The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update

Paul Saucier
Jessica Kasten
Brian Burwell
Lisa Gold

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Table of Contents

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Abbreviations Used

CMS	Centers for Medicare & Medicaid Services
ICF/MR	Intermediate Care Facilities for individuals with Mental Retardation
ID/DD	Intellectual/Developmental Disabilities
LOC	Level of Care
LTSS	Long-Term Services and Supports
MFP	Money Follows the Person
MLTSS	Managed Long-Term Services and Supports
PACE	Program of All-inclusive Care for the Elderly
PD	Physical Disabilities
OP	Older Persons (65+ years of age)
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SSI	Supplemental Security Income

Executive Summary

Between January and June 2012, Truven Health Analytics℠ conducted a national environmental scan of Medicaid managed long-term services and supports (MLTSS) for the Disabled and Elderly Health Programs Group at the Centers for Medicare & Medicaid Services (CMS). The scan included an inventory of all MLTSS programs that had been implemented as of June 2012, and a projection of future programs through January 2014.

State-by-State results are included in Appendix A (current programs) and Appendix B (projected programs). This report synthesizes the findings across States, reporting national enrollment, characteristics of contractors, and multiple program features.

Key findings include:

- MLTSS grew significantly between 2004 and 2012. The number of States with MLTSS programs doubled from 8 to 16, and the number of persons receiving LTSS through managed care programs increased from 105,000 to 389,000.
- By 2014, the number of States projected to have MLTSS programs is 26. This is based on States that have actually completed planning documents and submitted formal proposals or waiver applications to CMS.
- MLTSS arrangements are very diverse. They include several sub-population groups, a variety of contractors and degrees of integration across services. They include programs with capitated payments for limited Medicaid benefits, capitated payments for comprehensive Medicaid benefits, and capitated payments for comprehensive Medicaid and Medicare benefits.
- The States are about evenly split on type of enrollment. Eight States have mandatory enrollment, seven have voluntary enrollment, and one has both types. Among the voluntary States, only one uses a passive enrollment system.

- States use three major types of contractors: private for-profit; private not-for-profit; and public or quasi-public. Private for-profit contractors have the largest share of enrollment nationally, at 44 percent.
- The development of the MLTSS market was initially hampered by a very limited supply of organizations that had both the experience and ability to accept risk for LTSS. However, the supply of organizations that have decided to develop this product line has increased greatly since 2004, giving most States a larger selection of organizations with which to contract.
- Older persons and adults with physical disabilities are the most common population groups included in MLTSS. Eight States include adults with intellectual/developmental disabilities, and eight States include children with disabilities.
- About half of the MLTSS programs include only persons at the institutional level of care (in HCBS programs and institutions). Those programs account for 25 percent of enrollment nationally. Programs that serve people with a broader range of LTSS needs (including, for example, persons who are not at the institutional level of care, but qualify for personal care services) account for 75 percent of enrollment nationally.
- Fifteen of the 16 MLTSS States place their contractors at risk for all or some of the cost of institutional services.
- Twelve of the 16 States offer consumer-directed options through their MLTSS programs. Four of these include budget authority in their models.
- Eleven States include “Money Follows the Person” (MFP) or MFP-like services in their MLTSS programs.
- States use various methods for obtaining ongoing input from enrollees. Nearly all States require contractors to convene member advisory committees. States also require annual or biennial member satisfaction or experience surveys.
- States have taken a variety of approaches to Medicare in their MLTSS programs. These include programs in which Medicare must be fully capitated, programs in which contractors must offer a fully capitated option, and programs in which contractors are expected to coordinate with Medicare providers, whether or not they participate in the program. Reflecting the high interest in CMS’ Medicare-Medicaid Financial Alignment demonstration, most States planning new programs are at least tentatively planning to include Medicare on a fully capitated basis.

- Most States have incorporated LTSS-specific measures into their quality management programs, though the lack of a nationally endorsed set of measures has resulted in highly unique approaches from State to State.

1. Introduction

Current Context and Purpose of Study

In 2004, eight States had implemented Medicaid managed long-term services and supports (MLTSS) programs. By June 2012, six of them had more than doubled the size of their programs, and an additional eight States had implemented programs. Several States have proposed large new MLTSS initiatives as part of Section 1115 Medicaid demonstrations or Medicare-Medicaid Financial Alignment demonstrations.

The recent growth and future plans reflect an accelerating trend among States toward managed care purchasing strategies for LTSS. A need exists to provide current information about the features of MLTSS programs, both to inform stakeholders and to provide technical information to States that are designing or expanding programs. Beyond high-level descriptions of program models, little has been published about existing MLTSS programs to date.

Managed Long-Term Services and Supports Defined

MLTSS refers to an arrangement between State Medicaid programs and contractors through which the contractors receive capitated payments for LTSS and are accountable for the delivery of services and supports that meet quality and other standards set in the contracts.

MLTSS programs are very diverse. They include programs that make capitated payments to contractors primarily for LTSS, programs that make capitated payments to contractors for all or most Medicaid services, and fully integrated Medicare-Medicaid programs that include all Medicaid and Medicare services.

We included programs that deliver LTSS to older persons, persons with physical disabilities, and/or persons with intellectual/developmental disabilities. Several of these programs include persons with mental health and substance abuse conditions. We did not, however, include programs focused exclusively on mental health and substance abuse, such as the behavioral health carve-out programs that exist in many States. Although Program of All-inclusive Care for the Elderly (PACE) sites were among the first to deliver capitated LTSS, we have excluded them from this inventory because the PACE model has been described extensively elsewhere and site locations are published by the National PACE Association.[1]

Footnotes

1 See http://www.npaonline.org.

Study Approach

We began with 2004 baseline information that was published in 2005.[2] We then compiled a broadly inclusive list of States that had implemented programs since 2004, or were planning to implement programs by January 2014. Sources included recent surveys by the National Association of States United for Aging and Disabilities (NASUAD), AARP and Health Management Associates;[3] the list of States submitting letters of intent for the CMS Medicare-Medicaid Financial Alignment initiative; and a list of States with pending waiver requests provided by CMS. We then conducted internet searches and key informant interviews as needed (when no public information could be found) to narrow the list to States that had existing or planned programs. For those States, we analyzed contracts, waiver applications, formal proposals, planning documents and other publicly available information to populate individual State inventories as completely as possible with available information. We then sent draft profiles to State officials for review and edited them as needed, based on State feedback. In a few instances, we were not able to obtain State feedback by publication time. This is noted on the individual State profiles in Appendix A when applicable.

Enrollment data reflect the most current numbers available, ranging from mid-2011 through May 2012. For this reason, we date our national enrollment estimate as 2011-12. Many programs in the inventory include both LTSS and non-LTSS populations. We identified the LTSS subset of enrollees for purposes of estimating national enrollment.

More generally, the information presented herein reflects a snapshot in time and may not capture features of States' programs that are evolving or changing. This is particularly true of the projected new programs under development, which will continue to evolve as planning continues.

This report synthesizes key features across States. Persons interested in details about any particular program or initiative should refer to the individual State profiles included in the appendices.

Footnotes

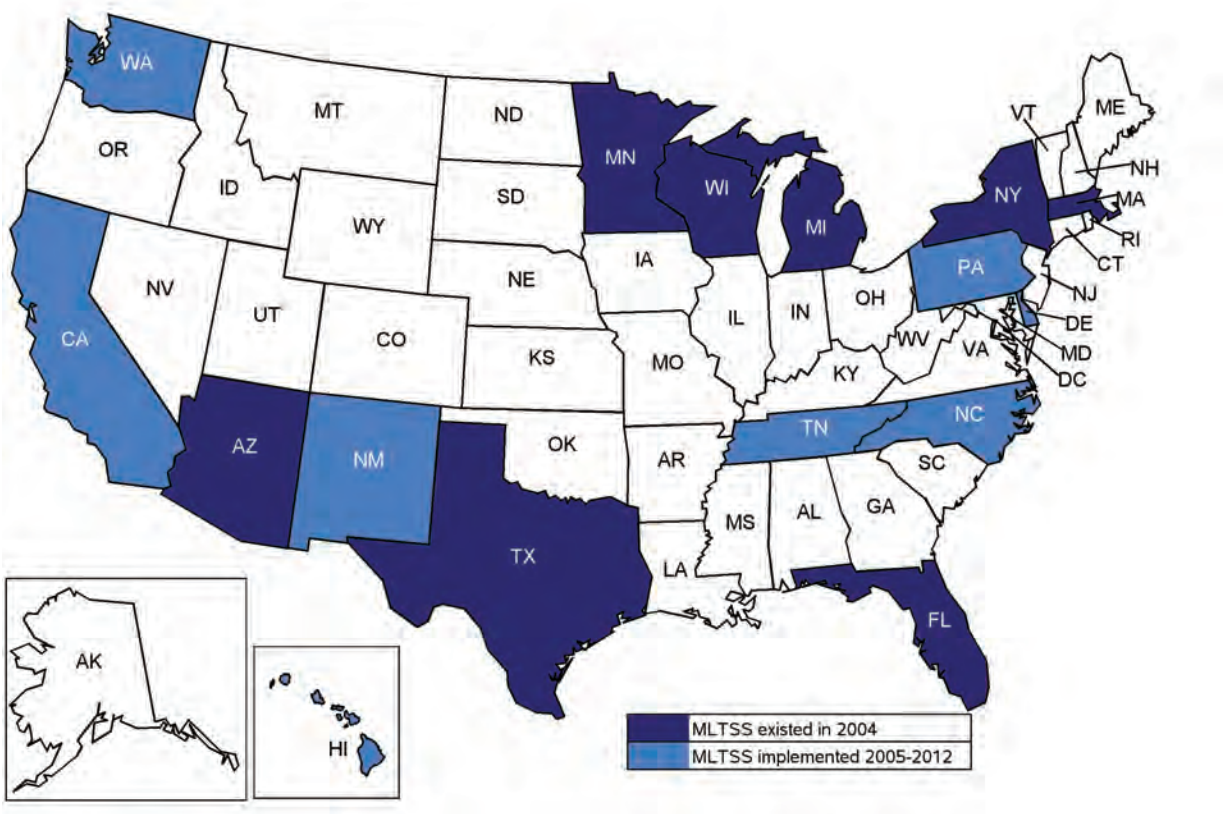
2 Saucier, P., B. Burwell and K. Gerst. The Past, Present and Future of Managed Long-term Care. 2005. Prepared for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning & Evaluation. Cambridge, MA: Thomson Medstat (now Truven Health Analytics). Available at: http://aspe.hhs.gov/daltcp/reports/mltc.htm

3 State of the States Survey 2011: State Aging and Disability Agencies in Times of Change. 2011. National Association of States United for Aging and Disabilities (NASUAD). Cheek, M., M. Roherty, L. Finnan, E. Cho, J. Walls, K. Gifford, W. Fox-Grage, and K. Ujvari. On the Verge: The Transformation of Long Term Services and Supports. 2012. AARP Public Policy Institute.

2. MLTSS Prevalence

This section describes the prevalence of MLTSS in terms of the number of States with programs and the number of LTSS-eligible enrollees. Prevalence in 2004 and 2012 are compared.

Figure 2.1: States with MLTSS Programs, 2004 and 2012



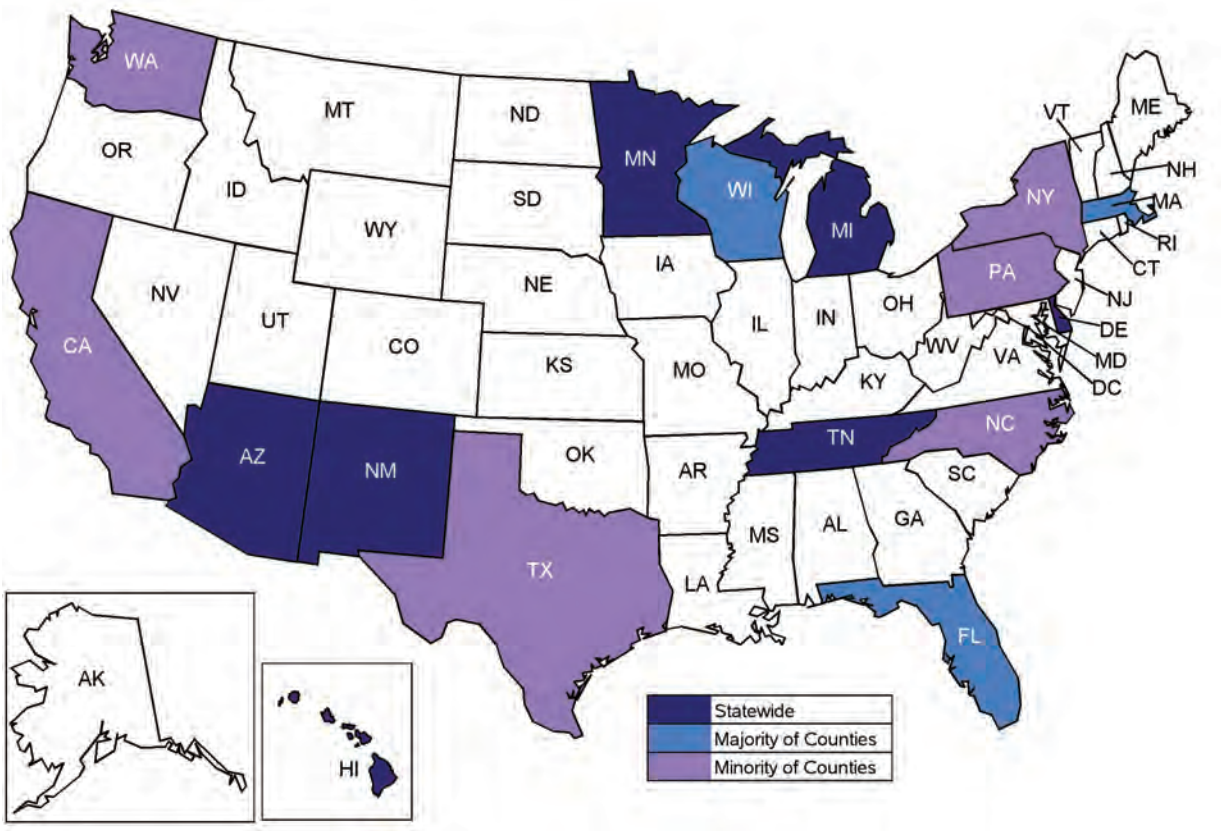
Notes: 1. Does not include PACE programs.
2. Three States (Minnesota, New York, and Wisconsin) operate two MLTSS programs each.

Figure 2.1 shows the 16 States that operate MLTSS programs. The number of States operating MLTSS programs has doubled from eight States in 2004 to 16 States in 2012. The eight States with programs in 2004 were Arizona, Florida, Massachusetts, Michigan, Minnesota, New York, Texas and Wisconsin. The eight States that implemented MLTSS programs since 2004 are California, Delaware, Hawaii, New Mexico, North Carolina, Pennsylvania, Tennessee, and Washington.

Three of the 16 States operate two programs each (Minnesota, New York, and Wisconsin), for a total of 19 programs. The first State to operate an MLTSS program was Arizona (1989), and the most recent State to implement was Delaware, in April 2012.

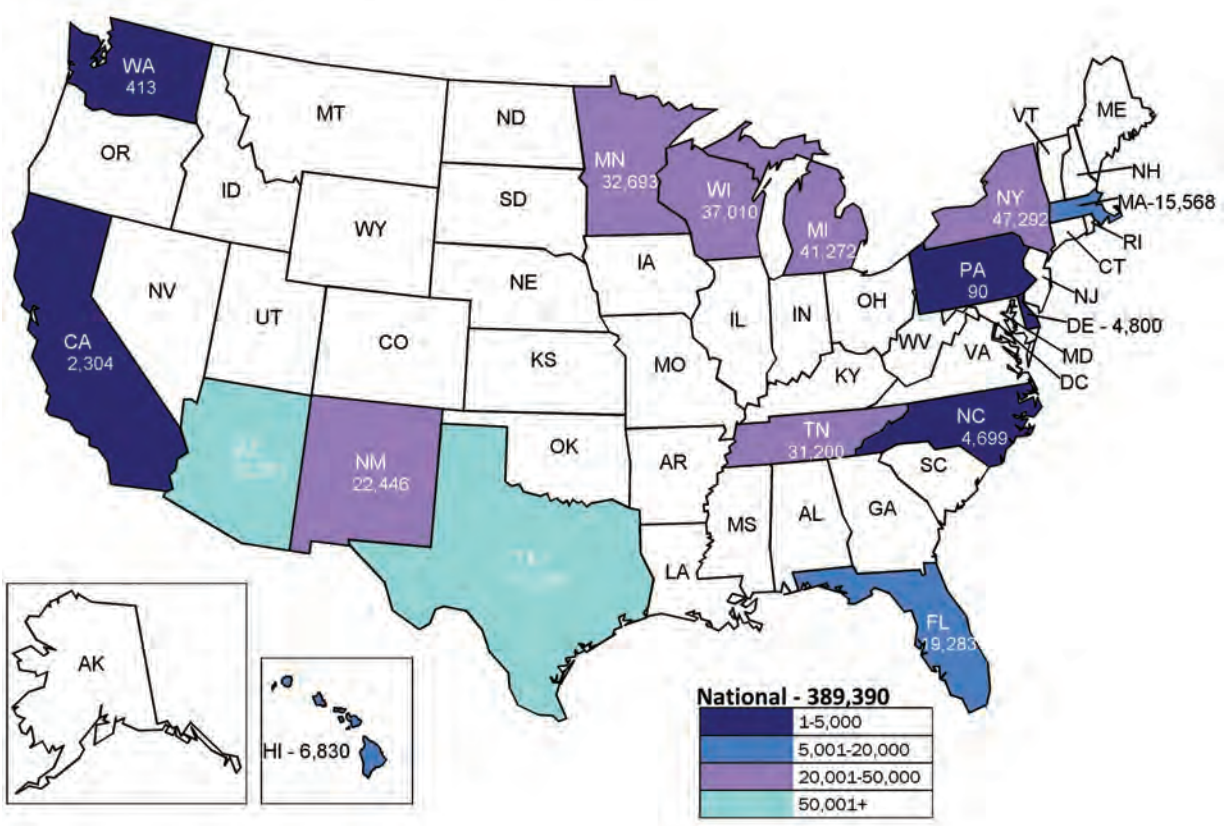
States with MLTSS programs are distributed throughout the U.S. Most programs are found in highly populated States, including the four most populous in the country (California, Texas, New York, and Florida), though three of the least populous States are also represented (New Mexico, Hawaii, and Delaware).

Figure 2.2: Geographic Reach of MLTSS by State, 2012



Several States have large MLTSS programs that operate statewide or nearly statewide. Figure 2.2 shows that seven States (Arizona, Delaware, Hawaii, Michigan, Minnesota, New Mexico, and Tennessee) operate programs statewide, and another three (Florida, Massachusetts, and Wisconsin) operate programs in a majority of counties. Of the remaining six State programs which operate in a minority of counties, two (New York and Texas) operate in the most heavily populated parts of those States and have high enrollment relative to other States, despite their more limited geographic reach. North Carolina is currently expanding its program to make it statewide. California plans to expand MLTSS significantly in 2013 and Washington plans to expand to areas where county legislatures are supportive.

Figure 2.3: LTSS Users in MLTSS Programs, 2011 12



Note: Number reported includes persons enrolled in MLTSS who were eligible to receive LTSS services. Date of enrollment count varied by State and was either 2011 or 2012. See Appendix A for State-by-State details.

The number of persons receiving LTSS through a managed care program in 2011-12 varied across the States, as shown in Figure 2.3. Half of the 16 States had enrollment of fewer than 20,000 persons (California, Delaware, Florida, Hawaii, Massachusetts, North Carolina, Pennsylvani,a and Washington), and half had enrollment of more than 20,000 (Arizona, Michigan, Minnesota, New Mexico, New York, Tennessee, Texas, and Wisconsin). The States with the fewest LTSS enrollees were Pennsylvania and Washington, each with fewer than 500 persons, and the largest were Arizona and Texas, each with more than 50,000.

The number of persons receiving LTSS through a managed care program remains small nationally, but has grown rapidly in recent years as Table 2.1 illustrates.

Table 2.1: Growth in MLTSS Enrollment by Program, 2004 2012

	Members Enrolled, 2011-12	LTSS Users Enrolled, 2011-12	LTSS Users Enrolled, 2004	% Change, LTSS Users Enrolled, 2004-2012
AZ Long-Term Care System	52,251	52,251	39,152	33%
CA SCAN Connections at Home	2,304	2,304	0	-
DE Diamond State Health Plan-Plus	4,800	4,800	0	-
FL Long-Term Care Community Diversion	19,283	19,283	3,070	528%
HI QUEST Expanded Access	44,600	6,830	0	-
MA Senior Care Options	21,785	15,568	100	-
MI Managed Specialty Support & Services	41,272	41,272	32,841	26%
MN Senior Health Options	36,128	25,819	3,910	560%
MN Senior Care Plus	11,995	6,874	0	-
NM Coordination of Long-Term Services	39,607	22,446	0	-
NY Managed Long-Term Care	45,417	45,417	7,078	542%
NY Medicaid Advantage Plus	1,875	1,875	0	-
NC MH/DD/SAS Health Plan Waiver	4,699	4,699	0	-
PA Adult Community Autism Program	90	90	0	-
TN CHOICES	31,200	31,200	0	-
TX Star+Plus	400,790	71,239	10,671	568%
WA Medicaid Integration Partnership	4,834	413	0	-
WI Family Care Partnership	3,869	3,869	1,644	135%
WI Family Care	33,144	33,141	6,998	374%
TOTAL, United States	**799,940**	**389,390**	**105,464**	**269%**

Notes: Source for 2004 Arizona enrollment is: AHCCCS Overview, 2005. Accessed 6/15/12 at http://www.azahcccs.gov/reporting/Downloads/AHCCCSOverview_2005.pdf. Source for 2004 Michigan enrollment is: Fingertip Report. Accessed 6/14/12 at http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_4902-188760--,00.html. Source for all other 2004 enrollment is: Saucier, Burwell and Gerst, 2005. The Past, Present and Future of Managed Long Term Care. Accessed 6/18/12 at http://aspe.hhs.gov/daltcp/reports/mltc.htm. LTSS enrollment for Massachusetts Senior Care Options is an estimate derived by applying the ratio that exists in Minnesota Senior Health Options, the program that most resembles the Massachusetts program in terms of design features (both are fully integrated Medicare-Medicaid programs with voluntary enrollment serving older persons).

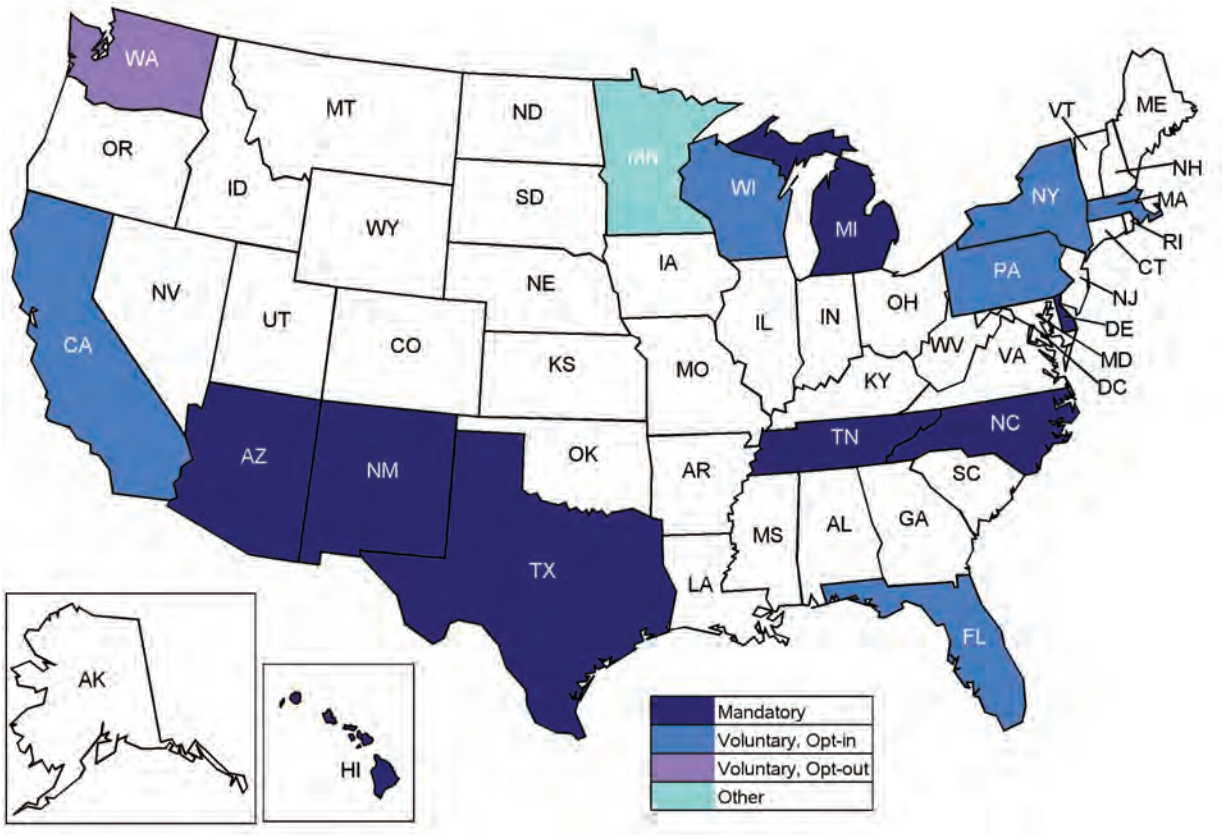
Table 2.1 shows the number of members enrolled in MLTSS Programs and sub-set using LTSS in these programs. Some programs, such as the Arizona Long-Term Care System and the New York Managed Long-Term Care program, serve persons with LTSS needs exclusively, so LTSS users comprise 100% of total members. Other programs, such as Hawaii Quest Expanded Access and Texas Star+Plus, enroll both persons with and without LTSS needs, so the number of persons using LTSS is smaller than the total number enrolled. The number of persons receiving LTSS through managed care programs in 2011-12 was 389,390, up from 105,464 in 2004. Five States (Minnesota, New York, Tennessee, Texas, and Wisconsin) added more than 25,000 LTSS users each to MLTSS programs during this period. Texas added the most, at 60,568. Most of the new enrollment was driven by expansions

of existing programs, but new mandatory enrollment programs since 2004 (in New Mexico and Tennessee, for example) also contributed significantly to the growth.

States by Type of Medicaid Enrollment (Voluntary or Mandatory)

One important factor that drives enrollment levels is the enrollment policy used by States (voluntary or mandatory).

Figure 2.4: States by Type of Enrollment



Note: Minnesota is shown as "other" because it has one voluntary program and one mandatory program.

The States are about evenly split on type of enrollment, as shown in Figure 2.4. Eight have mandatory enrollment programs (Arizona, Delaware, Hawaii, Michigan, New Mexico, North Carolina, Tennessee, and Texas). Seven have voluntary programs (California, Florida, Massachusetts, New York, Pennsylvania, Washington, and Wisconsin), and one State (Minnesota) has one voluntary and one mandatory program. Among the voluntary programs, one (Washington) uses a passive enrollment process, through which eligible persons are informed that they will be enrolled unless they opt-out, whereas the remaining voluntary States use an opt-in process, through which eligible persons must take action to enroll.

3. MLTSS Contractors

This section describes the contractors used by States to implement MLTSS and how the supply of contractors has changed in recent years.

A successful market for MLTSS requires both a strong demand side (State Medicaid programs) and a strong supply side (MLTSS contractors). The development of the MLTSS market was initially hampered by a very limited supply of organizations that had both the experience and ability to accept risk for LTSS. However, the supply of MLTSS contractors has increased significantly and States have a much greater selection of MLTSS contractors today than they had in 2004.

The supply of MLTSS contractors is highly diverse. A variety of corporate structures are represented (for-profit, not-for-profit, and public entities), and the size of contractors ranges from small local contractors to very large national contractors.

Figure 3.1: National and Local Contractor Presence in MLTSS Programs

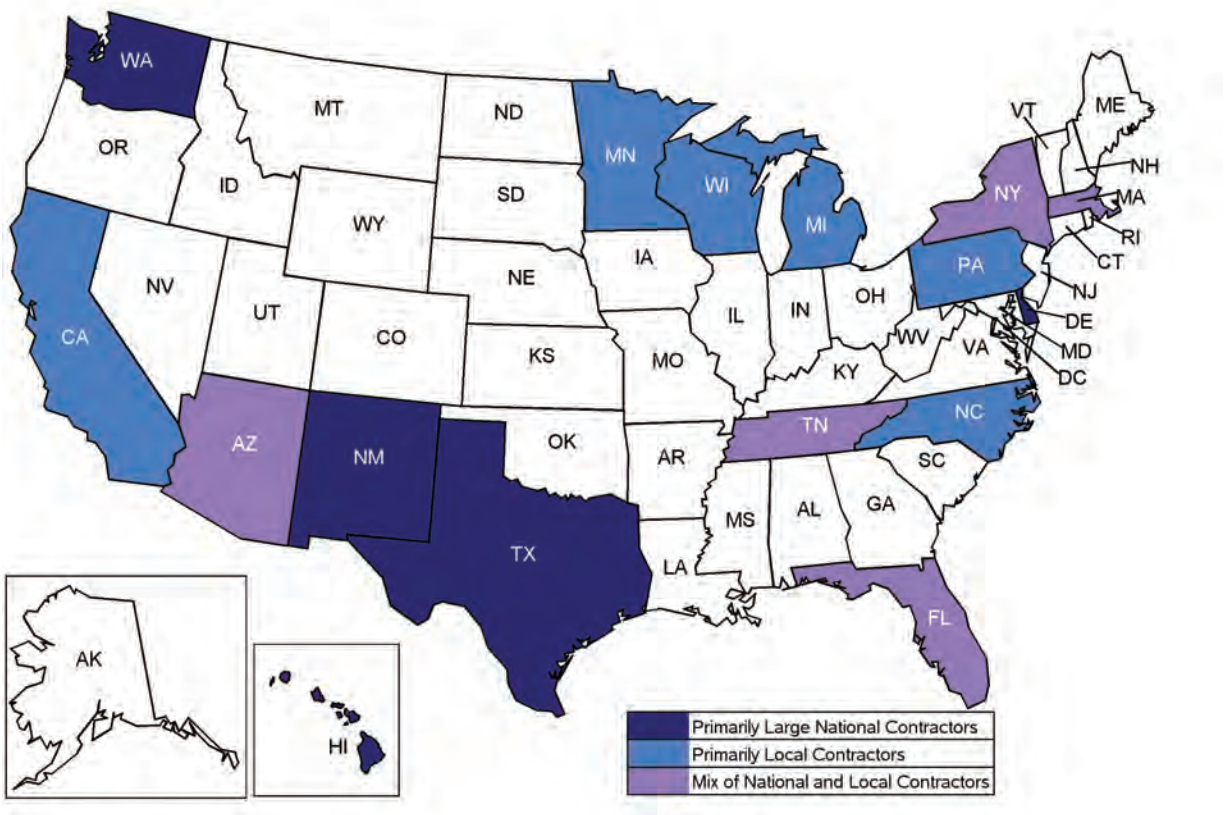
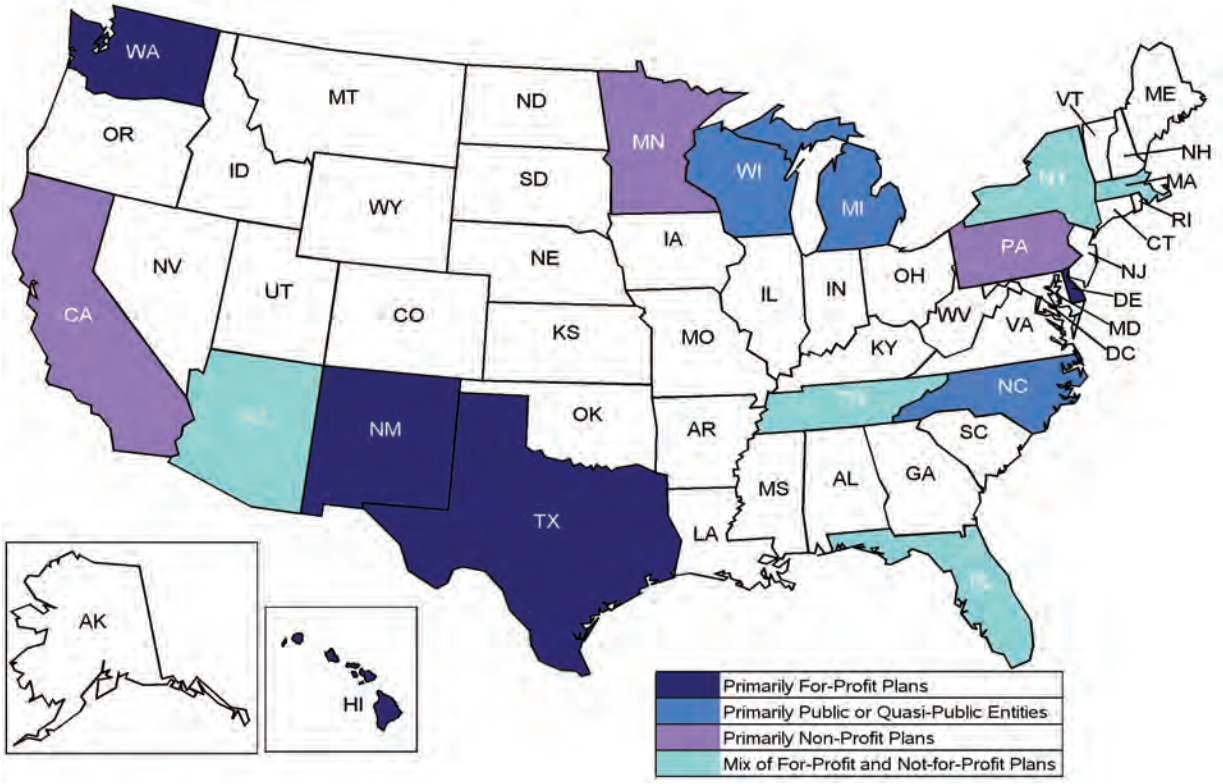


Figure 3.1 categorizes MLTSS States in terms of the presence of national and local contractors. Five States (Delaware, Hawaii, New Mexico, Texas, and Washington) have mostly large national contractors that operate in multiple States. Four of these States (Delaware, Hawaii, New Mexico, and Texas) have mandatory programs covering all or significant portions of their populations.

