



Hawaii Medicaid System: An *OPEN MINDS* State Profile



Hawaii Medicaid System Overview: Table Of Contents

1. [Medicaid System Overview](#)
2. [Medicaid Governance](#)
3. [Medicaid Program Spending](#)
4. [Medicaid Expansion Status](#)
5. [Medicaid Program Benefits](#)
6. [Medicaid Financing & Service Delivery System](#)
7. [Medicaid FFS Program](#)
8. [Medicaid Managed Care Program](#)
9. [Medicaid Program: Care Coordination Initiatives](#)
10. [Medicaid Program Waivers](#)
11. [Medicaid Program: New Initiatives](#)
12. [Appendix](#)

1. Medicaid System Overview

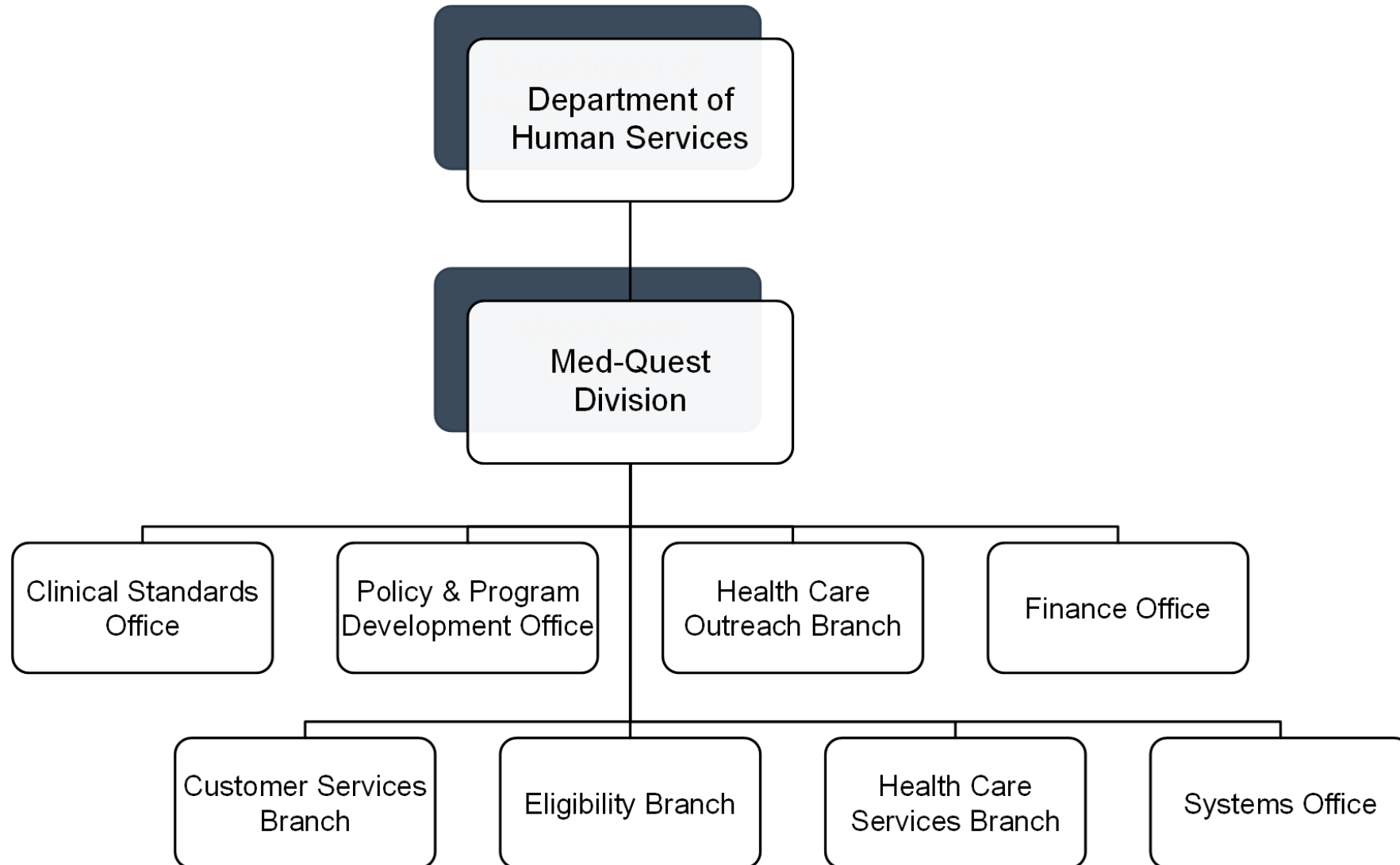
Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	- Hawaii operates a very limited fee-for-service (FFS) program - As of September 2023: 1% in FFS, 99% in managed care
SMI population inclusion in managed care	- Hawaii operates a very limited FFS program, which essentially covers individuals who are not eligible for full Medicaid benefits. As a result, most of the SMI population is enrolled in managed care. 1% in FFS, 99% in managed care
Dual eligible population inclusion in managed care	- All full benefit dual eligibles are required to enroll in managed care 100% of the population in managed care

