

**STATE OF RHODE ISLAND  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
NOTICE OF OPEN MEETING**

In accordance Rhode Island General Laws (RIGL) 42-46, notice is hereby given that the Executive Office of Health and Human Services proposes to hold an Open Meeting to obtain Public Comments regarding the attached reports:

- Integrated Care and Financing for Medicare and Medicaid Beneficiaries
- Integrated Care for Medicare and Medicaid Beneficiaries- *A Demonstration Proposal to the Center for Medicare and Medicaid Services*

The Integrated Care and Financing for Medicare and Medicaid Beneficiaries Report provides EOHHS' review of the challenging health care needs of adults with disabilities and elders (dual eligibles and non-duals or Medicaid-only beneficiaries), the foundations for building a better, more consumer-centered services system, and the options available to the state to more fully integrate how to pay for, manage and deliver care for these beneficiaries. From a service perspective, EOHHS is focused on integration and choice, moving towards delivery systems that include the full continuum of care. Integral to those delivery systems will be the coordination and management of services.

The service integration will occur in two paths:

**By January 2013:**

1. RI Medicaid will enter into contracts with qualified Managed Care Organizations (MCOs) for Medicaid-funded primary, acute, and Long Term Services and Supports (LTSS) services. The state will maintain the existing Rhody Health Partners (RHP) model and the PACE integrated model, therefore offering two MCO products for elders and adults w/disabilities: one product for just primary and acute care and two products for integrated care. Intensive Behavioral Health (BH) services and Developmental Disabilities (DD) system LTSS services will be excluded from these contracts.
2. RI Medicaid will contract with a coordinating care entity for the management of Medicaid-funded primary, acute, and LTSS services incorporated into the Connect Care Choice (CCC) delivery system

By January 1, 2013, Medicaid-only and dual-eligible adults with disabilities and elders can choose to enroll in:

- ⇒ PACE
- ⇒ RHP if they do not need LTSS; or
- ⇒ Integrated Medicaid-funded primary, acute and LTSS MCO model
- ⇒ Enhanced CCC

**By January 2014:**

RI Medicaid will enter into a contract with qualified MCOs and CMS for a fully integrated model including both Medicaid and Medicare-funded services.

By January 1, 2014, dual-eligible adults with disabilities and elders can choose to enroll in:

- ⇒ PACE
- ⇒ Integrated Medicaid and Medicare-funded MCO model
- ⇒ Enhanced CCC model

*Integrated Care for Medicare and Medicaid Beneficiaries- A Demonstration Proposal to the Center for Medicare and Medicaid Services* Report outlines EOHHS' approach to meet the guidance furnished by CMS for the Financial Alignment Demonstration Model. This guidance presents an opportunity for states to develop a three-way contract among CMS, EOHHS and MCOs for integrated care for Medicare and Medicaid Beneficiaries. MCOs will receive a blended capitated rate for the full continuum of benefits provided to Medicare-Medicaid enrollees across both programs. The capitated model will target aggregate savings through actuarially developed blended rates that will provide savings for both States and the Federal government. Plans will be required to meet established quality thresholds. The three-way contract among CMS, the State, and the MCOs will also test administrative, benefit and enrollment flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees utilizing a simplified and unified set of rules. The design model includes a thirty day public notice requirement to seek input to the proposal prior to submission of the proposal to CMS.

The Reports are accessible on the R.I. Secretary of State website (<http://www.sec.state.ri.us>) and the OHHS website ([www.ohhs.ri.gov](http://www.ohhs.ri.gov)) or available in hard copy upon request (401 462-2018 or RI Relay, dial 711). Two Open Meetings will be held to consider the public comments on the Reports. The first Open Meeting will be held on Thursday, May 3, 2012 at 11:00 AM at the Arnold Conference Center 111 Howard Avenue, Regan Building, Cranston, RI 02920. The second Open Meeting is scheduled on Tuesday May 15, 2012 at 4:00 PM at the DaVinci Center for Community Progress, Inc., 470 Charles Street, Providence, RI 02904. Persons wishing to submit written testimony may do so by Friday, May 25, 2012 to Kimberly Merolla-Brito, Office of Policy Development, Executive Office of Health and Human Services, Louis Pasteur Building, 57 Howard Avenue Fl # 1, Cranston, RI 02920.

The first Open Meeting will begin on May 3, 2012 at 11:00 A.M. and will conclude when the last speaker finishes testimony or at 1:00 P.M., whichever occurs first. The second Open Meeting will begin on May 15, 2012 at 4:00 P.M. and will conclude when the last speaker finishes testimony or at 6:00 P.M., whichever occurs first. The seating capacity will be enforced and therefore the number of persons participating in

the Open Meeting may be limited at any given time by the Open Meeting officer, in order to comply with safety and fire codes.

The Arnold Conference Center and the DaVinci Center are accessible to the handicapped. Individuals with hearing impairments may request an interpreter's presence by calling 711 or Relay RI 1-800-745-6575 (Voice) and 1-800-745-555 (TDD). Requests for this service must be made at least 72 hours in advance of the Open Meeting date.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap in acceptance for or provision of services or employment in its programs or activities.



**INTEGRATION OF  
CARE AND FINANCING  
FOR  
MEDICARE AND  
MEDICAID  
BENEFICIARIES**

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## EXECUTIVE SUMMARY

### **Overview**

Among the many health care issues facing the state today is how to improve the disjointed system for financing and delivering care to two of the most vulnerable populations the Medicaid program covers – Adults with Disabilities and Elders. Many of these beneficiaries have multiple chronic conditions and/or persistent behavioral health problems that require a mix of costly acute, sub-acute and long term services.

Complicating matters, a large number of the beneficiaries in this group are eligible for both Medicare and Medicaid – “dual eligibles” – and must navigate the complex rules, requirements and payment schemes of two distinct programs to obtain the full range of services necessary to meet their care needs. This report presents our review of the challenging health care needs of adults with disabilities and elders (dual eligibles and non-duals or Medicaid-only beneficiaries), the foundations for building a better, more consumer-centered services system, and the options open to the state today for more fully integrating how we pay for, manage and deliver their care.

### **The Service Landscape**

In the initial sections of the report, we provide a descriptive analysis of the service delivery system for adults with disabilities and elders covered by Medicaid across the care continuum and their current utilization patterns and care needs. The results of this analysis show clearly that the fragmentation in the delivery system is costly for dual eligibles and Medicaid-only beneficiaries – not only measured in real dollars, but also in terms of their health.

For example, we found that these beneficiaries are more likely to experience preventable emergency room visits, hospitalizations, serious health complications, and/or nursing home admissions. Moreover, Medicare’s primary role as a payer rather than care manager has magnified these costs for dually eligible beneficiaries, as has the disjuncture between payers, as the care needs of beneficiaries escalate and they transition into the Medicaid funded system of long-term care services and supports. The data in the report point to the improved health outcomes and lower costs resulting from mandatory care management of Medicaid-only beneficiaries for acute services as examples of the gains that could be achieved if the state had the authority and capacity to integrate services across payers and the care continuum.

Although our analysis indicates that all adults with disabilities and elders receiving publicly funded coverage will benefit from greater service integration, we recognize that there has been insufficient time to evaluate the impact of recent initiatives targeted at certain segments of the population included in the report. Specifically, the data analyzed predates full implementation of the redesigned system of care for adults with developmental disabilities. Similarly, the review of the care needs and service patterns for adults with severe and persistent mental illness (SPMI) does not show the effects of the health homes initiative, which has been underway less than a year. We note in the report that the optimum system would integrate all services for dually eligible and Medicaid-only beneficiaries, and in a manner that makes it possible to adapt or tailor the integrated system of services to meet their unique needs. However, in evaluating the options for a better system and the next steps for the state, we have taken the status of these initiatives into consideration.

## **Foundations of an Integrated System**

With these findings in mind, we devote the next section of the report to the functional performance capabilities or “domains” an integrated care system for dually eligible and Medicaid-only beneficiaries must have to improve service access and quality, optimize the health of beneficiaries, and maximize value for every dollar the state spends. They are summarized as follows:

- ***Outreach and Information*** – Provide beneficiaries with relevant, useful, and objective information, advice, counseling and assistance, at the points of need or risk.
- ***Long-Term Care Eligibility Determination and Service Initiation*** – Assure eligibility determination process is efficient and consumer friendly and facilitates the timely initiation of services through the care planning and case management required to effectively coordinate services.
- ***Identification of Risk and Emerging Needs to Target Efforts*** – Build the capacity to: identify and target services to respond to the changing needs of beneficiaries; recognize and address health risks; and intervene to prevent predictable and unnecessary acute episodes
- ***Robust Network of Health Care Services and Supports*** – Offer a network of quality medical, behavioral health, and long-term-care services providers capable of providing the full continuum of integrated services required to respond to the diverse needs of adults and elders with chronic illnesses, conditions and developmental and physical disabilities.
- ***Value Purchasing, Oversight and Continuous Quality Improvement*** – Encourage and reward positive health outcomes and excellence in service design, delivery and provider performance by leveraging the state’s purchasing power to assure maximum value.

The report illustrates how each of these functional domains will be guided by a set of performance standards that will ensure system capacity, accountability and responsiveness. In sum, as EOHHS moves forward, these performance standards serve as the foundation for both the initial design and the eventual evaluation of any integrated system of care the state pursues.

## **Evaluation of Options**

Over the last 25 years, the state has used organized delivery systems to bring high quality and cost effective health care services to many of the populations it serves. At the center of these systems is a “health home” that provides the level of care management and services coordination essential to promote positive outcomes and assure value. With approval of the Global Waiver in 2009, the state was authorized to enroll all Medicaid-only adults with disabilities and elders in one of the following delivery system models:

- Rhody Health Partners – a capitated risk-based managed care program administered through contracted health plans; or
- Connect Care Choice – a primary care case management model in fee for service that provides enhanced care management and services coordination through selected physician practices.

Note that neither delivery system covers dual eligibles or most facets of long-term care. The state’s Program of All-inclusive Care for the Elderly (PACE), is a risk based approach for providing care to dual eligibles and, thus, is an exception. Rhody Health Partners and PACE on the capitated side, and Connect Care Choice on the fee for service side, have been successful. As such, the Medicaid experience with these programs offers the state two distinct, but well-established models upon which to build a better system.

The report presents our evaluation of the advantages and drawbacks of each of these models vis-à-vis the complex needs of beneficiaries and the functional performance domains discussed in earlier sections. Our assessment of the various permutations an integrated system of services might take using a capitated risk based and/or enhanced fee for service model is provided in a detailed chart showing the complex choices associated with the task at hand.

Among the other issues addressed in this section is the feasibility of implementing each of the models given such factors as:

- Federal requirements pertaining to Medicare-Medicaid dual eligible demonstrations, including opportunities for public input, plan elements, and limitations related to carve outs for certain services/segments of the population;
- Challenges incumbent with incorporating recently redesigned systems of care for persons with developmental disabilities and serious and persistent mental illnesses;
- Resources required to reduce fragmentation in existing processes for determining financial and clinical eligibility, authorizing services and developing a care plan, and monitoring service quality and health outcomes;
- Ongoing efforts to divert/transition long-term care beneficiaries into home and community based settings;
- Technical and legal adoption requirements – i.e., federal waiver, change in state law, contractual changes, new arrangements v. building on existing partnerships, etc.
- State’s ability to effectively leverage its purchasing power if choosing an incremental rather than comprehensive approach to system redesign.

We also take into account such issues as ease of administration, adequacy of state resources including staffing, and provider capacity.

## **Conclusions and Plan of Action**

Upon completing the evaluation of the risk based managed care and enhanced fee for services models, we determined that both can and should have a role in serving Medicaid-only and dually eligible beneficiaries across the care continuum. However, as the report shows, a broad and varied set of implementation requirements and feasibility issues will affect the state’s ability to pursue comprehensive service integration across the care continuum for all adults with disabilities and elders in the scope and timeline specified in the General Assembly’s Joint Resolution – Section 3, Article 16 of the enacted SFY 2011 budget. An alternative plan of action using a phased-in, incremental approach for redesigning the existing system of care is presented below.

### **Phase 1 – January 2013**

In Phase I of the proposed redesign, our goal is to integrate acute care, primary care, and long-term care services for as many segments of the population of adults with disabilities and elders as is feasible given the constraints noted earlier in the report. The state has the greatest control over the services provided to beneficiaries who are Medicaid-only. As noted, all non-duals in this population are enrolled in either Rhody Health Partners or Connect Care Choice. We are confident that the state has the capacity to build on these programs and provide a capitated risk-based

managed care plan and enhanced fee for service plan integrating acute, primary and long-term care services for non-dual eligibles by January 2013.

Due to federal requirements, we will approach service integration for dual eligibles in a more measured approach during this phase. Our plan at this point is to again build on existing organized delivery systems and bring Medicaid and long-term care services to dual eligibles through wraparound coverage, with the exclusions noted in the next section.

The Medicaid agency issued a Request for Information (RFI) focusing in this area last year and is prepared to move forward on this aspect of service integration at present. The state will need to obtain approval for this change from the CMS via an amendment to the Global Consumer Choice Waiver. We do not anticipate gaining approval from our federal partners for this change will be problematic.

### ***Exceptions/Exemptions***

In this first phase of system redesign, we plan to exclude two service areas from the integrated package of benefits: long-term care services for adults with development disabilities and behavioral health services for individuals with serious and persistent mental illnesses (SPMI). As noted earlier in the report, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) just recently began implementing new systems of care for these beneficiaries. It is too soon to evaluate whether the service integration needs of beneficiaries have been addressed adequately by these initiatives at this time. Note also that the majority of beneficiaries in these segments are dual eligibles.

### **Phase 2 – January 2014**

In this second phase of the system redesign, our plan is to integrate the acute and primary care for dual eligibles into the system established in Phase I. We plan also to begin work on integrating services for adults with behavioral health needs and developmental disabilities.

The analysis presented in this report indicates that a managed care model for integrating services across the care continuum for dually eligible beneficiaries would best serve the state and beneficiaries. As the report also shows, the state must meet a rigorous set of federal requirements, and in a specified time frame, to pursue this option and enter into an agreement with Medicare or a CMS approved demonstration. We propose taking the steps necessary to meet these requirements and fully analyze the variations on the managed care model for dual eligibles. We know that implementation will not be feasible until 2014.

Toward this end, we have already begun working with stakeholders to obtain input about the alternative strategies for integrating services for dual eligibles using a managed care approach. *Two “public” meetings are currently scheduled for April 2012 to review a proposal in development that is based on the analysis in this report.* Feed back from these meetings will assist the state in determining whether further steps toward implementation should proceed and, if so, how quickly and in which direction. Beneficiaries with SPMI will be enrolled in the Medicaid-only integrated service system or the capitated system for dual eligibles at this time. Persons with developmental disabilities will be enrolled in the next phase.

### **Phase III – July 2014 to 2015**

The federal requirements for fully integrating care for dually eligible beneficiaries limit the states options for excluding certain segments of the population and/or carve-out services. The state does have the opportunity to phase-in beneficiaries in different coverage groups over time, however. As indicated above, adults with developmental disabilities are now being served by recently developed BHDDH system of care initiatives. Experience from Phases I and II and input from stakeholders, experts and policy leaders will assist the state in determining the best approach for bringing these beneficiaries into an integrated care delivery system over time.

### **Implementation Requirements**

To move forward with this plan of action, the Medicaid agency will need additional staffing and contractual resources to assist in program design, development and implementation.

## **SECTION I: INTRODUCTION**

The Rhode Island Medicaid program is the principal source of coverage for low income children and families, elders and persons with disabilities who are otherwise unable to afford or obtain the services and supports they need to live healthy lives. In state fiscal year (SFY) 2010 alone, the average number of Medicaid beneficiaries the program served was just over 189,000 Rhode Islanders. As the Medicaid state agency, the goal of the Executive Office of Health and Human Services (EOHHS) is to provide these beneficiaries with access to high quality, coordinated health care services in the most cost-efficient and effective manner possible.

