

Long-Term Services and Supports Opportunities in the Affordable Care Act

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States face multiple challenges in considering whether to pursue opportunities in the Affordable Care Act (ACA) that would increase the community-based long-term services and supports (LTSS) available to Medicaid beneficiaries. Currently, 43 states and the District of Columbia have Money Follows the Person (MFP) Demonstration projects and states are now reviewing three new opportunities: the Balancing Incentive Payments (BIP) Program, the Community First Choice Option State Plan option (1915(k)), and the modified Home- and Community-Based State Plan option (1915(i)). Part of states' decision-making process includes weighing the additional administrative costs these programs may create in today's challenging budget climate and the accompanying need for short-term savings. On a more basic level, states need assistance identifying how these new options may support each other and fit within their existing programs and how specific requirements including care coordination, data reporting, and performance measurement differ or potentially support each other across opportunities.

This technical assistance brief was developed by the Center for Health Care Strategies, with support from The SCAN Foundation, to help states assess LTSS options. It provides high-level descriptions of MFP, BIP, the Community First Choice Option, and modified Home- and Community-Based State Plan option, and describes specific features of each option:

- Budget impact/federal medical assistance percentage (FMAP) opportunity;
- Application process;
- Participant eligibility;
- Care coordination/plans; and
- Data reporting/performance measures/evaluations.

Money Follows the Person Demonstration

The MFP demonstration is a federal initiative to assist states in reducing the use of institutionally-based care for persons

IN BRIEF

States now have more tools available to rebalance the provision of long-term services and supports towards more home- and community-based services and away from institutionally based care. In addition to the Money Follows the Person demonstration program, the Affordable Care Act created the Balancing Incentive Payments program, the state plan Community First Choice Options program, and the modified Home- and Community-Based State Plan option (1915(i)). Selecting the appropriate program(s) to implement is made complicated by the sometimes overlapping and differing requirements of these options.

This technical assistance brief describes the different LTSS program options available to states with particular emphasis on their budget impacts; application processes; and requirements for participant eligibility, care coordination, and data reporting. It also discusses the ways in which the different options for providing LTSS interact with each other and with existing state LTSS structures.

needing LTSS and increasing the availability of home- and community-based services (HCBS). MFP was created by the Deficit Reduction Act of 2005 and expanded by the ACA, which extended the demonstration through September 2016 and appropriated an additional \$2.25 billion in support. Current grants cover state fiscal years 2012-2016.

The states participating in the original MFP demonstration each started their programs under a unique set of circumstances. Some were already actively attempting to rebalance their LTSS programs, while others faced rebalancing challenges related to their large size and low population density. Still other states developed their programs to confront serious budget constraints. These circumstances led some states to set ambitious goals for their MFP programs, while others were forced to plan for projects with a smaller scope.

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States just starting to implement their MFP programs and those with existing programs must not only consider the difficulty of implementing the MFP program's requirements, but also how MFP will interact with new LTSS opportunities in the ACA and their states' existing long-term care landscapes.

Budget Impact/FMAP Opportunity:

States receive enhanced FMAP for one year for qualifying beneficiaries who meet MFP eligibility criteria and transition to a qualifying residence in the community.¹ MFP funds are available for qualified HCBS and demonstration services, supplemental services only available through the MFP demonstration period and not covered by Medicaid, and specific administrative costs such as: key personnel; MFP travel, training, outreach and marketing; information technology infrastructure to accommodate the MFP reporting requirements; and completing the Quality of Life survey requirements. Costs associated with participation in the national demonstration evaluation and submission of financial and programmatic data may be reimbursed entirely through grant funding.²

Application Process: The MFP application period has closed; 43 states and the District of Columbia currently have MFP grant awards.

Participant Eligibility: Medicaid enrollees who currently reside in a nursing facility and have done so for 90 consecutive days.

Care Coordination/Plans: MFP permits transitions of beneficiaries who have been in institutions for “not less than 90 consecutive days” to be transitioned out, rather than the previous six month requirement.

The Centers for Medicare and Medicaid Services (CMS) Invitation to Apply allowed for states to provide beneficiaries with the opportunity to self-direct their services meaning that the participant has the authority to exercise decision making

authority over some or all of her/his services and accepts the responsibility for taking a direct role in managing them. It promotes personal choice and control over the delivery of waiver services. Supports for participant direction include information and assistance to help people manage their waiver services and financial management.

