June 1, 2014

State Medicaid Integration Tracker©

NASUAD
National Association of States
United for Aging and Disabilities

Welcome to the State Medicaid Integration Tracker©

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

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

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

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

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

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

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

This Installment's Updates

Medicaid Managed LTSS:

- **Illinois:** The state began its Integrated Care Program expansion into the City of Chicago in March 2014.
- **Louisiana:** The state released an MLTSS Implementation Concept Brief.
- **Missouri:** Legislation that would have expanded Medicaid managed care and created a care coordination initiative for LTSS stalled and was not passed by the legislature prior to its adjournment.
- **Nebraska:** The state temporarily suspended work on its MLTSS program to focus on its BIP grant application.
- **New Hampshire:** The state will likely delay transitioning its DD population to managed care until January 2015 to focus on the Medicaid expansion rollout.
- **New York:** On April 14, 2014, CMS approved the MRT waiver amendment to the state's §1115 Demonstration Waiver; the state has delayed transitioning nursing home populations into managed care until at least June 1, 2014; the state released its RFQ for the behavioral health carve-in.
- **Texas:** The state plans to release an RFP for its STAR Kids managed care program in July 2014 and accept proposals through October 2014.

Medicare-Medicaid Care Coordination Initiatives:

- **California:** CMS approved the §1115 Bridge to Reform waiver amendment; and the state launched its duals demonstration in five counties on April 1, 2014.
- **Illinois:** The state began opt in enrollment for its duals demonstration on March 1, 2014; passive enrollment will begin on June 1, 2014.
- **Michigan:** The state will begin opt in enrollment in Regions 1 and 4 no earlier than October 2014, effective January 2015; and the state will begin opt in enrollment in other regions in 2015.
- **Missouri:** The state has withdrawn from the demonstration.
- **North Carolina:** The state has withdrawn from the demonstration.
- **Ohio:** Individuals in the northeast region of the state began receiving services through MyCare Ohio on May 1, 2014.
- **Rhode Island:** The state released an updated timeline for its dual eligible demonstration; the state anticipates beginning the program in April 2015.
- **Texas:** CMS and the state announced that they finalized their MOU on May 23.
- **Virginia:** The state began voluntary enrollment in its duals demonstration in May 2014.

Balancing Incentive Program:

- **Massachusetts:** CMS has approved the state's BIP application.
- **Nebraska:** The state is working on a BIP grant application for July 31, 2014.
- **Ohio:** The state has submitted a revised Structural Change Work Plan.

Community First Choice option under §1915(k):

- **Wisconsin:** The state is planning to participate in the CFCO in FY 2014.

Medicaid Health Homes:

- **Iowa:** As of April 2014, Iowa has a total of three approved Health Home SPAs.
- **Maine:** The state has officially submitted a proposed SPA for its second Health Home.
- **Ohio:** The state has officially submitted a proposed SPA for its second Health Home.
- **Oklahoma:** The state plans to participate in the HH State Plan Option in FY 2014.
- **West Virginia:** The state has submitted a Health Home SPA to CMS for approval. The state plans to implement Health Homes beginning July 1, 2014.
- **Wisconsin:** The state has officially submitted a proposed SPA for its second Health Home.

Overview

Medicaid Managed LTSS:	AL, 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, 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*, GA*, IL*, IN*, IA*, KY*, LA*, ME*, MD*, MA*, MS*, MO*, NE, NV*, NH*, NJ*, NY*, OH*, TX*
• **Community First Choice option under §1915(k):**	~~AZ~~, AR, CA*(2), ~~LA~~, MD, MN, MT, ~~NY~~, OR*, TX, WI
• **Medicaid Health Homes:**	AL*, AZ, AR, CA, DC, ID*, IL, IN, IA*(3), KS, KY, ME*(2), MD*, MA, MI, MN, MS, MO*(2), NV, NJ, NM, NY*, NC*, OH*(2), OK, OR*, RI*(3), SD*, VT*, 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 submitted an 1115 Waiver Concept Paper in early 2013 and has plans to work with CMS regarding the development of an application for a §1115 Demonstration Waiver. The State Medicaid Agency plans to establish geographic Medicaid regions and designate RCOs or alternate care providers to operate in each region. Subject to approval of the CMS, the Medicaid Agency shall enter into a contract in each Medicaid region for at least one fully certified RCO to provide medical care to the Medicaid beneficiaries. (Source: National Academy for State Health Policy, 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)

State	State Updates
Alabama	RCO Rules **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 (Approved 4/9/2013))
Arizona	**Medicaid Managed LTSS Program** Under Medicaid §1115 waiver authority, **Arizona Health Care Cost Containment System** (AHCCCS) provides health care services through a prepaid, capitated managed care delivery model that operates statewide for 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 Website on AHCCCS Fact Sheet 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. Application for Amendment (11/9/2012) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** In May 2012, the state submitted a proposal for a statewide participation in

State	State Updates
Arizona	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 by leveraging D-SNPs. (Source: State Website) Arizona Capitated Financial Alignment 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. The state proposed to utilize the state plan option to adopt a new participant-directed alternative called "Agency with Choice." In May 2013, CMS determined that CFC services could only be provided to individuals eligible under the state plan; however, Arizona's comprehensive §1115 waiver establishes eligibility for LTSS. Therefore, in June 2013, Arizona withdrew its 1915(k) application, opting to implement its "Agency with Choice" service model under the state's §1115 waiver. (Source: National HCBS Conference Presentation, 9/11/2013) State Website on ALTCS Member-Directed Options State Plan Amendment (10/5/2012) Presentation (10/29/2012) **Health Homes** 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 serious mental illness (SMI). This RBHA model, known as "Recovery through Whole Health", is responsible for coordinated and integrated behavioral healthcare and physical healthcare for adults with SMI through the use of Health Homes Services. The model is based on the §2703 Health Home Provision of the Affordable Care Act. (Source: State Website on Health Homes)
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)

State	State Updates
Arkansas	BIP Structural Change Work Plan (Revised 6/28/2013) **Section 1915(k) Community First Choice Option** The state plans to submit a §1915(k) State Plan Amendment to CMS (Source: CFCO 6th Meeting Minutes) and to implement a CFCO program in 2014. (Source: State Website on CFCO) The program would provide additional resources to address the state's waiting list of people with developmental disabilities seeking services under the existing Alternative Community Services Waiver. (Source: Community First Choice Option Development and Implementation Council Presentation (11/20/2012)) Development & Implementation Council Meeting Documents **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); Letter of Request to CMS (01/31/2011))
California	**Medicaid 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

State	State Updates
California	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 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, San Diego, 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

State	State Updates
California	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) **Section 1915(k) Community First Choice Option** In September 2012, CMS approved California's CFCO SPA #11-034 and became the first state to receive approval from CMS to enact the Community First Choice Option (CFCO). The CFCO will provide the state an estimated $573 million in additional federal funds during the first two years of implementation and enhance Medi-Cal's ability to provide community-based services and support to seniors and persons with disabilities who otherwise would need institutional care. The CFCO funding is retroactive for most In-Home Supportive Services provided since December 1, 2011. (Source: Press Release, 9/4/2012) In May 2013, the state submitted its second CFCO SPA (CFCO SPA #13-007 to update the eligibility language related to Medi-Cal's Community First Choice Option. In July 2013, CMS approved the second CFCO SPA. (Source: State Website on CFCO) (Approval Letter). **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

State	State Updates
Colorado	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 Demonstration to Integrate Care for Dual Eligible Individuals** Colorado 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 Website on Duals Demonstration On February 28, 2014, CMS and the state signed a Memorandum of Understanding for the state's managed fee-for-service demonstration model. (Source: CMS Demonstration Approvals website; CMS website; NSCLC Dual Eligible State Profiles website, 4/2014; Kaiser Family Foundation Duals Demonstration Proposal Status Map (4/2014) Memorandum of Understanding (2/28/2014) **Section 1915(k) Community First Choice Option** The state is considering the Community First Choice Option. In 2012, Colorado's Long Term Services and Supports (LTSS) Strategic Planning Report identified Community First Choice as an important LTSS initiative, and the state formed a Community First Choice Council. (Source: Colorado Community First Choice Council website)
Connecticut	**Nonprofit Oversight of Medicaid 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)

State	State Updates
Connecticut	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 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
Delaware	**Medicaid Managed LTSS Program & State Demonstration to Integrate Care for Dual Eligible Individuals** In 1996, through its **Diamond State Health Plan (DSHP)** §1115 Medicaid 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 Medicaid 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
District of Columbia	**Health Homes** As of March 2014, CMS has approved the District of Columbia's Health Home Planning Request. (Source: CMS State Health Home Proposal Status, 3/2014)

State	State Updates
Florida	**Section 1115 Demonstration Waiver** Florida's Medicaid Reform is a comprehensive demonstration operated under an §1115 Demonstration Waiver initially approved by CMS in 2005, and extended in 2011 through June 30, 2014. Under the demonstration, most Medicaid beneficiaries in five counties are required to enroll in a capitated or fee-for-service managed care plan as a condition of eligibility for Medicaid. Participation is mandatory for TANF-related populations. Participation is voluntary for dual eligibles; individuals with DD; and individuals residing in nursing homes, sub-acute inpatient psychiatric facilities for individuals under age 21, or ICF-DDs. (Source: Fact Sheet; Florida Medicaid Reform website) Fact Sheet Florida Medicaid Reform website Approval Document Managed Care Policies Letter to CMS (10/13/2012) **Medicaid 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 In August 2011, the state submitted to CMS concurrent §1915(b) and §1915(c) waiver applications to implement the **Florida Long Term Care Managed Care Program**, as mandated by 2011 Florida legislation (House Bill 7107) requiring the state to create a statewide LTC managed care program for eligible Medicaid recipients (older persons or adults with a physical disability who meet nursing facility level of care) and to require beneficiaries to receive nursing facility, hospice, and HCBS through state-selected LTC plans. (Source: Florida Long-Term Care Managed Care Program Website; CMS and Truven Health Analytics, 7/2012) §1915(b) application §1915(c) waiver application In February 2013, CMS approved the state's §1915(b)(c) Florida Long Term Care Managed Care Program combination waiver, effective July 1, 2013 through June 30, 2016. From August 2013 through March 2014, the state regionally phased out five of its current HCBS waivers and transitioned eligible recipients from its LTC Community Diversion Program into its new

State	State Updates
Florida	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)
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 State Plan Amendment to CMS as part of its plan to implement a Medicaid Medical Coordination Program for aged, blind, or disabled Medicaid recipients. (Source: Georgia Department of Community Health Website) Public Notice, (10/10/2013) Medicaid State Plan Amendment, (10/10/2013) **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 Balancing Incentive Program website) CMS Award Announcement (6/13/2012) BIP Grant Application (3/3/2012) BIP Structural Change Work Plan
Hawaii	**Medicaid 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

State	State Updates
Hawaii	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 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 Medicaid Managed Care programs Hawaii operates independently under the QUEST Medicaid umbrella into a single Medicaid managed care program serving all of Hawaii's Medicaid population under §1115 Waiver authority. Hawaii's current separate Medicaid managed care programs – QUEST and 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) Medicaid 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

