homes initiative because there are not enough providers statewide to address the initiative's plan for treating Medicaid enrollees who are chronically ill with asthma or diabetes. This part of the initiative will now be reconsidered on January 1, 2015. Community providers that were preparing for the Health Homes initiative are concerned that this delay will kill the program altogether. (Kansas Health Institute, 7/1/2014; HMA Weekly Roundup, 7/2/2014) On July 28, 2014, CMS approved the state's Health Home SPA, effective July 1, 2014. (Source: Medicaid.gov State Resource Center) Approved Health Home SPA (7/28/2014)
Kentucky	**LTSS Reform Activities** On September 21, 2014, AP/Modern Healthcare reported that state lawmakers are working to improve access to HCBS waiver services for Kentucky's elderly to meet the demand for home and community care options and achieve the financial benefits of such services. Officials are trying to have regulations rewritten and approved by Spring 2015. (Source: HMA Weekly Roundup, 9/24/2014; Modern Healthcare, 9/21/2014) **Balancing Incentive Program** On October 24, 2013, Kentucky submitted an application for BIP funding. CMS subsequently approved Kentucky's application for additional BIP funding. The state will receive an enhanced Federal matching rate of 2% for non-institutional LTSS. (Source: CMS Balancing Incentive Program website; LeadingAge BIPP Update, 1/26/14) Kentucky's Balancing Incentive Program Application (10/24/2013) Structural Change Work Plan **Health Homes** Kentucky submitted a State Health Home Planning Request and CMS approved the Health Home Planning Request. (Source: CMS Health Home Proposal Status website, 2/2014)
Louisiana	**Managed LTSS Program** In August 2013, the Louisiana Department of Health and Hospitals (DHH) released a concept paper outlining the initial steps in a process to better

State	State Updates
Louisiana	manage LTSS in Louisiana. The document provides the initial framework for a discussion with consumers, community members, advocates and the public about the best path forward for implementing MLTSS in Louisiana. (Source: DHH Newsroom website) In February 2014, DHH released a MLTSS Implementation Concept Brief to describe its research into states' MLTSS best practices and solicit feedback about building a framework for transformation to MLTSS. (Source: State LTC website) Concept Brief On July 28, 2014, DHH issued a Request for Proposals to rebid the Bayou Health managed care program, which launched in 2012. Bayou Health currently serves around 900,000 Medicaid beneficiaries across five health plans – three of which are risk-based MCOs, and two of which are non-risk MCOs which are eligible to receive shared savings payments. The most significant change under the Bayou Health rebid is the elimination of the non-risk MCO program, which currently accounts for 54 percent of Bayou Health enrollees. These roughly 480,000 lives will be translated to risk-based managed care in 2015, which could more than double the $960.7 million spent in fiscal year 2013 on capitation payments to Bayou Health MCOs. Under the new Bayou Health contracts, Louisiana's Medicaid HCBS waiver participants may be eligible to voluntarily enroll in a Bayou Health MCO. This includes disabled adults and the I/DD population, as well as children on the waiting list for a waiver. Dual eligibles; individuals residing in a nursing facility or intermediate care facility for I/DD; and individuals enrolled in PACE are excluded from Bayou Health MCO enrollment. A separate RFP for a standalone MLTSS program is anticipated later this year. (Source: State DHH website; HMA Weekly Roundup, 8/6/2014) Request for Proposals (7/28/2014) On July 30, 2014, the state released an RFI related to Disease Management and Disease Management Services for Medicaid recipients with chronic diseases. The services would include identification of eligible participants; participant outreach and engagement; and direction, coordination, monitoring and tracking of disease management and disease management related services. The key objective for the disease management program is to improve coordination of care and health outcomes and reduce overall costs. Target populations include dual-eligibles; nursing home and adult home residents; and residents enrolled in Medicaid 1915 HCBS waiver services. (Source: State DHH website; HMA Weekly Roundup, 8/6/2014) Request for Information (7/30/2014) On August 15, 2014, the state released an RFP for the management of behavioral health services in the state through the **Louisiana Behavioral**

State	State Updates
Louisiana	**Health Program.** The purpose of the RFP is to solicit proposals from qualified behavioral health managed care entities to manage behavioral health services that serve adults with SMI and/or substance abuse disorders; children and adults with specialized behavioral health needs; eligible youth involved with the Department of Health and Hospitals, the Office of Juvenile Justice, the Department of Children and Family Services, and/or the Louisiana Department of Education; and a special population of children eligible for the Coordinated System of Care. The goal of this initiative is to increase access to behavioral health services for the populations most in need. Letters of Intent are due on August 25, 2014, and proposals are due on October 8, 2015. (Source: HMA Weekly Roundup, 8/20/2014) Request for Proposals (8/15/2014) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option (Withdrawn)** The state planned to replace its current Long-Term Personal Care Services Program with the Community First Choice Option. (Source: Louisiana Register Vol. 38, No.6, 6/20/2012; Notice of Intent, 6/20/2012) However, in August 2013, Louisiana withdrew its application for a CFC Choice State Plan Amendment. (Source: Kaiser CFC State Plan Option website) **Balancing Incentive Program** In March 2013, CMS awarded Louisiana an estimated $69.25 million in enhanced Medicaid funds (a 2% enhanced FMAP rate). (Source: BIP Award Letter, 3/15/2013) BIP Application (2/8/2013) Structural Change Work Plan
Maine	**Balancing Incentive Program** In June 2012, CMS awarded Maine an estimated $21 million in enhanced Medicaid funds. (Source: CMS Balancing Incentive Program website) BIP Application (5/1/2013) Structural Change Work Plan

State	State Updates
Maine	**Health Homes** In January 2013, CMS approved the state's Health Homes State Plan Amendment. The **MaineCare Health Home Initiative** includes Stage A Health Homes for people with chronic conditions and Stage B Behavioral Health Homes for individuals with serious mental illness or serious emotional disturbance. (Source: CMS website; MaineCare Services website) Approved Health Homes State Plan Amendment (1/22/2013) Maine previously implemented Stage A of its Health Home Initiative. On October 11, 2013, DHHS posted a Behavioral Health Home RFA for Stage B of its Health Home Initiative. The state will implement Stage B of its Health Home Initiative in April 2014. Practices may participate in both Stage A and Stage B of the Health Home Initiative beginning April 2014. (Source: MaineCare Services website) As of May 2014, Maine has officially submitted to CMS a proposed Health Home SPA for the state's second health home, but CMS has not yet approved the state's second Health Home SPA. (Source: CMS Health Home Proposal Status website, 4/2014; Kaiser Health Home State Plan Option website, 5/2014)
Maryland	**Balancing Incentive Program** In early 2012, CMS awarded Maryland $106.34 million through September 2015 in BIP funding. Maryland was the second state (after New Hampshire) to be awarded BIP funding. (Source: CMS Balancing Incentive Program website) BIP application (2/10/2012) Award Letter (3/20/2012) Structural Change Work Plan **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has not approved a §1915(i) HCBS State Plan Amendment for Maryland; however, the state plans to participate in the HCBS State Plan Option in FY 2014. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option** On January 6, 2014, Maryland converted to the new Community First Choice Option. Subsequently, on April 2, 2014, CMS approved the state's CFCO SPA, effective January 1, 2014. (Source: Kaiser CFCO website, 5/2014; Medicaid SPA website)

State	State Updates
Maryland	Approved CFCO SPA (4/2/2014) **Health Homes** On September 27, 2013, CMS approved Maryland's proposed Health Home State Plan Amendment for Health Homes targeting individuals with opioid substance use disorder and the risk of developing another chronic condition; or one or more serious and persistent mental health conditions. (Source: Medicaid.gov; CMS Health Home Proposal Status website, 2/2014; CMS Health Homes Matrix, 6/2014) Health Home State Plan Amendment (Approved 9/29/13)
Massachusetts	**Managed LTSS Program** The **Massachusetts Senior Care Options** program operates under Medicaid §1915(a) and §1915(c) authorities and provides services at a capitated rate to eligible adults age 65 and older. Enrollment is voluntary and available in most areas of the state. Services include primary, acute and behavioral health care; prescription drugs; and LTSS. LTSS services include nursing facility care; adult foster care; group adult foster care; adult day health; and other community-based LTSS. (Source: CMS and Truven Health Analytics, 7/2012) State Website on Senior Care Options **State Demonstration to Integrate Care for Dual Eligible Individuals** In August 2012, CMS and Massachusetts signed a Memorandum of Understanding for the state's **OneCare** capitated demonstration model. The demonstration requires a three-way contract between CMS, the state, and an integrated care organization in order to oversee the care of 110,000 dual eligibles. The demonstration will cover dual eligible age 21-64, carving in acute and behavioural health for I/DD populations and carving out ICF/MR services; HCBS services for persons with DD; and HCBS services for persons with TBI. (Source: CMS website; Truven Health Analytics, 7/2012; NASDDDS Managed Care Tracking Report) Duals Demonstration Proposal (2/16/2012) The state later postponed its demonstration implementation date from April 2013 to July 2013. (Source: CMS Press Release, 8/23/2012; CMS website; Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: California, Illinois, Massachusetts, Ohio, and Washington, Kaiser Commission on Medicaid and the Uninsured, 5/2013) Memorandum of Understanding State Duals Demonstration website Duals Demonstration Timeline

State	State Updates
Massachusetts	Three-Way Contract for Demonstration (7/11/2013) The state also updated its demonstration implementation timeline with new effective dates for three waves of auto-assignment: January 1, 2014; April 1, 2014; and July 1, 2014. (Source: State HHS website) One Care Implementation Council Work Plan (4/18/2014) On July 25, 2014, MassHealth announced it has cancelled the October 2014 round of OneCare passive enrollment to give participating plans and the state more time to assess the quality of care and services being provided to enrollees. (Source: Community Catalyst, 8/20/2014; State OneCare Implementation Council website) **Balancing Incentive Program** In January 2014, Massachusetts submitted to CMS a BIP application. As of May 2014, CMS has approved the state's BIP application. (Source: Kaiser BIP website; CMS BIP website) Approved BIP Application BIP Structural Change Work Plan (9/25/2014)
Michigan	**Managed LTSS Program** Under §1915(b) and §1915(c) waiver authority, Michigan's **Medicaid Managed Specialty Support & Services Program (MSS&S)** provides behavioral health services and LTSS to adults with I/DD or SMI and children with I/DD or SED. LTSS services provided under MSS&S include nursing facility services; ICF/MR; personal care; targeted case management, and HCBS waiver services for persons with DD. Enrollment is mandatory and services are provided at a capitated rate. (Source: CMS and Truven Health Analytics, 7/2012) On November 25, 2013, the state submitted a request for a six-month MSS&S 1915(b) waiver extension in order to align the waiver's effective date with Michigan's duals demonstration project. (Source: Michigan.gov website) On December 17, 2013, CMS granted the six-month MSS&S 1915(b) waiver extension through September 30, 2014. (Source: Michigan.gov website) CMS Approval Letter (12/17/2013) **State Demonstration to Integrate Care for Dual Eligible Individuals** In April 2012, the state submitted to CMS a demonstration proposal to integrate care for dual eligibles. The demonstration proposed a capitated model with opt out enrollment. The demonstration will cover all dual