Targeted case management for long-term care is defined in the invitation as “services that assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.”

HCBS waiver service definitions include Case Management Services defined as “Services which will assist beneficiaries served by a HCBS program in gaining access to needed HCBS and other state plan services, as well as needed medical, social, educational and other services, without regard to the payment source for the services to which access is gained. Components of case management may also include assessment, development of service plans, referral and related activities, oversight, quality monitoring, and participation in activities related to remediation.”

Data Reporting/Performance

Measures/Evaluations: CMS will be conducting a national evaluation that will collect data and report on the demonstration programs' impacts. Very specific information will be gathered from states, including evidence that:

- States administer Quality of Life (QoL) surveys and submit data. QoL surveys must assess MFP participants' living situations, choice and control, access to personal care, respect/dignity, community integration and inclusion, overall satisfaction with life, and health status. States must administer the QoL survey after an individual is accepted into the demonstration, prior to

transition to community, and at 11 months and then 24 months after transition to the community;

- Resources have been rebalanced to provide more beneficiaries with LTSS in the community, including how many consumers have successfully transitioned, of those, how many are now enrolled in HCBS waiver programs and number that have remained in the community two years following the initial 12 month transition period. If transitions to the community were not sustained, states must provide documentation of the reasons why;
- Barriers that prevented and/or restricted flexible use of Medicaid funds to support people in the setting of their choice have been eliminated;
- Sustainable processes and systems changes supporting beneficiaries in the community have been implemented, diversion of people to unnecessary institutionalization has been decreased, flexible use of Medicaid funds has been implemented, and the continuity of services and assurance of health and

safety after transitions has been assured;

- Quality assurance and quality improvement procedures and outcomes showing needed services are provided in the community are in place; and
- States are monitoring the costs of providing HCBS to populations and beneficiaries transitioned in comparison to cost of services provided in institution.

States may also choose to conduct their own individual evaluations. They must, however, provide individual MFP participant-level data prior to transition and during demonstration period from official administrative records. Semi-annual, web-based reports provide data that address the following aspects of program implementation:

- **Structure:** Implementation of program changes to rebalance resources and transition and maintain beneficiaries in community;

Case Study: Money Follows the Person Implementation

Washington State viewed the MFP program as another tool in its ongoing effort to rebalance its LTSS system. At the time of its application to the MFP program in 2006, Washington had already established a nursing facility transition program and supported more individuals in the community (76 percent) than in institutional settings (24 percent).³ MFP program funds were used to connect with beneficiaries and their families who previously declined to move to the community because they thought their service needs were too high. Washington's MFP program entitled "Roads to Community Living" (RCL) also targeted people with complex needs who had been unable to move within the existing system. RCL used targeted, intensive relocation services and behavioral supports to help. The state conducted outreach activities to families, providing them with intensive training and skill building to reassure them that their family members would do well in the community.

After steadily increasing the number of people transitioning to the community through the RCL program, Washington met its target of 660 people two and a half years into the five year grant and, as of September 2011, more than 1,500 people have transitioned back to the community.⁴ Washington's rapid implementation of its MFP demonstration program can be attributed to several factors. They had a well-established community-based LTSS system before the start of the demonstration, a standardized universal assessment tool, and good data to support the program. In addition, state staff and community providers were already familiar with the goals of and process for transitioning people to the community.

Other states starting their MFP programs with less established infrastructures to build upon have had a more difficult time with implementation. Many have faced budget shortfalls that have led to staffing reductions, cuts to HCBS program funding, and reduced provider reimbursement rates. Given this operating environment, states must leverage MFP funds as they consider whether to pursue BIP or 1915(i) and 1915(k) State plan options. One way to accomplish this would be to use MFP funds to bolster LTSS infrastructure (developing data collection instruments, acquiring new information technology) while using other programs to fund direct service provision.⁵

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- **Process:** Implementation of strategies and procedures of the demonstration including a Quality Management Strategy;
- **Output:** Products of the program such as waiver and state plan amendments, state legislation, agency changed, new policies and procedures; and
- **Outcomes:** Results of the program (i.e. what changed, who was transitioned, community settings beneficiaries moved to).