To date, six States (California, Michigan, Minnesota, North Carolina, Pennsylvania, and Wisconsin) have used primarily local contractors in their MLTSS programs. These include local health plans, such as SCAN in California, local provider-based contractors, such as Keystone Autism Services in Pennsylvania, and local entities originally established to plan and deliver mental health and developmental disability services on a fee-for-service basis, such as the multiple entities in Michigan and North Carolina.

Five States (Arizona, Florida, Massachusetts, New York, and Tennessee) use a mix of large, national contractors and smaller, local contractors in their programs. Arizona, Massachusetts and Tennessee use a mix of local and national health plans, while Florida and New York use a mix of national plans, local plans, and local provider-based organizations as contractors.

Figure 3.2: Dominant Corporate Status of MLTSS Contractors by State



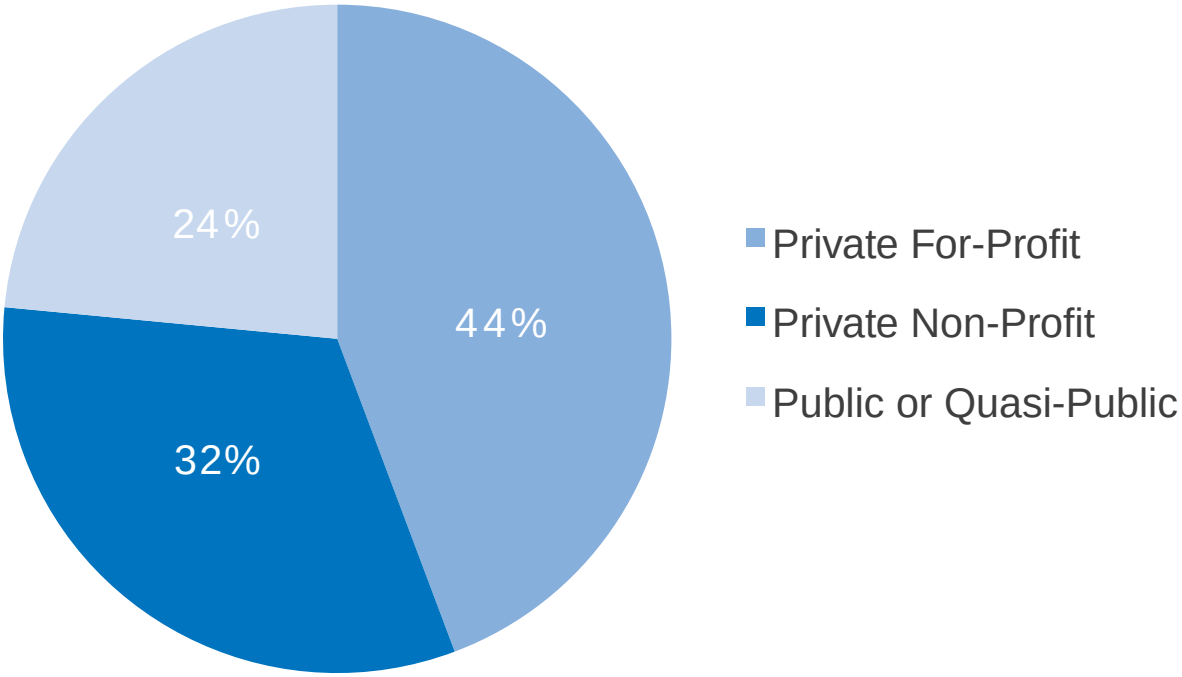
MLTSS contractors are also diverse in their corporate status, as Figure 3.2 shows. The categories of corporate status are for-profit, not-for-profit, and public or quasi-public organizations. The five States that rely on for-profit contractors (Delaware, Hawaii, New Mexico, Texas, and Washington) are the same States shown in the previous figure to have primarily large national contractors, reflecting that all of the large national contractors are for-profit organizations.

Three States (Michigan, North Carolina and Wisconsin) rely primarily on public or quasi-public organizations as their MLTSS contractors. In Michigan and North Carolina, for example, these are organizations designated by the State to be the mental health and intellectual/ developmental disabilities management entities in each region of the State.

Three States (California, Minnesota and Pennsylvania) rely on non-profit organizations. California contracts with a non-profit plan that had originally participated in the Medicare Social HMO demonstration program. Pennsylvania contracts with a small specialty provider to offer its Adult Community Autism Program. Under Minnesota State law, only non-profits are allowed to provide health insurance of any kind.

The remaining five States (Arizona, Florida, Massachusetts, New York and Tennessee) have a mix of for-profit and non-profit contractors. In Florida and New York, this includes both for-profit and non-profit provider organizations.

Figure 3.3: Market Share of Members Using LTSS by Corporate Type



N = 389,390

For-profit organizations have the greatest market share of members enrolled in MLTSS programs, driven by large national health plans. Figure 3.3 shows that for-profit organizations have 44 percent of members, private non-profit organizations have 32 percent of members, and public or quasi-public organizations have 24 percent of members.

Table 3.1: State Market Presence of Leading National Health Plans in MLTSS Market

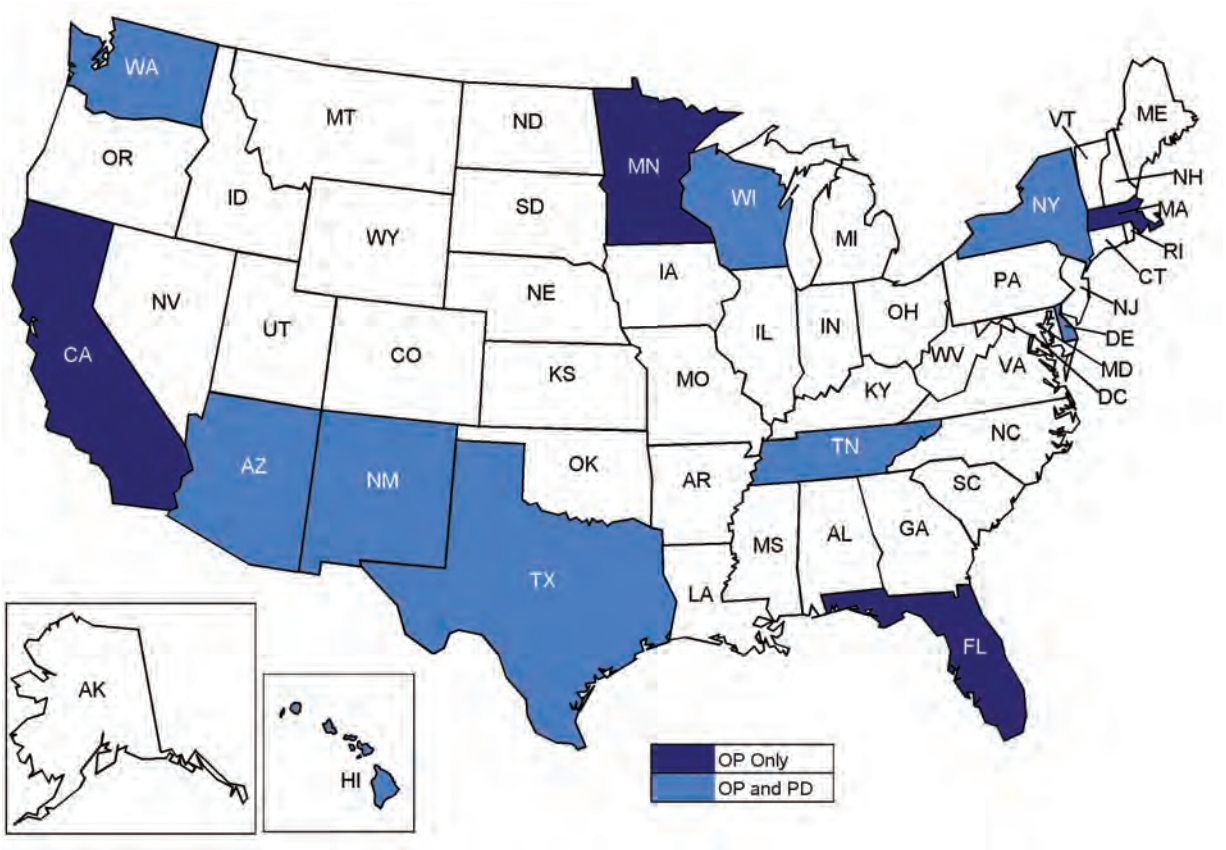
	AZ	DE	FL	HI	MA	NM	NY	TN	TX	WA
UnitedHealthcare	X	X	X	X	X	X		X	X	
Amerigroup			X			X	X	X	X	
Centene	X		X						X	
Molina Healthcare									X	X

The four national market leaders, based on MLTSS enrollment are UnitedHealthcare, Amerigroup, Centene, and Molina Healthcare. Table 3.1 indicates the States in which each of these has MLTSS contracts. UnitedHealthcare has contracts in eight States, Amerigroup in five States, Centene in three States, and Molina Healthcare in two. These companies all had experience providing managed care products to other State Medicaid populations prior to becoming MLTSS contractors.

4. Population Groups Enrolled in MLTSS Programs

MLTSS programs include several population groups, including older persons, persons with physical disabilities, persons with intellectual/developmental disabilities, and children with disabilities. Persons with serious mental illness are included in some programs, but generally need to fall into one of the other population groups to be enrolled in an MLTSS program. Most States with MLTSS programs include more than one population group in their programs. The following figures summarize population groups included by State. More detail about each State can be found in Appendix A.

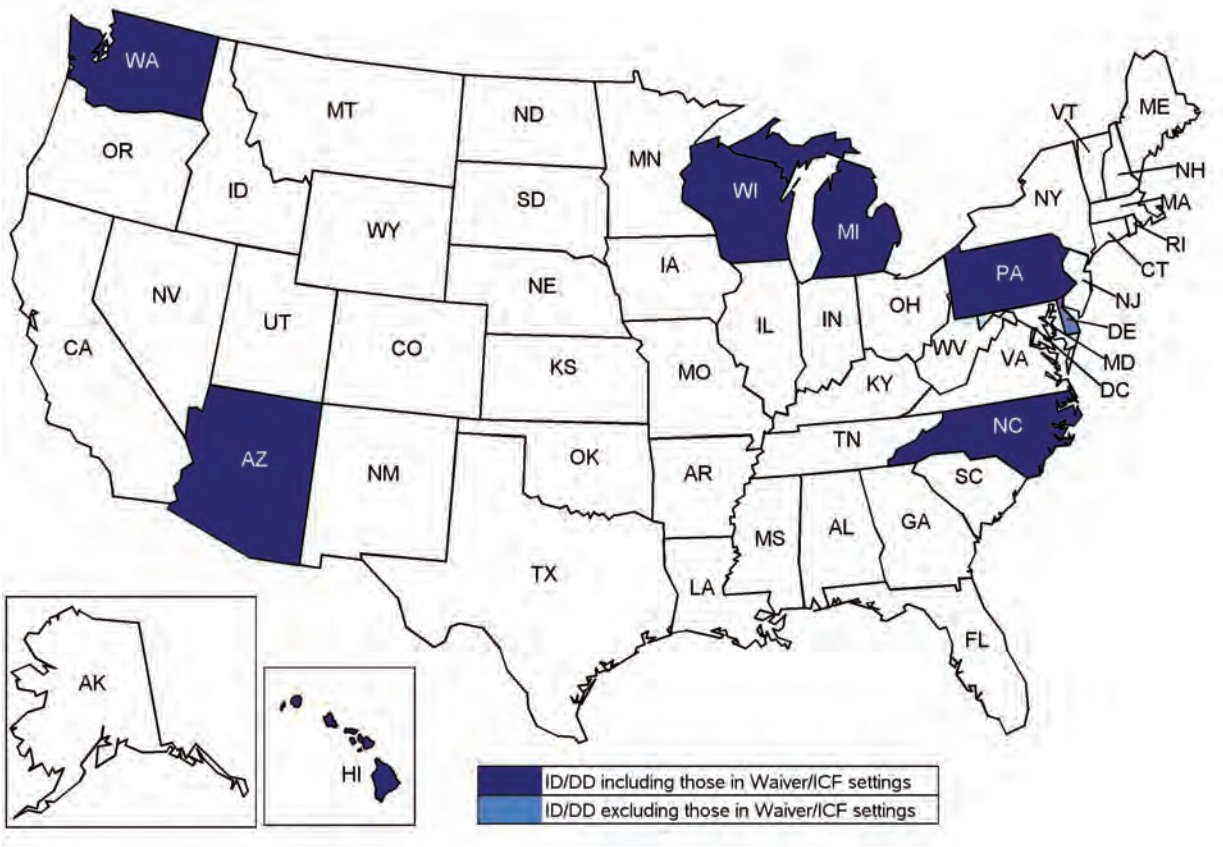
Figure 4.1: States That Include Older Persons and Adults With Physical Disabilities in MLTSS Programs, June 2012



Note: OP = Older Persons (65+), PD = Adults with Physical Disabilities

Four States (California, Florida, Massachusetts and Minnesota) had MLTSS programs that enrolled only older persons. An additional nine States (Arizona, Delaware, Hawaii, New Mexico, New York, Tennessee, Texas, Washington and Wisconsin) enrolled both older persons and adults with physical disabilities.

Figure 4.2: States that Include Adults with Intellectual/Developmental Disabilities (ID/DD) in MLTSS Programs, June 2012



Note: ID/DD = Adults with Intellectual/Developmental Disabilities

Eight States include adults with intellectual/developmental disabilities in MLTSS programs. Of these, seven include persons in all settings, including those receiving services in Intermediate Care Facilities for individuals with Mental Retardation (ICF/MRs) and in HCBS waiver programs for persons with intellectual/developmental disabilities (Arizona, Hawaii, Michigan, North Carolina, Pennsylvania, Washington, and Wisconsin).

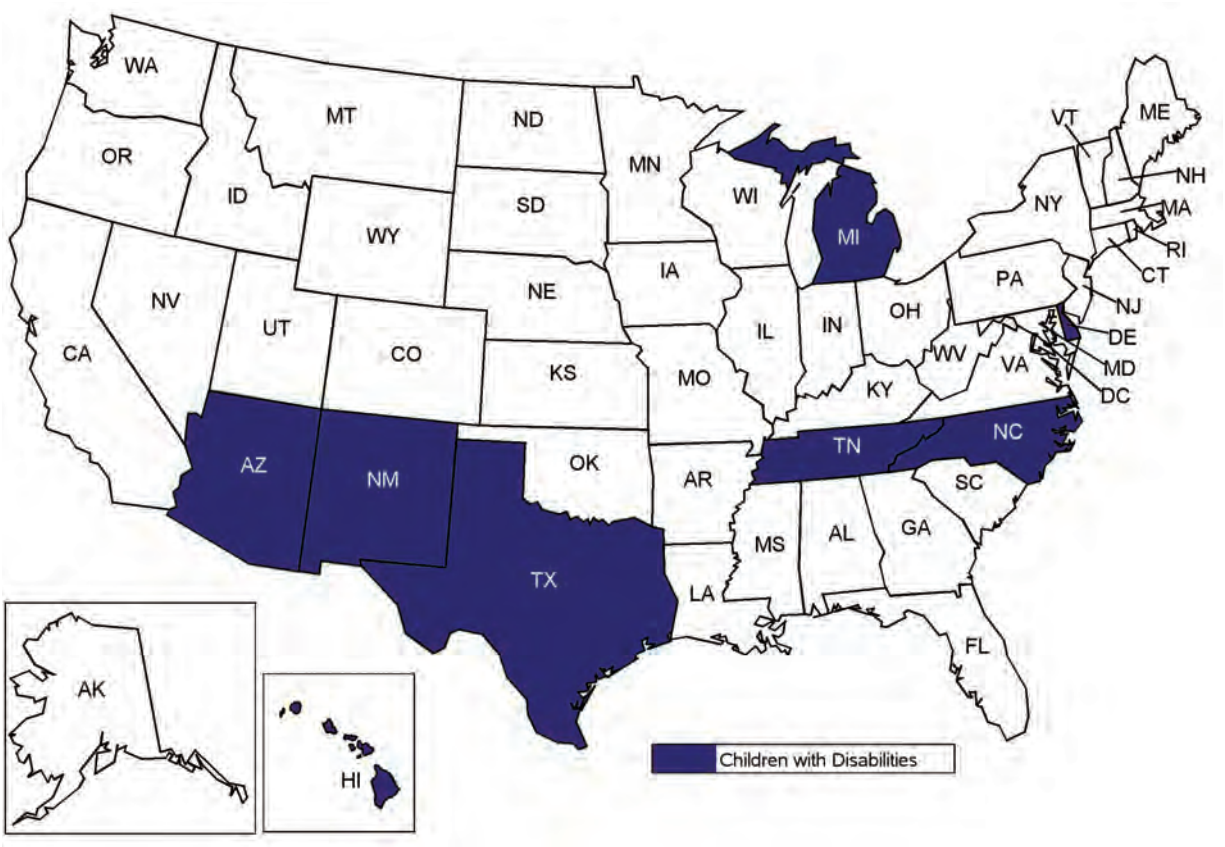
In two of the seven (Hawaii and Washington), ICF/MR and waiver services are delivered separately, outside the MLTSS program and enrollees receive all other services from the MLTSS program.

In one of the seven (Pennsylvania), the MLTSS program is targeted specifically to adults with autism.

One State (Delaware) does not enroll persons in ICF/MRs or HCBS waiver programs for persons with intellectual/developmental disabilities.

Three States (Michigan, North Carolina, and Washington) also serve persons with serious mental illness in their MLTSS programs. Mental health services are provided in most MLTSS programs, but in most States, a person must have a physical, intellectual/developmental or age-related disability in order to enroll in an MLTSS program.

Figure 4.3: States That Include Children in MLTSS Programs, June 2012

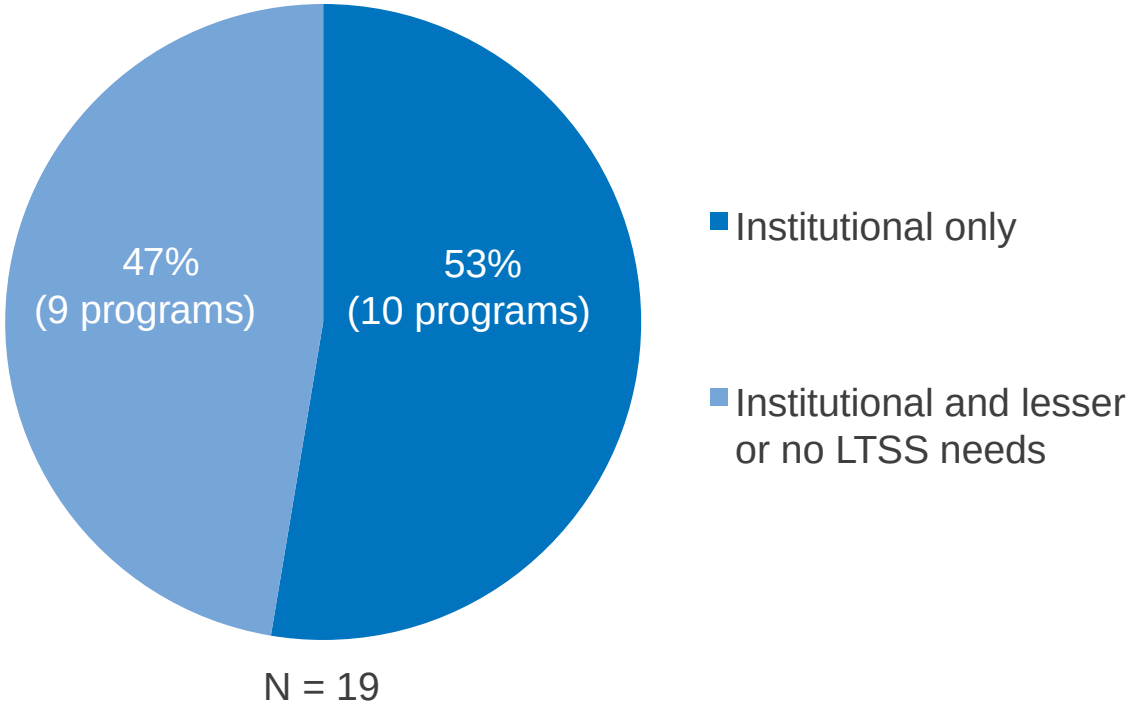


Eight States include children in their MLTSS programs (Arizona, Delaware, Hawaii, Michigan, New Mexico, North Carolina, Tennessee, and Texas). In two of these (Michigan and North Carolina), enrollment is limited to children with intellectual/developmental disabilities or serious emotional disturbance. In the remaining six states, most children with SSI-related Medicaid eligibility are enrolled.

5. Level of Care

In addition to defining eligible MLTSS populations by type of disability, States also define eligibility by the amount and type of LTSS needed, as determined by a Level of Care (LOC) assessment.

Figure 5.1: Distribution of MLTSS Programs by LTSS LOC Criteria, 2012



N = 19

As shown in Figure 5.1, just over half of the MLTSS programs limit enrollment to individuals assessed as eligible for institutional LOC. The remaining programs serve individuals with lower LTSS levels of care, and most of these are broader Medicaid managed care programs that also include people with no current LTSS needs, such as low-income older persons who qualify for Medicaid because they are 65 or older, but do not have LTSS needs.

Figure 5.2: Distribution of MLTSS Enrollees by LOC Criteria, 2012

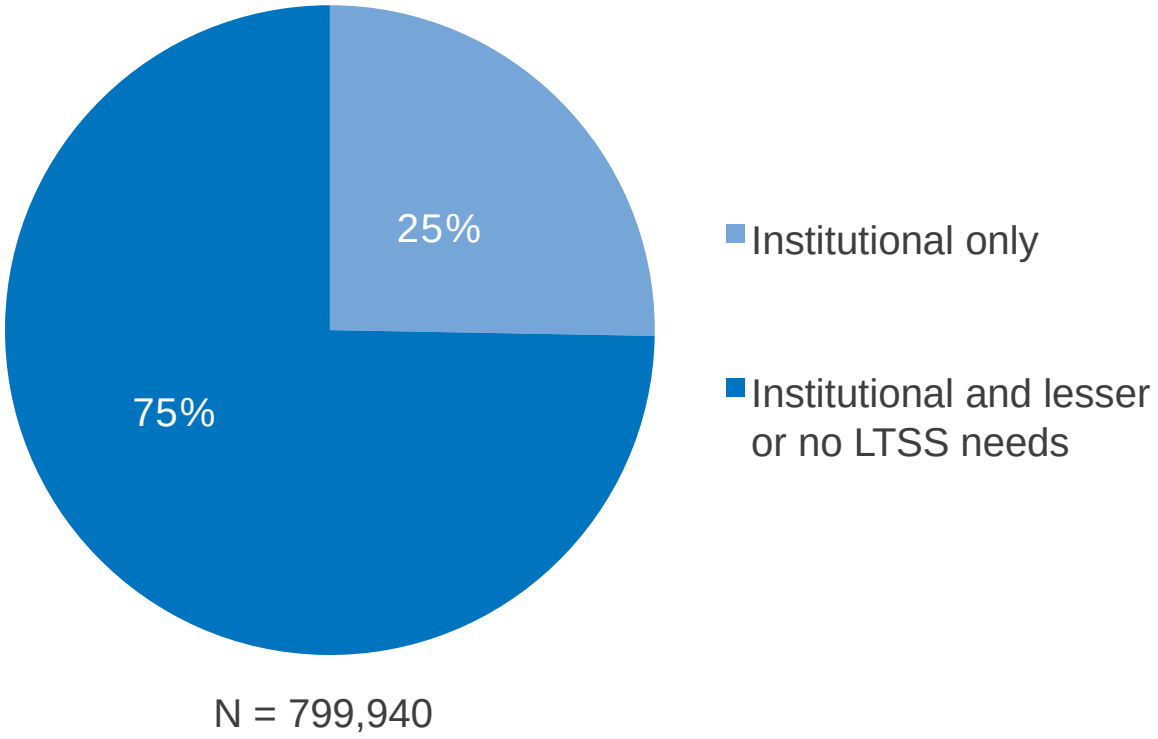
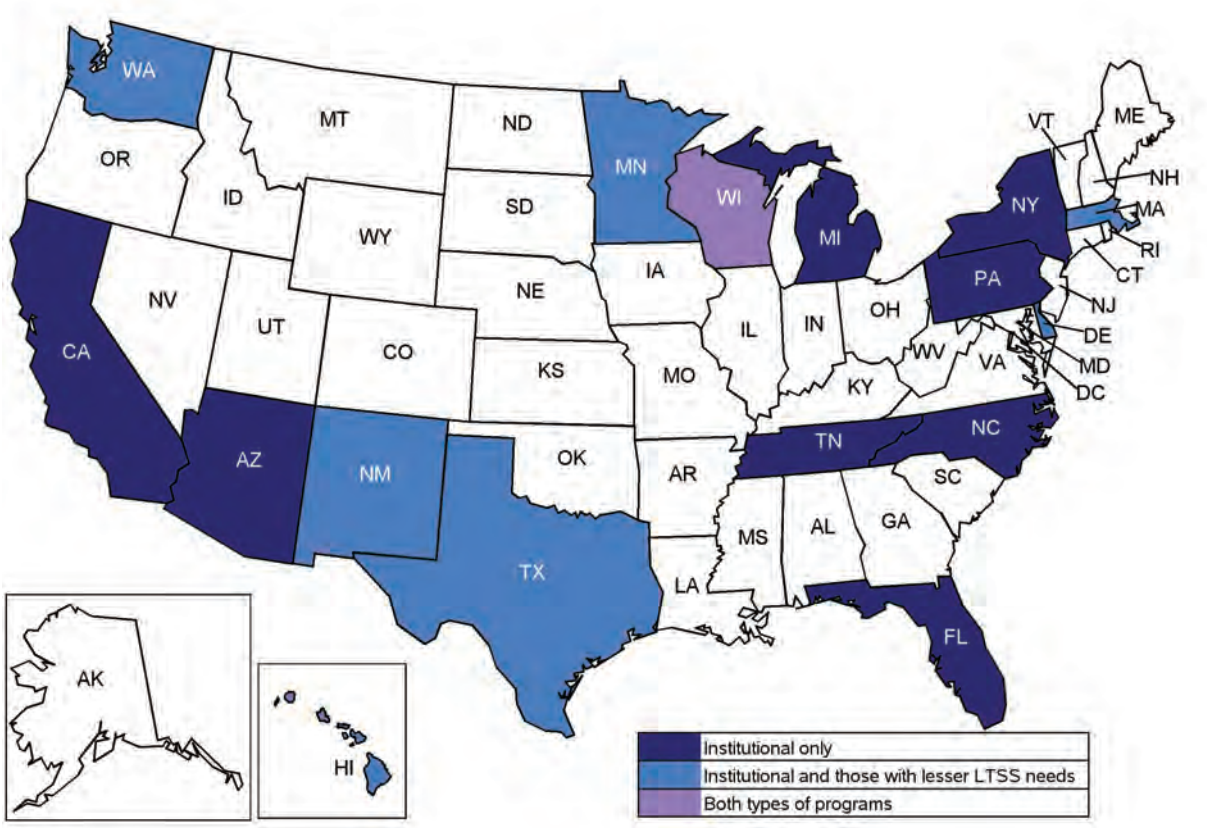


Figure 5.2 shows that 75 percent of enrollees in MLTSS programs are served in programs that include people with a broad range of LTSS needs and also people with no LTSS needs. This is not surprising given the smaller target groups of the programs serving only individuals at an institutional LOC.

Figure 5.3: MLTSS LOC Criteria by State



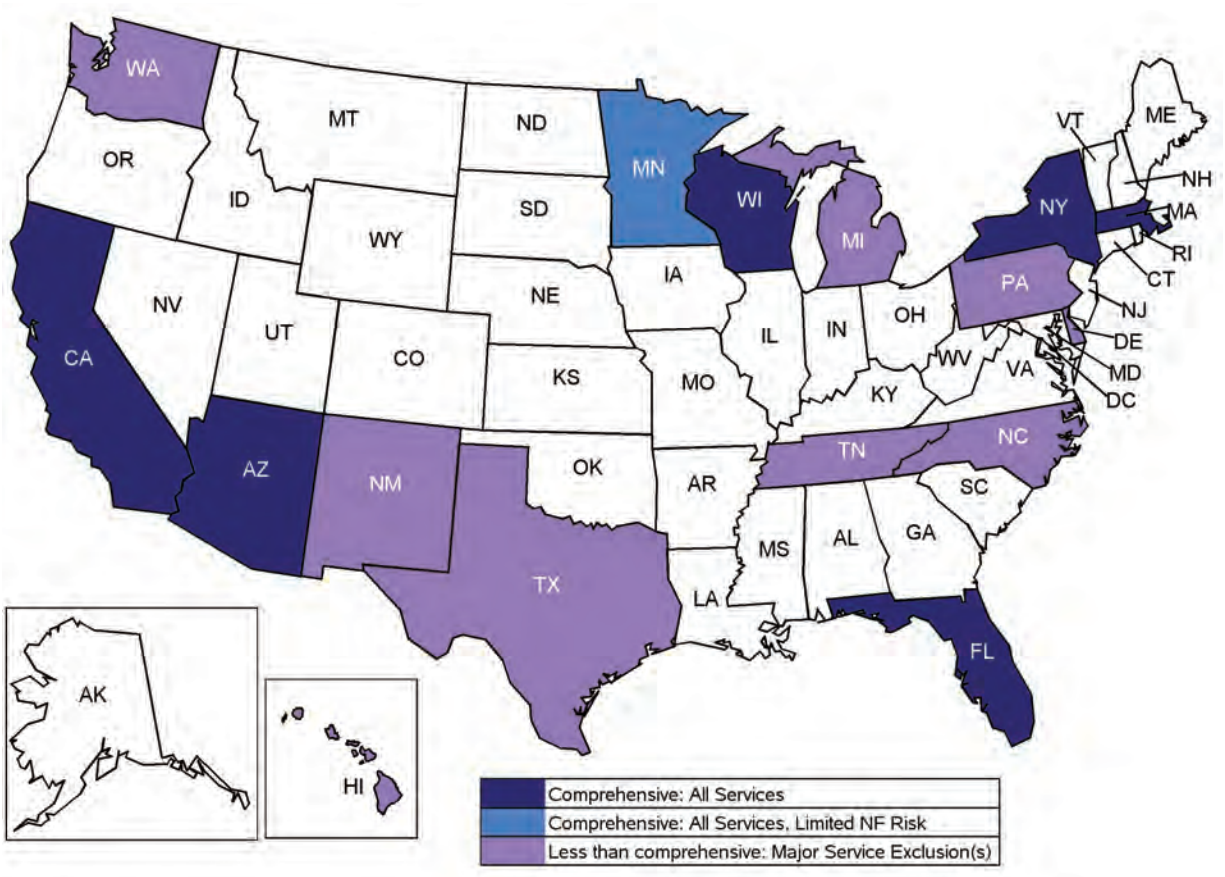
As shown in Figure 5.3, nine States have MLTSS programs that are limited to persons requiring an institutional LOC (Arizona, California, Florida, Michigan, New York, North Carolina, Pennsylvania, Tennessee, and Wisconsin).

