



Home and Community-Based Services Systems Map Report

Final Report

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I. Testing Experience and Functional Tools Demonstration Overview

With the Testing Experience and Functional Tools (TEFT) Demonstration, the Centers for Medicare & Medicaid Services (CMS) provided state grantees an opportunity to conduct on-the-ground testing of a new set of tools. These tools would improve the availability and use of health information technology (IT) in the long-term services and supports (LTSS) system and improve quality measurement and service planning in Medicaid home and community-based services (HCBS) programs. In March 2014, CMS awarded four-year TEFT grants to Arizona, Colorado, Connecticut, Georgia, Louisiana,¹ Kentucky, Minnesota, Maryland, and New Hampshire. Each state participates in at least one TEFT activity and some states have modified their participation (see Exhibit 1).

Exhibit 1: State Participation in TEFT Demonstration, by Activity

State	EoC	FASI	PHR	eLTSS
Arizona ²	√	√	-	-
Colorado	√	√	√	√
Connecticut	√	√	√	√
Georgia	√	√	√	√
Kentucky	√	√	√	√
Maryland	√	-	√	√
Minnesota ³	-	√	√	√
New Hampshire	√	-	-	-

- Experience of Care (EoC) Survey (seven states):** Field test two rounds of the Consumer Assessment of Healthcare Providers and Systems Home and Community Based Services (HCBS CAHPS®) Survey with multiple HCBS programs. The survey is a cross-disability tool that assesses beneficiary experience with services. In addition to receiving CAHPS® certification, nineteen measures emerging from the survey received National Quality Forum endorsement.
- Functional Assessment Standardized Items (six states):** Field test two rounds of a modified set of functional assessment measures for use with HCBS beneficiaries. The Functional Assessment Standardized Items (FASI) builds on lessons from the Continuity Assessment Record and Evaluation (CARE) tool used in post-acute care settings.
- Personal Health Record (six states):** Build or procure a Personal Health Record (PHR) and demonstrate the use of the system with HCBS beneficiaries. States are implementing systems that give beneficiaries access to social services information to support service delivery decision-making.
- Electronic LTSS Plan (six states):** States participated in the ONC Tech Lab (previously known as the Standards & Interoperability (S&I) Framework) electronic long-term services and supports (eLTSS) initiative to identify, evaluate, and harmonize an eLTSS dataset. The grantees facilitated two rounds of pilots to exchange the eLTSS dataset electronically or through fax across HCBS settings and organizations to improve care coordination.

Through a contract with CMS, Lewin conducted a rapid-cycle program evaluation of the TEFT Demonstration. The evaluation consisted of close program monitoring of various aspects of TEFT state activities, including changes in their IT systems, on which this report focuses.

¹ Louisiana participated in the first round of the EoC Survey testing then withdrew from TEFT.

² Arizona elected to withdraw from the PHR and eLTSS activities.

³ Minnesota participated in the first round of the EoC Survey and elected not to participate in the second round.

II. HCBS Systems

A. Evaluating TEFT's Impact on State IT Systems

As part of Lewin's program evaluation, Lewin assessed the impact of the TEFT tools on the states' IT systems. Lewin sought to document which system changes occurring at the state and county levels were a result of TEFT, influenced TEFT, or were unrelated but occurred during the TEFT Demonstration period (2014-2018). During Lewin's annual site visits, we reviewed Medicaid system documentation and discussed details about the states' HCBS processes, system vendors, system capabilities, individuals and their roles, and non-electronic tools for information exchange (e.g., phone, fax). The resulting documents were HCBS Systems Maps and Information Exchange Scans.

Both tools track the flow of information from when a beneficiary applies for and then receives services (see **Pathway to HCBS** to the right) and the levels of information exchange between the steps in the process (see **Information Exchange Levels** below). To align with ONC's 10-Year vision, states ultimately should aim to provide HCBS beneficiaries with interoperable products and services, in a way that all individuals, their families, and providers can send, receive, find, and use health information.⁴

Pathway to HCBS

1. Self-Service Access
2. Financial Eligibility
3. Functional Eligibility
4. Case Management
5. HCBS Service Provision
6. Service Billing
7. Acute Care Services

Lewin created an **HCBS Systems Map** for each TEFT state, showing the workflow behind the pathway to HCBS in a visual snapshot. States selected which Medicaid HCBS programs to include in Lewin's HCBS Systems Map, and with some states, Lewin mapped several programs. Because the maps focus on the pathway to HCBS, they recognize that recurring actions or processes exist, but do not provide details on such processes as a state sharing benefits updates with an individual, monitoring care plans, or remediating services. **Exhibit 2** is a generalized example of an HCBS Systems Map. The HCBS Systems Maps for the TEFT states are included in **Appendix A**.

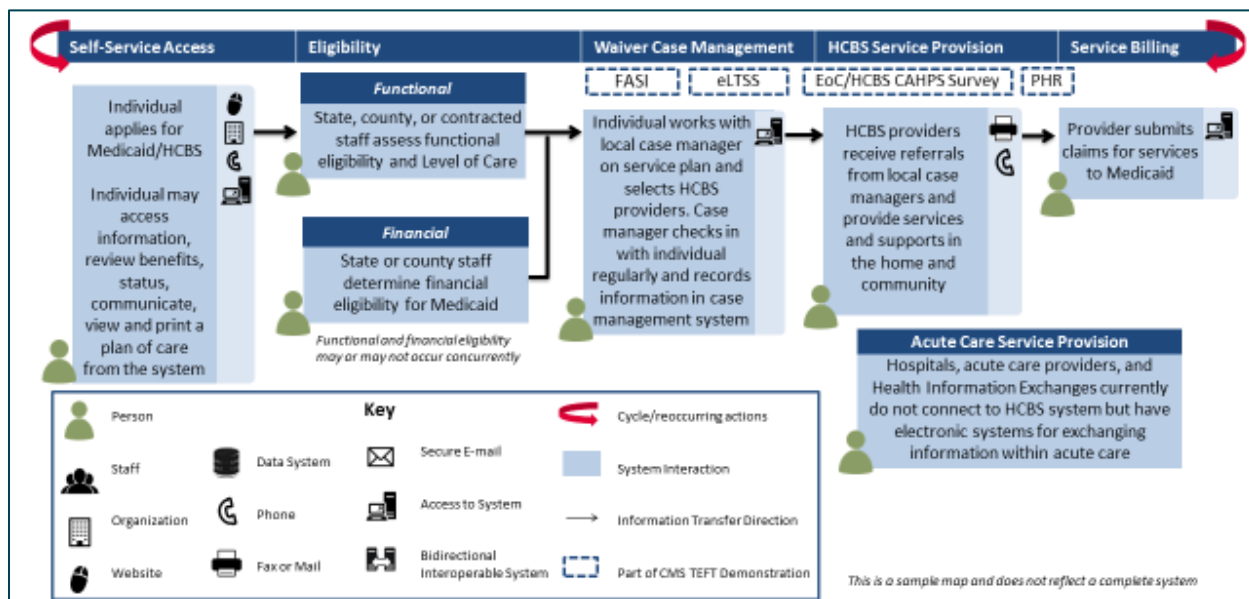
Information Exchange Levels

1. Mail, Phone, or Fax
2. Secure Email or Direct Secure Messaging
3. Access to a System
4. System to System Exchange
5. System to System Bi-Directional Exchange

The **Information Exchange Scans** supplement the HCBS Systems Maps and document whether the states electronically conduct HCBS processes. The Information Exchange Scans classify a process as: basic information exchange, where all or most information exchange is completed by mail, phone, fax or email; moderate information exchange, where all or most information exchange is completed by a recipient signing into a system and viewing a file; and advanced information exchange, where all or most information exchange is sent and received electronically in information systems.

⁴ ONC. (2015). Connecting Health and Care for the Nation: A 10-Year Vision to Achieve Interoperability. <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html?new>

Exhibit 2: General Example of an HCBS Systems Map



The HCBS Systems Maps and Information Exchange Scans vary significantly by state. Each state has a unique set of IT systems, unique processes for eligibility and case management, and its own services list and provider network. Lewin created baseline HCBS Systems Maps and Information Exchange Scans for each state in early 2015 and updated them annually through 2018. States reviewed and approved the documents annually. There were annual changes in every state’s map because of new state IT investments or involvement in federal initiatives. Lewin also tracked each state’s TEFT Demonstration efforts and determined where in the pathway to HCBS a state was changing an existing process to introduce a TEFT tool. For example, some states designed their PHRs to contain copies of care plans only, which case managers develop and fall under case management in the pathway to HCBS. Other states’ PHRs contained case management information and a record of HCBS services provided to HCBS beneficiaries. In the latter map, Lewin would show the TEFT Demonstration’s PHR spanning case management and HCBS service provision.

The following section explains a general version of the workflow behind the pathway to HCBS and presents Lewin’s findings on how state IT systems changed during the TEFT Demonstration, including changes that were connected or unrelated to TEFT. The sections below discuss how every TEFT state’s information exchange capabilities advanced during the course of the TEFT Demonstration.

B. General HCBS Workflow

State HCBS policies, regulations, and programs are unique, and state or county staff and local providers have developed different IT systems and operational processes to record, track, and exchange information about HCBS beneficiaries. Despite the differences between the states’ IT systems, Lewin found that information exchanged about or with prospective and enrolled Medicaid HCBS beneficiaries followed a similar series of steps, described below.

1. Self-Service Access

Self-service access is the first step a prospective Medicaid HCBS beneficiary takes to enroll in services, by navigating an agency website, calling 2-1-1, or visiting an agency's office. The agencies typically available to prospective beneficiaries for information and referral (I&R) to services and resources include state Medicaid Agencies, Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and I&R offices. Upon making contact with an agency or an agency's website, the prospective beneficiary will answer preliminary screening questions about his or her needs, such as nursing or transportation assistance. Staff conducting pre-screens and financial eligibility determinations may receive information collected at this stage, and copies of program applications and referral information are typically available for the prospective beneficiary. At this step, states are aiming to gather information about a prospective beneficiary and to refer him or her onward to Medicaid eligibility determination or to an appropriate community resource.

a. Changes in Self-Service Access Systems from 2014 to 2018

At the start of the TEFT Demonstration, most states had agency websites with the capability to gather prospective beneficiary questionnaires for agency staff to review. Arizona and Colorado's websites managed the entire Medicaid application process and pushed applications into the state Medicaid eligibility systems. In Arizona, prospective beneficiaries go to Health-e Arizona PLUS, which is also the state's health insurance exchange system. In Colorado, prospective beneficiaries go to the Colorado Program and Eligibility Kit (PEAK) website or mobile application.

During the TEFT Demonstration period, Kentucky implemented a website similar to Arizona and Colorado, containing a portal for prospective beneficiaries to apply for services and check eligibility status. Kentucky's self-service access system, benefind, also exchanges data with the state health information exchange. When benefind launched in February 2016, the system streamlined Kentucky's self-service access step. Previously, an applicant had to know which LTSS program to apply for and then locate, complete, and submit the forms. If the program did not accept the applicant, he or she needed to start over with a different application to apply to another program. Now, when a person accesses the benefind self-service portal, pre-screening questions determine the program and benefits for which the person may be eligible.

In many states, agency staff still conducts manual reviews of a prospective beneficiary's information and move his or her file onward to Medicaid eligibility determination staff if the person meets initial screening conditions. The websites in these states are not capable of prompting prospective beneficiaries about eligibility or changes in their application status. These are opportunity areas for streamlining Medicaid HCBS application processes and self-service access.

b. Self-Service Access-Related Initiatives

Prior to or during the TEFT Demonstration, seven of the eight TEFT states (Colorado, Connecticut, Georgia, Kentucky, Maryland, Minnesota, and New Hampshire) received No Wrong Door (NWD) grants from ACL to improve the self-service access step involving information,

referral, and applications for Medicaid HCBS.⁵ NWD is a federal initiative developed to simplify the process of obtaining information about LTSS in a state and applying for services. Initiated in 2012, ACL's aim was for any individual seeking services to go to any agency's office, website, or telephone hotline and easily receive help applying for state services, accessing information about state and community resources, and receiving assistance completing activities of daily living and other needs. As part of NWD, TEFT states implemented new self-service access websites, restructured case management around single entry points, and improved pre-screening interviews before or during TEFT.

2. Financial Eligibility

Prospective beneficiaries must be determined financially eligible based on each state's Medicaid requirements. State agency staff, usually in the financial division of the state Medicaid agency, reviews the applications to determine financial eligibility for Medicaid. At this step, the eligibility review staff processes information through various state and federal systems to assess income levels. Eligibility reviewers have access to state eligibility information systems where they review and store supporting income documentation. Prospective beneficiaries usually receive notification of their eligibility status through mail or secure email. The timespan between applying for services and receiving eligibility notification varies by program and state.

a. Changes in Financial Eligibility Systems from 2014 to 2018

During the TEFT Demonstration period, two states upgraded their eligibility information systems independently of the TEFT Demonstration. The new systems push application status updates to the state case management systems to notify Medicaid HCBS program staff to perform a functional assessment. These two states also began sending eligibility determination decisions electronically to applicants. Specifically, Arizona integrated the Arizona Technical Eligibility Computer System (AZTECS) into Health-E Arizona PLUS, an integrated system used by both the state health insurance exchange and Medicaid financial eligibility staff and beneficiaries. Arizona's Department of Economic Security and the state Medicaid agency, Arizona Health Care Cost Containment System, previously used AZTECS to determine financial eligibility for Medicaid, and AZTECS was a separate system from Health-E Arizona PLUS. Now, Medicaid staff use Health-E Arizona PLUS to determine financial eligibility, and that information is accessible in the same system as the health insurance exchange. Additionally, as of September 2017, the Connecticut ConneCT system replaced the legacy information management system for financial eligibility. ConneCT receives and stores information from an applicant's pre-screen and financial and functional eligibility determinations.