State	State Updates
Hawaii	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) **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 will implement 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, 5/2/2014) **Health Homes** CMS approved the state's Health Home State Plan Amendment, and Idaho began implementing the SPA in January 2013. The Health Home target

State	State Updates
Idaho	populations include individuals with serious mental illness; diabetes and an additional condition; or asthma and an additional condition. The Health Homes provide care for an individual's physical condition as well as links to long-term community care services and supports, social services, and family services. Payments are fee for service, as well as per member per month payments. (Source: Demonstration Proposal to Integrate Care for Dual Eligibles) Approved Health Homes State Plan Amendment (11/21/2012) State Website on Health Homes
Illinois	**Medicaid 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 Medicaid 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 February 2014, Illinois submitted a proposed **§1115 Reform Waiver for its Path to Transformation demonstration.** Among other things, the

State	State Updates
Illinois	waiver will provide flexibility to deliver appropriate and essential LTSS in a coordinated fashion through managed care entities and their provider networks. (Source: Illinois.gov website) Draft Waiver Concept Paper (11/7/13) §1115 Waiver Proposal (2/10/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals** 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 March 1, 2014. Passive enrollment will begin June 1, 2014. (Source: Illinois HFS website; HMA Weekly Roundup, 5/7/2014) Memorandum of Understanding State Duals Demonstration website **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) **Health Homes** In 2013, the state submitted a draft Health Home State Plan Amendment to CMS. However, as of April 2014, the state has not submitted a State Plan Amendment to CMS. (Source: CMS Health Home Proposal Status website, 4/2013; CMS Health Home Proposal Status website, 4/2014)
Indiana	**Balancing Incentive Program** In September 2012, CMS awarded Indiana an estimated $78.2 million of

State	State Updates
Indiana	enhanced Medicaid funds. (Source: Approved BIP Application) Approved BIP Application Structural Change Work Plan In October 2013, the state published a Balancing Incentives Program Work Plan. (Source: Indiana FSSA website) State of Indiana Balancing Incentives Program Work Plan Table (10/2013) **Health Homes** In 2013, the state was considering establishing 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, 1/22/2013; Indiana DDRS Provider Quarterly Update, 4/24/2013) In its January 2014 Community Integration and Habilitation Waiver application, the state said although it had explored the concept of Health Homes, stakeholder and advocate input led the state to redirect and develop Wellness Coordination services within its Community Integration and Habilitation Waiver. Wellness Coordination services provide a feasible and immediate response to the need for better coordination of waiver participants' health care issues. (Source: CMS Health Home Proposal Status website, 2/2014; Community Integration and Habilitation Waiver, Effective 2/1/2014)
Iowa	**State Demonstration to Integrate Care for Dual Eligible Individuals** 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; NASDDS Managed Care Tracking Report Vol.1 No.2; NSCLC Dual Eligibles website) **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) BIP application (Submitted to CMS: 4/30/2012) CMS Award Announcement (6/13/2012) IME Bureau of Long Term Care Revised Work Plan (1/2013) State Website on Balancing Incentive Program

State	State Updates
Iowa	NASDDS Managed Care Tracking Report Vol.1 No.2) **Health Homes** In June 2012, CMS approved Iowa's first Health Home State Plan Amendment to implement **Health Homes for Individuals with Chronic Conditions**. Effective July 1, 2012, qualified providers began offering advanced services to members with two chronic conditions or one chronic condition with the risk of developing another chronic condition. Services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. (Source: Integrated Care Resource Center, Health Homes State Plan Amendment Matrix: Summary Overview, 6/2012; Kaiser Commission on Medicaid and the Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, 8/2012) Approved Health Homes State Plan Amendment (6/2012) State Website on Health Homes CMS also approved Iowa's second Health Home State Plan Amendment to implement **Integrated Health Homes (IHH) for Individuals with Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)**. An Integrated Health Home (IHH) is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with SMI and children with SED. The IHH will be administered by the Medicaid Behavioral Health Care MCO and provided by community-based IHH. Compared to Health Homes for Individuals with Chronic Conditions, where targeted case management provides individual staff to coordinate care for individuals receiving community-based services, an IHH provides care coordination through a team of professionals and access to family and peer support services. Adults who meet the criteria for an SMI or children who meet the criteria for an SED will be eligible for IHH. Individuals who receive both habilitation and services through another HCBS Waiver (e.g. ID, PD, TBI) will not be eligible for IHH. The IHH program became effective in July 2013 in 5 counties and the remaining counties will be phased in through December 2014. (Source: Integrated Health Home FAQs, Revised 4/2013) Integrated Health Home Informational Flyer (Revised 4/2013) Integrated Health Homes for Medicaid Members with a Serious & Persistent Mental Illness PowerPoint Presentation (4/2013) As of April 2014, CMS has approved a total of three Health Home State Plan Amendments for Iowa. (Source: CMS Health Home Proposal Status website, 4/2014) Iowa DHS Health Home Presentation, 12/13/2013

State	State Updates
Kansas	**Medicaid Managed LTSS Program** In August 2012, the state resubmitted to CMS its **KanCare** §1115 demonstration waiver application, seeking waiver authority to move all 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 Department for Aging and Disability Services 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 **Health Homes** Health Homes for people with serious mental illness (SMI) or other chronic conditions are a component of the KanCare §1115 demonstration waiver. The state originally expected to implement Health Homes for people with SMI on January 1, 2014, but delayed implementation until July 1, 2014. The state also plans to implement Health Homes for KanCare members with other chronic conditions in July 2014. In August 2012, Kansas submitted to CMS a Health Homes concept paper and request for funding to plan and implement the KanCare Health Homes model and a formal Health Homes SPA. CMS approved the state's Health Homes Planning Request (Source: Kansas Health Homes website; CMS Health Home Proposal Status website,

State	State Updates
Kansas	4/2014) Concept Paper Letter of Request Approval Letter 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). In February 2014, the state also announced its release of the Health Homes Preparedness and Planning Tool to help providers determine their ability to serve as a Health Home and to develop a Health Home road map. (Source: Health Homes Herald, 2/2014) Health Homes Preparedness and Planning Tool
Kentucky	**Balancing Incentive Program** On October 24, 2013, Kentucky submitted an application for BIP funding. CMS subsequently approved Kentucky's application for additional BIP funding. The state will receive an enhanced Federal matching rate of 2% for non-institutional LTSS. (Source: CMS Balancing Incentive Program website; LeadingAge BIPP Update, 1/26/14) Kentucky's Balancing Incentive Program Application (10/24/2013) **Health Homes** Kentucky submitted a State Health Home Planning Request and CMS approved the Health Home Planning Request. (Source: CMS Health Home Proposal Status website, 2/2014)
Louisiana	**Medicaid 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 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

State	State Updates
Louisiana	**Section 1915(k) Community First Choice Option (Withdrawn)** The state proposed to replace the current Long-Term Personal Care Services (LT-PCS) Program by adopting provisions to establish Community First Choice Option services as a covered service under the Medicaid State Plan. The LT-PCS Program was to be terminated upon CMS approval of the corresponding Community First Choice option State Plan Amendment. (Source: Louisiana Register, Louisiana Register Vol. 38, No.6, June 20, 2012) Notice of Intent (Louisiana Register, 6/20/2012) In August 2013, Louisiana withdrew its application for a Community First 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 **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:

State	State Updates
Maine	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(k) Community First Choice Option** In 2012-2013, Maryland planned to implement CFCO in January 2014 and include in its program all required and optional services allowed under proposed federal regulations. (Source: CFC Meeting Notes, 1/10/2013) State Community First Choice Option website CFC Implementation Council Meeting Presentation (1/2012) CMS approved the state's a §1915(k) State Plan Amendment, and Maryland converted to the new CFCO on January 6, 2014. (Source: Kaiser Family Foundation website; CFC Council Meeting Minutes, 12/9/13) **Health Homes** In early 2013, the state submitted a draft Health Homes State Plan Amendment to CMS. (Source: CMS Health Home Proposal Status website, 4/2013) Maryland Health Home DRAFT SPA (2/15/2013) Maryland Health Homes DRAFT Regulations (6/10/2013) Chronic Health Homes DRAFT Criteria (12/10/2012) On September 27, 2013, CMS approved Maryland's proposed Health Home State Plan Amendment. The State Plan Amendment became effective October 1, 2013. (Source: Medicaid.gov; CMS Health Home Proposal Status website, 2/2014) Health Home State Plan Amendment (Approved 9/29/13)

State	State Updates
Massachusetts	**Medicaid 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 **One Care** 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) 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 website on the demonstration Duals Demonstration Timeline Massachusetts Contract 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, 3/2014) **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

State	State Updates
Massachusetts	**Health Homes** The state submitted to CMS a draft Health Homes State Plan Amendment. However, as of April 2014, no proposed Health Homes State Plan Amendment had been officially submitted to CMS. (Source: CMS Health Home Proposal Status website, 4/2014)
Michigan	**Medicaid 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 proposes a capitated model with opt out enrollment. The demonstration will cover all dual 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)

State	State Updates
Michigan	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) **Health Homes** As of April 2014, Michigan had not submitted a Health Home State Plan Amendment to CMS. (Source: CMS State Health Home Proposal Status website, 4/2014) 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 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. PIHPs will be required to deliver supports and services in the least restrictive setting, use person-centered planning, and make self-determination arrangements readily available. (Source: Demonstration Proposal) State Resource on Health Homes
Minnesota	**Medicaid 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, p.1580, 6/18/2012) **Minnesota Senior Care Plus (MSC+)** operates under §1915(b) and §1915(c) waiver authorities and provides LTSS; primary, acute and

State	State Updates
Minnesota	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) 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: Minnesota DHS News website, 11/2013) Alternative Care Program Fact Sheet (2/2014) DHS News Release (11/20/2013) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** The original financial alignment demonstration proposal included two

State	State Updates
Minnesota	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 (MSHO) and Minnesota SeniorCare Plus (MSC+). The second phase included dual eligibles age 18-64 with disabilities who were enrolled in Special Needs BasicCare (SNBC). Implementation would be statewide for older adults and statewide contingent on CMS negotiations for people with disabilities. Older adults would receive partial NF services and LTSS under a capitated model. 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 the 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) 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) **Health Homes** CMS has approved Minnesota's State Health Home Planning Request. Michigan has not yet submitted a proposed Health Home State Plan

State	State Updates
Minnesota	Amendment. (Source: CMS State Health Home Proposal Status website, 2/2014)
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 **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, 2/2014)
Missouri	**Medicaid Managed LTSS** The Missouri Senate Health Committee approved a bill to shift more children and adults into managed care, while authorizing a new model of coordinated care for many seniors and disabled patients. The bill aims to improve coordination of care for patients and to reduce cost for services. The legislation does not include provisions to expand Medicaid as outlined by the Affordable Care Act. The bill will now move to the full Senate for debate. (Source: HMA Weekly Roundup, 3/19/2014) Missouri Senate Interim Committee on Medicaid Transformation and Reform Draft Report (12/15/2013) On May 16, 2014, the Missouri legislature adjourned; and legislation to expand Medicaid managed care and establish a LTSS care coordination initiative was not 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. The demonstration proposes Medicare share any savings realized from the state's two Health Homes programs. The demonstration proposes a managed fee-for-service financing model. (Source: Demonstration Proposal) As of May 2014, the state has withdrawn its duals demonstration proposal. (Source: Kaiser Duals Demonstration website, 4/24/2014)

