

Reinventing Medicaid Working Group Meeting #6

June 24, 2015



Table of Contents

Analyzing the Proposed Principles	2
<i>Principle 1: Pay for value, not for volume</i>	2
Silent Brainstorming Input (via index cards)	Error! Bookmark not defined.
Group Discussion at Breakout Stations	3
<i>Principle 2: Coordinate physical, behavioral, and long-term health care</i>	4
Silent Brainstorming Input (via index cards)	Error! Bookmark not defined.
Group Discussion at Breakout Stations	5
<i>Principle 3: Rebalance the delivery system away from high-cost settings</i>	5
Silent Brainstorming Input (via index cards)	Error! Bookmark not defined.
Group Discussion at Breakout Stations	6
<i>Principle 4: Promote efficiency, transparency, and flexibility</i>	7
Silent Brainstorming Input (via index cards)	Error! Bookmark not defined.
Group Discussion at Breakout Stations	8
<i>Any Missing Principles?</i>	9
Analyzing the Proposed Goals	9
<i>Principle 1: Pay for value, not for volume</i>	9
Silent Brainstorming Input (via index cards)	Error! Bookmark not defined.
Group Discussion at Breakout Stations	10
<i>Principle 2: Coordinate physical, behavioral, and long-term health care</i>	11
Silent Brainstorming Input (via index cards)	Error! Bookmark not defined.
Group Discussion at Breakout Stations	12
<i>Principle 3: Rebalance the delivery system away from high-cost settings</i>	12
Silent Brainstorming Input (via index cards)	12
Group Discussion at Breakout Stations	13
<i>Principle 4: Promote efficiency, transparency, and flexibility</i>	13
Silent Brainstorming Input (via index cards)	13
Group Discussion at Breakout Stations	14
Public Comment	14
Graphic Facilitation	15
Other Pictures from the Session	15

Analyzing the Proposed Principles

Principle 1: Pay for value, not for volume

Silent Brainstorming Input (via index cards)

What are the benefits?

- Focus on outcomes
- Targets efforts on high cost measures
- Providers are rewarded for quality, not seeing/doing as much as possible
- Better care at lower costs
- Better coordination
- Value should increase better outcomes, which should benefit the customer and the system
- Reduce waste, unnecessary care
- Create new incentives for population health
- Eliminate incentives for over utilization
- Value is what we want for consumers if value means quality. We want to use Medicaid dollars wisely so “value” in what we buy is critical.
- Allow space for innovation and care focused on outcomes
- Alignment of payment with desired outcome
- Reduce cost – help drive coordinated care and serving the “whole patient”
- Motivates providers toward quality outcomes
- Encourages appropriate length of stay in settings
- Encourages collaboration for providers in different sectors to work together
- Resources used are most effectively utilized for best outcomes
- Incentives better aligned
- Over-utilization/treatment is bad for patients too
- Paying for volume means no coordination
- Reducing costs increases access to coverage
- Pay tied to outcomes or performance measures (i.e., value)
- Increase quality leads to better outcomes
- Less wasted
- More money for more important things
- Drive changes in delivery system

What considerations should we keep in mind?

- Not all providers are created equal and do not start in the same place
- Some volume helps drive value
- Impact on access
- Quality, quality, quality
- Trust
- Role of MCOs in direction
- Providers need to be kept financially whole, so they can afford to see less volume
- Providers need direct real time access to their value feedback so they can make changes as needed
- Savings need to be used for social determinants
- Patient choice
- How to establish outcomes
- Can't do it all at once
- Major consideration is how we define value so we are sure we aren't compromising quality. Also sometimes “volume” is related to access, so make sure to consider access.