State	State Updates
Michigan	eligibles, including children with disabilities; adults with PD, I/DD, or SMI; and persons age 65 and older. Existing pre-paid inpatient health plans (PIHPs) will remain in place, but if individuals with I/DD opt out, they will not receive the enhanced care coordination envisioned in the demonstration. (Source: CMS and Truven Health Analytics, 7/2012; NASDDDS Managed Care Tracking Report; Demonstration Proposal; NSCLC Dual Eligible State Profiles website) In September 2013, the state announced it will launch a phased regional enrollment in July 2014 and plans to implement the demonstration in four regions. (Source: Press Release, State of Michigan Department of Community Health, 9/17/2013) In October 2013, the state submitted a proposed Memorandum of Understanding to CMS. (Source: Stakeholder Forum PowerPoint Presentation, 10/23/2013) Program Website In April 2014, CMS and the state signed a Memorandum of Understanding for the state's capitated demonstration model. (Source: NSCLC Dual Eligible State Profiles website, 4/2014; Kaiser Duals Demonstration Proposal Status Map, 4/2014) Opt-in-only enrollment for Regions 1 and 4 will begin no earlier than October 1, 2014, with enrollments effective January 1, 2015. Opt-in-only enrollment for Regions 7 and 9 will begin no earlier than March 1, 2015, with enrollments effective May 1, 2015. (Source: HMA Weekly Roundup, 4/9/2014) Memorandum of Understanding (4/2014) **Section 1915(i) HCBS State Plan Option** In March 2013, CMS approved the state's §1915(i) HCBS State Plan Amendment, effective April 2013. (Source: Michigan.gov) Approved State Plan Amendment (3/26/2013) **Health Homes** As of June 2014, Michigan has not submitted a Health Home State Plan Amendment to CMS. (Source: CMS State Health Home Proposal Status website, 6/2014) However, the state's duals demonstration proposal includes a Health Homes concept established through Prepaid Inpatient Health Plans (PIHPs). PIHPs are the entities currently delivering Medicaid behavioral health and developmental disability benefits in the state; and the state anticipates Health Homes will become part of their services delivery model. For

State	State Updates
Michigan	persons with I/DD, SMI or a substance use disorder, the PIHP supports coordinator will be responsible for ensuring integration of participants' physical and behavioral health care across the delivery system. (Source: Demonstration Proposal) State Resource on Health Homes
Minnesota	**Managed LTSS Programs** In 2011, the Minnesota Legislature directed Minnesota DHS to reform its Medical Assistance Program to improve community integration and independence; improve health; reduce reliance on institutional care; and ensure the long-term sustainability of needed services through better alignment of available services. (Source: State Register Notice, 6/18/2012) **Minnesota Senior Care Plus (MSC+)** operates under §1915(b) and §1915(c) waiver authorities and provides LTSS; primary, acute and behavioral health services; and prescription drug services at a capitated rate to adults age 65 and over. Enrollment is mandatory, but dual eligibles can opt into **Minnesota Senior Health Options (MSHO)** as an alternative to MSC+. MSHO operates under §1915(a) and §1915(c) waiver authorities and provides the same services as Minnesota Senior Care Plus for dual eligible adults age 65 and older. (Source: CMS and Truven Health Analytics, 7/2012) State Website on Senior Care Plus State Website on Senior Health Options In February 2012 and November 2012, the state submitted a **Minnesota Long Term Care Realignment §1115 Demonstration Waiver** to revise its nursing facility level of care criteria (LOC). This LOC revision impacts eligibility not only for nursing facilities, but also for three of the state's §1915(c) HCBS waivers: Community Alternatives for Disabled Individuals (CADI), the Brain Injury waiver (BI), and the Elderly Waiver (EW). In its LTC Realignment waiver, the state also requested federal financial participation (FFP) for two limited benefit HCBS programs: the **Alternative Care Program (ACP)** and the **Essential Community Supports program (ECS)**. The ACP serves individuals age 65 and older who meet LOC criteria but have income exceeding Medicaid standards; while ECS serves individuals who do not meet the revised LOC criteria, regardless if income meets Medicaid standards. (Source: Medicaid.gov) In August 2012, the state submitted to CMS its initial **Reform 2020 Initiative: Alternative Care Program (ACP) §1115 Demonstration Waiver**. In November 2012, the state resubmitted to CMS an updated Reform 2020 §1115 Demonstration Application. (Source: Medicaid.gov) Initial Reform 2020 §1115 Demonstration Application (8/2012)

State	State Updates
Minnesota	Updated Reform 2020 §1115 Demonstration Application (11/21/2012) State's Reform 2020 §1115 Waiver website In October 2013, CMS approved the state's Reform 2020 Initiative, approving federal financial participation in the ACP, designed to provide HCBS pre-level-of-care in order to prevent and delay transitions to nursing facilities. Federal approval for the state's ACP will free up an additional $58 million over four years in state funds to reinvest in services to keep seniors and people with disabilities in their homes and communities. (Source: State DHS website, 11/2013; DHS News Release, 11/20/2013; Alternative Care Program Fact Sheet, 2/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** The original financial alignment demonstration proposal included two phases: the first phase included dual eligibles over age 65 who qualified for Medicaid managed care and were enrolled in or chose to enroll in Minnesota Senior Health Options and Minnesota SeniorCare Plus; the second phase included dual eligibles age 18-64 with disabilities who were enrolled in Special Needs BasicCare. Older adults would receive partial NF services and LTSS under a capitated model; and persons with disabilities would receive partial NF services and LTSS under a fee-for-service model. (Source: Demonstration Proposal; State Demonstration website) In June 2012, the state decided not to pursue the financial alignment demonstration because Medicare financing under the demonstration would result in significantly lower payments for senior Medicare beneficiaries than the state's current programs. (Source: State Demonstration website) **State Demonstration to Integrate Care for Dual Eligible Individuals** In January 2013, the state issued a Notice of Request for Public Input on its Duals Demonstration website to identify best practices for developing **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. (Source: State website) State Register, Vol. 37, No. 30 (1/22/2013) On September 12, 2013, the state and CMS signed an MOU for a modified capitation duals demonstration for seniors enrolled in MSHO and MSC+ managed care programs. (Source: State website) State Website on Demonstration to Integrate Care for Dual Eligibles Memorandum of Understanding (9/12/2013)

State	State Updates
Minnesota	Minnesota's Alternative Demonstration for People with Medicare and Medicaid (6/18/2013) **Section 1915(k) Community First Choice Option** The state will implement CFCO in FY 2014 under its §1115 LTC Realignment Waiver. (Source: Waiver Application; Kaiser Commission on Medicaid and the Uninsured, 4/2013; Kaiser CFCO website, 5/2014) **Health Homes** CMS has approved Minnesota's State Health Home Planning Request. Michigan has not yet submitted a proposed Health Home State Plan Amendment. (Source: CMS Health Home Proposal Status website, 6/2014)
Mississippi	**Balancing Incentive Program** In June 2012, CMS awarded Mississippi an estimated $68.5 million in enhanced Medicaid funds (a 5% enhanced FMAP rate). (Source: CMS Balancing Incentive Program website; CMS Award Announcement) BIP application (5/1/2012) Structural Change Work Plan **Section 1915(i) HCBS State Plan Option** In December 2013, CMS approved the state's §1915(i) HCBS State Plan Amendment, effective November 2013. (Source: CMS website) Approved State Plan Amendment (11/1/2013) **Health Homes** CMS has approved Mississippi's State Health Home Planning Request. Mississippi has not yet submitted a proposed Health Home State Plan Amendment. (Source: CMS State Health Home Proposal Status website, 6/2014)
Missouri	**Managed LTSS** In December 2013, the Missouri Senate Health Committee approved a bill to shift more children and adults into managed care and introduce a new model of coordinated care for seniors and disabled patients. The legislation moved on to the full Senate for debate. (Source: HMA Weekly Roundup, 3/19/2014; Missouri Senate Medicaid Reform Draft Report; 12/15/2013) On May 16, 2014, the Missouri legislature adjourned; legislation to expand managed care and establish a LTSS care coordination initiative was not

State	State Updates
Missouri	passed by the legislature prior to its adjournment. (Source: NASUAD; State Senate website) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** In 2012, Missouri submitted to CMS a duals demonstration proposal for a managed fee-for-service financing model. Under the proposed demonstration, Medicare would share any savings realized from the state's two Health Homes programs. (Source: Demonstration Proposal) As of May 2014, the state has withdrawn its duals demonstration proposal. (Source: Kaiser Duals Demonstration website, 4/24/2014) **Balancing Incentive Program** In June 2012, CMS awarded Missouri an estimated $100.9 million of enhanced Medicaid funds (a 2% enhanced FMAP rate). (Source: CMS Balancing Incentive Program website) CMS Award Announcement (6/13/2012) BIP application (3/28/2012) Structural Change Work Plan **Health Homes** In 2011, CMS approved the state's two Health Homes State Plan Amendments, effective January 1, 2012. The first Health Home program targets Medicaid beneficiaries with a serious and persistent mental health condition; or a mental health or substance abuse condition and another chronic condition or risk of developing another chronic condition due to tobacco use. The second Health Home program targets Medicaid beneficiaries who have two or more chronic physical conditions; or one chronic condition and risk of developing another chronic condition. (Source: Demonstration Proposal) Missouri Community Mental Health Center Health Home SPA (10/20/2011) Missouri Primary Care Practice Health Home SPA (12/22/2011)
Montana	**Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014)

State	State Updates
Montana	**Section 1915(k) Community First Choice Option** The state originally planned to submit its proposed Community First Choice State Plan Amendment to CMS in August 2013, and begin participating in the CFC State Plan Option in October 2013. (Source: 2013 National HCBS Conference Presentation; State Community First Choice Webinar, 1/2013) As of May 2014, CMS has not approved a CFC SPA for Montana. However, the state is still planning to participate in the §1915(k) Community First Choice State Plan Option in 2014. (Source: Kaiser CFCO website; 5/2014)
Nebraska	**Managed LTSS Program** The state is developing a state-wide managed care program for the delivery of long-term services and supports, with a July 2015 target implementation date. MLTSS will include physical and behavioral health care, dental care, and pharmacy coverage. (Source: State Medicaid MLTSS website) On May 13, 2014, Nebraska Medicaid announced the temporary suspension of its work on a statewide MLTSS program in order to devote resources to the state's July 2014 Balancing Incentive Program grant application. The state's new MLTSS target implementation date is January 2017. (Source: State Medicaid MLTSS website; State Medicaid MLTSS PowerPoint, 5/7/2014; HMA Weekly Roundup, 5/21/2014) **Balancing Incentive Program** On July 31, 2014, Nebraska submitted to CMS a Balancing Incentive Program application. On September 11, 2014, CMS approved the BIP application. The period for performance for the grant award is October 1, 2014 through September 30, 2015. (Source: State BIP website) BIP Application (7/31/2014) CMS Approval Letter (9/11/2014)
Nevada	**Managed LTSS Program** Nevada has amended its State Plan to reflect updated processes and eligibility groups as they relate to the DHCFP's Managed Care Programs. (Source: Medicaid State Resource Center website) Approved State Plan Amendment (2/21/2014) **Balancing Incentive Program** On January 7, 2014, Nevada submitted to CMS a Balancing Incentive Program application. Subsequently, CMS approved the BIP application. (Source: Medicaid.gov website)