State	State Updates
Missouri	**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** CMS approved the state's two Health Homes programs under §2703 of the Affordable Care Act (ACA). Implemented in January 2012 statewide, the Health Homes programs provide care coordination services to eligible Medicaid beneficiaries that meet the program criteria, including those beneficiaries who are dually-eligible for Medicare and Medicaid. The first approved program, Missouri Community Mental Health Center Health Homes State Plan Amendment (approved 10/20/2011) program targets Medicaid beneficiaries with (1) serious and persistent mental health condition, or (2) a mental health or substance abuse condition and another chronic condition or a risk of developing another due to tobacco use. The second approved program, Missouri Primary Care Practice Health Homes (PCP-HH) Clinic – State Plan Amendment (approved 12/22/2011) program targets Medicaid beneficiaries who have two or more chronic physical conditions or with one chronic condition and are at risk of developing another. (Source: Demonstration Proposal) Missouri Community Mental Health Center Health Homes SPA (approved) Missouri Primary Care Practice Health Homes (PCP-HH) Clinic SPA (approved)
Montana	**Section 1915(k) Community First Choice Option** The Governor's budget proposal included a request from Senior & Long Term Care Division (NP 22222) for $17 million in federal spending authority to be used to refinance and enhance Montana's system of Medicaid-funded in-home personal assistance services. Pursuing the option was also discussed at the Senior & Long Term Care budget hearing. (Source: Montana Department of Public Health & Human Services, January 2013 Minutes, 1/29/2013) Community First Choice 1/10/2013 (Webinar) According to Montana's 2013 Draft CFC Timeline, the state planned to submit a State Plan Amendment to CMS on August 29, 2013 and implement the Community First Choice option effective October 01, 2013. (Source:

State	State Updates
Montana	2013 National HCBS Conference Presentation) Community First Choice Frequently Asked Questions
Nebraska	**Medicaid Managed LTSS Program** Nebraska Medicaid has started the process of developing a statewide Medicaid managed care program for the delivery of long-term services and supports, with a targeted implementation date in July 2015. Examples of long-term services and supports include nursing facility services, Personal Assistance Service (PAS), home health services, and home and community-based waiver services such as Assisted Living; Home Care/Chore; Home-Delivered Meals; Personal Emergency Response Systems; and Respite Care. In addition to long-term services and supports, the benefits package for MLTSS will include physical and behavioral health care, dental care, and pharmacy. (Source: State Website on Medicaid MLTSS) On May 13, 2014, Nebraska Medicaid announced the temporary suspension of its work on a statewide MLTSS program in order to devote resources to its July 2014 Balancing Incentive Program grant application. Nebraska's new MLTSS target implementation date is January 2017. (Source: State Medicaid MLTSS website; HMA Weekly Roundup, 5/21/2014; State Medicaid MLTSS PowerPoint, 5/7/2014) **Balancing Incentive Program** Nebraska Medicaid is currently working on a Balancing Incentive Program grant application, due on July 31, 2014. BIP grant funding will enable the state to establish an infrastructure to strengthen access to statewide LTSS. (Source: State Medicaid MLTSS website)
Nevada	**Medicaid Managed LTSS Program** Nevada has amended its State Plan to reflect updated processes and eligibility groups as they relate to the DHCFP's Managed Care Programs. (Source: Medicaid State Resource Center website) Approved State Plan Amendment (Effective 10/1/2013) **Balancing Incentive Program** On January 7, 2014, Nevada submitted to CMS a Balancing Incentive Payment Program application. Subsequently, CMS approved the BIP application. (Source: Medicaid.gov website) **Health Homes** CMS approved Nevada's Health Home Planning Request. (Source: Integrated Care Resource Center)

State	State Updates
New Hampshire	**Medicaid Managed LTSS Program** (Approved 8/24/2012) & **State Initiative to Integrate Care for Dual Eligible Individuals** As required in Senate Bill 147 passed by the New Hampshire Legislature on June 2, 2011, the Department of Health & Human Services submitted (3/31/2012) a State Plan Amendment to CMS through the §1932(a) State Plan option for authorization of a statewide managed care delivery system, called **New Hampshire Medicaid Care Management Program.** On May 9, 2012, members of the governor's Executive Council approved a $2.3 billion contract establishing a managed care system for Medicaid recipients. CMS approved (8/24/2012) the State Plan Amendment. The state plans to launch the new care management system in three phases over the course of three years. In Phase 1, all Medicaid patients in the state would be required to enroll in one of the new care management plans offered by the MCOs. Beneficiaries eligible for both Medicare and Medicaid would have the option to opt out during Phase 1. For more information regarding populations served by the program, click here. LTSS would be added in Phase 2, currently estimated to begin January 2014. Groups that the state proposes to enroll by January 1, 2014 include children with physical, cognitive, or behavioral disabilities, adults with physical disabilities, adults with developmental/intellectual disabilities, and older persons. Enrollment would be mandatory. In the last phase, the program would include those newly eligible for Medicaid benefits by virtue of the Affordable Care Act. One percent of each Medicaid enrollee's capitated payment would be withheld by the state and repaid to the MCOs only if they satisfy performance measures. (Source: Care Management Program website; CMA and Truven Health Analytics, July 2012) Care Management Program website Care Management State Plan Amendment (3/30/2012) Approval Letter from CMS (8/24/2012) DHHS Medicaid Managed Care Info Meeting Final Report (August 2012) January 2013 Update on Medicaid Care Management (1/24/2013) On December 1, 2013, the state launched its transition to Medicaid 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)

State	State Updates
New Hampshire	**Balancing Incentive Program** New Hampshire was the first state to apply for and to receive CMS approval under the Balancing Incentive Program. CMS awarded the state $26.5 million in enhanced Medicaid funds. (Source: Award Letter, 3/1/2012) Approved work plan is available here . (Source: CMS Balancing Incentive Program website) BIP application (12/30/2011) BIP Structural Change Work Plan (10/23/2012)
New Jersey	**Medicaid Managed LTSS Program** (Approved 10/2/2012) & **State Initiative to Integrate Care for Dual Eligible Individuals** **New Jersey §1115 Comprehensive Waiver** (Submitted 9/9/2011; Approved 10/2/2012) New Jersey's §1115 Comprehensive Waiver seeks to provide State Plan benefits, as well as long-term care services & supports to Medicaid and CHIP beneficiaries. The §1115 demonstration waiver combines authority for several existing Medicaid and CHIP waiver and demonstration programs, including two §1915(b) managed care waiver programs; a Title XIX Medicaid and a Title XXI CHIP §1115 demonstration waiver and four §1915(c) HCBS waiver programs. **The first phase** includes the non-dual population of aged, blind and disabled Medicaid beneficiaries, populations served by the Department of Developmental Disabilities (DDD) including Community Care Waiver clients, clients already covered by a commercial or Medicare HMO, and breast or cervical cancer clients. **The second stage** includes all dual eligibles, an increased range of waiver clients, clients with traumatic brain injury, and those clients participating in the AIDS Community Care Alternatives Program and Community Resources for People with Disabilities. (Source: Waiver Application) Comprehensive Medicaid Waiver Website Waiver Application (9/9/2011) Approval Letter (10/2/2012) Recommendations by workgroup According to a state official, the state proposed to add nursing home and HCBS to Managed Care contracts for Medicaid-eligible individuals who meet a NF level of care. The state also worked with CMS on Special Terms and Conditions and Budget Neutrality. (Source: NASUAD Membership Meeting, 9/9/2012) According to a Press Release (10/4/2012) from the New Jersey Department of Human Services, some of the reform proposals in the application were denied by CMS, including the following: the State's request to no longer

State	State Updates
New Jersey	provide retroactive Medicaid eligibility for applicants; consolidation of all nine state waivers into one, and the state's appeal for an estimated $107 million in Medicare Part B retro payment for Medicare services erroneously billed to Medicaid. The federal government also determined that approval of future programmatic changes and that the Community Care Waiver will remain outside the comprehensive waiver. (Source: Press Release, State of New Jersey Department of Human Services, 10/4/2012) The New Jersey Division of Medical Assistance and Health Services (DMAHS) delayed its New Jersey §1115 Comprehensive Medicaid Waiver implementation date until July 1, 2014. The revised implementation schedule will shift both HCBS and custodial care in nursing facilities to managed care effective July 1, 2014. (Source: HMA Weekly Roundup, January 8, 2014) In March 2014, the state said it will ***not*** enroll existing nursing facility residents into managed care on July 1, 2014, as previously planned under the New Jersey Comprehensive Medicaid Waiver. Instead, when the state switches over to a managed care system on July 1, 2014, existing nursing facility residents can remain under the Medicaid fee-for-service system for at least two more years; and MCOs will only be responsible for new nursing facility residents and home and community services for waiver populations currently enrolled in managed care. (Source: MLTSS Weekly Roundup, March 14, 2014; HMA Weekly Roundup, March 19, 2014). **Balancing Incentive Program** On March 15, 2013, CMS approved New Jersey's Balancing Incentive Program Application. The grant program is funded through September 30, 2015. (Source: CMS website; New Jersey DHS website) BIP Application (12/20/2012) In January 2014, New Jersey submitted to CMS a Structural Change Work Plan. (Source: CMS website) Structural Change Work Plan (1/16/2014) **Health Homes** CMS has approved the state's Heath Home Planning Request. (Source: Integrated Care Resource Center)
New Mexico	**Currently Operating Medicaid Managed LTSS Program** Since 2008, **Coordination of Long-Term Services** (CoLTS) has provided managed LTSS to children with LTSS needs, adults less than age 65 with

