DRAFT -- State Proposals for "Integrating Care for Dual Eligibles" Initiative

State	Target Population	Description of Model	Stakeholder Involvement to Date	Role of Stakeholders Going Forward
CA	Target Population: Full benefit dual eligibles in four geographic areas	The pilots will provide coverage for Medicare and Medi-Cal services through an integrated delivery system that includes all medical, LTSS, and coordination with/or coverage for behavioral health services.	The CA Dept of Health Care Services (DHCS) began gathering input from stakeholders in 2010 when the state planned to include duals in its 1115 waiver. DHCS held technical workgroups to develop consensus on a model framework for integrating care for duals. SCAN Foundation has funded ongoing development of the framework by funding a small Technical Advisory Panel. AARP serves on Panel.	DHCS has continued to prioritize stakeholder involvement in dual integration activities. Focus groups of beneficiaries are planned in each of the four counties chosen for pilots.
CO	Target population: limited number of dual eligible clients (~60,000 statewide)	Department will implement an approach centered around the Accountable Care Collaborative (ACC) program that will ensure every Medicaid client has a medical home, clients and providers have partners to help guide them through the system and coordinate care, and outcomes are being measured and positive outcomes are rewarded. Three components will be central: (1) Regional Care Collaborative Organizations (RCCOs) responsible for ensuring accountable care and coordination; (2) Primary Care Medical Providers (PCMPs) that serve as the clients' medical home; and (3) statewide data and analytics contractor that will bring bring new level of data analytics to the Medicaid program to provide insight into variations across RCCOs and benchmark across key performance indicators.	The Long Term Care Advisory Committee (LTCAC) was established in 2008 as an advisory body to the Department's LTC Benefits Division. The group has solicited membership from a wide variety of perspectives, and meets monthly and provides input on policy directions such as delivery system capacity and models, accountability and responsiveness of the system, and eligibility determination.	Initial involvement of stakeholders will occur through established committees, including the LTCAC. The Department will utilize its alliances with community organizations, taskforces, and coalitions to share information. A workgroup will be established representing various stakeholders. The Department will also publish progress from the program design on its website and conduct public forums to allow external stakeholders to comment.
CT	Target Population: All dual eligibles ages 65 and over receiving care in nursing facilities and the community	Proposes to establish local Integrated Care Organizations (ICOs) to deliver coordination and management of primary, preventive, acute, and behavioral health care, integrated with LTSS and medication management. Will align financial incentives to promote value, quality of care, and health outcomes at lower overall cost to the Medicare and Medicaid programs. Includes partnerships among multiple providers and is facilitated by health information technology and electronic data systems. Incorporates health homes with a seamless continuum of enhanced medical, pharmacy, behavioral and long-term services and supports.	CT has engaged a wide variety of stakeholders in the design of the duals model, including dual eligibles, advocacy groups (including AARP)*, provider associations, legislative staff, and researchers. Demonstration model is a direct reflection of input received from the stakeholder community.	CT will continue to seek meaningful consumer and stakeholder input in program planning, implementation, and evaluation of the duals program and is committed to transparency in the development of the final demonstration proposal.

