State Demonstrations to Integrate Care for Dual Eligible Individuals
Design Contracts
Summary of State’s Initial Design Concepts
May 2011

**State:** California

<table>
<thead>
<tr>
<th><strong>Overview of Proposed Approach</strong></th>
<th>Medi-Cal, California’s Medicaid program, has been directed by the California Legislature (Senate Bill 208) and the Governor’s office to develop a program to provide more streamlined and effective care for California’s dual eligible beneficiaries.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>Full benefit dual eligible beneficiaries.</td>
</tr>
<tr>
<td><strong>Estimated Enrollment</strong></td>
<td>California Department of Health Care Services (DHCS) plans to enroll up to 150,000 dual-eligible beneficiaries in integrated care in the next 24 months. By 2015, DHCS hopes to expand integrated care Statewide, with maximum enrollment of 1.1 million dual-eligible beneficiaries.</td>
</tr>
<tr>
<td><strong>Planned Geographic Service Area</strong></td>
<td>The legislation directs the DHCS to initially implement integrated care pilots for full benefit dual eligible beneficiaries in four counties. At least one of these pilot programs will be managed by a County Organized Health System (COHS) and at least one will be piloted within California’s Two-Plan County Model.</td>
</tr>
</tbody>
</table>
| **Planned Stakeholder Process**  | Major stakeholder meetings will be held in May 2011, October 2011, March 2012. Targeted outreach to stakeholders will be conducted July – September, 2011. Local stakeholder meetings will commence after announcement of pilots in March 2012.
A Technical Advisory Panel, composed of stakeholders, will continue to meet to advise DHCS bimonthly. |
| **Proposed Implementation Date and Related Milestones** | Request for Proposals: October 2011
Announcement of Pilot Sites and Contractors: March 2012
Launch Pilots: Last Quarter 2012 |
| **State Contact Person and Email Address** | Paul Miller
Paul.miller@dhcs.ca.gov |
State: Colorado

| Overview of Proposed Approach | Colorado proposes to enroll dual eligibles into Colorado’s Accountable Care Collaborative, which is a hybrid of a primary care medical home and an accountable care organization. |
| Target Population | Individuals enrolled in Medicare (A, B, C, and/or D), and also eligible for the full array of benefits under Colorado’s Medicaid State plan. |
| Estimated Enrollment | Colorado proposes to make enrollee participation voluntary. Very conservatively, the State anticipates roughly half of Colorado’s dual eligibles, or at least 30,000 participants. Colorado expects full implementation to ramp up quickly, prior to the end of 2012. |
| Planned Geographic Service Area | Statewide |
| Planned Stakeholder Process | Colorado plans to establish an advisory committee with broad participation by various stakeholders as well as to engage stakeholders in a series of meetings throughout the State of Colorado. |
| Proposed Implementation Date and Related Milestones | June 2011: First large Stakeholder Forum: Regional Care Collaboration Organization kick-off meeting; obtain Medicare claims data on Colorado dual eligibles November 2011: Second large Stakeholder forum December 2011: Integrated data complete on Colorado dual eligibles and within our Statewide Data Analytics Contractor January 2011: Legislative changes proposed May 2012: Marketing materials approved June 2012: Submit plan to CMS |
| State Contact Person and Email Address | Jed Ziegenhagen Director of Rates and Analysis jed.ziegenhagen@state.co.us | Judy Zerzan, MD, MPH Chief Medical Officer judy.zerzan@state.co.us |
**State Demonstrations to Integrate Care for Dual Eligible Individuals**  
**Design Contracts**  
**Summary of State’s Initial Design Concepts**  
**May 2011**