Eight States have MLTSS programs that include both persons at an institutional LOC and those requiring lower LTSS levels of care (Delaware, Hawaii, Massachusetts, Minnesota, New Mexico, Texas, Washington, and Wisconsin). Wisconsin is in both categories as it is has two MLTSS programs, one of which restricts enrollment to persons at an institutional LOC and one that does not.

6. Capitation Rates

State MLTSS programs also vary in terms of what services are included in the capitation rates paid to contractors.

Figure 6.1: Services Included in MLTSS Program Capitation by State



As shown in Figure 6.1, seven States with MLTSS programs have comprehensive capitation rates that include all major Medicaid service categories (Arizona, California, Florida, Massachusetts, Minnesota, New York, and Wisconsin). Minnesota limits contractors' risk on nursing facility stays to 180 days.

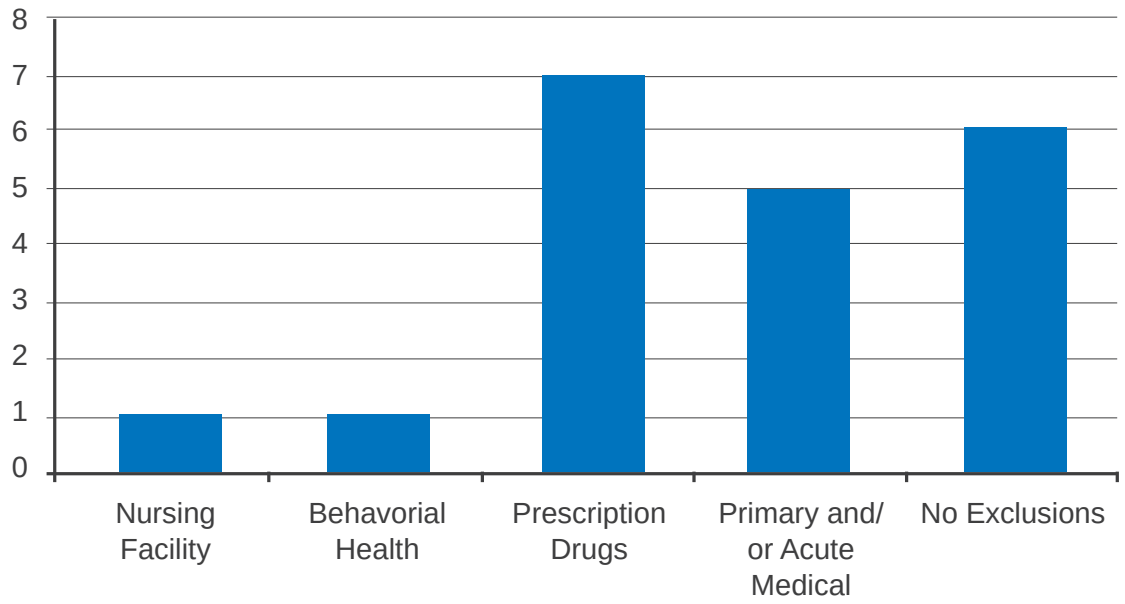
The other nine States (Delaware, Hawaii, Michigan, New Mexico, North Carolina, Pennsylvania, Tennessee, Texas, and Washington) exclude one or more major Medicaid service categories from their capitation rates. For the purposes of this analysis, "major" service categories include: primary, acute, behavioral, prescription drugs, and LTSS.[4]

New York and Wisconsin both have two MLTSS programs, one of which has comprehensive capitation rates and one which does not. These States were categorized as comprehensive in Figure 6.1.

Footnotes

4 Services such as dental and non-emergency transportation are not counted as "major" service categories because States commonly deliver these through a single source managed care arrangement.

Figure 6.2: Number of Programs Excluding Major Service Categories From Capitation Rates in MLTSS Programs



Note: Categories are not mutually exclusive.

Figure 6.2 shows the number of MLTSS programs that exclude specific Medicaid service categories. The service most commonly excluded is prescription drugs, followed by primary and/or acute medical care.

Table 6.1 shows the active MLTSS programs that have major Medicaid service categories excluded from their capitation rates and identifies the services that are excluded.

Table 6.1: Major Service Category Exclusions From State MLTSS Program Capitation Rates

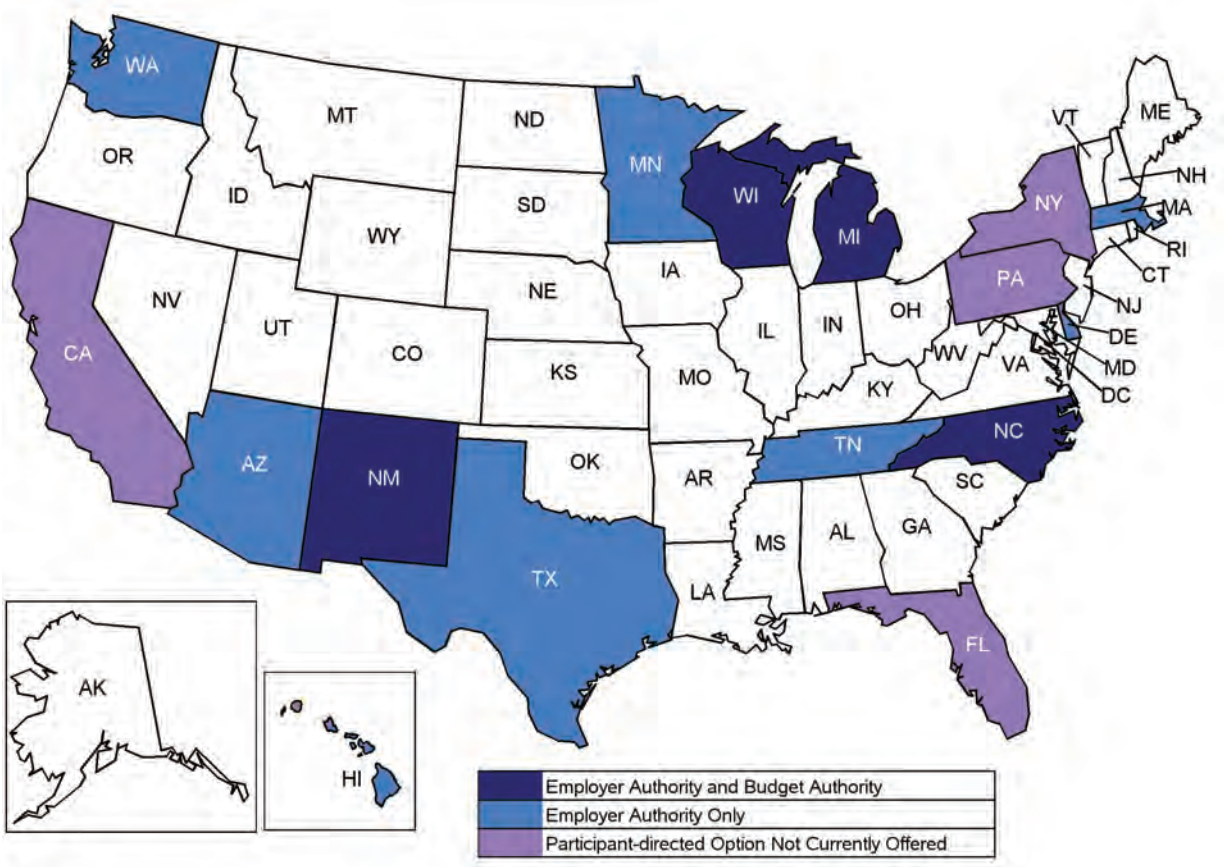
Program	Major Services Excluded from Capitation
Arizona Long-Term Care System	N/A
California SCAN Connections at Home	N/A
Delaware Diamond State Health Plan-Plus	Prescription Drugs
Florida Long-Term Care Community Diversion	N/A
Hawaii QUEST Expanded Access	ID/DD HCBS Waiver
Massachusetts Senior Care Options	N/A
Michigan Managed Specialty Support & Services	Primary and Acute Medical, Prescription Drugs
Minnesota Senior Health Options	Nursing Facility after 180 days
Minnesota Senior Care Plus	Nursing Facility after 180 days
New Mexico Coordination of Long-Term Services	Behavioral Health
New York Managed Long-Term Care	Primary and Acute Medical, Prescription Drugs
New York Medicaid Advantage Plus	N/A
North Carolina MH/DD/SAS Health Plan Waiver	Primary and Acute Medical, Prescription Drugs
Pennsylvania Adult Community Autism Program	Select Primary and Acute Medical: Inpatient Hospital, Ambulatory Surgical Center, Clinic, Lab and X-ray, Home Health, Prescription Drugs
Tennessee CHOICES	Prescription Drugs
Texas STAR+PLUS	Nursing Facility, Behavioral Health in Dallas Service Area
Washington Medicaid Integration Partnership	Nursing Facility after 180 days , ID/DD HCBS Waiver
Wisconsin Family Care Partnership	N/A
Wisconsin Family Care	Primary and Acute Medical, Prescription Drugs

Note: For the purpose of this analysis, we define "major" service categories as primary, acute, prescription drugs, behavioral health, and institutional and community-based LTSS. Services such as non-emergency transportation and dental, which States frequently provide through a separate capitated arrangement, are not included.

7. Consumer-Directed Options in MLTSS Programs

Of the 16 States that have MLTSS programs, 12 offer consumer-directed options. Self-direction features range from State-to-State, generally reflecting whatever features a State offers in its traditional fee-for-service programs. These include employer authority, in which the member can hire, dismiss and supervise LTSS workers; and budget authority, in which the member also has a flexible budget with which to purchase goods and services related to LTSS needs.

Figure 7.1: States That Offer Self Directed Options Through MLTSS Programs, June 2012



Note: Employer Authority enables individuals to hire, dismiss, and supervise individual workers (e.g., personal care attendants and homemakers). Budget Authority provides participants with a flexible budget to purchase a range of goods and services to meet their needs. Definitions from: Developing and Implementing Self-Direction Programs and Policies: A Handbook. 2010. National Resource Center for Participant Directed Services. Accessed June 19, 2012 at http://www.bc.edu/content/dam/files/schools/gssw_sites/nrcpds/cc-full.pdf

Figure 7.1 shows that eight States offer self-directed options with employer authority (Arizona, Delaware, Hawaii, Massachusetts, Minnesota, Tennessee, Texas, and Washington). An additional four States offer both employer and budget authority (Michigan, New Mexico, North Carolina, and Wisconsin).

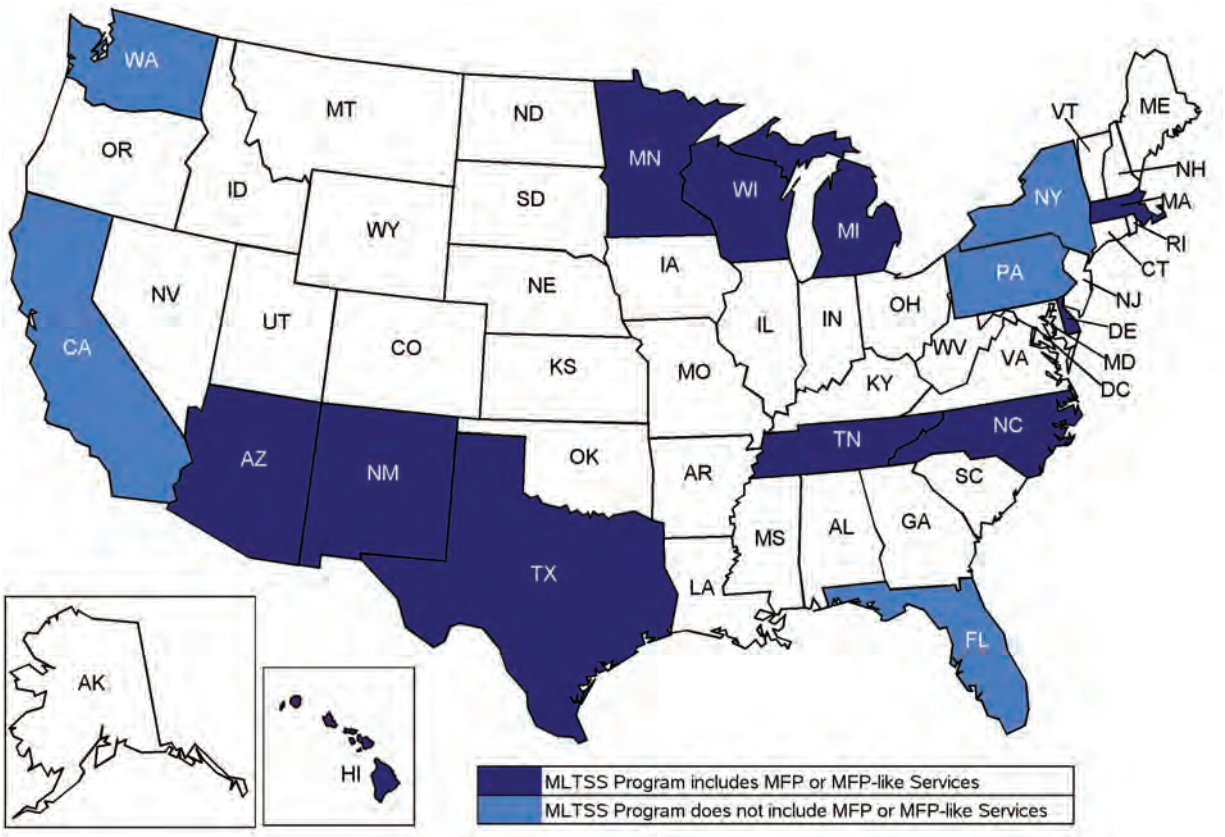
In most cases, States that offer self-directed options require their MLTSS contractors to discuss the option with all members at the initial assessment of LTSS needs and at regular reassessment intervals.

8. Money Follows the Person (MFP) through MLTSS Programs

The Money Follows the Person (MFP) Rebalancing Demonstration Program provides federal incentives to transition people from institutions to the community. MFP services are flexible and typically include identification of housing options; assistance with community set-up costs, such as security deposit and furnishings; development of a community services plan; and identification of community providers.

MFP is generally thought of as a fee-for-service intervention, but most MLTSS States include MFP or MFP-like services in their MLTSS programs.

Figure 8.1: States That Provide "Money Follow the Person" (MFP) or MFP like Services Through MLTSS Programs, June 2012



Note: "Money Follows the Person" is the name of a specific federal initiative that provides grants to States to assist Medicaid enrollees to transition out of institutional settings. By "MFP-like," we mean a similar set of services that is not formally funded by the federal MFP initiative. For example, prior to their participation in MFP, New Mexico had an MFP-like initiative called the Community Reintegration Program.

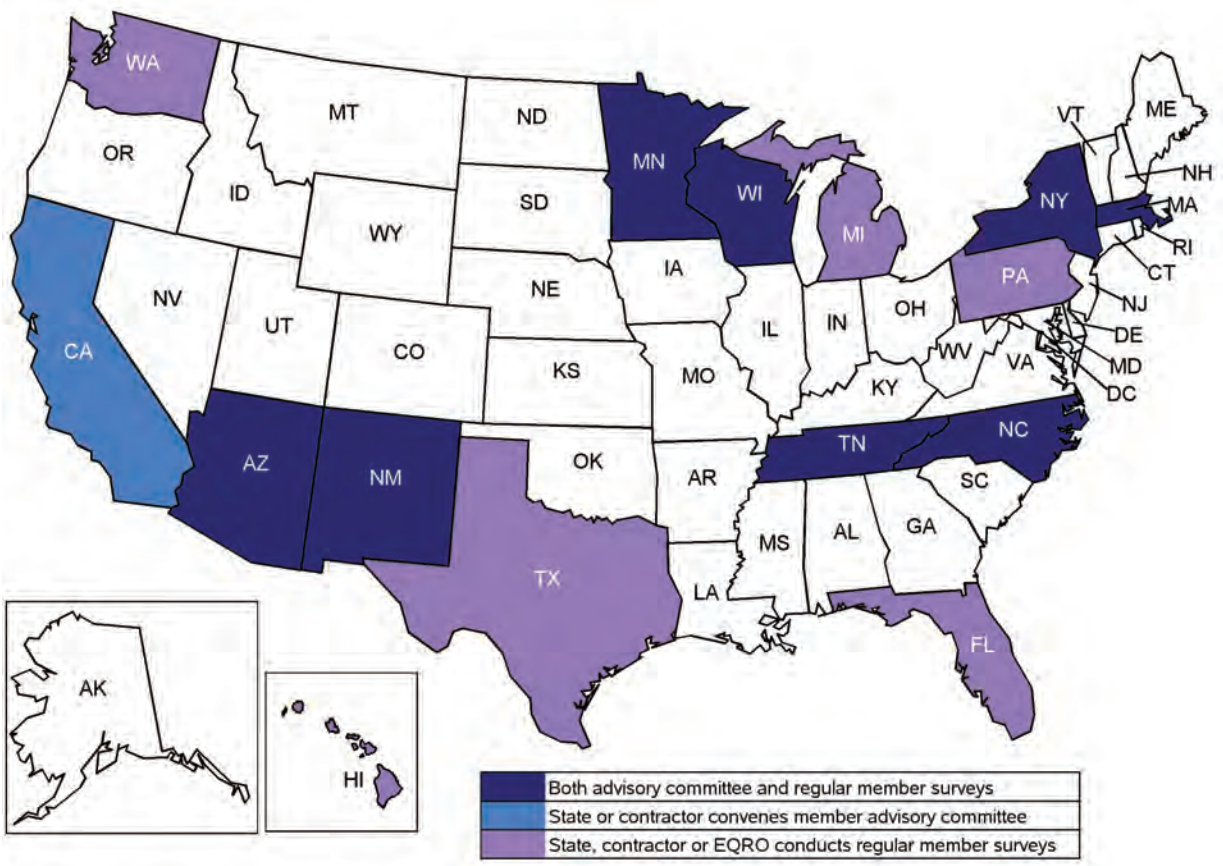
Eleven States offer MFP or MFP-like services through their MLTSS programs (Arizona, Delaware, Hawaii, Massachusetts, Michigan, Minnesota, New Mexico, North Carolina, Tennessee, Texas, and Wisconsin). Some States have developed MLTSS performance measures in regard to MFP participation and offer MLTSS contractors incentives based on those measures.

9. Ongoing Engagement of Members in MLTSS Programs

Once MLTSS programs are operating, States use at least two methods to ensure that members are systematically engaged in providing feedback and advice about the programs. One approach is to convene, or require the MLTSS contractors to convene, advisory committees that include members. Another is to require member surveys on an annual or biennial basis. Surveys include satisfaction and experience surveys

and are administered by the State, MLTSS contractors, External Quality Review Organizations, or other third parties. Individual States use other methods as well, but none are as common across States as these.

Figure 9.1: Two Common Methods for Engaging Members of MLTSS Programs, June 2012

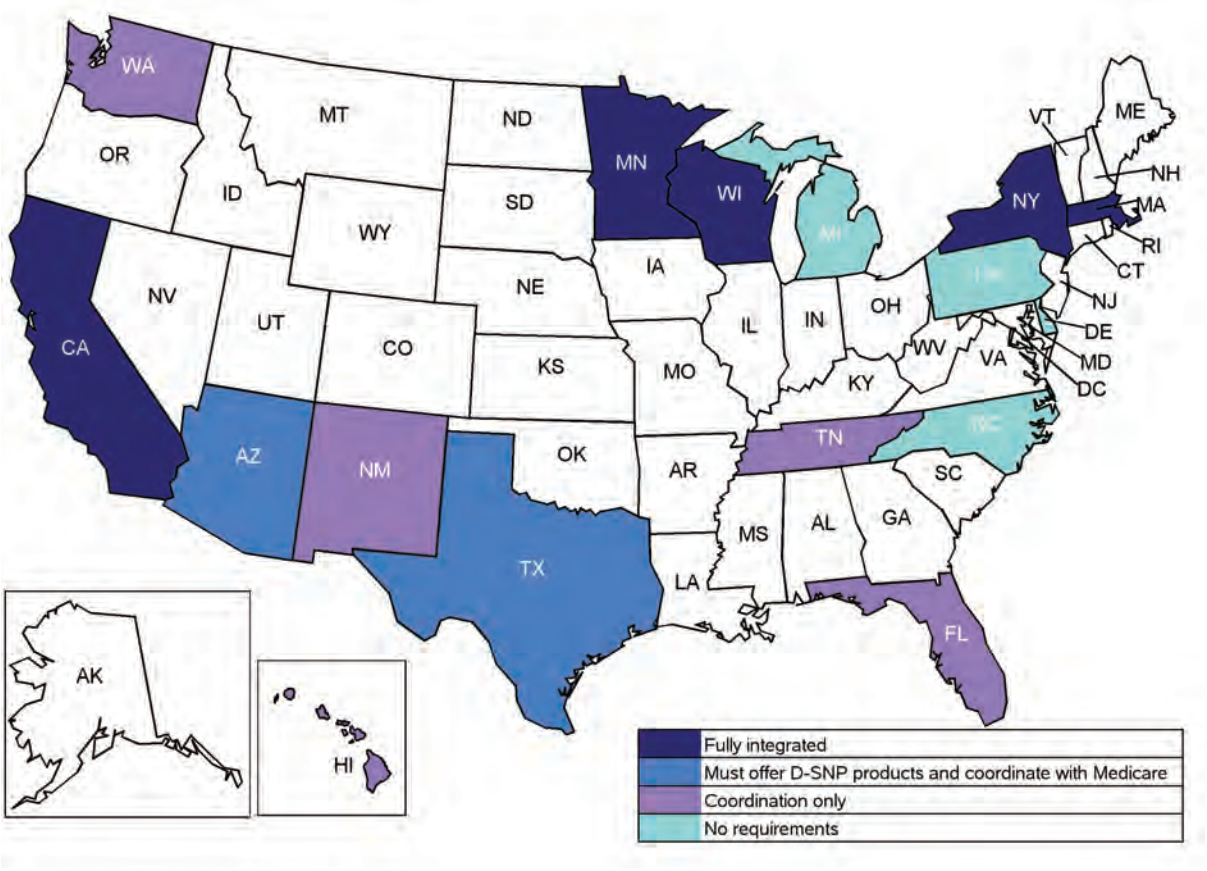


As shown in Figure 9.1, eight States use both member advisory committees and member surveys to collect regular feedback and advice from MLTSS program members (Arizona, Massachusetts, Minnesota, New Mexico, New York, North Carolina, Tennessee, and Wisconsin). Six States conduct or require others to conduct member surveys on a regular basis (Hawaii, Florida, Michigan, Pennsylvania, Texas, and Washington.)

10. Relationship to Medicare

Most LTSS users have Medicare coverage in addition to Medicaid and States have taken a variety of approaches to coordinating across the two programs.

Figure 10.1: MLTSS Approach to Medicare by State



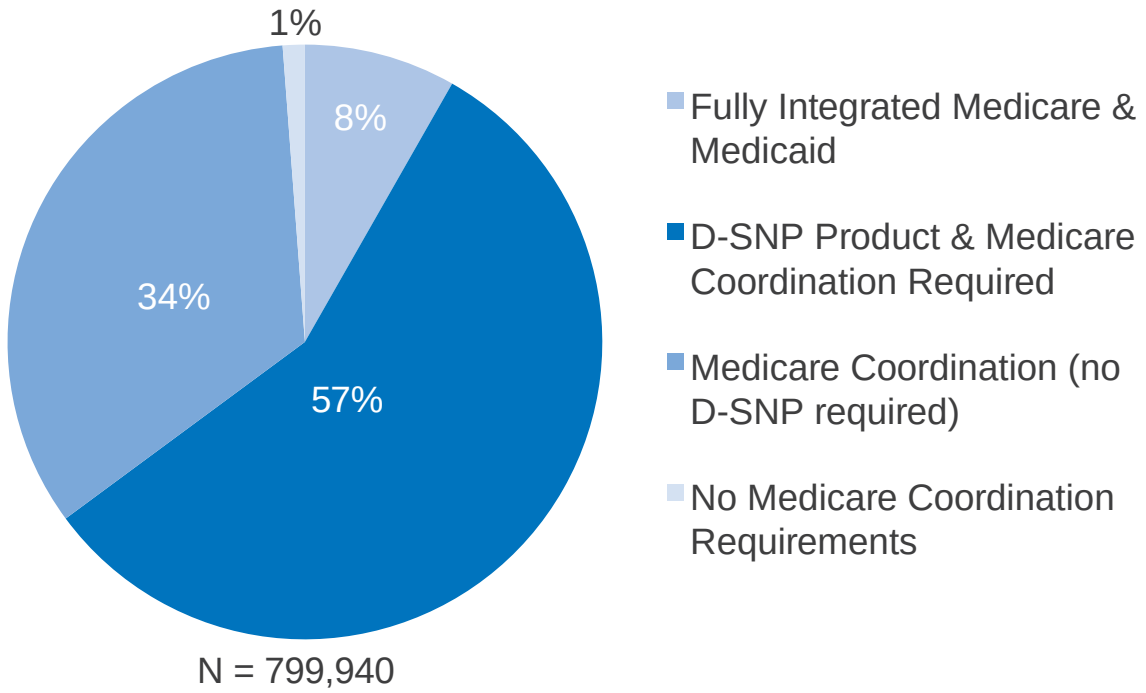
Note: "Fully integrated" refers to a program in which contractors receive both Medicaid and Medicare capitation rates and beneficiaries enroll in the same plan to receive both Medicare and Medicaid benefits.

Five of the 16 States have programs that are fully integrated, meaning the contractors are at risk for both Medicaid and Medicare services, and members must choose the same managed care entity for both sets of benefits (California, Massachusetts, Minnesota, New York, and Wisconsin).

Two States (Arizona and Texas) require coordination with Medicare and also require contractors to offer Medicare Advantage Special Needs Plan (SNP) products. Five States (Florida, Hawaii, New Mexico, Tennessee, and Washington) require their managed care plans to coordinate with Medicare, but do not require them to offer SNPs (though many of the plans participating in these programs do offer SNPs without a contractual requirement).

Delaware, Michigan, North Carolina, and Pennsylvania currently do not have contract requirements regarding the coordination of members' Medicaid and Medicare services.

Figure 10.2: Distribution of MLTSS Enrollees by Approach to Coordination With Medicare, 2012



Note: "Fully integrated" refers to a program in which contractors receive both Medicaid and Medicare capitation rates and beneficiaries enroll in the same plan to receive both Medicare and Medicaid benefits.

Nearly all MLTSS enrollees (99 percent) are in programs that require coordination with Medicare, but only 8 percent are in fully integrated programs, as shown in Figure 10.2.

11. LTSS Quality

Measures Specific to LTSS

Most State MLTSS programs include quality measures that are specific to LTSS, but the lack of a national set of LTSS measures has resulted in highly unique approaches across the States and little comparability across programs. Examples of measure topics include: timeliness of initiating community-based LTSS; timeliness of completing level of care assessments; nursing facility or other institutional admissions; maintenance of community transition; receipt of services authorized in the care plan; member-centeredness of care plan; number of home health visits; notification of appeal rights upon reduction or denial of service; participation in volunteer or paid work; member satisfaction; and member personal experience. States overlapped most on measures related to ensuring receipt of services in care plans, indicating most States use home and community-based services waiver program measures as a foundation for their MLTSS programs. Measures of member satisfaction and timeliness of initiating community-based LTSS and/or level of care assessments are also very common.

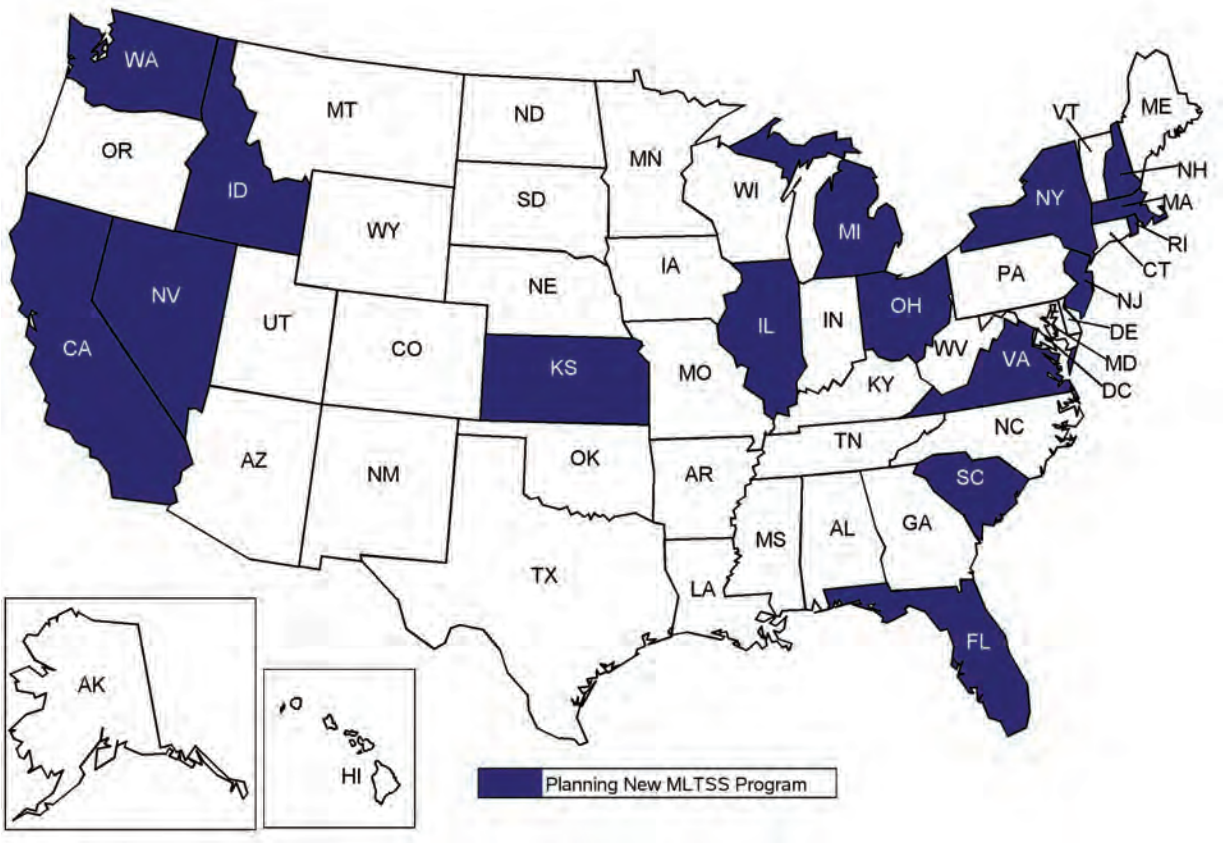
Monitoring Specific to LTSS

Fourteen States indicated that they perform monitoring activities that are specific to LTSS (Arizona, Delaware, Florida, Hawaii, Michigan, Minnesota, New Mexico, New York, North Carolina, Pennsylvania, Tennessee, Texas, Washington, and Wisconsin). As with the LTSS quality measure topics, there is a wide range of monitoring activities. These include: audits of care plans; observation of care coordination; review of LTSS provider network data; comparison of LTSS provider claims paid and LTSS encounters submitted; review of critical incidents; review of utilization of LTSS and gaps in services; review of timeliness of initiation of services and conducting level of care assessments; tracking of admissions to nursing homes and other institutions and face-to-face interviews with members. States overlapped most on conducting face-to-face interviews with members, auditing care plans, and reviewing critical incidents.

12. Projected New MLTSS Programs through January 2014

If current State plans come to fruition, MLTSS will increase significantly by 2014, both in terms of the number of States with programs and the number of persons enrolled in them.