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional behavioral health	Covered FFS by the state	- Individuals without SMI: Included in the health plan's capitation rate - Individuals with SMI: Excluded from the health plan's capitation rate and covered by the at-risk behavioral health organization (BHO), 'Ohana Health Plan
Specialty behavioral health	Covered FFS by the state	- Individuals without SMI: Services are not covered - Individuals with SMI: Covered by the at-risk BHO, 'Ohana Health Plan
Pharmaceuticals	Covered FFS by the state	- Individuals without SMI: All pharmacy is covered by the health plan - Individuals with SMI: Mental health and addiction treatment medications are covered by the BHO; all other pharmacy is covered by the health plan.
Long-term services and supports (LTSS)	Covered FFS by the state	Included in the health plan's capitation rate except for individuals with I/DD

1. Medicaid System Overview: Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Yes, the health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home		None
Patient-Centered Medical Home (PCMH)		None
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)	✓	Yes, the health plans are responsible for LTSS except for individuals with I/DD.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Hawaii has one CCBHC.

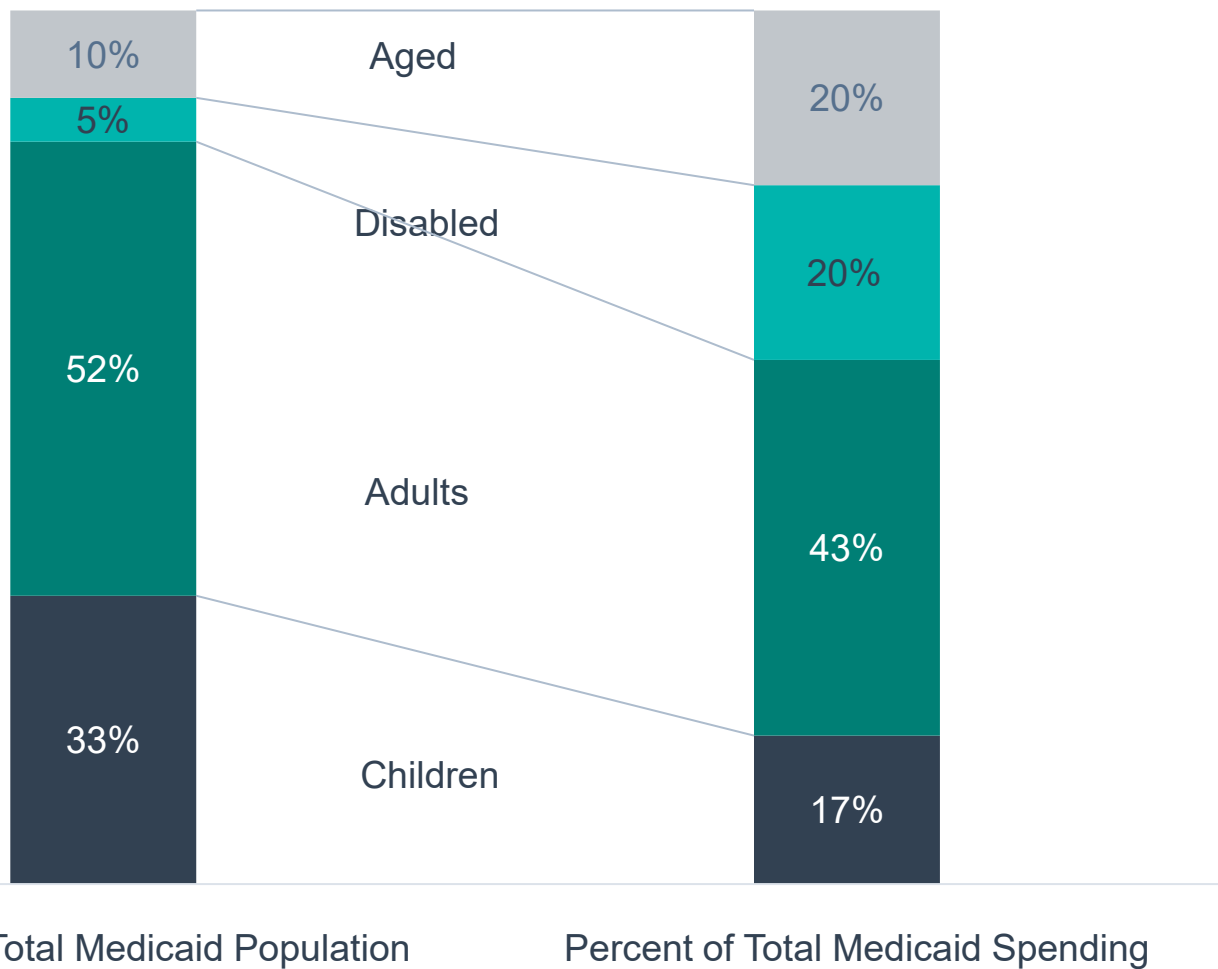
2. Medicaid Governance: Organization Chart



2. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Catherine Betts	Director	Department of Human Services	catherine.a.betts@hawaii.gov
Joseph Campos II	Deputy Director	Department of Human Services	jcampos@dhs.hawaii.gov
Judy Mohr Peterson	Medicaid Director, Administrator	Department of Human Services, Med-QUEST	jmohrpeterson@dhs.hawaii.gov
Meredith Nichols	Assistant Administrator	MQD, Department of Human Services	mnichols@dhs.hawaii.gov

3. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2021		
	U.S.	HI
All populations	\$8,651	\$7,185
Children	\$3,584	\$3,644
Adults	\$5,462	\$5,485
Expansion adults	\$7,486	\$6,252
Blind and disabled	\$23,935	\$25,702
Aged	\$18,514	\$14,502

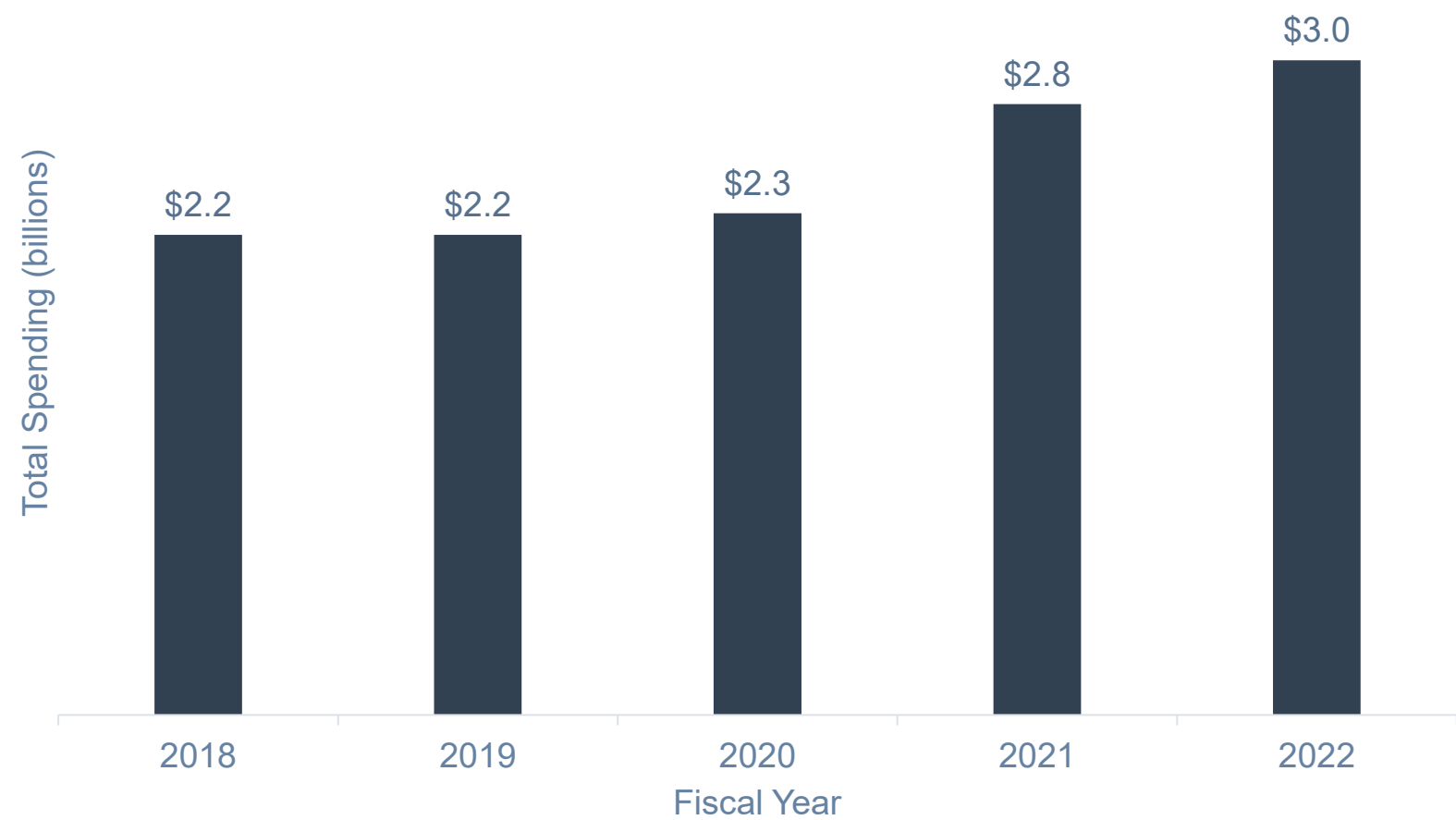
Based on FY 2021 data

3. Medicaid Program Spending: Budget

Budget Item	SFY22 Spending	Percent Of Budget
Managed care and premium assistance	\$2,688,000,000	89%
Home- and community-based LTSS	\$156,000,000	5%
Medicare premiums and coinsurance	\$52,000,000	2%
Hospital	\$37,000,000	1%
Other acute	\$34,000,000	1%
Dental	\$33,000,000	1%
Clinic and health center	\$27,000,000	1%
Institutional LTSS	\$10,000,000	<1%
Budget Total: \$3,037,000,000		

Federal & County Financial Participation	
FY 2024 Federal Medical Assistance Percentage (FMAP)	58.6%
CY 2024 Newly Eligible FMAP (expansion population)	88.0%
Counties contribute to state Medicaid share	No

3. Medicaid Program Spending: Change Over Time



4. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of Federal Poverty Level (FPL) Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded when determining eligibility.
Legislation Used To Expand Medicaid	None; executive implementation via Medicaid state plan amendment