**State: Connecticut**

| **Overview of Proposed Approach** | CONNECTICUT PROPOSES TO ESTABLISH LOCAL INTEGRATED CARE ORGANIZATIONS (ICOS) TO CREATE A SINGLE POINT OF ACCOUNTABILITY FOR THE DELIVERY, COORDINATION AND MANAGEMENT OF PRIMARY, PREVENTIVE, ACUTE AND BEHAVIORAL HEALTH, INTEGRATED WITH LONG-TERM SUPPORTS AND SERVICES AND MEDICATION MANAGEMENT FOR DUAL ELIGIBLES. THE ICO MODEL WOULD FEATURE PARTNERSHIPS AMONG MULTIPLE PROVIDER TYPES AND BE FACILITATED BY HEALTH INFORMATION TECHNOLOGY AND ELECTRONIC DATA GATHERING. THIS NEW INTEGRATED CARE PROGRAM WOULD OFFER DUAL ELIGIBLES A HEALTH HOME WHERE THEY MAY ACCESS A SEAMLESS CONTINUUM OF ENHANCED MEDICAL, PHARMACY, BEHAVIORAL AND LONG-TERM SERVICES AND SUPPORTS UNDER ONE PROGRAM. IN ADDITION, BECAUSE CONNECTICUT’S PRIMARY CARE SYSTEM IS PREDOMINANTLY COMPRISED OF SMALL GROUP PRACTICES, THIS APPLICATION AIDS TO DEMONSTRATE HOW THESE PRACTICES CAN AFFILIATE WITH LARGER, FULLY RESOURCED PRIMARY CARE CENTERS TO ENHANCE PRIMARY CARE WHILE MAINTAINING MAXIMUM FREEDOM OF CHOICE FOR DUAL ELIGIBLES, A MODEL THAT COULD BE APPLIED TO OTHER STATES WITH SIMILAR SYSTEMS. THE STATE PROPOSES TO ALIGN FINANCIAL INCENTIVES TO PROMOTE VALUE – THE ENHANCEMENT OF QUALITY OF CARE, THE CARE EXPERIENCE AND HEALTH OUTCOMES AT LOWER OVERALL COST TO THE MEDICARE AND MEDICAID PROGRAMS. QUALITY AND OUTCOME MEASURES WOULD FOCUS BOTH ON MEDICAL SERVICE OUTCOMES, AS WELL AS THE EFFECTIVENESS OF HOME- AND COMMUNITY-BASED SERVICES (HCBS) AND SUPPORTS, EMPHASIZING INDIVIDUAL SATISFACTION WITH THE PERSON-CENTERED AND DISABILITY COMPETENT CARE PROCESS. THE STATE PROPOSES TO ESTABLISH RISK-ADJUSTED GLOBAL BUDGETS FOR THE PURPOSE OF ASSESSING THE ICO’S EFFECTIVENESS IN MANAGING OVERALL COST, WHILE RETAINING EXISTING MEDICARE AND MEDICAID BENEFITS AND FFS REIMBURSEMENT. |
| **Target Population**  
(All duals/full duals/subset/etc.) | CONNECTICUT IS PROPOSING A PHASED-IN APPROACH THAT WILL OFFER PARTICIPATION INITIALLY TO ALL (FULL AND PARTIAL BENEFIT) DUAL ELIGIBLES AGES 65 AND OVER RECEIVING CARE IN NURSING FACILITIES AND THE COMMUNITY. DUAL ELIGIBLES ENROLLED IN A HCBS WAIVER OTHER THAN THE HOME CARE PROGRAM FOR ELDERS HCBS WAIVER WOULD NOT BE INCLUDED IN THE INITIAL IMPLEMENTATION. PROVIDING THIS OPPORTUNITY FIRST TO ELDERLY DUAL ELIGIBLES WILL COMPLEMENT THE MANY CURRENT INITIATIVES IN CONNECTICUT FOCUSED ON THE GERIATRIC POPULATION, WHILE PROVIDING TIME TO DEVELOP THE MODEL FURTHER FOR PARTICIPATION BY YOUNGER DUAL ELIGIBLES WITH DISABILITIES. (NOTE: DUAL ELIGIBLES CURRENTLY ENROLLED IN MEDICARE ADVANTAGE PLANS WOULD REMAIN ENROLLED IN THOSE PLANS, UNLESS AN INDIVIDUAL CHOOSES OTHERWISE.) BEGINNING IN THE THIRD YEAR OF IMPLEMENTATION, CONNECTICUT WOULD EXPAND ELIGIBILITY TO DUAL ELIGIBLES UNDER 65 AND OLDER DUAL ELIGIBLES WITH DISABILITIES AND INCORPORATE FEATURES INTO THE ICO MODEL NECESSARY TO MEET THE UNIQUE NEEDS OF THOSE POPULATIONS. |
| **Estimated Enrollment**  
(in 2012 and at full) | CONNECTICUT ESTIMATES APPROXIMATELY 13,000 TO 20,000 INDIVIDUALS WOULD PARTICIPATE IN THE INITIAL IMPLEMENTATION OF THE DEMONSTRATION, |
representing approximately 20% to 30% of dual eligibles ages 65 and over. (Note: dual eligibles currently enrolled in Medicare Advantage plans would remain enrolled in those plans, unless an individual chooses otherwise.) At full implementation, approximately 120,000 full and partial dual eligibles would be included in the demonstration.

<table>
<thead>
<tr>
<th><strong>Planned Geographic Service Area</strong></th>
<th>Statewide, but limited to 3 to 6 qualified integrated care organizations.</th>
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</table>

**Planned Stakeholder Process**

Connecticut will continue to engage a wide variety of stakeholders in the design of the duals demonstration model, including dual eligibles, advocacy groups, provider associations, the Department of Developmental Services and the Department of Mental Health and Addiction Services, legislative staff and researchers. This is a continuation of Connecticut’s successful past effort to work collaboratively with stakeholders, such as in the design of the State’s Multi-Payer Advanced Primary Care Practice (MAPCP) proposal, consultation with stakeholders, as part of the Mercer review of HCBS waivers and ongoing monthly meetings with consumers, and advocates as part of the Money Follows the Person (MFP) demonstration. The State’s proposed demonstration is a direct reflection of the input received from a stakeholder community with diverse needs and interests working collaboratively together for the end goal of high-quality, cost-effective care for Connecticut’s dual eligibles. Support for this proposal was received from over 30 groups representing consumer advocates, providers, and other State agencies (letters of support can be found at [http://www.ct.gov/dss/lib/dss/pdfs/duals.pdf](http://www.ct.gov/dss/lib/dss/pdfs/duals.pdf)). Going forward, the State intends to use a legislative oversight body know as the Medicaid Care Management Oversight Council and its various subcommittees to provide input into the design of the demonstration application and implementation.

<table>
<thead>
<tr>
<th><strong>Proposed Implementation Date and Related Milestones</strong></th>
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<tbody>
<tr>
<td>(Any implementation milestones are pending CMS Approval)</td>
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<tr>
<td>October 1, 2012 target implementation, with interim milestones to be determined</td>
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<tr>
<th><strong>State Contact Person and Email Address</strong></th>
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<tbody>
<tr>
<td>Mark Schaefer, Ph.D.</td>
</tr>
<tr>
<td>Director, Medical Care Administration</td>
</tr>
<tr>
<td><a href="mailto:mark.schaefer@ct.gov">mark.schaefer@ct.gov</a></td>
</tr>
</tbody>
</table>
### State Demonstrations to Integrate Care for Dual Eligible Individuals
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### May 2011