State	State Updates
Nevada	Approved BIP Application BIP Structural Change Work Plan (9/12/2014) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Health Homes** CMS has approved Nevada's Health Home Planning Request. (Source: CMS State Health Home Proposal Status website, June 2014)
New Hampshire	**Managed LTSS Program & State Initiative to Integrate Care for Dual Eligible Individuals** In March 2012, the state submitted a State Plan Amendment to CMS through the §1932(a) State Plan option for a statewide managed care delivery system known as the **New Hampshire Medicaid Care Management Program.** In May 2012, the state approved a $2.3 billion contract to establish a managed care system. In August 2012, CMS approved New Hampshire's State Plan Amendment. The state will launch its managed care system in three phases over the course of three years. In Phase 1, all Medicaid recipients will be required to enroll in an MCO, with opt out for dual eligibles. Phase 2 will add LTSS and enrollment will be mandatory. Phase 3 will include individuals newly eligible for Medicaid by virtue of the Affordable Care Act. (Source: Care Management Program website; CMA & Truven Health Analytics, 7/2012; Managed Care Info Meeting Final Report, 8/2012; Update on Medicaid Care Management, 1/24/2013) State Plan Amendment (3/30/2012) CMS Approval Letter (8/24/2012) On December 1, 2013, the state launched its transition to managed care. (Source: HMA Weekly Roundup, 12/19/2013) On April 3, 2014, New Hampshire Public Radio reported the planned December 1, 2014 transition to managed care for developmentally disabled Medicaid LTSS recipients will likely be delayed until January 2015 to focus on the Summer 2014 Medicaid expansion rollout. (Source: HMA Weekly Roundup, 4/9/14; New Hampshire Public Radio website) On October 2, 2014, the state announced it is delaying the second phase of the state's transition to managed care to allow more time to prepare for

State	State Updates
New Hampshire	implementation. Originally scheduled to begin January 1, 2015, this second phase would have required LTSS recipients (including individuals with DD and people in nursing homes) to enroll in managed care plans. (Source: Concord Monitor, 10/3/2014) **Balancing Incentive Program** In December 2011, the state submitted its BIP application to CMS. In March 2012, CMS awarded the state $26.5 million in enhanced Medicaid funds, making New Hampshire the first state to apply for and receive CMS approval under the Balancing Incentive Program. (Source: CMS Balancing Incentive Program website) BIP application (12/30/2011) BIP Award Letter (3/1/2012) BIP Structural Change Work Plan (10/23/2012) **Health Homes** As of June 2014, the state has not officially submitted a Proposed Health Home State Plan Amendment to CMS, but the state plans to participate in the Health Home State Plan Option in FY 2014. (Source: CMS Health Home Proposal Status website, 6/2014; Kaiser Health Home website, 6/2014)
New Jersey	**Managed LTSS Program & State Initiative to Integrate Care for Dual Eligible Individuals** The **New Jersey §1115 Comprehensive Medicaid Waiver** seeks to provide State Plan benefits, as well as LTSS, to Medicaid and CHIP beneficiaries. The 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. Phase 1 will include the non-dual population of aged, blind and disabled Medicaid beneficiaries; Community Care Waiver clients; clients already covered by a commercial or Medicare HMO; and breast or cervical cancer clients. Phase 2 will include dual eligibles; an increased range of waiver clients; TBI clients; and persons participating in the AIDS Community Care Alternatives Program and Community Resources for People with Disabilities. (Source: Waiver Application) Comprehensive Medicaid Waiver Website Waiver Application (9/9/2011) Approval Letter (10/2/2012) Recommendations by Workgroup

State	State Updates
New Jersey	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) In an October 2012 Press Release, the state announced CMS denied several of the state's reform proposals within its §1115 Comprehensive Medicaid Waiver application, including: 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, as well as the Community Care Waiver, will remain outside the comprehensive waiver. (Source: Press Release, New Jersey DHS, 10/4/2012) On June 25, 2014, the state issued a public notice of its plan to request a State Plan Amendment from CMS to establish a Qualified Income Trust, known as a Miller Trust, for Medically Needy Individuals. This will allow individuals with monthly income above the state's special income limit (SIL) to qualify for MLTSS, which includes nursing facility services. Income that exceeds the SIL would be transferred to the trust. The state must receive SPA approval from CMS before it can implement this feature of its §1115 Comprehensive Medicaid Waiver. The state is accepting comments in response to the public notice through July 30, 2014. (Source: State Public Legal Notice, 6/25/2014; HMA Weekly Roundup, 7/2/2014) On July 1, 2014, the state implemented its §1115 Comprehensive Medicaid Waiver by launching its Medicaid MLTSS program. Effective July 1, 2014, MLTSS includes: personal care; respite; care management; home and vehicle modifications; home delivered meals; personal emergency response systems; mental health and addiction services; assisted living; community residential services; and nursing home care. Participants in the following Medicaid waiver programs will be automatically enrolled into MLTSS through their current MCO: Global Options for LTC; AIDS Community Care Alternatives Program; Community Resources for People with Disabilities; and TBI Waiver. (Source: State MLTSS website, 7/2/2014) Any individuals with Medicaid entering a nursing home for the first time will have their acute and primary health care managed by the NJ FamilyCare MCOs with MLTSS or the PACE program. Individuals on MLTSS also will have their acute and primary health care services and nursing home care managed by a NJ FamilyCare MCO. Current custodial nursing home residents on Medicaid will remain in a fee-for-service environment.

State	State Updates
New Jersey	Medicaid beneficiaries living in SCNF as of July 1, 2014 will remain in the fee-for-service environment for two years. Any individual who is newly eligible for Medicaid and living in a nursing home after July 1, 2014 will have their care managed by a NJ FamilyCare MCO through the MLTSS program. Individuals who enter a SCNF after July 1, 2014 will have their acute and primary health care services and their nursing home care managed by a NJ FamilyCare MCO through the MLTSS program. (Source: State MLTSS website, 7/2/2014) In July 2014, the state notified Medicaid waiver service providers that Medicaid Fee-for-Service will pay for MLTSS for any Medicaid-eligible individuals requiring waiver services during the transition to the effective date of their MCO membership. (Source: HMA Weekly Roundup, 7/9/2014) **Balancing Incentive Program** In March 2013, CMS approved New Jersey's Balancing Incentive Program Application. The BIP program is funded through September 30, 2015. (Source: CMS website; New Jersey DHS website) BIP Application (12/20/2012) Structural Change Work Plan (1/16/2014) **Health Homes** CMS has approved the state's Heath Home Planning Request. (Source: CMS State Health Home Proposal Status website, 6/2014) On July 30, 2014, the state issued a public notice inviting public comment on a Medicaid state plan amendment to implement Health Homes in Mercer County for adults with SMI who are at risk for high utilization of medical and behavioral health care services; and to children, adolescents and young adults with SED and a chronic medical condition. (Source: State DHS website) Public Notice (7/20/2014)
New Mexico	**Managed LTSS Program** In August 2012, the state submitted its **Centennial Care §1115 Demonstration Waiver Proposal**. Under the demonstration, the state is consolidating its §1915(b) and 1915(c) waivers to create a comprehensive managed care delivery system. Centennial Care's contracted health plans offer acute; behavioral health; institutional; and community-based LTSS. The system features expanded care coordination; a beneficiary reward program to incentivize beneficiaries to pursue healthy behaviors; and a Safety Net Care Pool. Native American Medicaid beneficiaries can

State	State Updates
New Mexico	voluntarily opt-in; and the state auto-enrolls dually-eligible Native American beneficiaries and those who meet nursing facility level-of-care. (Source: State Centennial Care website; Centennial Care FAQs, 6/19/13) Waiver application (8/17/2012) In July 2013, CMS approved the demonstration proposal; and effective January 1, 2014, **Centennial Care** replaced New Mexico's previous managed care programs, CoLTS and Salud!. The demonstration will be implemented through December 31, 2018. (Source: State Centennial Care website; Centennial Care FAQs, 7/2/2013 Approval Letter, 7/12/2013) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** In August 2012, the state withdrew its demonstration proposal. Under the proposed demonstration, dually-eligibles receiving services through the state's Developmental Disabilities Waiver would have received regular medical benefits; but LTSS would have remained fee-for-service and carved out of managed care. (Source: Withdrawal Letter to CMS, 8/17/2012; Demonstration Proposal, 5/2012) **Health Homes** CMS has approved the state's Heath Home Planning Request. (Source: CMS State Health Home Proposal Status website, 6/2014) New Mexico is working under a §2703 planning grant to design a SPA establishing Behavioral Health Homes within Core Service Agencies statewide, coordinating the BHHs with MCOs established under the Centennial Care §1115 demonstration waiver. Once a recipient enrolls in a BHH, MCOs will delegate care management and care coordination responsibilities to the BHH. Over time, the state intends to establish Health Homes for other chronic conditions through the SPA process, continuing to coordinate the Health Homes models with Centennial Care to ensure care integration at all levels. (Source: Centennial Care §1115 Demonstration Waiver Application)
New York	**Managed LTSS Program** New York's Medicaid Redesign Team Proposal #90 and 2011 state budget legislation require the state to transition certain community-based Medicaid LTC service recipients into **Managed Long-Term Care Plans (MLTCPs)** or **Care Coordination Models (CCMs)**. New York operates three models of MLTCP: the **Program of All-Inclusive Care for the Elderly (PACE)**; **Medicaid Advantage Plus (MAP)**; and **partial risk MLTCPs**. All models provide community-based LTC services; nursing home care; and many

State	State Updates
New York	ancillary services. In 2012, CMS approved the state to proceed with auto-assignment into partial risk MLTCPs for Medicaid members in New York City. (Source: State Medicaid Update, September 2012; State Managed Long Term Care/Care Coordination Model website) In December 2013, New York's mandatory managed LTC program began in four upstate counties. The state plans to implement mandatory managed LTC for Medicaid beneficiaries requiring more than 120 days of community-based LTC in every county in the state by the end of 2014. (Source: MLTSS Network Weekly Roundup, 1/23/2014; HMA Weekly Roundup, 12/4/2013) New York has delayed transitioning nursing home populations into managed LTC until at least June 1, 2014, while the state negotiates with CMS to resolve details in the managed care program roll-out. (Source: HMA Weekly Roundup, 4/30/2014) The state's Office for People with Developmental Disabilities (OPWDD) and the Department of Health are working with CMS on an agreement called the **People First Waiver**, a concurrent §1915 (b)/(c) HCBS waiver. This agreement will renew the OPWDD §1915(c) Comprehensive HCBS Medicaid Waiver for People with DD and will also be the vehicle OPWDD uses to authorize the creation of a managed care delivery system for individuals with disabilities. The managed care delivery system will allow individuals to enroll on a voluntary basis in a Developmental Disability Individual Support and Care Coordination Organization (DISCO). Originally planned for October 2014, the state now expects that DISCOs will begin providing service in October 2015. (Source: HMA Weekly Roundup, 7/2/2014) On July 15, 2014, the New York Legal Assistance Group filed a class action lawsuit against the state's MLTSS program. The lawsuit accuses the state commissioners of the Department of Health and the Office of Temporary and Disability Assistance of allowing companies to quietly reduce or terminate Medicaid home care services to chronically ill and disabled people whose needs for services have not changed, without proper notice, the chance to appeal or even an explanation, protections required by law. (Source: New York Times website, 7/15/2014) The state released a new timeline for transitioning to mandatory managed LTC; the new timeline extends the transition period through February 2015. (Source: State Managed LTC website) Updated 2014-2015 MLTC Transition Timeline As of September 2014, the state has delayed transitioning nursing home populations into managed LTC; the nursing home benefit carve-in is now scheduled for January 2015. (Source: HMA Weekly Roundup, 9/24/2014)