In addition, states must submit specific financial reporting forms on a quarterly, semi-annual, or annual basis.⁶

State Balancing Incentive Payments Program

The State Balancing Incentive Payments (BIP) program (Section 10202 of the ACA) provides funds to rebalance LTSS expenditures toward HCBS provision. BIP enables states that currently spend less than 50 percent of their long-term care expenditures on HCBS to receive additional federal matching funds for HCBS for fiscal years 2012 through 2015. Effective October 1, 2011, the BIP program provides this targeted FMAP increase to states that achieve specified HCBS expenditure targets and undertake specific structural reforms designed to increase nursing home diversions and access to HCBS.

States must establish three structural changes: (1) a single point of entry system for individuals to access LTSS statewide (no wrong door/single entry point system); (2) conflict-free case management; and (3) a core standardized assessment instrument (CSA) for determining eligibility for services. These three requirements must be met within 6 months of submission of the state’s application.

Many states are currently reviewing this opportunity and are engaging in discussions with CMS for clarification on program requirements. Specifically, states are inquiring what the requirements are for

“conflict-free case management” in a managed long-term service environment. States are additionally considering how to set up information systems to support the no wrong door/single point of entry (NWD/SPE) system.

Budget Impact/FMAP Opportunity:

Participating states must also meet certain rebalancing targets for HCBS expenditures to receive the enhanced FMAP.⁷

States spending less than 25 percent of LTSS expenditures for community-based services will receive a five percent FMAP increase on LTSS expenditures and will be expected to reach a 25 percent expenditure target. States with 25 to 50 percent of LTSS expenditures for community-based services will receive a two percent FMAP increase on LTSS expenditures and be required to reach a 50 percent expenditure target. Both groups must achieve these targets by October 1, 2015.⁸

BIP payments must be invested in community-based direct services and states may couple efforts required as part of MFP demonstrations with the BIP program to meet streamlined eligibility and enrollment requirements (e.g., the NWD/SPE) and establish a core standardized assessment instrument. Additionally, funding plans must identify funding sources to support BIP (including developing NWD/SPE system and use of CSA).

Application Process: To participate in the BIP program, states must submit an application to the federal government that must specify the state’s plans to expand and diversify HCBS during the BIP program period and achieve the target spending percentage through implementing the required structural reforms.⁹

Participant Eligibility: States may not adopt more restrictive standards for HCBS eligibility than were in effect on December 31, 2010. However, states may raise financial eligibility standards to provide HCBS services to more people. Specifically,

they may propose to expand the provision of HCBS through a state plan amendment under section 1915 (i) and elect to increase income eligibility for such services from 150 percent of the federal poverty level (FPL) to a higher percentage not to exceed 300 percent FPL.

Care Coordination/Plans: States must provide conflict-free case management. This requires separation of case management from direct service provision and separation of eligibility determination from direct service provision. Additionally, case managers may not establish funding levels for beneficiaries and individuals performing evaluations, assessments, and plans of care cannot be related by blood or marriage to the beneficiary or any of the beneficiary's paid caregivers, financially responsible for the beneficiary, or empowered to make financial or health related decisions for the beneficiary.

States must develop CSAs to focus on the beneficiary's need for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and focused on beneficiary's true needs (i.e. person-centered). The CSA will include an initial assessment and a comprehensive assessment. The CSA is intended to provide states with information about the needs of all beneficiaries. CMS will make a prototype CSA tool available to states. For states not using the prototype, a CSA will be required to collect a core set of data elements.¹⁰ The BIP Implementation Manual (p. 69-72) provides a list of seven CSA tools developed by states, and six assessment instruments used more broadly by states highlighted by CMS for their "unique qualities."

Data Reporting/Performance

Measures/Evaluations: To evaluate states' performance, CMS will require the states to collect the following:

- Service utilization data from providers of non-institutionally-based LTSS on an individual beneficiary basis;

- Quality data on core quality measures that are linked to population-specific outcomes measures; and
- Data on a selected set of core population-specific outcomes measures, including beneficiary and family caregiver experience with providers and satisfaction with services and achieving desired outcomes appropriate to specific beneficiaries.