3. Functional Eligibility

The comprehensive assessments and periodic reassessments that determine functional eligibility for HCBS programs evaluate a person's needs to determine the need for any medical, educational, social, or other services. For example, for physical level of need, assessments evaluate how much help is needed in various instrumental activities of daily living (IADLs), such as house cleaning, money management, preparing meals, shopping, taking medications, communicating, and moving

⁵ ACL. (n.d.). Aging and Disability Resource Centers Program/No Wrong Door System.

<https://www.acl.gov/programs/connecting-people-services/aging-and-disability-resource-centers-program-no-wrong-door>

about in the community, as well as activities of daily living (ADLs) like bathing, dressing, eating, mobility, toileting, and hygiene. Staff or contractors designated by the Medicaid HCBS programs, typically nurses or case managers, meet with prospective beneficiaries to observe and evaluate his or her physical level of need and other needs. The staff or contractors enter their assessment results into a state or county case management system. As with financial eligibility, states have different levels of requirements for eligibility based on functional need. Comprehensive functional eligibility assessments may occur before, after, or at the same time as a financial eligibility review. At this step, functional assessors also often enter recommendations for services and programs into the case management system.

a. Changes in Case Management Systems from 2014 to 2018

Prior to TEFT, most Medicaid HCBS programs had case management systems operated at the state or county level for storing functional assessments and care plans, which specify a beneficiary's goals and services he or she will access. Case management systems are integral in meeting records management requirements. However, while the IT systems were capable of storing documents, it was not common to rely on case management systems for many operational efficiencies. For example, agency staff could not typically record functional assessments electronically and see them automatically populate in case management systems. Instead, functional assessors conducted the assessments on paper or on a laptop and then manually entered the information into the case management system. IT systems rarely automatically sent functional assessments or care plans onward to reviewers and electronic care plan copies to prospective or enrolled beneficiaries. These exchanges of information were usually conducted through mail, fax, or phone.

Case management systems historically were more commonly implemented at the county level than the state level. During the TEFT Demonstration period, Georgia implemented a statewide case management system. Georgia's Harmony system replaced the Aging Information Management System (AIMS) in February 2017. The Harmony system also connects to the eligibility information system, called Gateway. Maryland had a statewide case management system, Maryland LTSS, prior to TEFT and implemented several updates during TEFT. Kentucky also had a statewide case management system, Medicaid Waiver Management Application, and began requiring AAAs, case managers, and HCBS providers to use the system during TEFT.

In addition to shifting towards statewide case management systems, states and counties also updated their existing case management systems. Most changes during the TEFT Demonstration period improved information exchange about enrolled beneficiaries when they changed programs. For example, Colorado improved the integration between the Colorado Benefits Management System (CBMS) and Benefits Utilization System (BUS). Previously, Medicaid HCBS waiver programs had different eligibility information systems that did not cross-check or exchange information. Colorado implemented a new Business Intelligence and Data Management (BIDM) system in November 2016, which supports integrated checks and functions across CBMS and BUS. The new BIDM system also has a beneficiary portal, where enrolled beneficiaries can access their program enrollment information and care plan.

Some states also provided agency staff with electronic tools (e.g., web form for a laptop) to record functional assessments. Minnesota piloted a downloadable, electronic version of its functional assessment, MnCHOICES. This tool is capable of synchronizing automatically with the MNsure website in which prospective beneficiaries can check their Medicaid eligibility

status. State staff also record financial eligibility determinations in MnCHOICES, and MnCHOICES shares information with the state's service billing system. Similarly, New Hampshire piloted the electronic Medical Eligibility Assessment (MEA) in April 2016. Nurses performing functional assessments in homes without internet may download the MEA before the assessment and use it offline.

b. Initiatives Impacting Functional Eligibility

Five TEFT states (Connecticut, Georgia, Kentucky, Maryland, and New Hampshire) participated in Medicaid's Balancing Incentive Program (BIP), which provided states with additional funding to implement NWD, adopt standardized functional assessments, and implement conflict-free case management processes.⁶ As part of this program, Connecticut, Kentucky, and Maryland implemented new functional assessments, and Georgia implemented a new case management system during the TEFT Demonstration period. Specifically, Connecticut implemented a modified version of the interRAI-based Universal Assessment Tool, Maryland implemented the interRAI assessment, and Kentucky implemented the Kentucky Home Assessment Test. As discussed earlier, Georgia updated the state's case management system.

One of the TEFT Demonstration's tools, the Functional Assessment Standardized Items (FASI), can also impact a state's functional eligibility processes. FASI is available for states to adopt to evaluate functional needs as part of their comprehensive assessments. It is suitable to use in any Medicaid HCBS program. FASI cannot serve as a standalone comprehensive assessment, but can be used to replace or supplement the functional section. During the TEFT Demonstration, FASI was tested with enrolled HCBS beneficiaries rather than during comprehensive assessments to determine any prospective HCBS beneficiary's eligibility because the tool had not yet been formally adopted by states.

4. Case Management

Once prospective beneficiaries are determined both financially and functionally eligible for Medicaid HCBS programs, beneficiaries transition to care planning with the case managers who performed their assessments, or receive referrals to case managers or case management agencies. Case managers receive notifications about eligibility decisions from state staff through phone, fax, secure email, or through accessing their state or local case management systems. Case managers work with enrolled beneficiaries to create care plans based on the comprehensive assessments that incorporate information from individuals' functional assessments. . States also commonly refer to care plans as service plans, support plans, or LTSS plans. Case managers share copies of the care plans with HCBS service providers and the beneficiary. At this step, case managers are aiming to establish relationships with enrolled beneficiaries and understand their goals and preferences to help coordinate their services.

As case management systems are used to store and share functional assessments prior to beginning active case management, the changes in case management systems are discussed above in the Functional Eligibility section.

⁶ CMS. (n.d.). Balancing Incentive Program. <https://www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html>

a. Initiatives Impacting Case Management

Two of the TEFT Demonstration's tools, the PHR and eLTSS dataset, can support case management services. Care plans and case managers' contact information are among the most common PHR features included in the TEFT states' PHR pilots. Case managers have historically needed to share copies of the care plans with enrolled beneficiaries through mail, fax, or secure email because beneficiaries could not access their IT systems. States designed the PHR pilots to provide beneficiaries with access to a system containing select information about their HCBS programs, case managers, and services. The PHR features and information varied by state, but information from care plans were common in the PHRs.

The eLTSS dataset intends to help standardize the information in a care plan. TEFT states piloted and reached agreement on 56 standard items for a care plan. Among these items is information on beneficiary demographics, goals and strengths, plan information, plan signatures, risks, service information, and service provider information. As TEFT states and other stakeholders work through the Health Level Seven standardization process for the eLTSS dataset to be recognized as a health IT standard, there is momentum behind efforts to exchange care plans electronically between local providers, case managers, and beneficiaries.⁷ For additional information about the eLTSS initiative and dataset, please refer to the [ONC eLTSS website](#).

5. Service Provision

Once beneficiaries have arrangements to receive services and supports from local HCBS providers, they will receive services in their homes and communities. HCBS providers coordinate scheduling with case managers or directly with beneficiaries. Individuals may acknowledge receipt of services through a visit verification process, and providers send claims to the Medicaid billing system or the Medicaid managed care organization.

a. Changes in Provider IT Systems from 2014 to 2018

During the TEFT Demonstration, states and Lewin engaged local HCBS providers in several stakeholder engagement efforts to understand their interest in and use of health IT systems. Examples of health IT systems for clinical and non-clinical information include electronic health records (EHRs), electronic medical records (EMRs), telehealth, electronic assessments, and PHRs. The cost and resources required to implement and upgrade IT systems, as well as to train staff to use new systems, have made it difficult for HCBS providers to adopt health IT. There also have been organizational barriers for some providers that have difficulty switching from legacy, paper-based systems that they are comfortable using.

Generally, HCBS providers meet with beneficiaries to develop a service plan and document their services on paper forms, or input the information into an office billing system. Providers typically receive care plan information through secure email from case managers. In a few states, including Maryland and Kentucky, providers are able to access the case management system to view select information in care plans. For example, Maryland providers access the /In-house Support Assurance System (ISAS), a provider portal electronic visit verification (EVV) system integrated

⁷ Health Level Seven International. (n.d.). Project Summary for Electronic Long-Term Services and Supports Service Plan.

<http://www.hl7.org/special/Committees/projman/searchableProjectIndex.cfm?action=edit&ProjectNumber=1431>

in Maryland's case management system, to access and process some information about their beneficiaries. Providers rarely use electronic methods of information exchange and often only use IT systems for billing. A beneficiary usually receives a copy of the provider's service plan in-person or through mail and verifies that he or she received services in-person or on a call with the case manager.

In some states, such as Minnesota, where the PHR and eLTSS dataset were piloted, HCBS providers consistently used health IT systems for recording service plans but did not share the information electronically. Otter Tail County providers in Minnesota had not shared information between organizations prior to TEFT, but adopted the Otter Tail County dataset to help facilitate provider-to-provider information exchange.

b. Initiatives Impacting Service Provision

The 21st Century CURES Act, which became law in December 2016, includes a provision that requires Medicaid personal care services programs, such as HCBS programs, to adopt an EVV system by January 2020.⁸ EVV enables beneficiaries and providers to record electronically that services were delivered, and shifts away from current forms of paper-based verification. This policy intends to combat fraud, and it is beginning to influence IT use among HCBS providers and case managers. Maryland developed ISAS prior to TEFT to conduct EVV in a portal connected to the state's case management system. Maryland also made EVV one of the features of the PHR pilot it implemented for TEFT. The PHR was populated with real-time service provision data, and beneficiaries were encouraged to report incidents (i.e., services were not delivered as expected) to their case managers in the PHR.

The final TEFT Demonstration tool, the HCBS CAHPS[®] Survey, is connected to service provision because it measures beneficiaries' experience with their HCBS providers' services. Beneficiaries are also asked to consider their case management services in the HCBS CAHPS[®] Survey. The survey focuses on service experience, instead of satisfaction, and how an individual values his or her services. The survey is designed to apply to beneficiaries in any HCBS program, which is intentional to allow Medicaid quality improvement staff to compare results across programs and disability groups. The TEFT states conducted the HCBS CAHPS[®] Survey through in-person and phone interviews. Colorado also tested an electronic version of the survey. Following the TEFT pilots of the HCBS CAHPS[®] Survey, Connecticut developed a web form version of the survey that it will use to collect survey responses, interviewers will still conduct the survey over the phone or in person.

6. Service Billing

After beneficiaries receive HCBS, local providers submit Medicaid claims, usually through a Medicaid Management Information System (MMIS) or a Medicaid managed care organization's IT system. State eligibility information systems sometimes connect to the MMIS to populate basic eligibility and enrollment information about beneficiaries. States may send case managers and beneficiaries copies of service bills or explanations of benefits either through mail or by updating an IT system where they have access.

⁸ CMS. (December 2017). Section 12006 21st Century Cures Act Electronic Visit Verification Systems [PDF]. <https://www.medicaid.gov/medicaid/hcbs/downloads/training/evv-presentation-part-1.pdf>

a. Changes in MMIS and Other Billing Systems from 2014 to 2018

Prior to TEFT, all states had an MMIS for billing. On an ongoing cycle, states submit applications to CMS to update their MMIS. Some MMIS are capable of bidirectional information exchange with case management systems, which is useful for updating service and eligibility records. During TEFT, only one state replaced its MMIS. Colorado implemented interChange in 2016-2017, replacing a system that required manual data entry and querying with a new MMIS system that automates data exchange and has a data analytics system. Connecticut and Kentucky are currently beginning processes to replace their MMIS.

b. Initiatives Impacting Service Billing

During TEFT, CMS extended the enhanced federal match provided for new MMIS and eligibility information system implementations. The Mechanized Claims Processing and Information Retrieval Systems (90/10) Final Rule⁹ was issued in December 2015. States are permitted to apply for enhanced match for resources spent on design, development, installation, or enhancement of Medicaid IT systems. Connecticut and Kentucky received CMS approval for their MMIS replacement projects and are leveraging enhanced match funding for the systems.

7. Acute Care Services

While HCBS programs focus on providing long-term care services to beneficiaries in their own homes or communities, HCBS beneficiaries may also receive acute care services following a severe injury, illness, or surgery. States aim for HCBS and acute care providers to coordinate care and share information, when needed. However, case management systems, health IT systems used by acute care providers, and the limited IT systems used by HCBS providers are not typically interoperable. Some states aim to connect the IT systems to exchange social service and medical information or to identify a central location to store and access information. For example, the Chesapeake Regional Information System for our Patients (CRISP), a Maryland-based health information exchange, connects to all hospitals and nearly all skilled nursing facilities in the state. CRISP built a clinical data repository, from which connects organizations can retrieve care summaries for their patients. CRISP's participating hospitals also report admit, discharge, and transfer notification information to the repository. If HCBS providers participate in CRISP, they can access information about beneficiary status and whether a beneficiary recently visited a Maryland hospital. Through the TEFT Demonstration, the eLTSS dataset serves as a starting point to support information exchange between HCBS and acute care providers. The PHRs tested during TEFT also support the future movement towards sharing both social service and medical information with beneficiaries in a central location. Additional HCBS provider IT system improvements must occur before electronic health information exchange is possible.

⁹ Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10). (2015, December 04). Retrieved from <https://www.federalregister.gov/documents/2015/12/04/2015-30591/medicaid-program-mechanized-claims-processing-and-information-retrieval-systems-9010>

III. Takeaways and Looking Forward

Based on Lewin’s monitoring of state IT systems during the TEFT Demonstration, we found that states implemented major system updates, such as replacing a MMIS or case management system, and many smaller updates like creating an electronic tool for an HCBS program’s comprehensive assessment. MFP, BIP, and enhanced match opportunities for Medicaid IT systems largely financed these IT system changes. Specifically, Lewin has observed that the following IT system changes affected state HCBS programs in the TEFT states:

A. Self-Service Access

- Kentucky implemented a statewide case management system with a portal for prospective beneficiaries to apply for services and check eligibility status.