**State: Massachusetts**

| **Overview of Proposed Approach** | MassHealth proposes to combine Medicare and Medicaid funding for dual eligibles at the State level and procure contracts with entities that integrate comprehensive care at the person level, providing both MassHealth and Medicare funded services. By combining Medicare and Medicaid funding and aligning financial incentives, MassHealth proposes to offer a broader menu of services that will better meet the needs of the population in the most cost effective way. The contracted entities would offer practices that have experience with serving persons with disabilities, employ the principles of patient-centered medical homes, and would be evaluated based on a comprehensive set of quality metrics that will be developed to assess performance. Under this proposal, MassHealth would assume complete operational responsibility for the care of dual eligibles enrolled with the new entities — comparable to its responsibility for its MassHealth-only membership — including the administration, management and oversight of all Medicare-funded and Medicaid-funded services. |
| **Target Population** (All duals/full duals/subset/etc.) | Full dual eligible adults ages 21-64 (~115,000 individuals) |
| **Estimated Enrollment** (in 2012 and at full implementation) | MassHealth’s goal for enrollment is to develop a program that dual eligible adults ages 21-64 will find attractive and want to enroll in. Historically, enrollment by dual eligible individuals in managed care nationwide has been low due to the general lack of experience by care entities in managing long-term care, costly initial program investments and uncertain financial impacts, separate Medicaid and Medicare administrative rules, and discomfort of beneficiaries and their advocates with managed care. However, sufficient levels of enrollment in this new model will be critical to expand access to services and care coordination, improve quality of care and health outcomes, and effect delivery system and financing system changes. The ability to realize the savings potential of this proposed model is dependent on ensuring adequate enrollment in the integrated care entities. As Massachusetts designs the demonstration model, it will work closely with its actuary and with stakeholders, including consumers, advocates, and providers, to determine what features will provide the most value to beneficiaries and how best to encourage maximum participation. |
| **Planned Geographic Service Area** | Statewide |
| **Planned Stakeholder Process** | MassHealth has convened a consumer advocates group of more than 30 organizations that serve dual eligible adults ages 21-64 in order to build, create and support a service delivery model that fully integrates Medicare and Medicaid for these dual eligible individuals. MassHealth also has engaged other State agencies that serve the target population. These discussions have focused on the needs of the target population. |
population and the conceptual design of the demonstration model. The State agencies actively engaged in these discussions include the Executive Office of Health and Human Services Office of Disability Policy and Programs, the Executive Office of Elder Affairs, the Department of Mental Health, the Department of Developmental Services, the Massachusetts Rehabilitation Commission, the Department of Public Health, the Massachusetts Commission for the Blind, and the Massachusetts Commission for the Deaf and Hard of Hearing.

MassHealth is planning to hold focus groups with dual eligible beneficiaries in the target population to better understand individuals’ experiences with their care today and how the Integrated Medicare/MassHealth model can improve it. MassHealth will also be gathering input from groups of beneficiaries and caregivers that regularly interact with the other State agencies serving the target population. In order for the new program to be appealing to a significant percentage of the target population, MassHealth will seek input directly from the beneficiaries themselves about what they would like to see from the model.

MassHealth is also seeking input from a broad spectrum of stakeholders through the release of a Request for Information (RFI) on integrating Medicare and Medicaid for dual eligible adults ages 21-64. The RFI was released in March 2011, with responses due May 6, 2011. Interested parties can access the RFI on Comm-PASS (www.comm-pass.com). The RFI is the kickoff for a series of public meetings for all interested parties. MassHealth wants to gather input from providers and potential delivery system partners on the design of the model, tools providers have and need to meet the needs of the population, and ideas for adequate reimbursement and risk and savings arrangements.

| Proposed Implementation Date and Related Milestones (Any implementation milestones are pending CMS Approval) | MassHealth’s key milestones towards successful implementation include:  
- Drafting the Request for Responses (RFR) in the fall of 2011;  
- Releasing the RFR in January 2012; and  
- Awarding contracts to integrated care entities by fall of 2012. |
| State Contact Person and Email Address | Beth Tortolani, beth.tortolani@state.ma.us  
Robin Callahan, robin.callahan@state.ma.us |
## State: Michigan

| **Overview of Proposed Approach** | Michigan proposes to integrate Medicare and Medicaid funds to deliver all covered services for dually eligible beneficiaries. Under this proposal, those eligible would be enrolled, but with the ability to opt out of the plan. The State proposes to contract with one or more entities to administer the program under an acuity-based capitation arrangement. Risk would initially be shared between the State and the contracted entities, with full risk eventually transferred to the contractors. The financing arrangement between Medicare and Medicaid could range from full risk for the State to a shared risk / shared savings model. A robust care coordination program would be the hub of the delivery model, with each enrollee having a health home focused on person-centered care. |
| **Target Population** | All dually eligible individuals |
| **Estimated Enrollment** | Current Statewide enrollment for dual eligibles: 207,594 Estimated enrollment April 1, 2012 (with 6% trend): 220,050 |
| **Planned Geographic Service Area** | Statewide, but likely a phased implementation. |
| **Planned Stakeholder Process** | A thorough Statewide stakeholder process will be conducted to obtain input from all pertinent groups. This process will be carried out in summer of 2011. |
| **Proposed Implementation Date and Related Milestones** | The proposed implementation date is April 1, 2012. Proposed Milestones:

**May 2011 and ongoing:** Obtain Medicare data and link to Medicaid data; perform data analysis for overall population.

**June through August 2011:** Conduct stakeholder process.

**September-October 2011:** Review input from stakeholder process along with results from data analysis and supporting research to determine delivery model(s).

**September – December 2011:** Write and submit necessary waivers and address any necessary legislation. Create an enrollment process.

**November 2011:** Draft Request for Proposal (RFP).

**December 2011-February 2012:** Conduct RFP Process.

**February-March 2012:** Contracting process with selected entities.

**April 2012:** Implement Integrated Care for Dual Eligibles. |
| **State Contact Person and Email Address** | Susan Yontz
yontzs@michigan.gov |
**Overview of Proposed Approach**

Minnesota proposes to improve performance of primary care and care coordination models for dual eligibles served in integrated Medicare and Medicaid Special Needs Plans and fee for service delivery systems by building on current State initiatives. These initiatives include implementation of Health Care Homes (HCH) and provider level payment systems such as accountable care organizations (ACOs) and Total Cost of Care payment models. Proposed improvements include development of system-wide performance measures, risk adjustments, provider feedback systems and risk/gain sharing models specific to the dually eligible population. Minnesota plans to seek CMS waivers or modifications needed to stabilize Medicare Advantage Special Needs Plans (SNP) participation and to further integrate Medicare into these initiatives.