- Risk adjustment. How to account for impact of socioeconomic factors on outcomes.
- Separate insurance from performance risk
- Build on current initiatives and efforts as well as new models, ensuring that patient needs are met—that consumer satisfaction, patient directed care and considering the non-“Medical” needs that are critical to good health (a safe home, transportation, adequate food) are part of “value”
- How do we define value? What outcomes?
- Some high risk populations don’t have basic needs like housing
- Access to care still important
- Reducing “volume” can create access problems
- Defining “value” is hard, and can have unintended consequences (e.g., more access problems for very sick patients)
- How to determine “value”
- Done poorly, decreased cost will decrease quality
- Threatened specialists

Group Discussion at Breakout Stations

Benefits

- Better outcomes: patient health
- Reduce excess utilization (20-30% excess) without reducing value
- Value should mean quality
- Use savings to reinvest
- Performance vs. insurance
- Build capacity and data management
- Access is key
- Paying for value (impact on managed care)

Considerations

- Patient choice
- Ensure the tangible value
- Change incentives (change curve)
- Define outcomes: positive propositions
- Actual conscious change
- Mixed models
- New payment models
- Total cost of care and affordability
- Different ideas of value
- Flexibility models
- Encourage participation
- Cater to system
- Quality measurement
- Keep it simple—don’t reinvent
- Balance via data
- Reporting
- Non-medical needs (e.g., transportation, food, shelter)
- Health equity zones with Medicaid
- TACO
- Control outcomes
- Leave room for innovation
- Global
- Best options
- What do we mean by value?
- Get the formulas right

- Monitor results
- Keep protections/safeguards
- Scope finance, education

Principle 2: Coordinate physical, behavioral, and long-term health care

Silent Brainstorming Input (via index cards)

What are the benefits?

- Treat whole person – Reduce fragmentation
- Treat whole patient
- Better health outcomes
- Lower costs
- More fun for providers!
- More humane
- Efficiency, Effectiveness
- Less hospitalization
- Better service at the time of need
- Can't take head away from body – whole person
- Coordination can save money
- Behavioral health long overdue – neglected as part of total care
- Overall behavioral and physical health affects lifelong health and outcomes – start early, start good habits i.e., invest in children and the reap will be productive cost effective healthy adults
- One body – coordination will improve care
- Treat whole person
- One body, one life→Needs one care system
- Patient centered
- Treating the whole patient through broad lifecycle

What considerations should we keep in mind?

- Attention to social determinants related to health
- Who is in charge?
- Consider adding dental—which is an important aspect of good health
- How? How to evaluate? How to keep on course?
- The expectation is that once this council is over we can have everyone talking together
- In RI, people need to learn to play well in the sand box
- Systems and providers not equally capable
- Hard to define field and rules of game
- This is hard—co-integration is labor intensive and takes time and resources
- Be sure there is the capacity at practice level to be able to truly coordinate physical and behavioral health well
- Need cross institutional incentives (i.e., Hospitals, SNFs, Nursing Homes) with same incentives
- Who will coordinate the coordinators?
- Nursing home care is not as expensive as indicated current care (pay less than \$7 per hour)
- How will consumer choice be handled?
- Encourage beneficiary accountability with wellness
- Integration of partners not historically connected (CMHCs, EDs, EMs, FGHC, etc.)
- Site for services needs to be considered
- It is really hard work; need to reward it

- Payment score

Group Discussion at Breakout Stations

Benefits

- Cost effective
- Coordination is key
- Effective and efficient
- Treating the whole person
- Gets away from siloed approaches
- Better patient-centered health outcomes
- Look to health centers for models to emulate (e.g., Hasbro Children's Hospital)
 - Taking care of whole child on same floor
 - Challenge: aligning program with workable reimbursement model

Considerations

- Reducing the burdens of coordination
 - Want to do it, but lack tools/incentives to do it
 - Must create team incentives
- Difficult to co-integrate (workforce/capacity challenges)
- Sharing information and other barriers are tough to navigate
- How to bring in all relevant stakeholders needed to make efforts successful
- Include substance abuse
- Coordination

Principle 3: Rebalance the delivery system away from high-cost settings

Silent Brainstorming Input (via index cards)

What are the benefits?

- More person-centered settings
- This absolutely needs to be done to improve quality of care (and quality of life) and to reduce cost, especially of the 77% of users taking up 2/3 of the money
- Right place and right time
- Keep people at home
- Patients like it
- Better care for the people for the providers to know them and work with more closely
- Better for patient
- Lower costs
- Reduce costs
- Repurpose inpatient assets
- Save funds where needed
- Better service
- More care at home
- People want to stay in own home or in community vs. institutionalized care – until they truly need 2years (7 care – supports what people want)
- Need strategies to reach isolated seniors
- Community based care
- Continuity – chronic conditions are rarely improved through high ED utilization
- Care provided where patients prefer it most, especially the home

- Better use of scarce money
- Better distribution of limited financial resources
- Patients are often happier and heal faster when at home
- Savings couples with better outcomes
- Member satisfaction

What considerations should we keep in mind?