State	State Updates
New York	As of October 2014, as part of the state's implementation of mandatory managed long-term care for Medicaid beneficiaries requiring more than 120 days of community-based long-term care, the state is implementing a Conflict-Free Evaluation and Enrollment Center (CFEEC). The state has partnered with Maximus to provide all activities related to the CFEEC, including initial evaluations to determine if a consumer is eligible for community-based long-term care for more than 120 days. (Source: State Department of Health website; HMA Weekly Roundup, 10/1/2014) CFEEC FAQs (9/29/2014) **Medicaid §1115 Demonstration Waivers** In 1997, CMS approved the state's first §1115 Demonstration Waiver, known as the **Partnership Plan Medicaid §1115 Demonstration**. The Partnership Plan consists of four program components: the Medicaid Managed Care Program, which provides Medicaid State Plan benefits through comprehensive MCOs to most Medicaid recipients; the Family Health Plus Program, which provides limited benefits with imposed cost-sharing for adults who meet income eligibility; the Family Planning Benefit Program, which serves individuals not otherwise eligible for Medicaid who are in need of family planning services and meet specified income eligibility, and women who lose Medicaid eligibility 60-days postpartum; and the HCBS Expansion Program, which expands three §1915(c) waiver programs by eliminating the financial eligibility barrier for receiving care at home. (Source: State Website on Partnership Plan Waiver; Partnership Plan Fact Sheet) In April 2005, CMS approved the state's second §1115 Demonstration Waiver, known as the **Federal-State Health Reform Partnership (F-SHRP) Medicaid §1115 Demonstration**, effective September 2006. The F-SHRP supported a health reform program to modernize the state's acute and long-term care infrastructure; increase primary and ambulatory care capacity; and invest in health information technology. The F-SHRP also permitted mandatory managed care enrollment for Medicaid eligible aged, blind and disabled individuals statewide; and children, caretaker relatives, and pregnant women in selected counties. (Source: Medicaid.gov; State Federal-State Health Reform Partnership website; Fact Sheet on F-SHRP) In March 2014, CMS approved the state's November 2013 request to move authority for Medicaid eligibles receiving services under the F-SHRP Demonstration to the Partnership Plan under the state's **F-SHRP §1115 Demonstration Phase Out Plan**, when the F-SHRP Demonstration expired in March 2014. (Source: Medicaid Waiver website) F-SHRP Phase-Out Plan and Letter to CMS (11/27/2013)

State	State Updates
New York	CMS Approval Letter for F-SHRP Phase-Out (3/31/2014) On April 14, 2014, CMS approved the state's **Medicaid Redesign Team (MRT) Waiver**, which the state submitted in August 2012 as an amendment to its §1115 Partnership Plan Demonstration Waiver. The waiver includes three funding elements: a $500 million allocation for the Interim Access Assurance Fund to assure financially stressed hospitals have adequate funding until DSRIP funding becomes available in 2015; a $6.42 billion **Delivery System Reform Incentive Payment (DSRIP) program**; and $1.08 billion for other Medicaid Redesign Team activities, including Health Home support, investments in the LTC workforce, and funding for enhanced behavioral health services (1915(i) services) as part of the new **Health and Recovery Plans (HARPs)** for individuals with SMI. New York's DSRIP program under the state's MRT Waiver is significantly different from other state Medicaid DSRIP programs because it requires statewide accountability. The state must meet state-wide performance goals or be subject to funding reductions. Further, if CMS reduces DSRIP, the state must reduce funds in an equal distribution across all DSRIP projects. This is designed to move New York's managed care program from a volume-based fee-for-service payment system to a value-based payment system. (Source: State Medicaid website; HMA Weekly Roundup, 1/29/2014; HMA Weekly Roundup, 4/16/2014) MRT Waiver Application (8/6/2012) MRT Multi-Year Action Plan MRT Waiver Amendment Update Presentation (4/2014) CMS Approval Letter with Special Terms and Conditions (4/14/2014) Public Comments on Special Terms and Conditions (5/14/2014) On June 13, 2014, the state published a Draft Revised Medicaid Managed Care Program Quality Strategy for public comment as part of the Special Terms and Conditions of its §1115 Demonstration Waiver; comments are due by July 13, 2014. The revised Quality Strategy encompasses the state's traditional managed care plans, as well as recent improvements to the state's Medicaid program, including approval of the new MRT Waiver. (Source: State Medicaid Managed Care website) Draft Quality Strategy for the New York State Medicaid Managed Care Program 2014 (6/13/14) In July 2014, the New York Department of Health posted the DSRIP Design Grant applications it received from over 50 emerging Performing Provider Systems to receive money to plan and design their DSRIP applications. The state will announce design grant awards on August 1, 2014. (Source: HMA Weekly Roundup, 7/9/2014) DSRIP Project Design Grant Applications (7/2014)

State	State Updates
New York	On July 14, 2014, the state posted a Draft DSRIP Evaluation Plan for public comment. The state plans to submit its draft evaluation plan to CMS on August 14, 2014, and begin the procurement process for an independent evaluator in November 2014. (Source: State Department of Health website) Draft DSRIP Evaluation Plan (7/14/2014) On August 1, 2014, the state held a DSRIP update webinar, noting CMS and the state agreed to create a new project as a result of public comments about the state's Draft DSRIP Evaluation Plan. The new project will focus on increasing patient and community activation related to health care, paired with increased resources to help uninsured (UI), non-utilizing (NU), and low utilizing (LU) populations gain access to and utilize benefits associated with DSRIP PPS projects, particularly primary and preventative services. (Source: State Department of Health website) DSRIP Update PowerPoint (8/1/2014) On August 6, 2014, the state announced its funding awards to emerging Performing Provider Systems to develop comprehensive DSRIP project plans. (Source: State Department of Health website) DSRIP Project Design Grant Final Award Allocation (8/8/2014) The New York Department of Health, in partnership with Salient, developed DSRIP dashboards to generate data and analysis to assist with planning, community needs assessment, and application development for the DSRIP initiative. The dashboards present Medicaid utilization and enrollment data made available by the state DOH. The data will be updated monthly to present the most current information for service, beginning with data from 2011 through present. (Source: State DSRIP Dashboards website; HMA Weekly Roundup, 8/13/2014) On September 19, 2014, the state announced an updated timeline for the transition of behavioral health services to managed care. The revised implementation dates are as follows: April 1, 2015 for adults in in New York City; and October 1, 2015 for adults in the rest of the state. (Source: State Department of Health website) Letter from New York Medicaid Director (9/19/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals** The state initially proposed to integrate care for dual eligibles through two models: a Capitated Financial Alignment Model and a Managed Fee-for-Service Model. However, the state withdrew its Managed Fee-for-Service model. (Source: Withdrawal Letter, 3/21/2013) On August 23, 2013, the state and CMS signed an MOU for the Capitated

State	State Updates
New York	Financial Alignment Model, known as **Fully-Integrated Duals Advantage (FIDA)**. Built off the state's Medicaid Advantage Plus program, the FIDA program will cover full dual eligibles age 21 or older who require 120 or more days of LTSS. 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. (Source: CMS Press Release, 8/26/2013; State Dual Eligibles website) Memorandum of Understanding State Dual Eligibles website The state will establish FIDA plans in eight downstate counties. Voluntary enrollment for community-based and nursing home populations begins October 1, 2014; and passive enrollment for both populations begins January 1, 2015. The state intends to have final three-way contracts signed by July 2014. (Source: HMA Weekly Roundup, January 15, 2014; HMA Weekly Roundup, January 22, 2014; MLTSS Network Weekly Roundup, February 20, 2014; State Duals Demonstration website) The state has released its RFQ for the behavioral health carve-in, which is scheduled for New York City on January 1, 2015, and for the rest of the state on July 1, 2015. The RFQ lays out requirements for becoming a Health and Recovery Plan (HARP), a managed care program that will be offered to individuals with SMI or substance use disorder. (Source: HMA Weekly Roundup, 3/26/2014) On July 2, 2014, the state and CMS announced the FIDA enrollment start date will be postponed until January 1, 2015, to give plans three additional months to complete readiness review activities and fix plan deficiencies before FIDA begins. (Source: State Duals Demonstration website) **Balancing Incentive Program** In March 2013, CMS awarded New York an estimated $598.7 million in enhanced Medicaid funds (a 2% enhanced FMAP rate). (Source: BIP Award Letter, 3/15/2013) BIP Structural Change Work Plan (12/20/2013) BIP Work Plan Update (1/9/2014) Request for BIP Funding Grant Applications (3/21/2014) **Section 1915(k) Community First Choice Option** The state's Community First Choice Options Development and Implementation Council has been holding meetings to discuss the state's proposed application/implementation of the option. (Source: State CFCO website)

State	State Updates
New York	As of September 2014, New York is still in the process of developing a CFC application. (Source: Conversations with state officials) **Health Homes** New York has 3 approved Health Home State Plan Amendments. The Health Homes target Medicaid enrollees with SMI; chronic medical conditions; or behavioral health conditions. (Source: CMS State Health Home Proposal Status website, 6/2014; CMS State Health Home SPA Matrix, 3/2014) Approved State Plan Amendment (2/3/2012) As of September 19, 2014, the state is in the process of drafting a fourth Health Home State Plan Amendment for Health Homes to Better Serve Children; and the state plans to submit its proposed SPA to CMS on November 1, 2014. (Source: State Health Homes website) Revised Schedule for Health Homes to Better Serve Children (9/19/2014) Draft Health Home Application to Serve Children (6/30/2014)
North Carolina	**Managed LTSS Program** In April 2005, DHHS and PBH began operating a pilot program in five counties, under §1915(a) authority, for the delivery of services to individuals with mental illness; I/DD; and substance abuse disorders. In 2011, new state legislation required North Carolina DHHS to restructure management responsibilities for the delivery of these services through a **§1915 (b)(c) MH/DD/SA Waiver**. Since April 2013, the state's entire MH, DD, and SA system has operated under the §1915 (b)(c) MH/DD/SA managed care waiver. Under this waiver, the state's Local Management Entities (LME's), which once coordinated and offered publicly supported behavioral health care services, have become managed care organizations (MCO's). (Source: State §1915 (b)(c) Waiver Information website; DHHS §1915 (b)(c) Waiver website; NC Medicaid Reform Proposal, 3/17/2014) On March 17, 2014, the state released a detailed report of the Medicaid reform proposal the state Medicaid department recently submitted to the state legislature. Under Session Law 2013-360, the state DHHS was required to develop a detailed plan, known as the **Partnership for a Healthy North Carolina**, to reform the state's Medicaid program. The proposed plan will not pursue a traditional risk-based managed care model. Instead, the proposal will: 1. Establish provider-led Medicaid ACOs for the management of physical health; 2. Continue the consolidation and strengthening of the Local Management Entity Managed Care Organizations (LME-MCOs) providing services for the mental health, substance abuse, and I/DD populations; and 3. Streamline and strengthen the coordination of Medicaid LTSS. The legislature is expected to vote on the proposal as early