B. Financial Eligibility

- Arizona updated its eligibility information system to send eligibility decisions electronically to applicants and push application status updates to the state case management system to prompt the beginning of functional assessments.
- Connecticut implemented a new eligibility information system that is capable of storing information from all phases of the eligibility process, including comprehensive assessments.

C. Functional Eligibility

- Minnesota and New Hampshire piloted electronic functional assessment tools.
- Connecticut, Kentucky, and Maryland adopted new standardized functional assessments.

D. Case Management

- Colorado implemented a new system that links the eligibility information systems used by different Medicaid HCBS programs. Program staff can more easily exchange information about enrolled beneficiaries who change programs.
- Georgia implemented a new statewide case management system that is capable of connecting to the state’s eligibility information system.
- Maryland implemented several updates to its statewide case management system.
- Kentucky began requiring AAAs, case managers, and HCBS providers to use its statewide case management system.

E. HCBS Service Provision

- HCBS providers in Minnesota’s Otter Tail County and Southern Prairie initiatives began sharing service information between organizations.
- Maryland and Kentucky implemented HCBS provider portals linked to the statewide case management systems for HCBS providers
- Maryland will expand its PHR more broadly to Medicaid HCBS beneficiaries.

- Connecticut adopted the HCBS CAHPS[®] Survey and will offer an electronic version to beneficiaries.

F. Service Billing

- Colorado replaced its MMIS.
- Kentucky's new MMIS implementation is underway.
- Connecticut is beginning the process to replace its MMIS.

G. Acute Care Services

- Maryland is working with CRISP to connect the state's case management system to the health information exchange.

While most of these IT system changes occurred independently of the TEFT Demonstration, the eLTSS dataset standardization process will influence efforts in states and communities to exchange care plans electronically, and may lead to additional work in states and federal agencies to increase electronic information exchange capabilities and health IT adoption. Some of the IT system changes that occurred over the past four years also influenced the approaches states took in piloting the TEFT tools, such as whether a state had a statewide case management system. Overall, states made changes throughout the TEFT Demonstration period that positively impacted Medicaid HCBS program operations through increasing the volume of information shared electronically between IT systems and the number of program stakeholders capable of exchanging information electronically, such as eligibility reviewers, case managers, HCBS providers, and beneficiaries.

Appendix A: TEFT State HCBS Systems Maps

This appendix contains the final TEFT HCBS Systems Maps for the following states, as of February 2018: Arizona, Connecticut, Colorado, Georgia, Kentucky, Maryland, Minnesota, and New Hampshire. On an annual basis, Lewin met with state stakeholders to update these maps. State TEFT teams also reviewed and approved the updated maps. In the HCBS Systems Maps, Lewin shows the workflow behind the pathway to HCBS in a visual snapshot. States selected which Medicaid HCBS programs to include in the HCBS Systems Map. The maps track the flow of information from when a beneficiary applies for and then receives services.

A. Structure of a State’s HCBS Systems Map

All systems maps have two pages: the first page contains the systems map graphic with seven steps, and the offices, providers, other staff, and beneficiaries who exchange information across the continuum of HCBS programs. The systems maps reflect the operations of either one Medicaid waiver or a set of Medicaid waivers, as noted on the first page. The icons help describe the method and direction of information exchange. The second page has a narrative description of how and what information is exchanged in the map, an icon legend, and a state-specific glossary. Since the maps focus on the pathway to HCBS, they show a feedback loop, but do not provide details about state processes for care plan monitoring and other remediation of services. Additionally, systems maps show in dotted lines the TEFT tools states demonstrated with their waiver populations.

B. Acronym Glossary

This glossary (see **Exhibit 3**) contains acronyms common to all HCBS Systems Maps. State-specific acronyms are included in each state’s HCBS Systems Map description.

Exhibit 3: General Acronym Glossary

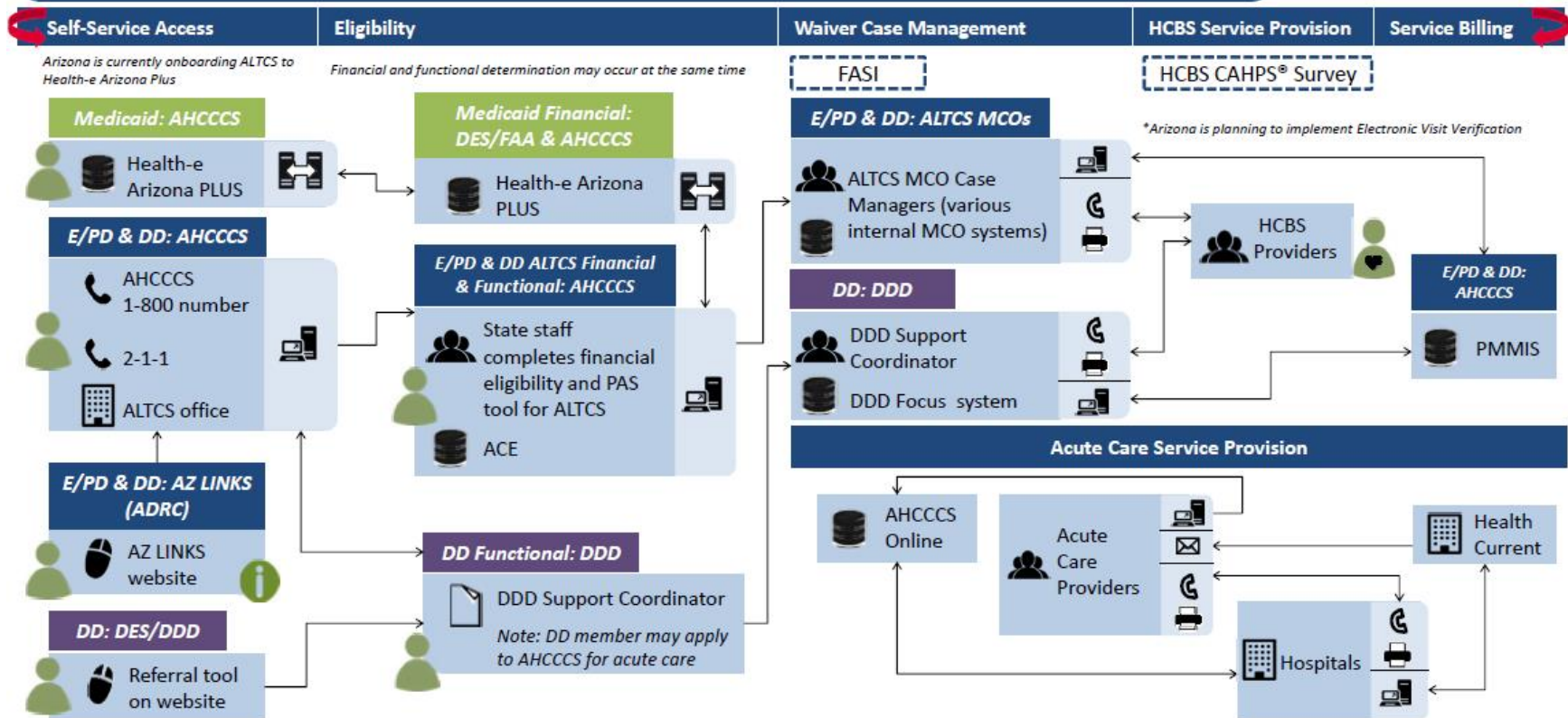
Acronym	Definition
LTSS	Long-Term Supports and Services
EoC	Experience of Care
HCBS CAHPS® Survey	Consumer Assessment of Health Providers and Systems Home & Community-Based Services Survey
FASI	Functional Assessment Standardized Items
PHR	Personal Health Record
eLTSS	electronic Long-Term Supports and Services

C. Considerations and Further Information

While the HCBS Systems Maps seek to show how information flows between state systems, the maps do not show every system or linkage that may exist in the future. For example, while states have care plan monitoring and other feedback loops to monitor and remediate services, the current systems maps do not provide that level of detail. Additionally, the maps show how information about an individual flows during acute care service provision and how acute care systems do not currently link to HCBS systems. Although linking acute care and HCBS systems is a goal for the future, the maps do not show that tentative linkage. For additional details, see the TEFT Evaluation Final Report.

Arizona HCBS Systems Map

1115 Demonstration Waiver: Elderly and Physically Disabled (E/PD) Populations and Populations with Developmental Disabilities (DD)
(as of January 2018)



Arizona HCBS Systems Map Description

1115 Demonstration Waiver: Elderly and Physically Disabled

- **Self-Service Access:** An individual may be referred to LTSS services from the private pay system. An individual can apply for AHCCCS Medicaid benefits via Health-e Arizona PLUS. An individual interested in services can access resources and complete AZ LINKS Screening Tool via AZ LINKS ADRC website or call AHCCCS 1-800 number or 2-1-1. An individual calls or visits ALTCS office in-person to apply for E/PD.
- **Financial Eligibility:** DES/FAA and AHCCCS determine financial eligibility using Health-e Arizona PLUS for acute AHCCCS Medicaid. AHCCCS determines financial eligibility for ALTCS.
- **Functional Assessment:** State staff (nurse or social worker) complete PAS Tool to determine Medical eligibility with separate domains and scoring for E/PD and DD. ALTCS PAS is entered into AHCCCS Customer Eligibility, a computer system that determines eligibility for ALTCS.
- **Medicaid Waiver Case Management:** ALTCS MCOs or health plans use the same universal tool. ALTCS MCOs complete assessments for care planning (vary by plan since only need to include basic parameters). MCOs send referral to HCBS providers via fax, phone, or mail. ALTCS MCOs use different IT systems to maintain and track case management activities.
- **Service Provision:** HCBS providers receive referral via fax, phone, or mail from ALTCS MCOs. Hospitals, pharmacies, acute care, and HCBS providers access enrollment verifications via AHCCCS Online.
- **Service Billing:** HCBS providers submit claims for services to MCOs and ALTCS. MCOs submit to PMMIS. Data is shared bidirectionally between MCOs and PMMIS but not integrated system.

1115 Demonstration Waiver: Developmental Disability

- **Self-Service Access:** An individual may be referred to LTSS services from the private pay system. An individual can apply for AHCCCS Medicaid benefits via Health-e Arizona PLUS. An individual interested in services can access resources and complete AZ LINKS Screening Tool via AZ LINKS ADRC website or call AHCCCS 1-800 number or 2-1-1. An individual can visit Department of Economic Security DDD website to complete referral tool or call 2-1-1 for DD services.
- **Financial Eligibility:** DES/FAA and AHCCCS determine financial eligibility using Health-e Arizona PLUS for acute AHCCCS Medicaid. AHCCCS determines financial eligibility for ALTCS.
- **Functional Assessment:** DDD Support Coordinators (case managers) determine functional need and develop individualized service plan in-person. DD members may apply to ALTCS for acute care. State staff (nurse or social worker) complete PAS Tool to determine Medical eligibility with separate domains and scoring for E/PD and DD. ALTCS PAS is entered into AHCCCS Customer Eligibility, a computer system that determines eligibility for ALTCS.
- **Medicaid Waiver Case Management:** DDD Support Coordinators (case managers) coordinate DD services and supports. Most information is stored as paper but DDD is transitioning to using DDD Focus system to maintain information on DD members.
- **Service Provision:** HCBS providers receive referral from DDD Support Coordinators via phone, fax, or mail. Hospitals, pharmacies, acute care, and HCBS providers access enrollment verifications via AHCCCS Online.
- **Service Billing:** HCBS providers submit claims for services to DDD. DDD submits to PMMIS. Data is shared bidirectionally between DDD and PMMIS but not integrated system.

Key

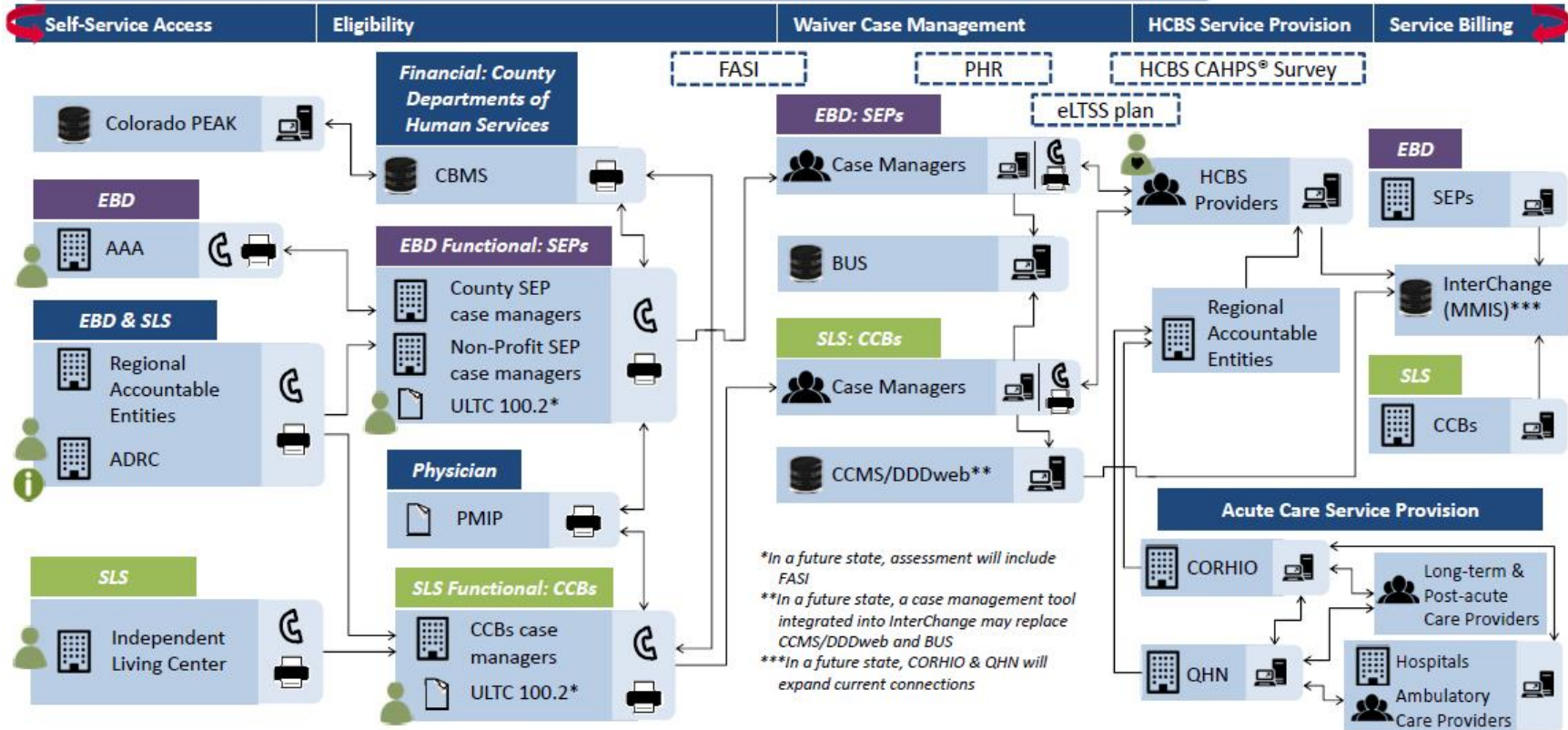
	Staff		Bidirectional Interoperable System
	Phone		Access to System
	Data System		Secure E-mail
	Form		Phone
	Website		Fax or Mail
	Organization		Information Transfer
	Information Received		System Interaction
	Services Received		Information Transfer Direction
	Person		Part of CMS TEFT Demonstration
	Feedback Loop		Medicaid Only
			E/PD & DD Population
			DD Population Only