State	State Updates
New Mexico	physical disabilities, and adults of age 65 and older through State Plan Personal Care Options and §1915(c) HCBS waivers. (Source: CMS and Truven Health Analytics, July 2012) Services include doctor visits, hospital services, home and community-based services and long-term care services. Examples of long-term care services include medical care, home health services, personal care & support, meal preparation and physical therapy. Long-term care services can be provided at home, in the community, in assisted living facilities, or nursing homes. (Source: State CoLTS Final Report (6/28/2013) Effective January 1, 2014, Centennial Care replaces New Mexico's previous Medicaid managed care programs, CoLTS and Salud!. The state will send out information beginning in October 2013 to Medicaid managed care members with instructions on how to choose a Centennial Care MCO. (Source: Centennial Care CoLTS FAQs 7/2/2013) **(See below)** **Projected Medicaid Managed LTSS Program (Approved)** In August 2012, New Mexico submitted a new §1115 Medicaid demonstration proposal entitled Centennial Care, and the proposal was approved by the CMS in July 2013. The demonstration will be implemented from January 1, 2014, through December 31, 2018. Under this demonstration, New Mexico will consolidate its existing §1915(b) and 1915(c) waivers to create a comprehensive managed care delivery system. Centennial Care's contracted health plans will offer the full array of current Medicaid services, including acute, behavioral health, institutional, and community-based long term services and supports. Other features of Centennial Care will include expanded care coordination for all beneficiaries and a beneficiary reward program, offered through managed care organizations, to provide incentives for beneficiaries to pursue healthy behaviors. Centennial Care also creates a Safety Net Care Pool made up of two sub-pools: an Uncompensated Care (UC) Pool and a Hospital Quality Improvement Incentive (HQII) Pool. The approval of this demonstration does not impose any new requirements for Native Americans to enroll in managed care. Native American Medicaid beneficiaries will have the opportunity to voluntarily opt-in to managed care. The state will still enroll dually-eligible Native American beneficiaries or those meeting nursing facility level-of-care in managed care, as was the case under the CoLTS §1915(b)(c) combo waiver. (Source: Approval Letter, 7/12/2013) Waiver application (Submitted 8/17/2012) State Website on Centennial Care Centennial Care general FAQs 6-19-13

State	State Updates
New Mexico	On January 1, 2014, the state implemented New Mexico Centennial Care as a replacement for the New Mexico Medicaid system. (Source: State website on Centennial Care) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** Department of Human Services submitted (8/7/2012) a letter to CMS withdrawing the state's previous proposal seeking permission to conduct this demonstration. In the demonstration proposal submitted on May 31, 2012, the state had proposed that dually-eligible individuals receiving services through the New Mexico Developmental Disabilities waiver would receive their regular medical benefits through the demonstration, but that their long-term care services would remain carved out of managed care and paid through a fee-for-service arrangement. Demonstration Proposal Letter to CMS to notify withdrawal (8/17/2012) **Health Homes** New Mexico seeks to establish health homes as an integral step in the integration of care under the §1115 demonstration waiver. The state is currently working under a §2703 planning grant to design its first SPA to establish health homes throughout the state that address recipients with a behavioral health condition. The state intends to develop health homes in Core Service Agencies (CSAs) statewide, designed in conjunction with the MCOs under Centennial Care. Once a recipient enrolls in a BHH, MCOs will delegate responsibility for both care management and care coordination to the BHH. Over time, the state intends to establish health homes for other chronic conditions through the SPA process. The state plans to coordinate the health homes model(s) with Centennial Care to ensure integration of care is achieved at all levels. (Source: Centennial Care §1115 Demonstration Waiver Application) CMS approved the state's Heath Home Planning Request. (Source: CMS State Health Home Proposal Status website, February 2014)
New York	**Medicaid Managed LTSS Program** **New York Medicaid Advantage Plus (MAP),** operating under Medicaid § 1915(a), provides LTSS in capitated rate to adults age 18-64 with physical disabilities and adults of age 65 and older. Enrollment is voluntary with opt in. (Source: CMS and Truven Health Analytics, July 2012)

State	State Updates
New York	**Partnership Plan Waiver & Federal-State Health Reform Partnership (F-SHRP) Waiver** In 1997, the state received approval from the federal government of its first § 1115 demonstration waiver known as the **Partnership Plan**. Since the original approval and subsequent Amendments, the Partnership Plan Demonstration currently consists of four major program components: **1. Medicaid Managed Care** providing Medicaid State Plan benefits through comprehensive MCOs to most recipients eligible under the State Medicaid Plan; **2. Family Health Plus** providing a more limited benefit package, with cost-sharing imposed, for adults with and without children with specified income; **3. Family Planning Benefit Program** serves men and women who are otherwise not eligible for Medicaid but are in need of family planning services who have net incomes at or below 200 percent of the federal poverty level (FPL) and to women who lose Medicaid eligibility at the end of their 60-day postpartum period; and **4. Home and Community-Based Services Expansion** providing an expansion of three §1915(c) waiver programs by eliminating a barrier to financial eligibility to receive care at home. The Partnership Plan Demonstration operates separately from, and complements, New York's Federal-State Health Reform Partnership (F-SHRP) §1115 Demonstration. **New York Federal-State Health Reform Partnership (F-SHRP)** was the state's second demonstration waiver approved by CMS. The demonstration provides federal financial support for a health reform program in New York that addresses the state's need to modernize its acute and long-term care infrastructure, increase capacity in primary and ambulatory care, and make investments in health information technology. The demonstration also allows the state to enroll certain Medicaid populations into managed care on a mandatory basis: aged, blind and disabled individuals statewide, and children, caretaker relatives, and pregnant women in selected counties. (Source: Medicaid.gov) State Website on Partnership Plan Waiver State Website on Federal-State Health Reform Partnership Fact Sheet on F-SHRP CMS approved (8/31/2012) the state's recent application for Amendments to Partnership Plan and F-SHRP. Click here to see approval letter. The state requested (10/31/2012) the federal government for extension of Partnership Plan beyond its current 12/31/2014 expiration date to 12/31/2017. The application for extension includes an interim evaluation of the Partnership Plan. New York has submitted an amendment to its §1115 Waiver, the Partnership Plan. The state and CMS are negotiating the $10 billion waiver request, which includes a large Delivery System Reform Incentive Payment (DSRIP) program. (Source: HMA Weekly Roundup, January 29, 2014)

State	State Updates
New York	**Medicaid Redesign Team (MRT) Waiver** The MRT waiver is an Amendment to the state's existing §1115 Demonstration waiver, Partnership Plan. The state recently submitted (8/6/2012) Medicaid Redesign Team (MRT) waiver, which will allow the state to invest up to $10 billion of $17.1 billion in federal savings generated by the Medicaid Redesign Team (MRT) reforms over a five-year period. The MRT waiver Amendment will be restricted to the portion of the Medicaid program controlled by the Department of Health. Specifically excluded from the 1115 waiver Amendment are those Medicaid services provided through waivers administered by the Office for People with Developmental Disabilities (OPWDD). The state is currently pursuing a different waiver agreement that will encompass services/waivers that relate to people with developmental disabilities. Both this waiver and the OPWDD waiver will rely on care management as the primary method for driving change and innovation. More information on the Medicaid 1115 waiver is available at State Website on Medicaid Redesign. (Source: Medicaid Redesign Team (MRT) waiver application) Medicaid Redesign Multi-year Action Plan On April 14, 2014, CMS approved an amendment to the state's MRT 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 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 for individuals with SMI. (Source: State Medicaid website; HMA Weekly Roundup, 4/12/2014) DSRIP is intended transform the health care delivery system from volume-based payments to value-based payments. New York's MRT waiver has a significant difference when compared with other state Medicaid DSRIP programs: 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 fee-for-service payment system to a value-based payment system. (Source: State Medicaid website; HMA Weekly Roundup, 4/12/2014) MRT Waiver Amendment Update Presentation, 4/2014 **Projected Medicaid Managed LTSS Program** Medicaid Redesign Team Proposal #90 and 2011 budget legislation requires

State	State Updates
New York	the transition and enrollment of certain community-based long term care services recipients into **Managed Long-Term Care Plans (MLTCPs) or Care Coordination Models (CCMs)**. New York state currently operates three models of MLTCP: the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Advantage Plus (MAP); and partially capitated managed long-term care plans. Currently there are no CCMs established. All models provide community-based long term care services, nursing home care and many ancillary services, including individualized care management. During July 2012, the Department received verbal approval from the Centers for Medicare and Medicaid Services (CMS) to initiate mail distribution of mandatory enrollment notifications. These notifications, alerting current members that they must choose a plan to continue receiving community based long-term care services, are being rolled out in New York City using a phased approach by borough and zip code. On August 31, 2012, the Department received written approval from CMS to proceed with auto-assignment of members into partial capitated managed long term care plans in New York City. The mandatory enrollment initiative will continue within the five boroughs of New York City until all eligible cases are transitioned. In January 2013, the initiative will move to Nassau, Suffolk and Westchester counties. (Source: State Medicaid Update, September 2012) State Website on Managed Long Term Care/Care Coordination Model **Additional Projected Medicaid Managed LTSS Program** **New York People First Waiver** (Pending as of 10/26/2013)**:** The target population for the People First Waiver is Medicaid enrollees of all ages with developmental disabilities. The state proposes to develop and implement creative service delivery and payment models that integrate acute and long-term care to achieve improved health outcomes and quality of care while lowering health care costs for the developmentally disabled population. (Source: Medicaid.gov) Mandatory services provided in capitation rate will include (1) family and individual support, integration and community habilitation, flexible goods and services, home and community-based clinical and behavioral supports; (2) Adult Day Health Care; (3) Assisted Living Facility; (4) Home Care (Nursing, Home Health Aide, PT, OT, SP, Medical Social Services); (5) ICF/MR; and (6) Skilled Nursing Facility. Pilot projects are projected to begin in October 1, 2012. Statewide launch of partial and fully capitated DISCOs begins in Summer 2015. (Source: New York's Response to Centers for Medicare & Medicaid Services' Request for Additional Information, April 2012) Enrollment is voluntary in pilot phase, and becomes mandatory when fully implemented. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012)

State	State Updates
New York	State Website on New York People First Waiver New York's Response to CMS' Request for Additional Information (April 2012) On December 1, 2013, Phase IV of New York's mandatory Medicaid long-term care program began in four upstate counties. Subsequent phases will not occur before April 2014. The state plans to implement mandatory managed long-term care for Medicaid beneficiaries requiring more than 120 days of community-based long-term care in every county by the end of 2014. (Source: MLTSS Network Weekly Roundup, January 23, 2014; HMA Weekly Roundup, December 4, 2013) The state has delayed transitioning its nursing home populations and benefits into Medicaid managed care until at least June 1, 2014, while the state negotiates with CMS to resolve details around the managed care program roll-out. (Source: HMA Weekly Roundup, 4/30/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn: Managed Fee-For-Service Model)** (Proposal Pending: Capitated Managed Care Model) On August 26, 2013, CMS announced that it will partner with the State of New York to test a new model for providing Medicare-Medicaid enrollees with a more coordinated, person-centered care experience. The federal-state partnership will include a three-way contract with Fully-Integrated Duals Advantage (FIDA) plans, Medicare-Medicaid Plans (MMPs) that will provide integrated benefits to those Medicare-Medicaid Enrollees residing in the targeted geographic area and who choose to participate in the demonstration. The demonstration will begin no earlier than July 1, 2014 and continue until December 31, 2017. The population eligible to participate in the FIDA demonstration is limited to "Full Benefit" Medicare-Medicaid Enrollees age 21 or older meeting the eligibility criteria outlined above. CMS will implement this initiative under Medicare Parts C and D and demonstration authority for Medicare, and State Plan, demonstration, and waiver authority for Medicaid. (Source: CMS Press Release, 8/26/2013) Memorandum of Understanding State Website on the demonstration The state initially proposed to integrate care for the dually-eligible population through two models: (1) Managed Care Model (Fully-Integrated Duals Advantage; FIDA), and (2) Managed Fee-for-Service Model (Health Homes). However, in a letter sent on March 21, 2013, the state notified CMS of its withdrawal of the Managed Fee-for-Service model. According to the state's original demonstration proposal, the now