State	State Updates
North Carolina	as May 2014. (Source: HMA Weekly Roundup, March 19, 2014) NC Medicaid Reform Proposal (3/17/2014) On May 29, 2014, WRAL/NC Capitol reported that the North Carolina Senate released its Senate budget proposal, which includes $4.9 million to create a new Medicaid center to oversee the state's Medicaid program in order to move the program out from under the state DHHS agency. The proposal also aims to dismantle CCNC and dramatically reduce Medicaid eligibility for the aged, blind, disabled, and medically needy, cutting off medical care to around 15,000 current recipients, many of whom are in assisted living and LTC facilities. (Source: WRAL/NC Capitol, 5/29/2014) Draft Senate Bill 744 (5/15/2014) On June 18, 2014, WRAL/NC Capitol reported that the North Carolina House released a Medicaid Reform Bill to the House Health and Human Services Committee. The bill includes much of the language from Governor McCrory's reform plan, which was based on developing ACO's to manage care of Medicaid patients. Under the House bill, providers would form organizations that would lead the Medicaid reform effort. The bill also calls for capitation of payment per Medicaid patient and tasks DHHS with developing the plans for Medicaid reform. (Source: WRAL/NC Capitol, 6/19/14; HMA Weekly Roundup, 6/25/2014) Draft House Bill 1181 (5/22/2014) On July 2, 2014, after a lengthy budget impasse, the state House and Senate settled on Medicaid figures for the state budget: $136.5 million for FY 2013-14; and $186 million for FY 2014-15. Other than the budget numbers, everything else in the two proposed budget bills, including potential Medicaid eligibility cuts, is still on the table for negotiations. (Source: WRAL/NC Capitol, 7/2/2014) The plan passed by the House would give local doctors and hospitals incentives to create ACO's to care for the state's Medicaid population for a set fee. The plan passed by the Senate would look to out-of-state managed care companies to care for the state's Medicaid population. Additionally, the Senate is pushing to restructure Medicaid and move it from NC DHHS into a new state agency. Either approach would be a major restructuring of the state's Medicaid program. (Source: WRAL/NC Capitol, 7/29/2014) On August 20, 2014, the North Carolina General Assembly adjourned, leaving behind the Medicaid reform bill. The Medicaid reform effort will have to wait until the next legislative session begins in January 2015. (Source: WRAL/NC Capitol, 8/20/2014) On September 24, 2014, the Charlotte Observer reported that state lawmakers plan to continue discussions about a possible state Medicaid

State	State Updates
North Carolina	overhaul before the General Assembly reconvenes early next year. (Source: HMA Weekly Roundup, 10/1/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** In May 2012, the state submitted to CMS a Demonstration Proposal to integrate care for dual eligibles statewide using a managed fee-for-service reimbursement model. (Source: Demonstration Proposal; State Duals Demonstration website) However, in 2013, the state received a §646 waiver expanding the reach of the state's Community Care of North Carolina (CCNC) program to include dually eligible beneficiaries. Therefore, as of May 2014, the state has withdrawn from the duals demonstration, choosing instead to pursue duals integration through its CCNC program. (Source: National Academy for State Health Policy website, 11/2013; NASUAD) **Health Homes** In May 2012, CMS approved the state's Health Home State Plan Amendment for Health Homes targeting beneficiaries with two chronic medical conditions or one chronic condition and at risk for another condition. Enrollment is voluntary through Community Care of North Carolina (CCNC), which provides Health Home services as Medical Homes. (Source: Demonstration Proposal; Kaiser Health Homes website, 6/2014; CMS State Health Homes SPA Matrix, 3/2014)
Ohio	**State Demonstration to Integrate Care for Dual Eligible Individuals & Managed LTSS Program** In December 2012, CMS and Ohio signed an MOU for Ohio's capitated managed care duals demonstration model. Ohio and CMS will contract with Integrated Care Delivery System (ICDS) plans that will oversee the delivery of covered Medicare and Medicaid services for approximately 115,000 Medicare-Medicaid enrollees in seven regions of the state. (Source: CMS website) The plans will serve most dual eligibles age 18 and older in 29 targeted counties; the plan will serve persons with I/DD who are otherwise served in §1915(c) HCBS waiver programs or in ICF/MR facilities. Voluntary enrollment began in September 2013. (Source: CMS and Truven Health Analytics, July 2012; CMS Press Release, 12/12/2012; State Medicaid website) Demonstration Proposal (4/2/2012) Memorandum of Understanding (12/11/2102) On February 11, 2014, CMS, the state, and the **MyCare Ohio Plan** entered into a three-way contract. On May 1, 2014, MyCare Ohio began enrolling

State	State Updates
Ohio	dual eligibles in MMPs on a voluntary basis only. Passive enrollment for duals will begin on January 1, 2015. (Source: State Medicaid website; MyCare Ohio Enrollment Update; MLTSS Weekly Roundup, March 6, 2014; Ohio Medicaid Press Release; HMA Weekly Roundup, 6/18/2014) Three-Way Contract (2/11/2014) On May 27, 2014, the Columbus Dispatch reported that Medicaid-enrolled Ohio veterans with at least a 70 percent service-connected disability may be eligible to receive free services through the Veterans Administration. The Ohio Department of Veterans Services favors the approach of letting veterans choose whether they want to rely on Medicaid or federal health benefits for long-term care and other types of health care. Senate Bill 101, introduced in 2013, would require the state to notify Medicaid-enrolled veterans that they might be eligible for federal military-related health-care benefits. State officials cannot yet say how many Ohio veterans are enrolled in Medicaid and how much money could potentially be saved by shifting care to VA medical centers. (Source: HMA Weekly Roundup, 5/28/2014; Columbus Dispatch, 5/27/2014) On September 25, 2014, the state released a MyCare Ohio Update. According to the update, as of September 25, 2014, MyCare Ohio plans have enrolled 100,934 Ohioans, processed 977,030 claims, and paid provider bills totaling $326,976,149. The health plans are working directly with provider associations and others to make it as easy as possible for providers to convert from government-run FFS to private health plans. The update also included an Implementation Update. (Source: Ohio Medicaid website) MyCare Ohio Update (9/25/2014) **Balancing Incentive Program** In June 2013, CMS awarded Ohio an estimated $169 million in enhanced Medicaid funds (a 2% enhanced FMAP rate). (Source: CMS BIP website) BIP Application (3/28/2013) Structural Change Work Plan (1/31/2014) On September 10, 2014, the Ohio Department of Medicaid announced it surpassed the 50% spending target for HCBS one full year ahead of the federal deadline of September 30, 2015. (Source: State Governor's Office of Health Transformation) HCBS Achievement Announcement (9/10/2014) **Health Homes** In September 2012, CMS approved Ohio's first Health Home State Plan Amendment for Health Homes targeting Medicaid beneficiaries with SPMI.

State	State Updates
Ohio	(Source: CMS Approval Letter; State Health Homes website) Approved Health Homes State Plan Amendment (9/17/2012) As of June 2014, Ohio has officially submitted to CMS a second proposed Health Home SPA, but CMS has not yet approved the second Health Home SPA. (Source: CMS Health Home Proposal Status website, 6/2014; Kaiser Health Home State Plan Option website, 6/2014)
Oklahoma	**State Demonstration to Integrate Care for Dual Eligible Individuals** The state has submitted a demonstration proposal to CMS for a managed fee-for-service duals demonstration model that includes an ACO, as well as expansion of a PACE program known as the Oklahoma Cherokee Elder Care Program. The state also proposed a capitated managed care model focused on dual eligibles with behavioral health needs. As of May 2014, the state's proposal for two demonstration models is still pending with CMS. (Source: Demonstration Proposal; NSCLC Dual Eligible State Profiles website, 6/2014; Kaiser Family Foundation Duals website) **Health Homes** As of June 2014, CMS has approved a Health Home Planning Request for Oklahoma. The state has not officially submitted a Proposed Health Home State Plan Amendment to CMS, but the state plans to participate in the Health Home State Plan Option in FY 2014. (Source: CMS Health Home Proposal Status website, 6/2014; Kaiser Health Home website, 6/2014)
Oregon	**Medicaid §1115 Demonstration Waiver** In 1994, CMS approved the state's §1115 Demonstration Waiver, known as the **Oregon Health Plan (OHP) §1115 Demonstration**. The driving forces behind the OHP demonstration were: expanding Medicaid eligibility; prioritizing the list of health services; and managed care. (Source: Oregon Demonstration Fact Sheet, 8/30/2013) In July 2012, CMS approved an amendment to the OHP §1115 Demonstration waiver, extending the demonstration through June 30, 2017; and allowing Oregon to launch **Coordinated Care Organizations (CCO's)** in the state's Medicaid program. CCO's are managed care entities that operate regionally, with enhanced local governance and provider payment structures promoting transparency and accountability. As of June 2014, Oregon has fifteen coordinated care organizations in operation around the state; and the majority of Oregon Medicaid recipients now receive care through a CCO. (Source: Press Release; 5/3/2012; Oregon Demonstration Fact Sheet, 8/30/2013; State Coordinated Care Organization website) Application for Amendment and Renewal (3/1/2012)

State	State Updates
Oregon	Current Approval Document (7/5/2012) On August 7, 2014, CMS informed Oregon of several fundamental issues with the state's CCO rate development process. CMS also proposed a path forward toward approval of the state's 2014 rates. CMS' letter indicates that the state must adhere to a number of core Medicaid requirements, including reporting encounter data and ensuring accuracy of the rate-setting process. CMS stated that it is particularly concerned about the methods used to develop the rates for the ACA expansion population, which is 100% Federally funded. (Source: Letter from CMS (8/7/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** In May 2012, Oregon submitted a duals demonstration proposal to CMS for a capitated payment demonstration model. In October 2012, the state decided not to pursue the demonstration because the demonstration was not financially viable for Oregon's CCO's and their affiliated Medicare Advantage plans. The state may consider a modified, non-financial alignment demonstration that focuses on CCO delivery system reforms and Medicare/Medicaid administrative alignments. (Source: State Duals Demonstration website; Letter to Coordinated Care Organizations and Stakeholders, 10/30/2012) Demonstration Proposal (5/2012) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option** On July 1, 2013, CMS approved the state's Community First Choice Option SPA, known as the **K Plan**, which will provide the state approximately $100 million to expand person-centered and community-based services for eligible individuals. (Source: Press Release, 7/1/ 2013) State Plan Amendment (7/1/2013) **Health Homes** In March 2012, CMS approved Oregon's Health Home State Plan Amendment for Health Homes targeting individuals statewide with two chronic conditions; one chronic condition and a risk of developing another; or one serious mental illness. (Source: Kaiser Brief on Medicaid Health Homes for