Number Of Individuals Enrolled In The Expansion Group (September 2023)	171,705
Number Of Enrollees Newly Eligible Due To Expansion	28,000
Benefits Plan For Expansion Population	The benefits listed in the Hawaii alternative benefit plan are the same as those listed in the state plan.

5. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Hawaii's Optional Services

1. Podiatry
2. Optometry and eyeglasses
3. Chiropractic services
4. Services of other practitioners
5. Private duty nursing
6. Clinic services
7. Dental services
8. Physical and occupational therapy
9. Services for individuals with speech, hearing, and language disorders
10. Prescribed drugs
11. Dentures and prosthetic devices
12. Diagnostic, screening, and preventive services
13. Rehabilitative services
14. Intermediate care facility services
15. Inpatient psychiatric services for individuals under age 22
16. Hospice care
17. Case management
18. Respiratory care
19. Personal care services

6. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	Medicaid Managed Care
Enrollment (September 2023)	67 (There are an additional 7,531 partial benefit dual eligibles that Hawaii does not count towards its FFS total)	460,694
SMI Enrollment	Hawaii operates a very limited FFS program, which essentially covers individuals who are not eligible for full Medicaid benefits. <i>OPEN MINDS</i> estimates less than 1% of the SMI population in FFS, 99% in managed care.	
Management	Med-Quest, Department of Human Services	Five health plans
Payment Model	FFS	Capitated rate
Geographic Service Area	Statewide	- Four plans are available statewide. - One plan, Kaiser Permanente, is available on Maui and Oahu only.