States are not required to report the above quality and outcome data and/or measures to CMS.¹¹ However, specific reporting to CMS includes:

- Submitting a preliminary work plan with the application and a finalized work plan within six months of submission describing in detail "how the NWD/SPE utilizing a CSA and conflict-free case management will be operationalized in the State during the four year Balancing Incentive Program period." Measurable milestones must be identified throughout the program period; and
- Submitting quarterly programmatic progress reports. The report is to include data reflecting status of meeting the milestones contained in work plans.

States also must describe where functional and financial assessment data will be housed and how they will be used by SPE agencies to determine eligibility. Form CMS 64 will be used to track expenditures associated with program eligible services and to claim FMAP.

Community First Choice Option

The Community First Choice (CFC) Option (Section 10202 of the ACA) became effective October 1, 2011 as a new state plan option, Section 1915(k), for providing community-based attendant services and supports to beneficiaries eligible for nursing homes and other institutional settings with incomes up to 150 percent FPL.

As a state plan amendment, services must be available statewide and states may not limit the number of eligible people receiving services by instituting a waiting list.

States that already have higher Medicaid income eligibility levels for beneficiaries requiring an institutional level of care may use the higher income level currently in place. The following services and supports are part of the CFC Option:

Required

- Attendant care services and supports that help eligible beneficiaries with ADLs and IADLs such as bathing and eating, and health-related tasks through hands-on assistance or supervision;
- Acquisition, maintenance, and enhancement of skills to complete those tasks;
- Back-up systems to ensure continuity of care and support; and
- Voluntary training on how to select, manage and dismiss attendants.

Optional

- Expenditures for transition costs related to moving beneficiaries from an institution to the community, such as security and utility deposits, first month's rent, and basic household supplies; and
- Expenditures noted in a beneficiary's care plan that will increase independence or substitute for human assistance.

Excluded

- Home modifications, room and board, medical supplies and equipment, and assistive technology devices and services unless those devices or services are back-up systems or mechanisms that ensure the continuity of services and supports; and
- Special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973.

Services must be provided under a person-centered plan of services and supports that

is based on an assessment of functional need in a home or community setting. As a state plan amendment, services must be available statewide and states may not limit the number of eligible people receiving services by instituting a waiting list. A number of states are considering CFC. However, they are concerned about CFC's potential impact on their budgets because of the program's prohibition on waiting lists for waiver services and the possible large increase in beneficiaries needing LTSS as the ACA-mandated expansion of Medicaid eligibility occurs in 2014.

Budget Impact/FMAP Opportunity:

States with approved state plan amendments will receive a six percent increase in FMAP for CFC services for an indefinite period. Important state budgetary considerations are the requirements to enroll all eligible beneficiaries and offer services statewide. Waiting lists may not be used. States must sustain maintenance of effort to spend what the state was spending or greater than the year prior to implementation of CFC.

Application Process: States must submit a state plan amendment to CMS.

Participant Eligibility: Participation is limited to Medicaid enrollees with incomes less than 150 percent FPL. Beneficiaries do not have to demonstrate a need for an institutional level of care.

Medicaid enrollees with incomes greater than 150 percent FPL are eligible if they need a nursing-home level of care and would, but for the provision of HCBS, require a level of care provided by a hospital, a nursing facility, intermediate care facility for the mentally retarded or a mental health facility, the cost of which would be reimbursed under the state plan.

Care Coordination/Plans: CFC expands the use of personal care attendants and includes the following:

- Provides for a person-centered planning process based on assessment of functional need that is agreed to in writing by the individual or, as appropriate, their representative;
- Allows for the use of other electronic back-up systems; and
- Provides that services may be self-directed.

The CFC Option requires use of a standardized assessment process and data collection to support quality assurance and reporting.

Data Reporting/Performance

Measures/Evaluations: Section 2401 of the ACA requires states to collect and report information, as determined necessary by the Secretary, for the purposes of approving the state plan amendment, providing Federal oversight, and conducting an evaluation including:

- How the state provides home and community-based (HCB) attendant services and supports and other HCB services;
- The cost of these services and supports; and
- How the state provides beneficiaries with disabilities who otherwise qualify for institutional care or under a waiver the choice to receive HCBS.

States are to provide information regarding provision of HCB attendant services and supports including the number of beneficiaries who received these services during the fiscal year and preceding fiscal year, the specific number of beneficiaries served by type of disability, age, gender, education level, and employment status and whether the beneficiaries had been previously served under any other HCBS program under state plan or waiver.