Despite these difficult economic times, the Medicaid program has continued to make progress toward achieving this goal. For example, enhanced care management through the RIte Care and Rhody Partners health plans and through Connect Care Choice has yielded better health outcomes and significant savings, particularly on the acute care side. Initiatives underway to rebalance the long-term care system have also succeeded in improving service coordination, choice and economy.

### **Purpose of the Study**

In 2010, the federal Affordable Care Act provided the state with both the impetus and the opportunity to extend these efforts further to include the coordination of services – across the care spectrum -- for two of the most vulnerable populations the Medicaid program covers -- adults with disabilities, ages 19 to 64, and elders, 65 and older. A year later, the RI General Assembly also recognized the importance of improving the system serving these beneficiaries:

*By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid Beneficiaries, the Executive Office of Health and Human Services (EOHHS) is directed to engage in a contractual arrangement for the expansion and integration of care management strategies by July of 2012 for Medicaid-only beneficiaries and beneficiaries dually eligible for Medicaid and Medicare.*

Toward this end, this report focuses on the options for integrating services for Medicaid eligible adults with disabilities and elders. Together, these beneficiaries represent about one quarter of the total RI Medicaid population, and just over 60 percent of total annual program expenditures. Although the service needs of adults with disabilities and elders do vary, the two populations share many common features: beneficiaries in both groups tend to have very low incomes and limited assets or must “spend down” what few resources they do have to become Medicaid eligible. Many of these beneficiaries have multiple conditions, one or more of which may result in a hospitalization or a nursing facility stay, and all must obtain the mix of acute, sub-acute and/or long-term care services they need in an often fragmented and difficult to navigate delivery system

### **Population Focus: Dual Eligibles and Medicaid-only Non-Dual Beneficiaries**

Within the Medicaid population of adults with disabilities and elders, there is a segment of beneficiaries who are eligible for both Medicare and Medicaid (“dual eligibles”). Although only a small percentage of the Rhode Island Medicaid caseload, dual eligibles are a costly population to serve. As they tend to be in poor health and have complex needs, they often require a network of intensive and/or continuous services and supports. Dual eligibles are also more likely than other Medicare and Medicaid beneficiaries to have chronic behavioral health conditions, use emergency rooms, and require long-term care. Among the lowest income and most frail of all Medicaid beneficiaries, dual eligibles seldom have access to alternative sources of coverage or services. As a result, they rely exclusively on Medicare and Medicaid to meet their care needs in most cases.

Medicare eligibility is based on age, disability or certain diagnoses.<sup>1</sup> Eligibility is also available to someone with an established work history who has reached the age of 65. Other persons become eligible for Medicare as beneficiaries of Social Security Disability Insurance (SSDI). Dual-eligibles become Medicaid eligible because of their low income and resource level and/or the high costs of needed medical care (commonly an admission to a nursing home). The Medicaid eligibility criteria are not only substantially different, but the process for making determinations is significantly more complicated than for Medicare.

Of the non-dually eligible persons in the population of elders and adults with disabilities there are approximately 15,000 beneficiaries who qualify for “Medicaid-only” coverage through this determination process on the basis of age (over 65), blindness or disability. These individuals may have similar health and income characteristics to the dually eligible population, though they do not yet or may never qualify for Medicare eligibility. For members of this group, Medicaid is responsible for all health coverage and services.<sup>2</sup>

Both the dually eligible and Medicaid-only adults with disabilities have a complex set of changing needs that are challenging to meet. As noted above, many have multiple chronic conditions complicated by pronounced behavioral health needs and cognitive impairments. The type of chronic condition generally dictates the scope of a beneficiary’s service needs. Consequently, the mix of services these beneficiaries receive and the settings in which they are provided can be quite variable. For example, some beneficiaries may require care in long-term care facilities, while others are able to remain at home or in residential settings with the assistance of home and community based services. Of those with chronic care needs able to remain in the community, the majority will need long-term-care services and supports in addition to acute care services.

The difficulties inherent with meeting these health care challenges have been compounded by the fragmented system that has evolved for everything from determining eligibility to financing and delivering services across the care spectrum. As indicated earlier, policymakers at both the state and national level have recognized the need for a more rational, consumer centered approach for financing and delivering services to adults with disabilities and elders who rely on this system. The following sections of this report examine the needs of this population and consider, at length, the options for integrating services in a more cost effective and efficient manner.

## **Organization of the Report**

The report is organized in the following manner:

Section 2 of this report provides a profile overview of the characteristics and needs of Medicaid Dual and Medicaid-only (Non-Dual) adult populations. Also covered in Section 2 is a review of Medicare and Medicaid eligibility, benefits, delivery systems, and expenditures. This section reviews the distinct structures and characteristics of the Medicare and Medicaid programs, with a focus on the misalignments that can negatively impact the health and outcomes of beneficiaries.

Section 3 examines what is needed to develop a better system, to achieve greater integration of care and improve outcomes, and the essential functional domains that are the pillars of a more integrated delivery system.

Section 4 introduces opportunities and sets forth model options.

Section 5 includes a summary and conclusions.

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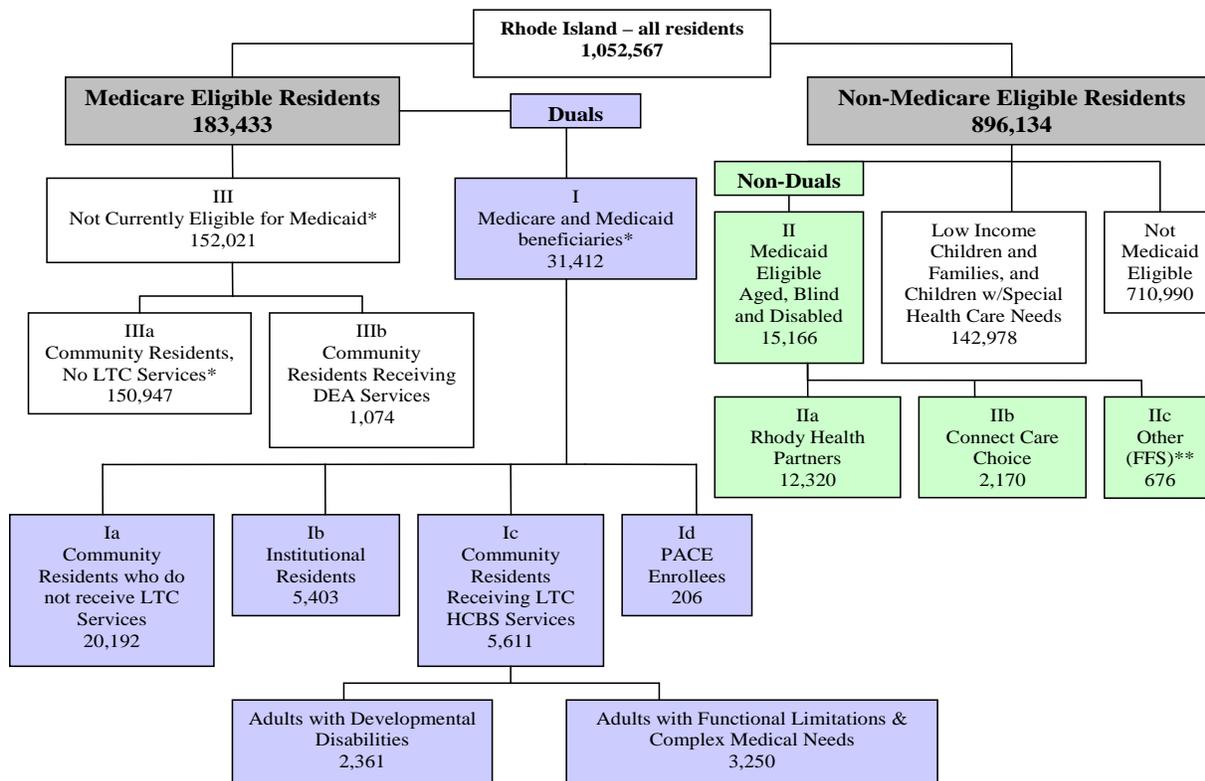
<sup>1</sup> Eligibility can be based on a diagnosis of end-stage renal disease or amyotrophic lateral sclerosis.

<sup>2</sup> The vast majority of persons in the children and families group and among children with special health care needs are, strictly speaking, “non-duals”. This report does not deal with those groups. When the term “non-duals” is used in this report it refers to adults, aged 21 and over, who qualify for Medicaid on the basis of income, assets and determination of a disability or level of care assessment.

## SECTION 2: OVERVIEW AND CHARACTERISTICS OF THE MEDICAID DUAL AND NON-DUAL POPULATIONS IN RHODE ISLAND

Medicaid is a primary payer of services for a significant proportion of elders and individuals with disabilities. *Figure 1*, titled **The Rhode Island Medicaid Population Profile**, provides a view of the population of dual eligibles and non-duals in the larger context of Rhode Island’s general population.

**Figure 1. The Rhode Island Medicaid Population Profile**



\*

*Note that in December 2010 there were 5,262 QMB, SLMB and QI beneficiaries not eligible for full Medicaid benefits for whom Medicaid pays only a Medicare premium plus the patient share (for QMBs) of Medicare services. These individuals are included in III and IIIa, above.*

*\*\* Includes non-dual beneficiaries who are either in institutions or have non-Medicare third party coverage.*

*Sources: Rhode Island – all resident population is from the 2010 US Census. Medicare enrollment comes from the Kaiser State Health Facts, 2011 data. Medicaid data are based on CY 2010 figures.*

Rhode Island’s total population of 1,052,567, is divided into Medicare beneficiaries (183,433) and non-Medicare eligible (869,134) residents, shaded grey in Figure 1. The majority of Medicare beneficiaries are not dual eligibles.

- The average number of dually eligible beneficiaries in Calendar Year 2010 (CY 2010) was 31,412<sup>3</sup> or 17.1% of all Medicare enrollees (Figure 1, Box I, shaded blue).

<sup>3</sup> Note that the Medicaid figures presented in Figure 1 are averages per day during calendar year 2010. Over the course of twelve months the number of unique individuals in any of these categories is larger.

- A Medicare-only population at risk of needing long-term care supports and services and becoming Medicaid eligible is shown in Box IIIb, Community Residents Receiving RI Department of Human Services (DHS), Division of Elderly Affairs (DEA) services. This group of Medicare beneficiaries receives services through DEA programs targeting individuals who have increasing health care needs not covered by Medicare, but are ineligible for Medicaid due to excess income or assets..

*Figure 1, Box Ia* illustrates that, at any given point in time, the majority of dual eligibles in Rhode Island reside in the community and are not directly connected with the long-term care system. Based on SFY 2010 experience:

- 20,192 dually eligible beneficiaries reside in the community without home and community-based services and supports (*Figure 1, Box Ia*). An estimated to ten percent (10%) or so are at increased risk for needing home and community-based supports within two years.
- 5,611 dually eligible beneficiaries reside in a non-institutional community setting and receive home and community-based services (HCBS) to help maintain their ability to remain living in the community (*Figure 1, Box 1c*).
- Of those dual eligibles currently receiving home and community-based supports and services, a large portion (3,250) are vulnerable adults with functional limitations and complex medical needs.
- 2,361 of the dual eligibles receiving HCBS have developmental disabilities. The service needs of beneficiaries in this group differ from most other dual eligibles in a variety of respects. For example, adults with developmental disabilities utilize more non-medical services such as vocational/employment training and supports. Services for deterioration due to disease generally come later, with age, rather than as a result of the developmental disability. (For more on the unique needs of this population see section 2).

*Figure 1, Box Ib*, shows that in CY 2010, there were 5,403 dually eligible beneficiaries residing in institutional settings on an average day. A portion of this group is relatively short stay residents who are preparing to return to the community and will likely be in need of community supports. In SFY 2010, the total number of unique beneficiaries who were in an institutional setting for at least one day during the year was close to 9,000; this number is indicative of the high volume of short stay residents who will need high quality service coordination/assistance to transition successfully back to the community. Note that upwards of 75% of beneficiaries residing in institutional settings on any given day have been there for nine or more months.

There are approximately 206 individuals enrolled in the Program for All-inclusive Care for the Elderly (PACE) Organization of Rhode Island (PORI, *Figure 1, Box Id*). For further details, regarding PACE refer to Section 2.5.

Medicaid-only (non-dual) adults with disabilities are shown in another section of *Figure 1, Box II*. This includes a total of 15,166 adults with disabilities with Medicaid-only coverage (Aged, Blind and Disabled). Beneficiaries in this group are required to enroll in one of the state's care management program options -- Rhody Health Partners, (*Figure 1, Box IIa*) which had 12,320 average members in CY 2010 or Connect Care Choice (*Figure 1, Box IIb*), which had 2,170 average members in CY 2010 (refer to Section 2.4). Approximately 15%-20% of these individuals will become dually eligible within two years of enrolling.

During CY 2010, the dual eligible and the Medicaid-only population totaled an average of 46,578.<sup>4</sup> As note earlier, beneficiaries in both groups have complex health care needs that are expensive to cover. A core goal for EOHHS is to provide a high quality, cost effective integrated system of care that addresses the needs not only of the adults and elders that are the focus of this study, but of all populations represented in *Figure 1*.

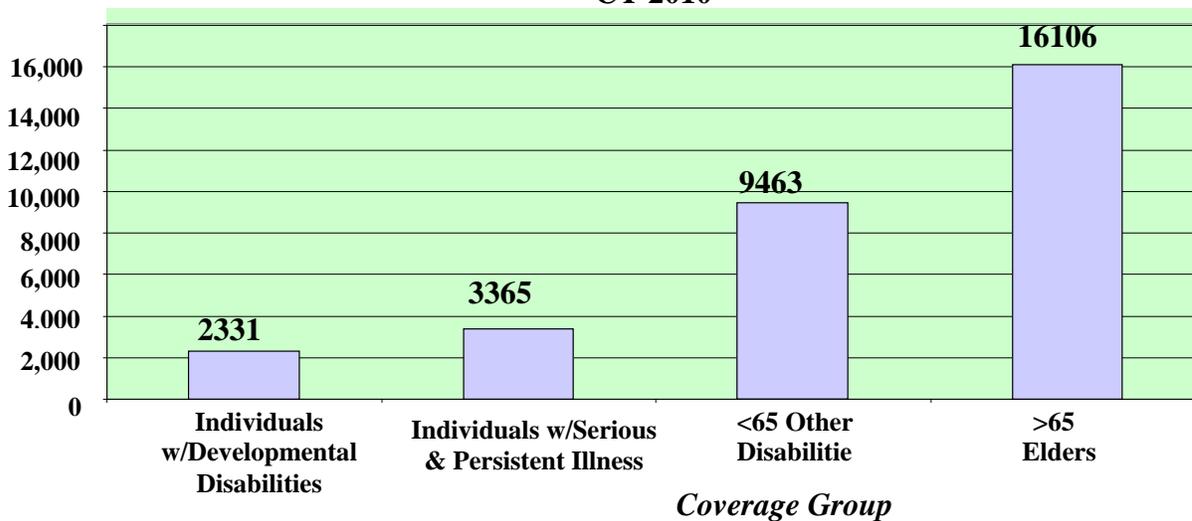
## SECTION 2.1: FURTHER CHARACTERISTICS OF THE DUAL ELIGIBLE POPULATION

The American Community Survey, conducted by the Census Bureau, indicates that forty-three percent (43%) of dual eligibles in Rhode Island live at one hundred and thirty three percent (133%) or less of the federal poverty level (FPL). This survey also tells us that the majority of dually eligible beneficiaries are women and approximately forty percent (40%) live alone. This same survey also showed that while the type of disability among dual eligibles varies, approximately forty percent (40%) have a serious cognitive disability; almost half (46.7%) have a serious mobility limitation combined with difficulty living independently.