Total Medicaid: 460,761 | Total Medicaid With SMI: 53,448

6. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles	X (partial benefit)		X (full benefit)
Medicaid expansion			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Individuals in foster care			X
Other populations	• Retroactive eligibility only • Eligible under non-aged, blind, and disabled medically needy spenddown • Breast and Cervical Cancer Program enrollees		

7. Medicaid FFS Program: Overview

- As of September 2023, FFS enrollment was 67.
 - There are an additional 7,531 partial benefit dual eligibles enrolled in the program. The state is responsible for their Medicare premiums but does not consider them as part of the FFS program.
- The state's FFS program is very limited and includes individuals eligible for retroactive eligibility only, eligible for the state's Breast and Cervical Cancer program, or non-aged, blind, and disabled individuals who are eligible for Medicaid spenddown.

7. Medicaid FFS Program: Pharmacy Benefit

Hawaii FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	No
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	No; however, the state has a drug formulary search that allows FFS provider organizations to identify covered medications using the medication's National Drug Code (NDC). The state is required to provide medications to treat mental or addiction disorders when deemed medically necessary.
State Uses A PDL For Mental Health Drugs	
State Uses A PDL For Addiction Treatment Drugs	
Coverage Of Antipsychotic Injectable Medications	Antipsychotic injectable medications are covered as a pharmacy benefit.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	• Certain mental health and addiction treatment medications, such as atypical antipsychotics, are subject to prior authorization if prescribed by a non-psychiatrist; a psychiatrist may prescribe most mental health and addiction treatment drugs without prior authorization. • Mental health and addiction treatment medications may be subject to quantity limits and age restrictions.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Hawaii's Medicaid program encourages provider organizations to report individuals with suspected medication abuse and restricts these individuals to one provider organization and one pharmacy.

8. Medicaid Managed Care Program: Overview

- As of September 2023, managed care enrollment was 460,694.
- Hawaii calls its managed care program QUEST Integration. QUEST stands for Quality care, Universal access, Efficient utilization, Stabilizing costs, and to Transform the way health care is provided to recipients.
- The state's five health plans cover nearly all Medicaid populations and provide physical health, behavioral health, pharmacy, and long-term services and supports.
 - Upon enrollment, Medicaid beneficiaries are assigned a plan. Beneficiaries can change health plans one time within 90 days from the date of enrollment in QUEST Integration. Once the 90-day period ends, beneficiaries can only change their health plan during open enrollment from October 1 to October 31.
 - QUEST Integration plans are available statewide except for Kaiser Permanente, which is available in Maui and Oahu only.
- The managed care contract includes a requirement for the health plans to use alternative payment models (APMs) defined as “fee-for-service with incentives for performance, capitation payment to providers with assigned responsibility for patient care, or a hybrid. Gain-sharing models also encouraged.” APM requires the following share of contracts with primary care provider organizations and hospitals be value-driven:
 - Year 1: 50%
 - Year 2: 65%
 - Year 3: 80%

8. Medicaid Managed Care Program: Health Plan Characteristics

AlohaCare

1. Profit status: Non-profit
2. Parent company: None
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: None
5. Service area: Statewide
6. Enrollment share: 19%

HMSA

1. Profit status: Non-profit
2. Parent company: Independent licensee of Blue Cross and Blue Shield
3. Behavioral health subcontractor: Caelon Behavioral Health
4. Pharmacy benefits manager: CVS/Caremark
5. Service area: Statewide
6. Enrollment share: 48%

Kaiser Permanente QUEST

1. Profit status: Non-profit
2. Parent company: Kaiser Permanente
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: None
5. Service area: Oahu and Maui
6. Enrollment share: 11%