State	State Updates
Oregon	Beneficiaries with Chronic Conditions, 8/2012) Approved Health Home State Plan Amendment (3/13/2012)
Pennsylvania	**Managed LTSS Program** Since 2009, Pennsylvania has provided **Adult Community Autism Program** to adults of age 21 or higher with diagnosis of Autism Spectrum Disorder under the authority of Medicaid §1915(a). Services included in the capitation rate are primary, behavioral, dental, ICF/MR, targeted case management, adult day, and occupational therapy/physical therapy/speech therapy (OT/PT/ST). The program is operating in four (out of 67) counties, and enrollment is voluntary. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Program Website On August 28, 2014, Pennsylvania became the 27th state to expand its Medicaid program under the Affordable Care Act. The state and CMS agreed to the "Healthy Pennsylvania' program – which will provide coverage to uninsured adults earning below 133 percent of the federal poverty line, or about $15,500. Coverage will begin in January 2015 and will be offered by private health plans. The state has authority to begin collecting premiums in year two of the waiver. However, adults will be able to receive premium discounts for healthy behaviors; these healthy behaviors have yet to be defined under the waiver. In conjunction with expanding Medicaid, the state plans to reform its existing Medicaid program by moving to a low-risk or high-risk benefit package, with "risk" referring to enrollee health status. (Source: Washingtonpost.com; CSNBC Healthcare) **Balancing Incentive Program** Pennsylvania submitted a BIP Application to CMS. Subsequently, CMS approved the state's BIP Application. (Source: CMS BIP website; Kaiser BIP website, 6/2014) BIP Application (4/18/2014)
Rhode Island	**Managed LTSS Program** On December 23, 2013, CMS approved the state's **Comprehensive §1115 Demonstration** renewal request. In its March 28, 2014 Draft Comprehensive Quality Strategy for the §1115 Demonstration, Rhode Island described **Rhody Health Options (RHO)** as the LTSS aspect of its Integrated Care Initiative. RHO represents the integration of Medicaid LTSS services into a managed care delivery system. (Source: Rhode Island HHS website) Approved Comprehensive §1115 Demonstration Renewal (12/23/2013)

State	State Updates
Rhode Island	Stakeholder Notice (3/28/2014) §1115 Demonstration Fact Sheet (12/23/2013) **State Demonstration to Integrate Care for Dual Eligible Individuals** Rhode Island's Integrated Care for Medicare and Medicaid Beneficiaries Demonstration proposes to enroll approximately 12,000 Medicaid-only enrollees and 23,000 Medicare-Medicaid enrollees into the **Rhode Island Integrated Care Initiative (ICI)** during two phases; the state plans to carve out individuals with I/DD and SMI. As of June 2014, the state's Demonstration Proposal is pending with CMS. (Source: CMS and Truven Health Analytics, 7/2012; Duals Demonstration Presentation; 7/23/2012; Kaiser Duals Demonstration Proposal Status Map, 5/2014) Demonstration Proposal In November 2013, the state implemented Phase I of the ICI. April 2015 is the tentative start date for Phase II of the ICI, which will fully integrate Medicaid and Medicare services delivered by a health plan. (Source: State Integrated Care Initiative Update, 2/2014) Integrated Care Initiative Phase II Draft Timeline (3/26/2014) In May 2014, Rhode Island released an updated ICI financial alignment timeline. The effective contract date and opt-in enrollment effective date for Phase II of the ICI will be April 1, 2015. (Source: State HHS website; HMA Weekly Roundup, 5/28/2014) Integrated Care Initiative Phase II Draft Procurement Timeline (5/30/2014) **Balancing Incentive Program** Rhode Island is planning to participate in the Balancing Incentive Program in FY 2014. However, the state has not yet submitted a BIP Application to CMS. (Source: Kaiser BIP website, 6/2014) **Health Homes** Rhode Island has two approved Health Homes State Plan Amendments implemented statewide, effective October 1, 2011. Rhode Island Community Mental Health Organization Health Homes State Plan Amendment (approved 11/23/2011) targets individuals with a serious and persistent illness (SPMI). Rhode Island CEDARR Family Center Health Homes State Plan Amendment (approved 11/23/2011) is for children and youth under age 21 with diagnosis of severe mental illness or serious emotional disturbance, or with two of the following chronic conditions, or have one and at risk of

State	State Updates
Rhode Island	developing another: mental health condition, asthma, diabetes, DD, Down syndrome, mental retardation, or seizure disorder. (Source: Integrated Care Resource Center, State-by-State Health Homes State Plan Amendment Matrix: Summary Overview, Updated June 2012; Kaiser Commission on Medicaid and the Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, August 2012) Approved CEDARR Health Home State Plan Amendment (Effective 10/1/2011) Approved Community Mental Health Organization Health Home State Plan Amendment (Effective 10/1/2011) The state submitted to CMS a draft Health Homes State Plan Amendment for a third health home. (Source: CMS Health Home Proposal Status website, 4/2013) On November 6, 2013, CMS approved the state's third Health Home State Plan Amendment, with an effective date of July 1, 2013. The Health Home targets opioid-dependent Medicaid recipients who currently receive or meet the criteria for Medication Assisted Treatment. (Source: CMS Health Home SPA Matrix, 3/2014; CMS Health Home Proposal Status website, 2/2014; Medicaid.gov website) Approved Opioid Treatment Health Home State Plan Amendment (Effective 7/1/2013)
South Carolina	**State Demonstration to Integrate Care for Dual Eligible Individuals** South Carolina recently signed a Memorandum of Understanding with CMS/CMMI to implement a dual eligible initiative titled **Healthy Connections Prime**. The South Carolina demonstration will employ a three-way contract with Coordinated & Integrated Care Organizations (CICOs) to provide benefits to dual eligibles statewide under a capitated-managed care model of financing. The state indicates that the demonstration will begin no sooner than July 1, 2014 and continue until December 31, 2017. Demonstration Proposal Memorandum of Understanding State Website on Duals Demonstration South Carolina has defined the individuals eligible to participate in the demonstration as persons 65 and over: (1) living in the community at the time of enrollment, (2) receiving full Medicaid benefits, (3) entitled to benefits under Medicare Part A, and (4) enrolled under Medicare Parts B and D. Individuals receiving HCBS services (e.g. HIV, Vent, and Community Choices) are also eligible for the demonstration. The state will not include individuals with intellectual or developmental disabilities in the

State	State Updates
South Carolina	demonstration. Enrollment includes an opt-in period followed by passive enrollment, but beneficiaries can opt-out, as well as change plans at any time. (Source: South Carolina Memorandum of Understanding; Integrated Care Workgroup Session, 10/17/2013) The state initially planned to carve HCBS waiver services out of the demonstration, but recently revised the proposed model to carve-in home- and community-based services. (Source: SCDuE Weekly Roundup, 7/2013) The state has delayed its duals demonstration implementation until January 2015. According to an updated implementation timeline, the state will begin opt-in enrollment in January 2015. The state will implement passive enrollment in three waves, beginning April 1, June 1, and August 1, 2015. (Source: State Duals Demonstration website) Healthy Connections Prime PowerPoint/Updated Timeline (8/14/2014)
South Dakota	**Health Homes** On November 22, 2013, CMS approved the state's Health Home State Plan Amendment, with an effective date of July 2, 2013. The Health Home program targets Medicaid recipients with two or more chronic conditions, one chronic condition and the risk of developing another, or one serious and persistent mental health condition. (Source: CMS Health Home SPA Matrix, March 2014; CMS Health Home Proposal Status website, 2/2014; Medicaid.gov website) CMS Approval Letter (11/22/2013) Approved Health Home State Plan Amendment (Effective 7/2/2013)
Tennessee	**Managed LTSS Program** Under TennCare II §1115 Demonstration Waiver, **TennCare CHOICES** provides primary, acute, behavioral, nursing facility, and HCBS waiver-type services to eligible persons of all ages residing in nursing homes, adults under age 65 with physical disabilities, and adults age 65 and higher. At inception in 2010, LTSS was added to the existing TennCare managed care demonstration. The program is operating statewide, and enrollment is mandatory. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Website on TennCare CHOICES **Amendment to TennCare II Section 1115 Demonstration Waiver** (Approved 6/15/2012; Extension request submitted 6/29/2012) Under this demonstration, all Medicaid State Plan-eligibles (except those eligible only for Medicare premiums) are enrolled in TennCare Medicaid and receive most of the State Plan services through the demonstration's

State	State Updates
Tennessee	managed care delivery system. The recently submitted amendment pertains to the CHOICES program, which is Tennessee's managed long-term care program. CHOICES serve three groups: CHOICES 1 serves nursing facility residents; CHOICES 2 serves elderly adults or adults with physical disabilities who meet nursing facility level of care, but who have elected to receive home and community based services; CHOICES 3 serves elderly adults or adults with physical disabilities who do not meet nursing facility level of care, but are "at risk" for institutionalization. The amendment seeks to increase the enrollment target for CHOICES 2, effective July 1, 2012. (Source: Medicaid.gov & application to CMS) Application for Amendment Amendments #14 and #16 for the demonstration were approved by CMS (6/15/2012). Amendment #14, effective as of July 1, 2012, authorizes an increase to the enrollment targets for the CHOICES 2 program and approves the rebalancing of the CHOICES managed long-term care program and the creation of *Interim* CHOICES 3. Amendment #16 pertains to Disproportionate Share Hospital allotment. The Department of Finance and Administration submitted a three-year extension request to CMS on 6/29/2012. (Source: Centers for Medicare & Medicaid Services) Current Approval Document Three-year Extension Request Document The Department of I/DD and TennCare have released a concept paper about the future of the state's HCBS Waivers for individuals with I/DD; the concept paper includes ideas for renewing and redesigning LTSS services for individuals with I/DD. (Source: State I/DD website) Concept Paper Summary Concept Paper **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** Tennessee submitted (12/21/2012) a letter to Medicare-Medicaid Coordination Office requesting to withdraw its financial alignment demonstration proposal. In the letter, the state expressed its concerns pertaining to the reimbursement methodology. (Source: Letter to Medicare-Medicaid Coordination Office) (Prior to Tennessee's decision to withdraw from the duals demonstration, the State had proposed, via **TennCare PLUS,** to enroll full benefit dual eligibles, except PACE participants, starting January 1, 2014, statewide. The demonstration would not have included LTSS for persons with intellectual disabilities (including ICF/MR and §1915(c) waiver services), but dually-eligible members receiving these services would have been included in the demonstration for all other Medicare and Medicaid services. The now-withdrawn demonstration would

State	State Updates
Tennessee	have operated under a capitated payment model. For more information, click here.) (Source: Demonstration Proposal)
Texas	**Currently Operating Managed LTSS Program** Through Medicaid §1115 authority, **Texas STAR+PLUS** (inception: 1998) provides primary, acute, behavioral, and LTSS (Personal Attendant, Assisted Living, PERS, nursing, Adult Foster Care, dental, respite, home-delivered meals, OT/PT/ST, consumer directed services, home mods, medical supplies) to eligible adults age 21 and older with disability (SSI), adults age 21 and older in Community-Based Alternatives HCBS waiver, adults age 65 and older, and full-benefit Medicare-Medicaid enrollees. Certain groups are excluded, such as people living in nursing facilities, ICFs-MR, and in HCBS waivers other than the community-based alternatives waiver. Enrollment is mandatory for full-benefit Medicare-Medicaid enrollees. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Program Website Under the **Healthcare Transformation and Quality Improvement Program §1115 demonstration waiver** (Approved 12/12/2011), Texas is expanding STAR and **STAR+PLUS** (MMLTC) statewide and using savings from the expansion of managed care and the discontinuation of supplemental provider payments to finance new funding pools to assist hospitals and other providers with uncompensated care costs and to promote delivery system transformation and improvement. The Texas Health & Human Services Commission submitted a proposed amendment to the §1115 on 5/3/2012, proposing to add Day Activity Health Services to the existing STAR+PLUS waiver, effective September 1, 2012. The service targets individuals who are eligible for the STAR+PLUS waiver and exceed the financial requirements for Day Activity and Health Services under the §1915(i) authority. Services include nursing and personal care, physical rehabilitation, noon meal and snacks, social, educational and recreational activities, and transportation. (Source: Medicaid.gov) CMS Approval Letter (12/12/2011) Approval Document (Effective 12/12/2011) The Texas Health and Human Services Commission (HHSC) promulgated new permanent payment rules that implement the provider eligibility requirements and payment methodologies approved by CMS under the §1115 Healthcare Transformation and Quality Improvement Program waiver. (Source: Texas Register, June 22, 2012) State information on the adopted rules On June 19, 2013, the state submitted a further amendment to its §1115

