A quick snapshot of Medicaid strategies for supporting Medicaid Members

ASO Intensive Care Management

Key goal: Enabling individuals in development of health goals and improved outcomes

Who: Individuals who risk stratify as in high need based on CareAnalyzer results, referrals, self-referrals

What: Care coordination; community care teams

How: Nurse care managers organized in geographic teams

Person Centered Medical Homes (PCMH)

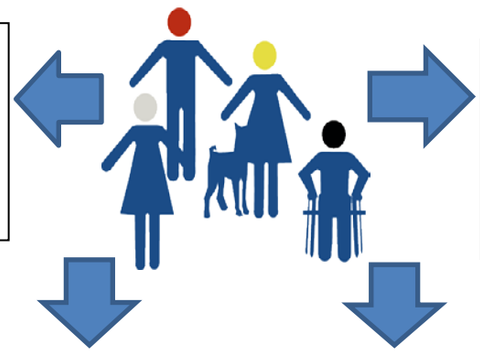
Key goal: Supporting individuals in effectively using primary care

Who: Individuals who select such practices for their care

What: Limited embedded care coordination supported by enhanced Medicaid fee-for-service payments

How: Practice elects the means of fulfilling this function

People with need for support in accessing and coordinating their services



People served by Medicaid who need community-based Long-Term Services and Supports (LTSS)

People with behavioral health conditions health conditions who receive services from Local Mental Health Authorities (LMHA)

People served by Medicaid who receive their care at Federally Qualified Health Centers and "advanced networks"

Health Homes

Key goal: Integration of behavioral health care, medical care and social services

Who: Individuals with Serious and Persistent Mental Illness served by LMHA, who have annual expenses in excess of $10,000; enrollment with provider from whom individual has received services, with opt-out

What: Care coordination team funded by Medicaid per member per month payments

How: multi-disciplinary team

Person-Centered Medical Home Plus (PCMH+)

Key goal: Clinical and community integration

Who: Medicaid members other than those served by long-term services and supports; assignment based on retrospective examination of where individual has received care

What: Care coordination funded by Medicaid supplemental payments to FQHCs; shared savings model

How: primary care-based care team

Home and Community-Based Waivers

Key goal: Diversion of individuals from institutional care

Who: Individuals who have functional limitations that put them at risk of nursing home placement; by application

What: Care coordination and LTSS services

How: Care coordination through assigned care manager or self-direction; services provided by a range of providers

Money Follows the Person

Key goal: Community integration

Who: Individuals with need for LTSS who have received care in a hospital or nursing home for three or more months; by application

What: Transition assistance, funded by a federal grant for first year; state-funded housing vouchers

How: Transition supports provided through assigned transition staff, services provided by a range of providers

Community First Choice

Key goal: Enabling individuals to self-direct services within individual budgets

Who: Individuals who are at nursing home level of care; by application

What: Self-directed PCA and related services funded under Medicaid State Plan; support from fiscal intermediary

How: Through self-direction