- Not always less costly
- Consider what we need in place as we shift to lower cost settings
- Expedite eligibility for low entry into the system
- Allow housing providers to also provide supportive services
- Need to select patients well!
- Can hurt hospitals and other high cost settings if not done thoughtfully
- Quality of care not enough supportive in-home care
- Right setting, right care
- Capacity analysis
- Not eliminate necessary services
- Some people need high cost settings, sometimes
- To succeed with goal of helping people stay at home with less—need to bring in other parts of government—affordable housing, for example. It is not just a Medicaid issue.
- How to maintain/right size necessary local infrastructure, and what does “necessary local infrastructure” mean?
- Resources need to be in place to facilitate this
- Investments needed in human capital
- There needs to be enough community resources to help keep patients in lower cost settings and access (i.e., extended office hours, more UNA and home health aides)
- Provider resistance
- Regulatory barriers
- Limited capacities
- Need to understand market shifts and business models

Group Discussion at Breakout Stations

Benefits

- When we do this right, we repurpose capacity
- Anticipated outcomes increase (increase by two member expansion)
- Right care—most appropriate setting at right time
- Enable option to choose; accept risk
- Person-centered settings
- Care is provided where families want it (“home”)
- Better use of scarce resources
- Setting high expectations
- Give flexibility together (no “same size”)
- Listen to family preference
- Community based=Access (vs. institution)
- Offers more effective options for chronic diseases than ED
- What care (preference) for lower acuity
- Most do this to address high utilizers

Considerations

- Need state health care capacity planning process
- Winners vs. losers (micro/macro)

- Need for cultural competency
- Accountability of high cost settings to manage costs
- Affordable housing is a factor here too, not just Medicaid
 - Allow housing providers to provide other services and support
- Transportation
- Infrastructure
- Flexibility—how does “state” know best setting
- Provider resistance—allow room/flexibility
- Innovation in HCBS=need revenue to trigger innovation
- Real bureaucratic barriers
- Challenge: institutional workforce-union; HCBS-not
- May not know current options/policies
- Opportunities to shift some accountability to members
- Expand where it’s working; This is a HUGE resource shift (people)
- Workforce: adequate direct care wages

Principle 4: Promote efficiency, transparency, and flexibility

Silent Brainstorming Input (via index cards)

What are the benefits?

- Being flexible is always beneficial
- Squeeze money out of the system
- Efficiency, transparency, and flexibility are all good. Flexibility will make money go further.
- Better utilization of resources
- Flexibility to repurpose assets
- Informed consumer markets
- Provide what persons need, not just what regulations/rules say can be paid for
- Rules need to be clear
- Knowledge and empowerment
- One size does not fit all
- Everyone will better buy in to the process
- Achieve value more quickly
- Align incentives
- Easier to measure and monitor improvements
- Transparency can create accountability for some, where payment (rewards, punishment) is not effective
- Flexibility in waiver programs would open more opportunity
- Show that state investments in Medicaid are being wisely used—to counter that MA is using up too much of the budget. Make this case as talking about “waste, fraud, abuse.”

What considerations should we keep in mind?

- Transparency is not always as transparent as we would assume
- High expectations, and need for capacity to deliver on them
- Recognize those already efficient
- Make sure in getting to efficiency we don’t curtail needed services
- How to do it
- Adds confusion until more systems of care (SOC) are in operations
- Consumer/person should be engaged in planning and truly understand choices and be aware of risk of decisions
- Tools and skills needed to understand complex issues
- Trade secrets

- Sometimes hard to keep people's individual agendas away from the core committee work
- One size does not fit all, especially for complex patients
- Not clear what this means in practice
- "Flexibility" can open door to nefarious conduct
- Risk adjustment for populations served by different populations
- Turnaround time on Medicaid eligibility determinations
- The need to maintain at least current eligibility levels for Medicaid because we have an insurance based system for accessing care