### Population Profile at a Glance

- Living at or below the FPL
- Predominantly Female
- Live with serious cognitive and ambulatory disabilities
- Reside in the poorest households of Rhode Island
- Significantly more likely to live alone
- Need assistance with independent living, self care and direction
- Significant higher use of Nursing Homes than the national average

**Figure 2. Rhode Island Average Dual Eligibles by Coverage Group CY 2010**



*Figure 2. Rhode Island Average Dual Eligibles by Population Group, CY 2010*, depicts four (4) population groups. In Rhode Island, 45% of the total Dual eligibles population is under the age of 65, qualifying for dual coverage due to SSDI disability status. Dual eligibles over the age of 65 are predominantly women.

In Rhode Island, the dually eligible age group of 65 to 84 years is the largest cohort in the total population. Typically, those under 65 and those over 65 have differing patterns of needs and strengths. The non-elderly beneficiaries with disabilities tend to have lower incomes and qualify for Medicaid sooner than the elderly population. Because of their disabilities, they often have significant health problems, compounded by functional limitations and cognitive impairments, requiring supportive services to assist with activities of daily living (ADLs). The elder dual eligibles

<sup>4</sup> Not included in these totals are the 5,262 persons who are sometimes referred to as “partial” duals, or Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicaid Beneficiaries (SLMB) and Qualified Individuals (QI-1).

are poor, though not necessarily disabled. They have diagnoses and related expenditures for conditions such as diabetes, heart disease, lung disease, mental illness and Alzheimer's disease.

A total of \$177,423,283, in Medicaid expenditures was spent on dually eligible adults with developmental disabilities in CY 10, at an average cost of \$75,148 per beneficiary.<sup>5</sup> Note that the costs for the dual eligibles in this population are somewhat higher on an average per person basis than for all adults with development disabilities – i.e., including Medicaid-only and dually eligible beneficiaries. As noted throughout this report, dually eligible beneficiaries tend to have more complex needs and are often more expensive to cover as a result. For adults with developmental disabilities, the scope and nature of these needs is different than for most other dual eligibles. Specifically, most of these beneficiaries are limited in basic life skills such as bathing, dressing, eating, and performing age-appropriate tasks. Thus, nearly all of these beneficiaries require long term services and supports such as residential and home care services in order to live in the community.

Meeting the unique needs of the entire population of adults with development disabilities – dual eligibles and non-duals – is the focus of Project Sustainability, an initiative recently implemented by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). To ensure the gains made in the system of care under this initiative continue, the EOHHS is committed to working closely with BHDDH in evaluating whether the service integration models under consideration have the capacity to meet the special needs of these beneficiaries.

A total of \$56,905,791 in Medicaid expenditures was spent on dually eligible beneficiaries with Serious and Persistent Mental Illness (SPMI) in CY 10, at an average cost of \$17,509 per person. This includes Medicaid services provided and paid for by both EOHHS Medicaid and BHDDH. Dually eligible beneficiaries in this coverage group often have serious behavioral health conditions that impair their functioning, particularly with respect to carrying out activities of daily life. As they are younger than the elder dual eligibles, the nature of their needs differ somewhat. The next section shows how utilization patterns reflect these differences. Many of these beneficiaries are hospitalized for their conditions and/or are dually diagnosed with substance abuse disorders and require treatment and rehabilitative services their elder counterparts do not typically require. As with the adults with developmental disabilities, the EOHHS is working with the BHDDH to tailor the most effective approach of inclusion and integration of care for dual eligibles who qualify for coverage on the basis of a serious and persistent mental illness.

A high percentage of elder dual eligibles in Rhode Island reside in long-term care settings, primarily nursing homes. Nursing home spending is a key driver of Medicaid expenditures in the state:

- Rhode Island has 56 nursing home residents per 1,000 residents age 65 and over compared to the US rate of 38 per 1,000.
- For Rhode Islanders age 75 and over, the rate of nursing home residents increases to 104 per 1,000 compared to a US average of 78 per thousand.

The lower acuity and longer lengths of stay for most nursing home residents contributes to an overall use of nursing homes in Rhode Island that is significantly above the national average.<sup>6</sup> Two recent studies conducted by Brown University in conjunction with the state's Real Choices System Transformation initiative indicate that the acuity level of nursing home residents is higher since the system rebalancing effort began in earnest under the Global Consumer Choice Compact Waiver in SFY 2010. Both studies note that if this trend is to continue further, efforts to transition

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<sup>5</sup> Note that these figures are for the calendar year 2010 and, as such, differ from those cited in Medicaid budget and expenditure reports that use state fiscal year data.

<sup>6</sup> Mor V, et. al., Prospects for transferring nursing home residents to the community. Health Aff (Millwood). 2007, Nov-Dec; 26 (6): 1762-71. PubMed PMID: 17978396.

beneficiaries back to the community must begin earlier in the beneficiary's institutional stay and be coupled with more intensive and ongoing service integration and coordination.<sup>7</sup>

## **SECTION 2.2: DIFFERENCES IN PATHWAYS TO MEDICARE AND MEDICAID ELIGIBILITY**

Dually eligible beneficiaries become eligible for Medicare and Medicaid through different processes.

### Medicare Eligibility:

To become eligible for Medicare, an individual (or spouse) must contribute payroll taxes for ten or more years (40 quarters). If the payroll tax requirement is met, a person will become eligible for Medicare when they reach age 65, regardless of income or health status. A person under 65 may qualify for Medicare after 24 months of receiving Social Security Disability Insurance (SSDI) payments, even if they have not made payroll tax contributions for 40 quarters. Individuals with end-stage renal disease or amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) become eligible for Medicare benefits as soon as they begin receiving SSDI payments without having to wait the 24 months. Medicare beneficiaries pay varying deductibles and coinsurance amounts that are indexed to rise annually.

### Medicaid Eligibility:

Medicaid eligibility for persons 19 years of age and older is based on income, resources, age and/or disability status. Medicaid eligibility qualifications can be based on low-income status, disability status or high medical or long-term care expenses relative to income. People receiving Supplemental Security Income (SSI) are automatically eligible for Medicaid.

### Medicare Savings Programs:

Medicare beneficiaries can receive assistance with Medicare premiums and cost-sharing through Medicaid administered Medicare Savings Programs for low to moderate income Medicare beneficiaries. This program covers Medicare out-of-pocket costs but does not include the Medicaid-covered services. Members of this group are often referred to as partial duals. As used in this report, the term "dual eligibles" (duals) is used to refer to beneficiaries who receive full Medicaid coverage, not just premium and cost-sharing assistance. Most of the dual eligible population in the state receive full Medicaid benefits as well as help with paying their Medicare premiums and cost-sharing expenses, such as the deductibles and co-insurance related to their hospital care, physician visits and other Medicare-covered services. Though this report does not deal directly with partial duals, a segment of beneficiaries will move from partial to full dual eligible status on any given day.

## **SECTION 2.2.1: MISALIGNMENTS BETWEEN MEDICARE ACUTE CARE SERVICES AND MEDICAID LONG-TERM-CARE SERVICES AND SUPPORTS**

Medicare and Medicaid were designed to serve different purposes and, as such, operate under different sets of rules and authorities. Misalignments occur with regularity and are often harmful.

Dually eligible beneficiaries and their families and caregivers may encounter obstacles to needed care when a critical event occurs. The differing coverage standards, processes and reimbursement rates make navigating the two systems difficult for providers and patients. Other than the PACE Program, the Rhode Island publicly-funded health care system does not currently offer dually eligible beneficiaries a model in which one entity is accountable for ensuring needs are met.

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To demonstrate the misalignments between the two programs and the typical lack of coordination, efficiency and cost-effectiveness between them, we provide a profile of “Millie’s Story” in Appendix A.

### SECTION 2.3: MEDICARE AND MEDICAID BENEFIT COVERAGES

For dual eligibles, Medicare is the primary payer for acute and primary care services, such as hospital and physician services, hospice, skilled short stay nursing facility (SNF), skilled home health care, durable medical equipment, and prescription drugs. The emphasis is on providing medical interventions that are expected to address acute needs with curative therapies and to restore the health status of the person to full recovery within given timeframes.

Medicaid coverage and payments for dual eligibles often begins at the point that Medicare coverage is no longer adequate to support the beneficiary’s long-term care services and supports needs; this includes non-skilled nursing home stays, home and community-based care, personal care services, dental care, and non-emergency transportation. As a result of having two sets of benefits (Medicare and Medicaid), dual eligibles often receive uncoordinated services. This causes many potentially avoidable high-cost episodes of care with long term implications for the beneficiary’s health and ability to retain their independence.

*Figure 3. Services and Costs Covered by Medicare and Medicaid for Dually Eligible Beneficiaries, shows the break down in coverage in the two programs.*

<b>Figure 3. Services and Costs Covered by Medicare and Medicaid for Dually Eligible Beneficiaries</b>	
<b>Medicare</b>	<b>Medicaid</b>
<b>Hospital Care:</b> <ul style="list-style-type: none"> <li>• \$1,132 deductible and no coinsurance for days 1-60 for each benefit period</li> <li>• \$283 per day for days 61-90 each benefit period</li> <li>• \$566 per “lifetime reserve day” after day 90 each benefit period</li> <li>• All costs for each day after the lifetime reserve days</li> <li>• Inpatient mental health care in psychiatric hospital limited to 190 days in a lifetime</li> </ul>	Hospital Care once Medicare benefit exhausted. Medicare co-insurance and deductibles covered to the extent that the Medicaid rate exceeds the Medicare rate.
<b>Skilled Nursing Facility Care:</b> <ul style="list-style-type: none"> <li>• \$0 for the first 20 days each benefit period each benefit period</li> <li>• \$141.50 per day for days 21-100 each benefit period</li> <li>• All costs for each day after day 100 in a benefit period</li> </ul>	Skilled Nursing Facility/Nursing Home Care once Medicare benefit exhausted. Medicare co-insurance and deductibles through 100 days – Medicaid thereafter.
Skilled Home Health Care	Skilled Home Health Care not otherwise covered
Prescription Drugs	Drugs that are not covered by Medicare
Durable Medical Equipment (DME)	DME that is Not Covered by Medicare
Physician and Ancillary Services	Medicare Cost Sharing
	Home and Community-Based Services
	Personal Care

Medicare provides for and bears almost all of the acute care costs for dual eligibles while Medicaid provides for and bears nearly all of the long-term costs. For non-duals, Medicaid is the primary insurer for both acute and long-term care services. Accordingly, any discontinuities between those systems of care are not due to the presence of two different payers. Rather, for a variety of reasons, the acute and long-term care systems have long been structured and treated separately by Medicaid.

#### **SECTION 2.4: CURRENT MEDICAID DELIVERY SYSTEMS FOR ACUTE CARE SERVICES**

Rhode Island's Primary Care Case Management (PCCM) model, Connect Care Choice (CCC), represented in Box IIb of Figure 1, began enrolling individuals aged 21 and over, living in the community and eligible for Medicaid-only, in physician-based practice sites -- "medical homes"-- on a voluntary opt-out basis in September of 2007. In April of 2008, the state launched Rhody Health Partners (RHP) (Box IIa in *Figure 1*), a managed care delivery system for Medicaid-only adults with disabilities. RHP enrollment into managed care organizations (MCOs) began on a voluntary opt-out basis and became mandatory in July of 2009. Since then, Medicaid-only beneficiaries have the option to choose between Rhody Health Partners or Connect Care Choice.

Today, all adult Medicaid beneficiaries with the exception of dual eligibles are enrolled in one of these two organized delivery systems. However, when a beneficiary becomes eligible for Medicare, participation in these care management programs is no longer permitted. The beneficiary is dis-enrolled. Over the past two to three years, approximately 15% to 20% of RHP and CCC members have been dis-enrolled because they have become eligible for Medicare coverage. Those who have established relationships with these better organized systems of care frequently face significant disruptions in their continuity of care as a result.

#### **SECTION 2.5: DUAL ELIGIBLES PARTICIPATION IN MEDICARE ADVANTAGE PLANS AND PACE**

##### Medicare Advantage

The vast majority of dual eligibles, over 27,000 people, access their acute benefits through the traditional Medicare Fee for Service (FFS) system. Medicare offers a managed care option via Managed Care Organizations (MCOs), referred to as Medicare Advantage. Approximately 3,677, RI Medicare dual eligibles are enrolled in Medicare Advantage Plans offered by Blue CHIP and United Senior Care of Rhode Island (30% in Blue CHIP and 70% in United).

##### Program for All-inclusive Care for the Elderly (PACE)

On average, an additional 206 beneficiaries are enrolled in the Program of All-inclusive Care for the Elderly Organization of RI (PORI). This is a fully integrated program for dually eligible frail elders. PORI is a provider-based Medicare and Medicaid managed care program that provides acute, chronic and long-term care. PACE is operated and funded through a three-way agreement between CMS/Medicare, Rhode Island Medicaid, and PORI.

PORI serves the entire state, providing a continuum of care and services to frail individuals with chronic care needs. Services include medical care provided by a PACE physician, prescription medications, hospital and nursing home care, specialty care, home health care, personal care, adult day care, and social services. An interdisciplinary team of professionals assesses the patient's needs and works together with the client and his or her family (when appropriate), to develop an effective plan of care.

To be eligible for PACE under federal rules, beneficiaries must be age 55 or older, meet a nursing facility level of care, and live in the PACE organization service area. In RI, under the authority of the Global Consumer Choice Compact Waiver Demonstration, dual eligibles with high and highest level of care needs are eligible for PORI. The PACE program features a comprehensive medical and social service delivery system in an adult day health center that is supplemented by in-home and

referral services that complement a beneficiary’s needs. By coordinating and delivering a full spectrum of services, PACE helps beneficiaries remain independent in the community for as long as possible. During the summer of 2011, PORI received CMS approval to expand to a second site in Rhode Island.

## SECTION 2.6: MEDICAID AND MEDICARE EXPENDITURES

Linking and understanding Medicare and Medicaid expenditure data is a critical step when planning and designing integrated systems of care for beneficiaries.

### SECTION 2.6.1: MEDICAID EXPENDITURES FOR DUAL ELIGIBLES AND NON-DUALS

In calendar year 2010, the dual eligibles represented 17% of the total Medicaid population and accounted for expenditures of \$722 million. Medicaid-only adults with disabilities represented 8% of the population with expenditures totaling \$375 million. Combined, these two groups account for 25% of beneficiaries and at \$1.097 billion, approximately 60% of total Medicaid expenditures.

The expenditure data shown in *Figure 4* illuminate the different roles played by Medicare and Medicaid with respect to utilization by dually eligible and Medicaid-only beneficiaries and in the distribution of expenditures between the acute and long-term care systems.

<b>Figure 4. Total Medicaid Expenditures for Dual Eligibles and Non-Duals by Type of Service, CY 2010</b>				
(Totals in millions of dollars)				
TYPE OF SERVICE	DUAL ELIGIBLES		NON-DUALS	
	Total \$	PMPM	Total \$	PMPM
<b>Acute Care</b>				
Inpatient Hospital	16.4	43.52	101.6	557.99
Outpatient Hospital	4.1	10.76	45.0	247.40
Professional	20.8	55.18	43.0	236.07
Pharmacy	2.9	7.70	47.8	262.64
Crossover (Medicare coinsurance)	12.9	34.25		
<b>Subtotal Acute Care</b>	<b>57.1</b>	<b>151.41</b>	<b>237.3</b>	<b>1,304.11</b>
<b>Long-term-care services and supports</b>				
Group Homes, Behavioral Health & Related (including BHDDH)	216.4	574.04	85.4	469.51
Institutional (Nursing Home, Hospice, ESH, Zambarano and Tavares)	396.0	1050.63	42.2	231.82
Home and Community Based Services	53.2	141.00	10.1	55.64
<b>Subtotal, Long-term-care services and supports</b>	<b>665.6</b>	<b>1,765.67</b>	<b>137.8</b>	<b>756.98</b>
<b>Total Medicaid Expenditures</b>	<b>\$722.6</b>	<b>\$1,917.08</b>	<b>\$375.1</b>	<b>\$2,061.09</b>

Residential and long-term care expenditures for institutional and waiver services constitute over 90% of the Medicaid cost for dual eligibles. By contrast, 63% of the expenditures for the Medicaid-only beneficiaries lie in acute care services. For this group, the costs for hospital services represent 62% of the total acute care cost. The hospital setting of care is the most utilized and leading cost of care for the Medicaid-only beneficiaries. An important component of the overall utilization and expenditure pattern not shown in *Figure 3* is the cost for acute care services for dual eligibles paid by Medicare.