State	State Updates
New York	withdrawn Managed Fee-for-Service (FFS) Health Homes program would have provided care coordination for a dually-eligible population with complex medical, behavioral, social service and long term care needs requiring less than 120 days of long term care services. According to the letter to CMS, the state will keep its commitment to enroll qualifying dually-eligible members in its health home program (Please refer to Health Homes section for more information). Such change does not affect the Managed Care financial model in the demonstration. Built off the state's **Medicaid Advantage Plus** program, **Fully-Integrated Duals Advantage (FIDA)** program would cover full dual eligibles (age 21 or older) who require 120 or more days of Long-Term Supports and Services (LTSS). Starting January 2014, these individuals would be provided the entire range of Medicare and Medicaid services as well as an extensive list of LTSS many of which were previously only available in New York State's Home and Community-Based Services Waiver programs. The FIDA program would serve eight NY counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. Full dual eligibles (age 21 or older) who are receiving services through the Office of Persons with Developmental Disabilities (OPWDD) system will be served under **FIDA OPWDD** statewide. The FIDA OPWDD program will include only developmental disabilities waiver services and ICF/MR services. (Source: CMS and Truven Health Analytics, July 2012; New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals) New York's duals demonstration program will establish FIDA plans in eight downstate counties. Voluntary enrollment for community-based and nursing home populations begins October 1, 2014, and passive enrollment for both populations begins January 1, 2015. The state intends to have final three-way contracts signed by July 2014. (Source: HMA Weekly Roundup, January 15, 2014; HMA Weekly Roundup, January 22, 2014; MLTSS Network Weekly Roundup, February 20, 2014) The state 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 also lays out requirements for becoming a Health and Recovery Plan (HARP), a managed care product that will be offered to individuals with serious mental illness or substance use disorder. (Source: HMA Weekly Roundup, 3/26/2014) **Health Homes** New York Health Homes State Plan Amendment for Individuals with Chronic

State	State Updates
New York	Behavioral and Mental Health Conditions (approved 2/3/2012) targets Medicaid enrollees with two or more chronic conditions; or HIV/AIDS and a risk of developing another chronic condition; or one serious mental illness. The initiative does not include those receiving long-term care and those with intellectual disabilities, and the state intends to seek approval of a separate health homes SPA that will specifically target these populations. Enrollment began in February 2012. (Source: State Website on Health Homes) Approved State Plan Amendment (2/3/2012) State Website on Medicaid Health Homes (April 2012) State Website on Medicaid Health Homes (November 2012) **New York State Medicaid Director Testified before the U.S. Senate on its Medicaid Redesign and Duals Demonstration** (7/18/2012) Complete Testimony **Balancing Incentive Program** The Centers for Medicare & Medicaid Services (CMS) announced (3/15/2013) that New York will receive an estimated $598.7 million in enhanced Medicaid funds (2% enhanced FMAP rate). (Source: State Website) BIP Application (12/20/2012) Revised BIP Application (2/26/2013) BIP Award Letter (3/15/2013) On December 20, 2013, the state submitted to CMS a BIP Structural Change Work Plan. On January 9, 2014, the state published a BIP Work Plan Update (Source: CMS website; New York State Medicaid website) BIP Structural Change Work Plan (12/20/2013) BIP Work Plan Update (1/9/2014) On March 21, 2014, the state issued a Request for Applications for BIP funding grants. The application deadline is May 7, 2014. (Source: New York State Medicaid website) Request for Applications (3/21/2014) **Section 1915(k) Community First Choice Option** In 2012, the Commissioner's Advisory Group held several meetings to discuss the Community First Choice Option. (Source: State CFCO website) However, as of May 2014, the state does not plan to participate in the §1915(k) Community First Choice Option in FY 2014. (Source: Kaiser CFCO website, 5/2014)

State	State Updates
North Carolina	**Medicaid Managed LTSS Program** **MH/DD/SAS Health Plan Waiver** (formerly Piedmont Cardinal Health Plan – Innovations (PCHP)), under §1915(a) authority, began operating in 2005 as a five-county pilot, and is scheduled to become statewide in 2013. The program targets Children and adults of all ages with serious emotional disturbance, developmental disabilities, mental illness, or substance abuse disorders. Services provided in capitated rate are inpatient and outpatient behavioral health (mental health and substance abuse), including enhanced community services, Psychiatric Residential Treatment Facilities (PRTFs), Emergency Room visits for behavioral health treatment, and LTSS (ICF/MR, HCBS waiver services for persons with developmental and intellectual disabilities, Therapeutic Foster Care (TFC), Residential Child Care). (Source: CMS and Truven Health Analytics, July 2012) State Website on MH/DD/SAS Health Plan Waiver North Carolina's Medicaid department recently submitted a Medicaid reform proposal to the state legislature. On March 17, 2014, the state released a detailed report of the proposed Medicaid reform proposal plan, known as the **Partnership for a Healthy North Carolina**. The proposed plan does not pursue a traditional risk-based Medicaid managed care model. Instead, the reforms detailed in this proposal would: 1. Establish provider-led Medicaid accountable care organizations (ACOs) for the management of physical health; 2. Continue the consolidation and strengthening of the Local Management Entity Managed Care Organizations (LME-MCOs) providing services for the mental health, substance abuse, and intellectual and developmental disabilities (I/DD) populations; and 3. Streamline and strengthen the coordination of Medicaid long-term services & supports (LTSS). The legislature is expected to vote on the proposal as early as May 2014. (Source: HMA Weekly Roundup, March 19, 2014) **State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** The state's demonstration targets full benefit dually-eligible beneficiaries, age 21 and older. It does not include individuals with mental health, intellectual/developmental disabilities, and substance abuse needs receiving services under Medicaid Prepaid Inpatient Health Plan (PHIP)/§1915(b)/(c) Medicaid Waiver. It will implement statewide using a managed fee-for-service reimbursement model. (Source: Demonstration Proposal; State Website on Duals Demonstration) Community Care of North Carolina (CCNC) is expanding services beyond Medicaid enrollees. The state received a §646 waiver that expanded CCNC's reach to include dually eligible (Medicare and Medicaid) beneficiaries,

State	State Updates
North Carolina	thereby covering Medicare patients in 26 counties. CMS also awarded the state a Multi-Payer Advanced Primary Care Practice demonstration grant. Under this demonstration, certain CCNC networks coordinate the care and improvement for patients covered by Medicaid, Medicare, Blue Cross Blue Shield of North Carolina, and State Health Plan (which together represent about 80 percent of covered lives). (Source: National Academy for State Health Policy, November 2013) National Academy for State Health Policy Brief (11/2013) In March 2014, North Carolina's Demonstration Proposal was still pending with CMS. (Source: Kaiser Family Foundation website) As of May 2014, the state has withdrawn from the demonstration, choosing to pursue duals integration through its Community Care North Carolina program. (Source: NASUAD) **Health Homes** North Carolina Health Homes State Plan Amendment (approved 5/24/2012) targets beneficiaries with two chronic medical conditions or one and at risk of another condition. The state also adds ten qualifying conditions to the list, including blindness, congenital anomalies, and chronic neurological diseases. Enrollment in the program is voluntary through Community Care of North Carolina (CCNC), which will provide health homes services. (Source: Integrated Care Resource Center, State-by-State Health Homes State Plan Amendment Matrix: Summary Overview, Updated June 2012; Kaiser Commission on Medicaid and the Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, August 2012) The SPA will expire in October 2013. (Source: Demonstration Proposal) Health Home-eligible duals will transition to the managed fee-for-service model when the Health Homes SPA expires in October 2013. (Source: NC Response to CMS Questions on Duals Demonstration, 11/2012)
Ohio	**State Demonstration to Integrate Care for Dual Eligible Individuals & Medicaid Managed LTSS Program** CMS announced on December 12, 2012 that Ohio would be the third state to enter into a Memorandum of Understanding (MOU) to test a new model for Medicare-Medicaid enrollees. Ohio and CMS will contract with **Integrated Care Delivery System** (ICDS) plans that will oversee and be accountable for the delivery of covered Medicare and Medicaid services for approximately 115,000 Medicare-Medicaid enrollees in seven regions of the state. (Source: Centers for Medicare and Medicaid Services) The plans will serve most dual eligibles age 18 and older in 29 targeted counties (out of a total 88 counties statewide), and will not include persons with intellectual or developmental disabilities who are otherwise served in §1915(c) HCBS waiver programs or

State	State Updates
Ohio	in ICF/MR facilities. (Source: CMS and Truven Health Analytics, July 2012; State Website) According to an updated timeline posted on the state website, voluntary enrollment in the plans will begin September 1, 2013. (Source: State Website) The demonstration will implement in seven regions composed of three to five counties each, and will use a capitated financial alignment model. (Source: Demonstration Proposal) State Website on Integrated Care Delivery System Notice of delay in implementation (10/5/2012) CMS Press Release (12/12/2012) Memorandum of Understanding The state's three-year duals coordination demonstration – named **MyCare Ohio** – will use a managed care approach to coordinate benefits for residents covered by both Medicare and Medicaid. (Source: State Medicaid website) On February 11, 2014, CMS, the Ohio Department of Medicaid, and the MyCare Ohio Plan entered into a three-way contract, establishing an integrated care delivery system plan to provide integrated care, including LTSS, to Ohio's Medicare-Medicaid beneficiaries. (Source: State Medicaid website) On May 1, 2014, individuals in Northeastern Ohio will begin enrolling in a MyCare Ohio managed care program. Enrollment will be phased in through June and July, until all eligible individuals are enrolled. (Source: MLTSS Weekly Roundup, March 6, 2014; State Medicaid website; MyCare Ohio Enrollment Update) Three-Way Contract (2/11/2014) MyCare Ohio Enrollment Update (1/2014) On May 1, 2014, individuals in Northeastern Ohio began receiving services through MyCare Ohio. (Source: Ohio Medicaid Press Release) **Balancing Incentive Program** CMS announced June 12, 2012 that Ohio will receive an estimated $169 million in enhanced Medicaid funds (2% enhanced FMAP rate). (Source: CMS Balancing Incentive Program Website) BIP Application (Submitted 3/28/2013) On September 30, 2013, the Ohio Department of Medicaid submitted to CMS a Draft BIP Structural Change Work Plan. On January 31, 2014, Ohio submitted to CMS a revised Structural Change Work Plan. Structural Change Work Plan (1/31/2014)