Group Discussion at Breakout Stations

Benefits

- Encourage experiments (Don't be afraid to pilot innovative solutions)
- One size does not fit all
- If achieved, shows value of Medicaid
- Learn from each other (best practices)
- Recognize places we are efficient and build on them (e.g., Rite Care, Parent Information Network)
- Transparency creates accountability
- Transparency: Knowledge is empowering (e.g., why doing, what doing, cost) and enables better decisions
- Transparency helps consumers understand choices (evaluation measures)
- Need for price and quality transparency
- Need systemic buy-in above patients too
- Integration (e.g., integrated behavioral health) – a person or family should be able to easily access information about all services/options available and have a straightforward process for eligibility
- Efficiency can bring many people together. What is the role of Primary Care? Who makes decisions?
- Blending of care to make appropriate decisions

Considerations

- Concerns regarding regulating for outliers
- Need to simplify system – rules need to be clearer and more consistently communicated
- Challenges to automation (don't overreach)
- Don't sacrifice capacity in the name of efficiency; capacity important for quality
- Inconsistencies in different systems/channels
- State as purchaser but not user. What role does price pay?
- Clear rules needed
- State role: Turnaround time can delay needed service
- "Efficiency" needs clear targets
- State should be promoting efficiency, transparency, and flexibility
- Population has trouble with health literacy
- Contracts considered industrial secrets
- Use of technology (room for growth)

Any Missing Principles?

- Equity should include decreased disparity (which includes decreased costs)
 - This will help lead to improved population health
 - Equity should be across education, language, etc.—Are we providing culturally competent care across *all* populations? This is important for all care, not just Medicaid. Medicaid can be a model for this
- Should there be a principle specifically about quality
- Access
 - Enough providers to drive the shift needed?
 - Includes access to oral health too
- Patient-centric; patient experience
- Note – the principles that will be highlighted in the next Working Group report are specific to Medicaid reform (vs broad public health principles)

Analyzing the Proposed Goals

Principle 1: Pay for value, not for volume

- a. **Goal: Substantially transition away from fee-for-service models**
 - i. **80% of Medicaid payments through value-based payment arrangements by 2018**
 - ii. **50% of Medicaid payments through alternative payment models by 2018**
 - iii. **25% of Medicaid members enrolled in an accountable care network by 2018**
- b. **Goal: Define Medicaid-wide population health targets, and, where possible, tie them to payments**

Silent Brainstorming Input (via index cards)

What do you like about these goals?

- High expectations (i.e., 80% and 50% targets), but might be too aggressive
- Still not sure what “value based payment arrangements” means
- Make that goal more clear if that means managed care—I am in favor of quality Medicaid managed care
- Targets are set—but no clear data on evidence that alternative payments models increase value (there are many definitions of “value”)
- If value is well defined, they are okay
- Delivers change
- Aggressive if done right
- That we have set targets to work towards
- Very aggressive; some change
- Align with what is happening nationally
- Medicaid-wide population health targets—identify and help folks connect to the care they need
- Like that including population health targets

How might you change these goals to better achieve the principle?

- Aren't value-based payment and alternative payment aligned concepts?
 - Value-based arrangements and alternative payment are the same yet different
 - The terms “value-based” and “alternative payment models” need to be carefully defined
 - Value-based payment and alternative payment modes→Same thing?
- Too heavily dependent on definitions. Goals can be very fuzzy depending on exact definition of accountable care network, alternative payment models, and value-based payment