Acronym Glossary	
ACE	AHCCCS Customer Eligibility
ADRC	Aging and Disability Resource Center
AHCCCS	Arizona Health Care Cost Containment System
ALTCS	Arizona Long Term Care System
AzHeC	Arizona Health-e Connection now Health Current
DDD	Department of Developmental Disabilities
DD	Developmental Disabilities
DES/FAA	Department of Economic Security Family Assistance Administration
E/PD	Elderly and Physically Disabled
MCO	Managed Care Organization
PAS	Pre-Admission Screening
PMMIS	Pre-Paid Medical Management Information System



Colorado HCBS Systems Map

1915(c) Waivers: Elderly, Blind, and Disabled (EBD) Waiver; and Supported Living Services (SLS) Waiver for Populations with Intellectual Disabilities (as of February 2018)



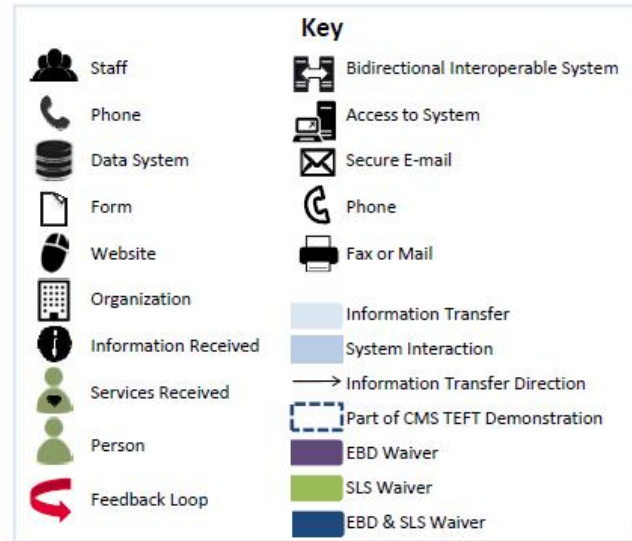
Colorado HCBS Systems Map Description

Elderly, Blind, and Disabled Waiver

- **Self-Service Access:** An individual can screen and apply for public assistance benefits via Colorado PEAK website or mobile application. An individual calls ADRC or AAA to discuss options. ADRCs provide options counseling and some application assistance and make referrals to SEPs or CCBs. AAAs provide information, assistance, and services to older adults and make referrals to SEPs via phone or fax. Regional Accountable Entities help Medicaid clients find community and social services.
- **Financial Eligibility:** County Departments of Human Services determine financial eligibility for Medicaid HCBS using the CBMS.
- **Functional Assessment:** Non-profit SEPs or County SEPs serve older adults and people with physical disabilities and mental health needs on the EBD Waiver. SEP staff provide information, screening, assessment of need and case management. SEPs complete ULTC 100.2 functional screen and input functional eligibility determination into BUS. Physicians complete the PMIP to certify medical necessity for LTC services and fax PMIP to SEPs.
- **Medicaid Waiver Case Management:** Non-profit and County SEPs provide case management services for EBD Waiver. SEPs use BUS for care planning and referrals are made to HCBS providers via phone, fax, and mail. SEP case managers access InterChange (new MMIS) to update Prior Authorization Request information.
- **Service Provision:** HCBS providers login to the InterChange provider portal to submit claims for services. Regional Accountable Entities connect Medicaid clients to Medicaid providers.
- **Service Billing:** HCBS providers receive referrals via phone, fax, or mail from SEPs.

Supported Living Services Waiver

- **Self-Service Access:** An individual can screen and apply for public assistance benefits via Colorado PEAK website or mobile application. An individual calls ADRC or Independent Living Center to discuss options. ADRCs provide options counseling and some application assistance and make referrals to SEPs or CCBs. ILCs provide information, assistance, and services to older adults and make referrals to CCBs via phone or fax. RAEs help Medicaid clients find community and social services.
- **Financial Eligibility:** County Departments of Human Services determine financial eligibility for Medicaid HCBS using the CBMS.
- **Functional Assessment:** CCBs serve individuals with developmental disabilities on the SLS Waiver. Staff at the 20 CCBs serve non-overlapping geographic regions and provide information, screening, assessment of need and case management. CCBs complete ULTC 100.2 functional screen and input functional eligibility determination into BUS. Physicians complete the PMIP to certify medical necessity for LTC services and fax PMIP to CCBs.
- **Medicaid Waiver Case Management:** CCBs provide case management services for SLS Waiver. CCBs use BUS for care planning and referrals are made to HCBS providers via phone, fax, and mail. CCB case managers upload PAR information into InterChange (MMIS) and CCMS. The maximum expenditure for Waiver services is determined by assessing support levels using the Supports Intensity Scale tool. CCBs can access the CCMS to view client information. CCMS or DDDweb is a statewide automated basic client data and billing system for DDD that authorizes services, collects individual data, and bills for DDD services. In a future state, Vital Tool may replace CCMS/DDDweb.
- **Service Provision:** HCBS providers login to the InterChange provider portal to submit claims for services. RAEs connect Medicaid clients to Medicaid providers.
- **Service Billing:** HCBS providers receive referrals via phone, fax, or mail from CCBs.



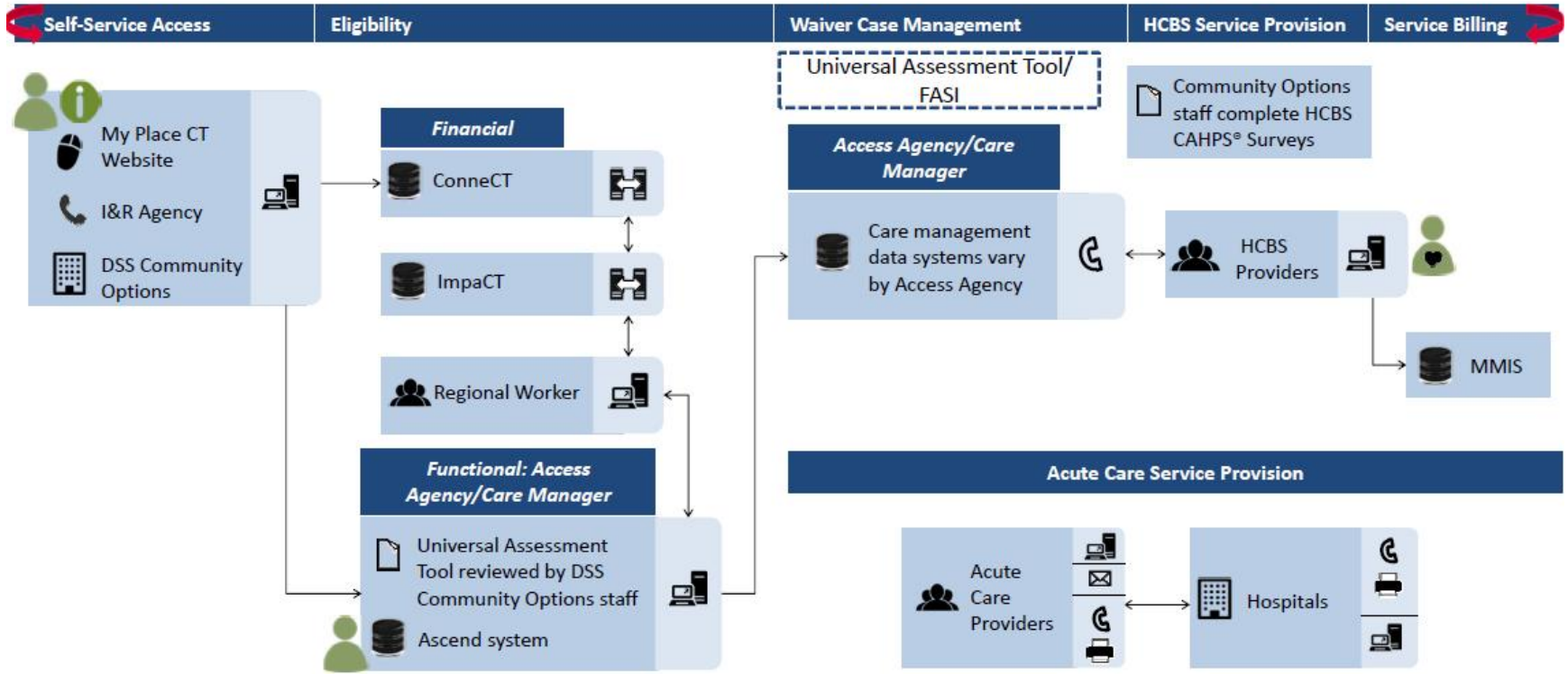
Acronym Glossary

AAA	Area Agencies on Aging
ADRC	Aging and Disability Resource Center
BUS	Business Utilization System
CBMS	Colorado Benefits Management System
CCBs	Community Center Boards
CCMS	Community and Contracts Management System
DDD	Department of Developmental Disabilities
EBD	Elderly, Blind, and Disabled
MMIS	Medicaid Management Information System
PEAK	Program and Eligibility Kit website
PMIP	Professional Medical Information Page
SEPs	Single Entry Points
SLS	Supported Living Services
ULTC	Uniform Long Term Care, Colorado's assessment tool



Connecticut HCBS Systems Map (1)

1915(i) Waiver: Home Care Program for Elders (as of February 2018)



*Connecticut tested the HCBS CAHPS® Survey and FASI with the Home Care Program for Elders and the PHR and eLTSS plan with the Community First Choice program

Connecticut HCBS Systems Map Description (1)




















Home Care Program for Elders

- **Self-Service Access:** Individuals can enter the HCBS system by accessing information through agency websites, being referred by ADRCs, or calling the DSS office. The agency websites include My Place CT, which is a website that helps consumers identify their needs and informs them of how to seek services. Individuals can also access pre-screen tool, application, and program information through ConneCT, a portal that can be used by current DSS clients to get information on their benefits and by new clients to apply online for services and check their eligibility for services.
- **Financial Eligibility:** ConneCT serves as a front-end portal through which an individual can apply for services. The DSS ImpaCT system is the financial eligibility verification system, which replaced EMS. ConneCT and ImpaCT are bi-directional interoperable systems.
- **Functional Assessment:** After an individual applies for services, the results of the pre-screen come to care managers through the Ascend system. The care managers complete assessments of the consumer in-person. The care managers complete a summary document of the assessment and upload the PDF of the care plan to the Community Options staff through the Ascend system for review and approval by DSS.
- **Medicaid Waiver Case Management:** Care management data is uploaded into the Community Options platform. Care management data systems vary by Access Agency. Care managers will call HCBS providers to set up services.
- **Service Provision:** HCBS providers mostly communicate via telephone. Direct messaging is offered by the state, but not highly utilized by HCBS providers. Community Options staff administer HCBS CAHPS® Surveys as needed with the Home Care Program for Elders, Autism, Katie Beckett, Personal Care Assistance, and Acquired Brain Injury programs to achieve representative sample for each waiver operated by the Medicaid agency.
- **Service Billing:** Providers submit claims for services through MMIS.