‘Ohana Health Plan

1. Profit status: For-profit
2. Parent company: WellCare-Centene
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: WellCare Pharmacy
5. Service area: Statewide
6. Enrollment share: 9%

UnitedHealthcare Community Plan

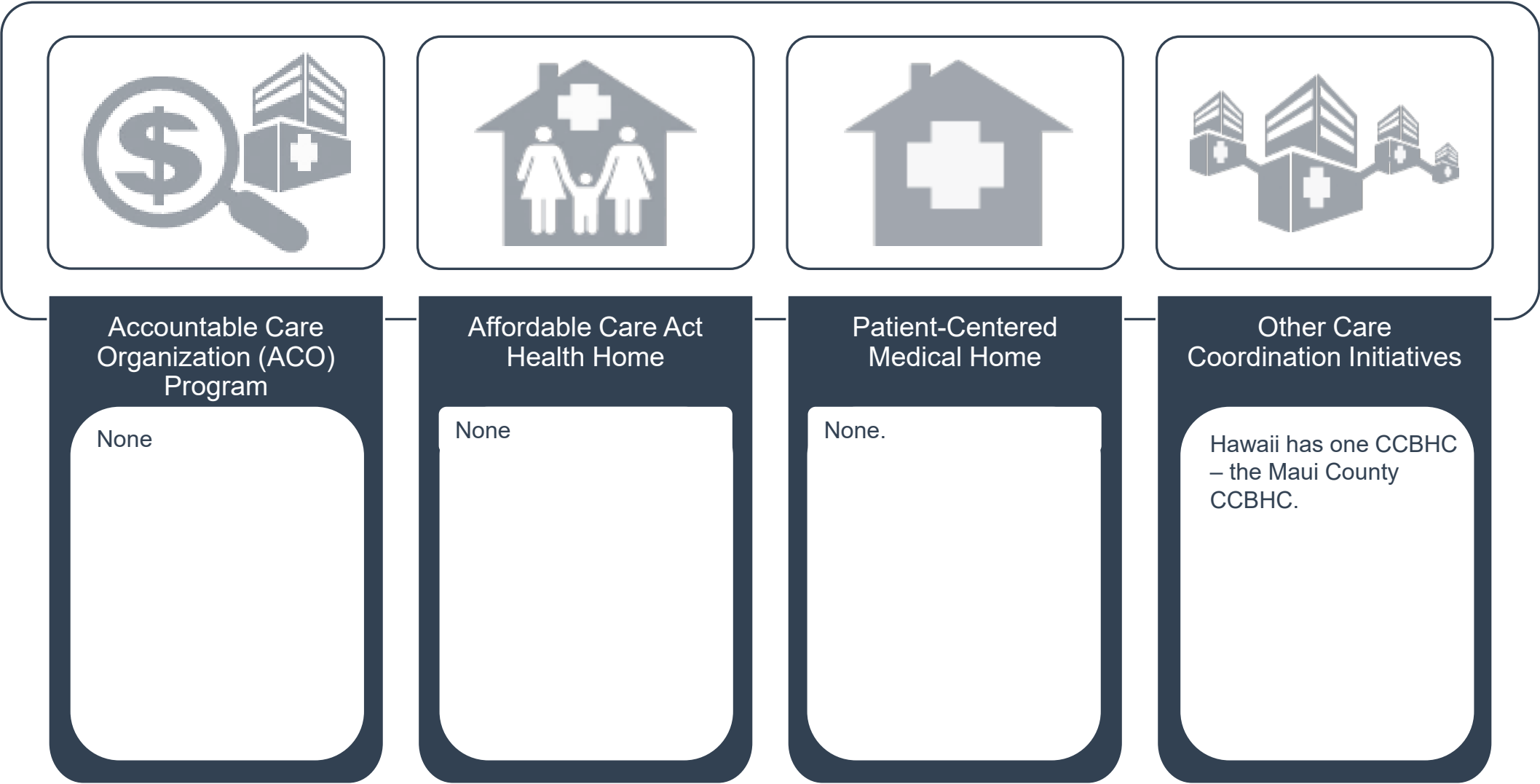
1. Profit status: For-profit
2. Parent company: UnitedHealthcare
3. Behavioral health subcontractor: Optum
4. Pharmacy benefits manager: OptumRX
5. Service area: Statewide
6. Enrollment share: 14%

Totals may not equal 100% due to rounding.