## SECTION 2.6.2: MEDICARE EXPENDITURES FOR DUAL ELIGIBLES

*Figure 5* shows Medicare expenditures for Rhode Island dually eligible beneficiaries for the Calendar Year 2009<sup>8</sup>. Note that there are important Medicare expenditures that are not included in the data presented in *Figure 5*. First, expenditures for the 3,677 dual eligibles that are enrolled in Medicare Advantage plans are omitted. Second, Medicare Part D pharmacy benefits are also excluded. Combined, adding both would raise total expenditures by over \$100 million.

Hospitalization is usually the result of a significant life event, as is entry into a nursing facility. Hospital services account for more than 40% of total Medicare expenditures. With expenditures of \$34.1 million, skilled nursing care is also a significant part of the total Medicare expense for dual eligibles.

<b>Figure 5. Medicare Expenditures for Dually Eligible Beneficiaries in Rhode Island, CY 2009 (Excluding Medicare Advantage and Pharmacy)</b>	
	<b>Total \$ in millions</b>
Inpatient Hospital	\$110.1
Outpatient Hospital, Dialysis	\$14.0
Professional (Physician, non-physician)	\$41.4
Home Health	\$8.9
Diagnostic Testing	\$20.4
Transportation	\$10.8
DME and Supplies	\$7.9
Other therapies (e.g. chemotherapy, home infusion)	\$12.1
Mental Health/SA Clinic	\$0.2
Skilled Nursing Facility	\$34.1
Hospice	\$33.1
<b>Total Medicare Expenditures</b>	<b>\$292.8 M</b>

Medicare benefits emphasize medical interventions that are expected to restore the health status or functioning of the individual. Consequently, most Medicare costs are contained in acute expenditures. For the majority of Medicare beneficiaries, the coverage is adequate. However, as health status becomes more complex or deteriorates, Medicare's coverage frequently becomes too limited. Medicare does not cover custodial services provided in long-term care settings or home and community-based services. The lack of coverage for the latter set of services for adults with developmental disabilities, many of whom will require such care on a continuous basis, typically brings Medicaid eligibility early on as an adult, usually as part of the transition from youth-based programs. By contrast, for elders and other adults with disabilities, it is an adverse health event that creates the need for the non-Medicare covered services. At such points, Medicaid becomes the payer for the wide array of critical services and supports needed across both institutional and community-based settings.

<sup>8</sup> Medicare data was drawn from the Integrated Medical Management Research System (iMMRS), hosted by Jen Associates, Inc. 2009 is most current year available.

## **SECTION 3.0: CHARACTERISTICS OF A BETTER SYSTEM**

EOHHS has sought out national and local key experts to identify best practice models of care to inform our efforts to improve service integration for dually eligible and Medicaid-only beneficiaries. Appendix B contains a brief overview of initiatives with care models that have had notable successes. Additionally, EOHHS has embarked on a series of stakeholder activities to inform the development of this report and will continue to build on this outreach and engagement of stakeholders in the months ahead. A website link at <http://www.ohhs.ri.gov>, provides a summary of stakeholder and key informant activities to date and can be found in Appendix C.

### **SECTION 3.1: IMPROVEMENT OPPORTUNITIES**

EOHHS has identified many factors and elements that are critical to successful integrated models of care as well as additional considerations for program design and planning. As EOHHS redesigns the care delivery system, the fundamental characteristics we strive to include are:

- Promotion of Access and Choice
- Comprehensive Care Coordination - Acute, Primary, Behavioral and Long-Term Care
  - Safe and Effective Transitions
  - Timely identification of need combined with rapid and reliable deployment of services
  - Single Point of Accountability
  - Enhanced Communication among Providers, Beneficiaries and Caregivers
- High Touch, Person-Focused Encounters
  - Home based primary care for frail and very high need individuals
- Appropriate Consumer Protections
- Aligned Financial Incentives
- Stakeholder Engagement
- Cost Effectiveness
- Quality Oversight and Monitoring
- Promotion of autonomy, independence, and function to the maximal extent possible for the individual beneficiary

The publicly-funded system of care that exists today in Rhode Island has not yet succeeded in fully incorporating the characteristics outlined above. As the design of new delivery system options proceeds, EOHHS intends to build on the existing programs that have demonstrated success, and apply these principles to guide the development and implementation of care integration models.

### **SECTION 3.2: NEED FOR RESPONSIVE SYSTEM TO MEET NEEDS AND RISK LEVELS**

In November 2010, EOHHS issued a Managed Long-Term Care Request for Information (RFI). As highlighted in the RFI, there is great diversity and complexity among Rhode Islanders, who are, or are likely to begin, accessing publicly-funded long-term care services and supports. Six stratification levels for long-term care services and supports were identified to demarcate the critical transition points where beneficiaries, families, caregivers and discharge planners make decisions

about meeting needs for and accessing long-term care services. The levels represent the progression of increasing complexity to meet individual needs.

Moving forward, these risk levels represent critical points for ensuring timely and responsive care that effectively reduces secondary medical complications and substitutes home and community-based services (HCBS) for institutional care when appropriate. The structure of an effective system is organized and capable of continuously identifying and monitoring needs and health status indicators according to risk levels in order to respond and intervene flexibly and according to the differing and changing care needs of individuals.

**Figure 6. Description of Need and Risk Levels along the Care Continuum**

Need/Risk Level	Description of Level and Needs by Risk
<b>Risk Level I: Residing in Community Successfully</b>	Individuals in Risk Level I are successfully residing in the community with their medical needs being met and coordinated by Medicare fee-for-service, Medicare Advantage or the RHP and CCC programs. There is no indication that they need long-term care services and supports. ( <i>Figure 1, III, Ia, IIa, IIb</i> )
<b>Risk Level II: Residing in Community, Becoming Vulnerable</b>	Individuals in Risk Level II are beginning to experience the onset of increasing medical need and need for assistance with ADLs. They have not yet met the level of care need that would qualify them for HCBS and have escalating needs making it progressively more difficult for them to remain independent in the community. They are incurring medical expenses. Awareness of those needs and attentive care coordination and supports serve to forestall preventable acute medical episodes and/or support continued ability to function successfully at home. Depending on income level they may be deemed eligible for DEA services if they are deemed ineligible for Medicaid. ( <i>Figure 1, IIIb</i> )
<b>Risk Level III: Residing in Community, Supported at Home</b>	Individuals in Risk Level III have been determined eligible for Medicaid long-term care services. Having met the clinical and financial requirements, home and community-based services have been put in place to meet their increased care needs. Their care management requires responsive, high touch coordination by an accountable entity to monitor and adjust their service mix as needed in order to continue residing in the community, including the involvement and support of caregivers and resolving problems or eliminating barriers to successful community-based care to avert hospitalizations and emergency department visits. ( <i>Figure 1, Ic</i> )
<b>Risk Level IV: In Hospital, In Need of Discharge Plan</b>	Individuals in Risk Level IV have been hospitalized to meet an acute medical need. Their care management requires clinical coordination and discharge planning from the onset of hospitalization between the hospital and care providers in the community to plan and arrange the necessary coordination for required care upon return to the community. Timely and effectively deployed supports in the community help prevent avoidable admissions to a nursing home. In instances where the individual requires long-term-care services and supports for successful return to the community, timely initiation of clinical and financial eligibility determination for Medicaid may be required. Once the individual is successfully discharged to the community, their care management requires responsive, high touch coordination by an accountable entity to monitor and adjust their service mix as needed in order to continue residing in the community, including the involvement and support of caregivers and resolving problems or eliminating barriers to successful community-based care to avert hospitalizations and emergency department visits.

Need/Risk Level	Description of Level and Needs by Risk
<b>Risk Level V: New to Nursing Home, Planning for Discharge</b>	Individuals in Risk Level V are similar to those in Risk Level IV, except they are discharged from the hospital to a nursing home as opposed to the community. Their care management requires clinical coordination and immediate planning to arrange the necessary care and supports for return to the community to avoid long-term stays in the nursing home. Once the individual is successfully discharged to the community, their care management requires responsive, high touch coordination by an accountable entity to monitor and adjust their service mix as needed in order to continue residing in the community, including the involvement and support of caregivers and resolving problems or eliminating barriers to successful community-based care to avert hospitalizations and emergency department visits.
<b>Risk Level VI: Long Term Residents in LTC Facility</b>	Individuals in Risk Level VI are long-term residents of long-term care facilities, mostly nursing homes. While some of these individuals' needs cannot be met in the community setting, many can and would prefer to live there. Rhode Island's Money Follow the Person demonstration grant is designed to develop systems and services to help these long-term residents of long-term-care facilities who want to move back to home or community-based settings paid by Medicaid. Early identification of individual needs for safe discharge is key and must consider housing support needed. Once the individual is successfully discharged to the community, their care management requires responsive, high touch coordination by an accountable entity to monitor and adjust their service mix as needed in order to continue residing in the community, including the involvement and support of caregivers and resolving problems or eliminating barriers to successful community-based care to avert hospitalizations and emergency department visits. (Figure 1, Ib)

An organized delivery system will systematically assess and profile the risk level and needs of the enrolled population to deploy targeted and individualized solutions that utilize effective information systems, timely communication, care coordination by a multi-disciplinary team, and management of medical interventions and community-based care options to help defer or avert nursing home care, preventable hospitalizations and avoidable emergency department visits.

**SECTION 3.3: WHAT DOES A MAXIMALLY EFFECTIVE SYSTEM NEED TO BE ABLE TO DO?**

As EOHHS moves forward in designing more integrated options for Medicaid beneficiaries, the system must incorporate functional performance capabilities to ensure individuals receive the most clinically appropriate, person-centered, cost-effective care in the least restrictive setting. Performance in these functional domains must be timely and vary with beneficiaries as they experience the onset and progression of need and risk levels. Each functional domain requires standards to ensure the performance capabilities of an effective system are structured and organized along the continuum. Performance standards serve as the state's foundation for tracking accountability of services rendered, areas for improvement, and recognition when deserved.

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| <p><b>FUNCTIONAL DOMAINS of a MAXIMALLY EFFECTIVE SYSTEM</b></p> <ul style="list-style-type: none"> <li>• Outreach and Information</li> <li>• Long-Term Care Eligibility Determination and Service Initiation</li> <li>• Identification of Risk and Emerging Needs to Target Efforts</li> <li>• Robust Network of Health Care Services and Supports</li> <li>• Value Purchasing, Oversight and Continuous Quality Improvement</li> </ul> |
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**Domain 1: Outreach and Information**

Essential to a successful system is the capacity to inform Rhode Islanders of the full range of available options so that they can make the best decisions for their lives, particularly at points of crisis and transition (e.g. upon discharge from a hospital). This system needs to provide relevant,

useful, and objective information, advice, counseling and assistance, at the points of need or risk. Performance standards for the domain of Outreach and Information include:

- Well established, informative, and responsive sources of information about available options
- Accessible and understandable information on benefits, eligibility and enrollment options

Currently, information on options comes from various sources, and can be contradictory, inaccurate or incomplete. Rhode Islanders need to have ready access to unbiased, timely and accurate information that can help them prevent common and predictable health issues from developing into health crises.

In response to this need, Rhode Island has developed THE POINT, which serves as Rhode Island's "virtual front door" to inform and connect aging and disabled residents and their families of their options available in the state.

There is consensus on the need for effective outreach and information system that can serve to simplify the ability of Rhode Islanders to effectively navigate it. Efforts are currently underway to enhance and build on the existing capacity of THE POINT to promote and support the Money Follows the Person (MFP) demonstration effort with options counseling and transition support services, including:

- **Patient Coaching** based on the care transitions intervention (CTI), into its options counseling and person-centered discharge planning;
- Developing and implementing a **Community Outreach Plan** to increase linkages with the healthcare community, helping to increase awareness; and
- Enhancement of **Quality Assurance and Evaluation Processes** to include the identification, collection and analysis of a series of metrics that will assess customer service (e.g., trust, ease of access, responsiveness, efficiency), as well as local trends in healthcare utilization (e.g., emergency room and nursing home utilization) and cost.

Stakeholders have expressed the need for strengthened integration of Outreach and Information services for both the elderly and adults with disabilities through a single point of entry. Given the broad scope and knowledge base required in performing the functions of providing timely information in accordance with the evolving needs of Rhode Islanders, state agency lead in coordination and further strengthening of these functions with THE POINT is relevant and logical. The Division of Elderly Affairs within the Department of Human Services is the lead on these efforts.

### **Domain 2: Long-Term Care Eligibility Determination and Service Initiation**

Essential to a high-performing delivery system is the capacity to process applications for eligibility for publicly-funded services quickly and accurately. Eligibility is a necessary pre-condition for provider payment and beneficiary receipt of services. Timely initiation of services, based on determination of eligibility and authorization, can be critical to the pathway of care and outcomes. Eligibility determination and service initiation is both complex and confusing for beneficiaries, their families and caregivers.

Performance standards for the domain of Eligibility Determination and Service Initiation include:

- Timely and accurate determination of eligibility services, including assessment of financial and functional levels of need, when appropriate.
- Universal, standardized assessment of functional capacity and level of need as the basis for service initiation and care coordination (Service Plan)

- Facilitating timely initiation of service plan and authorization of services based on changing levels of need and risk

Service Initiation:

In conducting the review of state agency roles, we separately identified and defined the tasks of *case planning* and *care management*. At present, both of these activities are performed by various public agencies as well as several service providers.

*Case planning* functions constitute the necessary pathway to care for beneficiaries. These functions include activities to ensure that eligibility determination is completed and that authorization and arrangement for initial services occurs. Performing these tasks requires thorough knowledge of state and federal regulatory requirements and comprehensive knowledge of the service provider network and capacity. The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals; the Department of Human Services Office of Long-Term Care, Division of Elderly Affairs Home and Community Care Office, and the EOHHS Office of Institutional and Community Services and Supports, all play roles in case planning.

*Care management* then pertains to what happens from the point that the case planning activities are completed. Care management functions are focused on a person’s unique needs to ensure that care is provided in an integrated and seamless manner. Care management must be highly attentive and responsive to the daily needs and changes in a beneficiary’s health and support systems.

Care management activities are currently performed by a variety of community-based (e.g., skilled nursing agencies and hospice providers) and institutional providers (e.g., Nursing Homes and Hospital Discharge Planners) each with different points of view and institutional interests, as well as by different state agencies (e.g., DHS, EOHHS, and BHDDH). Effective care management requires real-time information sharing, problem solving and feedback, all of which are essential to promote care that is coordinated with evidenced-based practices and patient-centered. For the most vulnerable populations, maintaining the necessary level of attention to the changing needs of a beneficiary often challenges existing resources and systems. As the number of beneficiaries receiving care in the community increases, approvals and authorizations performed by state agencies performing case planning functions will increase and must be expedited to ensure that eligibility and authorizations are in place for timely and appropriate care management to proceed.

**Domain 3: Identification and Targeting**

Essential to a successful delivery system is the capacity to identify needs and target responsive services to meet those needs as they occur. The system should recognize deteriorating conditions in real time to intervene and prevent predictable and unnecessary acute episodes. Performance standards for the Identification and Targeting domain must promote:

- Systematic methods of identifying, organizing, and monitoring indicators for an “Early Warning System” of beneficiary needs
- Predictive modeling tools to focus and allocate resources according to need and risk levels
- Immediate identification of key events such as hospital admission or nursing home admission in order to facilitate safe and timely discharge home.
- Processes for identifying candidates for discharge from long-term care facilities to the community with appropriate supports in place.