Acronym Glossary

ADRC	Aging and Disability Resource Centers
ConneCT	Web portal used for DSS clients to get benefit information or apply for services and check eligibility online
DSS	Connecticut Department of Social Services
EMS	Eligibility Management System
ImpaCT	New financial eligibility system under the Balancing Incentive Program
I&R	Information & Referral
MMIS	Medicaid Management Information System

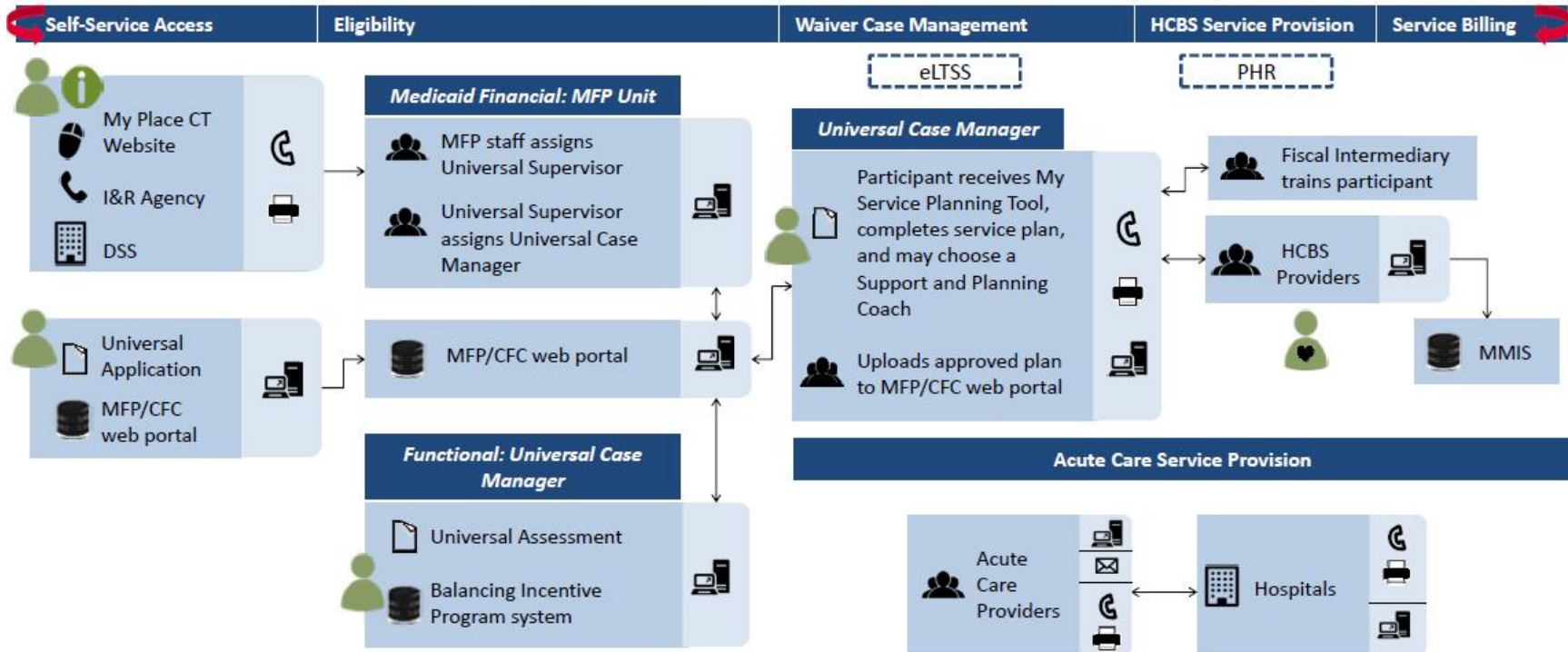
Key

 Staff	 Bidirectional Interoperable System
 Phone	 Access to System
 Data System	 Secure E-mail
 Form	 Phone
 Website	 Fax or Mail
 Organization	 Information Transfer
 Information Received	 System Interaction Point
 Services Received	 Information Transfer Direction
 Person	 Part of CMS TEFT Demonstration
	 Feedback Loop



Connecticut HCBS Systems Map (2)

1915(k) State Option: Community First Choice for Populations with Intellectual or Developmental Disabilities (I/DD)
(as of February 2018)



*Connecticut tested the HCBS CAHPS[®] Survey and FASI with the Home Care Program for Elders and the PHR and eLTSS plan with the Community First Choice program

**Personal Care Assistance Waiver follows similar processes for individuals seeking and receiving services.

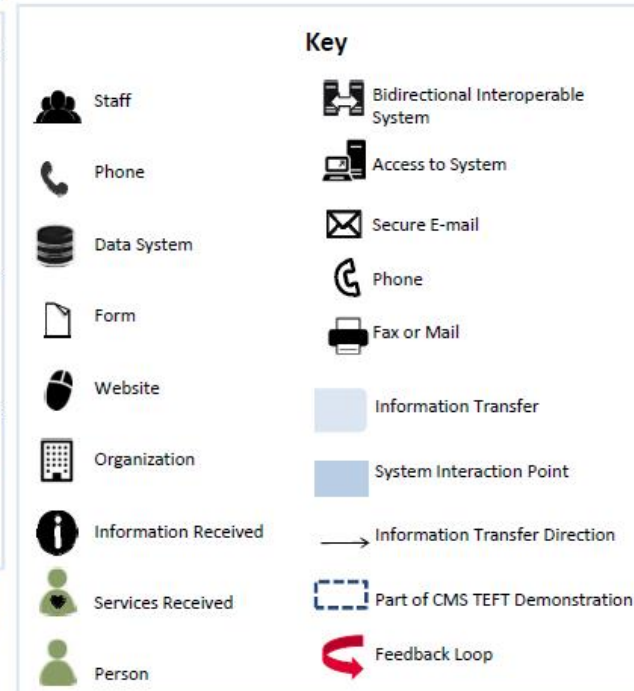
Connecticut HCBS Systems Map Description (2)

Community First Choice

- **Self-Service Access:** Individuals can enter the system through many different avenues. This includes accessing information through agency websites, being referred by ADRCs, or calling the DSS office. The agency websites include My Place CT, a website that helps consumers identify their needs and informs them how to seek services. Individuals applying for the CFC program submit the universal application electronically through the MFP/CFC web portal.
- **Financial Eligibility:** The MFP Unit screens for Medicaid eligibility and institutional level of care in the MFP/CFC web portal. If individual is active on Medicaid (Title 19) then the next step is for the applicant to be determined functionally eligible. The Universal Supervisor is assigned by MFP staff in the MFP/CFC system. If individual is not active, the individual applies for Medicaid.
- **Functional Assessment:** The Universal Supervisor assigns a Universal Case Manger in the MFP/CFC system to complete the Universal Assessment in the BIP system.
- **Medicaid Waiver Case Management:** If level of care is confirmed in the BIP system, then the Universal Case Manager reviews the participant’s assessment and discusses a service plan in alignment with applicant’s personal preferences in-person. The Universal Case Manager gives the participant “My Service Planning Tool” and discusses his or her responsibility for development and submission of completed service plan to Universal Case Manager within 30 days. The Universal Case Manager also shares information about Support and Planning Coach providers. Participant develops service plan within 30 days of assessment. The Universal Case Manager uploads approved service plans to MFP/CFC web portal for approval and authorization by DSS. The Universal Case Manager receives electronic notice of service plan approval from CFC Unit.
- **Service Provision:** Once DSS approves service plan, fiscal intermediary trains consumer on Employer Responsibilities and sets consumer up with employer in-person. The Universal Case Manager sends a copy of authorized plan to participant and conservator or guardian, if applicable, by fax.
- **Service Billing:** Participants work with fiscal intermediary.

Acronym Glossary

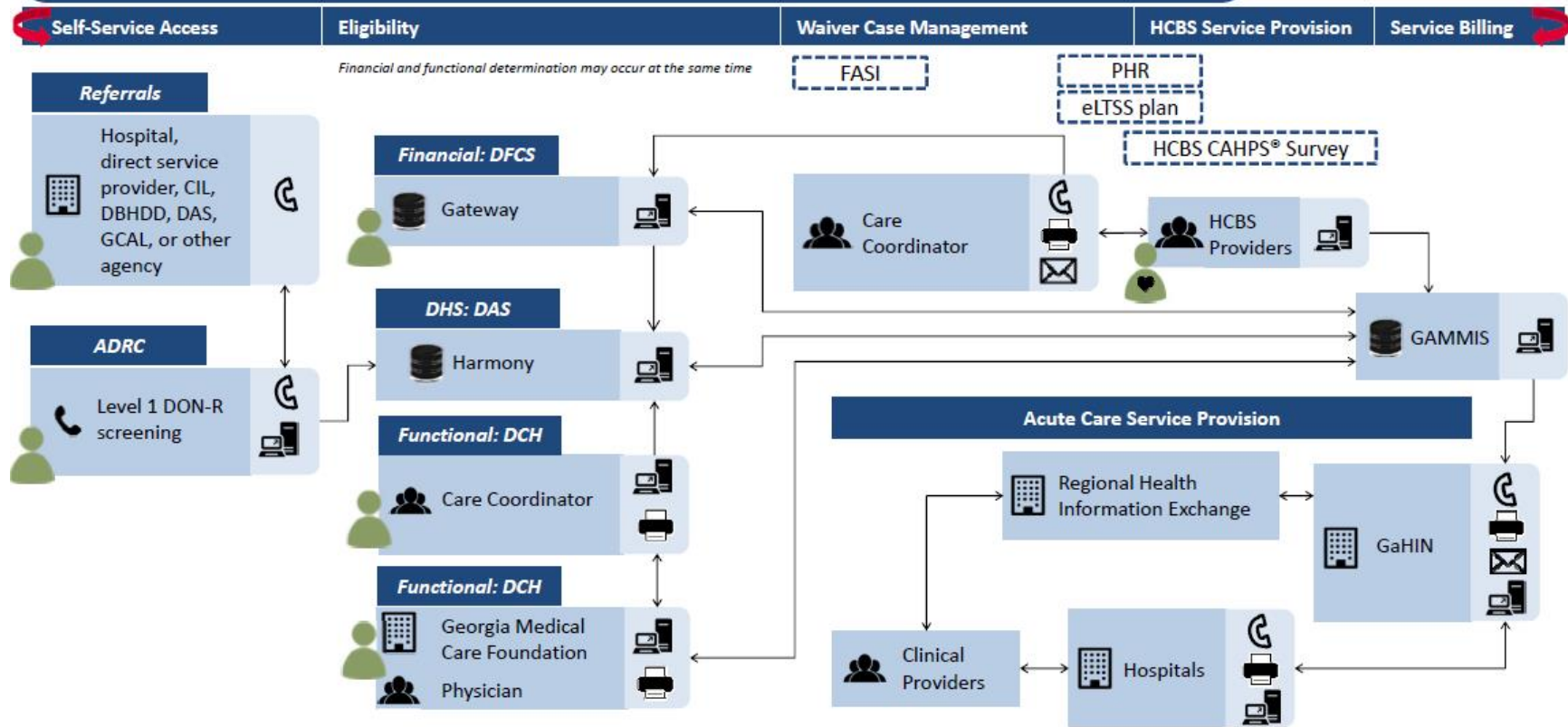
ADRC	Aging and Disability Resource Centers
BIP	Balancing Incentive Program
CFC	Community First Choice
DSS	Connecticut Department of Social Services
I&R	Information & Referral
MFP	Money Follows the Person
MMIS	Medicaid Management Information System





Georgia HCBS Systems Map (1)

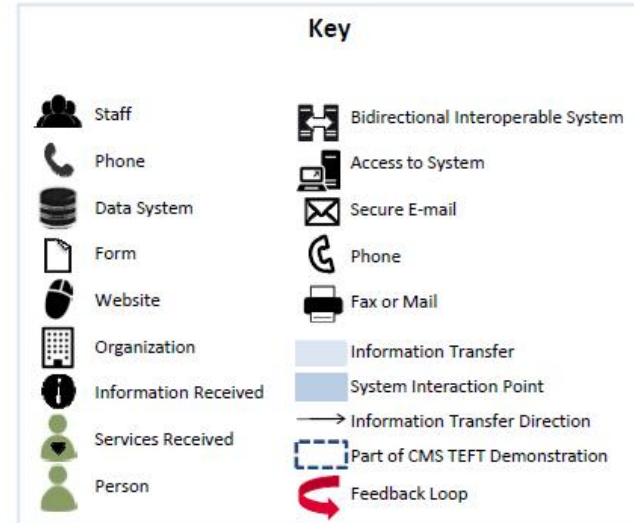
1915(c) Waiver: Community Care Services Program for Elderly Populations and Populations with Physical Disabilities (as of January 2018)



Georgia HCBS Systems Map Description (1)

Community Care Services Program

- **Self-Service Access:** Hospital, direct service provider, CIL, DBHDD, DAS, GCAL, or other agencies refer individuals to ADRC via phone. An individual calls the ADRC Gateway Counselor to discuss options. Receives options counseling. Counselor conducts pre-screen Level 1 DON-R and enters information into Harmony. Harmony replaced the AIMS Database as of February 2017.
- **Financial Eligibility:** DFCS determines financial eligibility. Gateway replaced the Compass and Success system in September 2017. DFCS staff receive a CCSP communicator form via fax or secure e-mail from Care Coordinator.
- **Functional Assessment:** RN conducts in-person assessment (MDS-HC) and determines care plan. Inputs information into Harmony. AIMS was replaced by Harmony as of February 2017. Also inputs LoC, DON-R, and CCP. Faxes physician LoC and CCP for approval. Contacts service provider (by phone) for referral. If provider accepts member, emails provider referral packet (LoC, MDS-HC, CCP). Providers can log into GAMMIS to be transferred to the Georgia Medical Care Foundation system and can download LoC documents.
 - **Physician Role:** Provides medical information for functional assessment. Physician signs LoC and CCP and faxes back.
- **Medicaid Waiver Case Management:** Care Coordinator develops care plan and contacts service provider (by phone, fax, e-mail) for referral.
- **Service Provision:** Provides services and supports in the home and community. After the provider receives referral (phone), the provider conducts and initial evaluation. If provider accepts referral, notify Care Coordinator via CCNF (fax). Receive referral packet via secure e-mail.
- **Service Billing:** Provider submits claims for services to GAMMIS. Individuals can login to GAMMIS. GAMMIS is connected to GaHIN unidirectional.