Figure 12.1: States Planning to Implement New MLTSS Programs by January 2014

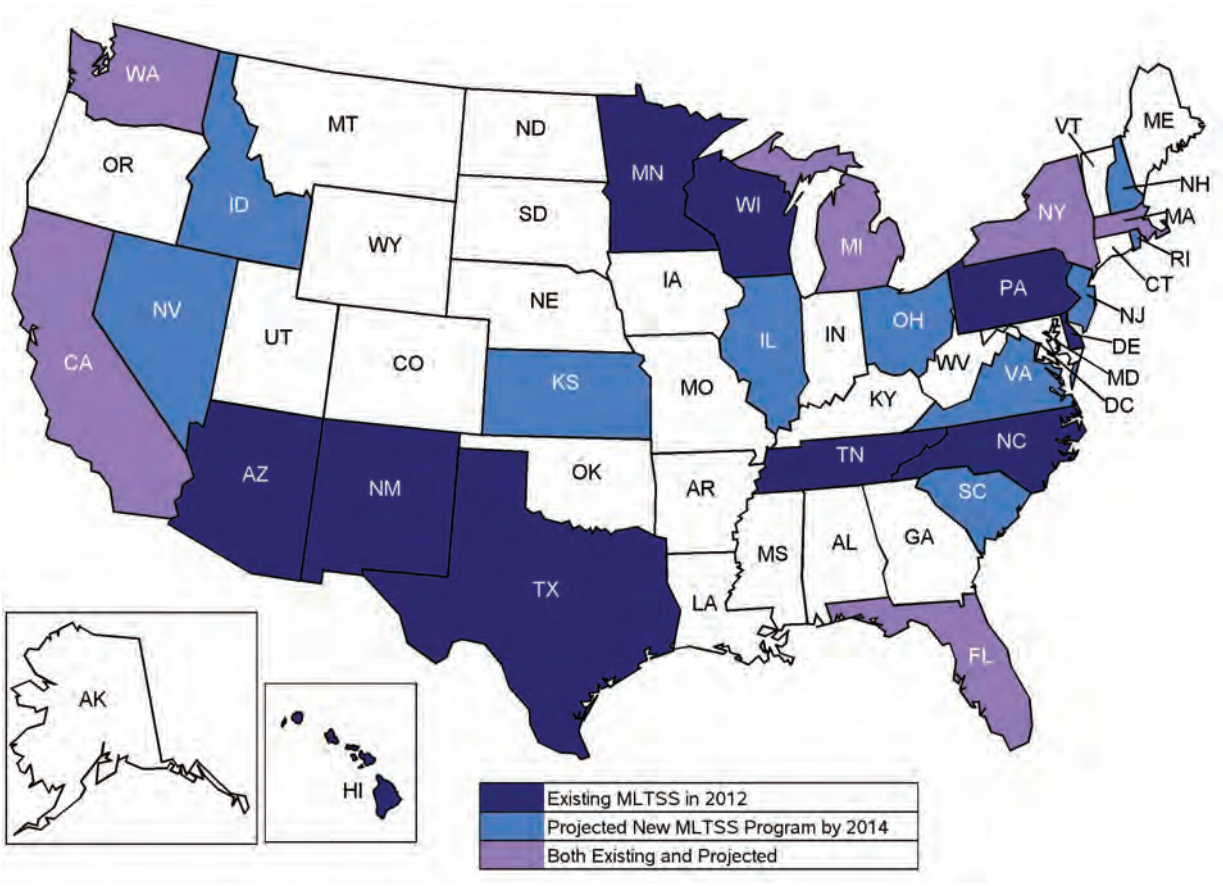


Note: We included States that have public plans for new MLTSS programs that include: a public planning document, request for information, request for proposals; proposal to CMS or waiver application to CMS. Submitting a letter of intent to CMS for the Medicare-Medicaid Financial Alignment Demonstration was not by itself sufficient to be included here.

Sixteen States plan to implement new MLTSS programs by January 2014, as shown in Figure 12.1. They are: California, Florida, Idaho, Illinois, Kansas, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New York, Ohio, Rhode Island, South Carolina, Virginia, and Washington. Several of these are proposing MLTSS as part of a Medicare-Medicaid Financial Alignment Demonstration.

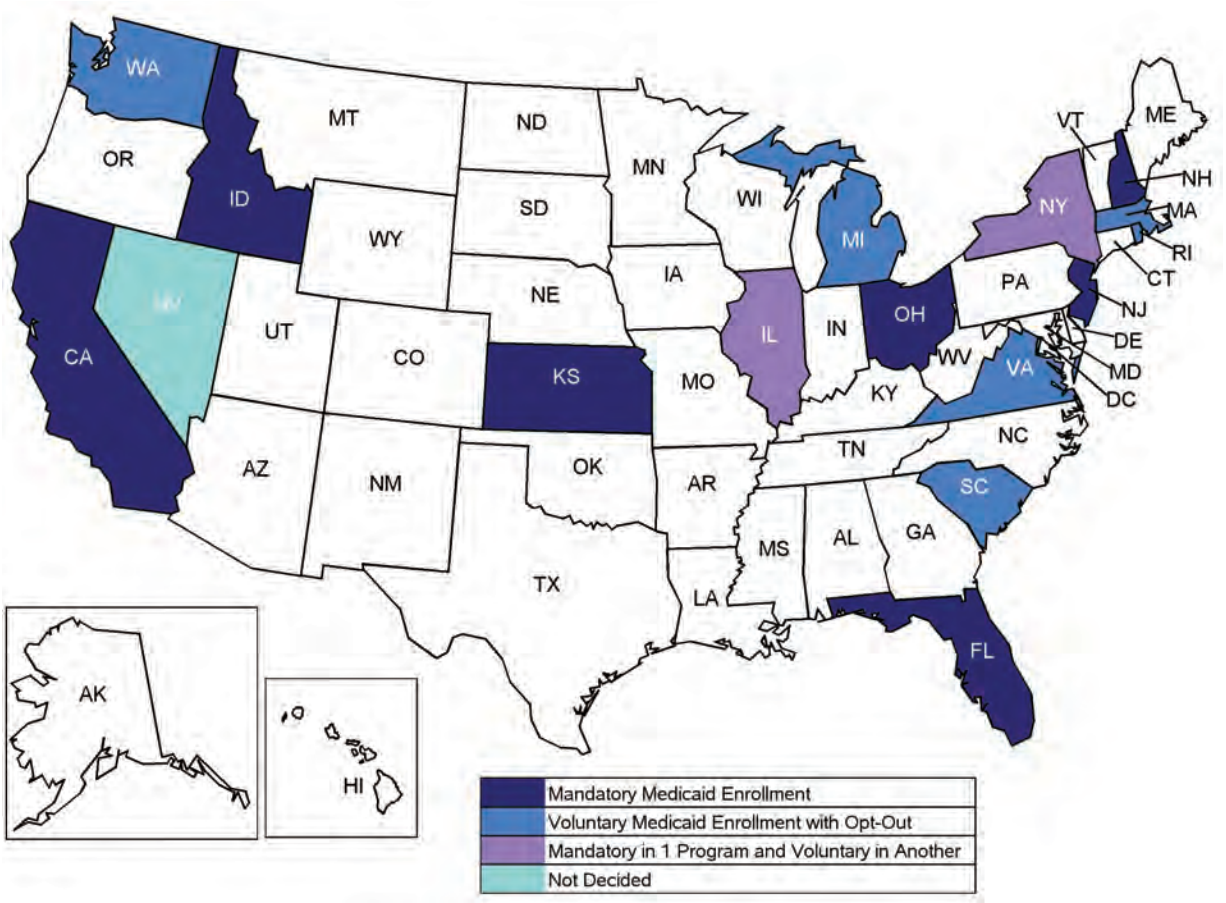
Two of these are proposing more than one new program. New York is proposing three, and Illinois is proposing two.

Figure 12.2: All States Projected to Have MLTSS Programs by January 2014 (Existing and New)



When existing MLTSS States and projected States are combined, the total number of States expected to have MLTSS programs by January 2014 is 26. Of these, six have both existing programs and plan to implement additional programs by 2014 (California, Florida, Massachusetts, Michigan, New York, and Washington). Ten have existing programs only, and 10 have new projected programs only.

Figure 12.3: Type of Medicaid Enrollment in Future Programs (Mandatory or Voluntary)

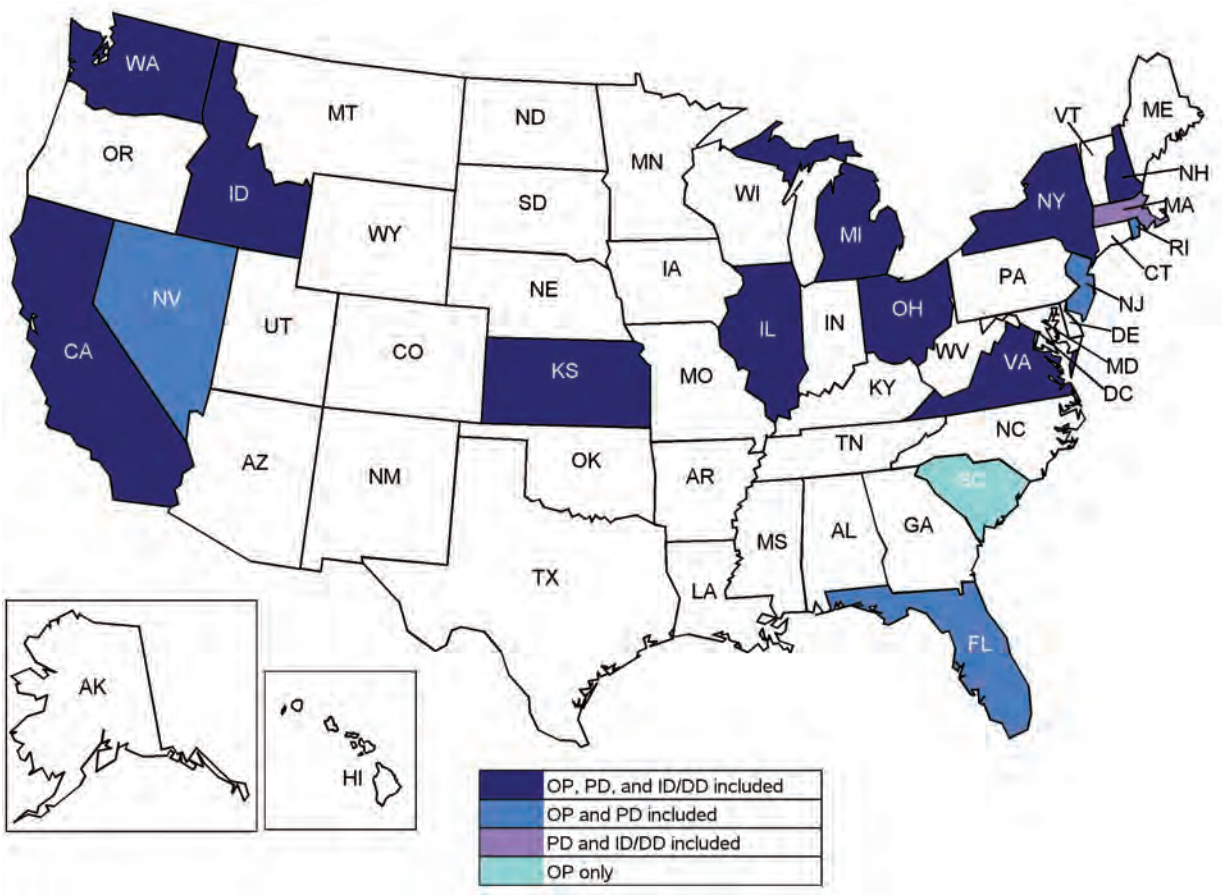


The future programs are about evenly split in terms of the type of Medicaid enrollment proposed. Seven are proposed to have mandatory Medicaid enrollment (California, Florida, Idaho, Kansas, New Hampshire, New Jersey, and Ohio). Six are slated for voluntary Medicaid enrollment (Massachusetts, Michigan, Rhode Island, South Carolina, Virginia, and Washington). All of the voluntary proposals plan a passive enrollment system in which eligible persons would be automatically enrolled unless they specifically opt out.

The two States that are proposing more than one new initiative are developing both mandatory and voluntary programs (Illinois and New York).

One State (Nevada) has not yet decided what type of enrollment it will use.

Figure 12.4: Population Groups Being Considered for Enrollment by January 2014



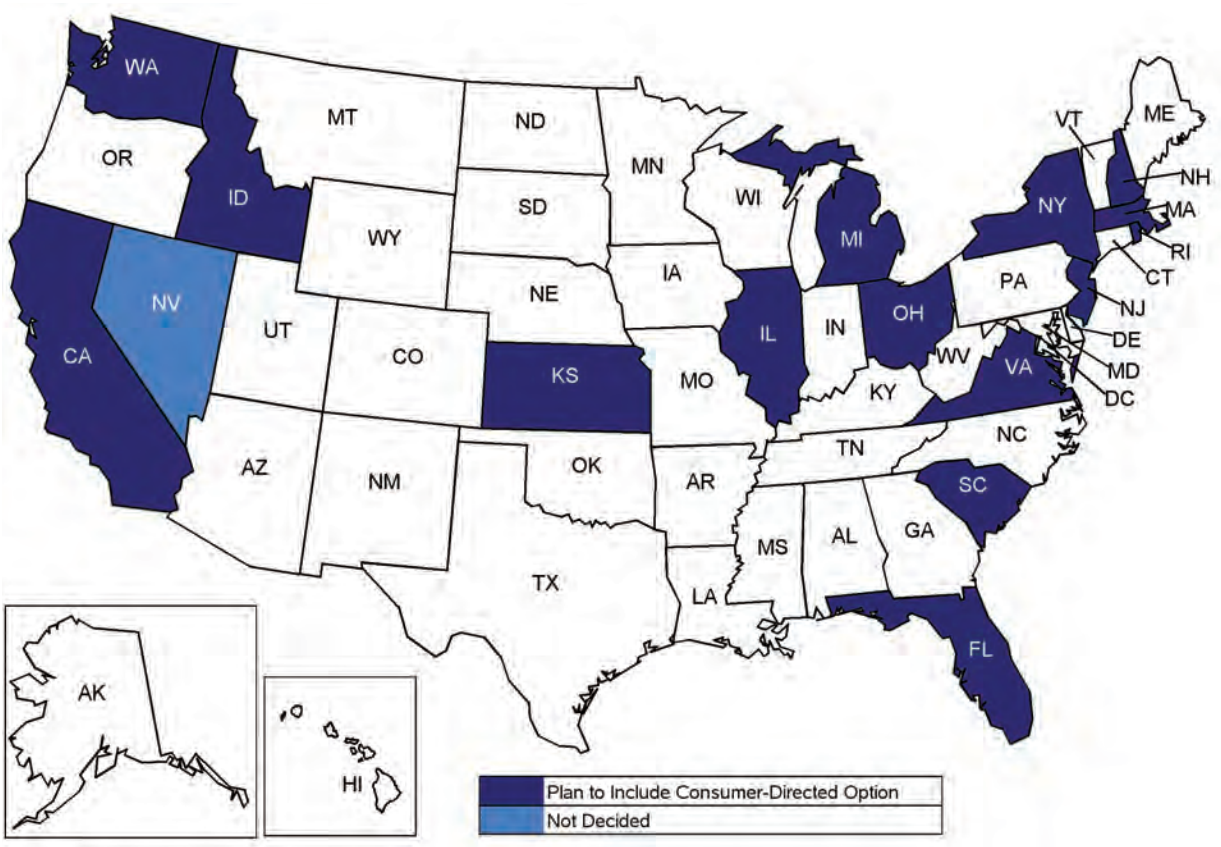
Note: OP = Older Persons (65+), PD = Adults with Physical Disabilities, ID/DD = Adults with Intellectual/Developmental Disabilities. Some States are proposing additional populations beyond the ones captured in this figure, including children with disabilities and persons with serious mental illness. For more State specific information, see Appendix B.

Most States are proposing to serve multiple population groups in their future MLTSS programs. Ten programs plan to include older persons (65+), adults with physical disabilities, and adults with intellectual/developmental disabilities (California, Idaho, Illinois, Kansas, Michigan, New Hampshire, New York, Ohio, Virginia, and Washington).

Four States will enroll older persons (65+) and adults with physical disabilities but not include adults with intellectual/developmental disabilities (Florida, Nevada, New Jersey, and Rhode Island).

One State will enroll adults with physical disabilities and adults with intellectual/developmental disabilities, but not older persons (Massachusetts), and one State will enroll only older persons (South Carolina).

Figure 12.5: States Planning to Include Consumer Directed Option in Future MLTSS Programs



All but one of the 16 States planning new programs will include consumer-directed options, as shown in Figure 12.5. One State (Nevada) has not yet decided.

Figure 12.6: States Planning to Integrate Medicare in Future MLTSS Programs

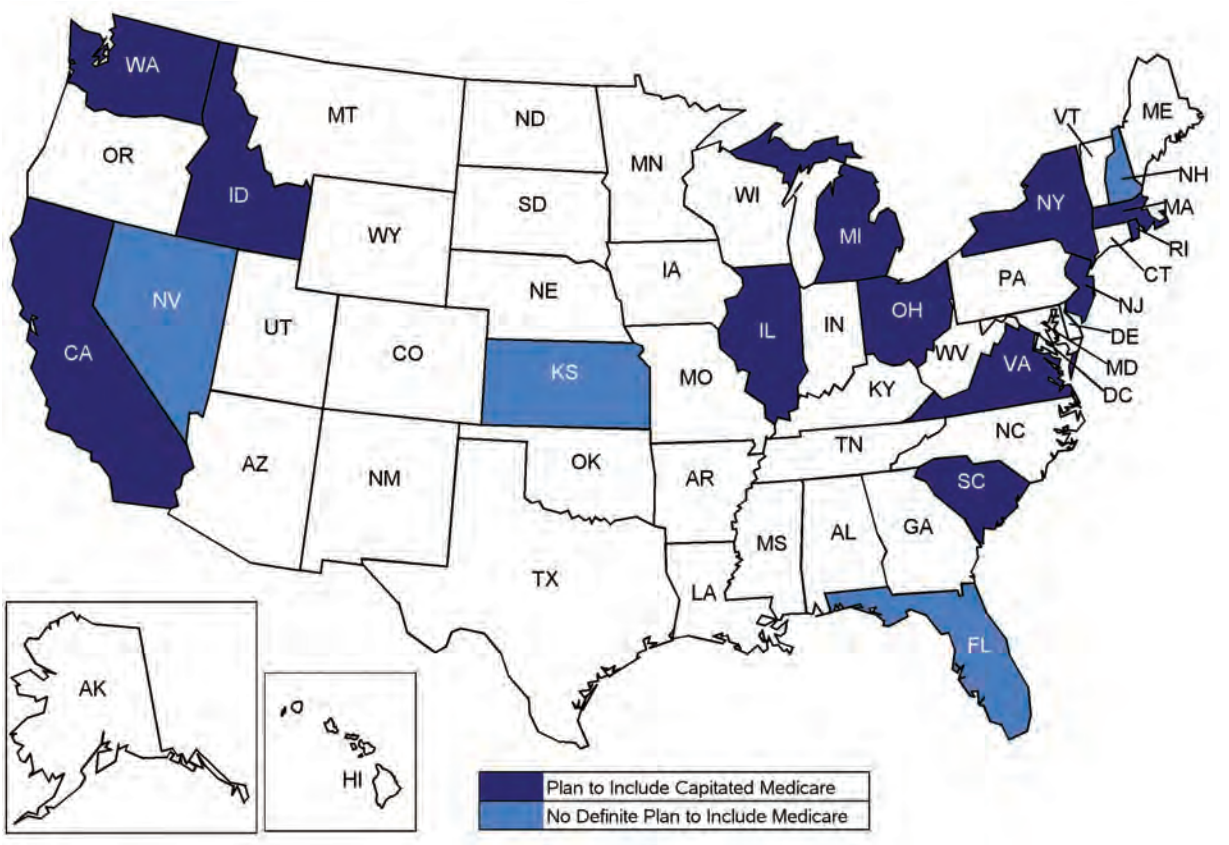


Figure 12.6 shows that several States plan to include Medicare in their future MLTSS programs on a fully capitated basis, reflecting the significance of the CMS Medicare-Medicaid Financial Alignment demonstration in States' planning efforts. Twelve States have definite plans to include Medicare (California, Idaho, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Rhode Island, South Carolina, Virginia, and Washington). Four States are focused primarily on Medicaid and have no definite plan to include Medicare at this point in their planning (Florida, Kansas, Nevada, and New Hampshire).

13. Conclusion

Medicaid managed long-term services and supports (MLTSS) has grown significantly since 2004, and growth is projected to accelerate in the next two years, in terms of the number of States, the number of programs, and the number of enrollees.

Though it remains a small phenomenon nationally compared to traditional fee-for-service delivery, MLTSS has become a significant part of the system in several States. The number of States and contractors that now have experience offers an advantage to new States planning

to implement programs in the future. New States have the benefit of expertise, contracts, protocols, monitoring systems, and other resources from the States that were early implementers.

The development of the MLTSS market was initially hampered by a very limited supply of organizations that had both the experience and ability to accept risk for LTSS. However, the supply of experienced organizations has increased in recent years and most States should experience greater choice of suppliers.

Many of the early States adopted important design features that have not been widely associated with managed care. One is the inclusion of consumer-directed options, and another is the incorporation of Money Follows the Person (MFP) or MFP-like features into MLTSS programs. In most States, MLTSS is not a competing approach to consumer direction and MFP, but rather an overarching structure through which these and other innovations may be delivered.

In the absence of a set of national LTSS performance measures, States have implemented their own unique approaches to measuring quality. These include system measures (e.g., progress on rebalancing) and person-level measures around use of institutional services, community inclusion, experience, and satisfaction. Because each State has developed its own unique approach to measuring quality in MLTSS, there is currently no clear method to compare the quality of LTSS services across MLTSS programs.

The opportunity to participate in the CMS Medicare-Medicaid Financial Alignment demonstration is a significant factor, but not the only one driving States toward MLTSS. Several States are structuring their current program development efforts in phases, beginning with a Medicaid-only MLTSS program, with a Medicare component to be added in later years as feasible. Several States see MLTSS as the logical final phase of their Medicaid managed care programs and are proposing MLTSS as part of a comprehensive reform of their Medicaid programs.

This inventory provides more detail than previously available on the features of MLTSS programs and should contribute to a common understanding of MLTSS as stakeholders engage in policy and design discussions across the country. Major themes have been synthesized in the report and State-by- State details are available in the appendices.

Appendix A

Description of Existing MLTSS Programs as of June, 2012

TRUVEN HEALTH ANALYTICS™

Table of Contents

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Arizona Long-Term Care System

	Element	Description/Notes
1	State and Lead Agency	Arizona Arizona Health Care Cost Containment System (AHCCCS)
2	Program	Arizona Long-term Care System (ALTCS)
3	Inception	1988-1989
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1115
6	# Enrolled	52,251 (May 2012) Subset of members using LTSS: 52,251
7	Evolution	Originally, most of the contractors were counties, but over time the State has moved to a system of private contractors
8	Contractors	**Persons with Physical Disability; Persons 65+:** 1 Mercy Care Plan 2 Bridgeway Health Solutions 3 Evercare Select **Persons with Developmental Disability:** 4 AZ Division of Developmental Disabilities
9	Contractors, Type	**Contractor 1: Mercy Care Plan** ▪ Parent Company: Southwest Catholic Health Network ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 2 of 15 ▪ MCO/HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 11,309
9	Contractors, Type	**Contractor 2: Bridgeway Health Solutions** ▪ Parent Company: Centene ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 6 of 15 ▪ MCO/HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 6,047
9	Contractors, Type	**Contractor 3: Evercare Select** ▪ Parent Company: UnitedHealthcare ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 10 of 15 ▪ MCO/HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 8,086

9	**Contractors, Type**	**Contractor 4: Division of Developmental Disabilities** ▪ Parent Organization: AZ Dept of Economic Security ▪ State Agency ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 15 of 15 ▪ State Agency ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 24,391
10	**Geographic Reach of Program**	Statewide
11	**Includes rural areas?**	Yes
12	**Groups Enrolled**	▪ Children ▪ Adults < 65 with PD ▪ Adults < 65 with ID/DD ▪ Adults 65+
13	**Program Eligibility in terms of LTSS Needs**	▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver
14	**Type of Medicaid Enrollment**	Mandatory If voluntary, opt in or opt out? N/A Lock-in period (specify): 12 months in the two counties with choice of plans In all other counties, there is one contractor
15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute ▪ Behavioral ▪ Rx Drugs **LTSS** ▪ NF ▪ ICF/MR ▪ HCBS waiver-like services (under 1115): personal care; adult day health; attendant care; community transitional services; emergency alert system; group respite; habilitation; home delivered meals; home health service, homemaker, home modification; hospice; PDN; respite
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Attendant care, which includes personal services, homemaking, general supervision and limited skilled services Populations that may self-direct: Adults with PD, adults 65+ Model Features: Employer Authority (both employer and co-employer models) Does the program require the managed care contractor to contract out the Financial Management Services role? Yes If Yes, what entity performs this role? Any qualified entity selected by contractor What entity performs the support broker role? Contractor (through the case management function)
17	**LTSS Level of Care**	What entity determines Level of Care? State AHCCCS staff in local offices Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Contractor What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Contractor decides how to perform function within contract specifications.
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18)**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? N/A If yes, is it mandated by the State? N/A If yes, describe the role: Prior to ALTCS, case management was a county function, and many former county case managers now work for the contractors

20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives **Community First Choice** – Contractors have participated on the planning council and will be key to implementation Their roles will include: 1) getting participation from and paying providers; 2) implementing new encounter codes for training and other costs; and 3) educating members about the option at initial assessment and at regular intervals **Money Follow the Person** – AZ does not have an MFP grant, but contractors are required to provide community transitional services, which are MFP-like services provided to members in nursing homes who wish to move into the community
21	**Member Engagement**	Specify any contractual requirements for engaging members: Member Adviory Committee – Contractor must establish Member Council which meets at least quarterly. Should include cross-representation of members, family members, and significant others Annually, contractor submits meeting schedule and draft council goals to AHCCCS Agendas and meeting minutes also must be sent to the State **Member surveys** – Contractor may be required to conduct annual general or focused survey and send results to AHCCCS AHCCCS may conduct its own surveys (reimbursed by contractor) At least quarterly, contractor surveys a sample of members to ensure services were provided as required **Other** – Contractors should "actively participate" with other LTC and related organizations to better understand LTC issues in the community and impact on members
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: Hotline – Yes **Other** – Contractor must "dispose of each grievance" within 90 days
23	**LTSS Quality**	What LTSS performance measures are in use? Initiation of HCBS (timeliness) and pressure ulcer prevalence Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Yes. The contract references the AHCCCS Medical Policy Manual (AMPM) which requires contractors to perform performance improvement projects (PIPs) specified by AHCCCS. ALTCS contractors were recently required to conduct a 3-year PIP on advance directives Contractors must also meet minimum performance standards and improve outcomes from year to year Does the State conduct any oversight activities specific to LTSS? In addition to the LTSS measures above, AHCCCS monitors: ▪ Case management case loads ▪ Timely initiation of service ▪ Timely reassessment of need ▪ Consistency of services delivered and plan of care ▪ Gaps in service for: attendant care; personal care; housekeeping and respite
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes (all services) If yes, does the State validate it for completeness and accuracy? Yes

25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes Arizona uses a blended rate, which pays the same regardless of setting (nursing home, residential alternative, in-home) This creates an incentive to maximize the use of cost-effective HCBS The blend assumes a certain mix, and a year-end reconciliation process further rewards HCBS as follows: ▪ If the contractor's actual HCBS mix percentage is over/under the assumed percentage (from start of contract year) by 1% or less (0% - 1%) AHCCCS will not recoup from or reimburse the contractor ▪ If the contractor's actual HCBS mix percentage is over/under the assumed percentage by >1%, AHCCCS will recoup or reimburse at 50% of the over/under payment For example, if the contractor overspends because it places more members in NFs and does not meet the HCBS placement target, the CONTRACTOR is only reimbursed for 50% of its costs above the 1% risk corridor; if contractor profits because it places more members in HCBS and exceeds the HCBS placement target, AHCCCS only recoups 50% of the profit above the 1% risk corridor If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Community-based LTSS based on person-centered assessment of needs and cost effectiveness study
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members:
28	**Medicare Authority/Vehicle (if applicable)**	SNP or Medicare Advantage Plan
29	**Evaluation**	Has the program been formally evaluated? Yes "Utilization of Services in Arizona's Capitated Medicaid Program for Long-Term Care Beneficiaries," Nelda McCall and Jodi Korb, Health Care Financing Review, Winter 1997.

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

California SCAN Connections at Home

	Element	Description/Notes
1	State and Lead Agency	California Department of Health Care Services
2	Program	SCAN Connections at Home
3	Inception	1985
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1915(a)
6	# Enrolled	2,304 (April 2012 CMS SNP enrollment report) Subset of members using LTSS: 2,304
7	Evolution	SCAN was one of the original Medicare Social HMO sites in the mid-1980s When the S/HMO demonstration was ended, SCAN converted to a Special Needs Plan and obtained a contract with the State of California to provide LTSS The contract with the State ends on December 31, 2012
8	Contractors	One local plan
9	Contractors, Type	**Contractor 1: Scan Connections at Home** ▪ Parent Company: SCAN Health Plan ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 3 of 58 ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 2,304
10	Geographic Reach of Program	3 of 58 counties
11	Includes rural areas?	No
12	Groups Enrolled	Medicare-Medicaid enrollees 65+ years of age
13	Program Eligibility in terms of LTSS Needs	Institutional level of care
14	Type of Medicaid Enrollment	Voluntary If voluntary, opt in or opt out? Opt in Lock-in period (specify): None- members may disenroll on a month-to-month basis
15	Medicaid Services in Capitation	To the extent not covered by Medicare: ▪ Primary ▪ Acute ▪ Behavioral ▪ Rx Drugs **LTSS:** ▪ NF ▪ HCBS waiver-like services, including homemaker, home delivered meals, personal care, transportation escort, custodial care, in-home respite, adult day and DME
16	Participant-directed Services	Participant-directed options offered? No Services that may be directed: Populations that may self-direct: Model Features: Does the program require the managed care contractor to contract out the Financial Management Services role? If Yes, what entity performs this role? What entity performs the support broker role?

17	**LTSS Level of Care**	What entity determines Level of Care? Department of Health Care Services Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (nursing home level of care)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Contractor What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Contractor decides
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18)**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? No If yes, is it mandated by the State? If yes, describe the role:
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives No role specified.
21	**Member Engagement**	Specify any contractual requirements for engaging members: Member advisory committee
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ Medi-Cal Managed Care Ombudsman and ▪ The Department of Managed Health Care maintains Help Center, which all managed care enrollees (public and private) may access through a toll-free number
23	**LTSS Quality**	What LTSS performance measures are in use? Not found Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Not found Does the State conduct any oversight activities specific to LTSS? Not found
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Not found If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A – one level of care only
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Contractor is a Medicare Advantage Special Needs Plan and integrates Medicare and Medicaid for its members
28	**Medicare Authority/Vehicle (if applicable)**	Medicare Advantage Special Needs Plan statutory authority
29	**Evaluation**	Has the program been formally evaluated? No

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Delaware Diamond State Health Plan-Plus

	Element	Description/Notes
1	State and Lead Agency	Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance
2	Program	Diamond State Health Plan-Plus (DSHP-Plus)
3	Inception	April 1, 2012
4	Year LTSS included, if added to existing MMC program.	2012 (LTSS added to Diamond State Health Plan)
5	Medicaid Authorities	1115 Demonstration Waiver
6	# Enrolled	4,800 Subset of members using LTSS: 4,800
7	Evolution	N/A
8	Contractors	Two commercial plans
9	Contractors, Type	**Contractor 1: Delaware Physicians Care** ▪ Parent Company: Aetna Health Plans ▪ Private ▪ For-profit ▪ National (parent company is national) ▪ Number of counties contractor operates in within the State: 3 of 3 (statewide) ▪ HMO ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): Approximately 2,400
9	Contractors, Type	**Contractor 2: UnitedHealthcare** ▪ Parent Company: UnitedHealthcare (UnitedHealth Group) ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 3 out of 3 (statewide) ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Institutional (nursing home) ▪ Number of members in program (if available) Approximately 2,400
10	Geographic Reach of Program	Statewide
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ All SSI-eligible children and adults except persons in ICF/MRs and persons in DD/MR 1915(c) waiver ▪ Includes older persons, persons with physical disabilities, persons with HIV/AIDS, persons using Money Follows the Person services, workers with disabilities using Buy-in, and Medicare-Medicaid enrollees
13	Program Eligibility in terms of LTSS Needs	▪ Institutional- in facility (except not ICF/MR) ▪ Institutional- in community (except not in DD/MR waiver) ▪ At risk of becoming institutional level of care ▪ No LTSS need
14	Type of Medicaid Enrollment	Mandatory If voluntary, opt in or opt out? N/A Lock-in period (specify): 12 months. Members may also switch plans in the first 90 days of enrollment.