**Target Population**

| (All duals/full duals/subset/etc.) | All full benefit dually eligible seniors and people with disabilities (about 107,000) in managed care and fee for service. |

**Estimated Enrollment**

| (in 2012 and at full implementation) | About 48,500 seniors enrolled in managed care including 96% who are dually eligible. 75% are already enrolled in integrated dual eligible SNPs. |
| | About 5,800 people with disabilities 18-64 enrolled in managed care and/or integrated SNPs. 60% are dually eligible. |
| | About 53,000 mostly people with disabilities 18-64 who remain in fee for service. |

**Planned Geographic Service Area**

| (Statewide or listing of pilot service areas) | Statewide |

**Planned Stakeholder Process**

The State will consult numerous existing stakeholder groups including the Disability Managed Care Stakeholders group, a SNP Leadership Collaborative, the Board on Aging and HCH Advisory groups, but will also establish a Dual Demo Stakeholder group comprised of representatives from these groups and others to specifically advise on this project.
| Proposed Implementation Date and Related Milestones | Implementation targeted for 5/12 or upon CMS approval.  
4/11 Disability Stakeholder’s meeting, hire project manager  
9/11 Linked dual eligibles data due, interim progress report to CMS  
9/11 SNP contracting process begins, amend contracts as needed  
11/11 Preliminary performance metrics and payment models due  
11/11 RFI Responses for SNPs due for 2013 contract period  
12/11 Stakeholder review, NOI for SNPs to CMS for 2013  
1/12 Integrated care planning tools plan due  
2/12 Draft Outline of CMS Proposal review, finalize waiver requests |
|-----------------------------------------------|
| State Contact Person and Email Address | Pamela Parker, Manager, Special Needs Purchasing  
Pam.parker@state.mn.us  
David Godfrey, Medical Director  
David.godfrey@state.mn.us  
Jeff Schiff, Medical Director  
Jeff.schiff@state.mn.us |
State: North Carolina

<table>
<thead>
<tr>
<th>Overview of Proposed Approach</th>
<th>North Carolina will partner with long-term care providers, home and community-based providers, area agencies on aging and other stakeholders to design, in concert with dual eligibles and their families, a health care delivery system that provide the right care at the right time and will help the State achieve the “triple aims” of better care, better health, and lower costs through improvements. North Carolina’s approach for integrating care for dual eligibles is to build on its existing Statewide population management infrastructure (Community Care of North Carolina – CCNC). Community Care has a proven track record of improving care and containing costs. It is a public-private collaborative through which the State has partnered with community physicians, hospitals, health departments and other community organizations to build regional networks to improve the quality, efficiency and cost-effectiveness of care for Medicaid and Medicare beneficiaries. CCNC currently serves over 1 million Medicaid enrollees, over 50,000 uninsured, and over 83,000 dual eligibles, through 14 networks, and approximately 1,300 medical home and over 4,000 primary care providers. CCNC is currently working with dual eligibles in the Medicare Healthcare Quality (646) Demonstration and in the near future with the Multi-Payer Advanced Primary Care Practice (MA PCP) Demonstration.</th>
</tr>
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<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>At this time, North Carolina is planning to target all dual eligibles.</td>
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<tr>
<td>(All duals/full duals/subset/etc.)</td>
<td><strong>Estimated Enrollment</strong></td>
</tr>
<tr>
<td>(in 2012 and at full implementation)</td>
<td><strong>Planned Geographic Service Area</strong></td>
</tr>
<tr>
<td>(Statewide or listing of pilot service areas)</td>
<td><strong>Planned Stakeholder Process</strong></td>
</tr>
</tbody>
</table>
| **Proposed Implementation Date and Related Milestones**  
(Any implementation milestones are pending CMS Approval) | ● Identification of stakeholder groups and plan regular stakeholder meetings at the local and State level throughout the 12 month planning process.  
● Draft of preliminary plan design document completed in 10 months and final document completed in 12 months.  
● Meet all identified reporting and meeting expectations from CMS in the 12 month period of time.  
● Implementation date 12 months from the start of the design contract (Late April 2012). |
| **State Contact Person and Email Address** | Project Director to be hired and identified. In the interim: Denise Levis Hewson, Director of Clinical Programs and Quality Improvement for CCNC [dlevis@n3cn.org](mailto:dlevis@n3cn.org) |
State: New York

**Overview of Proposed Approach**

New York State (NYS) will explore a range of options in designing a proposal which will improve care and efficiencies of service for dual eligibles. Such options may include State management of the delivery and financing of the combined Medicare/Medicaid benefit package; actualizing increased participation in operational managed long-term care (MLTC) plans through passive or mandatory enrollment of dual eligibles; collaborating with nursing homes and Special Needs Plans (SNPs) to provide effective care coordination for dual eligibles residing in NYS nursing homes; utilizing a care management with gain sharing design; and/or, piloting specialized case management programs serving individuals with developmental disabilities and/or dual eligibles under 55 in a flexible Program of All Inclusive Care for the Elderly (PACE) arrangement.

**Target Population**

(All duals/full duals/subset/etc.)

To be determined based on data analysis and stakeholder input and as they relate to the options described above.

**Estimated Enrollment**

(in 2012 and at full implementation)

To be determined based on data analysis and stakeholder input and as they relate to the options described above.

As of December 2009, there were over 709,430 dual eligibles in the State.

**Planned Geographic Service Area**

(Statewide or listing of pilot service areas)

To be determined based on data analysis and stakeholder input and as they relate to the options described above.

**Planned Stakeholder Process**

A series of stakeholder sessions will be scheduled to obtain input on proposed program models, financing and issues related to care coordination and quality. NYS will obtain the services of a qualified consultant with experience in working with diverse advocacy, service and consumer groups. Key informants in the development of any dual eligible program design include State agencies that serve large numbers of the dually eligible such as the Office for People with Developmental Disabilities and the Office for Mental Health. NYS believes that effective stakeholder information input will be key in identifying the current and projected capacity within the existing healthcare system and in identifying areas where infrastructure needs further development and support.