- Not clear what the definitions mean: “alternative payment models,” “value-based payment,” and “accountable care network” mean...
- Assumes accountable care networks are effective
- How do you hold accountable?
- Make sure definitions and requirements are flexible enough to handle different capacities and creativity
- Also—what is “alternative payment model”?
- Also, be sure that the 25% in ACOs are the populations that are biggest cost drivers rather than the ones that are already well managed/good value such as RICARE members
- Be careful modeling this after a Medicare/Manual Care ACO—Medicaid population is much different—high risks due to lack of basic needs
- Reverse it to say only 20% fee for service for more flexibility with a percentage of alternative payment programs
- Do not prescribe VBC/alternative payments programs—set outcomes and guiding principles not details
- New payment models must preserve ACCESS
- No clue if these targets are realistic. Where are we now?
- OHIC engaged in long data-driven process to set its targets
- Define fee for value
- Make payment systems cross provider silos
- Start from proposition that there is more than enough money in the system in total
- Second goal is much too vague—by when? For what, to be used in contracting?
- Might be easiest to say less than 20% payments strictly volume-based by 2018 rather than above. Requires less definition work.
- Tension between too fast and not fast enough
- I think we can move more than 25% into ACO before 2018
- Should identify changes to improve “value” vs. “volume” within current 2-MCO environment and take advantage of fact that one MCO is provider owned.
- 77% of population is managed care—Not FFS. Targets from other states or insurers (e.g., Medicare) are starting from true FFS. So don’t say “transition from” but set goal as what want to achieve to move from current MCO-based system.

Group Discussion at Breakout Stations

- Clear-cut definitions
- Define top 2% goals to prevent dilution
- What is value-based vs. alternative?
- Current state to jump off from
- Amount of scale
- Credibility
- Shouldn’t cost anything to change fee-for-service
- Payments solely based off volume or a percent
- What level of system get paid x amount (Define and detail payment methodology)
- Status of provider and payments
- Changing payment models to work efficiently
- Goal of access (preserve)
- Incentives and disincentives
- Balance speed and efficiency for developing
 - Aggressive goals
 - Achievable

Principle 2: Coordinate physical, behavioral, and long-term health care

- a. **Goal: Maximize enrollment in integrated care delivery systems**
 - i. **90% of Medicaid long-term care beneficiaries enrolled in managed care by 2018**
 - ii. **90% of Medicare/Medicaid dual-eligibles enrolled in integrated managed care by 2018**
- b. **Goal: Coordinated, accountable care for high-cost/high-need populations**
 - iii. **100% of Medicaid beneficiaries with an SPMI diagnosis enrolled in an accountable health home by 2018**
- c. **Goal: Ensure access to high-quality primary care**
 - i. **Align with OHIC standards for PCMH enrollment target**
- d. **Goal: Leverage health information systems to ensure quality, coordinated care**
 - i. **75% of Medicaid members enrolled in CurrentCare by 2018.**

Silent Brainstorming Input (via index cards)

What do you like about these goals?

- 90% good for managed care; same with 90% duals
- We have seen Medicaid managed care work well (kids) and can for other populations
- Need to take advantage of Health Centers
- Targets—but need to align targets with customer satisfaction—MCO needs to be high performing
- Managed care can be flexible and recognizes it sometimes needs to increase payment for complex needs
- CurrentCare goal is good!
- Ambitious
- Bias toward coordinated, patient centric system development
- Targets are good to have; some might be aggressive
- Aggressive
- Forces change
- Specific
- 100% of Medicaid beneficiaries into Accountable health homes by 2018

How might you change these goals to better achieve the principle?

- Argue with all other goals above except the first one
- Opt out to FFS? Flexibility in rules?
- Provider resistance?
- 90% of Medicare/Medicaid dual-eligibles enrolled in integrated managed care by 2018: Need mandatory enroll to do this
- Need to address provider enrollment in CurrentCare—not just members of MCO
- Lack of choice for long term care population in managed care insurer
- Health homes need to go to next level—include medical and behavioral health; current model not accomplishing
- OHIC PCMH Standards=spend in primary care; Not 100% transferable to Medicaid; FQHCS-PPS system
- Access to all care as a standard, not just Primary Care (PCP, Specialty, BH, Dental)
- 100%? What if patient has a psychiatrist who's not a health home?
- Get OHIC out of the policymaking business; Centralize health policy at HHS
- Seems like just another way to describe principle 1 goal
- Align OHIC standards with transformation goals
- Goal 3 could be more specific
- Enrollment in CurrentCare is good, but need to use the data
- Make a stretch to include Affordable Housing/Recovery housing available, even covered, for these people if needed