Acronym Glossary

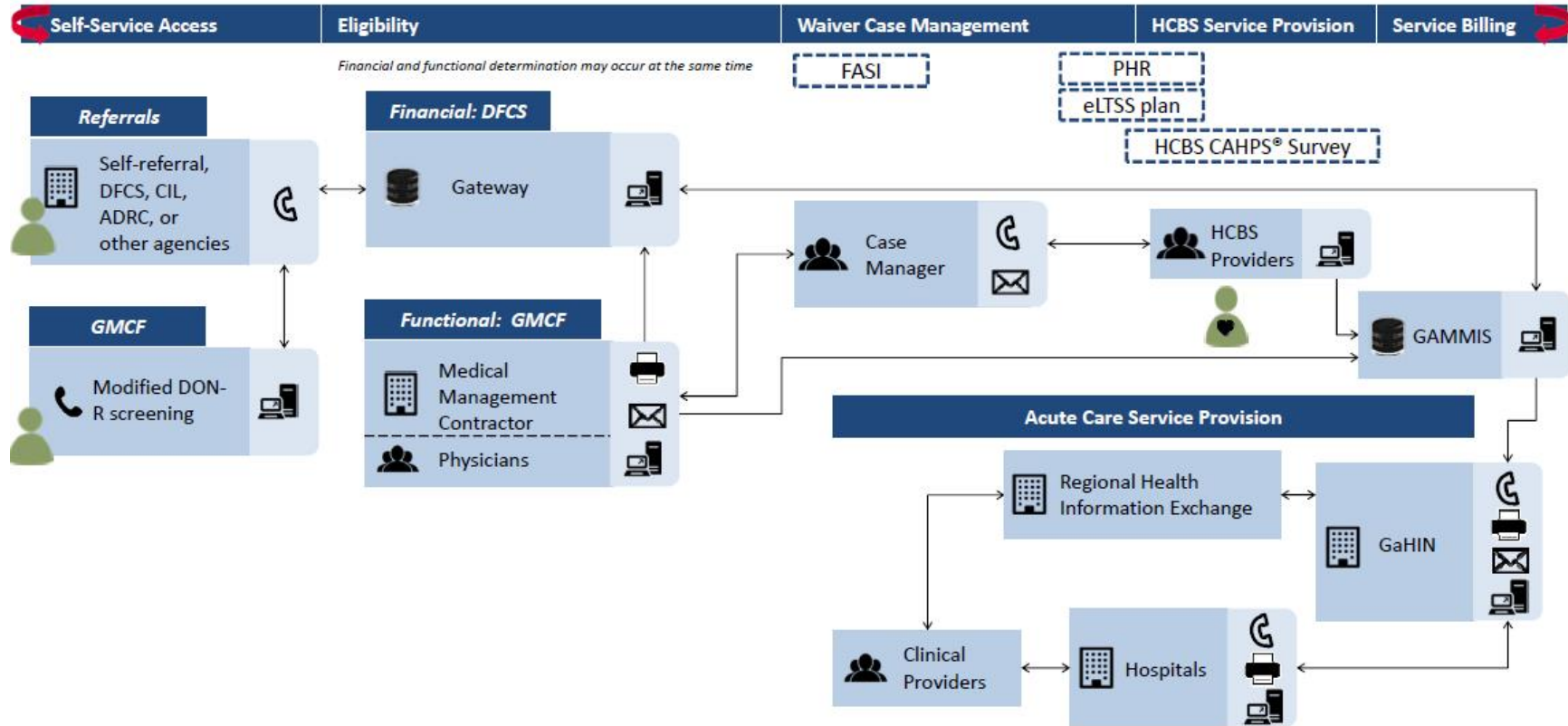
ADRC	Aging and Disability Resource Center
AIMS	Aging Information Management System
CCNF	Community Care Notification Form
CCP	Comprehensive Care Plan
CCSP	Community Care Services Program
CIL	Center for Independent Living
DAS	Division of Aging Services
DBHDD	Department of Behavioral Health and Developmental Disabilities
DCH	Department of Community Health

DFCS	Department of Family and Children Services
DHS	Department of Human Services
DON-R	Determination of Need Revised
GaHIN	Georgia Health Information Network
GCAL	Georgia Crisis and Access Line
GAMMIS	Georgia Medicaid Management Information System
LoC	Level of Care
MDS-HC	Minimum Data Set-Home Care



Georgia HCBS Systems Map (2)

1915(c) Waiver: Independent Care Waiver Program for Populations with Physical Disabilities (as of January 2018)



Georgia HCBS Systems Map Description (2)

Independent Care Waiver Program

- **Self-Service Access:** DFCS, CIL, ADRC, or other agencies refer individuals to GMCF via phone. Numerous avenues into the GMCF to apply for ICWP services. GMCF conducts telephone screening using modified DON-R. If eligible, GMCF mails the applicant an application. After receiving the application back, GMCF schedules a face-to-face assessment.
- **Financial Eligibility:** DFCS determines financial eligibility. Gateway replaced the Compass and Success system in September 2017. DFCS staff receive an ICWP communicator form via fax or secure e-mail from MMC.
- **Functional Assessment:** MMC conducts face-to-face assessment, including the Participant Assessment Form. Develops initial plan of care. Member is placed on waitlist until there are spots available. GMCF sends member list of case managers. Member selects case manager. GMCF securely e-mails member information to case manager. Case manager assists member in obtaining DMA-6 from physician. Sends this back securely to GMCF.
 - **Physician Role:** Physician sends DMA-6 to case manager/member.
- **Medicaid Waiver Case Management:** Selected case manager receives initial member assessment and information. Conducts face-to-face assessment. Sends assessment and individual plan of care to GMCF via secure e-mail. Case manager develops care plan and contacts service provider (by phone) for referral.
- **Service Provision:** Case manager contacts service providers and oversees plan of care. The HCBS providers initiate services after plan of care is approved.
- **Service Billing:** Provider submits claims for services to GAMMIS. Individuals can login to GAMMIS. GAMMIS is connected to GaHIN unidirectional.



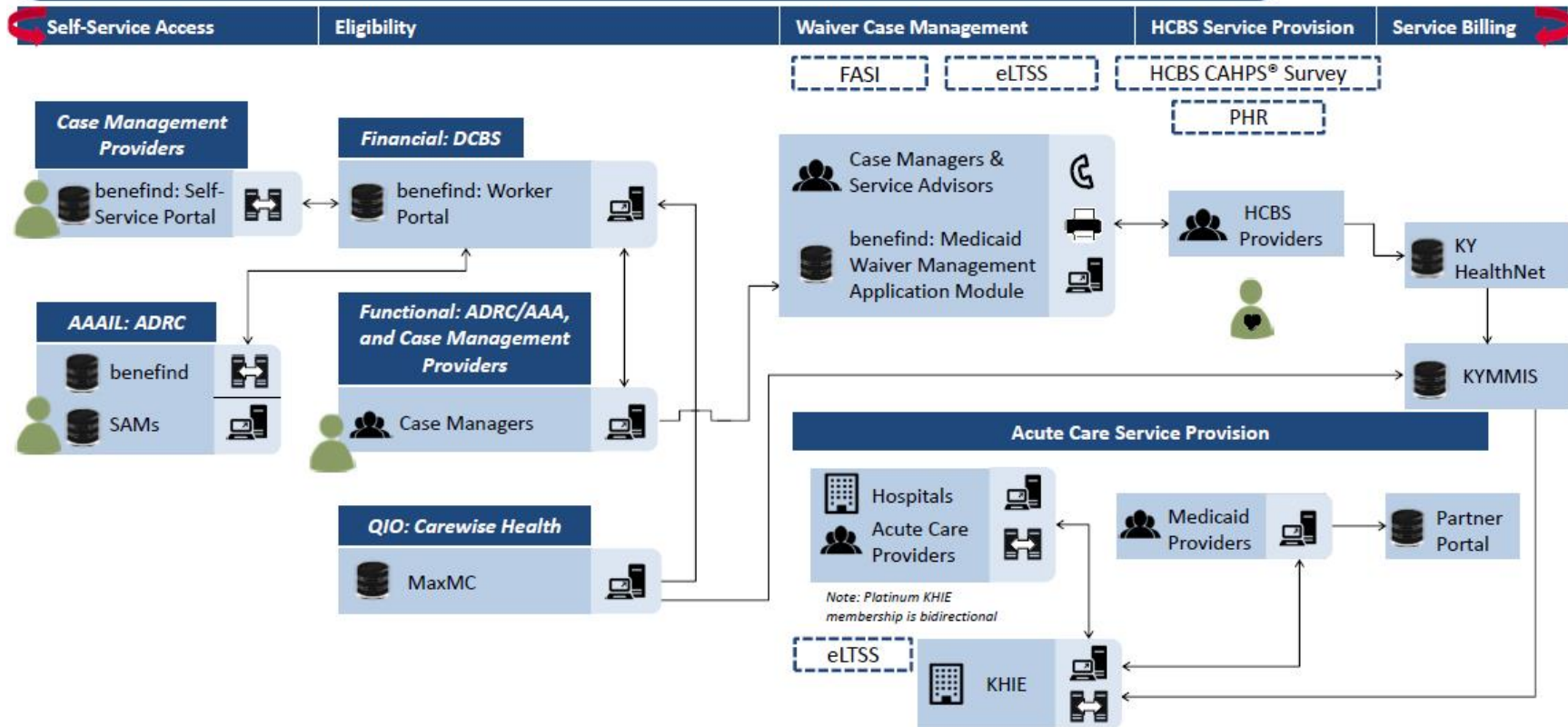
Acronym Glossary

ADRC	Aging and Disability Resource Center	GaHIN	Georgia Health Information Network
CIL	Center for Independent Living	GAMMIS	Georgia Medicaid Management Information System
DFCS	Department of Family and Children Services	GMCF	Georgia Medical Care Foundation
DMA	Department of Medical Assistance	ICWP	Independent Care Waiver Program
DON-R	Determination of Need Revised	MMC	Medical Management Contractor



Kentucky HCBS Systems Map

1915(c) Waivers: Acquired Brain Injury Waiver, Supports for Community Living (SCL) Waiver and Michelle P. Waiver for Populations with I/DD, and HCB Waiver for Elderly Populations and Populations with Physical Disabilities (as of February 2018)



Kentucky HCBS Systems Map Description




















1915(c) Waivers

- **Self-Service Access:** An individual can visit benefitfind: Self-Service Portal website using Kentucky Online Gateway to apply for Medicaid and to submit a waiver application. An individual can also call or visit the ADRC, CMHC, or other waiver case management agency to discuss options. ADRC staff provide information and referral specific to aging and physical disability populations. CMHC staff provide information and referral specific to intellectual/developmental disability and behavioral health.
- **Financial Eligibility:** DCBS uses benefitfind: Worker Portal to determine financial eligibility.
- **Functional Assessment:** Once Medicaid coverage is secured, a LoC assessor conducts the assessment, records the results, and uploads the functional assessment document into benefitfind. The QIO Carewise Health reviews the LoC assessments to determine level of care in the QIO MaxMC system that connects to benefitfind. Benefitfind is also designed for entry and submission of the service plan (completed by the case managers) for review and prior authorization of services (completed by the QIO). Benefitfind interfaces with MaxMC and KYMMIS. For the HCB Waiver, a physician recommends the waiver by completing a Medicaid MAP 10 form and ADRC staff upload this form into benefitfind. Other forms required for each waiver are also uploaded into benefitfind.
- **Medicaid Waiver Case Management:** Case managers update information into benefitfind: MWMA Module. Case managers gather and share consumer information via fax, phone, or secure e-mail with HCBS providers. ADRC/AAA service advisors (case managers for self-direction) gather and share consumer information via fax, phone, or secure e-mail with HCBS providers. The benefitfind: MWMA Module is set up to include access for other service providers but the Kentucky Medicaid office has decided not to open it to other providers until the Kentucky waiver redesign is complete.
- **Service Provision:** HCBS providers receive referrals from case managers and ADRC/AAA service advisors via fax, phone, mail, or secure e-mail. HCBS providers require forms specific to each Waiver from case managers/support brokers before services can begin. The benefitfind: MWMA module includes functionality for access for other service providers, but the Kentucky Medicaid office has decided not to open it to other providers until the Kentucky waiver redesign is complete.
- **Service Billing:** HCBS providers access provider enrollment file online, submit claims for services, and can verify member status via KY HealthNet. KY HealthNet interfaces with KYMMIS. KYMMIS sends all claims to KHIE in daily batch files.

Acronym Glossary

AAAIL	Area Agencies on Aging and Independent Living
ADRC/AAA	Aging and Disability Resource Center, Area Agency on Aging
CMHC	Community Mental Health Center
DCBS	Department for Community Based Services
KHIE	Kentucky Health Information Exchange
KYMMIS	Kentucky Medicaid Management Information System
LoC	Level of Care
MWMA	Medicaid Waiver Management Application, module of benefitfind
QIO	Quality Improvement Organization
SAMs	Social Assistance Management System