**Proposed Implementation Date and Related Milestones**

(Any implementation milestones are pending CMS Approval)

October 2012

Planning milestones include:
- Complete vendor contracting process;
- Review Medicare/Medicaid linked data;
- Conduct stakeholder sessions; and
- Review of proposed demonstration designs.

**State Contact Person and Email Address**

Vallencia Lloyd  Joseph Anarella

Director   Deputy Division Director
<table>
<thead>
<tr>
<th>Division of Managed Care</th>
<th>Office of Health Insurance Programs</th>
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</thead>
<tbody>
<tr>
<td>NYS Department of Health</td>
<td>NYS Department of Health</td>
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<tr>
<td><a href="mailto:vml05@health.state.ny.us">vml05@health.state.ny.us</a></td>
<td><a href="mailto:jpa02@health.state.ny.us">jpa02@health.state.ny.us</a></td>
</tr>
</tbody>
</table>
State: Oklahoma

| Overview of Proposed Approach | Oklahoma’s proposal involves taking a three-pronged approach to determining the most efficient methods of care integration. Each of the three proposed concepts identifies a different aspect of care for the dual eligibles and will be developed to identify the feasibility and effectiveness of each concept.  
- Concept #1 involves creating an Accountable Care Organization (ACO) with embedded medical education programs (Health Innovation Zone) that specifically serves high cost patients that are eligible for both Medicare and Medicaid.  
- Concept #2 involves exploring the feasibility of establishing a benefit plan and network, administered and operated by the State. Oklahoma proposes combining the funding streams from Medicare and the Oklahoma Health Care Authority (OHCA) and using these funds to purchase coverage through a plan and network developed and administered by OHCA.  
- Concept #3 looks at the expansion of Oklahoma’s Cherokee Elder Care Program of All-inclusive Care for the Elderly (PACE) program Statewide. The PACE model combines the services of an adult day health center, primary care office, and rehabilitation facility into a single location. PACE provides an all-inclusive and comprehensive continuum of care designed to maintain and ideally to improve the quality of life for the elderly. |
|---|---|
| Target Population | Concept #1 would target individuals from north, east and west Tulsa who are dually eligible for Medicare and Medicaid coverage.  
Concept #2 would target all dual eligibles with a particular focus on those dual eligibles with behavioral health needs.  
Concept #3 would target dual eligibles certified to need nursing level of care. |
| Estimated Enrollment | Estimated enrollment for Concept #1 is about 2,200 individuals from north, east and west Tulsa. The estimated enrollment numbers for the other two design concepts will be determined as the planning and design process moves forward. |
| Planned Geographic Service Area | Concept #1 will be centered in the Tulsa region. The remaining two concepts will be exploring a Statewide service area during the design process. |
| Planned Stakeholder Process | Oklahoma anticipates seeking the involvement of partners by invitation to an initial meeting to discuss the opportunity, then following the processes already set forth by OHCA, convening a large working group, smaller sub-groups tasked with specific solution gathering, and ad hoc discussions. All workgroups will meet monthly, and more frequently if needed. A website for distribution of meeting information (i.e. agendas, minutes, action plans, outstanding questions, etc) will be created to ensure transparency in the design process. |
The development and design process for this proposal will begin immediately. As the design phase moves along appropriate milestones and potential dates for implementation will be determined.

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<thead>
<tr>
<th>Proposed Implementation Date and Related Milestones (Any implementation milestones are pending CMS Approval)</th>
<th>Buffy Heater</th>
<th><a href="mailto:Buffy.heater@okhca.org">Buffy.heater@okhca.org</a></th>
</tr>
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<tbody>
<tr>
<td><strong>State Contact Person and Email Address</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
## Overview of Proposed Approach

- Oregon proposes blending Medicare and Medicaid funding streams to contract with regional plans to provide coordinated acute and behavioral health services for dual eligible individuals.
- The State proposes a global budget for providing care and coordination would be set at levels appropriate to achieve best practices and to address unsustainable increases in the cost of care and services.
- Contracts would require person-centered plans for those with most acute needs and would phase in health homes for all beneficiaries as soon as possible.
- Contracts would require plans to coordinate with long-term care services and supports for this population. Contracts with Area Agencies on Aging would require coordination with the plans.
- The program for dual eligibles would be part of a broader effort to provide integrated care for all Medicaid and CHIP enrollees.

## Target Population

| All duals/full duals/subset/etc. | Dual eligible persons entitled to the full Medicaid benefit. It would not include dually eligible persons who receive only premium or cost-sharing assistance through the Medicaid program. |

## Estimated Enrollment

| in 2012 and at full implementation | By mid-2012, Oregon proposes to have the basic program fully implemented with an expected enrollment: 59,000. |

## Planned Geographic Service Area

| Statewide or listing of pilot service areas | Statewide |

## Planned Stakeholder Process

- Oregon’s governor appointed a 40-plus stakeholder “Health System Transformation Team,” including legislators, members of the Oregon Health Policy Board, client and legal advocates, health care and long-term care providers, existing Medicaid plans, and other health insurers. The group met weekly during February and March 2011 to discuss the concept in Oregon’s proposal. As of late Spring 2011, the Legislature is now considering a bill to create the necessary State law framework and an initial meeting with stakeholders was held in April 2011. Once the Legislature completes the framework bill (by the end of June 2011), the State will do broader outreach to clients, providers, plans, county health departments, and the agencies now responsible for long-term care case management. The State will develop specialized groups to react to ideas as they are developed, including both broad stakeholder groups and client groups, and will conduct town hall style meetings. The State expects to work particularly intensely with stakeholders to develop a strong model for coordinating long-term care with health care. |