15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute ▪ Behavioral **LTSS** ▪ Nursing Facility ▪ Community Based Residential Alternatives ▪ HCBS waiver-type services including respite; adult day; day habilitation; cognitive services; personal care, emergency response systems (PERS); support for participant direction; chore; nutrition, medical equipment and supplies; home modification; home delivered meals. Note: Prescription drugs are carved out of both DSHP and DSHP Plus
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Personal care services Populations that may self-direct: not found Model Features: Employer authority (co-employer model) Does the program require the managed care contractor to contract out the Financial Management Services role? Yes If Yes, what entity performs this role? Personal Care providers What entity performs the support broker role? Personal Care providers
17	**LTSS Level of Care**	What entity determines Level of Care? State Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? Two (institutional level of care (2 ADLs); and at-risk for becoming institutional level-of-care (1 ADL))
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Contracted Managed Care Organizations What entity performs ongoing service coordination for HCBS waiver and State plan services? Contracted Managed Care Organizations Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Contracted Managed Care Organizations may choose to subcontract function
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? No If yes, is it mandated by the State? If yes, describe the role:
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing “Money Follows The Person”, Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Money Follows the Person** – Contractors provide MFP transition coordinators and nurses to assist with transitions Contractors include MFP service vendors in their networks and reimburse them ▪ **Balancing Incentive Payments** – Delaware has just begun looking at this opportunity
21	**Member Engagement**	Specify any contractual requirements for engaging members: Not found
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ Contracted Managed Care Organizations are required to operate a 24/7 member Hotline ▪ Contracted Managed Care Organizations are required to have at least one member advocate to work with members and providers to facilitate the provision of benefits. ▪ State Community and Institutional Ombudsman available to assist members in problem resolution ▪ Members can appeal MCO service decisions via both MCO and State fair hearing process
23	**LTSS Quality**	What LTSS performance measures are in use? The State is developing these as part of a revision and expansion of its current Medicaid managed care Quality Management Strategy Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? See above Does the State conduct any oversight activities specific to LTSS? EQRO, State & MCO joint home visits

24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes MCOs receive the same blended rate for both institutional and HCB members If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? Actuary estimates number of members in community vs nursing facility in setting the rate range New Medicaid LTS applicants must require assistance with at least 2 ADLs to be approved for admission to a nursing facility New Medicaid LTS applicants must require assistance with at least one ADL to be approved for HCBS Previously, NF applicants just had to require assistance with one ADL
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: All Medicare-Medicaid enrollees are now served by the Contracted Managed Care Organizations Contractors are encouraged to develop companion Special Needs Plans in 2013
28	**Medicare Authority/Vehicle (if applicable)**	N/A
29	**Evaluation**	Has the program been formally evaluated? Not yet The program was just implemented 04/01/12

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Florida Long-Term Care Community Diversion Program

	Element	Description/Notes
1	State and Lead Agency	Florida Department of Elder Affairs, via a cooperative agreement with the Agency for Health Care Administration
2	Program	Long-term Care Community Diversion Program
3	Inception	1998
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1915(a) & 1915(c)
6	# Enrolled	19,283 (April 2012)
7	Evolution	Following a pilot in four counties, the program was expanded incrementally through 2010, when it became authorized statewide The program operates in 46 of Florida's 67 counties The Department is currently processing applications for the remaining 11 counties Once approved the program will be statewide
8	Contractors	Seventeen national and local managed care contractors, which include but are not limited to HMOs. Other qualified providers (OQPs), defined in Florida law, are also eligible. Examples of OQPs are nursing homes, home health agencies, hospice providers, adult day care centers, and assisted living facilities
9	Contractors, Type	**Contractor 1: American Eldercare** ▪ Parent Company: Heritage Park Retirement Communities, LLC ▪ Private ▪ For-profit ▪ Local ▪ Number of counties contractor operates in: 38 ▪ Provider organization ▪ Operates companion/related SNP? No ▪ SNP type: Numbers in program (if available): 4,373
9	Contractors, Type	**Contractor 2: Amerigroup** ▪ Parent Company: Amerigroup ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates: 45 ▪ HMO ▪ Operates companion/related Medicare Advantage Plan? Yes ▪ Type MA: Medicare-Medicaid enrollee SNP ▪ Number of members in program (if available): 2,612
9	Contractors, Type	**Contractor 3: Vista Health Plan Inc.** ▪ Parent Company: Coventry Health Care ▪ Private ▪ For-profit ▪ National (parent is national) ▪ Number of counties contractor operates in: 3 ▪ HMO ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 1,068

9	Contractors, Type	**Contractor 4: Hope Choices** ▪ Parent Company: Hope Hospice ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in: 5 ▪ Provider organization ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 181
9	Contractors, Type	**Contractors 5 & 6: Humana Florida Comfort Choice and Humana Florida Seniors Choice** ▪ Parent Company: Humana ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in: 33 ▪ HMO ▪ Operates companion/related Medicare Advantage Plan? Yes ▪ Type MA: Medicare-Medicaid enrollee and Chronic SNPs ▪ Number of members in program (if available): 1,463
9	Contractors, Type	**Contractor 7: Little Havana Forever Home Program** ▪ Parent Company: Little Havana Activities and Nutrition Centers of Dade County, Inc (LHANC) ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in: 3 ▪ Provider organization ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 1,098
9	Contractors, Type	**Contractor 8: Neighborly Care Network** ▪ Parent Company: Neighborly Care Network, Inc ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in: 18 ▪ Provider organization ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 790
9	Contractors, Type	**Contractor 9: Project Independence at Home** ▪ Parent Company: Miami Jewish Health Systems ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in: 2 ▪ Provider organization ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 754

9	Contractors, Type	**Contractor 10: Simply Healthcare** ▪ Parent Company: Simply Healthcare, Inc ▪ Private ▪ For-profit ▪ Local ▪ Number of counties contractor operates in: 6 ▪ HMO ▪ Operates companion/related Medicare Advantage Plan? Yes ▪ Type MA: Medicare-Medicaid enrollee SNP ▪ Number of members in program (if available): 113
9	Contractors, Type	**Contractor 11: Sunshine State Tango Plan** ▪ Parent Company: Centene ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in: 20 ▪ HMO ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 2,056
9	Contractors, Type	**Contractor 12: United HomeCare** ▪ Parent Company: United HomeCare ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in: 1 ▪ Provider Organization ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 1,136
9	Contractors, Type	**Contractor 13: United HealthCare of Florida** ▪ Parent Company: United HealthCare ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in: 36 ▪ HMO ▪ Operates companion/related Medicare Advantage Plan? Yes ▪ Type MA: Medicare-Medicaid enrollee SNP ▪ Number of members in program (if available): 2,048
9	Contractors, Type	**Contractor 14: Universal Health Care** ▪ Parent Company: Universal Health Care Group ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in: 24 ▪ HMO ▪ Operates companion/related Medicare Advantage Plan? Yes ▪ Type MA: Medicare-Medicaid enrollee and Chronic SNPs ▪ Number of members in program (if available): 1,194
9	Contractors, Type	**Contractor 15: Urban Jacksonville Senior Connections** ▪ Parent Company: Aging True ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in: 3 ▪ Provider organization ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 186

9	Contractors, Type	**Contractor 16: Worldnet** ▪ Parent Company: Universal American Corp ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in: 4 ▪ HMO ▪ Operates companion/related Medicare Advantage Plan? Yes ▪ Type MA: Medicare-Medicaid enrollee and Chronic SNPs ▪ Number of members in program (if available): 35
9	Contractors, Type	**Contractor 17: YourCare Brevard** ▪ Parent Company: Brevard Alzheimer's Foundation, Inc ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in: 1 ▪ Provider organization ▪ Operates companion/related Medicare Advantage Plan? No ▪ Type MA: ▪ Number of members in program (if available): 176
10	Geographic Reach of Program	46 of 67 counties (February 2012)
11	Includes rural areas?	The Department is currently working to evaluate and approve expansion applications from current providers Once approved, Nursing Home Diversion program would be offered in all counties
12	Groups Enrolled	▪ Medicare-Medicaid enrollees 65+ years of age
13	Program Eligibility in terms of LTSS Needs	▪ Institutional level of care, and able to be served safely in the community at time of enrollment
14	Type of Medicaid Enrollment	Voluntary If voluntary, opt in or opt out? Opt in Lock-in period (specify): None – participants may disenroll on a month-to-month basis
15	Medicaid Services in Capitation	▪ Primary ▪ Acute ▪ Behavioral ▪ Rx Drugs **LTSS** ▪ Nursing facility ▪ Occupational, physical and speech therapies ▪ HCBS waiver: adult companion; adult day health; assisted living services; chore services; consumable medical supplies; environmental accessibility adaptation; escort; family training; financial assessment/risk reduction; home-delivered meals; homemaker; nutritional assessment/risk reduction; personal care; personal emergency response systems; respite care
16	Participant-directed Services	Participant-directed options offered? No Services that may be directed: Populations that may self-direct: Model Features: Does the program require the managed care contractor to contract out the Financial Management Services role? If Yes, what entity performs this role? What entity performs the support broker role?

17	**LTSS Level of Care**	What entity determines Level of Care? State, through its CARES (Comprehensive Assessment and Review for Long-Term Care Services) program, administered in field offices throughout the State Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (NF level of care)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? State CARES staff provide an initial assessment, which is supplemented by the contractor's own assessment Contractor develops service plan What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Mandated (contractor may not subcontract the service, though the State is exploring this option to promote more rural availability of program)
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18)**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? No If yes, is it mandated by the State? If yes, describe the role
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives No role specified.
21	**Member Engagement**	Specify any contractual requirements for engaging members ▪ Member surveys – Contractor must conduct enrollee satisfaction survey each year using statistically sig sample Copy of survey and results must be sent to the State
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ Hotline – Yes (statewide abuse hotline)
23	**LTSS Quality**	What LTSS performance measures are in use? Whether services are being provided to enrollees as instructed in the enrollee's care plan; whether case managers are discussing advanced directives with enrollees; whether subcontractors are qualified service providers; and whether subcontractors have received the appropriate training for reporting abuse, neglect, and exploitation Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Yes Current EQRO studies have included ▪ Retention of members ▪ Timeliness of service provision ▪ Use of advanced directives Does the State conduct any oversight activities specific to LTSS? ▪ State staff conduct face-to-face visits with members
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes, encounter data are submitted to the Department on a quarterly basis If yes, does the State validate it for completeness and accuracy? The encounter data are validated internally before being sent to an actuary that is contracted outside of the Department
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? There are currently no incentives offered in the rate methodology for expansion If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A – only one level of care used
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition

27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare is not included, but contractors must coordinate services Some contractors offer companion Medicare Advantage products, which members may join voluntarily for a more integrated experience
28	**Medicare Authority/Vehicle (if applicable)**	Medicare Advantage program, when applicable
29	**Evaluation**	Has the program been formally evaluated? Yes “Managed LTC and the Rebalancing of State Long-term Support Systems, Topics in Rebalancing State Long-Term Care Systems, Topic Paper #3,” Robert Kane, Reinhard Priester, Rosalie Kane, and Dann Milne, December 2007.

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Hawaii QUEST Expanded Access Program

	Element	Description/Notes
1	**State and Lead Agency**	Hawaii Department of Human Services
2	**Program**	QUEST Expanded Access Program (QExA)
3	**Inception**	2009
4	**Year LTSS included, if added to existing MMC program.**	N/A
5	**Medicaid Authorities**	1115
6	**# Enrolled**	44,600 (December 2011) Subset of members using LTSS: 6,830
7	**Evolution**	N/A
8	**Contractors**	Two national health plans
9	**Contractors, Type**	**Contractor 1: United Healthcare Community Plan** ▪ Parent Company: UnitedHealthcare (UnitedHealth Group) ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the state: Four counties Not operating on islands of Molokai and Lanai in Maui County ▪ MCO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 20,656
9	**Contractors, Type**	**Contractor 2: ‘Ohana Health Plan** ▪ Parent Company: WellCare Health Insurance of Arizona (WellCare Health Plans, Tampa, FL) ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the state: Statewide All four counties including the islands of Molokai and Lanai in Maui County ▪ MCO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 23,944
10	**Geographic Reach of Program**	Statewide
11	**Includes rural areas?**	Yes
12	**Groups Enrolled**	▪ Children ▪ Adults < 65 with PD ▪ Adults < 65 with ID/DD ▪ Adults 65+
13	**Program Eligibility in terms of LTSS Needs**	▪ Eligibility for program is not dependent on LTSS need (mandatory regardless of need for LTSS)
14	**Type of Medicaid Enrollment**	Mandatory If voluntary, opt in or opt out? N/A Lock-in period (specify): 90-day grace period to change plan After that, can change once a year

15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute ▪ Behavioral ▪ Rx drugs **LTSS** ▪ Nursing Facility ▪ Participants in the DD/ID Home and Community-Based 1915(c) waiver must enroll in one of the 2 plans, but waiver services will be provided outside QExA through the Department of Health ▪ Other waivers were rolled into QExA (NH Without Walls, Residential Alternatives Community Care, Medically Fragile, HIV/AIDS) Note: Home and community-based waiver services for people with ID/DD are excluded from the capitation rate as are additional behavioral health services for members who are adults with serious and persistent mental illness or children with serious emotional disturbances
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Personal assistance, respite, attendant care Populations that may self-direct: All Model Features: Employer Authority Does the program require the managed care contractor to contract out the Financial Management Services role? Yes If Yes, what entity performs this role? Ceridian What entity performs the support broker role? Contractor
17	**LTSS Level of Care**	What entity determines Level of Care? Department of Human Services (DHS) designee Health Services Advisory Group (HSAG) A State tool is used by the health plans and providers Same or different entity from FFS program? Same Entity mandated by state, or contractor decides? Mandated by State How many LTSS levels of care are recognized by the program, and what are they? Three (intermediate care, skilled nursing, and subacute)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Health plan What entity performs ongoing service coordination for HCBS waiver and state plan services? Health plan Same or different entity from FFS program? Different Entity mandated by state, or contractor decides? N/A
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? Yes For one of the former waivers (Residential Alternative Community Care (RACC) Program) If yes, is it mandated by the state? Yes If yes, describe the role: The RACC waiver required that the Community Care Foster Family Homes (CCFFH) have a Case Management Agency that performed certain functions The role of the Case Management Agency (called Community Care Management Agency (CCMA) in the QExA program) has remained the same in the QExA program as it was under the RACC waiver
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing “Money Follows The Person”, Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Health Homes:** Contractor is responsible for establishing a “provider home” but Hawaii is not participating the Health Home State Plan Amendment option ▪ **Money Follows the Person:** Contractors must coordinate with the State’s Money Follows the Person grant called the Going Home Plus (GHP) program The State has a designated employee who oversees GHP and works with the contractors to assure the program is implemented according to the grant requirements Both nursing facilities and plans make referrals for potential participants The contractors provide options counseling and work with the State to arrange for members’ transitions to the community Costs associated with these services are included in the contractors’ capitation payments

21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member surveys** – CAHPS survey administered by the State ▪ **Other** – The State used many stakeholder engagement activities prior to implementation of the program and during the year following implementation, including an Advisory Committee, Roundtables, and an ombudsman program
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ **Hotline** – Yes (call center for general questions) ▪ **Ombudsman** – Yes Plan must have an inquiry process that includes the capacity to handle any complaint as a potential grievance or appeal and educate the member or his/her representative of the member's grievance and appeal rights
23	**LTSS Quality**	What LTSS performance measures are in use? None at this time The State is in the process of implementing the CMS HCBS quality framework performance measures for LTSS in the QExA program Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? The health plans are required to submit reports on use of LTSS, including transfers from institutional to community settings and vice-versa Also, plans are required to submit reports showing evidence of their efforts to expand capacity for personal assistance and HCBS services. Specific goals for expansion of capacity of these services are stated in the RFP, such as reducing the number of people on personal assistance and HCBS waiting lists Does the state conduct any oversight activities specific to LTSS? See above. In addition, the State performs oversight on changes to LTSS for QExA members
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the state validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes Health plans are paid a capitation rate that promotes use of HCBS instead of institutionalization If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? Only one blended rate is used for all QExA members
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? The definition of medical necessity cited in the RFP (from State statute) is the same as that used across all services
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Both MCOs operate D-SNPs in the State, allowing for aligned enrollment But, the State does not require QExA plans to offer companion MA plans The QExA service coordinator is required to coordinate QExA services with Medicare
28	**Medicare Authority/Vehicle (if applicable)**	N/A
29	**Evaluation**	Has the program been formally evaluated? No known evaluations to-date Bills were introduced this session in the Hawaii Senate and House to fund an evaluation of QExA and report findings to the legislature prior to the 2013 session. These bills did not pass in the legislative session

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Massachusetts Senior Care Options

	Element	Description/Notes
1	State and Lead Agency	Massachusetts MassHealth, Executive Office of Health and Human Services (EOHHS)
2	Program	Massachusetts Senior Care Options (SCO)
3	Inception	2004
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1915(a) and 1915(c)
6	# Enrolled	21,785 (May 2012) Subset of members using LTSS: 15,568 (estimate[1])
7	Evolution	N/A
8	Contractors	Two national and two local plans
9	Contractors, Type	**Contractor 1: Commonwealth Care Alliance (CCA)** ▪ Parent Company: Commonwealth Care Alliance, Inc ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 6 of 14 ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 4,047
9	Contractors, Type	**Contractor 2: UnitedHealthcare Community Plan** ▪ Parent Company: UnitedHealth Group ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 8 of 14 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 7,904
9	Contractors, Type	**Contractor 3: NaviCare** ▪ Parent Company: Fallon Community Health Plan ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 6 of 14 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 1,206
9	Contractors, Type	**Contractor 4: Senior Whole Health** ▪ Parent Company: Senior Whole Health ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 7 of 14 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 8,628

1 The subset of SCO members with LTSS needs was not available. We arrived at this estimate by applying the ratio that exists in the Minnesota Senior Health Options Program, which is similar in key design features: both are voluntary programs that integrate Medicare and Medicaid for persons over 65 at all levels of clinical need.

10	**Geographic Reach of Program**	Nearly statewide (far western Massachusetts and outer Cape Cod not covered)
11	**Includes rural areas?**	Yes
12	**Groups Enrolled**	▪ Adults 65+
13	**Program Eligibility in terms of LTSS Needs**	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment ▪ Institutional – living in community ▪ Less than institutional level ▪ No LTSS need
14	**Type of Medicaid Enrollment**	Voluntary If voluntary, opt in or opt out? Opt in Lock-in period (specify): None
15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute ▪ Behavioral ▪ Rx drugs **LTSS** ▪ NF ▪ Adult foster care and group adult foster care ▪ Adult day health ▪ Other community-based LTSS including chore, companion, day habilitation, grocery shopping and delivery, homemaker, home health aide, home modification, home delivered meals, laundry, personal care attendant (PCA) , personal care services, Personal Emergency Response System (PERS), respite, social day care, and, transportation to medical visits
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: PCA services Populations that may self-direct: Enrollees eligible for PCA services Model Features: Employer Authority Does the program require the managed care contractor to contract out the Financial Management Services role? Yes If Yes, what entity performs this role? SCOs all contract with the same fiscal intermediaries as MassHealth FFS (CPMA, NEARC and Stavros) What entity performs the support broker role? The SCOs all contract with the same providers (Personal Care Management agencies) as MassHealth FFS
17	**LTSS Level of Care**	What entity determines Level of Care? Contractors conduct assessments and make an initial determination The assessment is sent to the State, where a clinician reviews it and makes the final determination. Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Contractor decides how assessment is conducted, but must submit to the State in all cases How many LTSS levels of care are recognized by the program, and what are they? Five (listed below): 1 Alzheimer's/chronic mental illness in community 2 NF level of care in community 3 Living in NF Tier 1 4 Living in NF Tier 2 5 Living in NF Tier 3
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Contractor What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor's team, which includes a Geriatric Support Services Coordinator (GSSC), who is an employee of an Aging Services Access Point (ASAP) Same or different entity from FFS program? Hybrid – ASAPs conduct the function in the FFS program Entity mandated by State, or contractor decides? Contractor is mandated to contract with at least 1 ASAP, but may decide which one(s) To date, contractors have chosen to subcontract with all ASAPs in their service areas

19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? Yes If yes, is it mandated by the State? Yes If yes, describe the role: Contractors must subcontract with at least one Aging Services Access Points for Geriatric Support Services Coordinators
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives
21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member advisory committee** – contractor must establish at least one consumer advisory committee and a process for the committee to provide input to the governing board ▪ **Member surveys** – contractor must administer annual survey to all enrollees and report results to EOHHS ▪ **Other** – Governing board – At least one consumer must serve on the contractor's governing board
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: Hotline – yes
23	**LTSS Quality**	What LTSS performance measures are in use? Appropriate nursing facility institutionalization is a quality program initiative Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Contractors must develop 2 PIPs per year in the primary care, LTSS or behavioral health areas Appropriate nursing facility institutionalization is a program initiative as is discharge planning (including from a nursing facility), and management of dementia with a focus on community-based care Does the State conduct any oversight activities specific to LTSS? State reviews contractor reporting of utilization of nursing facility and community LTSS
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? In the process of establishing encounter reporting requirements; and expect to begin requiring submissions this calendar year If yes, does the State validate it for completeness and accuracy?
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes Members admitted to nursing homes are paid at the lower community rate for the first 3 months Members who have been in a nursing home for at least 3 months and move into the community are paid at the higher nursing home rate for the first 3 months in the community. If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? Each level of care is tied to a rate cell, and reimbursed at a level specific to that rate cell
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition.
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare included on a fully capitated basis for Medicare-Medicaid enrollees
28	**Medicare Authority/Vehicle (if applicable)**	SNP
29	**Evaluation**	Has the program been formally evaluated? Yes 1 "MassHealth SCO Program Evaluation: Nursing Facility Entry Rate in CY 2004-2005 Enrollment Cohorts," JEN Associates, March 5, 2009 2 "MassHealth SCO Program Evaluation: Pre-SCO Enrollment Period CY 2004 and Post-SCO Enrollment Period CY 2005 Nursing Home Entry Rate and Frailty Level Comparisons," JEN Associates, June 6, 2008 3 "Senior Care Options Evaluation Phase 2: Member Experience Report of Individual Interviews," Center for Health Policy and Research, December 2007

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Michigan Medicaid Managed Specialty Support & Services Program[2]

	Element	Description/Notes
1	State and Lead Agency	Michigan Department of Community Health
2	Program	Medicaid Managed Specialty Support & Services Program
3	Inception	1998 (as 1915(b) only)
4	Year LTSS included, if added to existing MMC program.	1915(c) HCBS services for persons with developmental disabilities (DD) were added in 2002
5	Medicaid Authorities	1915(b) and 1915(c)
6	# Enrolled	41,272[3] (with DD or dually diagnosed with DD and mental illness in SFY 2011) Subset of members using LTSS: 41,272
7	Evolution	N/A
8	Contractors	18 county-based contractors, with one contractor designated per service area
9	Contractors, Type	**Contractor 1: Access Alliance** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 6 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,482 in SFY11
9	Contractors, Type	**Contractor 2: CMH Affiliation of Mid-Michigan** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 8 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 2,369 in SFY11
9	Contractors, Type	**Contractor 3: CMH Central Michigan** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 6 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,460 in SFY11

[2] We were not able to obtain a State review of this profile by publication. All information was gathered from publicly available sources.

[3] Enrollment figure is for SFY 2011, and includes children and adults with developmental disability (DD) or dually diagnosed with DD and mental illness. Source is "Fingertip Report: Summary Statistics for Michigan's Public Mental Health System", accessed on June 12, 2012 at http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_4902-188760--,00.html.

9	Contractors, Type	**Contractor 4: CMH Partnership of SE Michigan** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 4 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 2,389 in SFY11
9	Contractors, Type	**Contractor 5: Detroit – Wayne CMH Agency** ▪ Parent Company: Detroit-Wayne County ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 1 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 9,004 in SFY11
9	Contractors, Type	**Contractor 6: Genesee Co. Community Mental Health** ▪ Parent Company: Genesee County ▪ Governmental ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 1 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,907 in SFY11
9	Contractors, Type	**Contractor 7: Lakeshore Behavioral Health** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 2 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,600 in SFY11
9	Contractors, Type	**Contractor 8: LifeWays Community Mental Health** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 2 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 721 in SFY11

9	Contractors, Type	**Contractor 9: Macomb Co. CMH** ▪ Parent Company: Macomb County ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 1 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 3,045 in SFY11
9	Contractors, Type	**Contractor 10: Network 180** ▪ Parent Company: Kent County ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 1 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 2,143 in SFY11
9	Contractors, Type	**Contractor 11: NorthCare Network** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Local ▪ Number of counties contractor operates in within the State: 15 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,531 in SFY11
9	Contractors, Type	**Contractor 12: Northern Affiliation** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 13 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,343 in SFY11
9	Contractors, Type	**Contractor 13: Northwest CMH Affiliation** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 9 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,114 in SFY11

9	Contractors, Type	**Contractor 14: Oakland Co. CMH Authority** ▪ Parent Company: Oakland County ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 1 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 4,732 in SFY11
9	Contractors, Type	**Contractor 15: Saginaw Co. CMH Authority** ▪ Parent Company: Saginaw County ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 1 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 928 in SFY11
9	Contractors, Type	**Contractor 16: SW MI Urban & Rural Consortium** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 4 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,752 in SFY11
9	Contractors, Type	**Contractor 17: Thumb Alliance** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 3 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,897 in SFY11
9	Contractors, Type	**Contractor 18: Venture Behavioral Health** ▪ Parent Company: partnership of counties ▪ Governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the state: 5 of 83 counties ▪ PIHP ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (with DD or DD/mental health dual diagnosis): 1,855 in SFY11

10	**Geographic Reach of Program**	Statewide
11	**Includes rural areas?**	Yes
12	**Groups Enrolled**	▪ Children with intellectual/developmental disabilities ▪ Children with serious emotional disturbance ▪ Adults with intellectual/developmental disabilities ▪ Adults with SMI
13	**Program Eligibility in terms of LTSS Needs**	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver
14	**Type of Medicaid Enrollment**	Mandatory If voluntary, opt in or opt out? N/A Lock-in period (specify):Not applicable—there is a single contractor per service area
15	**Medicaid Services in Capitation**	▪ Behavioral **LTSS** ▪ NF ▪ ICF/MR ▪ Personal care ▪ Targeted case management ▪ HCBS waiver services for persons with developmental disabilities Note: primary and acute medical services and prescription drugs are not included in the capitation rate
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Flexible supports and services that may be directed to pursuing the individualized service plan Populations that may self-direct: Persons with DD, employing a self-determination philosophy Model Features: Employer authority (employer and co-employer) Budget authority Does the program require the managed care contractor to contract out the Financial Management Service role? Yes If Yes, what entity performs this role? Any qualified organization(s) designated by the contractor What entity performs the support broker role? The contractor is required to provide the supports necessary for members to exercise this option
17	**LTSS Level of Care**	What entity determines Level of Care? Not found Same or different entity from FFS program? Not found Entity mandated by state, or contractor decides? Not found How many LTSS levels of care are recognized by the program, and what are they? One (institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Contractor What entity performs ongoing service coordination for HCBS waiver and state plan services? Contractor Same or different entity from FFS program? N/A – no comparable FFS program Entity mandated by state, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? Yes The contractors were the traditional service providers If yes, is it mandated by the state? Yes If yes, describe the role: The traditional county-based mental health agencies became the contractors for this program
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing “Money Follows The Person”, Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Money Follows the Person:** Contractors are required to provide MFP-like services to return members to community settings when appropriate

21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member surveys** – MDCH (State) conducts quality of life surveys Contract also requires that contractors have mechanisms in place to assess customer satisfaction ▪ **Other** – Contract requires consumers be actively involved in Quality Assurance and Quality Improvement program
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: Not found
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Number of consumers engaged in meaningful employment, ▪ Number of consumers with a self-determination arrangement, ▪ Percentage of adults and children receiving pre-admission screening within 3 hours ▪ Percentage of new persons receiving in-person assessment within 14 days of non-emergent assessment ▪ Percentage of new persons starting ongoing service within 14 days of non-emergent assessment ▪ Percentage of Medicaid recipients who have received PIHP services ▪ Percentage of Habilitation Service Waiver (HSW) enrollees receiving at least one HSW service each month (except supports coordination) ▪ Percentage of DD adults competitively employed Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Not found Does the state conduct any oversight activities specific to LTSS? ▪ Biennial site review that examines consumer involvement, person-centered planning, and staff qualifications/supervision/training ▪ State monitors adverse events ▪ Monitoring community care through the Habilitation Supports Waiver (allocated slots compared to enrollees) ▪ Tracking ICF placement (census, admissions, discharges)
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the state validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Not found (relative to rates) Financial awards are available to plans that have shown relative improvement (from the prior year) in areas such as # of consumers engaged in meaningful employment and number with a self-determination arrangement If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Not addressed
28	**Medicare Authority/Vehicle (if applicable)**	N/A
29	**Evaluation**	Has the program been formally evaluated? No known evaluations

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Minnesota Senior Care Plus

	Element	Description/Notes
1	State and Lead Agency	Minnesota Department of Human Services
2	Program	MN Senior Care Plus
3	Inception	2005
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1915(b) & 1915(c)
6	# Enrolled	11,995 (April 2012) Subset of members using LTSS: 6,874 (NHC)
7	Evolution	MSC+ began in 2005 in 25 counties, expanded to an additional 53 counties in 2008 and became statewide in 2009 with the expansion to the remaining 9 counties Prior to MSC+ members were enrolled in managed care, but it did not include LTSS under 1915(c)
8	Contractors	Eight private and county-based plans
9	Contractors, Type	**Contractor 1: Blue Plus** ▪ Parent Company: BCBS of MN (independent licensee of BCBS Ass'n) ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 60 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 2,973
9	Contractors, Type	**Contractor 2: HealthPartners** ▪ Parent Company: HealthPartners ▪ Private ▪ Non-profit ▪ Regional Number of counties contractor operates in within the State: 12 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 1,218
9	Contractors, Type	**Contractor 3: Itasca Medical Care** ▪ Parent Company: Itasca County Health and Human Services ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 1 of 87 counties ▪ County-Based Purchaser ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 132
9	Contractors, Type	**Contractor 4: Medica** ▪ Parent Company: Medica Holding Company ▪ Private ▪ Non-profit ▪ Regional Number of counties contractor operates in within the State: 29 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 2,738

9	Contractors, Type	**Contractor 5: Metropolitan Health Plan** ▪ Parent Company: Hennepin County, MN ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 4 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 618
9	Contractors, Type	**Contractor 6: PrimeWest Health** ▪ Parent Company: Joint Powers Board consisting of county commissioners from each county it serves ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 13 of 87 counties ▪ County-based purchasing plan ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 771
9	Contractors, Type	**Contractor 7: South Country Health Alliance** ▪ Parent Company: South Country Health Alliance ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 12 of 87 counties ▪ County-based purchasing Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 737
9	Contractors, Type	**Contractor 8: UCare Minnesota** ▪ Parent Company: UCare ▪ Private ▪ Non-profit ▪ Regional ▪ Number of counties contractor operates in within the State: 53 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 2,808
10	Geographic Reach of Program	Statewide
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ Adults 65+
13	Program Eligibility in terms of LTSS Needs	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver ▪ Less than institutional level ▪ No LTSS need
14	Type of Medicaid Enrollment	Mandatory (but duals can choose MSHO, and voluntary for 65+ with SPMI) Mandatory (but duals can choose MSHO, and voluntary for 65+ with SPMI) If voluntary, opt in or opt out? N/A Lock-in period (specify): One-year