To be most effective, these data-driven identification and targeting tools should be well integrated with the care management functions described in Functional Domain 2: Long-Term-Care Eligibility Determination and Service Initiation, including mechanisms for service re-authorization and modification.

Adoption of health information technology to generate key information for tracking individual and population level health events and costs is necessary to prompt the actions needed for improved integration of care. An early warning system can systematically identify events where timely intervention can reduce service fragmentation, and preventable emergency department (ED) visits, hospitalizations, and nursing facility (NF) admissions. Key indicators include:

- Utilization patterns associated with high incidence of readmissions and shifts within acute settings
- Lack of preventive care utilization and use of post-discharge services
- Pharmacy utilization patterns indicating poly-pharmacy use and contraindications
- Home health service overlaps between Medicare and Medicaid driven by cost-shifting
- Avoidable hospitalizations for both institutionalized and community-based beneficiaries

A universal and automated Identification and Targeting system in place would greatly enhance the profiling, segmentation, prioritization and targeting of individuals for interventions that can make a difference. EOHHS has worked to develop approaches to meet this need. Nonetheless, the current system does not have a formalized and integrated system focused on early identification and targeting. EOHHS is examining expanding proficiency in this domain through the purchase and use of predictive modeling tools as the foundation for identifying short and medium term increased service needs. Such a system can support care management efforts to provide information about community-based care prior to a conversation in an acute setting precipitated by a decline in health status. In the pathways that are based on contracting with an accountable entity for care management, demonstration of strong capacity in this domain is essential. In this regard, Domain 3 and Domain 4 are integrally linked. Further exploration of available products and resource requirements to support the products is needed, however.

For the domain of Identification and Targeting, EOHHS will need to:

- Explore products, pricing and options to secure an “early warning system” and predictive modeling tools
- Incorporate defined requirements and demonstrated capability in any contracts with accountable entities.

#### **Domain 4: Robust Network of Health Care Services and Supports**

At the heart of the delivery system is the network of quality providers available to meet the populations’ needs for medical, behavioral health, and long-term care services. To be effective, the continuum of services available in the integrated delivery system must be responsive to the breadth of disabilities and chronic illnesses and conditions affecting beneficiaries, including physical disabilities and illness, behavioral health needs, and developmental disabilities.

A fundamental goal is to achieve a person-centered and strength based system with services available in the least restrictive and most community-based setting appropriate to meet a beneficiary’s need. This means providing a continuum of care ranging across the spectrum of intensive inpatient care to community based supports across and within disciplines. Given the prevalence of behavioral health conditions and disorders in the population of adults with disabilities and elders, it must be an essential component of the network configurations built into the system. Strong care management is also necessary to bridge over the cracks in the system that fragment services care across providers, disciplines and episodes of care, particularly at critical transitions.

**Figure 7: Elements of a Full Service Continuum for Integrated Care**

Acute and Primary Care	Behavioral Health Care	Long-Term Care Services and Supports
Inpatient hospital care Outpatient Hospital Services Physician Services Primary care Patient centered medical homes Specialty care Home based primary care Emergency room services Emergency transportation Prescription drugs Laboratory and Radiology Services Home health services Physical therapy Speech therapy Occupational therapy Durable medical equipment Optometry Nutrition	Emergency service interventions Crisis Stabilization Acute inpatient Acute stabilization unit 24 hour crisis services Hospital step down Case management Psychiatric services Evidence based co-occurring Treatment services Group and individual counseling Discharge planning Family psychological and supportive services Intermediate Services Partial hospitalization Day/Evening treatment Intensive outpatient treatment Enhanced outpatient services Outpatient Services Diagnostic evaluation Psychological testing Individual, group, family therapy Community support services	Long-Term care hospital services Nursing home care and skilled nursing facility care Hospice services Home care Home and community based services Personal care services Medications management Meals on wheels Adult Day Assisted living Shared living Housing supports, home modifications Community transition services Self-Directed services Respite Durable Medical Equipment
<b>INTEGRATED CARE MANAGEMENT ACROSS ALL SERVICE AREAS</b>		
Strongly connected multi-disciplinary care across acute, primary, behavioral health and long-term care services and supports.		
Effective coordination of Medicaid and Medicare covered services		

An effective and responsive behavioral health care continuum of acute care services ranging from inpatient psychiatric hospitalization to observation/crisis stabilization and residential treatment, to outpatient services for individuals and specialized groups is essential. It is important to create the incentives for the providers of services and supports to coordinate the care provided. Performance standards for the Services and Supports domain must ensure:

- Aligned financial incentives across the physical and behavioral health systems for timely and necessary service provision
- Real-time information sharing across systems to ensure that relevant information is available to all members of the interdisciplinary care team
- Multidisciplinary care teams, accountable for coordinating the full range of medical, behavioral, and long-term services and supports, as needed

- Competent Provider Networks
- Mechanisms for assessing and rewarding high-quality care in community settings

Because the population is prone to having chronic conditions, they require robust and continuous care coordination of the full range of medically necessary services as well as behavioral health and home and community-based long-term services and supports to help prevent or delay deterioration in health or functional status. Critical to the availability of covered benefits is the definition of “medical necessity.” Given the diverse needs of the population, including those needing assistance with daily living in the community, the medical necessity standard will need to accommodate the inherent diagnoses, illnesses and conditions within the population.

Refer to Section 4.1: Delivery System Options for related information.

**Domain 5: Value Purchasing, Oversight and Continuous Quality Improvement**

EOHHS has deliberately worked to transform Medicaid from being a payer for services to an active purchaser. The challenge is to establish a performance-based business relationship with a means of enforcing and/or incentivizing standards and achieving defined outcomes. In this respect, the state must define what it believes to be the essential features of an effective health services delivery system and incorporate those features into a contract for improved outcomes. Further, the state can define the quality and outcome measures it is seeking through these arrangements.

The capacity needed for oversight, evaluation and continuous quality improvement must exist in order to monitor and measure the performance of our business partners. Metrics such as duration in the community, overall cost of care, and the redistribution of care away from acute settings to the community are the essence of this domain.

One of the greatest opportunities in designing and developing integrated models of care is the use of payment methodologies to provide incentives to deliver effective health care services and improve quality. Applying value based purchasing reforms can help to transform how we deliver and pay for the care delivered as well as the performance of the delivery system overall. Moving away from the volume-based delivery of services to a more value-based delivery can benefit the beneficiaries, providers and payers. As described in earlier sections of this report, Rhode Island Medicaid has systematically pursued contractual partnerships with managed care organizations and PCCM sites to improve program quality and effectiveness. These partnerships have leveraged the state’s purchasing dollars to hold these partners accountable for performance and clinical outcomes, improve reporting systems and delivery system accountability.

Given the Rhode Island Medicaid program’s significant purchasing position in the state’s health care system, this opportunity to increasingly shift payments away from fee-for-service reimbursement towards more outcome-based payments is both timely and appropriate. Structuring contracts to tie some portion of reimbursement or enrollment to outcomes and/or value-based measures would allow the Medicaid program to ensure better management for highly complex and costly dually eligible beneficiaries who are not yet enrolled in an organized delivery system.

Bundled payment methodologies are another option. Bundling payments through a capitation payment to a health plan or another contracted entity gives the entity more flexibility to provide a wider range of services that can both improve quality of life and cost effectiveness of care.

EOHHS will develop the core performance standards so that the patient-centered approach is evident in the delivery models to promote outcome-based contracting and improve quality by incentivizing best medical practice, the prevention of adverse outcomes and the adoption of quality reporting mechanisms.

In traditional fee-for-service systems Medicaid was configured primarily as a payor for services. Over time Rhode Island Medicaid has deliberately focused on its role as a purchaser of services and delivery systems when paying for institutional services and when entering into contracts with managed care organizations. To the degree that Medicaid pursues its objectives through contracts with accountable entities; EOHHS specifies the features and performance requirements of the contract. Within managed care, components such as scope of network, access standards, member service requirements, quality performance and others are specified. Within the Enhanced PCCM model the recommendation is to enter into a contract with a partner to provide a set of essential care management services. This contract would also set forth core performance requirements.

Health service purchasers are increasingly defining specific quality objectives and desired outcomes and explicitly incorporating them into contracts, moving beyond more standard but essential contract elements such as of network and coverage provisions. Standards of both types are appropriate. As the purchaser, EOHHS then plays a fundamental role in monitoring performance, assessing outcomes and pursuing continuous quality improvements. This pertains to both an Enhanced PCCM model and a Capitated model.

For example, for beneficiaries at an identified level of care and being supported in the community, outcomes to consider might include:

- Length of time successfully supported in the community/delay of institutionalization
- Minimization of avoidable events such as:
  - Hospitalizations
  - Re-admissions
  - Emergency Room visits
  - Prevent/reduce social isolation
    - Member satisfaction
    - Ensure Safety
    - Rate of falls, accidents
    - Improvement or maintenance of ability to perform activities of daily living (ADLs)
  - 100% Coverage of authorized night/weekends/holidays for home-based services
- Comparative rates of nursing home days
  - Rates of admissions and re-admissions
  - Average length of stay for short term (less than 30 stays)
  - Numbers of persons returned safely to the community after being in a nursing home for 90 days or more.

In order to effectively design, implement and monitor the performance of such programs – capitated and enhanced FFS, EOHHS will need dedicated resource to perform this work.

#### **SECTION 4: HOW TO GET THERE – OPTIONS AND APPROACHES FOR A BETTER SYSTEM**

EOHHS is preparing to undertake critical actions to strengthen and improve upon the health system for some of Rhode Island’s most vulnerable citizens. As noted in the introduction, there is a growing momentum at the federal level to address and support states in their efforts to integrate care for the dually eligible population, based on the provisions in the Affordable Care Act. The ACA provides Rhode Island with a series of opportunities and required actions to consider in parallel with the state’s steps towards a more integrated delivery system, including: enhanced Medicaid matching payments, demonstration funding, new state plan options and technical assistance to state efforts with dual eligibles and others with chronic conditions. A summary of the relevant ACA opportunities can be found in Appendix C to this report.

The primary purpose of this report is to make recommendations for program initiatives to strengthen the publicly-funded system of care so that it is more responsive to meet the needs of dually eligible Medicaid beneficiaries and Medicaid-only adults – the dual eligibles and the non-duals. The needs and characteristics of the population, as detailed in this report are complex. Also detailed earlier in this report are the fragmentations and disconnects of care delivered to and experienced by the population. Having examined the care needs and system realities that exist, there is tremendous opportunity to better organize the publicly-funded system of care to serve this population. The underlying tenets for improving the system include:

- Improve the integration and coordination of the acute, behavioral and long-term care systems
- Address the fragmentations in coverage between the Medicare and Medicaid programs
- Ensure alignment of incentives for the development of a more person-centered system of care with quality outcomes
- Coordinate efforts for dual and non-dual populations

Critical core values and guiding principles were applied by EOHHS in the conceptualization and design of pathways and model options set forth as recommendations in this section, especially in relationship to the necessary functional elements of a person-centered system of care.

The recommendations put forth incorporate each of the five functional domains of a maximally effective system presented in Section 3, though the primary emphasis is on the domain elements of organizing the delivery system design (Identification and Targeting, Robust Network of Health Care Services and Supports). In approaching these system design issues, EOHHS must evaluate which of the functions are best and most appropriately performed by uniquely experienced and skilled state staff and which functions may be performed more effectively and efficiently by contracted partner entities.

#### **SECTION 4.1: DELIVERY SYSTEM OPTIONS**

EOHHS presents two primary pathways to follow:

##### **Pathway I: Enhanced PCCM Models (Models #1 and #3)**

##### **Pathway II: Capitated Models (Models # 2, # 4, #5 and #6)**

Each of the models represented in Figure 8 are not exclusive of one another and it is recommended that both major pathways be pursued for Rhode Island in parallel. A summary of the primary pathways and corresponding models to achieve a more integrated delivery system, organized by the dual eligibles and non-duals population groups, is captured in *Figure 8*. The areas of program expansion or change are shown in blue.

EOHHS intends to continue pursuit and evaluation of each of these opportunities to assess their feasibility for Rhode Island and for potential federal support for the investments needed to perform the critical functions of a maximally effective integrated system. The opportunity for a fully integrated program in partnership with CMS Medicare is particularly intriguing in that it holds the potential to be able to systematically address many of the issues raised in this report. It is, however, a major undertaking for state resources to assess the opportunities and risks with federal participation requirements that have yet to be fully defined. EOHHS continues to participate in regularly scheduled technical assistance sessions with CMS in order to more fully evaluate and assess the feasibility and value add of the Fully Integrated Capitated Model (#5) for Rhode Island.

#### **Enhanced PCCM Models**

In Pathway I: Enhanced PCCM Models, the Enhanced PCCM Model builds on the demonstrated capacity and experience with the care needs of medically complex individuals within the Connect Care Choice (CCC) program. The strengths of CCC are combined with an enhanced capacity in care management and service integration across all service categories, acute, behavioral health and long-term care. More incremental in approach than the capitated models, this pathway preserves the core person-centered medical home aspect of the CCC and builds on the established chronic care model of best practices.

Currently, 17 practice sites, meeting standards of performance adopted from the chronic care model of “best practices” serve approximately 1,800 non-dual beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused and holistic care to beneficiaries. This model is designed to achieve and preserve access to primary, preventive, behavioral health and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care. Any effort will be closely coordinated with and not duplicative of on-going efforts by BHDDH and the behavioral health homes initiative.

To address the needs for a greater integration of acute care and long-term care services and for high touch care management for the most vulnerable, a bundled service contract would be sought to build a Community Health Care Team (CHCT) that would focus on long-term care services and supports. This community based entity would have demonstrated expertise and the necessary tools to perform the care/ case management, care coordination, transition services, nursing facility inpatient management for non skilled care, social supports, housing, and transportation supports, and services integration functions in collaboration with the PCCM.. For non-duals, the Enhanced PCCM will be a direct expansion of the existing CCC program to include a sharper focus on long-term care services. For dual eligibles the contracted entity will take core responsibility for ongoing care coordination and integration, service authorizations and modifications and supporting successful transitions through the Community Health Care Team. This program would be operated under the direction of the Office of Community Programs within EOHHS.

Building on the advanced model of primary care established by the CCC program, and the contracted Community Health Care Team, EOHHS will also work to further evolve the capacity and commitment of this model by contracting with them as “Health Homes”, seeking federal approval for the enhanced federal cost sharing provide for under ACA. They will be responsible for preventing illness, reducing wasteful fragmentation, and averting the need for unnecessary and costly emergency department visits, hospitalizations and institutionalizations on behalf of the estimated two to three thousand dual eligibles expected to choose this model.

Designing CCC / CHCT as a Health Home would enhance the delivery system, and would allow the state to received increased federal matching for a period of time. Pursuit of this option would require an investment of state resources; staffing in particular. Community Health Care Team staff would need to be contracted out in this model.