State	State Updates
Texas	demonstration waiver; and CMS approved the amendment on March 6, 2014. The amendment allows the state to make several managed care changes to the §1115 waiver, including carving nursing facility services into managed care and adding additional mental health services and HCBS to managed care. The addition of cognitive rehabilitative services is effective March 6, 2014; all other amendment changes are effective September 1, 2014. (Source: CMS.gov) Request for Amendment (Submitted 6/19/2013) Approval Document (Effective 3/6/2014 and 9/1/2014) In a March 2014 information session, Texas HHS verified it will expand STAR+PLUS statewide on September 1, 2014. On this date, the state will implement the Behavioral Health carve-in to managed care and I/DD acute care service carve-ins to managed care. People living in nursing facilities will move into STAR+PLUS Medicaid managed care on March 1, 2015. (Source: HMA Weekly Roundup, January 29, 2014; Texas HHS Managed Care Informational PowerPoint, March 2014; State Health and Human Services website) Texas HHS Managed Care Informational PowerPoint (3/2014) On June 16, 2014, the state released an update on its §1115 waiver Delivery System Reform Incentive Payment (DSRIP) project related to Behavioral Health. The five-year Medicaid demonstration waiver includes an $11.4 billion DSRIP pool to support coordinated care and quality improvements through 20 regional healthcare partnerships. (Source: HMA Weekly Roundup, 6/18/2014; Presentation to the House Appropriations Article II Subcommittee: Behavioral Healthcare Projects in the 1115 Transformation Waiver; 6/16/2014) **STAR Kids** Beginning September 1, 2015, most children and young adults under the age of 21 who get SSI Medicaid or HCBS will receive some or all of their Medicaid services through a new program known as **STAR Kids**. This program is a Medicaid managed care model designed specifically for children and young adults with special needs. Enrollees will receive comprehensive service coordination. Children and youth enrolled in the Medically Dependent Children Program and children enrolled in the Youth Empowerment Services mental health and substance abuse waiver will receive all of their services (LTSS and acute care) through STAR Kids. Individuals who receive services through other home and community-based programs administered by DADS will continue to receive LTSS through that program, but will receive acute care through STAR Kids. (Source: Texas HHS Managed Care Informational PowerPoint, March 2014; HMA Weekly Roundup, January 29, 2014)

State	State Updates
Texas	On March 19, 2014, the state released a draft RFP for establishment of the STAR Kids Medicaid managed care program. The state will release the final RFP in July 2014, and the state will accept proposals through late October 2014. (Source: HMA Weekly Roundup, 3/26/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals** In May 2012, the state submitted to CMS a proposal for the **Texas Dual Eligibles Integrated Care Demonstration Project**. (Source: NASDDDS Managed Care Tracking Report, October 2012) Demonstration Proposal (5/2012) On May 23, 2014, CMS and the state signed an MOU for the Texas Dual Eligibles Integrated Care Demonstration Project. The demonstration will be open to all duals in six counties (Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant) aged 21 and older, with exception of following: 1) Duals residing in ICF/IIDs; and 2) Duals receiving services through the following §1915(c) waivers: Community Living Assistance and Support Services; Deaf Blind with Multiple Disabilities Program; Home and Community-Based Services; and Texas Home Living Program. Additionally, duals currently enrolled in a Medicare Advantage plan operated by a parent organization that is not participating in the demonstration must disenroll from their current MA plan. Existing STAR+PLUS Medicaid managed care plans in the six counties will serve the duals demonstration population as STAR+PLUS Medicare-Medicaid Plans (MMPs). STAR+PLUS MMPs will begin receiving opt-in enrollment in January 2015, with passive enrollment set to begin on March 1, 2015. Enrollees will be able to opt-out of enrollment at any time, effective on the first day of the following month. (Source: HMA Weekly Roundup, 5/28/2014; CMS.gov, 7/2014; State Duals Demonstration website, 7/2/2014) Memorandum of Understanding (5/23/2014) MOU Addendum (6/6/2014) The state has delayed its duals demonstration implementation until March 1, 2015. The state will begin opt-in enrollment in March 2015 and passive enrollment in April 2015. (Source: Texas HHS website) Texas HHS Commission Presentation (9/3/2014) Texas Readiness Review Tool (9/29/2014) **Balancing Incentive Program** On September 4, 2012, CMS approved the state's BIP application, awarding $301.5 million of enhanced Medicaid funds. Texas must implement the required structural changes and achieve a 50 percent benchmark of

State	State Updates
Texas	Medicaid community-based LTSS expenditures by October 2015. HHSC has delegated coordination of BIP activities to DADS. (Source: State website) BIP Application (6/29/2012) BIP Structural Change Work Plan **Section 1915(i) HCBS State Plan Option (Withdrawn)** Texas submitted a proposed §1915(i) HCBS State Plan Amendment to CMS; however, the state later withdrew its proposed SPA. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option** Senate Bill 7 from the 2013 Texas Legislature required the state to put in place a cost-effective option for attendant and habilitation services for people with disabilities who have STAR+PLUS Medicaid coverage. The Community First Choice Option will provide a 6 percent increase in federal matching funds for Medicaid for these services. Texas is planning to begin a Community First Choice program on March 1, 2015. This means: individuals on a 1915(c) waiver interest list who meet eligibility and coverage requirements will be eligible on March 1, 2015 to get Community First Choice services; and individuals already getting services through a 1915(c) waiver will continue to get those services exactly as they do today from their existing providers. (Source: State CFC website, 6/2014)
Vermont	**Vermont Choices for Care—Section 1115 Demonstration Waiver** The Vermont long-term care §1115 demonstration, known as "Choices for Care," is a statewide initiative to rebalance long-term care services through managing nursing facility admissions and increasing community-based options. The demonstration does not include children or individuals receiving institutional services through Intermediate Care Facilities for persons with Mental Retardation (ICF/MR). Choices for Care created an entitlement to Home and Community-Based Services (HCBS) for individuals with the highest need for services and also implemented a person-centered assessment and options counseling process to identify what services would be needed to enable individuals to remain in their own homes. The state also implemented the Program of All-inclusive Care for the Elderly (PACE) in two locations, one of which is rural. (Source: Medicaid.gov) Fact Sheet Current Approval Document (9/21/2010)

State	State Updates
Vermont	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** The proposed demonstration would have included full benefit dual eligibles, including those with intellectual/developmental disabilities. The now-withdrawn proposal originally would have implemented statewide under a capitated payment model starting January 1, 2014. Vermont's duals demo would not have included PACE participants (approximately 120 people). (Source: Demonstration Proposal) State website on the demonstration As of March 2014, the state has withdrawn its Demonstration Proposal and no longer plans to participate in the demonstration. (Source: Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014) **Health Homes** On March 4, 2014, CMS approved the state's first Health Home State Plan Amendment, effective July 1, 2013. The Health Home program targets beneficiaries in nine counties receiving medication assisted therapy for opioid dependency. (Source: CMS Health Home Proposal Status website, 3/2014; Medicaid.gov website; Approved Health Home SPA, 7/2/2013) On April 10, 2014, CMS approved the state's second Health Home SPA, effective January 1, 2014. The Health Home program targets beneficiaries in five additional counties receiving medication assisted therapy for opioid dependency. (Source: CMS Health Home Proposal Status website, 6/2014; Approved Health Home SPA, 4/10/2014)
Virginia	**State Demonstration to Integrate Care for Dual Eligible Individuals** Virginia's duals demonstration proposes to cover full benefit Medicare-Medicaid enrollees (age 21 and older), older persons and persons with physical disabilities, nursing facility residents, and persons who receive services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver. Persons with intellectual/developmental disabilities who are not in the EDCD Waiver are excluded from the program. Assisted living services, intellectual/developmental disability services, and PACE programs will be carved out. The state targeted January 2014 for initial implementation in four regions, utilizing voluntary enrollment with opt out. The demonstration will use a capitated-managed care model. (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

State	State Updates
Virginia	On May 21, 2013, then-Governor Bob McDonnell announced that Virginia has signed a Memorandum of Understanding (MOU) with CMS to implement its Medicare-Medicaid Enrollee Financial Alignment Demonstration, aimed at coordinating care for more than 78,000 Virginians currently enrolled in Medicare and Medicaid. Under this initiative, branded as **Commonwealth Coordinated Care**, Virginia and CMS will enter into a contract with health plans for the delivery of coordinated services and supports to enrollees. Eligible individuals include older adults and individuals with disabilities, including those receiving long-term services and supports, and who live in designated regions around the Commonwealth. The regions include the areas surrounding: Central Virginia/Richmond, Charlottesville, Tidewater, Roanoke and Northern Virginia. (Source: Press Release, May 21, 2013) Memorandum of Understanding On December 4, 2013, the state and CMS entered into a three-way contract with health plans for the delivery of coordinated services and supports to enrollees. (Source: NSCLC Dual Eligible State Profiles website, March 2014) Three-Way Contract (12/4/2013) In March 2014, Virginia began voluntary opt-in enrollment in Commonwealth Coordinated Care; and passive enrollment began May 1, 2014. Residents must be dual eligibles and at least 21 years old to participate in the demonstration. Residents can opt out or withdraw from the plan at any time. (Source: Newsleader.com website; HMA Weekly Roundup, 6/18/2014) In August 2014, Virginia released a Commonwealth Coordinated Care Update. As of August 1, 2014, there were 11,176 Virginians enrolled in the CCC program. This includes 2,825 individuals who have opted in to the CCC program across the five CCC regions. On September 1, 2014, approximately 13,000 individuals are scheduled to auto-enroll in CCC in the Central Virginia area. (Source: State Medicaid website) Commonwealth Coordinated Care Update (8/2014) In September 2014, Virginia released a Commonwealth Coordinated Care Update. As of September 1, 2014, there were 20,824 Virginians enrolled in the CCC program. This includes 3,266 individuals who have opted into the CCC program across the five CCC regions. Approximately 10,000 individuals are scheduled to auto-enroll in CCC on October 1, 2014 in the Charlottesville and Roanoke regions. (Source: State Medicaid website) Commonwealth Coordinated Care Update (9/2014)