- Where are we starting from?
- Add dental goal—access to oral health for adults
- Add goal regarding children behavioral health
- Add build on CHC network, which is providing integrated care

Group Discussion at Breakout Stations

- Including children with SED, not just adults with SDMI
- Must be willing to have mandatory enrollment
- High opt-out rate in Phase I; need to be reasonable about expectations (not aligned with rules)
- Need a goal related to FQHCS
- CMHCs
- Outcome measurement
- Access not addressed
 - Payment rates to manage access

Principle 3: Rebalance the delivery system away from high-cost settings

- a. **Goal: Shift Medicaid expenditures from high-cost institutional settings to community-based settings**
 - i. **50% of Medicaid long-term care spending in HCBS by 2020**
 - ii. **Achieve year-over-year declines in hospital inpatient admissions per thousand members**
 - iii. **Achieve year-over-year declines in ED utilization**
 - iv. **Align Medicaid primary care spending target with OHIC targets**
- b. **Goal: Encourage the development of at least three accountable integrated long-term care provider entities**

Silent Brainstorming Input (via index cards)

What do you like about these goals?

- Sets targets
- Social determinants are key to rebalancing the system; how can RI think more globally for the overall health and wellbeing of Medicaid recipients?
 - Transportation
 - Housing
 - Employment skills
 - Workforce training
 - Banking access
- Agree with 50% goal for HCBS; to get there successfully, need to urgently build capacity for quality HCBS
- Second goal assumes accountable integrated long-term care provider entities are better
- Right targets
- Goal a1 is specific but others are not; all goals should be measurable, quantifiable
- Great goals but we need system capacity to support
- Community based settings are better for people

How might you change these goals to better achieve the principle?

- Payments for HCBS need to increase and recognize differences in acuity in adult day health
- Need to offer and support investments to strengthen HCBS and community services
- Add readmission rate
- Total cost of care=Behavioral health + Med + Pharm.+ Dental
- Capacity issues

- Flexibility in rules
- Save interim goals around investment needed to achieve rebalancing
- Where are we now on primary care spend target?
- Need more specificity to targets
- Encourage/incentivize Medicaid ACOs
- Set specific target for the three targets listed below the first goal (Achieve..., Achieve..., and Align...), or at least set a goal to set a target
- Tie OHIC spending targets to improvements in general
- Should there be bed goals for the state
- I don't want to make nursing home beds or long-term beds unavailable for people
- "50% of Medicaid long-term care spending in HCBS by 2020" – For which populations?
- "Align Medicaid primary care spending target with OHIC targets" – Where are we starting from?

Group Discussion at Breakout Stations

Shift Expenditures

- Like: 50% HCBS = good
- Change: 50% HCBS...or more? 60%

Encourage Development of Integrated LTC Provider Entities

- Need HCBS capacity—may not be "integrated"
- Why? Why is this solution considered the "answer"

Summary: Agree with aggressive goal to shift capacity. Not sure that integrated LTC is the solution.

Principle 4: Promote efficiency, transparency, and flexibility

- a. **Goal: Improve operational efficiency**
 - i. **Member satisfaction target**
 - ii. **90% of eligibility decisions made within 45 days**
- b. **Goal: Provider quality transparency**
- c. **Goal: Program integrity**
 - iii. **Ensure that 99% of Medicaid payments are accurate and timely**

Silent Brainstorming Input (via index cards)

What do you like about these goals?

- Efficiency vs. capacity
- 45 days could mean a 45 day delay in getting access to care that is needed immediately
- Member satisfaction target is good, but how is satisfaction quantified?
- Ensure that 99% of Medicaid payments are timely then maybe we will get a "Yes I'm accepting New Patient Answer" when we call

How might you change these goals to better achieve the principle?