**FIGURE 8. PATHWAY FOR INTEGRATED SYSTEM REDESIGN**

<i>Continuum of Services</i>	NON-DUALS MODELS		DUAL ELIGIBLE MODELS			
	Enhanced PCCM Model	Fully Integrated Capitated Model	Enhanced PCCM for Long-Term Care	Managed LTCSS Model	Fully Integrated Capitated Model	PACE
	Model #1	Model #2	Model #3	Model #4	Model #5	Model #6
<i>Acute Care</i>	Connect Care Choice	Rhody Health Partners	Medicare Advantage and FFS	Medicare Advantage & FFS Rhody Health Partners	EOHHS/ CMS/ MCO Contract	PORI
<i>Primary Care</i>	Connect Care Choice	Rhody Health Partners	Medicare Advantage and FFS	Medicare Advantage & FFS Rhody Health Partners	EOHHS/ CMS/ MCO Contract	PORI
<i>Behavioral Health Care</i>	Connect Care Choice in partnership with BHDDH licensed providers and other community-based providers	Rhody Health Partners in partnership with BHDDH	Medicare Advantage and FFS, including BHDDH licensed providers	Medicare Advantage & FFS Rhody Health Partners, in partnership with BHDDH	EOHHS/B HDDH/ CMS/ MCO Contract	PORI
<i>Long-Term Services and Support</i>	Purchase Care Mgt. & Service Integration in partnership with BHDDH for services for persons with developmental disabilities	Rhody Health Partners Expansion in partnership with BHDDH for behavioral health and services for persons with developmental disabilities	Purchase Care Mgt. & Service Integration in partnership with BHDDH for services for persons with developmental disabilities	Rhody Health Partners Expansion LTSS only in partnership with BHDDH for services for persons with developmental disabilities	EOHHS/B HDDH/ CMS/ MCO Contract	PORI

## Capitated Models

In Pathway II: Capitated Models, the design entails procuring and contracting with Managed Care entities for a range of expanded scope in services and beneficiaries served that does not exist in today's RHP contracts. Identification, Targeting and Care management and service integration functions will be embedded in the managed care model as a fundamental performance requirement, whether performed directly by the managed care organization or through the work of contracted providers. Enhanced and specific requirements will need to be developed to meet the increased complexity of the needs of beneficiaries across the full continuum of services. Any effort will be closely coordinated with BHDDH.

The managed care model routes include:

- PACE:
  - Preserve and expand the existing PACE program, taking advantage of unique qualifications and experience of PORI serving the dual eligibles population and supporting expansion of PORI capacity wherever possible.
- Managed Long-Term Care:
  - *For non-duals*, extend covered benefits beyond the current acute care benefit package to include long-term care services and supports
  - *For dual eligibles*, contract with a managed care entity for all long-term care services and supports paid for by Medicaid and for all acute care services paid by Medicaid as wraparound of Medicare coverage. This would include defined requirements for active coordination with Medicare covered services to minimize fragmentation. This could be facilitated where dual eligibles are currently enrolled in Medicare Advantage plans.
  - The population for inclusion in this model would be all dual eligibles who have a level of care determination as the highest, high or preventive levels.
- Fully Integrated Medicaid and Managed Care Program for Dual Eligibles:
  - Develop a comprehensive managed care program including all Medicare and Medicaid covered services within a single contract. This requires pursuing a three-year Centers for Medicaid and Medicare Services (CMS) demonstration for a capitated payment model utilizing a three way contract between CMS, the state and qualified health plans to provide the spectrum of fully integrated Medicare and Medicaid services to dual eligibles. This arrangement would include shared savings targeted for both programs. The statewide target population for enrollment in the integrated models are people with Medicare and Medicaid that do not meet any of the following exclusions:
    - Clients who are not “full-duals” would be excluded from the enrollment (SLMBs, and QIs) in the capitated model. (approximately 5000 people)

The Fully Integrated Capitated Model #2 for non-duals builds on the Rhody Health Partners proficiencies and capabilities gained since 2009 in serving adults with disabilities. The expanded scope and responsibilities involves extending the care management and services integration of long-term-care services and supports paid for by Medicaid into the existing programs – highlighted in blue in the non-duals models section of Figure 9.

For both model #1 and #2 approvals would be needed from CMS, but these are within the traditional scope of Medicaid programs and Medicaid funding. Pursuit of Model #2 for the non-duals requires enhanced performance requirements of and amendments to the Rhody Health Partners program for inclusion of coverage and management of the long-term care services and supports.

Focusing on dual eligibles, in addition to PACE expansion, three pathways are delineated. Model #3 Enhanced PCCM for Long Term Care and #4 Managed Long Term Care Services and Supports, also would require CMS approval, but are also clearly within the scope of scope of traditional Medicaid authority and responsibility.

Model #5, however, represents a clear departure from traditional authorities and an opportunity for enhanced integration. As noted, it also carries some additional risks that need to be examined and understood. Accordingly, engagement of CMS program authority and systems is required in each of these models, particularly for Model #5, though the degree of engagement with CMS varies.

The most elaborated model, the Fully Integrated Capitated Model (#5), is the CMS demonstration offering to enter into a three-way contract to test integrated payment and services for dual eligibles. This would be a fully blended model in which CMS Medicare and Medicaid would be in a shared savings arrangement. Because this demonstration is combining Medicare and Medicaid authorities to provide the full continuum and integrated delivery of benefits, the managed care organizations must have demonstrated capacity to meet the combination of Medicare and Medicaid specified requirements. EOHHS is engaged in active dialog with CMS to further define program requirements, the respective roles of Medicare and Medicaid and to assess potential for state savings through the shared savings provisions.

Of the capitated models the essential choice to be made regarding dual eligibles is between the Managed Long Term Care option and the fully integrated managed care partnership with CMS Medicare. Operating within the traditional scope of Medicaid programs, several states have developed successful managed care programs for long term care. The CMS demonstration for fully integrated managed care programs holds considerable potential for transforming systems of care but, as noted, many questions remain to be answered. One approach is that these options could be pursued sequentially, with managed long-term care as the initial step with the more comprehensive program to follow one year later.

Determining how best to serve adults with developmental disabilities through each of these models will require additional study with BHDDH. States that have pursued each of these models have implemented widely different approaches that range from carving the population out entirely to absorbing the existing system of care in as a whole. EOHHS is committed to reviewing the experiences and best practices of other states in this area in partnership with BHDDH to ensure that the needs of adults with developmental disabilities will be well served by any option for integrating care the state chooses to pursue.

## **SECTION 5: CONCLUDING REMARKS**

The Rhode Islanders considered in this report include the most vulnerable individuals in the Medicaid program. There is both are clear opportunities to do better for this group of Rhode Islanders, to improve systems of care, and to improve the cost effectiveness of care. This report highlights the range and complexity of the issues EOHHS must address for the integration of care and financing for Medicare and Medicaid-only beneficiaries of Rhode Island. The approach will continue to be informed by stakeholder perspectives, detailed data analysis and evidence-based policy to drive best practices in the procurement of provider agreements and contracts to deliver care and services for these most vulnerable Rhode Islanders.

EOHHS is committed to a service delivery system that is continuously innovating and learning, facilitating improvements in quality, value and the individual's experience using it. Working together with consumers, providers, advocates, policy makers and families of Rhode Island, we

must create an integrated continuum of services and supports to bring about higher quality care, better health outcomes, reduction in preventable and costly adverse events, and increased capacity for beneficiaries to remain at home and in their communities with dignity to the greatest extent possible.

Underlying our efforts is the most pressing need for containment of costs. Redesigning the way services are organized and delivered by using the purchasing strategies proposed in this report is an approach to cost-containment. With rising costs principally driven by patients with severe and chronic conditions, often complicated by behavioral health issues, EOHHS, in partnership with BHDDH, is committed to better integrating and coordinating the financing of care as a means to containing state Medicaid costs.

A systemic approach to expanding and integrating care management and coordination strategies and standards will benefit individuals eligible for publicly-funded health care as well as tax-payers. Addressing the complex needs of dually-eligible and Medicaid-only elders and adults with disabilities by aligning our resources more effectively can significantly improve the quality of their lives, and the lives of their caregivers and families. It is the clinical needs and preferences of the individual that must drive the redesign of the system and the reallocation of resources to meet those individual needs and preferences. EOHHS is committed to organize, manage and contract for an accountable and quality-driven continuum of services and supports to achieve these goals.

## APPENDIX A

### Millie's Story

To illustrate today's realities, we present a case study of one "typical" individual, a person with complex medical needs navigating the existing system. Because of her age, Millie is covered by Medicare. Because of her low income, Millie is covered by Medicaid. Millie is a "dual-eligible beneficiary."

Millie, aged 70, suffers from asthma, diabetes and hypertension, and several strokes which have caused weakness in her left side. She has many providers at her local hospital and health center, a personal care attendant who helps her to live alone at home, and a variety of physician specialists. She often has trouble getting to medical appointments due to her mobility problems and coordinating arrangements for transportation. Millie has been hospitalized five (5) times in the past year and required nursing home placement before returning home in two (2) instances. Her family supports her choice to live at home, yet has noticed that she is becoming more emotionally withdrawn and increasingly forgetful when they visit her. They notice that her traditionally fierce independence is waning and are increasingly concerned about her emotional health.

Traditional Medicare covers her basic acute-care services such as physician, hospital and prescription drug costs. Medicaid pays for most of her long-term care needs. Medicaid pays for her personal care assistance at home and her Medicare deductibles, co-payments and other cost-sharing responsibilities she otherwise would pay for out of pocket.

Millie has never had an established relationship or usual source of care for her medical or behavioral health care needs. In fact, all of her care has been episodic and reactive across a range of services and settings. Her story demonstrates the typical experience of a dual eligible with complex needs. Her recurring visits to the hospital and recovery periods at different nursing homes were arranged by different providers each time. Two of her hospital admissions were precipitated by contraindicated medications. Her nursing home stays were necessitated by the lack of accountable and available community-based resources to support and coordinate her escalating behavioral health needs with her medical needs. Millie's needs have not been met in the current unaligned system in which both payers (Medicare and Medicaid) and providers have shifted her between services and settings, which has resulted in uncoordinated and fragmented care.

The Millie's Story outline contrasts her "Today" with the envisioned experience in a redesigned, aligned and integrated care system.

<b>Millie's Story</b>	
<b>Today</b>	<b>Redesigned, Aligned, and Integrated Care System</b>
<b>Three ID Cards: Medicare, Medicaid and Prescription Drugs</b>	Millie's insurance information is gathered one time and documented for all team members for billing purposes only. As Millie's care needs change, new providers are equipped with her billing information along with her history and presenting needs. Millie's identity as a person precedes her identity by insurance status.
<b>Three different sets of Benefits/ No Coordinated Care</b>	A multi-disciplinary team organizes a coordinated set of comprehensive benefits (primary, acute, behavioral, prescription drugs, and long-term care supports and services) designed and arranged to serve Millie's needs. Using a standardized assessment tool, all aspects of Millie's health and living situation are evaluated to ensure that the resulting plan of care is designed to support Millie's entire scope of needs. Millie has an individualized care plan.
<b>Multiple Providers without structured communications/ No</b>	A single, accountable network of providers communicates to Millie and her family as well as one another as she transitions across all settings due to changes in her care needs – improvements and

<b>Millie's Story</b>	
<b>Today</b>	<b>Redesigned, Aligned, and Integrated Care System</b>
<b>Patient-Centered Primary Care Home</b>	declines. Millie has consumer protections to ensure her preferences are respected and she is involved in the design and ongoing changes of her care. Her accountable network of providers has systems in place to communicate and promote the coordination of her care, including attending to her emerging behavioral health condition impacting her physical health. Her family is engaged by her providers to face the daunting responsibilities with preparedness and support.
<b>Uncoordinated and medically focused decisions are made by clinicians in isolation of one another</b>	Clinical decisions are based on Millie's needs and preferences, taking into account any opportunities to effectively intervene on predictable complications. A professional and community support team assess, manage and coordinate all of her care across multiple settings taking into account her family and care giver's skills, abilities, and comfort with involvement in her care.
<b>Rules-Based Interruption of Benefit Coordination</b>	Millie's care is no longer dependent on separate programs and conflicting benefit limitations and prior approvals. Barriers to Millie receiving integrated care are mitigated by blended financing and/or shared risk and gains of providing services.
<b>Limited Home Health and Community Based Services</b>	Millie's need to live safely and independently is preserved with a team that is focused on preventing a decline in her health status and preventing re-admittance to acute settings. Millie receives the services and supports she needs to help her stay at home, avoid predictable and unnecessary acute episodes and coordinated supports for discharge back to her home and community.

Millie has not received high touch coordinated care that is tailored to her needs or collaboratively planned by a care team with knowledge about her specific needs. Millie is an example of a dually eligible individual whose care is inadequate and as a consequence, unnecessarily costly. Her story demonstrates the need for a fundamental redesign of the delivery system by realigning the financing and integration of her care in order that the delivery system is organized and accessible to meet her needs.

## APPENDIX B

### Successful Models of Care

#### Massachusetts' Senior Care Options

Since most fully integrated programs are still in their very early implementation stages, there are very few proven models available of fully integrated programs that have shown results. The Senior Care Organization (SCO) model adopted by Massachusetts in 2004 began as a demonstration program that blended Medicare and Medicaid funding into one capitated rate received by accountable entities responsible for the entire range of services, for clients over the age of 65. Commonwealth Care Alliance (described below), a state-wide, not-for-profit, consumer governed prepaid care delivery system, entered into a three-way contract with CMS and Massachusetts Medicaid (Mass Health). The Commonwealth Care Alliance (CCA) experience was successful in several key domains including decreasing spending growth, increasing primary care access, and reducing hospitalizations.

- The number of primary care visits per member in CCA was 20, compared with an average of 3.7 in historical fee-for-service
- 10.5% of CCA members became Long-Term nursing home Residents post hospital SNF Facility stays, compared to 32% in historical fee-for-service
- Average annual medical expense increase for CCA ambulatory members, from 2004 to 2010 was 2.6%
- CCA hospital admissions per 1000 per year were 141 in 2010 compared with 671 in fee-for-service in 2008
- CCA showed a \$16.9M increase in primary care expenditures over FFS Medicare, in 2010.

#### Commonwealth Care Alliance

The Commonwealth Care Alliance operates a fully integrated Dual Eligible Medicare Advantage Special Needs Plan. The program relies on Medicare and Medicaid risk adjusted premium to redesign care with a focus on investment in primary care. The care model features enhanced primary care and care coordination capabilities through deployment of multi-disciplinary Primary Care Teams. The program strives to achieve the following programmatic goals: (1) Create partnerships between those receiving care and those providing and managing care, (2) Promote autonomy, independence, and function to the maximal extent possible for all members and (3) Provide responsive, continuous care that effectively reduces secondary medical complications and substitutes support, home and community services for institutional care when appropriate.

Although the characteristics of the individuals served by Commonwealth Care Alliance have a diverse and complex set of needs, there are common care system principles that are key to improving care and managing costs. These principles can be summarized as follows:

- A mission to serve special populations
- Specialized clinical care programs
- Selective primary care networks with expertise in the management of those with special needs
- Team approach to care management by supporting the primary care clinician with nurse practitioners, nurses, behavioral health practitioners
- Care coordination by the primary care team to optimize the management of medical and psychosocial issues and promote stability
- 24 hours a day, 7 days a week access to care providers
- Clinical information systems to support the entire network
- Promotion of enrollee empowerment and participation in care planning

- Flexible benefit design to provide care in the most appropriate setting, whether community or facility
- Contain and stabilize medical costs
- Accountable for quality and improved health outcomes

Through the integrated Medicare and Medicaid financing of the model, the Commonwealth Care Alliance has been successful at operating a care model that is designed to meet the full spectrum of services in a variety of settings, rather than authorizing care according to the benefit limitation of the different programs. The Commonwealth Care Alliance experience has demonstrated that for persons with high needs an enriched, high touch primary care model is essential, a model that works with the member where he or she is in terms of independence and vulnerability, maintains close contact so as to anticipate, recognize and respond to the needs immediately. Dr. Robert Master, President and CEO of The Commonwealth Care Alliance stated that, "...primary care is grossly under resourced in both current FFS and managed care iterations. 30-50% of total medical expenditures are for recurrent hospital care, as a consequence of the missed opportunities to effectively intervene on predictable complications."<sup>9</sup>

### Tennessee – Managed Long-term Care

The three TennCare managed care organizations are responsible and at-risk for providing the full continuum of LTSS services, including nursing facility and Home and Community Based Services (HCBS), in addition to all acute and behavioral health services for eligible members. Care coordination is provided by the health plans, and focuses on support for member preferences regarding services and settings as well as intensive case management of transitions between care settings. In Tennessee's "Middle Region", the nursing home placement rate dropped from 83% to 74% in just eight months. In the first four months the East" Region rate dropped from 81% to 76% and the West Region rate dropped from 84% to 80%.