Evaluation: The Secretary will conduct an evaluation of the provision of HCB attendant services and supports under CFC to determine the following:

- Effectiveness of the provision of the services and supports in allowing beneficiaries receiving services lead an independent life to the maximum extent possible;
- Impact on the physical and emotional health beneficiaries served by CFC; and
- A comparative analysis of costs of services provided through the state plan amendment and those provided under institutional care in nursing facilities, institutions for mental diseases or intermediate care facilities for the mentally retarded.

Home- and Community-Based State Plan Option (1915(i))

Finally, the ACA made important changes to Section 1915(i) of the Social Security Act. Originally added by Section 6806 of the Deficit Reduction Act of 2005, Section 1915(i) was enacted to expand HCBS in ways that could not be done under the 1915(c) waiver, such as waiving the requirement that beneficiaries need to meet an institutional level of care to qualify for HCBS.

Under the ACA, the 1915(i) option was amended for states to target HCBS to particular groups of people and to make the HCBS benefit accessible to more beneficiaries. Specific changes to the 1915(i) option include:

- No “Waiting-Lists”: The ACA expands the 1915(i) option by no longer permitting states to limit the number of eligible enrollees served under the 1915(i) option or to establish waiting lists. All eligible enrollees must be able to receive services if they meet the eligibility criteria;
- Statewideness: Like the 1915(c), the 1915(i) is only able to be offered statewide and can no longer be limited

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to specific geographical regions of the state;

- Expanded 300 percent of FPL: The ACA preserved the states' option to provide HCBS services to individuals who are eligible for Medicaid, but may or may not be eligible for institutional level of care up to 150 percent of the FPL. However, the ACA also added a new section giving states the option to provide HCBS services to individuals with incomes up to 300 percent of the Social Security Income (SSI) rate;¹² and
- Targeted Benefits: The ACA does permit states to have multiple 1915(i) state plans and allows states to target benefits provided under these plans to specific population groups such as people with intellectual/developmental disabilities, children or adults with HIV/AIDS.

Budget Impact/FMAP Opportunity:

No additional FMAP is available. States must consider the budget impact of having to enroll all eligible individuals and services must be offered statewide. They may not institute waiting lists to control expenditures. However, the 1915(i) can be limited to very specific populations and offer a limited number of services, which would help to control its costs.

Application Process: States must submit a state plan amendment to CMS.

Participant Eligibility: Regardless of income level, beneficiaries must meet the non-financial needs-based criteria the state establishes for access to services under the 1915(i) state plan amendment. States are required to demonstrate that the needs-based criteria are less stringent than the state's institutional level of care criteria. Financial eligibility permits states to provide services to beneficiaries with income up to 300 percent of the SSI federal benefit rate (FBR).¹⁴

Care Coordination/Plans: States are required to ensure that the individualized care plan for a beneficiary is developed with input from not only the individuals providing care to the beneficiary, but also in consultation with the beneficiary so that it reflects his or her needs and goals. In addition, the beneficiary's family or caregiver may be consulted as appropriate. Care plans must be reviewed at least annually and after a significant change in the beneficiary's status. States may choose to allow beneficiaries to self-direct the LTSS they receive.

Data Reporting/Performance Measures/Evaluations:

States must provide a projection of the number of beneficiaries to be served and submit an annual report on the number of beneficiaries served and total expenditures in the aggregate.

Case Study: 1915(i) Option Implementation

In general, states have not pursued the 1915(i) option as vigorously as the 1915(c). A significant reason states have not pursued this option is the inability to limit enrollment and use waiting lists to address program budget constraints. Washington is an example of a state that decided to drop its 1915(i) state plan amendment.