8. Medicaid Managed Care Program: Pharmacy Benefit

Hawaii Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	General pharmacy services are included in the health plan's capitation rate.
Responsible For Financing Mental Health Pharmacy Benefit	• Non-SMI population: Mental health and addiction treatment drugs are included in the health plan's capitation rate • SMI population: Mental health and addiction treatment drugs are excluded from the health plan's capitation rate. Mental health and addiction treatment pharmacy benefits are covered by 'Ohana Health, the BHO for individuals with SMI.
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, the health plans can establish their own PDL.
Health Plan Uses A PDL For Mental Health Drugs	
Health Plan Uses A PDL For Addiction Treatment Drugs	
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	• Certain mental health and addiction treatment medications, such as atypical antipsychotics, are subject to prior authorization if prescribed by a non-psychiatrist; a psychiatrist may prescribe most mental health and addiction treatment drugs without prior authorization. • Mental health and addiction treatment medications may be subject to quantity limits, step therapy requirements, and age restrictions.
Health Plan Allowed To Implement Pharmacy Lock-In Program	Hawaii's Medicaid program encourages provider organizations to report individuals with suspected medication abuse and restricts these individuals to one provider organization and one pharmacy.

9. Medicaid Program: Care Coordination Initiatives



10. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Hawaii QUEST Integration	Authorizes the state’s managed care program including managed long-term services and supports for most populations	1115	None	07/31/2019	03/31/2025

10. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2024 Enrollment Cap	Operating Unit	Concurrent Management Authority
HI HCBS for People w/DD (0013.R08.00)	Individuals with I/DD of any age	3,097	Department of Health, Developmental Disabilities Division	No

11. Medicaid Program New Initiatives: Palliative Care Coverage

- In 2024 Hawaii DHS and Med-QUEST Division announced that CMS approved a new state plan amendment (SPA) to cover community palliative care services through Medicaid.
 - Hawaii is now the first state to offer palliative care services through Medicaid.
- Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness, with a goal of improving quality of life for both the patient and the family.
- This new benefit allows Medicaid beneficiaries who are suffering from serious illness, to receive specialized services that address physical, intellectual, emotional, social, and other needs throughout the continuum of care.

Looking For More Information About Hawaii's Health Care Financing & Service Delivery System?

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Hawaii Health & Human Services System Market Profile

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Hawaii Behavioral Health System Profile



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Hawaii Dual Eligible System Profile

Appendices

12. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.2% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicaid	11.6% of persons enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicare	22.7% of persons in the Medicare population, not dually eligible for Medicaid	Figueroa, J. F., Phelan, J., Orav, E. J., Patel, V., & Jha, A. K. (2020). Association of mental health disorders with health care spending in the Medicare population. Retrieved July 2024 from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948#:~:text=Results%20Of%204%20358%20975,had%20no%20known%20mental%20illness

12. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	21% of persons in the Medicare population dually eligible for partial Medicaid benefits	ATI Advisory. (2022). A Profile of Medicare-Medicaid Dual Beneficiaries. Retrieved March 2023 from https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf
	16% of persons in the Medicare population dually eligible for full Medicaid benefits	
Other Public	4.5% of persons served by the Veterans Administration health care system or the TRICARE military health system	U.S. Census Bureau (2022). Table HHI-01. Health Insurance Coverage Status and Type of Coverage--All Persons by Sex, Race and Hispanic Origin: 2017 to 2021. Retrieved March 2023 from https://www2.census.gov/programssurveys/demo/tables/health-insurance/time-series/hic/hhi01.xlsx
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabSect6pe2021.htm#tab6.8a

13. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

13. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(l) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2024, the FPL is \$14,580 for an individual and \$30, 000 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit-by-unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A “whole person” care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

13. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

13. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

13. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

13. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

14. Sources

1. Medicaid System Overview

1. Information derived from sources found throughout Section D.

1. Medicaid System Overview: Care Coordination Initiatives

1. Information derived from sources found throughout Section D.

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