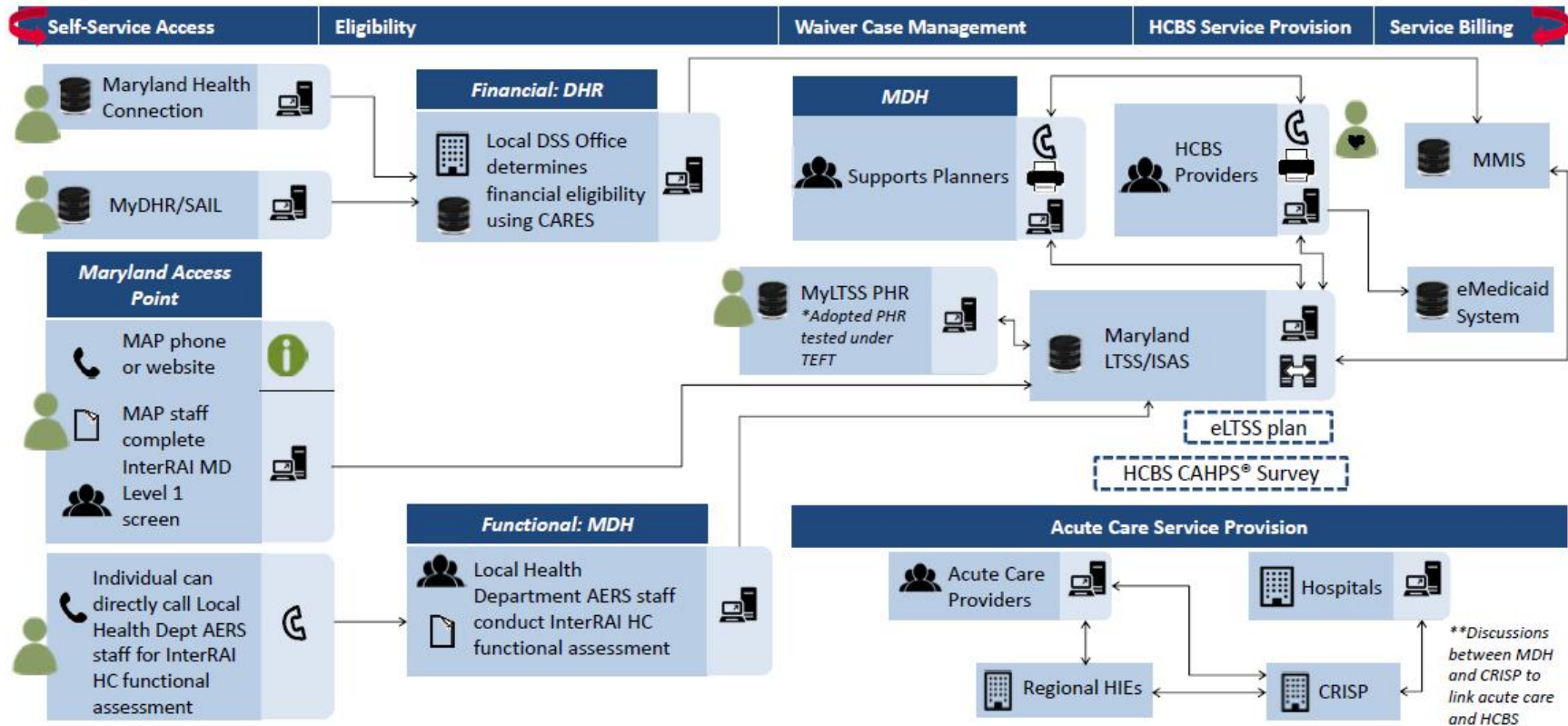
Key

<ul style="list-style-type: none">  Staff  Phone  Data System  Form  Website  Organization  Information Received  Services Received  Person 	<ul style="list-style-type: none">  Bidirectional Interoperable System  Access to System  Secure E-mail  Phone  Fax or Mail  Information Transfer  System Interaction  Information Transfer Direction  Part of CMS TEFT Demonstration  Feedback Loop
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Maryland HCBS Systems Map

1915(c) Waiver: Community Options Waiver for Elderly Populations and Populations with Physical Disabilities (as of February 2018)



Maryland HCBS Systems Map Description




















Community Options Waiver

- **Self-Service Access:** An individual calls the MAP to discuss options or visits the MyDHR website (also referred to as SAIL or the Maryland Health Connection website) to complete the Medicaid application. MAP staff conducts InterRAI Level 1 screen and enters information into Maryland LTSS system. The individual can also call the local AERS staff for the InterRAI HC Functional Assessment.
- **Financial Eligibility:** Department of Human Resources determines Medicaid financial eligibility at the local Department of Social Services offices using CARES. Individuals must be determined financially eligible before the functional assessment is conducted.
- **Functional Assessment:** Local Health Department AERS staff conducts InterRAI HC functional assessment and determines care plan. Inputs information into Maryland LTSS system. The individual must secure Medicaid financial eligibility prior to the functional assessment.
- **Medicaid Waiver Case Management:** Support planners receive referral in Maryland LTSS system, input case notes and use LTSS system to track case management activities. The individual uses the MyLTSS module in LTSS/ISAS to flag services for review.
- **Service Provision:** HCBS providers from agencies provide services and supports in the home and community. HCBS providers use the ISAS phone-based billing system to track service delivery. LTSS/ISAS system are integrated systems with role-based access.
- **Service Billing:** HCBS Providers bill for personal assistance services through ISAS, which processes payments through MMIS. All other waiver services are billed through eMedicaid. Not all providers have access to eMedicaid. Individuals do not have access.

Acronym Glossary

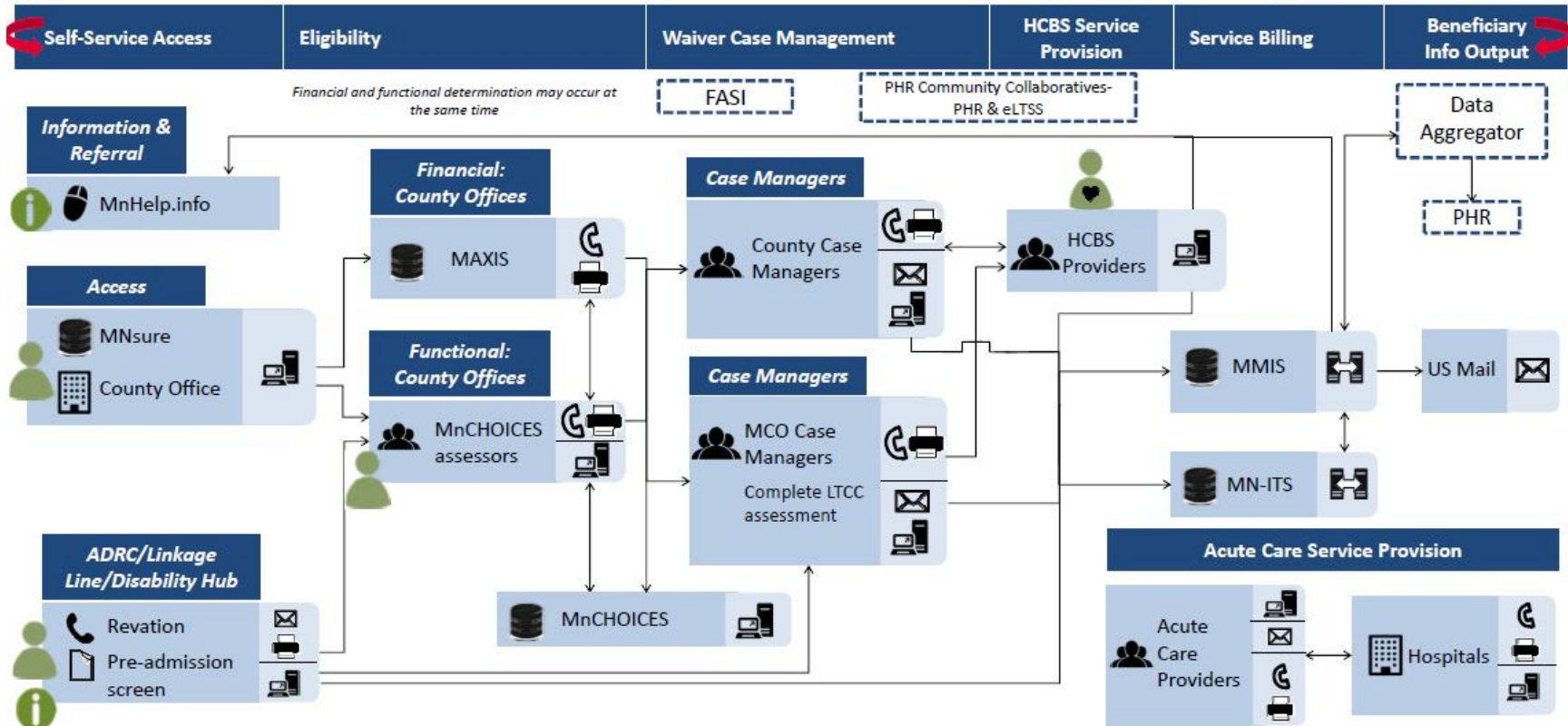
AERS	Adult Evaluation and Review Services
CARES	Client Automated Resources Eligibility System
CRISP	Chesapeake Regional Information System for Our Patients, Maryland Health Information Exchange
DHR	Department of Human Resources
DSS	Department of Social Services
LTSS/ISAS System	Maryland Long-Term Services and Supports/In-home Supports Assurance System
MAP	Maryland Access Point, Maryland Aging and Disability Resource Center
MDH	Maryland Department of Health
MMIS	Medicaid Management Information System
MyDHR/SAIL	My Department of Human Resources/Service Access and Information Link
MyLTSS	PHR tested under TEFT and adopted by state for Medicaid Community Options Waiver beneficiaries (future plans for additional programs)

Key

	Staff		Bidirectional Interoperable System
	Phone		Access to System
	Data System		Secure E-mail
	Form		Phone
	Website		Fax or Mail
	Organization		Information Transfer
	Information Received		System Interaction
	Services Received		Information Transfer Direction
	Person		Part of CMS TEFT Demonstration
			Feedback Loop

Minnesota HCBS Systems Map

1915(c) Waivers: Home and Community Based Waivers for Populations with Brain Injury, Developmental Disabilities, and Elderly Populations (as of February 2018)



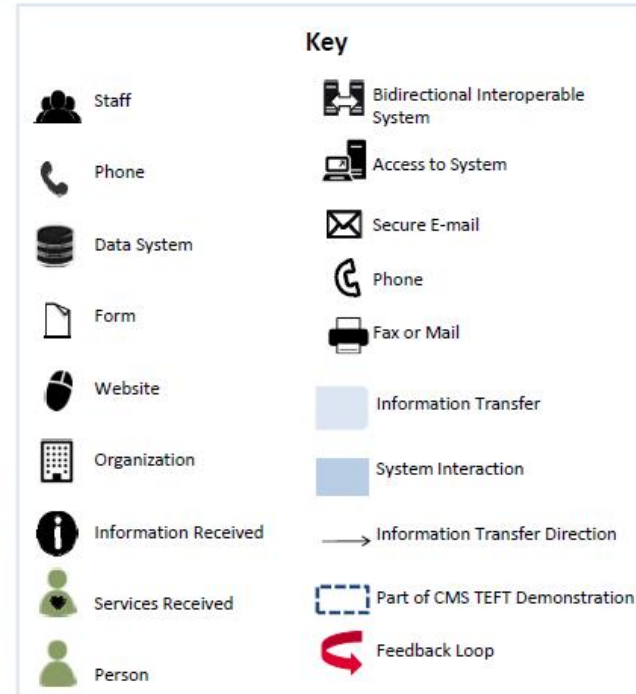
Minnesota HCBS Systems Map Description

Home and Community Based Waivers

- **Self-Service Access:** An individual calls the ADRC/Linkage Lines to discuss options. Regional Call Centers operated by AAAs and Centers for Independent Living for Senior Linkage Line, Veterans Linkage Line and Disability Hub use Revation, a Voice Over IP and secure messaging system. ADRC/Linkage Lines can view MMIS and make referrals for assessments. Based on the results of the pre-admission screen, an individual may be referred to County Offices or MCOs for assessments. Each County Office has an intake system and completes a pre-admission screen. The ADRC communicates using Revation with 37 counties. An individual can access resources via MnHelp.info, a resource database offering information on LTSS and other human services programs, and can apply for Medicaid via MNsure website. HCBS Providers push information to MnHelp.info.
- **Financial Eligibility:** County Offices determine financial eligibility and state and county workers use MAXIS computer system to determine eligibility (links all 87 counties). Financial eligibility may be determined simultaneously with functional eligibility.
- **Functional Assessment:** Certified MnCHOICES assessors (nurse or social worker) from the County Offices complete the web-based assessment. Currently, MnCHOICES is used in all counties. Managed care uses the paper-based Long-Term Care Consultation assessment.
- **Medicaid Waiver Case Management:** Case management software for tracking case notes varies by County or MCO case management agency. County case managers have designated staff to enter service plan into MMIS. MCO case managers conduct LTCC assessment and enter assessment data into MMIS. Case managers access MN-ITS mailboxes.
- **Service Provision:** HCBS providers receive referrals via mail or fax from County or MCO case managers. HCBS providers share service plans back with case managers via mail or fax. HCBS provider agencies use different IT systems to track services delivered. Case managers and providers access MN-ITS for electronic copies of the service agreement.
- **Service Billing:** HCBS providers submit claims for services to MMIS. MMIS interfaces with MNsure, MAXIS, and other Department of Human Services IT systems.