## Proposed Implementation Date and Related Milestones

| Oregon’s proposed implementation timeframe is as follows: |
| Stakeholder Meeting. April 2011 |
| (Any implementation milestones are pending CMS Approval) | • Necessary legislative changes in place. July 2011.  
• Initial proposal for the all-Medicaid approach submitted to CMS. July 2011.  
• Demonstration proposal submitted to CMS. Fall 2011.  
• Procurement process defined and requirements announced for the all-Medicaid integrated care program. November 2011.  
• Necessary administrative rules in place. December 2011.  
• Preliminary contractor selection completed. February 2012.  
• Contractor selection finalized and contracts issued. April 2012.  
• Beneficiaries enrolled in new entities and changeover complete. No later than July 2012. |
| State Contact Person and Email Address | Lynn-Marie Crider  
[lynn-marie.crider@state.or.us](mailto:lynn-marie.crider@state.or.us) |
**State Demonstrations to Integrate Care for Dual Eligible Individuals**  
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**Summary of State’s Initial Design Concepts**  
**May 2011**

**State: South Carolina**

| **Overview of Proposed Approach** | The South Carolina Department of Health and Human Services (SCDHHS) has significant experience in developing care interventions targeting people with complex conditions and those who are dually eligible for Medicaid and Medicare. Dual eligibles make up approximately 16 percent of the SC Medicaid enrollment, but account for approximately 50 percent of expenditures. SCDHHS proposes to develop an integrated care model for dual eligibles using the new Health Home option outlined in the Affordable Care Act. The proposed model would integrate primary care and behavioral health services as well as provide linkages to community based long-term care services, and social/family support services. SCDHHS will work with an Integrated Care Workgroup to design the model and develop the implementation plan including organizational structure, population, service delivery, financing, evaluation, implementation, and legislative oversight. The analysis and design process will use the extensive data, analytical and geographic information resources of SCDHHS/CLTC, Institute for Families in Society and Office of Research and Statistics. |
| **Target Population**  
(All duals/full duals/subset/etc.) | SC’s proposed target population, a subset of the total dual population, is individuals with a behavioral health diagnosis in one the major diagnostic mental disorders or Alzheimer’s Disease. The diagnosis must impair activities for daily living (e.g., increased need for caregiver support; limited self directed care or choice of living arrangements); must be of a duration of two or more years; and must require ongoing supervision and prescription medications to address behavioral health diagnosis. |
| **Estimated Enrollment**  
(in 2012 and at full implementation) | To be determined during the planning and design phase. |
| **Planned Geographic Service Area**  
(Statewide or listing of pilot service areas) | To be determined during the planning and design phase. SC would like to begin with a pilot service and then systematically roll-out Statewide. |
| **Planned Stakeholder Process** | SC will actively engage stakeholders in the design of an integrated primary, behavioral health and long-term care system. Building on an existing LTC Workgroup, SC will establish an Integrated Care Workgroup comprised of consumers/advocacy organizations representing older adults, Alzheimer’s, AARP, multiple sclerosis, cancer, people with disabilities, TBI, mental health, State agencies/executive level policy makers (e.g., SCDHHS/CLTC, Dept. of Disabilities and Special Needs ; Head and Spinal Cord Injury Division; Dept. of Health and Environmental Control, Lt. Governor’s Office on Aging, Area Agencies on Aging, Silver Haired Legislature), and providers representing adult day services, personal care, disability resources, home health, home care and hospice, respite, hospitals, independent living centers and a consortium of gerontology |
Legislative stakeholders will be engaged through this process. The stakeholder workgroup is designed to serve as an independent body composed of agency, clinical and methodological experts and consumer representatives with expertise to compliment SCDHHS.

<table>
<thead>
<tr>
<th>Proposed Implementation Date and Related Milestones</th>
<th>Planning and Design Phase: April 1, 2011 - March 30, 2012:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Any implementation milestones are pending CMS Approval)</td>
<td>April - May 2011: Recruit project staff, formalize Workgroup, conduct research, and finalize data agreement to obtain Medicare Claims Data; compile enhanced Medicaid data set for dual eligibles for FY 2008 – 2010 for analysis. Present overall strategy to stakeholders.</td>
</tr>
<tr>
<td></td>
<td>June-July 2011: Link data sets and conduct proposed data analysis. Begin working with CMS to explore options for Medicaid to receive shared savings. Hold second Workgroup on data analysis. Engage Actuarial and HIT consultants with IFS to address workgroup identified issues. Document process and next steps for analysis.</td>
</tr>
<tr>
<td></td>
<td>August-October 2011: Complete data analysis/actuarial modeling of different approaches. Develop payment methodology and recommendations for long-term data linkages. Explore legislative requirements and pursue State Plan Amendment with CMS for recommended model. Hold third Workgroup to discuss recommendations on proposed model design and approach. Submit interim report.</td>
</tr>
<tr>
<td></td>
<td>Nov - December 2011: Develop model design and strategic plan with sub-committees of the Workgroup, agency personnel and contractors. Draft Model Design and Implementation Plan with consumer, legislative and other stakeholders’ input.</td>
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<td></td>
<td>Jan-March 2012: Finalize Model Design and submit Implementation Plan to CMS.</td>
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<tr>
<th>Implementation of Demonstration Project</th>
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</thead>
<tbody>
<tr>
<td>April 1, 2012 - March 30, 2013: Phase 1 - Establish evaluation indicators and requirements for contracting for Health Home Dual Eligible Demonstration. Conduct and modify policy review to ensure full implementation beyond Phase 1.</td>
</tr>
<tr>
<td>April 1, 2013 - March 30, 2014: Phase 2 - Expand requirements for contracting for Health Home Dual Eligible Demonstration and initiate pilot. Evaluate and modify model to ensure full implementation beyond Phase 2.</td>
</tr>
<tr>
<td>April 1, 2014 - March 30, 2015: Phase 3 - Expand requirements for contracting for Health Home Dual Eligible Demonstration for Statewide geographical implementation. Evaluate and modify policy and evaluation plan to ensure full implementation beyond Phase 3.</td>
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<table>
<thead>
<tr>
<th>State Contact Person and Email Address</th>
<th>Roy Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="mailto:SMITHROY@scdhhs.gov">SMITHROY@scdhhs.gov</a></td>
</tr>
</tbody>
</table>
State Demonstrations to Integrate Care for Dual Eligible Individuals
Design Contracts
Summary of State’s Initial Design Concepts
May 2011