15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute ▪ Behavioral ▪ Rx drugs **LTSS** ▪ NF (180 day limit) ▪ Personal care/Home Care (PDN, SK RN Visits, Home Health Aide ▪ State plan (1915(b)): inpatient psychiatric hospital, MH clinic, TCM, substance abuse ▪ HCBS waiver: Elderly Waiver (homemaker, home delivered meals, adult foster care, transportation, chore, customized living, home mods, residential services, personal response, adult day care, companion, consumer directed, care giver support, specialized medical supplies and equipment, respite, extended State plan home health, PDN, PCA, etc)
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: State Plan Personal Care and those in Elderly Waiver (EW) except for residential, customized living adult foster care and adult day care (fiscal agent) Populations that may self-direct: Any served by Elderly Waiver who can direct own care (with exception of people living in residential settings licensed by MDH and DHS such as family foster care, board and lodge, supported living service facilities) Model Features: Employer Authority (employer and co-employer) Does the program require the managed care contractor to contract out the Financial Management Services role? Yes, to fiscal support entities If Yes, what entity performs this role? Members have a choice of entities What entity performs the support broker role? Not required, but consumer can hire a support planner, or use contractor's care coordinator
17	**LTSS Level of Care**	What entity determines Level of Care? MCO Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? Three (institutional, less than institutional, and no LTSS need)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? MCO What entity performs ongoing service coordination for HCBS waiver and State plan services? MCO Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? In some cases If yes, is it mandated by the State? No If yes, describe the role: In some areas, MCOs contract with county social service agencies or county contracted case management agencies to provide care coordination
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Health Homes:** Contractors are required to have health care homes in their provider networks and pay them a care coordination fee or an alternative payment reform arrangement ▪ **Money Follows the Person:** Contractors participate in Return to Community Initiative (similar to Money Follows the Person). If member is identified through RTC process, contractor's care coordinator is notified to initiate the RTC protocol and follow up. MFP details in Minnesota are still in development, but contractors will be participating
21	**Member Engagement**	Specify any contractual requirements for engaging members ▪ **Member advisory committee** – MCOs have member advisory groups or sponsor member educational activities The State has an Advisory Group for MSHO and MSC+ in which families and members are encouraged to participate Local advisory groups will be required for the 2013 contacts ▪ **Member surveys** – State conducts CAHPs at product level and periodic annual enrollee satisfaction survey for Elderly Waiver consumers MCOs provide State with any other survey results done by MCO or subcontractors

22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ 24/7 RN Hotline ▪ Program Staff in State unit (Special Needs Purchasing) ▪ Recipient Help Desk ▪ Provider Help Desk ▪ MCO Member Services ▪ Contract Managers for each plan ▪ Ombudsman – through State's Prepaid Medical Assistance Program ▪ LTC Ombudsman ▪ Mental Health Ombudsman
23	**LTSS Quality**	What LTSS performance measures are in use? A large number of the measures are used, several to meet 1915(c) assurances These include: ▪ Timeliness of initial health risk screenings/assessments as submitted and documented in State MMIS system ▪ Care plan audit factors based on the CMS Quality Framework ▪ State HEDIS measures and other MCO generated measures Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Yes Annual quality assessment and performance improvement program evaluation must include an analysis on the impact and effectiveness of MSC+ care coordination activities as well as performance standard measures and performance improvement projects Does the State conduct any oversight activities specific to LTSS? Yes ▪ Annual review of care system subcontractors, county care coordination and case management systems along with annual care plan audits using uniform State audit protocols ▪ Review of annual submission of LTSS networks
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes The rate cell for community elderly waiver members includes a risk adjusted elderly waiver monthly payment (adjusted for ADL, age geographic and customized living/ adult foster care factors) in addition to the base noninstitutional rate And, the rate cell for community elderly waiver members who are enrolled in hospice includes 50% of that payment amount MCOs are also at risk to pay the first 180 days of SNF/NF care for each community member and receive a Medicaid payment amount covering the expected average admission rate, average length of stay and average payment for all community members adjusted for expected Medicare stays The MCO is at risk for any admissions that exceed these average payments If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? There are different rate cells for institutionalized, community elderly waiver (EW), community EW hospice, community non-EW, and community non- EW hospice Components of the rates differ by rate cell
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Medical necessity definition doesn't apply to community-based LTSS.
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare not included but contractors expected to coordinate care for Medicare-Medicaid enrollees MSC+ members are free to enroll in any available MSHO integrated D-SNP but then would switch to the MSHO product They could also enroll in a Medicare Advantage plan sponsored by their current MCO If they enroll in a Medicare Advantage plan that is not sponsored by their MCO, they would be excluded from enrollment in MSC+
28	**Medicare Authority/Vehicle (if applicable)**	N/A
29	**Evaluation**	Has the program been formally evaluated? Yes MSC+ was evaluated as required by CMS for 1915(b) programs by an independent contractor, APS In addition, a study of care coordination in MSC+ and MSHO was conducted in 2007 by Halleland Health Consulting with Malone, Morishita and Paone

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Minnesota Senior Health Options

	Element	Description/Notes
1	State and Lead Agency	Minnesota Department of Human Services
2	Program	MN Senior Health Options (MSHO)
3	Inception	1997
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1915(a) & 1915(c)
6	# Enrolled	36,128 (April 2012) Subset of members using LTSS: 25,819 are nursing home certifiable (presumably using LTSS)
7	Evolution	Began as 1115 demo in 1997, converted to a 1915(a)/(c) in 2000 Expanded statewide in 2005 One-time passive enrollment with Part D implementation in 2006
8	Contractors	Eight private contractors and county-based plans
9	Contractors, Type	**Contractor 1: Blue Plus** ▪ Parent Company: BCBS of MN (independent licensee of BCBS Ass'n) ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 61 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 9,546
9	Contractors, Type	**Contractor 2: HealthPartners** ▪ Parent Company: HealthPartners ▪ Private ▪ Non-profit ▪ Regional ▪ Number of counties contractor operates in within the State: 12 of 87 counties ▪ HMO Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 2,911
9	Contractors, Type	**Contractor 3: Itasca Medical Care** ▪ Parent Company: Itasca County Health and Human Services ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 1 of 87 counties ▪ County Based Purchasing ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 494
9	Contractors, Type	**Contractor 4: Medica** ▪ Parent Company: Medica Holding Company ▪ Private ▪ Non-profit ▪ Regional ▪ Number of counties contractor operates in within the State: 33 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 9,599

9	Contractors, Type	**Contractor 5: Metropolitan Health Plan** ▪ Parent Company: Hennepin County, MN ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 4 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 674
9	Contractors, Type	**Contractor 6: PrimeWest Health** ▪ Parent Company: Joint Powers Board consisting of county commissioners from each county it serves ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 13 of 87 counties ▪ CBP (County-based purchasing) ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 2,085
9	Contractors, Type	**Contractor 7: South Country Health Alliance** ▪ Parent Company: South Country Health Alliance ▪ County ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 12 of 87 counties ▪ CBP ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 1,792
9	Contractors, Type	**Contractor 8: UCare Minnesota** ▪ Parent Company: UCare ▪ Private ▪ Non-profit ▪ Regional ▪ Number of counties contractor operates in within the State: approx 57 of 87 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 9,027
10	Geographic Reach of Program	Statewide
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ Adults 65+ eligible for both Medicaid and Medicare Parts A & B
13	Program Eligibility in terms of LTSS Needs	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver ▪ Less than institutional level ▪ No LTSS need
14	Type of Medicaid Enrollment	Voluntary (option to mandatory MSC+ program for people 65+ with some exceptions) If voluntary, opt in or opt out? Opt in Lock-in period (specify): None

15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute, ▪ Behavioral ▪ Rx Drugs **LTSS** ▪ NF (180 day limit) ▪ Personal care/Home Care (PDN, SK RN Visits, Home Health Aide ▪ State plan:, inpatient psychiatric hospital, MH clinic, TCM, substance abuse ▪ HCBS waiver: Elderly Waiver (homemaker, home delivered meals, adult foster care, transportation, chore, customized living, home mods, residential services, personal response, adult day care, companion, consumer directed, care giver support, specialized medical supplies and equipment, respite, extended State plan home health/PDN/PCA, etc)
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: State Plan Personal Care and those in Elderly Waiver (EW) except for residential, customized living, adult foster care and adult day care, (fiscal agent) Populations that may self-direct: Any served by Elderly Waiver who can direct own care (with exception of people living in residential settings licensed by MDH and DHS such as family foster care, board and lodge, supported living service facilities) Model Features: Employer Authority (employer and co-employer) Does the program require the managed care contractor to contract out the Financial Management Services role? Yes, to fiscal support entities If Yes, what entity performs this role? Members have a choice of entities What entity performs the support broker role? Not required, but consumer can hire a support planner, or use contractor's care coordinator
17	**LTSS Level of Care**	What entity determines Level of Care? MCO Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? Three (institutional, less than institutional, and no LTSS need)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? MCO What entity performs ongoing service coordination for HCBS waiver and State plan services? MCO Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? In some cases If yes, is it mandated by the State? No If yes, describe the role: In some areas MCOs contract with county social service agencies or county contracted private case management agencies to provide care coordination
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Health Homes:** Contractors are required to have health care homes in their provider networks and pay them a care coordination fee or an alternative payment reform arrangement ▪ **Money Follows the Person:** Contractors participate in Return to Community Initiative (similar to Money Follows the Person). If member is identified through RTC process, contractor's care coordinator is notified to initiate the RTC protocol and follow up. MFP details in Minnesota are still in development, but contractors will be participating

21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member advisory committee** – Contractors have member advisory groups or sponsor member educational activities The State has an Advisory Group for MSHO and MSC+ in which families and members are encouraged to participate Local advisory groups will be required for the 2013 contacts ▪ **Member surveys** – – State conducts CAHPS at product level – SNP conducts CAHPS as required by CMS and shares results with State – State conducts periodic enrollee satisfaction survey for Elderly Waiver consumers – MCO provides State with any other survey results done by contractor or subcontractors
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ 24/7 RN Hotline ▪ Program Staff in State unit (Special Needs Purchasing) ▪ Recipient Help Desk ▪ Provider Help Desk ▪ MCO Member Services ▪ Contract Managers for each plan ▪ Ombudsman – through State's Prepaid Medical Assistance Program ▪ LTC Ombudsman ▪ Mental Health Ombudsman
23	**LTSS Quality**	What LTSS performance measures are in use? A large number of the measures are used, several to meet 1915(c) assurances These include: ▪ Timeliness of initial health risk screenings/assessments as submitted and documented in State MMIS system ▪ Care plan audit factors based on the CMS Quality Framework, ▪ All SNP measures ▪ State HEDIS measures and other MCO generated measures Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Yes Annual quality assessment and performance improvement program evaluation must include an analysis on the impact and effectiveness of MSHO care coordination activities as well as performance standard measures and performance improvement projects Does the State conduct any oversight activities specific to LTSS? Yes ▪ Annual review of care system subcontractors, county care coordination and case management systems along with annual care plan audits using uniform State audit protocols ▪ Review of annual submission of LTSS networks
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes The rate cell for community elderly waiver members includes a risk adjusted elderly waiver monthly payment (adjusted for ADL, age, geographic and customized living/ adult foster care factors) in addition to the base non-institutional rate And, the rate cell for community elderly waiver members who are enrolled in hospice includes 50% of that payment amount MCOs are also at risk to pay the first 180 days of SNF/NF care for each community member and receive a Medicaid payment amount covering the expected average admission rate, average length of stay and average payment for all community members adjusted for expected Medicare stays The MCO is at risk for any admissions that exceed these average payments If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? There are different rate cells for institutionalized, community elderly waiver (EW), community EW hospice, community non-EW, and community non- EW hospice Components of the rates differ by rate cell
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Medical necessity definition doesn't apply to community-based LTSS

27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare included, fully capitated Members that disenroll from MSHO would automatically be enrolled in that plan's MSC+ product unless they have chosen a separate Medicare Advantage plan not sponsored by an MSC+ plan, in which case they would be excluded from managed care enrollment
28	**Medicare Authority/Vehicle (if applicable)**	SNP
29	**Evaluation**	Has the program been formally evaluated? Yes 1 "Multistate Evaluation of Dual Eligibles Demonstration - Final Report," Robert Kane and Patricia Homyak, Division of Health Services Research and Policy, University of Minnesota School of Public Health, August 2004 (rev) 2 "MSHO Care Coordination Study - Final Report," Co-Investigators: Joelyn Malone, Lynne Morishita, Deboarh Paone, and Cheryl Schraeder, June 2004 In addition, a follow up study of care coordination in MSC+ and MSHO was conducted in 2007 by Halleland Health Consulting with Malone, Morishita and Paone

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

New Mexico Coordination of Long-Term Services

	Element	Description/Notes
1	State and Lead Agency	New Mexico Human Services Department, Medical Assistance Division
2	Program	Coordination of Long-Term Services (CoLTS)
3	Inception	2008
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	Enrollment: ▪ 1915(b) **LTSS:** ▪ State Plan Personal Care Option ▪ 1915(c)
6	# Enrolled	39,607 (March 2012) Subset of members using LTSS: 22,446
7	Evolution	State is seeking to merge CoLTS with Salud! (MMC for other populations) and the State's behavioral health carve out plan via a 1115 waiver
8	Contractors	Amerigroup Community Care Inc and UnitedHealthcare Community Plan of New Mexico Inc
9	Contractors, Type	**Contractor 1: Amerigroup Community Care Inc.** ▪ Parent Company: Amerigroup ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: all (33) ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 20,484
9	Contractors, Type	**Contractor 2: UnitedHealthcare Community Plan** ▪ Parent Company: UnitedHealthcare (UnitedHealth Group) ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: all (33) ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 19,123
10	Geographic Reach of Program	Statewide (33 counties)
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ Children with LTSS needs ▪ Adults < 65 with physical disabilities ▪ Adults 65+
13	Program Eligibility in terms of LTSS Needs	▪ Institutional Level of Care ▪ Personal Care State Plan Option also available, and also requires Institutional Level of Care ▪ 1915(c) HCBS waiver eligible ▪ No LTSS needs with dual Medicare-Medicaid status (so-called "Healthy Duals")
14	Type of Medicaid Enrollment	Mandatory Lock-in period (specify): One year; may change with cause anytime

15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute ▪ Prescription Drugs – (only non D covered for Medicare-Medicaid enrollees) **LTSS** ▪ HCBS Waiver ▪ State Plan Personal Care ▪ Nursing Facility Note: Behavioral health services are not included in the capitation rate
16	**Participant-directed Services**	Participant-directed options offered? Yes If waiver slot is available, persons at NF level of care may choose Mi Via self directed or the Traditional CoLTS C waiver service delivery Persons using the State plan personal care option (PCO) may self direct within the CoLTS program Services that may be directed: ▪ Mi Via: Homemaker, Direct Support, Home Health Aide, Employment Supports, Related Goods, Living Supports, Community Membership Supports, Health and Wellness and other supports ▪ Personal Care Option: homemaker, personal care Populations that may self-direct: Any member requiring LTSS Model Features Employer Authority (employer and co-employer models) Budget Authority (in the Mi Via option only) Does the program require the managed care contractor to contract out the Financial Management Services role? FMS role is provided only by State-designated entities There is a single FMS for Mi Via For the PCO, members may choose from among entities in each contractor's network If Yes, what entity performs this role? Mi Via: ACS/Xerox PCO: Any contracted agencies What entity performs the support broker role? Mi Via: All 5 designated "Consultant" agencies perform a support broker "like" role per the State approved scope of work for Mi Via Consultants
17	**LTSS Level of Care**	What entity determines Level of Care? Third party assessor contracted by HSD (Molina) Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (NF Level of Care, which applies to nursing homes, HCBS waiver, and PCO services)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? MLTSS Contractors, except when members choose Mi Via, in which case a third-party Consultant agency works with the member to develop the service plan What entity performs ongoing service coordination for HCBS waiver and State plan services? MLTSS contractor Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Contractor decides (could choose to subcontract the function)
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? No If yes, is it mandated by the State? If yes, describe the role:
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Money Follows the Person:** Contractors must work with the State to implement MFP initiatives Prior to MFP, New Mexico has had a community reintegration program, and MLTSS contractors were required to work toward reintegration for members in nursing homes

21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ Member Advisory Committee: Each contractor is required to have a Consumer Advisory Board comprised of a representation of members ▪ Member surveys - member and network provider satisfaction surveys and other relevant member and family/caregiver surveys Must submit to State for "purposes of compliance audits and/or other contract oversight activities "
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: None identified.
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Nursing home admissions and readmissions ▪ Number of home safety evaluations; percent of home safety evaluations requiring follow up for safety issues ▪ Members 75+ or at risk for falls who have been asked about falls and treated for related risks ▪ Number of members who transition from NF to community and stay in community at least 6 mos Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Yes State may "seek input on health and long-term service related issues from advisory groups, steering committees, or other consultants " Does the State conduct any oversight activities specific to LTSS? Critical incidents and network updates (all provider types)
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes (volume and quality)
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes A blended rate is paid regardless of setting (NF or community) in order to incentivize the MCOs to maximize use of community options If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare not included in program but contractors expected to offer related SNP product to members (Primarily offered in urban areas)
28	**Medicare Authority/Vehicle (if applicable)**	Medicare Advantage Special Needs Plan
29	**Evaluation**	Has the program been formally evaluated? Yes "Human Services Dept , Program Evaluation: Medicaid Coordination of Long-Term Services Program," State of Mexico Legislative Finance Committee, Human Services Department, Report #11-04, February 14, 2011

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

New York Medicaid Advantage Plus

	Element	Description/Notes
1	State and Lead Agency	New York NYS Department of Health
2	Program	Medicaid Advantage Plus (MAP)
3	Inception	2006
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1915(a)
6	# Enrolled	1,875 (April 2012) Subset of members using LTSS: 1,875
7	Evolution	N/A
8	Contractors	Eight national, regional, and local plans
9	Contractors, Type	**Contractor 1: Fidelis Care** ▪ Parent Company: NYS Catholic Health Plan ▪ Private ▪ For-profit ▪ Local ▪ Number of counties contractor operates in within the State: 5 of 62 counties (including NYC) ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 96
9	Contractors, Type	**Contractor 2: Senior Whole Health** ▪ Parent Company: Senior Whole Health ▪ Private ▪ For-profit ▪ Regional ▪ Number of counties contractor operates in within the State: 12 of 62 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 294
9	Contractors, Type	**Contractor 3: AmeriGroup** ▪ Parent Company: AmeriGroup ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: NYC ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 9
9	Contractors, Type	**Contractor 4: Elderplan** ▪ Parent Company: MJHS ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: NYC ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 633

9	Contractors, Type	**Contractor 5: Guildnet** ▪ Parent Company: Jewish Guild for the Blind ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: NYC ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 373
9	Contractors, Type	**Contractor 6: Health Insurance Plan of NY** ▪ Parent Company: EmblemHealth ▪ Private ▪ Non-profit ▪ Regional ▪ Number of counties contractor operates in within the State: 2 + NYC ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 324
9	Contractors, Type	**Contractor 7: VNS Choice Plus** ▪ Parent Company: Visiting Nurse Service of NY ▪ Private ▪ For-profit ▪ Local ▪ Number of counties contractor operates in within the State: NYC ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 101
9	Contractors, Type	**Contractor 8: WellCare** ▪ Parent Company: WellCare, Inc ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: NYC ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 45
10	Geographic Reach of Program	14 counties + 5 counties that make up NYC
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ Adults 18 - 64 with physical disabilities ▪ Adults 65+
13	Program Eligibility in terms of LTSS Needs	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment
14	Type of Medicaid Enrollment	Voluntary If voluntary, opt in or opt out? Opt in Lock-in period (specify): None
15	Medicaid Services in Capitation	Acute, primary, preventive for people with Medicaid only **LTSS** ▪ Nursing Facility (no limit specified) ▪ Personal Care ▪ Other: dental, home health, OT/PT/ST, vision, PDN, transportation, PERS, adult day

16	**Participant-directed Services**	Participant-directed options offered? No Services that may be directed: N/A Populations that may self-direct: N/A Model Features: N/A Does the program require the managed care contractor to contract out the Fiscal Agent role? N/A If Yes, what entity performs this role? N/A What entity performs the support broker role? N/A
17	**LTSS Level of Care**	What entity determines Level of Care? Contractor (MCO) Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Contractor (MCO) What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor (MCO) Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? N/A If yes, is it mandated by the State? N/A If yes, describe the role: N/A
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives. No role specified.
21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member Advisory Committee** – NYS MCO regulation requires that MCOs either 1) have members on their governing boards, or 2) have a member council ▪ **Member surveys** – CAHPS survey, Health Outcomes Survey (HOS)
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes May include, but not limited to: ▪ **Hotline** – through State Department of Health
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ number of home health visits per beneficiary ▪ member satisfaction Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? PIPs related to: advance directives, effective use of PERS, improved assessment scoring, and DME tracking Does the State conduct any oversight activities specific to LTSS? ▪ review of provider network information quarterly
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes (all Medicaid encounters) If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? No If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Plans must offer Medicare Advantage Those who choose MAP must enroll in the same plan for both Medicaid and Medicare
28	**Medicare Authority/Vehicle (if applicable)**	SNP
29	**Evaluation**	Has the program been formally evaluated? No known evaluations

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

New York Managed Long-term Care Program

	Element	Description/Notes
1	State and Lead Agency	New York NYS Department of Health
2	Program	Managed Long-term Care (MLTC, or Partial Cap)
3	Inception	1998
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1915(a)
6	# Enrolled	45,417 (April 2012) Subset of members using LTSS: 45,417
7	Evolution	N/A
8	Contractors	Fourteen plans, mostly provider-based
9	Contractors, Type	**Contractor 1: AmeriGroup** ▪ Parent Company: AmeriGroup ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 5 of 62 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 1,478
9	Contractors, Type	**Contractor 2: Comprehensive Care Management Select** ▪ Parent Company: Center Light Healthcare ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 5 of 62 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 4,014
9	Contractors, Type	**Contractor 3: Elant Choice** ▪ Parent Company: Elant, Inc ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 2 of 62 counties ▪ Provider-based organization ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 177
9	Contractors, Type	**Contractor 4: HomeFirst** ▪ Parent Company: MJHS ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 5 of 62 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 5,327

9	Contractors, Type	**Contractor 5: ElderServe Health, Inc.** ▪ Parent Company: Hebrew Home for Aged at Riverdale ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 8of 62 counties ▪ Provider-based organization ▪ Operates a companion/related SNP? No ▪ SNP type: ▪ Number of members in program (if available): 5,675
9	Contractors, Type	**Contractor 6: Fidelis Care at Home** ▪ Parent Company: New York State Catholic Health Plan, Inc ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 2 of 62 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 446
9	Contractors, Type	**Contractor 7: GuildNet** ▪ Parent Company: Jewish Guild for the Blind ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 6 of 62 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 8,002
9	Contractors, Type	**Contractor 8: HHH Choices Health Plan** ▪ Parent Company: Hebrew Hospital Home Continuum of Care ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 1 of 62 counties ▪ Provider-based organization ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 1,316
9	Contractors, Type	**Contractor 9: Independence Care System** ▪ Parent Company: Cooperative Home Care Associates ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 3 of 62 counties ▪ Provider-based organization ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 2,074

9	Contractors, Type	**Contractor 10: Senior Health Partners** ▪ Parent Company: Healthfirst ▪ Private ▪ Non-profit ▪ Regional ▪ Number of counties contractor operates in within the State: 4 of 62 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 3,705
9	Contractors, Type	**Contractor 11: Senior Network Health** ▪ Parent Company: Mohawk Valley Network, Inc ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 2 of 62 counties ▪ Provider-based organization ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 389
9	Contractors, Type	**Contractor 12: Total Aging in Place** ▪ Parent Company: Weinberg Campus, Inc ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 1 of 62 counties (part of Erie County) ▪ Provider-based organization ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 124
9	Contractors, Type	**Contractor 13: VNS Choice** ▪ Parent Company: Visiting Nurse Service of NY ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 5 of 62 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 10,524
9	Contractors, Type	**Contractor 14: Wellcare Advocate** Parent Company: Wellcare Health Plans, Inc Private For-profit National Number of counties contractor operates in within the State: 4 of 62 counties HMO Operates a companion/related SNP? Yes SNP type: Dual Number of members in program (if available): 2,166
10	Geographic Reach of Program	Nine counties (mostly NYC Metro area)
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ Adults ages 18-64 with physical disabilities ▪ Adults 65+
13	Program Eligibility in terms of LTSS Needs	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver

14	**Type of Medicaid Enrollment**	Voluntary If voluntary, opt in or opt out? Opt in Lock-in period (specify): None
15	**Medicaid Services in Capitation**	**LTSS** ▪ Nursing Facility ▪ Personal Care ▪ Other: PDN, adult day, home care, PT/OT/ST, care management, nutrition, DME, audiology, home-delivered and congregate meals, social day care, social and environmental supports Note: Primary and acute medical services and prescription drugs are not included in the capitation rates
16	**Participant-directed Services**	Participant-directed options offered? No Services that may be directed: N/A Populations that may self-direct: N/A Model Features: N/A Does the program require the managed care contractor to contract out the Financial Management Services role? N/A If Yes, what entity performs this role? N/A What entity performs the support broker role? N/A
17	**LTSS Level of Care**	What entity determines Level of Care? Plan Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Plan at least once every 6 months What entity performs ongoing service coordination for HCBS waiver and State plan services? Plan Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? N/A If yes, is it mandated by the State? N/A If yes, describe the role: N/A
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing “Money Follows The Person”, Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives. No role specified.
21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Other** – “enrollee and caregiver involvement in quality assurance and performance improvement activities and evaluation of satisfaction with services”
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ MLTC Hotline
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Number of home health visits per beneficiary ▪ Member satisfaction Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? ▪ PIPs related to: advance directives, effective use of PERS, improved assessment scoring, and DME tracking Does the State conduct any oversight activities specific to LTSS? ▪ Review of provider network information quarterly

24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Payments are risk-adjusted based on the Semi-Annual Assessment of Members (SAAM) form, which provides an incentive to serve people with high needs in the community If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Plans are required to coordinate LTSS with members' medical services
28	**Medicare Authority/Vehicle (if applicable)**	N/A (some partial cap plans do offer Medicare-Medicaid Enrollee SNPs)
29	**Evaluation**	Has the program been formally evaluated? Yes 1 "Two Models of Managed Long-Term Care: Comparing PACE with a Medicaid-Only Plan," Pamela Nadash, The Gerontologist, 44(5) 2 "New York State Managed Long-Term Care, Final Report," Antonia Novello, March 28, 2006

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

North Carolina MH/DD/SAS Health Plan Waiver

	Element	Description/Notes
1	State and Lead Agency	North Carolina Department of Human Services, Division of Medical Assistance (DMA)
2	Program	MH/DD/SAS Health Plan Waiver (formerly Piedmont Cardinal Health Plan – Innovations (PCHP))
3	Inception	2005
4	Year LTSS included, if added to existing MMC program.	
5	Medicaid Authorities	1915(b) & 1915(c)
6	# Enrolled	4,699 with developmental disabilities (July 2011) Subset of members using LTSS: 4,699
7	Evolution	Began as a 5-county pilot in the Piedmont region Statewide expansion began in late 2011 and is expected to be completed in 2013
8	Contractors	Local management entities (LMEs), which are established in NC statute as political subdivisions for purposes of managing behavioral health and developmental disabilities services As of June, 2012, three MMEs were contracted on a capitated basis
9	Contractors, Type	**Contractor 1: PBH** ▪ Parent Company: N/A ▪ Public ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 15 of 100 ▪ Local Political Subdivision ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program: 4,699 as of July 2011 (reflects the 5 original counties in which PBH operated at the time)
9	Contractors, Type	**Contractor 2: Western Highlands Network** ▪ Parent Company: N/A ▪ Public ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 8 of 100 ▪ Local Political Subdivision ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program: Not available (reporting period pre-dates contractor start-up)
9	Contractors, Type	**Contractor 3: East Carolina Behavioral Health** ▪ Parent Company: N/A ▪ Public ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 19 of 100 ▪ Local Political Subdivision ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program: Not available (reporting period pre-dates contractor start-up)
10	Geographic Reach of Program	41 out of 100 counties in June, 2012 Scheduled to become statewide in 2013
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ Children and adults of all ages with serious emotional disturbance, developmental disabilities, mental illness, or substance abuse disorders

13	**Program Eligibility in terms of LTSS Needs**	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment ▪ Institutional level of care receiving HCBS waiver services
14	**Type of Medicaid Enrollment**	Mandatory If voluntary, opt in or opt out? Lock-in period (specify): Not applicable—there is one contractor per service area
15	**Medicaid Services in Capitation**	▪ 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 **LTSS** ▪ ICF/MR ▪ HCBS waiver services for persons with developmental and intellectual disabilities ▪ Therapeutic Foster Care (TFC) ▪ Residential Child Care Note: primary and acute medical services and prescription drugs are not included in the capitation rate
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Community guide services; Community networking services; in-home supports; intensive in-home supports, individual goods and services; natural support education; respite services; personal care and supported employment services Populations that may self-direct: Persons with intellectual or developmental disabilities eligible for the HCBS waiver Model Features: Employer Authority (both employer and co-employer models available) Budget Authority Does the program require the managed care contractor to contract out the Financial Management Services role? Yes. Contractor selects qualified FMS organizations through a procurement process If Yes, what entity performs this role? Multiple organizations, as selected by the contractors What entity performs the support broker role? “Community guides” are available from provider agencies as a waiver service
17	**LTSS Level of Care**	What entity determines Level of Care? Contractor Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Contractor What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor Same or different entity from FFS program? Depends on County- in some counties, the contractor is the same entity that managed the FFS program, but in others, it’s a new entity Several LMEs have been consolidated simultaneously with the expansion Entity mandated by State, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? Yes If yes, is it mandated by the State? Yes If yes, describe the role: Contractors are also the designated case management entities in the FFS program
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing “Money Follows The Person”, Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Health Homes:** Contractor required to coordinate with health homes ▪ **Money Follows the Person:** Contractors required to assist in the development of transition plans for MFP participants

21	**Member Engagement**	Specify any contractual requirements for engaging members: **Member surveys** – annual consumer satisfaction survey **Member Advisory Committee** – Contractor must provide support to a Consumer and Family Advisory Committee that meets 6 times per year
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: None found
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Process for review of person-centered plans; ▪ Service authorization decisions within required timelines; ▪ Percent of persons starting a new episode of care who are in need of urgent mh/dd/sa services and receive their first face-to-face service (assessment and/or treatment) within 48 hours; ▪ Percent of persons starting a new episode of care who are ▪ In need of routine mh/dd/sa services and receive their first face-to-face service (assessment and/or treatment) within 14 calendar days of the request for care ▪ Percent of persons estimated to have a mh/dd/sa disability ▪ who received at least one service during the prior rolling one year period ▪ Percent of persons with intellectual or developmental ▪ disabilities who receive a single billable service for within 30 days of an initial screening ▪ Percent of persons discharged from a community-based ▪ Crisis service who receive a community-based or State facility service within five calendar days Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Not found Does the State conduct any oversight activities specific to LTSS? Oversight of LTSS includes: ▪ Desk reviews of data and reports (e g , regarding above performance measures); ▪ On-site reviews ▪ Interviews with consumers
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Not found If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology?
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Not found
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare not addressed
28	**Medicare Authority/Vehicle (if applicable)**	N/A
29	**Evaluation**	Has the program been formally evaluated? No known evaluations

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Pennsylvania Adult Community Autism Program

	Element	Description/Notes
1	**State and Lead Agency**	Pennsylvania Bureau of Autism Services
2	**Program**	Adult Community Autism Program (ACAP)
3	**Inception**	2009
4	**Year LTSS included, if added to existing MMC program.**	N/A
5	**Medicaid Authorities**	1915(a)
6	**# Enrolled**	90 out of 108 available openings (December 2011) Subset of members using LTSS: 90 (all ICF level of care)
7	**Evolution**	N/A
8	**Contractors**	One local contractor
9	**Contractors, Type**	**Contractor: Keystone Autism Services** ▪ Parent Company: Keystone Autism Services ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 4 of 67 counties ▪ Prepaid Inpatient Health Plan (Provider based) ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 90
10	**Geographic Reach of Program**	4 of 67 counties
11	**Includes rural areas?**	Yes
12	**Groups Enrolled**	▪ Adults 21+ with diagnosis of Autism Spectrum Disorder
13	**Program Eligibility in terms of LTSS Needs**	▪ Institutional level of care (ICF) but living in community without 16 or more hours of awake paid and unpaid staff and supervision per day
14	**Type of Medicaid Enrollment**	Voluntary If voluntary, opt in or opt out? Opt in Lock-in period (specify): None Participants may enroll or disenroll on a month-to-month basis
15	**Medicaid Services in Capitation**	▪ Primary ▪ Behavioral ▪ Dental **LTSS** ▪ ICF/MR ▪ Targeted Case Management ▪ Adult day, OT/PT/ST Note: Inpatient facility, ambulatory surgical center, home health care, clinic-including family planning, transportation, renal dialysis center, laboratory, x-ray clinic, prescription drugs are not included in the capitation rate
16	**Participant-directed Services**	Participant-directed options offered? No Services that may be directed: N/A Populations that may self-direct: N/A Model Features: N/A Does the program require the managed care contractor to contract out the Fiscal Management Services role? N/A If Yes, what entity performs this role? N/A What entity performs the support broker role? N/A