### Veteran's Administration (VA) Home-Based Primary Care (HBPC) program

The Veteran's Administration (VA) Home Based Primary Care (HBPC) program illustrates another example of innovated service delivery integration for people with the highest level of need. The VA program is a home care program that provides comprehensive, interdisciplinary primary care in the homes of veterans who have complex medical, social and behavioral conditions. These are individuals that are not able to travel from their homes to a VA clinic for care. The primary goals of the VA's HBPC program are:

- To promote the veteran's maximum level of health and independence by providing comprehensive care and optimizing physical, cognitive and psychosocial functions.
- To reduce the need for and provide an alternative to hospitalization, nursing home care, ED visits, and outpatient clinic visits through longitudinal care that provides close monitoring, early intervention, and a therapeutically safe home environment.
- To assist in the transition from a health care facility to the home by providing patient and caregiver education, guiding rehabilitation and use of adaptive equipment in the home, adapting the home as needed for a safe and therapeutic environment and arranging for and coordinating supportive services including home Telehealth.
- To support the veteran's caregivers.
- To meet the changing needs and preferences of the veteran and family throughout the course of the chronic disease, often through the end of life.

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<sup>9</sup> Dual Integrated Financing and Its Opportunity to Fundamentally Improve Care and Reduce Costs: The Commonwealth Care Alliance, Primary Care Redesign and Enhancement Experience, NHPRI/RIHCA Policymaker Breakfast, November 16, 2011

- To enhance the veterans' quality of life through symptom management and other comfort measures.
- To allow the veteran the option of dying at home.
- To help the veteran and family cope with all elements of chronic disease.
- To promote an enduring network of skilled home care professionals by providing an academic and clinical setting for health care trainees to experience interdisciplinary delivery of primary care in the home.<sup>10</sup>

The VA HBPC approach is both interdisciplinary and coordinated as it brings together a team comprised of a social worker, pharmacist, dietician, rehabilitation therapist, nurse, and physician who meet regularly and work with the patient to develop an appropriate customized care plan. Other disciplines are oftentimes involved on the team as well including a chaplain, physician assistant, psychologist, or psychiatrist.

There have been many internal and external studies of the VA's HBPC program and all, in general, conclude the program demonstrates improvement in health care quality, decreases in costs, and enhanced patient satisfaction. Research shows that that success in reducing costs and improving quality of care for the high cost, frail beneficiary population depends on a relationship of trust built over time with face-to-face contact between the patient and the physician or nurse practitioner in the patient's home. This has been a central feature of the VA HBPC program and clearly one of the critical elements to the program's success.

In a retrospective case-control national analysis of all VA HBPC patients in 2002, enrollment into HBPC was associated with the following:

- 62% reduction in hospital days and a substantial reduction in ER visits
- 88% reduction in nursing home days
- Net 24% reduction in total costs for the over 11,300 patients in the HBPC program.

A more recent utilization comparison for over 15,900 patients enrolled in FY 09, found:

- 60% decrease in hospital use
- 90% decrease in nursing home use
- 30-day readmission rate decreased by 18.2%
- High patient satisfaction rate (82.7%), the highest overall satisfaction rating of all VA patient surveys.<sup>11</sup>

### *Best Practices in Long-Term Care Profiled by the Center for Health Care Strategies*

The Center for Health Care Strategies (CHCS) report, "Profiles of State Innovation: Roadmap for Rebalancing Long-Term Supports and Services" offers mileposts to help states explore and understand emerging options, best practices, and proven models of success in three areas: (1) rebalancing LTSS care options to support home- and community based services; (2) the development and implementation of a managed long-term Care Services and Supports (LTSS) program; and (3) integrating care for adults who are dually eligible for Medicaid and Medicare. The ten mileposts are outlined below.

1. Communicate a clear vision for LTSS and identify a champion to promote program goals.
2. Bridge the gaps between state officials responsible for medical assistance and long-term care.
3. Engage stakeholders to achieve buy-in and foster smooth program implementation.

<sup>10</sup> VHA Handbook 1141.01, Home-Based Primary Care Program, January 31, 2007

<sup>11</sup> Edes, Thomas, Safe Transitions — Comprehensive Coordinated Care through VA Home Based Primary Care, October 4, 2010

4. Embrace a “No Wrong Door” philosophy for all HCBS to help consumers fully understand their options.
5. Deploy case management resources strategically.
6. Use a uniform assessment tool, independent of provider influence, to ensure consistent access to necessary LTSS services.
7. Support innovative alternatives to nursing homes.
8. Expand the pool of personal care workers to increase the numbers of beneficiaries in home and community settings.
9. Take advantage of initiatives that help people move out of nursing homes and into the community.
10. Analyze relevant data to measure quality of care metrics that reflect the vision of the long-term care program.<sup>12</sup>

Aligned with the recommendations from the Center for Health Care Strategies, is the Center for Medicare and Medicaid (CMS) State Balancing Incentive Payment Program. This program assists states in transforming LTC systems by lowering costs through improved system performance and efficiency, creating tools to facilitate person-centered assessment and care-planning and improving quality measurement and oversight. States are eligible for enhanced Federal Medical Assistance Percentage (FMAP) by implementing structural changes to the LTC system including:

- No Wrong Door –Single Point of Entry (ADRC)
- System Conflict-Free Case Management Services
- Core Standardized Assessment Instruments

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<sup>12</sup> Center for Health Care Strategies: Profiles of State Innovation: Roadmap for Rebalancing Long-Term Supports and Services, November 2010

## APPENDIX C

<b>EOHHS Stakeholder Meetings and Key Informant Interviews through December 22, 2011</b>	
<b>Date</b>	<b>Key Informants and Stakeholder(s)</b>
<b>September 16, 2011</b>	United Healthcare
<b>September 22, 2011</b>	Blue Cross Blue Shield
<b>October 5, 2011</b>	Commonwealth Care Alliance (CCA) of Massachusetts Lois Simon, COO
<b>October 7, 2011</b>	Program of All Inclusive Care of the Elderly of Rhode Island (PORI)
<b>October 11, 2011</b>	DEA Program Staff
<b>October 31, 2011</b>	Mass Senior Care of Massachusetts Scott Plumb, Senior Vice President
<b>November 8, 2011</b>	DEA Case Management Team
<b>November 9, 2011</b>	Key Informant Interview with State of Vermont Julie Wasserman and Bard Hill, Agency for Health Services (AHS)
<b>November 10, 2011</b>	Key Informant Interview with North Carolina Denise Levis and Angela Floyd North Carolina Community Care of North Carolina (CCNC)
<b>November 16, 2011</b>	Neighborhood Health Plan of Rhode Island and Rhode Island Health Center Association Policy Makers Breakfast on Dual eligibles
<b>November 22, 2011</b>	DEA Home and Community Care Advisory Committee
<b>November 23, 2011</b>	Key Informant Interview with State of Tennessee Patti Killingsworth, Assistant Commissioner, Chief of LTC, Bureau of TennCare
<b>November 28, 2011</b>	Global Waiver Task Force
<b>December 1, 2011</b>	Deb Castellano, Chief Casework Supervisor, DHS Long-Term-Care
<b>December 1, 2011</b>	Home and Community-Based Services Trade Associations and Advocates
<b>December 13, 2011</b>	DEA Academy
<b>December 14, 2011</b>	Long-Term-Care Coordinating Council

## APPENDIX D

### SUMMARY of AFFORDABLE CARE ACT (ACA) OPPORTUNITIES

#### State Balancing Incentive Payments Program (SBIPP)

Beginning October 1, 2011, enhanced federal matching funds were made available to states to increase the proportion of HCBS compared to 2009 levels of institutional expenditures between years 2012 through 2015 with structural changes to achieve a “No Wrong Door” (NWD) and statewide entry point (SEP) system. To qualify for the enhanced payment, Rhode Island must submit an application with accompanying work plan and budget, along with a commitment to data reporting and the following structural attributes implemented within 6 months:

- A single point of entry for accessing long-term care services and supports (LTSS);
- A standardized assessment tool for determining eligibility for non-institutional LTSS used statewide; and
- A “conflict free” case management system for consumers

The administrative changes required by this program have been used in some states as a means to increase in the use of non-institutional services in Medicaid and, over time, a reduction in the growth in Medicaid long-term care spending. However, making those administrative changes can cost money. EOHHS is currently assessing this opportunity for potential alignment with fulfillment of the desired characteristics of the outreach and information and long-term-care eligibility determination and service initiative domain functions. EOHHS is awaiting final regulations as well as further guidance from CMS on this program to determine whether the requirements and added federal funding align with our goals.

#### Money Follows the Person

The ACA extended the timeframe for the MFP demonstration through 2016, added \$450 M to the allocation of funds increasing total funds available to \$2.25B, and reduced the institutional level of stay needed to qualify for MFP from 180 to 90 days. ACA also significantly increased the enhanced federal match for home and community-based services (HCBS) as system wide investments to improve the delivery of community-based care. States may receive full reimbursement for approved administrative costs, not exceeding 20% of the award.

Clearly, this opportunity is aligned with and helps us to fulfill our services and supports domain for a more integrated system promoting, and building capacity for home and community-based services. EOHHS applied for and received MFP funding. EOHHS intends to integrate and promote the coordination of the MFP across the delivery system.

#### Community First Choice Option

A new Medicaid State Plan option called Community First Choice (CFC) was established by the ACA to promote “person-centered” home and community-based attendant services and supports statewide. For individuals up to 150% of the Federal Poverty Level (FPL) without need for institutional level of care, and those above 150% of the FPL meeting institutional level of care, CFC provides attendant services and supports consistent with their person-centered care plan based on a functional needs assessment. An enhanced 6% Medicaid matching rate is available to those states electing this option and meet significant imposed requirements, including:

Service availability: States must make services available statewide, with no caps or targeting by age, severity of disability, or any other criteria. Services must be provided in the most integrated setting appropriate, given an individual's needs.

Maintenance of Effort: During the first year, a state must maintain or exceed its prior year Medicaid expenditure level for optional services provided to elderly individuals and people with disabilities.

Implementation Council: States must establish a Development and Implementation Council to collaborate on program design and implementation. The Council must have majority membership of the elderly, people with disabilities, or their representatives.

Quality Systems and Data: States must develop quality systems that incorporate consumer feedback and monitor health measures. The state must submit program reports to the Department of Health and Human Services.

Although the option provides a strong financial incentive to expand home and community-based care services as a Medicaid benefit, it may also open eligibility to individuals with higher incomes for those services, having a financial impact on the state budget. EOHHS intends on assessing the potential of this opportunity upon issuance of the final regulations when a cost-benefit analysis can be performed.

### **Health Homes Option**

The ACA offers states the opportunity to receive 90% federal matching funds via a State Plan Amendment (SPA) for a set of services defined in the law as "Health Homes" for individuals with two chronic conditions, one chronic condition and at risk of another, or one serious and persistent mental health condition. The following services are reimbursable under the Health Home initiative:

- Comprehensive Care Management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and families support, which includes authorized representatives
- Referral to community and social support services, if relevant
- The use of health information technology to link services, as feasible and appropriate

RI Medicaid was among the first states in the nation to receive approval and enhanced funding for two Health Home State Plan Amendments, beginning October 1, 2011. There is opportunity to submit additional SPAs to seek approval for entities providing Health Home services to those not yet enrolled with a health home. The potential for further adoption of the health home model as a means of accountability for the coordination of services and supports requires more study and analysis by EOHHS.

### **CMS Financial Alignment Demonstrations**

The Federal Coordinated Care Health Care Office (Office of the Duals), was formed to facilitate a working relationship between federal and state officials to better integrate service delivery and payment mechanisms for dually eligible beneficiaries. Since July of 2011, 37 states, including Rhode Island, have been working with another newly established office, the Medicare-Medicaid Coordination Office (MMCO), to create new models by streamlining and bridging the chasms between the two programs. Prior to this opportunity for collaboration, states had no financial incentives to pursue integrated programs without a stake of share in Medicare savings.

As a state interested in the federal opportunity to pursue the CMS capitated financial alignment demonstration, EOHHS received an outline of the initial parameters and key target dates for

participation in late December from the MMCO and further guidance in January of 2012. Fundamentally, the materials issued indicate that the MMCO intent is to have the Medicare Advantage (Medicare Part D requirements) Program serve as the platform around which current Medicare policies and procedures will remain in place. Where greater flexibility is needed, in order to successfully align rules and incentives with Medicaid, regulations can be waived with the appropriate authority and within pre-established parameters articulated by CMS. Preliminary modeling of savings, based on assumed national averages for each of the three years during the demonstration period were also provided. Additional details are expected to be released in late January of 2012. Each participating state has been asked to provide CMS with Medicaid expenditure and population data for state residents covered by both programs over the two most recent years (post Part D implementation) and to review the aggressive operational timeline and preferred requirement standards provided.

At the time of this report submission, EOHHS continues to review and assess the opportunity to participate in the new capitated payment model using a three way contract between CMS, Rhode Island and health plans for the integrated delivery of the full continuum of Medicare and Medicaid benefits beginning in 2013. Further development and exploration of the available Medicare data sets from CMS and the state's Medicaid data to identify areas of overlap between the coverage's and potential for improved care coordination for Rhode Island's dual beneficiaries is needed for an informed decision about whether participating is in the state's best interest.

More information can be found at:

<http://www.cms.gov/medicare-medicaid-coordination/Downloads/FederalRegisterNoticeforComment052011.pdf>

Rhode Island Executive Office of Health and Human Services

# Integrated Care for Medicare and Medicaid Beneficiaries

A Demonstration Proposal to the Center for Medicare and  
Medicaid Services

Posted for Public Comment  
Public Comment Period  
April 26, 2012 through May 25, 2012

April 26, 2012 Version  
May 31, 2012

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## I. EXECUTIVE SUMMARY

The Rhode Island Executive Office of Health and Human Services/ Medicaid (RI Medicaid) is committed to delivering quality health care to all Medicaid beneficiaries. EOHHS has achieved this goal by developing Medicaid managed care programs that have received national recognition. The Medicaid program will continue this culture of quality by expanding managed care to people who are eligible for both Medicaid and Medicare.

Commonly referred to as dual eligibles, individuals become eligible for both the Medicaid and Medicare programs in a variety of ways. Most individuals qualify for Medicare when they turn 65, or after receiving Social Security Disability Income (SSDI) payments for 24 months. Working-age adults qualify for SSDI due to illness or injury. These Medicare beneficiaries qualify for Medicaid later in life, either because they have been unable to work and have become increasingly impoverished or because their level of need has increased and they need to receive additional supports and services that are not provided by the Medicare program. Additionally, low-income disabled individuals receiving SSDI may need to apply for Medicaid to cover the cost of their health care needs during the 24-month Medicare waiting period.

As this demonstration proposal will illustrate, dual eligibles are often the most destitute, chronically ill and costly individuals in both programs. Despite this intense need, the care that approximately 9 million dual eligibles receive is from two separate programs whose providers, benefits and enrollment policies were not designed to work together. This misalignment contributes to increased but not necessarily cost-effective utilization of the health care system.

Congress recognized the disjointed nature of these two programs in the Affordable Care Act (ACA). There are several initiatives inside the ACA that address the integration of care for dual eligibles, and allow states to work with the Centers for Medicare and Medicaid Services (CMS) to create models that align the financing and care for dual eligibles.

This proposal describes EOHHS' general approach to the delivery of care to Medicaid-eligible adults with disabilities and specifically, one component of that approach: the development of a managed care program that enables the State to enter into an agreement with CMS for coordinated care across Medicaid and Medicare.