State: Tennessee

| Overview of Proposed Approach | The TennCare managed care program has been in existence for 17 years. In recent years the program has successfully integrated medical and behavioral health services for all enrollees and long-term care services for those enrollees who are elderly or have disabilities. The long-term care program is called “CHOICES.” Almost all TennCare services, with the exception of dental care and prescription drugs, are furnished by TennCare Managed Care Organizations (MCOs). Enrollees in every part of the State have their choice of two MCOs. Full benefit dual eligibles currently receive all TennCare covered services that are not covered by Medicare through their MCO. They receive Medicare Part A and Part B services through Original Medicare or, for some, through Special Needs Plans (SNPs) and/or Medicaid Advantage Plans (MAPs). TennCare proposes to expand its managed care service package to include Medicare Part A and Part B services, in order to offer improved continuity of care for full benefit dual eligibles. In the process, TennCare hopes to reduce the inefficiencies and fragmentation that are inevitable when two major payers are involved in delivering health care to a vulnerable population. By integrating Medicare Part A and Part B services with TennCare services, Tennessee expects to be able to generate program savings for Medicare and, to a lesser extent, Medicaid. Tennessee proposes to request sharing in those savings in order to add a care coordination component for all full benefit dual eligibles. |

<p>| Target Population (All duals/full duals/subset/etc.) | All full benefit dual eligibles. |
| Estimated Enrollment (in 2012 and at full implementation) | ~137,000. |
| Planned Geographic Service Area (Statewide or listing of pilot service areas) | Statewide |
| Planned Stakeholder Process | TennCare will build on work already done with stakeholders as part of the planning and development of the TennCare CHOICES program (the program that integrates long-term care for elderly and individuals with disabilities into the TennCare managed care program). TennCare will focus on stakeholder groups with particular interest and expertise in Medicare, including Medicare beneficiaries. |
| Proposed Implementation Date and Related Milestones (Any implementation milestones) | Program design will begin within one month of contract execution. Selected milestones: |</p>
<table>
<thead>
<tr>
<th>Month</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review consultant contracts.</td>
</tr>
<tr>
<td>3</td>
<td>Develop plan for engaging internal and external stakeholders. Identify waivers that will be required to implement the proposal.</td>
</tr>
<tr>
<td>6</td>
<td>Complete description of the benefit package. Determine any changes needed to the State infrastructure to be able to implement and monitor the proposal.</td>
</tr>
<tr>
<td>9</td>
<td>Identify key performance metrics and develop a proposed evaluation plan. Determine methodology for blended Medicaid and Medicare funding.</td>
</tr>
<tr>
<td>12</td>
<td>Finalize the plan for integrating Medicare Part A and Part B services with TennCare services and assess, in consultation with CMS and State stakeholders, the feasibility of developing the plan into a proposed amendment to the TennCare demonstration.</td>
</tr>
</tbody>
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**State Contact Person and Email Address**

<table>
<thead>
<tr>
<th>Name</th>
<th>Email Address</th>
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<tbody>
<tr>
<td>Susie Baird</td>
<td><a href="mailto:Susie.Baird@tn.gov">Susie.Baird@tn.gov</a></td>
</tr>
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</table>
State: Vermont

<table>
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<tr>
<th><strong>Overview of Proposed Approach</strong></th>
<th>Vermont’s proposed plan is for the State to become a managed care entity to manage both Medicare and Medicaid services for the dual eligibles, in conjunction with its two current 1115 Medicaid waivers. As part of its broader statewide delivery system reform and community-based infrastructure development for integrating care, Vermont would expand its Advanced Primary Care Practices and add existing case management in conjunction with its Blueprint community health teams to more comprehensively link case management services offered for dual eligibles and improve the coordination of primary, acute and long term care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong>&lt;br&gt;(All duals/full duals/subset/etc.)</td>
<td>All dual eligibles</td>
</tr>
<tr>
<td><strong>Estimated Enrollment</strong>&lt;br&gt;(in 2012 and at full implementation)</td>
<td>21,379</td>
</tr>
<tr>
<td><strong>Planned Geographic Service Area</strong>&lt;br&gt;(Statewide or listing of pilot service areas)</td>
<td>Statewide</td>
</tr>
<tr>
<td><strong>Planned Stakeholder Process</strong></td>
<td>Vermont will establish a Statewide advisory group of consumers and providers that will meet at least monthly to discuss draft proposals for all aspects of the demonstration proposal. Other stakeholder input will be gained by attending the regular meetings of advocate groups, provider groups and other involved advisory groups. Vermont will also use a web-based tool to gather input as well as share developments and comments with all stakeholders.</td>
</tr>
<tr>
<td><strong>Proposed Implementation Date and Related Milestones</strong>&lt;br&gt;(Any implementation milestones are pending CMS Approval)</td>
<td>Vermont will have a demonstration ready for submission to CMS by mid-April 2012. Vermont intends to have a fairly complete draft proposal available for State legislative consideration by January 15, 2012. Assuming CMS approval of the demonstration proposal, Vermont would begin actual implementation of service changes within three months of approval by CMS.</td>
</tr>
<tr>
<td><strong>State Contact Person and Email Address</strong></td>
<td>Patrick Flood, Deputy Secretary, Vermont Agency of Human Services <a href="mailto:patrick.flood@ahs.state.vt.us">patrick.flood@ahs.state.vt.us</a></td>
</tr>
</tbody>
</table>
State: Washington

| Overview of Proposed Approach | Washington State proposes the multi-phased implementation of innovative service delivery and payment models that integrate physical and behavioral health, and long-term supports and services for individuals that are dually eligible for Medicare and Medicaid.