As an early adopter of the 1915(i), Washington was attracted to the 1915(i) option provided by the ACA for its ability to cap enrollment into the HCBS programs for those beneficiaries who were not yet eligible for HCBS programs under the 1915(c) waiver. This allowed the state to implement a targeted expansion of HCBS options without creating a new entitlement. However, like most states, Washington is facing financial cut-backs in their Medicaid program and removal of the ability to control growth in enrollment under a 1915(i) has left them little advantage to continuing to operate the option. In this budget climate, the need to control enrollment growth outweighs other positives of the 1915(i), since the same array of services can be offered under a 1915(c) waiver. Thus, Washington has decided not to pursue 1915(i) implementation.¹³

Conclusion

Many states are in the process of reviewing options for rebalancing LTSS while working hard to preserve their Medicaid programs during the current economic downturn. Program opportunities must be considered in the context of the potential to add additional costs to the program that cannot be sustained. The budgeting uncertainties inherent in the new CFC and 1915(i) state plan amendment options are a concern to states. However, as pointed out in the BIP Implementation Manual, funding sources do exist to support BIP structural changes.

By 2014, states must build a new eligibility system using Medicaid Information Technology Architecture (MITA) to modernize state Medicaid systems focusing on streamlining and simplifying enrollment. From 50 to 90 percent FMAP is available through December 2015 for such MMIS work. Additional Aging and Disability Resource Center funding available through the ACA will assist with NWD/SPE by providing information and assisting with eligibility applications.¹⁵ States can also look to efforts already required of them under MFP demonstration programs and those that would be required under BIP to align the two programs so that they work together.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs.

Visit www.chcs.org for additional resources and tools for improving the quality and cost-effectiveness of care for Medicaid beneficiaries with complex needs.

Endnotes

¹ The enhanced FMAP rate is calculated by subtracting a state's FMAP rate from 100 percent, dividing the resulting number by two, and adding that percentage to the published FMAP. The enhanced MFP FMAP cannot exceed 90 percent. CMS State Medicaid Director Letter SMDL# 10-012, ACA# 3 "Extension of the Money Follows the Person Rebalancing Demonstration Program." June 22, 2010.

² Centers for Medicare and Medicaid Services. State Medicaid Director Letter # 10-012, June 22, 2010.

³ These data were provided in a December 9, 2011 e-mail message from Bea Rector, Project Director, Duals Innovation Grant, Aging and Disability Services Administration, Washington State Department of Social and Health Services, to Sarah Barth.

⁴ Ibid.

⁵ Centers for Medicare and Medicaid State Medicaid Director Letter # 10-012, June 22, 2010, page 2 states "the MFP Demonstration Program offers an enhanced FMAP, as well as significant financial resources, to support the administration of the demonstration and implementation of broader infrastructure investment . . . [that] include initiatives such as: creating systems for performance improvement and quality assurance, developing housing initiatives, supporting staff for key transition activities, improving the direct care workforce, and building 'no wrong door' access to care systems."

⁶ These forms include: CMS64.9i; 64.10i, 10Pi; MFP Program Files; MFP Financial Reporting Forms; Financial Status Report form (SF-269); Payment Management System Smartlink SF-425; Maintenance of Effort form; MFP Worksheet for Proposed Budget. Centers for Medicare and Medicaid Services, Money Follows the Person Rebalancing Grant Demonstration Invitation to Apply for FY 2011.

⁷ Mission Analytics Group, The Balancing Incentive Program: Implementation Manual, October, 2011, p. 2.

⁸ The BIP application states that "the applicable percentage point increase is two percent for non-institutionally-based LTSS in States in which 25-50 percent of the total expenditures for medical assistance under the State Medicaid program are for non-institutionally-based LTSS and five percentage point increase in FMAP for non-institutionally-based LTSS in States in which less than twenty-five percent of total expenditures are for non-institutionally based LTSS."

⁹ The BIP program application is available at: <http://www.cms.gov/smdl/downloads/Final-BIPP-Application.pdf>.

¹⁰ CMS State Balancing Incentive Payments Program Initial Announcement, OMB Control No: 0938-1145.

¹¹ Mission Analytics Group, The Balancing Incentive Program: Implementation manual, October, 2011.

¹² Centers for Medicare and Medicaid Services. State Medicaid Director Letter # 10-015, August 6, 2010.

¹³ These data were provided in a December 9, 2011 e-mail message from Bea Rector, Project Director, Duals Innovation Grant, Aging and Disability Services Administration, Washington State Department of Social and Health Services, to Sarah Barth.

¹⁴ Centers for Medicare and Medicaid Services. State Medicaid Director Letter # 10-015, August 6, 2010.

¹⁵ Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Patient Protection and Affordable Care Act Section 10202 State Balancing Incentive Payments Program Initial Announcement*, October 2011.