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MA	Target population: MassHealth beneficiaries ages 21-64 who receive full MassHealth benefits and who are also eligible for Medicare.	MassHealth would assume complete operational responsibility for the care of dual eligible individuals with the goal of achieving better health outcomes, higher quality, cost effectiveness, and person-centered care. Initiatives include development of patient-centered medical homes, a new reimbursement system with bundled payments, accountable care organizations, and transition from fee-for-service to global payment methodologies.	MassHealth has convened a group of more than thirty organizations including AARP*.	Developing plans to broaden stakeholder engagement to include beneficiary input and public meetings for interested parties.
MI	Target Population: Dual Eligibles	Integrated care demo where Medicaid serves as entity assuming financial and administrative oversight, serving participants through MCO organization in traditional managed care and accountable care organizations. Benefit package will include acute, pharmaceutical, LTC, and behavioral health for target group. Enrollment will be mandatory.	In the past few years, the Medicaid director has met with multiple provider groups and provider industry associations to discuss integrated care. Plans for developing a model have also been discussed with the Medicaid Medical Care Advisory Committee, a consumer and provider group that meets to advise the Medicaid agency.	During a 6-month stakeholder process, state will conduct regional meetings to solicit input from consumers, advocacy and provider groups. State will finalize list of stakeholder participants (and ensure diverse representation), conduct outreach to solicit participants, and develop website to notify stakeholders of meetings.
MN	Target Population: Dual Eligibles	Demo seeks to take existing primary care and care coordination models to new levels of consistency and performance, advance provider level payment reforms, stabilize the SNP platform, develop linked Medicare and Medicaid databases, and develop cross system sub-population performance metrics and risk sharing models for use across all service delivery systems.	State had discussions with integrated SNP and MCO contractors on the need to strengthen health care home (HCH) and ACO model implementation for dual eligibles enrolled in integrated SNPs.	MN will establish a group of stakeholders made up of consumers, community measurement experts, providers, health plans, staff involved in other related projects on HCHs and ACOs.
NY	Target population: Varies by proposal	Proposal options include exploration of: (1) increasing enrollment in existing state managed long term care initiatives, (2) care coordination for nursing home residents, (3) options to the basic PACE model to build in additional flexibility and attract a larger group of dually eligible enrollees, (4) managed care for persons with developmental disabilities.	Meetings are routinely scheduled with advocates, industry representatives, health plans, providers, and other interested parties to obtain input on new models of care, financing, and issues related to care coordination and quality.	Consultant will conduct formal stakeholder interviews with individuals and groups representing all interested parties.
NC	Target population: Dual eligibles living at home, in nursing homes, and adult care homes	NC will build on the statewide infrastructure (Community Care of NC) and partner with LTC providers, HCBS providers, AAAs, and other stakeholders to improve the health of dual eligible populations; improve the quality, access and reliability of care; and reduce/contain the costs of care.	The NC Medicaid Agency Division of Medical Assistance (DMA) continues to partner with the Dept. of Insurance regarding duals issues. DMA is working with AARP* regarding focus group studies of duals and their caregivers.	AARP*, among other consumers, providers, advocacy groups, community based organizations, and state agencies that work with duals will be identified as key stakeholders to provide input for the demonstration.

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OK	Target population: Varies by proposal	Identifies three concepts to improve care integration in OK, including: (1) creation of an accountable care organization with embedded medical education programs that serves high cost dual eligibles; (2) establishment of a new benefit plan and network administered and operated by the state, patterned after a shared savings model; and (3) statewide expansion of Cherokee Elder Care, the state's PACE Program.	The OK Health Care Authority (OHCA) meets with advocacy groups, legislators, and other stakeholders annually to help guide and set the agency's strategic plan for the year. OHCA staff conducts numerous discussions with stakeholders across the state as to the design and implementation of projects.	OHCA's planning unit convenes workgroups, etc. for the planning process. Staff will seek out involvement of partners to an initial meeting to discuss the opportunity, and a large working group & smaller subgroups will be created and meet monthly. A website will be created to ensure transparency in the process.
OR	Target population: Dual elibibles who are entitled to full Medicaid benefits	Proposal realigns full range of Medicare/Medicaid acute, behavioral, LTSS for duals. Coverage would include preventive, case management and behavioral health services, and services supporting independence and continued residence at home. Will use capitation payments and/or global budgets. Incentives will be structured to maximize efficient care choices, eliminate cost shifting, and develop intensive care management that addresses social supports as well as health care. Proposal is not clear if participation is voluntary or mandatory.	The Governor's office named a 38-member Health System Transformation Team to provide recommendations and feedback as proposal was developed.	All Oregon communities will be invited to provide input on priorities and preferences. Stakeholders directly affected by the LTC system and dual eligible issues will be strategically consulted through structured meetings, web based surveys, and public hearings. AARP has been asked to be involved.
SC	Target Population: Individuals with behavioral health diagnosis in one of the major diagnostic mental disorders and Alzheimer's Disease	Model will integrate primary care and behavioral health services as well as provide linkages to community based LTSS and family support services.	AARP* is involved in the state's LTC Workgroup and will continue to participate under the Integrated Care Workgroup (an expanded version of the LTC workgroup).	The Integrated Care Workgroup will be designed to accentuate its role as an independent body composed of agency, clinical and methodological experts and consumer representatives, including AARP*.
TN	Target population: Full benefit dual eligibles (FBDEs)	Proposal will develop "TennCare PLUS", which includes the addition of Medicare Part A & B services to the array of Medicaid services available to full benefit dual eligibles under TennCare as well as the addition of a care coordination component for FBDEs who are not participants in the state's CHOICES (Medicaid managed long-term care) program.	There was extensive stakeholder involvement in the development and implementation of the CHOICES program.	TennCare meets regularly with a number of groups, through monthly calls, face-to-face meetings, and information communication processes - these forums will provide ongoing opportunities to provide information and gather input.
VT	Target population: All dual eligibles in the state	Proposal builds upon and connects previous and ongoing efforts to integrate care, including Medicaid waiver programs, the Blueprint for Health Multipayer Demonstration, Medicaid Medical Home initiative, and the state's significant and ongoing HIT investments.	VT has and will continue to engage stakeholders (including consumers, advocates, providers and other interested parties) in the planning process.	State has existing venues to seek input from all stakeholders such as regular advisory board meetings that include consumers, providers, and advocates.