These proposed phases include:
- Chronic Care Management expansion (for high risk/high cost dual eligible individuals);
- Transition to managed care for (low risk/low cost dual eligible individuals);
- Integrated financing pilots; and
- Fully integrated delivery and financing system of care for all dual eligible individuals. |

| Target Population | Individuals who are fully eligible for Medicare and Medicaid and are categorically needy aged, blind and disabled. |

| Estimated Enrollment (in 2012 and at full implementation) | 2012: Approximately 25,000 persons (Washington State’s demonstration proposal initially targets high risk/high cost and low risk/low cost dual eligibles through separate but parallel efforts)

2017: Approximately 101,000 persons (full implementation) |

| Planned Geographic Service Area | Statewide: Chronic Care Management expansion (for high risk/high cost dual eligible individuals) (2012)

Statewide: Transition to managed care for (low risk/low cost dual eligible individuals) (2012)

Pilot Counties: Integrated financing pilots (late 2012)

Statewide: Fully integrated delivery and financing system of care for all dual eligible individuals (2017) |

| Planned Stakeholder Process (during planning phase) | Outreach to ongoing workgroups and coalitions to identify barriers and concerns.

Targeted focus groups/discussions with beneficiaries and their representatives, providers, healthcare plans, and community-based providers.

Stakeholder process to focus on knowledge, beliefs, perceptions regarding access, integration, barriers, costs, program efficiencies/inefficiencies and person-centered service delivery. |
<table>
<thead>
<tr>
<th>Proposed Implementation Date and Related Milestones (Any implementation milestones are pending CMS Approval)</th>
<th>Planning Milestones (April 2011 – March 2012):</th>
</tr>
</thead>
</table>
| **Planning Milestones (April 2011 – March 2012):** | • Stakeholder and beneficiary engagement  
• Medicare data interface  
• Expansion of Predictive Risk Intelligence Modeling System (PRISM)  
• Refined population analysis  
• Viable delivery/financing models selected  
• Alignment with ACA /State health reform direction  
• Implementation design details  
• Legislative requirements |
| **Proposed Implementation Milestones (2012 – 2017):** | • Medicare/Medicaid data integration (late 2011)  
• Statewide Chronic Care Management expansion for high cost/high risk dual eligibles (2012)  
• Increased enrollment in managed care for low cost/low risk dual eligibles (July 2012)  
• Integrated financing pilots (late 2012)  
• Integrated delivery system pilots (late 2013)  
• Array of Medicaid and Medicare services with integrated financing and delivery through managed care and medical/health home models (in 2017) |
| State Contact Person and Email Address | Marietta Bobba, bobbam@dshs.wa.gov |
Overview of Proposed Approach  
Wisconsin Department of Health Services (DHS) proposes to secure Federal authority for the State to function as the Medicare/Medicaid entity to serve elders and adults aged 18 and over with physical and developmental disabilities who are at a nursing home level of care as determined through the State’s long-term care functional screen. Under the proposal, DHS would receive a Medicare capitation payment for each enrollee from the Federal government. Subcontracts would be negotiated with entities to provide the full range of Medicare and Medicaid benefits to dual eligibles at the nursing home level of care based on risk-based capitated rates. The State would combine the Medicare capitation payment with a Medicaid capitation payment to generate a single, fully integrated capitation payment to the contracted entities.

Target Population  
(All duals/full duals/subset/etc.)  
Full benefit dual eligibles served in a State Medicaid Long-Term Managed Care Program. This population includes elders and adults aged 18 and over with physical and developmental disabilities who are at a nursing home level of care as determined through the State’s long-term care functional screen.

Estimated Enrollment  
(in 2012 and at full implementation)  
2012: 20,000  
Full implementation: 53,000 in 2015.

Planned Geographic Service Area  
(Statewide or listing of pilot service areas)  
To Be Determined. A pilot program will be implemented in three to four demonstration sites by July 2012.

Planned Stakeholder Process  
DHS maintains a Statewide Long Term Care Council that is composed of a broad range of stakeholders, including consumers, advocates, Partnership and Family Care MCOs, ADRCs, and long-term care service providers. The Council actively carries out its charge to monitor and provide advice to the Department on the long-term care system. DHS proposes to create a Subcommittee of the LTC Council charged with providing advice on the development of the proposed demonstration project. The Subcommittee would be composed of interested LTC Council members along with additional representatives with expertise that is relevant to the demonstration project, including representatives of the acute/primary health care industry.

DHS will conduct focus groups on the new program initiative to identify concerns and develop effective, positive strategies to address them.

DHS will leverage the existing collaborative structure in place with the managed care organizations (MCOs) in its current long-term managed care programs, Family Care and Partnership/PACE, to involve these organizations in the development of the new program. Meetings
between the MCO leadership and senior DHS staff are held on a monthly basis to discuss program issues and policy development. In addition, DHS/MCO workgroups on specific topic areas have been established and meet on a regular basis. DHS will use the existing consultative structure with the MCOs.

<table>
<thead>
<tr>
<th>Proposed Implementation Date and Related Milestones (Any implementation milestones are pending CMS Approval)</th>
<th>February-December 2011:</th>
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<tbody>
<tr>
<td></td>
<td>A. Develop details of new program design</td>
</tr>
<tr>
<td></td>
<td>B. Determine three to four demonstration sites</td>
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<td></td>
<td>C. Select external evaluator</td>
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</table>

January-December 2012:
A. January to June 2012: Outreach to existing long-term managed care participants and applicants in demonstration sites
B. July 2012: Initiate new program in three to four demonstration sites; begin receipt of Medicare capitation payments from CMS to the State; and begin payments from the State to the participating entities
C. Monitor demonstration site performance
D. Based on demonstration site performance, identify appropriate revisions to program design
E. Determine pace and trajectory of expansion to additional sites

January-December 2013:
A. Establish additional demonstration sites, as warranted by evaluation of initial sites

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<thead>
<tr>
<th>State Contact Person and Email Address</th>
<th>Tom Lawless</th>
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<tbody>
<tr>
<td></td>
<td><a href="mailto:Thomas.Lawless@wisconsin.gov">Thomas.Lawless@wisconsin.gov</a></td>
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