Acronym Glossary

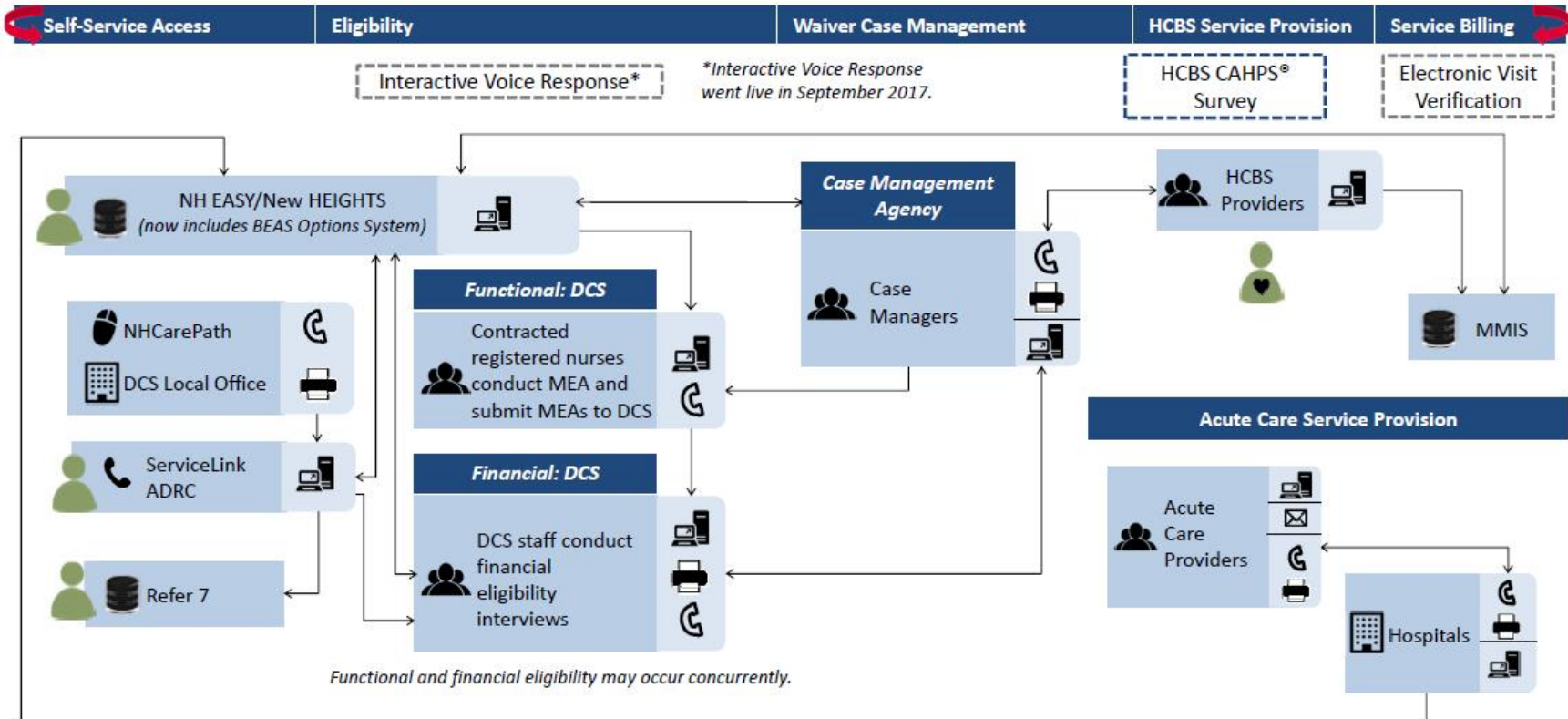
AAA	Area Agency on Aging
ADRC/Linkage Lines	Regional Call Centers operated by AAAs and Centers for Independent Living (Senior, Disability, Veterans) use Revation, a Voice Over IP and secure messaging system
MAXIS	System used by state and county workers to review eligibility for public assistance and health care
MCO	Managed Care Organization
MnCHOICES	Comprehensive web-based application and integrates assessment and support planning for HCBS
MnHelp.info	Resource database offering information on a wide range of community services
MN-ITS	Minnesota Information Technology System; “front end” mailbox of MMIS
MNsure	Minnesota’s health insurance marketplace
MMIS	Medicaid Management Information System; for claims processing and information retrieval





New Hampshire HCBS Systems Map (1)

1915(c) Waiver: Choices For Independence Waiver for Elderly Populations and Populations with Physical Disabilities (as of January 2018)



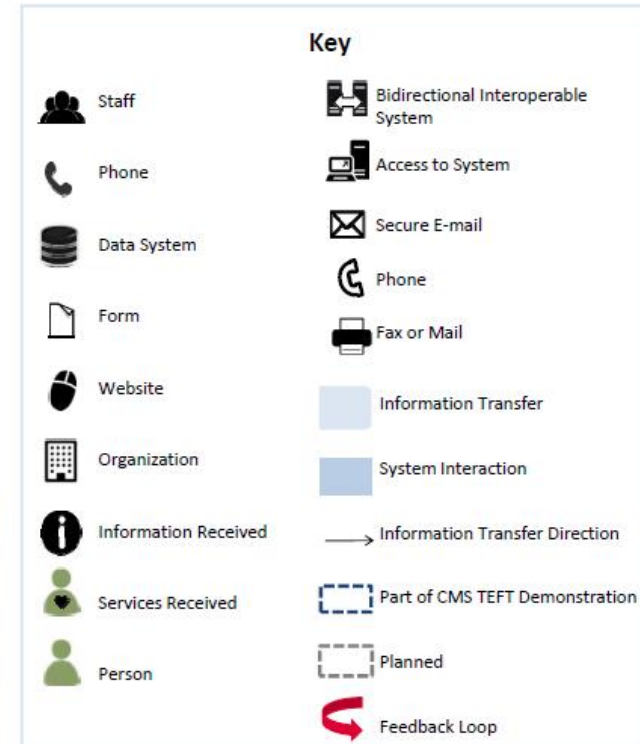
New Hampshire HCBS Systems Map Description (1)

Choices For Independence Waiver

- **Self-Service Access:** Individuals can apply online and screen for potential eligibility for community-based LTSS via New Hampshire EASY Gateway to Services (NH EASY). Individuals access NH EASY to see approval. To access information about services, individuals can call or visit the DCS local office, visit the NHCarePath website, or call the ServiceLink ADRC to discuss options. NHCarePath connects individuals to statewide partners, including DHHS, ServiceLink, Area Agencies, and Community Mental Health Centers. ServiceLink ADRC staff use Refer 7 to provide information and referrals. ServiceLink ADRC staff conduct preliminary screen and Level 1 Screen Form 800 Division of Family Assistance Application. ServiceLink ADRC staff access New Heights to schedule financial eligibility appointments with the DCS.
- **Financial Eligibility:** DCS staff determine financial eligibility in person or via telephone, and input the information in New HEIGHTS. DCS staff conduct in-person interviews at local DHHS offices or ServiceLink offices.
- **Functional Assessment:** Contracted registered nurses complete the electronic MEA and enter information into the New HEIGHTS system (which now houses the BEAS Options System), and which manages medical application status, functional eligibility, and the plan of care. Contracted registered nurses also submit completed MEAs to DCS for review. The MEA is electronic and downloadable for use on a portable device in areas without internet connection. DCS assigns or individual chooses case manager and BEAS Options notifies case management agency.
- **Targeted Case Management:** Case management agencies perform person centered planning, develop plans of care, communicate with the participants, and coordinate service delivery from service provider networks. Case managers request authorizations for providers to provide services in plans of care. Case managers access some New HEIGHTS information via NH EASY.
- **Service Provision:** HCBS providers provide services and supports in the home and community. HCBS provider agencies vary in the IT system used to track service delivery and receive referral from case managers via phone or fax.
- **Service Billing:** Provider submits claims for services to MMIS.

Acronym Glossary

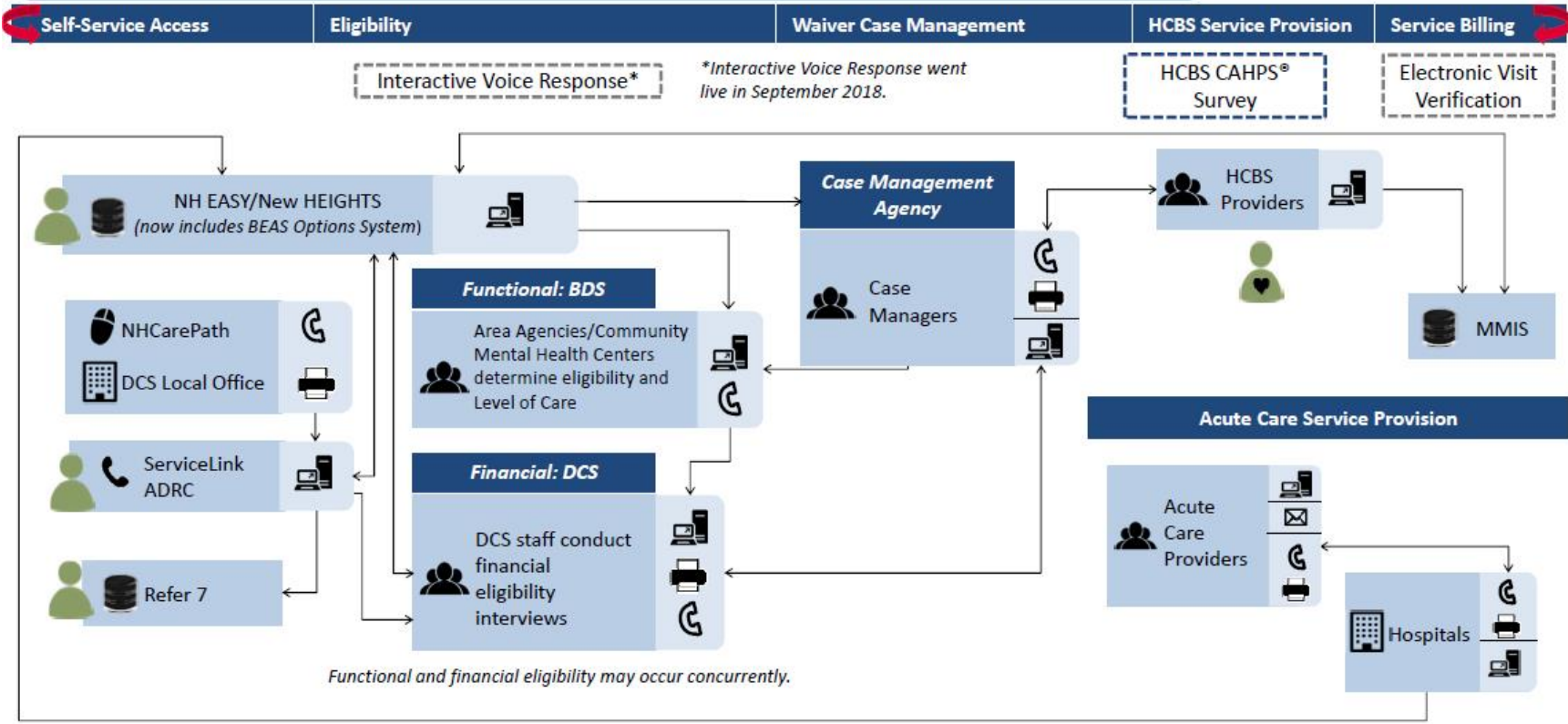
ADRC	Aging and Disability Resource Center, ServiceLink
DCS	Division of Client Services
BEAS	Bureau of Elderly and Adult Services
DHHS	Department of Health and Human Services
MEA	Medical Eligibility Assessment
MMIS	Medicaid Management Information System
New HEIGHTS	Computer system that automates benefit issuance, client scheduling, reporting, and a driver flow for eligibility for 32 programs
NH EASY	New Hampshire EASY Gateway to Services





New Hampshire HCBS Systems Map (2)

1915(c) Waivers: Acquired Brain Disorder Waiver, Developmental Disability Waiver, and Community Mental Health Services for Populations with Severe Mental Illness (as of January 2018)



New Hampshire HCBS Systems Map Description (2)

Acquired Brain Disorder Waiver, Developmental Disability Waiver, and Community Mental Health Services for Populations with Severe Mental Illness




















Acquired Brain Disorder/Developmental Disability Waiver

- **Self-Service Access:** Individuals can apply online and screen for potential eligibility for community-based LTSS via NH EASY. Individuals access NH EASY to see approval. To access information about services, individuals can call local DCS offices, visit the NHCarePath website, or call the ServiceLink ADRC to discuss options. NHCarePath connects individuals to statewide partners, including DHHS, ServiceLink, Area Agencies, and Community Mental Health Centers. ServiceLink ADRC staff use Refer 7 to provide information and referrals. DCS staff and ServiceLink ADRC staff conduct preliminary screen and Level 1 Screen Form 800 DFA Application for Assistance. ServiceLink ADRC staff access New HEIGHTS to schedule financial eligibility appointments with the Division of Client Services.
- **Financial Eligibility:** DCS staff determine financial eligibility and tracks information in New HEIGHTS. Staff conduct in-person or telephone interviews at local DCS offices or ServiceLink offices.
- **Functional Assessment:** Trained providers at one of 10 local Area Agencies determine eligibility through assessment of physical, intellectual, cognitive and behavioral status and an age-appropriate functional assessment.
- **Targeted Case Management:** Case managers at each Area Agency provide case management services and receive referral by phone, fax, or secure e-mail from the referring Area Agency for individuals eligible for ABD or DD Waivers.
- **Service Provision:** HCBS providers provide services and support in the home and community. HCBS provider agencies vary in the IT system used to track service delivery and receive referral from case managers via phone or fax.
- **Service Billing:** Provider submits claims for services to MMIS.

Community Mental Health Services

- **Self-Service Access:** Individuals can apply online and screen for potential eligibility for community-based LTSS via NH EASY. Individuals access NH EASY to see approval. To access information about services, individuals can call local DCS offices, visit the NHCarePath website, or call the ServiceLink ADRC to discuss options. NHCarePath connects individuals to statewide partners, including DHHS, ServiceLink, Area Agencies, and Community Mental Health Centers. DCS staff and ServiceLink ADRC staff use Refer 7 to provide information and referrals. ServiceLink ADRC staff conduct preliminary screen and Level 1 Screen Form 800 DFA Application for Assistance. ServiceLink ADRC staff access New HEIGHTS to schedule financial eligibility appointments with the DCS.
- **Financial Eligibility:** DCS staff determine financial eligibility and tracks information in New HEIGHTS. Staff conduct in-person or telephone interviews at local DCS offices or ServiceLink offices.
- **Functional Assessment:** Providers at Community Mental Health Centers determine functional eligibility for LTSS.
- **Targeted Case Management:** 10 Community Mental Health Centers provide case management services across the state for Medicaid state plan services. Case managers receive referral via phone, fax, or secure e-mail from the referring Community Mental Health Center for individuals eligible for state plan services.
- **Service Provision:** HCBS providers provide services and support in the home and community. HCBS provider agencies vary in the IT system used to track service delivery and receive referral from case managers via phone or fax.
- **Service Billing:** Provider submits claims for services to MMIS.

Key

 Staff	 Bidirectional Interoperable System
 Phone	 Access to System
 Data System	 Secure E-mail
 Form	 Phone
 Website	 Fax or Mail
 Organization	 Information Transfer
 Information Received	 System Interaction Point
 Services Received	 Part of CMS TEFT Demonstration
 Person	 Planned
	 Feedback Loop

Acronym Glossary

ADRC	Aging and Disability Resource Center, ServiceLink
DCS	Division of Client Services
BEAS	Bureau of Elderly and Adult Services
DHHS	Department of Health and Human Services
MEA	Medical Eligibility Assessment
MMIS	Medicaid Management Information System
New HEIGHTS	System that automates benefit issuance, client scheduling, reporting, and a driver flow for eligibility for 32 programs
NH EASY	New Hampshire EASY Gateway to Services