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WA	Target population: High risk/high cost duals and eventually all duals	Proposes three-phase approach to: (1) Provide expanded chronic care management services for the high cost/high risk duals with nurse managers, coaching and social service supports; (2) Transfer the medically needy (aged, blind and disabled) to managed care; (3) Expand to include remaining dual eligibles by 2017. Each phase would integrate primary and long-term care, including existing waiver programs, through managed care plans with person-centered care, optimized outcomes and incentives for cost containment.	WA has actively engaged a broad array of stakeholders on initiatives that consider and incorporate the goals of public programs, including health care providers, health plans, insurance payers, and consumers. Ongoing workgroups currently address a variety of topics, including: chronic care management, behavioral health and primary integration, etc.	Will hold targeted focus groups that reach out to beneficiaries, providers, health care plans, and community based and health care services. Also will hold one-on-one discussions with health plans and other key delivery system partners currently engaged in successful pilots that offer potential models for future phases of the WA approach.
WI	Target population: Elders and adults 18 and over with physical and developmental disabilities at nursing home level of care	Proposes to secure federal authority for the state to function as the Medicare/Medicaid entity, similar to PACE authority, but service delivery would not be restricted to a specific physical site. DHS would receive a Medicare capitated payment for each enrollee and 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.	WI's LTC redesign was the result of an extensive, multi-year planning process with broad stakeholder involvement from consumers, advocates, providers, and other parties. Since the inception of the new LTC system, the Department has maintained a statewide LTC Council composed of a broad range of stakeholders, including consumers, advocates, ADRCs, LTC service providers, Partnership and Family Care MCOs, etc.	DHS will continue its commitment to stakeholder input by conducting focus groups on the new initiative to identify concerns and develop strategies to address them. Also, DHS/MCO workgroups on specific topic areas have been established and meet on a regular basis.

Timetable
Pilots begin operation in November-December 2012. By 2015, DHCS hopes to expand integrated care statewide based on successes and lessons learned in the pilots.
Dual eligibles will be enrolled in the ACC program by October 2012.
State will be ready to implement in the last quarter of 2012. State currently has legislative authority to implement a care management initiative for duals.

Timetable
Key milestones include: (1) releasing a Request for Information (RFI) in February 2011, (2) drafting the Request for Responses in the fall of 2011, (3) releasing the RFR in January 2012, and awarding contracts to integrated care entities in the fall of 2012.
Implementation - April 1, 2012 (Legislative authority is not required, but given Legislature's responsibility to appropriating funds to agencies, need to gain legislative support)
Implementation in March 2012
Implementation of demonstration in 2012. NY does not anticipate legislative authority being required to proceed with a planning process for dual integration.
Implementation will be done immediately following the twelve month planning phase.

Timetable
Varies, as each proposal has a specific timeline tied to it.
Implementation no later than July 2012
Implementation in 2012
Implementation in 2012
Target date for implementation is April 2012

Timetable
Phase 1: implementation by September 2012; Phase 2: (lower risk/cost duals) anticipated to be included in 2012; Phase 3: access to fully integrated/primary LTSS systems in all counties by 2017.
New program will be piloted in three to four sites starting in July 2012