17	**LTSS Level of Care**	What entity determines Level of Care? Certified by a physician completing the MA 51 form as requiring ICF level of Care. If the physician certifies the level of care as ICF/MR, then a Qualified Mental Retardation Professional (QMRP) must certify the level of care. The MA 51 is submitted to Bureau of Autism Services and is reviewed Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (ICF)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Bureau of Autism Services completes assessment and contractor develops individual service plan What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor (Keystone) Same or different entity from FFS program? There are several service coordination providers in the FFS program, including Keystone. In this program, Keystone is the exclusive service coordination provider Entity mandated by State, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? Just one - Keystone Autism Services If yes, is it mandated by the State? Yes If yes, describe the role: Keystone develops the ISP and coordinates the “waiver-like” services
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing “Money Follows The Person”, Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives. No role specified.
21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member Advisory Committee** – no general advisory committee found, through members participate on Complaint and Governance Committee (see #22) ▪ **Member survey**s – Contractor must conduct annual participant satisfaction survey and other surveys as Department deems necessary
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: **Hotline** – toll free number for filing complaints and reporting problems. **Complaint and Governance Committee** – reviews contractor’s performance in executing complaint and grievance procedures and recommends improvements in process
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Satisfaction and quality of life for members and parents ▪ Percentage of participants with jobs or engaging in volunteer work ▪ Number of hours Participants work or are engaged in volunteer work ▪ Participants’ independence and social skills ▪ Level of law enforcement involvement ▪ Psychiatric emergency room care ▪ Psychiatric inpatient hospitalization ▪ Mental Health crisis interventions ▪ Crisis Intervention Plan use Due to traditional access barriers to medical care, the program also seeks improvement in access to medical services including PCP visits, diabetes management, and gynecological exams Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Reports of above measures Does the State conduct any oversight activities specific to LTSS? Yes Oversight includes: ▪ Review of Individual Service Plans ▪ Participant file reviews ▪ Annual interviews with at least 10% of participants ▪ Review of quarterly reports which include, enrollment, financial, provider and service utilization ▪ Bimonthly operations/clinical meetings held with contractor ▪ Bimonthly joint BAS-contractor in-depth participant reviews ▪ Annual contract review by clinical and operations staff ▪ Through incident management system, monitoring and trending of incidents

24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? No If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Across all services. There are specialized service definitions for all HCBS but the medical necessity definition standard includes all services within the agreement.
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Coordination with Medicare is not addressed
28	**Medicare Authority/Vehicle (if applicable)**	N/A
29	**Evaluation**	Has the program been formally evaluated? No

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Tennessee TennCare CHOICES

	Element	Description/Notes
1	State and Lead Agency	Tennessee Department of Finance and Administration, Bureau of TennCare Division of Long-term Services and Supports
2	Program	TennCare CHOICES
3	Inception	2010
4	Year LTSS included, if added to existing MMC program.	At inception (2010), LTSS was added to the existing TennCare managed care demonstration It is administered by the same plans as the "regular" TennCare program, but operates as a distinct program within TennCare
5	Medicaid Authorities	1115
6	Number Enrolled	31,200 (estimate, March 2012) Subset of members using LTSS: All CHOICES members use LTSS; 1 2 million enrolled in the broader TennCare managed care program
7	Evolution	N/A
8	Contractors	Two national and one local plan
9	Contractors, Type	**Contractor 1: AmeriGroup** ▪ Parent Company: AmeriGroup ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 39 (Middle Tennessee Region) ▪ HMO ▪ Operates a companion/related SNP? In selected counties ▪ SNP type: Dual ▪ Number of members in program (if available): 5,100 (March 2012)
9	Contractors, Type	**Contractor 2: Volunteer State Health Plan** ▪ Parent Company: BCBS (independent licensee) ▪ Private ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 56 (East and West Tennessee Regions) ▪ HMO ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 9,600 (estimate March 2012)
9	Contractors, Type	**Contractor 3: United Healthcare Community Plan** ▪ Parent Company: UnitedHealthcare (UnitedHealth Group) ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 95 (statewide) ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 16,500 (estimate March 2012)

10	**Geographic Reach of Program**	Statewide
11	**Includes rural areas?**	Yes
12	**Groups Enrolled**	▪ Persons of all ages residing in nursing homes ▪ Adults < 65 with physical disabilities ▪ Adults 65+
13	**Program Eligibility in terms of LTSS Needs**	Currently: ▪ Institutional LOC – in facility at time of enrollment ▪ Institutional LOC – living in community New LOC Pending: ▪ "At risk" of meeting institutional LOC
14	**Type of Medicaid Enrollment**	Mandatory Lock-in period (specify): 12 months
15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute ▪ Behavioral **LTSS** ▪ Nursing Facility ▪ HCBS waiver-type services (but offered under 1115): personal care visits, attendant care, home-delivered meals, PERS, adult day care, respite, assistive technology, home modifications, pest control, community based residential alternatives Note: prescription drugs are not included in the capitation rate
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Personal care; attendant care; in-home respite; and companion care Populations that may self-direct: All eligible CHOICES populations receiving 1 or more HCBS available through self-direction Model Features: Employer Authority Budget Authority Does the program require the managed care contractor to contract out the Financial Management Services role? State contracts directly with FMS and requires MLTSS contractors to use the State's chosen FMS If Yes, what entity performs this role? Public Partnerships What entity performs the support broker role? Public Partnerships and its subcontractor, The ARC of Tennessee
17	**LTSS Level of Care**	What entity determines Level of Care? TennCare conducts the initial LOC Plans conduct subsequent LOCs, unless there is a change in LOC, which must be submitted to TennCare for review and determination Same or different entity from FFS program? No FFS program for this population In previous FFS waiver program, TennCare conducted initial LOC; Case Management agency conducted subsequent LOCs Entity mandated by State, or contractor decides? State law mandates initial LOC determination by TennCare How many LTSS levels of care are recognized by the program, and what are they? Presently one: NF level of care (in NF or in community) There are plans to add an additional level of care for those who do not meet NF LOC, but are "at risk" of NF placement

18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Contractor What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor Same or different entity from FFS program? No FFS program for this population In previous FFS waiver program, initial assessment/POC developed by Area Agency on Aging and Disability (AAAD), and subsequent assessments/POCs by the Case Management agency Entity mandated by State, or contractor decides? Contractors could choose to subcontract, but all three perform it directly
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? Yes AAADs performing intake/assessment in the previous FFS waiver program are the Single Point of Entry (SPOE) for new LTSS applicants from the community They conduct initial assessments and assist with Medicaid and LOC application processes, before a plan is selected If yes, is it mandated by the State? Yes, the SPOE function is designated by the State If yes, describe the role: See above
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing “Money Follows The Person”, Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Money Follows the Person** – Plans are expected to implement MFP for their members in nursing homes when appropriate Transition services must be discussed with NF-residing members at least annually Plans have incentives to help members transition and to achieve program benchmarks
21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member Advisory Committees** – CHOICES Advisory Group with at least 51% members/member representatives (each contractor must convene); and Behavioral Health Advisory Committee with 51% member/family members (Applies to the TennCare program overall, and may include CHOICES members)
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ CHOICES Consumer Advocate ▪ Consumer Advocate for members receiving behavioral health ▪ LTS Ombudsman Program for persons receiving services in a NF or community-based residential alternative ▪ Ability to request an objective State review of needs assessment/care planning processes performed by the MLTSS contractor

23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Number and percent of CHOICES Group 2 members who had an approved CHOICES PAE (i e , nursing facility level of care eligibility determination) prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS ▪ Number and percent of CHOICES Group 2 member records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional services and HCBS ▪ Number and percent of CHOICES Group 2 member records reviewed whose plans of care were reviewed and updated prior to the member's annual review date ▪ Number and percent of CHOICES HCBS providers reviewed for whom the MCO provides documentation that provider meets minimum qualifications established by the State and was credentialed by the MCO in accordance with NCQA guidelines prior to enrollment in CHOICES and delivery of HCBS ▪ Number and percent of CHOICES Group 2 member records reviewed which document that the member (or their family member/authorized representative) received education/info at least annually about how to identify and report instances of abuse, neglect and exploitation ▪ Number and percent of critical incident records reviewed in which the incident was reported within timeframes specified in the Contractor Risk Agreement. ▪ Number and percent of MCO provider agreements reviewed which meet uniform requirements set forth in the Contractor Risk Agreement ▪ Number and percent of CHOICES Group 2 member records reviewed in which HCBS were denied, reduced, suspended or terminated as evidenced in the Plan of Care and, consequently, the member was informed of and afforded the right to request a Fair Hearing when services were denied, reduced, suspended or terminated as determined by the presence of a Grier consent decree notice ▪ Number and percent of in-person visits that were on time, late or missed Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? Yes ▪ Baseline Data Plan – State reports baseline and annual data to CMS, including number and percent of HCBS/NF participants; cost and percentage of HCBS/NF expenditures; average per person HCBS/NF expenditures; number and percentage of new enrollment in HCBS/NF, average LOS in HCBS/NF; number of NF-to-community transitions ▪ Member surveys – EQRO to administer annual survey of CHOICES members to determine members' quality of life and/or caregiver satisfaction w/program Does the State conduct any oversight activities specific to LTSS? Yes ▪ Quarterly and annual monitoring of appropriate disease mgmt interventions and intervention adequacy ▪ Quarterly CHOICES Care Coordination Report (may include site visits to contractor audit charts and calls, etc) ▪ Quarterly monitoring of contractor's efforts to transition members from NFs ▪ Quarterly HCBS consumer direction report ▪ Semi-annual NF diversion report ▪ Semi-annual CHOICES Advisory Group report ▪ Monthly monitoring of missed/late visits ▪ Monthly CHOICES utilization report ▪ Quarterly cost effective alternatives report ▪ Quarterly monitoring of provider network file ▪ Annual Qualified Workforce Strategies report ▪ Quarterly Critical incidents report
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes Blended rate across NF and community provides incentive to serve as many members as possible in community. Also, MFP provides specific incentive payments for members who transition out of NFs If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A at present Once the At-Risk LOC is implemented, there will be a separate rate cell for persons "at risk" of NF placement

26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Single definition, with the ability to make limited special exceptions for particular items or services, such as long-term care
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: MLTSS contractors are required to coordinate with Medicare services The State plans to integrate Medicare in the future through its TennCare PLUS initiative
28	**Medicare Authority/Vehicle (if applicable)**	N/A
29	**Evaluation**	Has the program been formally evaluated? No known evaluations

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Texas STAR+PLUS

	Element	Description/Notes
1	State and Lead Agency	Texas Health and Human Services Commission (HHSC)
2	Program	STAR+PLUS
3	Inception	1998
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1115
6	# Enrolled	400,790 (June 2012) Subset of members using LTSS: 71,239 (sum of STAR+PLUS waiver and people using Primary Home Care State Plan benefit)
7	Evolution	Major expansions from one county to 29 counties in 2007 and again in 2011 to the Dallas and Tarrant service areas
8	Contractors	Five national
9	Contractors, Type	**Contractor 1: Amerigroup** ▪ Parent Company: Amerigroup ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 58 of 254 ▪ MCO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 116,201
9	Contractors, Type	**Contractor 2: Molina Healthcare of Texas** ▪ Parent Company: Molina Healthcare ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 47 of 254 ▪ MCO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 112,169
9	Contractors, Type	**Contractor 3: Superior HealthPlan** ▪ Parent Company: Centene Corporation ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 54 of 254 ▪ MCO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 95,073
9	Contractors, Type	**Contractor 4: UnitedHealthcare Community Plan** ▪ Parent Company: UnitedHealthcare (UnitedHealth Group) ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 43 of 254 ▪ MCO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 57,592

9	**Contractors, Type**	**Contractor 5: HealthSpring** ▪ Parent Company: Cigna ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 16 of 254 ▪ MCO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 19,755
10	**Geographic Reach of Program**	90 of 254 counties
11	**Includes rural areas?**	Yes
12	**Groups Enrolled**	▪ SSI or Social Security Exclusion Children under 21 ▪ Adults 21+ with disability (SSI) ▪ Adults 21+ in Community-based Alternatives HCBS waiver Adults 65+ ▪ Full-benefit Medicare-Medicaid enrollees
13	**rogram Eligibility in terms of LTSS Needs**	▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver ▪ Below institutional level of care for Primary Home Care and Adult Day Health
14	**Type of Medicaid Enrollment**	Mandatory for all but children under age 21 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. Beneficiaries can change plans monthly. If voluntary, opt in or opt out? N/A Lock-in period (specify): N/A
15	**Medicaid Services in Capitation**	▪ Primary ▪ Acute ▪ Behavioral (carved out in some areas) **LTSS** ▪ HCBS waivers: STAR+PLUS waiver offering services such as Personal Attendant, Assisted Living, PERS, nursing, Adult Foster Care, dental, respite, home-delivered meals, OT/PT/ST, consumer directed services, home mods, medical supplies Note: Nursing facility services are excluded from capitation and members must disenroll from STAR+PLUS after 120 days in a nursing facility (which do not have to be consecutive)
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Primary home care (available to all members) or personal assistance, nursing, PT, OT, SLT, and respite for members in the STAR+PLUS waiver Populations that may self-direct: Anyone meeting functional requirements for Primary Home Care Services waiver and those in the STAR+PLUS waiver who meet the requirements for PAS and who are eligible for in-home or out-of-home respite, or PT/SLT/OT Model Features: Employer Authority (both employer and co-employer models) Does the program require the managed care contractor to contract out the Financial Management Services role? Yes If Yes, what entity performs this role? Choice among a large number of consumer directed services agencies (CDSAs) What entity performs the support broker role? Contractors' service coordinators
17	**LTSS Level of Care**	What entity determines Level of Care? MCO (must use Community Medical Necessity and LoC Assessment Instrument) A 3rd party (TMHP) reviews LOC assessments Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? One (institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? MCO (with the exception of "MAO" eligibles who enroll via the State's interest list - then level of care assessment is performed by DADs staff at STAR+PLUS support offices) What entity performs ongoing service coordination for HCBS waiver and State plan services? Home and Community Support Services Agencies (DADS contractors) Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? State mandated

19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? Only for a transition period If yes, is it mandated by the State? Yes If yes, describe the role: FFS case manager remains involved through a transition period for members who were enrolled in the community-based alternatives waiver prior to STAR+PLUS launching in his/her area or for STAR+PLUS members who move from a STAR+PLUS to a FFS service area
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Money Follows the Person:** STAR+PLUS Contractors must participate in the State's Money Follows the Person Demonstration There is a sub-project focusing on adding additional behavioral health services to individuals transitioning from a nursing facility to the community (joint collaboration between HHSC, Department of Aging and Disability Services (DADS), TX Dept of State Health Services, UT and various local authorities in the San Antonio and Austin metro areas) The Star+Plus contractors participate in community planning groups related to MFP (part of the State's Promoting Independence program) There is a more flexible STAR+PLUS enrollment process for people transitioning to the community from NFs such that the STAR+PLUS start date is the first day of the month in which discharge from the NF is planned People found eligible for the STAR+PLUS waiver who are residing in NFs can bypass the State's waiting list ▪ **Balancing Incentive Payments:** The State plans to apply for BIP DADS will be the designated agency; thus there is not expected to be a direct relationship with STAR+PLUS
21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member surveys** – MCO to work w/EQRO on studies, surveys, or "other analytical approaches" to gauge service quality for members HHSC conducts CAHPS and HOS surveys ▪ **Meetings** – HHSC has quarterly meetings for stakeholders interested in the STAR+PLUS program During the last three expansions, HHSC conducted numerous stakeholder and training meetings for providers and consumers
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: **Ombudsman, Hotline** – MCOs must operate a hotline from 8am to 5pm that is staffed and provide access to recorded information outside those hours The hotline does not have to be program-specific as long as staff are knowledgeable about all the MCOs' programs. **Other** – MCO must track and resolve complaints within 30 days of receipt and face possible liquidated damages if at least 98% are not resolved Same is true for appeals, though MCOs can get extensions if MCO requests for time or MCO needs more time to gather additional information which is in member's interest
23	**LTSS Quality**	What LTSS performance measures are in use? ISP documentation, nursing facility admissions, percent of STAR+PLUS waiver members who return to the community following a nursing facility admission and % of members using personal assistance or respite services who self-direct these services Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? MCO to work w/ EQRO on studies, surveys or "other analytical approaches" to gauge service quality for members The EQRO is currently conducting a 2-year STAR+PLUS Dual Eligibles: Long-Term Care Focus Study Results will be available the fall of 2012 The EQRO is also conducting the Health Outcomes Survey and developing qualitative studies for the State to elicit input from members on patient-centered planning HHSC has a performance-based capitation rate such than plans are at risk for up to 5% of the capitation payments if they do not meet performance measures The monies collected through this requirement are used to fund a quality challenge for which MCOs that demonstrate superior quality may compete This year, the quality challenge focused on improving rates of self-direction in LTSS HHSC is vetting a comprehensive quality strategy for its Medicaid managed care programs Does the State conduct any oversight activities specific to LTSS? Monitors MCOs' submission of their LTSS provider networks monthly via a LTSS interface Also, the State's 1915(c) HCBS waiver subassurances are still in effect. These relate to level of care, service plans, qualified providers, health & welfare, administrative authority and financial accountability. These will be replaced by the comprehensive quality strategy

24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes (complete encounter data for all covered services) If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? STAR+PLUS waiver capitation rates are higher than those for non-HCBS STAR+PLUS waiver members Members who are placed in NFs are paid at the lower non-HCBS STAR+PLUS waiver rates (cost of NF care is carved out) If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Specialized – functionally necessary. The definition is: Community-based Long-term Services and Supports services provided to assist STAR+PLUS Members with activities of daily living based on a functional assessment of the Member's activities of daily living and a determination of the amount of supplemental supports necessary for the STAR+PLUS Member to remain independent or in the most integrated setting possible
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: MCOs in most populous areas must offer Medicare D-SNPs MCOs are required to coordinate members' Medicare services
28	**Medicare Authority/Vehicle (if applicable)**	Medicare Advantage
29	**Evaluation**	Has the program been formally evaluated? Yes 1 "Star+Plus Dually Eligible Consumer Study Technical Report," Texas Health Quality Alliance, November 28, 2001 2 "Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program," Public Policy Research Institute, Texas A&M University, June 28, 2002

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Washington Medicaid Integration Partnership

	Element	Description/Notes
1	State and Lead Agency	Washington Department of Social and Health Services (DSHS)
2	Program	Washington Medicaid Integration Partnership (WMIP)
3	Inception	2005
4	Year LTSS included, if added to existing MMC program.	2006
5	Medicaid Authorities	1932(a)
6	# Enrolled	4,834 (May 2012) Subset of members using LTSS: 413 (May 2012)
7	Evolution	Added behavioral health 10/1/05 and LTSS 10/1/06 It is notable that the majority of people enrolled in the program who need LTSS end up disenrolling from the program (per a 2008 monitoring report)
8	Contractors	One national
9	Contractors, Type	**Contractor 1: Molina Healthcare of Washington, Inc.** ▪ Parent Company: Molina Healthcare ▪ Private ▪ For-profit ▪ National ▪ Number of counties contractor operates in within the State: 1 of 39 ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 4,834
10	Geographic Reach of Program	1 of 39 counties + 1 zip code on Camano Island (part of Island County)
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ Adults 21-64 with SSI or SSI-related Medicaid ▪ Adults 65+
13	Program Eligibility in terms of LTSS Needs	▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver ▪ Less than institutional level ▪ No LTSS need
14	Type of Medicaid Enrollment	Voluntary If voluntary, opt in or opt out? Opt out for new enrollees Opt in for Medicare/Medicaid enrollees, Native Americans, and LTC enrollees Lock-in period (specify): None
15	Medicaid Services in Capitation	▪ Primary ▪ Acute ▪ Behavioral ▪ Rx drugs **LTSS** ▪ NF (up to 6 months, then no longer at risk) ▪ Community-based services, including Adult Day Care, Adult Day Health, Caregiver/Recipient Training Services, Environmental Modifications/Assistive Technology, Home Health Care, Minor Household Repairs, Nurse Delegation, Personal Care Services, Personal Emergency Response System, Home delivered meals, Residential Programs, Adult Family Homes, Boarding Homes (ARC, EARC, AL), Community Transition Services Note: people with DD receiving Medicaid personal care receive all services through WMIP except for certain services provided by the DDD (e g , supported employment) Those receiving LTSS through DDD waivers receive their medical, mental health and chemical dependency services through WMIP, but continue to receive waiver services through the DDD waivers

16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Direct/supervise workers Populations that may self-direct: Adult with a functional disability living in own home Model Features: Employer authority Does the program require the managed care contractor to contract out the Financial Management Services role? It was not required. The plan chose to contract with a fiscal agent to handle the independent provider payments and tracking If Yes, what entity performs this role? AccentCare of Washington What entity performs the support broker role? Contractor
17	**LTSS Level of Care**	What entity determines Level of Care? DSHS/AAA determines eligibility for LTSS Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? Two (institutional and less than institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? For personal care services, the DSHS/DDD/AAA performs the needs assessment and the level of personal care hours the member is eligible to receive is determined through that assessment The contractor can authorize more hours or fewer hours based upon its assessment and member consent What entity performs ongoing service coordination for HCBS waiver and State plan services? Contractor Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? Yes They assess for initial and ongoing eligibility and if there is a significant change in condition. If yes, is it mandated by the State? Yes If yes, describe the role: DSHS/AAA case managers continue to do initial and yearly assessments of functional status
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing “Money Follows The Person”, Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives. No role specified.
21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member surveys** – 1) CAHPS survey for Medicaid and Medicare enrollees 2) Survey of enrollee satisfaction of a “physician or physician group at substantial financial risk.”
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ Ombudsman, Hotline – available to residents of licensed community residential or nursing facility settings ▪ Ombudsman and crisis line for mental health services ▪ 24 hour care nurse hotline
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Non-HEDIS measures related to falls, critical incident reporting Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? ▪ A geriatric specialist with involvement in the implementation of the LTSS aspects of the QAPI must be on the QI Committee ▪ MCO must adopt at least 2 LTSS-specific practice guidelines including documentation of why they were adopted Does the State conduct any oversight activities specific to LTSS? ▪ DSHS Research and Data Analysis Division has produced several monitoring reports related to utilization of services, including LTSS, and expenditure trends ▪ Annually, the State reviews files specific to LTSS and follow up and Individual provider contracts MCO must provide an annual report on LTSS utilization with unduplicated counts of users and total dollars by service category, and days in licensed boarding homes ▪ State conducts member field visits with contractor staff to monitor performance.
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes

25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? A blended LTSS rate is used to help incentivize use of community based services. Contractor is at risk for first 6 months of nursing home placement If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? A blended rate is paid across levels of care
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? Specific definition for LTSS as specified in Washington Administrative Code and contract.
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare not included but contractor offers a D-SNP and the WMIP guide for consumers recommends that dually-eligible members enroll in the contractor's D-SNP for better coordination The contractor must coordinate WMIP services with services members receive through other care systems and must ensure access to and integration of: preventive, primary, acute, post-acute, mental health, chemical dependency and LTSS
28	**Medicare Authority/Vehicle (if applicable)**	SNP
29	**Evaluation**	Has the program been formally evaluated? Yes ▪ "Evaluation of the Medicaid Value Program: Health Supports for Consumers with Chronic Conditions," Dominick Esposito, Erin Fries Taylor, Kristin Andrews, Marsha Gold, Mathematica Policy Research, Inc , August 14, 2007 ▪ "2008 External Quality Review: Washington Medicaid Integration Partnership," Acumentra Health, December 2008 ▪ "2010 Performance Measure Comparative Analysis Report," Acumentra Health, November 2010 ▪ "WMIP: Medical Care, Behavioral, Health, Criminal Justice, and Mortality Outcomes for Disabled Clients Enrolled in Managed Care," David Mancuso, Melissa Ford Shah, Barbara Felver, Daniel Nordlund, Washington Department of Social and Health Services, Research and Data Analysis Division, December 2010

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Wisconsin Family Care

	Element	Description/Notes
1	State and Lead Agency	Wisconsin Department of Health Services, Division of Long-term Care
2	Program	Family Care (FC)
3	Inception	1999
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1915(b) and 1915(c)
6	# Enrolled	33,141 (April 2012) Subset of members using LTSS: 33,141
7	Evolution	The program expanded from five pilot counties in 1999 to 57 counties as of April 2011. No current expansion being actively planned for this biennial budget period, over 6/13 Wisconsin legislature capped enrollment in current biennial budget, then reversed that so no enrollment caps in effect as of April 3, 2012 The State has sustainability initiatives to implement as part of the overall plan to lift the caps See DHS website at http://www dhs wisconsin gov/ltcare/WhatsNew htm and http://www dhs wisconsin gov/ltcreform/
8	Contractors	Nine private non-profit or county-based (quasi-governmental Family Care Districts) authorities
9	Contractors, Type	**Contractor 1: Care Wisconsin** ▪ Parent Company: Care Wisconsin First, Inc ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 8 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? Yes, but subset for Partnership only ▪ SNP type: Dual ▪ Number of members in program (if available): 3,363
9	Contractors, Type	**Contractor 2: Community Care of Central Wisconsin** ▪ Parent Company: N/A (State authorized long-term care district) ▪ Quasi-governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 5 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 3,173
9	Contractors, Type	**Contractor 3: Community Care** ▪ Parent Company: Community Care, Inc ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 11 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? Yes, but subset for Partnership only ▪ SNP type: Dual ▪ Number of members in program (if available): 7,478
9	Contractors, Type	**Contractor 4: Community Health Partnership** ▪ Parent Company: Partnership Health Plan, Inc ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 5 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? Yes, but subset for Partnership only ▪ SNP type: Dual ▪ Number of members in program (if available): 1,191

9	Contractors, Type	**Contractor 5: Lakeland Care District** ▪ Parent Company: N/A (State-authorized long-term care district) ▪ Quasi-governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 3 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 2,637
9	Contractors, Type	**Contractor 6: Milwaukee County Dept. of Family Care** ▪ Parent Company: N/A ▪ Quasi-governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 3 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 7,692
9	Contractors, Type	**Contractor 7: NorthernBridges** ▪ Parent Company: N/A (State-authorized long-term care district) ▪ Quasi-governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 11 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 2,009
9	Contractors, Type	**Contractor 8: Southwest Family Care** ▪ Parent Company: N/A (State-authorized long-term care district) ▪ Quasi-governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 8 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 1,948
9	Contractors, Type	**Contractor 9: Western Wisconsin Cares** ▪ Parent Company: N/A (State-authorized long-term care district) ▪ Quasi-governmental ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 8 of 72 counties ▪ Prepaid Inpatient Health Plan (PIHP) ▪ Operates a companion/related SNP? No ▪ SNP type: N/A ▪ Number of members in program (if available): 3,650
10	Geographic Reach of Program	57 of 72 counties
11	Includes rural areas?	Yes
12	Groups Enrolled	▪ Adults < 65 with PD ▪ Adults < 65 with ID/DD ▪ Adults 65+
13	Program Eligibility in terms of LTSS Needs	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver ▪ Less than institutional level

14	**Type of Medicaid Enrollment**	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) If voluntary, opt in or opt out? Opt in Lock-in period (specify): None
15	**Medicaid Services in Capitation**	▪ Behavioral health not provided inpatient or by a physician **LTSS** ▪ NF ▪ ICF/MR ▪ Personal care ▪ State plan: respite, case management, DME, MH day treatment,OT/PT/ST, mental health services not provided inpatient or by a physician ▪ HCBS waiver: adult day, adaptive aids, care management, counseling, therapies, home modifications, PERS, FMS, respite, housing counseling, residential care, supported home care, habilitation, etc Note: primary and acute medical care and prescription drugs are not included in the capitation rate HCBS waiver services are only available to members who are at a nursing home level of care
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: Home and community-based waiver services and State Plan personal care services in Family Care Benefit package (the State will be amending its waiver to indicate not all State Plan services are included) Populations that may self-direct: All Model Features: Employer Authority (both employer and co-employer models) Budget Authority Does the program require the managed care contractor to contract out the Financial Management Services role? Yes If Yes, what entity performs this role? Different contractors use different fiscal intermediaries What entity performs the support broker role? Member can use interdisciplinary team or hire someone for this role (paid for through budget)
17	**LTSS Level of Care**	What entity determines Level of Care? ADRC for initial eligibility, for MCO members the MCO updates the functional screen that determines level of care Same or different entity from FFS program? Same Entity mandated by State, or contractor decides? Mandated How many LTSS levels of care are recognized by the program, and what are they? Two (institutional and less than institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Interdisciplinary team (IDT) which includes the member and his/her identified representatives. What entity performs ongoing service coordination for HCBS waiver and State plan services? MCO Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? State mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? No (IRIS is the FFS HCBS waiver option and there is no case management in that program) If yes, is it mandated by the State? N/A If yes, describe the role: N/A
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Money Follows the Person:** Contractors are required to screen members and referred individuals who are in qualified institutions for MFP eligibility and discuss participation with them If the member participates and is transitioned from an institution, the MCO must send specified materials to the State.