State	State Updates
Ohio	**Health Homes** Ohio's Health Homes State Plan Amendment was approved on September 17, 2012. According to the state's duals demonstration proposal, the Ohio State Medicaid agency engaged in discussions with CMS regarding a proposed State Plan Amendment to create Health Homes for Medicaid beneficiaries who meet the state's definition of serious and persistent mental illness, or SPMI (including adults with serious mental illness, or SMI, and children with serious emotional disturbance, or SED) in five sites (Butler County, Adams County, Scioto County, Lawrence County, and Lucas County), effective October 1, 2012. (Source: CMS Approval Letter) The state planned to expand the services statewide in Spring 2013. (Source: NASUAD) Designed to enhance the traditional patient-centered medical home, the SPA will allow better coordination of physical and behavioral health services. Community behavioral health centers (CBHCs) will be eligible to apply to become Medicaid health homes for individuals with SPMI. At a later date, Ohio Medicaid will implement Medicaid Health Homes focusing on individuals with qualifying chronic physical health conditions. (Source: Duals demonstration proposal) Approved Health Homes State Plan Amendment (9/17/2012) Approval Letter (9/17/2012) State Medicaid Health Homes Website On August 14, 2013, the Ohio Department of Medicaid and the Ohio Department of Mental Health and Addiction Services announced they had decided to delay the Health Home rule packages in order to change the originally proposed rule filings and guarantee program sustainability. The state delayed, but did not withdraw the rule packages. (Source: State Medicaid Health Homes Website; Health Home Packages Delay Notice, 8/14/2013) As of May 2014, Ohio 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)
Oklahoma	**State Demonstration to Integrate Care for Dual Eligible Individuals** The demonstration will cover all full benefit Medicare-Medicaid enrollees including those with intellectual/developmental disabilities statewide, starting July 2013. Under this demonstration, Oklahoma would pursue a three-pronged approach to integrating care for the state's dually-eligible population. The first concept, **SoonerCare Silver** care coordination program will cover dually-eligible members residing in all of Oklahoma's counties

State	State Updates
Oklahoma	(with limited exceptions), utilizing a fee-for-service payment model. Individuals receiving care coordination through other programs, such as Tulsa's Health Innovation Zone (THIZ), PACE and the ICS would be excluded from the SoonerCare Silver care coordination program. All other dually-eligible individuals not receiving care coordination services through their current benefit program would receive care coordination through the SoonerCare Silver program. The second concept, **Tulsa Health Innovation Zone** covers those Medicare-Medicaid members who receive primary care services through participating practices in Tulsa and the surrounding region with a per-member-per-month payment model. The third concept, **ICS Demonstration Model** covers all full benefit Medicare-Medicaid enrollees age 45 and older living in the Oklahoma City or Lawton metropolitan areas and rural areas of the state under a capitated payment model. (Source: Demonstration Proposal) As of March 2014, Oklahoma's Demonstration Proposal is still pending with CMS. (Source: Kaiser Family Foundation website) **Health Homes** Oklahoma has submitted a draft State Plan Amendment to CMS. (Source: CMS Health Home Proposal Status website, 5/2013) According to the state's duals demonstration proposal, Oklahoma Health Care Authority **(**OHCA) is currently partnering with the State Mental Health Authority (SMHA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to implement the health homes model. Health homes are designed to serve people with chronic mental illnesses. Children diagnosed as Serious Emotional Disturbance (SED) - the term used to describe children who qualify, and Seriously Mentally Ill (SMI) - the term for qualifying adults are served by a nurse care manager, who coordinates a team of homes will be hosted by ODMHSAS through the statewide network of community mental health centers (CMHCs) and their satellite locations, which have historically provided community-based mental health services. The CMHCs provide screening, assessment and referral services, emergency services, therapy, psychiatric rehabilitation, case management, and other community support services designed to assist adult mental health consumers with living as independently as possible and to provide therapeutic services for children who are demonstrating symptoms of emotional disturbance. All CMHCs provide services to both adults and children. (Source: Duals Demonstration Proposal) As of April 2014, Oklahoma has not officially submitted a Proposed Health Home State Plan Amendment to CMS. However, the state plans to participate in the Health Home State Plan Option in FY 2014. (Source: CMS Health Home Proposal Status website, 4/2014; Kaiser Health Home website,

State	State Updates
Oklahoma	5/2014)
Oregon	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** Oregon submitted its proposal to CMS on May 11, 2012, but decided not to pursue the demonstration as currently described, which would have relied on a capitated payment model. Oregon Health Authority (OHA) has determined that the demonstration is not likely to be financially viable for Oregon's **Coordinated Care Organizations** (CCOs) and their affiliated Medicare Advantage plans. OHA will explore the feasibility of a modified demonstration with CMS, focusing on delivery system reforms underway in CCOs, paired with Medicare/Medicaid administrative alignments, without the proposed financial component of the financial alignment demonstration. (Source: State website on the demonstration) Demonstration Proposal State website on the demonstration Letter to Coordinated Care Organizations and Stakeholders (10/30/2012) **Amendment to Oregon Health Plan Section 1115 Demonstration Waiver** *(Approved 7/5/2012; Submitted to CMS 3/1/2012)* Oregon Health Plan 2 §1115 Demonstration provides coverage to mandatory and optional State Plan populations through the OHP Plus benefits package, and expands populations with a limited benefits package through OHP Standard. Medicaid eligibles may also elect to receive benefits through a premium assistance program which allows individuals to purchase coverage through the commercial insurance market. (Source: Medicaid.gov) The state (3/1/2012) submitted a Request for Amended Waiver to CMS to seek federal flexibility in several areas including the following: (1) Alternative payment methodologies to reimburse providers on the basis of outcomes and quality through shared savings and incentives; (2) Ability to reimburse non-traditional health care workers such as community health workers, peer wellness specialists, Duals, and personal health navigators; (3) Flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State Plan service but help keep people living in the community; (4) Developing an alternative payment methodology to allow a unique prospective payment system/alternative payment methodology for Federal Qualified Health Centers. (Source: Oregon Division of Medical Assistance Programs Update) Application for Amendment and Renewal (3/1/2012) The Amendment was approved (7/5/2012) by CMS. The demonstration has been extended through June 30, 2017. Under the demonstration, Oregon will launch new **Coordinated Care Organizations** (CCOs), which are managed

State	State Updates
Oregon	care entities that will operate on a regional basis, with enhanced local governance and provider payment structures that promote transparency and accountability. CCOs will replace the specialized managed care entities currently contracted through the Oregon Health Plan. (Source: Current Approval Document, 7/5/2012) Program Website **Coordinated Care Organizations** On May 3, 2012, the U.S. Department of Health and Human Services (HHS) has given the state preliminary approval of a five-year, $1.9 billion demonstration program to create Coordinated Care Organizations (CCOs) in the state's Medicaid program, which Oregon estimates will save $11 billion over coming years by setting a "global budget" for the state's Medicaid program and lowering the percentage it will grow each year. Press Release (5/3/2012) State resource on Coordinated Care Organization 1 Senate Bill 1580 (2012 CCO Implementation) HB 3650 (2011 CCO Creation) **Section 1915(k) Community First Choice Option** Oregon is the second state to receive approval from CMS to implement §1915(k) Community First Choice Option. The approval of Oregon's Community First Choice Option, or **K Plan**, will provide the state approximately $100 million to expand person-centered and community-based services for eligible individuals, effective July 1, 2013. (Source: Press Release, July 1, 2013) State Plan Amendment and other resources **Health Homes** Oregon's Health Homes State Plan Amendment was approved by CMS on 3/13/2012. Oregon's Health Homes targets individuals with two chronic conditions, one chronic condition and a risk of developing another, or one serious mental illness. Services are offered statewide. (Source: Kaiser Commission on Medicaid and the Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, August 2012) Approved Health Homes State Plan Amendment (3/13/2012)
Pennsylvania	**Currently Operating Medicaid Managed LTSS Program** Since 2009, Pennsylvania has provided **Adult Community Autism Program** to adults of age 21 or higher with diagnosis of Autism Spectrum Disorder under the authority of Medicaid §1915(a). Services included in the

State	State Updates
Pennsylvania	capitation rate are primary, behavioral, dental, ICF/MR, targeted case management, adult day, and occupational therapy/physical therapy/speech therapy (OT/PT/ST). The program is operating in four (out of 67) counties, and enrollment is voluntary. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Program Website
Rhode Island	**Medicaid Managed LTSS Program** On December 23, 2013, CMS approved the state's **Comprehensive §1115 Demonstration** renewal request. In its March 28, 2014 Draft Comprehensive Quality Strategy for the §1115 Demonstration, Rhode Island described **Rhody Health Options (RHO)** as the LTSS aspect of its Integrated Care Initiative. RHO represents the integration of Medicaid LTSS services into a managed care delivery system. (Source: Rhode Island HHS website) Rhode Island Comprehensive Demonstration (Approved 12/23/2013) Stakeholder Notice (3/28/2014) **State Demonstration to Integrate Care for Dual Eligible Individuals** Under the demonstration titled **Integrated Care for Medicare and Medicaid Beneficiaries,** Rhode Island proposes to enroll approximately 12,000 Medicaid-only enrollees and 23,000 Medicare-Medicaid enrollees. Services for persons with Intellectual/developmental disabilities and persons with serious mental illness are carved out in 2013, with possibility of being included in 2014. (Source: CMS and Truven Health Analytics, July 2012) Demonstration Proposal State Presentation on Duals Demonstration (7/23/2012) In November 2013, the state implemented Phase I of the **Integrated Care Initiative**. In February 2014, the final group of Medicare/Medicaid recipients and Medicaid-only recipients to enroll (adults with I/DD and Adults with Serious and Persistent Mental Illness (SPMI)) received voluntary enrollment letters. The following services will remain the same during Phase I: Long-term Services & Supports for adults with IDD; and Intensive Behavioral Health Services for adults with SPMI. April 2015 has been set as the tentative start date for Phase II of the Integrated Care Initiative. Phase II will fully integrate Medicaid and Medicare services delivered by a health plan. (Source: State Integrated Care Initiative Update, February 2014) Integrated Care Initiative Update (2/18/2014) Integrated Care Initiative Phase II Draft Timeline (3/26/2014)

State	State Updates
Rhode Island	As of March 2014, the state's Demonstration Proposal is pending with CMS. (Source: Kaiser Duals Demonstration Proposal Status Map, March 2014) In May 2014, Rhode Island released an updated timeline for its dual eligible demonstration; the state anticipates beginning the program in April 2015. (Source: State HHS website) Integrated Care Initiative Phase II Timeline, 5/5/2014 **Health Homes** Rhode Island has two approved Health Homes State Plan Amendments implemented statewide, effective October 1, 2011. Rhode Island Community Mental Health Organization Health Homes State Plan Amendment (approved 11/23/2011) targets individuals with a serious and persistent illness (SPMI). Rhode Island CEDARR Family Center Health Homes State Plan Amendment (approved 11/23/2011) is for children and youth under age 21 with diagnosis of severe mental illness or serious emotional disturbance, or with two of the following chronic conditions, or have one and at risk of developing another: mental health condition, asthma, diabetes, DD, Down syndrome, mental retardation, or seizure disorder. (Source: Integrated Care Resource Center, State-by-State Health Homes State Plan Amendment Matrix: Summary Overview, Updated June 2012; Kaiser Commission on Medicaid and the Uninsured, Medicaid Health Homes for Beneficiaries with Chronic Conditions, August 2012) Approved CEDARR Health Home State Plan Amendment (Effective 10/1/2011) Approved Community Mental Health Organization Health Home State Plan Amendment (Effective 10/1/2011) The state submitted to CMS a draft Health Homes State Plan Amendment for a third health home. (Source: CMS 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 will target opioid-dependent Medicaid recipients who currently receive or meet the criteria for Medication Assisted Treatment. (Source: CMS Health Home SPA Matrix, March 2014; 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