State	State Updates
Washington	**State Demonstration to Integrate Care for Dual Eligible Individuals** (Managed Fee-For-Service Model & Capitated Model) **HealthPath Washington** (formerly Pathways to Health), Washington State's Medicare & Medicaid Integration Project, proposes to realign and integrate care through three strategies: 1. Health Homes (managed fee-for-service financial model); 2. Full Financial Integration Capitation (three-way capitation financial model); and 3. Modernized and Consolidated Service Delivery with Shared Outcomes and Aligned Financial Incentives (capitation and fee-for-service). The project's target population is full benefit Medicare-Medicaid enrollees of all ages. **Strategy 1: Health Homes (Managed Fee-For-Service Model)** On October 25, 2012, CMS approved the first strategy in the state's Financial Alignment demonstration proposal. According to the Memorandum of Understanding, the state would implement this Managed Fee-for-Service Financial Alignment Demonstration on April 1, 2013. The Washington Health Care Authority Department of Social and Health Services later said the state will introduce Health Homes on July 1, 2013. (Source: Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: California, Illinois, Massachusetts, Ohio, and Washington, Kaiser Commission on Medicaid and the Uninsured, May 2013; Washington Health Care Authority Pilot Program website) Under the demonstration, eligible Medicare-Medicaid enrollees elect to receive health home services from Health Home Care Coordinators, supplemented by multidisciplinary teams that coordinate across disciplines, including primary, acute, prescription drugs, behavioral health, and long-term services and supports (LTSS). Health home services include: comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family supports; referral to community and social support services; and the use of a web-based clinical decision support tool (PRISM) and other health information technology to improve communication and coordination of services. The geographic area for this Demonstration encompasses all counties in the state, with the exception of any counties in which the state receives approval from CMS to implement a capitated Financial Alignment Demonstration (Strategy 2). At this time, the exceptions include King, Snohomish, and Whatcom counties. If the state no longer seeks to implement a capitated model in any of the three counties, Washington may expand this Demonstration to those additional counties beginning by November 1, 2013, at the latest. (Source: Memorandum of Understanding) Memorandum of Understanding (10/24/2012) Addendum to Demonstration Proposal

State	State Updates
Washington	Washington Managed FFS Model Final Demonstration Agreement (6/28/13) **Strategy 2: Full Integration Capitation (Three Way Contract between Health Plan/State/CMS)** **HealthPath Washington** is Strategy 2 Financial Alignment Demonstration; this strategy will use a full-risk managed care model of health delivery that coordinates Medicare and Medicaid medical services, behavioral health services, and long-term services and supports. The Demonstration will be available to adults and children of King County and Snohomish County who are eligible for both Medicare and Medicaid, and for whom the state has a responsibility for payment of cost sharing obligations under the Washington State Plan. Beneficiaries may not be concurrently enrolled in the Demonstration and a Medicare Advantage Plan, the Program of All-inclusive Care for the Elderly (PACE), or a Medicare Hospice Program. Beneficiaries may participate in and are eligible for enrollment in the Demonstration if they voluntarily dis-enroll from their existing programs. Beneficiaries who are on the Medicaid Fee-for-Service delivery system and the Medicare Fee-for-Service delivery system and are receiving Medicare ESRD benefits may also voluntarily enroll in the Demonstration. At a future date, subject to additional discussions with CMS and other interested parties, Washington may also include beneficiaries receiving developmental disabilities §1915(c) home and community-based waiver services. If this population is included, the Medicare-Medicaid Integrated (MMI) Plans (managed care plans) will be responsible for services specified in the negotiated 3-way contract. The capitated demonstration is currently scheduled to begin with opt-in enrollment commencing on October 1, 2014 and passive enrollment starting in January 2015. (Source: Washington State Health Care Authority Request For Application (RFA) NO. 2013-003, revised April 17, 2013, CMS Washington State Financial Alignment Initiative Website, July 2014) HealthPath Washington project website HealthPath Washington Medicaid Health Homes Website HealthPath Washington Medicaid Health Homes Presentation (6/21/2012) In November 2013, CMS and the state signed a Memorandum of Understanding for the state's capitated model demonstration proposal. (Source: CMS Demonstration Approvals website; Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014; NSCLC Dual Eligible State Profiles website, March 2014) Memorandum of Understanding (11/25/2013) Washington Capitation Readiness Review Tool (12/27/2013) Washington Health Care Innovation Plan (12/2013) In mid-September, 2014, the state announced it is delaying implementation

State	State Updates
Washington	of the HealthPathWashington program until July 2015 due to bidder dropout. (Source: Business Examiner website, 9/18/2014) **Section 1915(i) HCBS State Plan Option (Withdrawn)** Washington submitted a proposed §1915(i) HCBS State Plan Amendment to CMS; however, the state later withdrew its proposed SPA. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option** In Engrossed Substitute House Bill 2746 and Substitute Senate Bill 6387, the 2014 Washington State Legislature directed the Department of Social and Health Services (DSHS) to seek stakeholder input on program and system design for CFCO. The CFCO entitlement program is intended to refinance personal care services offered through state plan and waiver programs. DSHS intends to fully implement CFCO no later than August 30, 2015. (Source: State CFCO website) **Health Homes** Effective July 1, 2013, CMS approved the state's first Health Home State Plan Amendment. The Health Home will target Medicaid recipients 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; which the state will begin in 2014. (Source: Health Homes News Release, 6/28/2013) State Website on Health Homes Health Homes Updated Fact Sheet (6/8/2013) Washington Health Home State Plan Amendment (Effective 7/1/2013) In December 2013, CMS approved the state's second Health Home State Plan Amendment, effective October 1, 2013. The Health Home will target Medicaid recipients with two or more chronic conditions; one chronic condition and the risk of developing another; or one serious and persistent mental health condition. (Source: CMS Health Home Proposal Status website, 2/2014; Medicaid.gov website) CMS Approval Letter (12/11/2013) Approved Health Home State Plan Amendment (Effective 10/1/2013)
West Virginia	**Health Homes** CMS has approved West Virginia's Health Home Planning Request for Health Homes targeting Medicaid recipients with bipolar disorder, with specific

State	State Updates
West Virginia	attention given to beneficiaries at risk for contracting Hepatitis B or C. As of June 2014, the state has officially submitted a Health Home SPA to CMS for approval. The proposed effective date for the Health Home SPA is August 1, 2014; and the state plans to implement Health Homes beginning July 1, 2014. (Source: CMS Health Home Proposal Status website, 6/2014; State Health Homes website; NASUAD) Proposed Health Home State Plan Amendment
Wisconsin	**Managed LTSS Programs** Wisconsin has two MLTSS programs. **Wisconsin Family Care** (under §1915(b) and §1915(c)) provides LTSS to adults under age 65 with physical disabilities, adults under age 65 with intellectual/developmental disabilities, and adults of age 65 and older. HCBS waiver services are only available to members who are a nursing home level of care, and primary, acute, and prescription drugs services are excluded from capitation rate. Enrollment is voluntary (choice of Family Care, Family Care Partnership, PACE, or IRIS depending on what is offered in the county and individual's functional level of care) with opt in. The program covers 57 counties in the state (out of 72 counties). Effective April 3, 2012, temporary caps on enrollment in the Family Care or IRIS programs were lifted. More information on Family Care is available here and here. (Source: dhs.wisconsin.gov) **Wisconsin Family Care Partnership** (FC-P) (under §1932(a) and §1915(c)) provides Medicare cost-sharing, behavioral health (not covered by Medicare), prescription drugs (not covered by Medicare), LTSS (HCBS and institutional), and other services including case management, dental, hospital, hospice, and therapies. Groups enrolled are adults under age 65 with physical disabilities, adults under age 65 with developmental disabilities, and frail adults of age 65 and older. Enrollment is voluntary with opt in. The program covers 19 counties in the state (out of 72 counties). (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012; State Program website) Waiver Application NASUAD & n4a presentation (4/5/2011) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** Wisconsin's proposed demonstration, Virtual PACE, will include all people who are full dual eligible members over the age of 18 residing in a Nursing Home (NH) on a long-term basis and receiving Medicaid services via the fee-for-service system at the time of enrollment. On January 1, 2013, Wisconsin will implement Virtual PACE in the Southeastern region, and then statewide

State	State Updates
Wisconsin	in 2015. The demonstration will use a capitated payment model. (Source: Demonstration Proposal) State website on the demonstration Wisconsin Department of Health Services (DHS) submitted a revised draft Memorandum of Understanding (MOU) to CMS on August 12, 2013. This state drafted version reflects the design proposal of Wisconsin's Integrated Demonstration, with updates from versions previously submitted to CMS. While CMS considers the proposed MOU, DHS is working to leverage the innovative ideas and investments in building more integrated systems by applying the "lessons learned" to current Wisconsin-administered Medicaid programs while awaiting CMS' response. (Source: State website on the demonstration) DHS letter to CMS (8/12/2013) DHS Memorandum of Understanding (revised draft) (8/12/2013) On November 22, 2013, CMS informed Wisconsin DHS it was unable to approve the state's MOU as currently proposed. In response, the state withdrew from the Demonstration to Integrate Care for Dual Eligible Individuals on December 19, 2013. (Source: Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014; NSCLC Dual Eligible State Profiles website, March 2014) CMS Letter to Wisconsin DHS (11/22/2013) State Demonstration Withdrawal Letter (12/19/2013) **Section 1915(i) HCBS State Plan Option** As of May 2014, CMS has approved the state's §1915(i) HCBS State Plan Amendment; and the state is currently participating in the HCBS State Plan Option. (Source: Kaiser HCBS State Plan Option website, 5/2014) **Section 1915(k) Community First Choice Option** The state is planning to participate in the Community First Choice Option in FY 2014. (Source: Kaiser Community First Choice website, 5/2014) **Health Homes** In October 2012, CMS approved the state's Health Homes State Plan Amendment targeting Medicaid and BadgerCare Plus members with a diagnosis of HIV/AIDS who have at least one other diagnosed chronic condition or who are at risk of developing another chronic condition. (Source: Approved Health Homes State Plan Amendment, 10/1/2012) As of June 2014, Wisconsin has officially submitted to CMS a second

State	State Updates
Wisconsin	proposed Health Home SPA. CMS has not yet approved the state's second Health Home SPA. (Source: CMS Health Home Proposal Status website, 6/2014; Kaiser Health Home website, 6/2014)

State Medicaid Integration Tracker©

NASUAD National Association of States United for Aging and Disabilities

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 10/3/2014)

	States	Proposed Financing Model	Submitted to CMS	Status	Target Implementation Date[1]
1	**Arizona**	~~Capitated~~	~~5/31/2012~~	**Withdrew**	~~1/2014~~
2	**California**	Capitated	5/31/2012	**MOU Signed** 3/27/2013	4/2014 (opt-in); 8/2014, 10/2014, 1/2015, 7/2015 (passive)
3	**Colorado**	Managed FFS	5/2012	**MOU Signed** 2/28/2014	9/2014 (passive)
4	**Connecticut**	Managed FFS	5/31/2012		N/A
5	**Hawaii**	~~Capitated~~	~~5/25/2012~~	**Withdrew**	~~1/2014~~
6	**Idaho**	~~Capitated~~	~~5/2012~~	**Withdrew**	~~1/2014~~
7	**Illinois**	Capitated	4/6/2012	**MOU Signed** 2/22/2013	3/2014 (opt-in); 6/2014 (passive)
8	**Iowa**	~~Managed FFS~~	~~5/29/2012~~	**Withdrew**	~~N/A~~
9	**Massachusetts**	Capitated	2/16/2012	**MOU Signed** 8/23/2012	10/2013 (opt-in); 1/2014, 4/2014, & 7/2014 (passive)
10	**Michigan**	Capitated	4/26/2012	**MOU Signed** 4/2014	1/2015 (opt-in); 4/2015 (passive)
11	**Minnesota**	Admin. Alignment ~~Capitated~~	~~4/26/2012~~	**Admin. Alignment MOU Signed** (9/12/2013) **Withdrew Capit.**	9/2013 (opt-in) ~~12/2012~~

[1] Implementation dates are based on demonstration proposals submitted to CMS, Memoranda of Understanding, and Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS, 7/24/2014.

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

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

National Association of States

United for Aging and Disabilities

1201 15th Street NW, Suite 350

Washington, DC 20005

Phone: 202-898-2578

www.nasuad.org