- Use existing metrics; do not reinvent the wheel
- For the 99% target for the final goal, 1% error rank? With new payment models and value-based?
- Eligibility within 45 days not ambitious enough
- Eligibility should be presumed for timely access to care, state takes the risk and goes after applicant if bad info is given in application
- Not sure what 45 days compares to—still seems like a long wait
- Seems odd to have a 99% goal—either go for 100% or make it realistic (95%)
- Program integrity→If move to MCO, this occurs—it's a FFS issue
- With CHIP, most MAGI decisions should be very fast. This 15-day goal is not nearly ambitious enough, unless it's specific to LTC/non-MAGI
- "Provider quality transparency" is too vague

- “90% of eligibility decisions made within 45 days” – How about 80% decisions real-time? (or something like that)
- What’s the member satisfaction target—95th percentile? 90th?
- Define quality transparency; how do you measure that?
- Need more focus on how easy the Medicaid benefits are to understand
- Simplify the “system” for participants
- The value survey data should be available to providers in a timely fashion too
- I think members should be encouraged to report at every appointment how they were treated/cared for (i.e., if customer survey is bad, contract ends)
- “90% of eligibility decisions made within 45 days”—30 days for Medicaid for LTSS. Add: Access to LTSS on expedited basis.

Group Discussion at Breakout Stations

Benefits

- Member satisfaction
- Provider transparency
- State recognizes need for eligibility timeliness

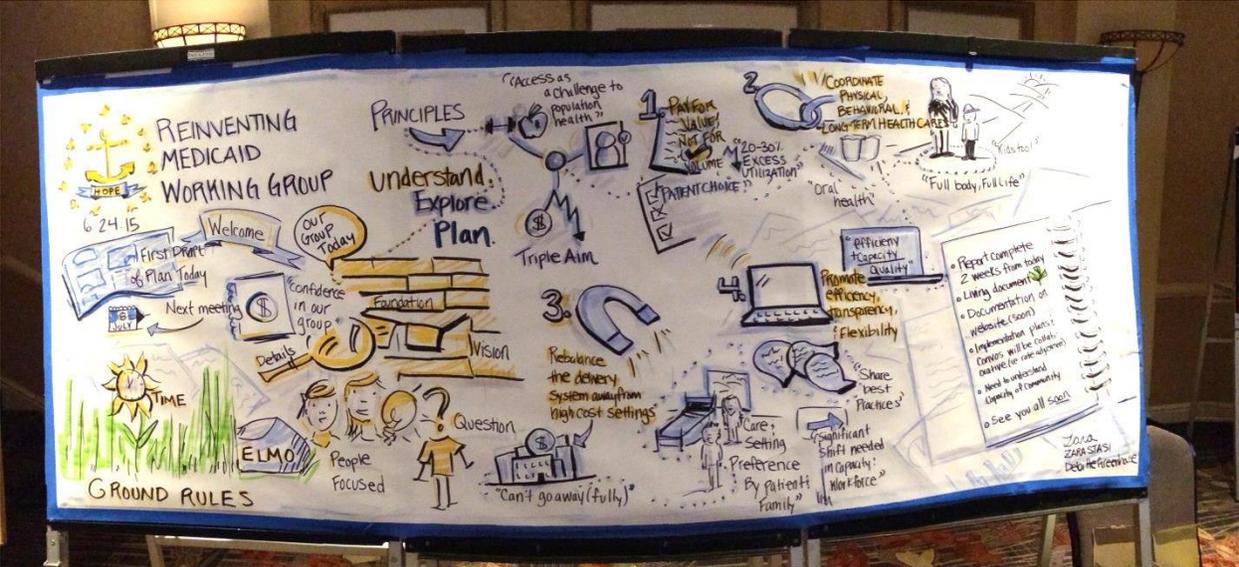
Considerations

- 45 days is a long time; could Rhode Island strive to establish a lower target? What are other states doing?
- It’s in the state’s interest to do presumed eligibility→Requirement around potential recovery needed
- Clearly communicate eligibility requirements, exceptions and apply consistently
- What is “timely” and “accurate”? Need definitions
- Bring Department of Health into the conversation
- Need to use state’s claims data to measure performance
- Lack of good information; need clear rules for consumers
- Goal related to flexibility? Rule-related flexibility
 - Look at rules to promote more flexibility in the system

Public Comment

- Workshops should include more structure/process for public hear the conversations of full working group and break out groups
- Would like more communication from EOHHS about changes/impact of FY16 budget impacts on rates, program design
- PCP capacity—not just long-term care; provider capacity too

Graphic Recording



Other Pictures from the Session