State	State Updates
South Carolina	CMS/CMMI to implement a dual eligible initiative titled **Healthy Connections Prime**. The South Carolina demonstration will employ a three-way contract with Coordinated & Integrated Care Organizations (CICOs) to provide benefits to dual eligibles statewide under a capitated model of financing. The state indicates that the demonstration will begin no sooner than July 1, 2014 and continue until December 31, 2017. Demonstration Proposal Memorandum of Understanding State Website on Duals Demonstration South Carolina has defined the individuals eligible to participate in the demonstration as persons 65 and over: (1) living in the community at the time of enrollment, (2) receiving full Medicaid benefits, (3) entitled to benefits under Medicare Part A, and (4) enrolled under Medicare Parts B and D. Individuals receiving HCBS services (e.g. HIV, Vent, and Community Choices) are also eligible for the demonstration. The state will not include individuals with intellectual or developmental disabilities in the demonstration. Enrollment includes an opt-in period followed by passive enrollment, but beneficiaries can opt-out, as well as change plans at any time. (Source: South Carolina Memorandum of Understanding; Integrated Care Workgroup Session, 10/17/2013) The state initially planned to carve HCBS waiver services out of the demonstration, but recently revised the proposed model to carve-in home- and community-based services. (Source: SCDuE Weekly Roundup, 7/3/2013)
South Dakota	**Health Homes** The state submitted a draft Health Homes State Plan Amendment to CMS. (Source: CMS Health Home Proposal Status website, 4/2013) On November 22, 2013, CMS approved the state's Health Home State Plan Amendment, with an effective date of July 2, 2013. The Health Home will target Medicaid recipients with two or more chronic conditions, one chronic condition and the risk of developing another, or one serious and persistent mental health condition. (Source: CMS Health Home SPA Matrix, March 2014; 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	**Currently Operating Medicaid Managed LTSS Program** Under TennCare II §1115 Demonstration Waiver, **TennCare CHOICES** provides primary, acute, behavioral, nursing facility, and HCBS waiver-type

State	State Updates
Tennessee	services to eligible persons of all ages residing in nursing homes, adults under age 65 with physical disabilities, and adults age 65 and higher. At inception in 2010, LTSS was added to the existing TennCare managed care demonstration. The program is operating statewide, and enrollment is mandatory. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Website on TennCare CHOICES **Amendment to TennCare II Section 1115 Demonstration Waiver** (Approved 6/15/2012; Extension request submitted 6/29/2012) Under this demonstration, all Medicaid State Plan-eligibles (except those eligible only for Medicare premiums) are enrolled in TennCare Medicaid and receive most of the State Plan services through the demonstration's managed care delivery system. The recently submitted amendment pertains to the CHOICES program, which is Tennessee's Medicaid managed long-term care program. CHOICES serve three groups: CHOICES 1 serves nursing facility residents; CHOICES 2 serves elderly adults or adults with physical disabilities who meet nursing facility level of care, but who have elected to receive home and community based services; CHOICES 3 serves elderly adults or adults with physical disabilities who do not meet nursing facility level of care, but are "at risk" for institutionalization. The amendment seeks to increase the enrollment target for CHOICES 2, effective July 1, 2012. (Source: Medicaid.gov & application to CMS) Application for Amendment Amendments #14 and #16 for the demonstration were approved by CMS (6/15/2012). Amendment #14, effective as of July 1, 2012, authorizes an increase to the enrollment targets for the CHOICES 2 program and approves the rebalancing of the CHOICES managed long-term care program and the creation of *Interim* CHOICES 3. Amendment #16 pertains to Disproportionate Share Hospital allotment. The Department of Finance and Administration submitted a three-year extension request to CMS on 6/29/2012. (Source: Centers for Medicare & Medicaid Services) Current Approval Document Three-year Extension Request Document **State 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-

State	State Updates
Tennessee	Medicaid Coordination Office) (Prior to Tennessee's decision to withdraw from the duals demonstration, the State had proposed, via **TennCare PLUS,** to enroll full benefit dual eligibles, except PACE participants, starting January 1, 2014, statewide. The demonstration would not have included LTSS for persons with intellectual disabilities (including ICF/MR and §1915(c) waiver services), but dually-eligible members receiving these services would have been included in the demonstration for all other Medicare and Medicaid services. The now-withdrawn demonstration would have operated under a capitated payment model. For more information, click here.) (Source: Demonstration Proposal)
Texas	**Currently Operating Medicaid Managed LTSS Program** Through Medicaid §1115 authority, **Texas STAR+PLUS** (inception: 1998) provides primary, acute, behavioral, and LTSS (Personal Attendant, Assisted Living, PERS, nursing, Adult Foster Care, dental, respite, home-delivered meals, OT/PT/ST, consumer directed services, home mods, medical supplies) to eligible adults age 21 and older with disability (SSI), adults age 21 and older in Community-Based Alternatives HCBS waiver, adults age 65 and older, and full-benefit Medicare-Medicaid enrollees. Certain groups are excluded, such as people living in nursing facilities, ICFs-MR, and in HCBS waivers other than the community-based alternatives waiver. Enrollment is mandatory for full-benefit Medicare-Medicaid enrollees. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Program Website Under **Healthcare Transformation and Quality Improvement Program §1115 demonstration waiver** (Approved 12/12/2011), Texas is expanding STAR and **STAR+PLUS** (MMLTC) statewide and using savings from the expansion of managed care and the discontinuation of supplemental provider payments to finance new funding pools to assist hospitals and other providers with uncompensated care costs and to promote delivery system transformation and improvement. The Texas Health & Human Services Commission submitted a proposed amendment to the §1115 on 5/3/2012, proposing to add Day Activity Health Services to the existing STAR+PLUS waiver, effective September 1, 2012. The service targets individuals who are eligible for the STAR+PLUS waiver and exceed 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)

State	State Updates
Texas	The Texas Health and Human Services Commission (HHSC) promulgated new permanent payment rules that implement the provider eligibility requirements and payment methodologies approved by CMS under the §1115 Healthcare Transformation and Quality Improvement Program waiver. (Source: Texas Register, June 22, 2012) State information on the adopted rules On June 19, 2013, the state submitted a further amendment to its §1115 demonstration waiver; and CMS approved the amendment on March 6, 2014. The amendment allows the state to make several managed care changes to the §1115 waiver, including carving nursing facility services into managed care and adding additional mental health services and HCBS to managed care. The addition of cognitive rehabilitative services is effective March 6, 2014; all other amendment changes are effective September 1, 2014. (Source: CMS.gov) Request for Amendment (Submitted 6/19/2013) Approval Document (Effective 3/6/2014 and 9/1/2014) In a March 2014 information session, Texas HHS verified it will expand STAR+PLUS statewide on September 1, 2014. On this date, the state will implement the Behavioral Health carve-in to managed care and I/DD acute care service carve-ins to managed care. People living in nursing facilities will 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) **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** Texas' **Dual Eligible Integrated Care Model** targets full dually-eligible adults, who are required to participate in STAR+PLUS. Capitated Medicaid Managed Care Organizations will offer a full array of Medicaid and Medicare services for the targeted population. Starting January 1, 2014, the demonstration was originally planned to be implemented statewide, with the possibility of phase-in implementation beginning with the most populous counties. (Source: Demonstration Proposal) A Texas state official, however, confirmed that the demonstration would be implemented in limited geographic areas, i.e., 19 counties with the largest number of dually-eligible beneficiaries. (Source: NASUAD) Individuals with intellectual/developmental disabilities are fully carved out of this demonstration. (Source: NASDDDS Managed Care Tracking Report, October 2012) As of March 2014, the state's Demonstration Proposal is pending with CMS. (Source: Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014) On March 24, 2014, the state provided an update on its dual eligible demonstration, indicating it is close to entering into three-way contracts with CMS and STAR+PLUS health plans in six counties. The state plans to finalize contracts with MCOs by August 2014 and begin the project by January 15, 2015. Duals can opt out of the demonstration. (Source: HMA Weekly Roundup, January 29, 2014; HMA Weekly Roundup, March 26, 2014) On May 23, 2014, CMS and the state announced that they finalized their MOU. (Source: CMS.gov) Memorandum of Understanding **Cost-Sharing Methodology for Dual Eligibles** HHSC also amended regulations regarding the coordination of Medicaid with Medicare Parts A, B, and C. The rule authorizes the Commission to make higher cost-sharing payments for dual eligibles for certain services if the commission determines that a higher payment amount is necessary to ensure adequate access to care or would be more cost-effective to the state. HHSC will have to request and receive approval for a Medicaid State Plan

State	State Updates
Texas	Amendment from the Centers for Medicare & Medicaid Services in order to implement specific adjustments to the Medicare Equalization policy. The changes will implement coincident with the effective date of the State Plan Amendment. (Source: Texas Register, June 22, 2012) State information on the adopted rules **Balancing Incentive Program** On September 4, 2012, CMS approved the state's BIP application, awarding $301.5 million of enhanced Medicaid funds. Texas must implement the required structural changes and achieve a 50 percent benchmark of Medicaid community-based LTSS expenditures by October 2015. HHSC has delegated coordination of BIP activities to DADS. (Source: State website) BIP application (Submitted 6/29/2012) BIP Structural Change Work Plan **Section 1915(k) Community First Choice Option** Senate Bill 7 calls for implementation of the Community First Choice Option for individuals with intellectual/developmental disabilities in STAR+PLUS. For more information on the bill, click here. If enacted, the option would allow managed care organizations to provide basic attendant and habilitation service to 11,902 people with intellectual/developmental disabilities. (Source: Texas Legislature Key Features of SB7, April 29, 2013) The state currently provides these services to certain elderly or disabled Medicaid enrollees who would otherwise be eligible for nursing facility care. The bill sponsor projects that implementing Community First Choice would expand services to Medicaid enrollees with a disability who might otherwise be eligible for care in an ICF/IID. The 6% enhanced match would apply to certain existing services and those provided to the expanded population. According to a timeline contained in the Fiscal Note attached to the Senate bill, implementation of CFC would begin by September 1, 2014. (Source: Fiscal Note, 83rd Legislative Regular Session, February 25, 2013) Cost projections in the Fiscal Note attached to the legislation indicate that wages for those that provide habilitation services would be about 25% less than current HCS habilitation wages. IDD Local Authorities would coordinate the new CFC service, but would not provide the CFC service. Current CLASS, HCS and TxHmL providers would be eligible to provide the new IDD service. (Source: Texas Legislature Key Features of SB7, April 29, 2013)