21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member surveys:** 1) The WI EQRO, Metastar, is using the Personal Experience Outcomes iNtegrated Interview and Evaluation System (PEONIES) to assess personal experience outcomes for the Family Care Partnership and other Wisconsin LTSS programs; 2) Annual surveys of members must be conducted by contractor ▪ **Advisory Committees** – Contractors are required to create a means for members to participate in the QM program and must document the level of participation ▪ **Other:** 1) At least one-fourth of the members of the contractor's governing board must be "representative of" members or members' family members, guardians, or other advocates;" 2) The contractors must provide input to Regional Long-Term Care Advisory Committees on their responsiveness to members; 3) MCOs are required to ensure that members have a meaningful opportunity to participate in development and updating of his/her member-centered plan
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ Hotline – Yes ▪ Ombudsman – Yes **Other:** ▪ Member Rights Specialist and MCO Advocacy Services – MCOs are required to have a Member Rights Specialist (advocate) to help members understand their rights and responsibilities. This role is clearly defined in the contract. ▪ Informal Resolution – whenever possible, the MCO should try to resolve a problem informally, though this does not relieve the MCO of responsibility to comply with the grievance and appeals process
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Care management (interdisciplinary team) turnover ▪ Risk assessments performed timely ▪ Members/guardians participation in care plan ▪ Member-centered plans address all assessed needs and outcomes and are updated/revised when these change ▪ In developing member-centered plans, MCO must assess personal experience outcome domains (identified and defined in an addendum to the contract) ▪ Services delivered in accordance with type, scope, amount and frequency specified in member-centered plan ▪ Members afforded choice among covered services and providers ▪ Quality of purchased services (e g , caregiver background checks, have education and skills to meet required standards and expectations) ▪ Report critical incidents, investigate root cause, remediate problems Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? MCO must make active progress on at least one PIP relevant to LTSS; this project can be collaborative with other MCOs Requirements related to PIPs are very specific. Does the State conduct any oversight activities specific to LTSS? The EQRO uses a new personal experience tool, PEONIES (Personal Experience Outcomes iNtegrated Interview and Evaluation System), as part of annual review of the program EQRO conducts an Annual Quality Review on-site at each MCO, including evaluation of implementation of program standards, review of sample of member records, and interviews of care teams, providers and members. State conducts rigorous certification process prior to annual re-contracting that includes review of adequacy of service delivery capacity, care management competencies, ability to offer prevention and wellness, address risk, monitor quality of care management and service provision
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? MCO must certify its encounter reporting State application contains quality edits and periodic reconciliations

25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes The rates include funding to support relocation of members from institutional settings into the most integrated settings If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? The methodologies used to develop rates for NH LOC and non-NH LOC are different NH LOC rates are based on a regression model conducted separately for each of the 3 target groups served (those with developmental disabilities, physical disabilities, and frail older adults) 12 variables are used in the model to adjust for functional status, service needs, and Medicare-Medicaid enrollee eligibility Trend rates also differ by target group The non-NH LOC rates also adjust for functional status and stratify the population into 4 cohorts representing mixes of IADL and ADL level of need
26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? A specific definition is used for "necessary Long-Term Care Services and Supports" (vs. the definition for medically necessary services)
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare not included, but contractors are expected to coordinate with Medicare services
28	**Medicare Authority/Vehicle (if applicable)**	N/A
29	**Evaluation**	Has the program been formally evaluated? Yes: ▪ "Wisconsin Family Care Final Evaluation Report," Lisa Maria B Alecxih, BrieAnne Olearczyk, Christina Neill, Sharon Zeruld, The Lewin Group, June 30, 2003 ▪ "Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness for CY 2003-2004," APS Healthcare, Inc , October 7, 2005 ▪ "An Evaluation: Family Care" 2011-2012 Joint Legislative Audit Committee, Report 11-5, April 2011

Inventory of State Managed Long-Term Services and Supports (MLTSS) Programs:

Wisconsin Family Care Partnership

	Element	Description/Notes
1	State and Lead Agency	Wisconsin Department of Health Services, Division of Long-term Care
2	Program	Family Care Partnership (FC-P)
3	Inception	1996
4	Year LTSS included, if added to existing MMC program.	N/A
5	Medicaid Authorities	1932(a) and 1915(c)
6	# Enrolled	3,871 (April 2012) Subset of members using LTSS: 3,869
7	Evolution	Expanded from 2 to 4 HMOs and from a handful to 19 counties The State had four HMOs, but lost one (Community Living Alliance) and added another (iCare) iCare will be offering FC-P in Racine and Kenosha counties as of May 2012.
8	Contractors	Four HMOs with companion SNPs
9	Contractors, Type	**Contractor 1: Care Wisconsin First** ▪ Parent Company: Care Wisconsin First, Inc ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 5 of 72 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 1,277
9	Contractors, Type	**Contractor 2: Community Care** ▪ Parent Company: Community Care, Inc ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 9 of 72 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 550
9	Contractors, Type	**Contractor 3: Community Health Partnership** ▪ Parent Company: Partnership Health Plan, Inc ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 5 of 72 counties ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 1,567
9	Contractors, Type	**Contractor 4: iCare** ▪ Parent Company: Independent Care Health Plan ▪ Non-profit ▪ Local ▪ Number of counties contractor operates in within the State: 3 of 72 counties Is currently expanding into Racine and Kenosha Counties as well. ▪ HMO ▪ Operates a companion/related SNP? Yes ▪ SNP type: Dual ▪ Number of members in program (if available): 475

10	**Geographic Reach of Program**	19 of 72 counties
11	**Includes rural areas?**	Yes
12	**Groups Enrolled**	▪ Adults <65 with DD ▪ Adults < 65 with PD ▪ Frail Adults 65+
13	**Program Eligibility in terms of LTSS Needs**	▪ Institutional – in facility at time of enrollment ▪ Institutional – admitted to facility post-enrollment ▪ Institutional – HCBS waiver
14	**Type of Medicaid Enrollment**	Voluntary If voluntary, opt in or opt out? Opt in Lock-in period (specify): None
15	**Medicaid Services in Capitation**	▪ Medicare cost-sharing ▪ Behavioral health (not covered by Medicare) ▪ Rx drugs (not covered by Medicare) ▪ LTSS (HCBS and institutional) ▪ Other: case management, dental, hospital, hospice, therapies
16	**Participant-directed Services**	Participant-directed options offered? Yes Services that may be directed: All Medicaid HCBS and State Plan LTSS Populations that may self-direct: All Model Features: Employer Authority (both employer and co-employer models) Budget Authority Does the program require the managed care contractor to contract out the Financial Management Services role? Yes If Yes, what entity performs this role? Varies by contractor What entity performs the support broker role? Member can use interdisciplinary team or hire someone for this role (paid for through budget)
17	**LTSS Level of Care**	What entity determines Level of Care? ADRC pre-enrollment, HMO post-enrollment Same or different entity from FFS program? Same (pre-enrollment) Entity mandated by State, or contractor decides? State mandated How many LTSS levels of care are recognized by the program, and what are they? One (institutional)
18	**HCBS Service Coordination**	What entity performs a needs assessment and develops the service/care plan? Interdisciplinary team (IDT) with members identified by MCO. What entity performs ongoing service coordination for HCBS waiver and State plan services? MCO Same or different entity from FFS program? Different Entity mandated by State, or contractor decides? Mandated
19	**Role of Traditional HCBS Waiver Case Management Organizations (If not already addressed in 18**	If HCBS waiver services are included in program, do the organizations providing case management in the traditional FFS programs have a role in the MLTSS program? No If yes, is it mandated by the State? N/A If yes, describe the role: N/A
20	**Relationship to CMS LTSS Initiatives**	If applicable, indicate the role contractors play in implementing "Money Follows The Person", Health Homes, Balancing Incentives Payments (BIP), Community First Choice, or Psychiatric Residential Treatment Facilities initiatives ▪ **Money Follows the Person:** Contractors are required to screen members and refer individuals who are in qualified institutions for MFP eligibility and discuss participation with them If the member participates and is transitioned from an institution, the MCO must send specified materials to the State.

21	**Member Engagement**	Specify any contractual requirements for engaging members: ▪ **Member surveys**: 1) The WI EQRO, Metastar, is using the Personal Experience Outcomes iNtegrated Interview and Evaluation System (PEONIES) to assess personal experience outcomes for the Family Care Partnership and other Wisconsin LTSS programs; 2) Annual surveys of members must be conducted by contractor ▪ **Advisory Committees** – Contractors are required to create a means for members to participate in the QM program and must document the level of participation ▪ **Other:** 1) At least one-fourth of the members of the contractor's governing board must be "representative of" members or members' family members, guardians, or other advocates;" 2) The contractors must provide input to Regional Long-Term Care Advisory Committees on their responsiveness to members; 3) MCOs are required to ensure that members have a meaningful opportunity to participate in development and updating of his/her member-centered plan
22	**Problem Resolution Mechanisms**	Specify any special mechanisms beyond federally required processes: ▪ Hotline – Yes ▪ Ombudsman – Yes **Other:** Member Rights Specialist and MCO Advocacy Services – MCOs are required to have a Member Rights Specialist (advocate) to help members understand their rights and responsibilities. This role is clearly defined in the contract. Informal Resolution – whenever possible, the MCO should try to resolve a problem informally, though this does not relieve the MCO of responsibility to comply with the grievance and appeals process
23	**LTSS Quality**	What LTSS performance measures are in use? ▪ Care management (interdisciplinary team) turnover ▪ Risk assessments performed timely ▪ Members/guardians participation in care plan ▪ Member-centered plans address all assessed needs and outcomes and are updated/revised when these change ▪ In developing member-centered plans, MCO must assess personal experience outcome domains (identified and defined in an addendum to the contract) ▪ Services delivered in accordance with type, scope, amount and frequency specified in member-centered plan ▪ Members afforded choice among covered services and providers ▪ Quality of purchased services (e g , caregiver background checks, have education and skills to meet required standards and expectations) ▪ Report critical incidents Does the contract include special studies, reports or other activities designed to measure quality or promote quality improvement specific to LTSS? MCO must make active progress on at least one PIP relevant to LTSS; this project can be collaborative with other MCOs Requirements related to PIPs are very specific. Does the State conduct any oversight activities specific to LTSS? The EQRO uses a new personal experience tool, PEONIES (Personal Experience Outcomes iNtegrated Interview and Evaluation System), as part of annual review of the program EQRO conducts an Annual Quality Review on-site at each MCO, including evaluation of implementation of program standards, review of sample of member records, and interviews of care teams, providers and members. State conducts rigorous certification process prior to annual re-contracting that includes review of adequacy of service delivery capacity, care management competencies, ability to offer prevention and wellness, address risk, monitor quality of care management and service provision
24	**Data Reporting**	Does the program require submission of all encounters, including LTSS? Yes If yes, does the State validate it for completeness and accuracy? Yes
25	**HCBS Incentives**	Have incentives to expand HCBS been built into the rate methodology? Yes The rates include funding to support relocation of members from institutional settings into the most integrated settings If the program uses more than one LTSS Level of Care, how do these tiers factor into the rate-setting methodology? N/A

26	**Medical Necessity Definition**	Single definition across all services or specialized definition applied to LTSS? A specific definition is used for “necessary Long-Term Care Services and Supports” (vs. the definition for medically necessary services)
27	**Medicare Approach**	Indicate how the program approaches Medicare for dually eligible members: Medicare included on fully capitated basis
28	**Medicare Authority/Vehicle (if applicable)**	SNP
29	**Evaluation**	Has the program been formally evaluated? Yes “Variations on a Theme Called PACE,” Robert L. Kane, Patricia Homyak, Boris Bershadsky, Shannon Flood, Journal of Gerontology: Medical Sciences, July 2006

Appendix B

States Projecting New MLTSS Program Implementation By January 2014

TRUVEN HEALTH ANALYTICS™

Table of Contents

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

California Coordinated Care Initiative

	Element	Description/Notes
1	**State and Lead Agency**	California Department of Health Care Services
2	**Program**	Coordinated Care Initiative
3	**Projected Inception (expected date of first enrollment)**	6/1/13
4	**LTSS add-on to existing Medicaid Managed Care program?**	Yes In 2011, the State added Medi-Cal-only older persons and persons with disabilities to its MediCal managed care programs CCI will contract with existing MediCal contractors to add LTSS and Medicare-MediCal enrollees
5	**Projected enrollment (as of 1/1/14)**	685,000
6	**Projected Geographic Reach of Program**	To date, four counties are legislatively authorized to participate in the demonstration in 2013, with legislation pending to increase the initial number of counties to 8 The State projects statewide enrollment by 2015
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	▪ Persons 65+ years of age ▪ Persons with Physical Disabilities ▪ Persons with Developmental Disabilities ▪ Persons with Serious Mental Illness
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ ICF/MRDD, including private and state facilities ▪ Developmental Disabilities HCBS Waiver Services
9	**Type of Medicaid Enrollment Planned**	Mandatory Medicaid, with passive, voluntary Medicare If voluntary, opt in or opt out? Opt out for Medicare Lock-in period (specify): State is seeking 6 month lock-in
10	**Will Participant-Directed Services be Offered?**	Yes
11	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes
	Other	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Florida Long-Term Care Managed Care Program

	Element	Description/Notes
1	**State and Lead Agency**	Florida Agency for Health Care Administration
2	**Program**	Florida Long-term Care Managed Care Program
3	**Projected Inception (expected date of implementation)**	October, 2013
4	**LTSS add-on to existing Medicaid Managed Care program?**	The program is a component of a larger initiative to provide statewide Medicaid managed care for most populations and services
5	**Projected enrollment (as of 1/1/14)**	The target population is about 85,000 at full implementation
6	**Projected Geographic Reach of Program**	Statewide Contractors are invited to bid in any or all of 11 regions
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	▪ Older persons who meet NF level of care ▪ Adults with physical disability who meet NF level of care
9	**Scope of LTSS**	What, if any, LTSS will be carved out? No LTSS is carved out for the target population
10	**Type of Medicaid Enrollment Planned**	Mandatory If voluntary, opt in or opt out? N/A Lock-in period (specify): 12 months, with an initial 90-day open period during which members may change plans
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Medicare Advantage Special Needs Plans are eligible to apply as contractors but not required
13	**Other**	When fully implemented, this program replaces: ▪ The Long-term Care Community Diversion Program waiver; ▪ The Aged and Disabled HCBS waiver; ▪ The Assisted Living waiver; and ▪ The Channeling Program waiver

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Idaho Demonstration to Integrate Care for Dual

	Element	Description/Notes
1	**State and Lead Agency**	Idaho Department of Health and Welfare, Division of Medicaid
2	**Program**	Demonstration to Integrate Care for Dual Eligibles
3	**Projected Inception (expected date of first enrollment)**	1/1/14
4	**LTSS add-on to existing Medicaid Managed Care program?**	No, though the program will replace the existing Medicare-Medicaid Coordinated Plan
5	**Projected enrollment (as of 1/1/14)**	About 18,000 (there were 17,735 who meet eligibility as of March 2012)
6	**Projected Geographic Reach of Program**	Statewide
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	All Medicare-Medicaid enrollees (“full dual eligibles”) ages 18+, including: ▪ Older persons ▪ Persons with physical disabilities ▪ Persons with developmental/intellectual disabilities ▪ Persons with serious mental illness
9	**Scope of LTSS**	What, if any, LTSS will be carved out? None Includes all State plan, HCBS waiver and institutional services
10	**Type of Medicaid Enrollment Planned**	Mandatory Medicaid If voluntary, opt in or opt out? Passive enrollment with opt out for Medicare benefits Lock-in period (specify): No lock-in period Participants may change to a different health plan on the first day of any month, so long as Mediciad is notified and the change is requested fifteen (15) days in advance.
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Illinois Medicare-Medicaid Alignment Initiative

	Element	Description/Notes
1	**State and Lead Agency**	Illinois Department of Healthcare and Family Services
2	**Program**	Illinois Medicare-Medicaid Alignment Initiative
3	**Projected Inception (expected date of first LTSS enrollment)**	January, 2013
4	**LTSS add-on to existing Medicaid Managed Care program?**	No
5	**Projected enrollment (as of 1/1/14)**	An estimated 156,000 will be eligible for the program
6	**Projected Geographic Reach of Program**	21 out of 102 counties
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	Medicaid-only adults in the Aged, Blind and Disabled eligibility category, including: ▪ Older persons ▪ Adults with physical disability ▪ Adults with developmental/intellectual disability
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ Institutional and HCBS waiver services for persons with developmental/intellectual disability are excluded
10	**Type of Medicaid Enrollment Planned**	Voluntary If voluntary, opt in or opt out? Opt out Lock-in period (specify): None
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Illinois Integrated Care Program

	Element	Description/Notes
1	**State and Lead Agency**	Illinois Department of Healthcare and Family Services
2	**Program**	Integrated Care Program
3	**Projected Inception (expected date of first LTSS enrollment)**	Second half of 2012
4	**LTSS add-on to existing Medicaid Managed Care program?**	Yes The program currently serves about 36,000 older persons and persons with disabilities (May, 2012) LTSS is currently carved out, but the existing contract allows the State to add LTSS upon providing 30 days notice
5	**Projected enrollment (as of 1/1/14)**	Unknown
6	**Projected Geographic Reach of Program**	Six northeastern counties around Chicago
7	**Will Include Rural Areas?**	No
8	**Groups Projected to Be Enrolled by 1/1/14**	Medicaid-only adults in the Aged, Blind and Disabled eligibility category, including: ▪ Older persons ▪ Adults with physical disability ▪ Adults with developmental/intellectual disability
9	**Scope of LTSS**	What, if any, LTSS will be carved out?
10	**Type of Medicaid Enrollment Planned**	Mandatory If voluntary, opt in or opt out? N/A Lock-in period (specify):12 months, with an initial 90-day open period during which members may change plans
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	No Medicare-Medicaid enrollees are not eligible for the program
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Kansas KanCare

	Element	Description/Notes
1	**State and Lead Agency**	Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF)
2	**Program**	KanCare
3	**Projected Inception (expected date of first enrollment)**	January 2013
4	**LTSS add-on to existing Medicaid Managed Care program?**	No Seeking a global 1115 waiver that covers all major populations and services, including LTSS
5	**Projected enrollment (as of 1/1/14)**	Approximately 26,000 members who use HCBS waiver services would be included in KanCare as of 1/1/14
6	**Projected Geographic Reach of Program**	Statewide
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	At this time, all LTSS groups are proposed for inclusion, including: ▪ Children with disabilities ▪ Adults with physical disabilities ▪ Adults with developmental/intellectual disabilities ▪ Older persons (65+)
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ No carve-outs proposed at this time HCBS DD waiver services will have a staged implementation, one year after the remainder of KanCare programs are launched
10	**Type of Medicaid Enrollment Planned**	Mandatory If voluntary, opt in or opt out? n/a Lock-in period (specify): One year, following an initial 45 day period during which the member can switch plans
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	State is considering capitated Medicare under the CMS financial alignment initiative
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals

	Element	Description/Notes
1	**State and Lead Agency**	Massachusetts Executive Office of Health and Human Services, Office of Medicaid
2	**Program**	State Demonstration to Integrate Care for Dual Eligible Individuals
3	**Projected Inception (expected date of first enrollment)**	January, 2013
4	**LTSS add-on to existing Medicaid Managed Care program?**	No
5	**Projected enrollment (as of 7/1/14)**	115,000 are projected to be eligible
6	**Projected Geographic Reach of Program**	Potentially statewide, depending on contractor interest The State will ask potential contractors to express interest by county in a Request for Responses process
7	**Will Include Rural Areas?**	Yes, depending on contractor interest
8	**Groups Projected to Be Enrolled by 7/1/14**	Full Medicare-Medicaid enrollees, ages 21-64, not currently enrolled in an HCBS waiver program nor living in an ICF/MR (Persons in HCBS waiver programs may be added in the future Massachusetts HCBS waivers relevant to the target population include 4 for persons with developmental disabilities and 3 for persons with brain injury)
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ ICF/MR services ▪ HCBS waiver services for persons with developmental disabilities ▪ HCBS waiver services for persons with brain injury These may be added in the future
10	**Type of Medicaid Enrollment Planned**	Voluntary If voluntary, opt in or opt out? Opt out Lock-in period (specify): None
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Michigan Integrated Care

	Element	Description/Notes
1	**State and Lead Agency**	Michigan Department of Community Health (MDCH)
2	**Program**	Integrated Care for People who are Medicare-Medicaid Eligible
3	**Projected Inception (expected date of first enrollment)**	2013 (state proposes to phase-in groups over the year)
4	**LTSS add-on to existing Medicaid Managed Care program?**	Yes
5	**Projected enrollment (as of 1/1/14)**	About 200,000 will be eligible to enroll
6	**Projected Geographic Reach of Program**	Statewide
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	All Medicare-Medicaid enrollees, including: ▪ Children with disabilities ▪ Adults with physical disabilities ▪ Adults with developmental/intellectual disabilities ▪ Adults with serious mental illness ▪ Older persons (65+)
9	**Scope of LTSS**	What, if any, LTSS will be carved out? Nothing is carved out, but mental health, developmental disabilities, and substance abuse service will be delivered through the States existing network of PIHPs
10	**Type of Medicaid Enrollment Planned**	Voluntary If voluntary, opt in or opt out? Opt out Lock-in period (specify): One year. Members may opt out or switch plans during the first 60 days
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Nevada Comprehensive Care Waiver (NCCW)

	Element	Description/Notes
1	**State and Lead Agency**	Nevada Department of Health and Human Services, Division of Health Care Financing and Policy
2	**Program**	Nevada Comprehensive Care Waiver (NCCW)
3	**Projected Inception (expected date of first enrollment)**	To be determined, but not until after ACA expansion populations have been added to the program
4	**LTSS add-on to existing Medicaid Managed Care program?**	No
5	**Projected enrollment (as of 1/1/14)**	Unknown at this time
6	**Projected Geographic Reach of Program**	Potentially statewide, but not decided
7	**Will Include Rural Areas?**	Potentially yes
8	**Groups Projected to Be Enrolled by 1/1/14**	Contingent on further planning and the experience with Phase I of the program, the following groups could potentially be included in capitated LTSS arrangements: ▪ Older persons with Medicare and Medicaid ▪ Persons with physical disability who have Medicare and Medicaid ▪ Children with Special Health Care Needs
9	**Scope of LTSS**	What, if any, LTSS will be carved out? Unknown at this time
10	**Type of Medicaid Enrollment Planned**	Unknown at this time If voluntary, opt in or opt out? Lock-in period (specify):
11	**Will Participant-Directed Services be Offered?**	Unknown at this time
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	The State is exploring Medicare-Medicaid options but has not made a decision at this time
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

New Hampshire Medicaid Care Management Program

	Element	Description/Notes
1	**State and Lead Agency**	New Hampshire Department of Health and Human Services
2	**Program**	New Hampshire Medicaid Care Management Program
3	**Projected Inception (expected date of first enrollment)**	LTSS will be added in Step 2, currently estimated to begin January, 2014
4	**LTSS add-on to existing Medicaid Managed Care program?**	Yes LTSS will be added as a second step, approximately one year into implementation of the overall program
5	**Projected enrollment (as of 1/1/14)**	Not known at this time
6	**Projected Geographic Reach of Program**	Statewide
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	▪ Children with physical, cognitive, / behavioral disabilities ▪ Adults with physical disabilities ▪ Adults with developmental/intellectual disabilities ▪ Older persons
9	**Scope of LTSS**	What, if any, LTSS will be carved out? None anticipated at this time
10	**Type of Medicaid Enrollment Planned**	Mandatory Mandatory Lock-in period (specify): 12 months, with an initial 90-day period during which members may change plans for any reason
11	**Will Participant-Directed Services be Offered?**	Plan to expand current participant –directed services to encompass all ages and disabilities
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Contemplating a Medicare / Medicaid ‘duals’ pilot if demonstration projects are still available, in 2014
13	**Other**	Plan to use recently awarded ‘Balancing Incentive Grant’ to build and enhance, infrastructure / capacity within community-based MLTSS

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

New Jersey Managed Long-Term Care

	Element	Description/Notes
1	**State and Lead Agency**	New Jersey Department of Human Services, in Cooperation with the Department of Health and Senior Services
2	**Program**	Managed Long-Term Care (part of the State's 1115 Demonstration Comprehensive Waiver)
3	**Projected Inception (expected date of first enrollment)**	January, 2013
4	**LTSS add-on to existing Medicaid Managed Care program?**	Yes State proposes to amend existing MCO contracts to add LTSS
5	**Projected enrollment (as of 1/1/14)**	Not found
6	**Projected Geographic Reach of Program**	Statewide
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	▪ Persons 65+ years of age ▪ Adults with physical disabilities
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ No carve-outs found
10	**Type of Medicaid Enrollment Planned**	Mandatory If voluntary, opt in or opt out? Lock-in period (specify): Members may switch in first 90 days, and annually thereafter.
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	MCOs will be required to offer Medicare Advantage Special Needs Plans to integrate services for Medicare-Medicaid enrollees
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

New York Fully Integrated Duals Advantage (FIDA), FIDA/OPWDD and Managed Fee for Service Health Home[1]

	Element	Description/Notes
1	**State and Lead Agency**	New York State Department of Health
2	**Program**	Fully Integrated Duals Advantage (FIDA) and Managed Fee for Service Health Home FIDA/OPWDD (Office of Persons with Developmental Disabilities)
3	**Projected Inception (expected date of first enrollment)**	January, 2014 for FIDA component
4	**LTSS add-on to existing Medicaid Managed Care program?**	The program builds off of NYS's Medicaid Advantage Plus program
5	**Projected enrollment (as of 1/1/14)**	About 124,000 will be eligible for FIDA Up to 10,000 will be enrolled in FIDA/OPWDD
6	**Projected Geographic Reach of Program**	FIDA – Eight counties in the greater NYC/Long Island region FIDA/OPWDD – Statewide
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	**FIDA** ▪ 21 or older; ▪ Medicare-Medicaid enrollee; and ▪ In need of community-based Long-Term services and supports for at least 120 days ▪ NOT receiving services from OPWDD, nor in an Office of Mental Health facility **FIDA/OPWDD** ▪ 21 or older; ▪ Medicare-Medicaid enrollee; ▪ Receiving services from OPWDD ▪ NOT in an Office of Mental Health facility
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ None, although developmental disabilities waiver services and ICF/MR services will only be included in the FIDA/OPWDD program
10	**Type of Medicaid Enrollment Planned**	Eligible persons will already be enrolled in Mandatory Managed Long-Term Care Passive enrollment into FIDA is planned for purposes of fully integrating Medicare and Medicaid If voluntary, opt in or opt out? Lock-in period: The State has proposed having 2 enrollment periods per year
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes, in the FIDA components (There will also be a FFS component to the program)
13	**Other**	

[1] *New York State's initiative will include both capitated and fee-for-service portions. This profile addresses primarily the capitated portions (FIDA and FIDA OPWDD).*

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

New York Mandatory Managed Long-Term Care

	Element	Description/Notes
1	**State and Lead Agency**	New York State Department of Health
2	**Program**	Mandatory Managed Long-Term Care
3	**Projected Inception (expected date of first enrollment)**	July, 2012
4	**LTSS add-on to existing Medicaid Managed Care program?**	The program builds off of NYS's longstanding Managed Long-Term Care program, with some differences in target group
5	**Projected enrollment (as of 1/1/14)**	Estimated at 125,000
6	**Projected Geographic Reach of Program**	Five counties in the NYC region in 2012, and an additional nine counties in 2013
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	Must be: ▪ 21 or older; ▪ Medicare-Medicaid enrollee; and ▪ In need of community-based Long-Term services and supports for at least 120 days
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ This program will not include developmental disabilities waiver services or ICF/MR services
10	**Type of Medicaid Enrollment Planned**	Mandatory If voluntary, opt in or opt out? Lock-in period (specify): None
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Eligible persons will have the choice of enrolling in PACE and Medicaid Advantage plans if they are available in their service areas Both of those programs include Medicare on a fully capitated basis Those enrolling in partial capitation plans will not immediately have capitated Medicare from the same plan Enrollees in some counties will have fully integrated Medicare-Medicaid options in 2014 when the State expects to begin its FIDA program (See separate profile on NYS's Fully Integrated Duals Advantage initiative.)
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

New York People First Waiver

	Element	Description/Notes
1	**State and Lead Agency**	NYS Office for People With Developmental Disabilities
2	**Program**	People First Waiver
3	**Projected Inception (expected date of first enrollment)**	Mid- to late 2013. The State projects first enrollment to occur 1 year after CMS waiver approval, which is pending as of this date
4	**LTSS add-on to existing Medicaid Managed Care program?**	No
5	**Projected enrollment (as of 1/1/14)**	Unknown at this time
6	**Projected Geographic Reach of Program**	Statewide in 2015, following a period of demonstration pilots and roll-out in 2013 and 2014
7	**Will Include Rural Areas?**	Potentially yes
8	**Groups Projected to Be Enrolled by 1/1/14**	▪ Persons of all ages with developmental disabilities
9	**Scope of LTSS**	What, if any, LTSS will be carved out? No carve-outs found
10	**Type of Medicaid Enrollment Planned**	Voluntary in pilot phase, and mandatory when fully implemented Lock-in period (specify): Not found
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	No plan to include Medicare at this time
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Ohio Integrated Care Delivery System

	Element	Description/Notes
1	**State and Lead Agency**	Ohio Department of Job and Family Services
2	**Program**	Integrated Care Delivery System
3	**Projected Inception (expected date of first enrollment)**	April, 2013
4	**LTSS add-on to existing Medicaid Managed Care program?**	No ICDS will be a new, free-standing program
5	**Projected enrollment (as of 1/1/14)**	About 115,000
6	**Projected Geographic Reach of Program**	Seven regions, covering 29 out of 88 counties
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	Most adults (18+) with full Medicare-Medicaid benefits. Persons served in Developmental Disabilities waiver programs or in ICF/MR facilities are excluded
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ Developmental Disabilities waiver services and ICF/MR facility services ▪ PACE services are carved out
10	**Type of Medicaid Enrollment Planned**	Mandatory Medicaid enrollment, with opt-out for Medicare Lock-in period (specify): None (members may switch plans, or opt out of Medicare, on a month-to-month basis
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Rhode Island Integrated Care for Medicare and Medicaid Beneficiaries

	Element	Description/Notes
1	**State and Lead Agency**	Rhode Island Executive Office of Health and Human Services/Medicaid
2	**Program**	Integrated Care for Medicare and Medicaid Beneficiaries
3	**Projected Inception (expected date of first enrollment)**	1/1/13
4	**LTSS add-on to existing Medicaid Managed Care program?**	Yes The State proposes to add LTSS to its existing Rhody Health Partners program
5	**Projected enrollment (as of 1/1/14)**	Approximately 35,000 will be eligible to enroll, including about 12,000 Medicaid-only enrollees and about 23,000 Medicare-Medicaid enrollees
6	**Projected Geographic Reach of Program**	Statewide
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	▪ Older adults ▪ Adults with physical disabilities To be determined is whether and how persons with Intellectual/developmental disabilities and persons with serious mental illness will be enrolled (They are excluded in 2013, and may be included in 2014)
9	**Scope of LTSS**	What, if any, LTSS will be carved out? Services for persons with Intellectual/developmental disabilities and persons with serious mental illness are carved out in 2013 To be determined is whether and how those services will be included in 2014
10	**Type of Medicaid Enrollment Planned**	Voluntary If voluntary, opt in or opt out? Opt out Lock-in period (specify): None (may opt out monthly)
11	**Will Participant-Directed Services be Offered?**	Yes (agency model)
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes, in 2014 Program will begin as Medicaid-only model in 2013
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

South Carolina Dual Eligible Demonstration

	Element	Description/Notes
1	**State and Lead Agency**	South Carolina Department of Health and Human Services
2	**Program**	South Carolina Dual Eligible Demonstration (SCDuE)
3	**Projected Inception (expected date of first enrollment)**	1/1/14
4	**LTSS add-on to existing Medicaid Managed Care program?**	No
5	**Projected enrollment (as of 1/1/14)**	68,000 are estimated to be eligible for the program
6	**Projected Geographic Reach of Program**	Statewide by July, 2014, when the 2nd of 2 regions is phased in
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	Full benefit Medicare-Medicaid enrollees who are: ▪ 65 years of age and older ▪ Not living in institutions at time of enrollment ▪ Not enrolled in a PACE program There are no exclusions based on diagnosis or condition(s)
9	**Scope of LTSS**	What, if any, LTSS will be carved out? HCBS waiver services will be coordinated by the program, but not included in the capitation They will continue to be delivered by the current HCBS delivery system, and reimbursed on a fee-for-service basis
10	**Type of Medicaid Enrollment Planned**	Voluntary If voluntary, opt in or opt out? Opt out Lock-in period (specify): Annual, after an initial 90 day period, during which members may opt out
11	**Will Participant-Directed Services be Offered?**	Yes, indirectly Self direction will continue to be available for HCBS waiver services, which are carved out, but closely coordinated with this program
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Virginia Demonstration to Integrate Care for Dual Eligible Individuals

	Element	Description/Notes
1	**State and Lead Agency**	Virginia Department of Medical Assistance Services (DMAS)
2	**Program**	State Demonstration to Integrate Care for Dual Eligible Individuals
3	**Projected Inception (expected date of first enrollment)**	1/1/14
4	**LTSS add-on to existing Medicaid Managed Care program?**	No
5	**Projected enrollment (as of 1/1/14)**	About 65,000 will be eligible for demonstration
6	**Projected Geographic Reach of Program**	Four regions initially (Central VA, Northern VA, Tidewater, Western/Charlottsville) SW/ Roanoke expected after first year.
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	▪ Full benefit Medicare-Medicaid enrollees ▪ 21+ years ▪ Older persons and persons with physical disabilities ▪ Nursing facility residents ▪ Persons who receive services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver This includes persons with intellectual or developmental disabilities who are being served through this waiver Persons with Intellectual/developmental disabilities who are not in the EDCD Waiver are excluded
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ Assisted Living services ▪ Intellectual/developmental disability services ▪ PACE programs
10	**Type of Medicaid Enrollment Planned**	Voluntary If voluntary, opt in or opt out? Opt out Lock-in period (specify): None
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes
13	**Other**	

Projected State Managed Long-Term Services and Supports (MLTSS) Program:

Washington HealthPath

	Element	Description/Notes
1	**State and Lead Agency**	Washington Department of Social and Health Services Aging and Disability Administration and the State Health Care Authority
2	**Program**	HealthPath Washington (Strategy 2: Capitated model)
3	**Projected Inception (expected date of first enrollment)**	1/1/14 for Strategy 2
4	**LTSS add-on to existing Medicaid Managed Care program?**	Yes The State is rolling out Medicaid medical managed care for the SSI population in July, 2012
5	**Projected enrollment (as of 1/1/14)**	27,000 are projected for Strategy 2
6	**Projected Geographic Reach of Program**	Unknown Strategy 2 will be implemented only in counties where the County Legislative Authority has agreed to implementation
7	**Will Include Rural Areas?**	Yes
8	**Groups Projected to Be Enrolled by 1/1/14**	▪ Older adults ▪ Adults with physical disabilities ▪ Adults with intellectual/developmental disabilities Persons residing in State Residential Habilitation Centers are excluded
9	**Scope of LTSS**	What, if any, LTSS will be carved out? ▪ Waiver services for persons with intellectual/developmental disabilities will be carved out
10	**Type of Medicaid Enrollment Planned**	Voluntary If voluntary, opt in or opt out? Opt out Lock-in period (specify): First 90 days, after which member may disenroll on a month-to-month basis
11	**Will Participant-Directed Services be Offered?**	Yes
12	**Projected Medicare Approach: Will the program include Medicare on a fully capitated basis?**	Yes, in Strategy 2
13	**Other**	

FOR MORE INFORMATION

Send us an email at
paul.saucier@truvenhealth.com or
brian.burwell@truvenhealth.com

TRUVEN HEALTH ANALYTICS™

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