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

State	State Updates
Vermont	Amendment, with an effective date of July 1, 2013. (Source: CMS Health Home Proposal Status website, 3/2014; Medicaid.gov website) Approved Health Home State Plan Amendment (Effective 7/2/2013)
Virginia	**State Demonstration to Integrate Care for Dual Eligible Individuals** Virginia's duals demonstration proposes to cover full benefit Medicare-Medicaid enrollees (age 21 and older), older persons and persons with physical disabilities, nursing facility residents, and persons who receive services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver. Persons with intellectual/developmental disabilities who are not in the EDCD Waiver are excluded from the program. Assisted living services, intellectual/developmental disability services, and PACE programs will be carved out. The state targeted January 2014 for initial implementation in four regions, utilizing voluntary enrollment with opt out. (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) Demonstration Proposal State Website on Duals Demonstration On May 21, 2013, then-Governor Bob McDonnell announced that Virginia has signed a Memorandum of Understanding (MOU) with CMS to implement its Medicare-Medicaid Enrollee Financial Alignment Demonstration, aimed at coordinating care for more than 78,000 Virginians currently enrolled in Medicare and Medicaid. Under this initiative, branded as **Commonwealth Coordinated Care**, Virginia and CMS will enter into a contract with health plans for the delivery of coordinated services and supports to enrollees. Eligible individuals include older adults and individuals with disabilities, including those receiving long-term services and supports, and who live in designated regions around the Commonwealth. The regions include the areas surrounding: Central Virginia/Richmond, Charlottesville, Tidewater, Roanoke and Northern Virginia. (Source: Press Release, May 21, 2013) Memorandum of Understanding On December 4, 2013, the state and CMS entered into a three-way contract with health plans for the delivery of coordinated services and supports to enrollees. (Source: NSCLC Dual Eligible State Profiles website, March 2014) Three-Way Contract (12/4/2013) In May 2014, Virginia began voluntary enrollment in Commonwealth Coordinated Care in the Staunton-Augusta-Waynesboro areas of the state and sent enrollment letters to area residents. Automatic enrollment in these locations will begin in August 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;

State	State Updates
Virginia	HMA Weekly Roundup, 5/21/2014)
Washington	**Currently Operating Medicaid Managed LTSS Program** After inception in 2005, an LTSS component was added to **Washington Medicaid Integration Partnership** (WMIP). Under the program, WMIP covers primary, acute, behavioral, prescription drugs, and LTSS (nursing facilities and community-based services) at a capitated rate. Groups enrolled include adults age 21-64 with SSI or SSI-related Medicaid and adults age 65 and older. Enrollment is voluntary, and a very limited geographic area is covered. (Source: CMS and Truven Health Analytics, July 2012) State Resource on WMIP (December 2010) **State Demonstration to Integrate Care for Dual Eligible Individuals** (Managed Fee-For-Service Model & Capitated Model) **HealthPath Washington** (formerly Pathways to Health), Washington State's Medicare & Medicaid Integration Project, proposes to realign and integrate care through three strategies: 1. Health Homes (managed fee-for-service financial model); 2. Full Financial Integration Capitation (three-way capitation financial model); and 3. Modernized and Consolidated Service Delivery with Shared Outcomes and Aligned Financial Incentives (capitation and fee-for-service). The project's target population is full benefit Medicare-Medicaid enrollees of all ages. **Strategy 1: Health Homes (Managed Fee-For-Service Model)** Approved (10/25/2012) On October 25, 2012, CMS approved the first strategy in the state's Financial Alignment demonstration proposal. According to the Memorandum of Understanding, the state would implement this Managed Fee-for-Service Financial Alignment Demonstration on April 1, 2013. The Washington Health Care Authority Department of Social and Health Services later said the state will introduce Health Homes on July 1, 2013. (Source: Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: California, Illinois, Massachusetts, Ohio, and Washington, Kaiser Commission on Medicaid and the Uninsured, May 2013; Washington Health Care Authority Pilot Program website) Under the demonstration, eligible Medicare-Medicaid enrollees elect to receive health home services from Health Home Care Coordinators, supplemented by multidisciplinary teams that coordinate across disciplines, including primary, acute, prescription drugs, behavioral health, and long-term services and supports (LTSS). Health home services include:

State	State Updates
Washington	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 Washington Managed FFS Model Final Demonstration Agreement (6/28/13) **Strategy 2: Full Integration Capitation (Three Way Contract between Health Plan/State/CMS)** MOU Signed (11/25/2013) **HealthPath Washington** is Strategy 2 Financial Alignment Demonstration; this strategy will use a full-risk managed care model of health delivery that coordinates Medicare and Medicaid medical services, behavioral health services, and long-term services and supports. The Demonstration will be available to adults and children of King County and Snohomish County who are eligible for both Medicare and Medicaid, and for whom the state has a responsibility for payment of cost sharing obligations under the Washington State Plan. Beneficiaries may not be concurrently enrolled in the Demonstration and a Medicare Advantage Plan, the Program of All-inclusive Care for the Elderly (PACE), or a Medicare Hospice Program. Beneficiaries may participate in and are eligible for enrollment in the Demonstration if they voluntarily dis-enroll from their existing programs. Beneficiaries who are on the Medicaid Fee-for-Service delivery system and the Medicare Fee-for-Service delivery system and are receiving Medicare ESRD benefits may also voluntarily enroll in the Demonstration. At a future date, subject to additional discussions with CMS and other interested parties, Washington may also include beneficiaries receiving developmental disabilities §1915(c) home and community-based waiver services. If this population is included, the Medicare-Medicaid Integrated (MMI) Plans (managed care plans) will be responsible for services specified in the negotiated 3-way contract. The demonstration will begin on April 1, 2014. (Source: Washington State Health Care Authority Request For Application (RFA) NO. 2013-003, revised April 17, 2013)

State	State Updates
Washington	Strategy 3 will be provided in counties where full capitation is not available. It will include Medicaid services for individuals with intellectual or developmental disabilities (I/DD) through a fee-for-service model. (Source: Demonstration Proposal; NASDDDS Managed Care Tracking Report, October 2012) HealthPath Washington project website HealthPath Washington Medicaid Health Homes Website HealthPath Washington Medicaid Health Homes Presentation (6/21/2012) In November 2013, CMS and the state signed a Memorandum of Understanding for the state's capitated model demonstration proposal. (Source: CMS Demonstration Approvals website; Kaiser Family Foundation Duals Demonstration Proposal Status Map, March 2014; NSCLC Dual Eligible State Profiles website, March 2014) Memorandum of Understanding (11/25/2013) Washington Capitation Readiness Review Tool (12/27/2013) Washington Health Care Innovation Plan (12/2013) **Health Homes** The state submitted a draft Health Home State Plan Amendment to CMS. (Source: CMS Health Home Proposal Status website, 4/2013) Following CMS approval of the SPA, implementation of Health Homes started on July 1, 2013. The initial strategy focuses on all Medicaid clients in 37 of 39 counties who have select chronic conditions and at greater risk for costly and poorly coordinated health care services. The state plans a second strategic approach for the remaining two counties (Snohomish and King), but that phase won't begin until next year. (Source: Health Homes News Release, June 28, 2013) State Website on Health Homes Health Homes Updated Fact Sheet (6/8/2013) Washington Health Home State Plan Amendment (Effective 7/1/2013) On September 17, 2013, the state submitted an additional proposed Health Home State Plan Amendment to CMS. On December 11, 2013, CMS approved the state's Health Home State Plan Amendment, with an effective date of October 1, 2013. The Health Home will target Medicaid recipients with two or more chronic conditions; one chronic condition and the risk of developing another; or one serious and persistent mental health condition. (Source: 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)

State	State Updates
West Virginia	**Health Homes** According to West Virginia's proposed Health Home State Plan Amendment, the state will implement Health Homes in a limited geographic area. Individuals eligible for health home services will have a diagnosis of bipolar disorder, with specific attention being given to risk for Hepatitis B and/or C. (Source: State Website on Health Homes) Proposed Health Home State Plan Amendment CMS has approved West Virginia's Health Home Planning Request. (Source: CMS Health Home Proposal Status website, 4/2014), and as of May 2014, the state has 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: State Website on Health Homes; NASUAD)
Wisconsin	**Currently Operating Medicaid Managed LTSS Programs** Wisconsin has two MLTSS programs. **Wisconsin Family Care** (under §1915(b) and §1915(c)) provides LTSS to adults under age 65 with physical disabilities, adults under age 65 with intellectual/developmental disabilities, and adults of age 65 and older. HCBS waiver services are only available to members who are a nursing home level of care, and primary, acute, and prescription drugs services are excluded from capitation rate. Enrollment is voluntary (choice of Family Care, Family Care Partnership, PACE, or IRIS depending on what is offered in the county and individual's functional level of care) with opt in. The program covers 57 counties in the state (out of 72 counties). Effective April 3, 2012, temporary caps on enrollment in the Family Care or IRIS programs were lifted. More information on Family Care is available here and here. (Source: dhs.wisconsin.gov) **Wisconsin Family Care Partnership** (FC-P) (under §1932(a) and §1915(c)) provides Medicare cost-sharing, behavioral health (not covered by Medicare), prescription drugs (not covered by Medicare), LTSS (HCBS and institutional), and other services including case management, dental, hospital, hospice, and therapies. Groups enrolled are adults under age 65 with physical disabilities, adults under age 65 with developmental disabilities, and frail adults of age 65 and older. Enrollment is voluntary with opt in. The program covers 19 counties in the state (out of 72 counties). (Source: CMS and Truven Health Analytics, The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012) State Program Website Waiver Application NASUAD & n4a presentation (4/5/2011)

State	State Updates
Wisconsin	**State Demonstration to Integrate Care for Dual Eligible Individuals (Withdrawn)** Wisconsin's proposed demonstration, Virtual PACE, will include all people who are full dual eligible members over the age of 18 residing in a Nursing Home (NH) on a long-term basis and receiving Medicaid services via the fee-for-service system at the time of enrollment. On January 1, 2013, Wisconsin will implement Virtual PACE in the Southeastern region, and then statewide in 2015. The demonstration will use a capitated payment model. (Source: Demonstration Proposal) State website on the demonstration 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(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** The state's Health Homes State Plan Amendment received approval from CMS (10/1/2012). The service targets Medicaid and BadgerCare Plus members with a diagnosis of HIV/AIDS and who have at least one other diagnosed chronic condition or is at risk of developing another chronic condition. (Source: Approved Health Homes State Plan Amendment)

State	State Updates
Wisconsin	Approved Health Homes State Plan Amendment (Effective 10/1/2012) As of May 2014, Wisconsin 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)

State Medicaid Integration Tracker©

NASUAD National Association of States United for Aging and Disabilities

STATE TRACKER FOR DUALS DEMONSTRATION

(Updated as of: 6/1/2014)

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

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

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

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

National Association of States

United for Aging and Disabilities

1201 15th Street NW, Suite 350

Washington, DC 20005

Phone: 202-898-2578

www.nasuad.org