## II. BACKGROUND

The Rhode Island Medicaid program is the principal source of health care coverage for low income children and families, pregnant women, elders and persons with disabilities who are otherwise unable to afford or obtain needed services and supports. In state fiscal year (SFY) 2010, the average number of Medicaid beneficiaries the program served was just over 189,000 Rhode Islanders. As the Medicaid state agency, the mission of the Executive Office of Health and Human Services (RI Medicaid) is to provide these beneficiaries with access to high quality, coordinated health care services in the most cost-efficient and effective manner possible.

In 2010, the Affordable Care Act provided the state with both the impetus and the opportunity to extend efforts to include the coordination of services for two of the most vulnerable populations the Medicaid program serves:

- adults with disabilities, ages 19 to 64
- elders: age 65 and older

In July 2011, the RI General Assembly also recognized the importance of improving the system serving these beneficiaries:

*By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid Beneficiaries, the Executive Office of Health and Human Services (EOHHS) is directed to engage in a contractual arrangement for the expansion and integration of care management strategies by July of 2012 for Medicaid-only beneficiaries and beneficiaries dually eligible for Medicaid and Medicare.*

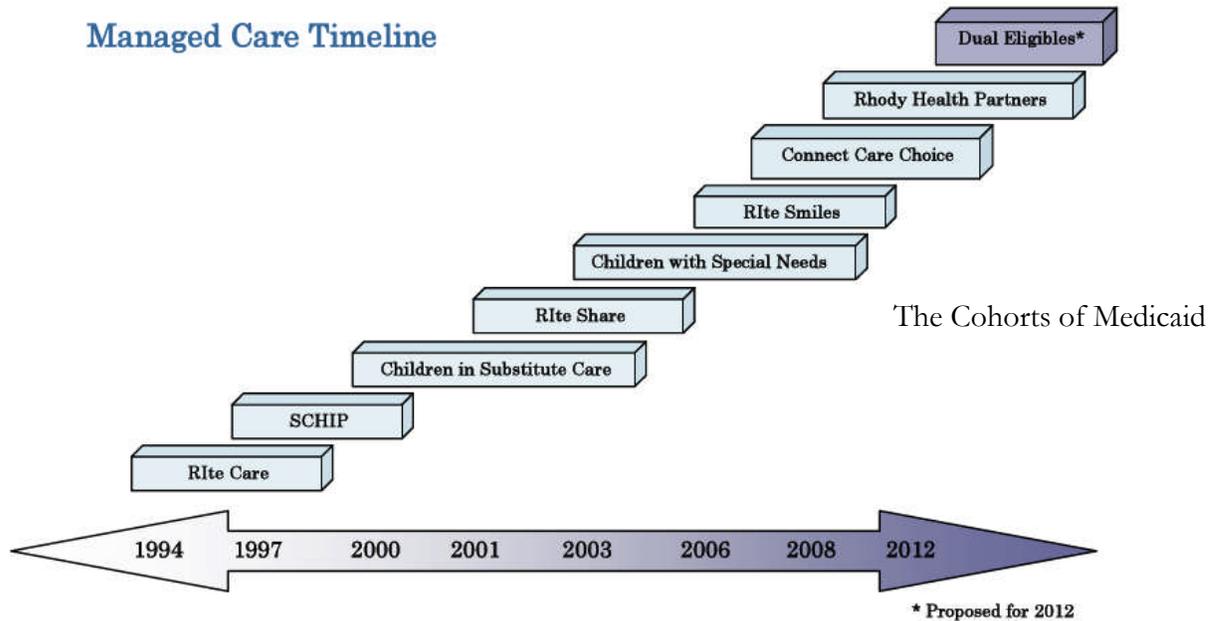
Toward this end, this state issued a report<sup>1</sup> that focuses on the options for improving the way in which Medicaid eligible adults with disabilities and elders access health care services and long-term services and supports. Medicaid eligible adults with disabilities and elders represent about one quarter of the total RI Medicaid population, and just over 60 percent of total annual program expenditures. Although the service needs of adults with disabilities and elders do vary, the two populations share many common features. The beneficiaries in both groups tend to have very low incomes and limited assets. Many of these beneficiaries have multiple chronic conditions, one or more of which may result in a hospitalization or a nursing facility stay, and all require a mix of acute, sub-acute and long term care services. These services are often fragmented and difficult to navigate.

For several years, the Rhode Island Medicaid program has implemented reform initiatives to enhance and evolve the Medicaid-funded delivery systems. In state fiscal year 2011, of the Medicaid beneficiaries for whom Medicaid was the primary insurer; approximately 95% were enrolled in some form of a coordinated primary and acute care program. The progression of these program advancements to improve the quality, coordination and cost-effectiveness for Rhode Island Medicaid beneficiaries is represented in the timeline below.

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<sup>1</sup> This report, *Integration of Care and Financing for Medicare and Medicaid Beneficiaries*, was posted to the EOHHS website on April 24, 2012

## Managed Care Timeline

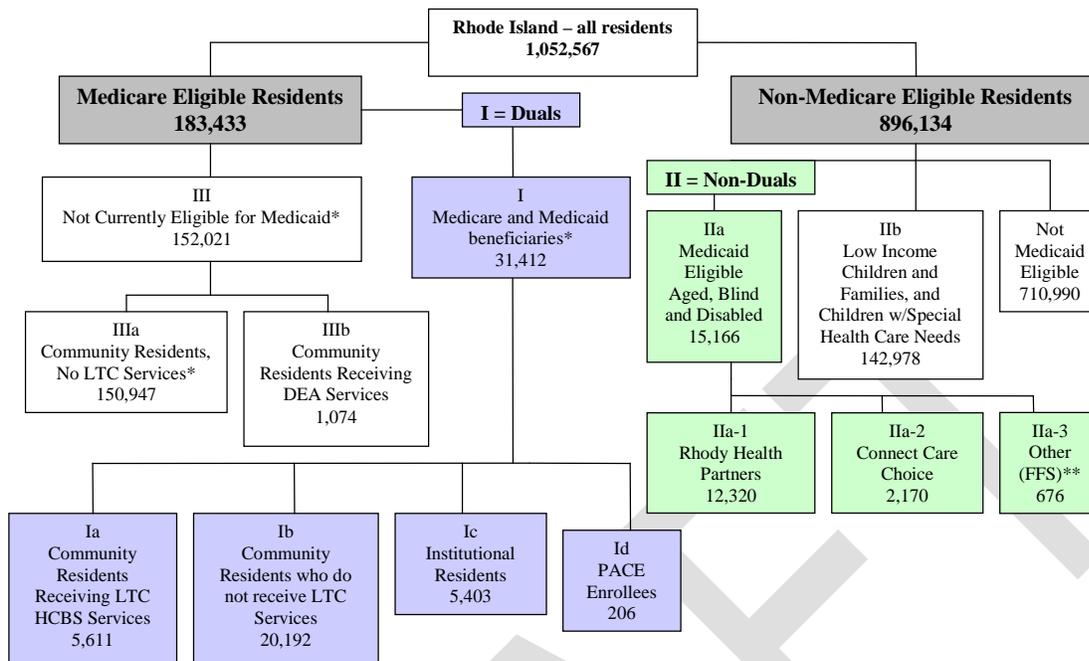


RI Medicaid is examining options to design and develop the delivery and payment systems to improve the quality, coordination and cost-effectiveness of services for Medicaid beneficiaries requiring long-term services and supports, including those who are eligible for both Medicaid and Medicare. As the state has explored these options, a core set of design principles emerged that the state believes is vital to create, incentivize and sustain the delivery and payment of appropriate and efficient care. These design features will be described in the next sections.

Although this proposal is specific to the population of dual eligibles, it is important that RI Medicaid's program development takes in to consideration those populations who are at risk of becoming dually eligible, and is coordinated and consistent with other programs for people with disabilities and elders. To that end, Figure 1 depicts the total population of Medicaid members and how the eligible population relates to one another.

The figure below offers detail on the different types of programs Medicaid beneficiaries are enrolled in. For non-dual eligible adults with disabilities and elders, there are two delivery system options: Connect Care Choice and Rhody Health Partners. Connect Care Choice began in 2007 and is a primary care case management (PCCM) program, administered through contracts with 17 medical home practices throughout the state (Figure 1, Box IIb). These practices meet state-specified requirements for participation, and include an on-site nurse case manager, for those clients who need that level of care management. Rhody Health Partners began in 2008, and is administered through value-based purchasing contracts with two managed care organizations (Figure 1, Box IIa). MCOs receive a prospective capitation payment, in exchange for providing a comprehensive set of in-plan benefits, as well as requirements for care management.

**Figure 1. Distribution of Dual Eligibles in Rhode Island by Need and Delivery System.**



The data in Figure 1 describes the overall population in Rhode Island, and provides some detail on the subset of Rhode Islanders who are eligible for Medicare, eligible for Medicaid, and eligible for both programs. The shaded box Ia illustrates that the majority of dual eligibles in Rhode Island reside in the community, and are not yet connected with the long-term care system. Of these roughly 26,000 dual eligible individuals who presently reside in the community without home and community-based services (HCBS, Fig 1., Box Ia), approximately 4,000 of them are persons with severe and persistent mental illness (SPMI). Also within this group of community-based dual eligibles, RI estimates that upward of ten percent (10%) are at increased risk for needing home and community-based supports within two years<sup>2</sup>. Effective identification and preventive services could help delay this and other costly acute episodes.

#### Background on Medicaid-only Members and Members with Medicaid and Medicare

Based on a comprehensive needs assessment administered by the State, 5,611 dual eligible beneficiaries are presently receiving HCBS to help maintain their ability to remain living in the community (Fig. 1 Box 1c). Of those currently receiving home and community-based supports and services, approximately 2,366 of those individuals have developmental disabilities. Additionally, there are 5,400 duals living in institutional settings (Fig. 1 Box Ib). Rhode Island’s recently awarded Money Follows the Person (MFP) grant focuses on transitioning these clients to community living arrangements. There are approximately 210 individuals enrolled in the PACE Organization of Rhode Island (PORI, Fig. 1, Box Id). PORI has recently received CMS approval to expand to a second site in Rhode Island during calendar year 2011. There are currently 2,000 Medicare-only clients who receive certain home and community-based supports via a program administered by the RI Division of Elderly Affairs (DEA). These individuals are at risk for becoming dual eligibles (Fig. 1, Box IIIb). For the 15,000 disabled adults with only Medicaid coverage, they must choose between

<sup>2</sup> Based on historical utilization patterns

enrollment in the state's capitated managed care program, Rhody Health Partners, (Fig. 1, Box Ia) or the primary care case management model, Connect Care Choice (Fig. 1, Box Ib). It is estimated that at least one-third of these members will become dual eligibles within two years of obtaining Medicaid eligibility.

In 2011, Rhode Island applied to receive funding support from the Centers of Medicare and Medicaid Services (CMS) to plan a demonstration model to integrate care for the dually eligible of Rhode Island. This model is part of the state's overall strategy to advance the fundamental commitment to expanding the reach of reform efforts; particularly for the dually eligible of Rhode Island. Although Rhode Island did not receive the funds to support the necessary planning activities, CMS subsequently invited the state to participate in technical assistance sessions in recognition of the state's commitment and interest in proceeding with its planning efforts. By participating in these sessions, RI Medicaid gained invaluable insights into the Medicare timelines and standards and conditions that are required to participate in CMS' State Demonstrations to Integrate Care for Dual Eligible individuals.

In order to achieve the goal of full integration (primary care, acute care, behavioral health and long-term services and supports), the state proposes to follow two primary pathways. This approach will allow for consumer choice and will ensure accountability, access and improved outcomes for dual eligible members. Each of the models is not exclusive of the other and the state will pursue both major pathways in parallel. A summary of the primary pathways is below.

#### Pathway #1: Enhanced Primary Care Case Management (PCCM) Models

*January 1, 2013*

In Pathway I: Enhanced PCCM Models, the Enhanced PCCM Model builds on the Connect Care Choice Program's demonstrated capacity and experience with the care needs of medically complex individuals. Currently, 17 CCC practice sites, meeting standards of performance adopted from the chronic care model of "best practices" serve approximately 1,800 non-dual beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused and holistic care to beneficiaries. CCC is designed to achieve and preserve access to primary, preventive, behavioral health and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care.

Under the Enhanced PCCM model, the strengths of CCC are combined with an enhanced capacity in care management and service integration across all service categories: acute, behavioral health and long-term care. This pathway preserves the core person-centered medical home aspect of the CCC and builds on the established chronic care model of best practices. To address the needs for greater integration of primary care, acute care and long-term care services and for high touch care management, a bundled service contract will be sought to build a Community Health Care Team (CHCT) that will focus on long-term care services and supports. This community based entity will have demonstrated expertise and the necessary tools to perform the care/ case management, care coordination, transition services, nursing facility inpatient management for non skilled care, social supports, housing, and transportation supports, and services integration functions in collaboration with the CCC practices. For non-duals, the Enhanced PCCM will be a direct expansion of the existing CCC program to include a sharper focus on long-term care services. For dual eligibles, the

contracted entity will take core responsibility for ongoing care coordination and service integration, through the Community Health Care Team. This program will be operated under the direction of the Office of Community Programs within the RI Medicaid Program.

RI Medicaid will seek to define the advanced model of primary care established by the CCC program and the contracted Community Health Care Team as “health homes,” as defined by the ACA. Under the health homes program, the CCC practice and the Community Health Care Team will be required to prevent illness, reduce wasteful fragmentation, and avert the need for unnecessary and costly emergency department visits, hospitalizations and institutionalizations. We anticipate that an estimated two to three thousand dual eligibles as well as approximately 2,000 Medicaid only eligible adults with disabilities or elders will choose this model.

### Pathway #2: Capitated Model

#### *Phase I: January 1, 2013*

Phase I of Pathway #2 is the procurement for contracts with Medicaid Managed Care organizations for the full spectrum of Medicaid services for Medicaid-eligible individuals, including those who also have Medicare coverage. These contracts will be effective January 1, 2013. The following populations will be able to choose this delivery model:

- Medicaid-only individuals currently enrolled in Rhody Health Partners (RHP), who utilize long-term services and supports
- Dual eligible individuals residing in the community who are not currently utilizing long-term services and supports
- Dual eligible individuals in need of long-term services and supports
- Dual eligible individuals who receive their Medicare benefit through a Medicare Advantage Plan.

In this first phase of system redesign, we anticipate excluding two service areas from the integrated package of benefits: long-term care services for adults with development disabilities and behavioral health services for individuals with serious and persistent mental illnesses (SPMI). The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) just recently began implementing new systems of care for these beneficiaries. It is too soon to evaluate whether the service integration needs of beneficiaries have been addressed adequately by these initiatives at this time. Note also that the majority of beneficiaries in these segments are dual eligibles.

#### *Phase II: January 1, 2014*

The second phase of pathway #2, involves the State, CMS, and the managed care organizations (MCOs) entering into a three-way contract, in which the MCOs receive a prospective blended payment to provide comprehensive, coordinated care to Rhode Island’s dually eligible individuals. In a State Medicaid Director’s Letter dated July 8, 2011, CMS outlined this opportunity for states and established specific timeframes and deliverables that must be met in order to enter into the three-way contract. This proposal satisfies one of the deliverable required by CMS.

Figure 2 below represents these pathways in a visual format in order to describe the state’s efforts in terms of services and populations, as well as the target timeframes for implementation.

FIGURE 2. PATHWAY FOR INTEGRATED SYSTEM REDESIGN						
Continuum of Services	NON-DUALS MODELS		DUAL ELIGIBLE MODELS			
	Enhanced PCCM Model 1/1/13	Fully Integrated Capitated Model 1/1/13	Enhanced PCCM for LTSS – 1/1/13	Managed LTSS Model 1/1/13	Fully Integrated Capitated Model 1/1/14	PACE
	Model #1	Model #2	Model #3	Model #4	Model #5	Model #6
Acute Care	Connect Care Choice	Rhody Health Partners	Medicare Advantage and FFS	Medicare Advantage & FFS Rhody Health Partners	EOHHS/CMS/MCO Contract	PORI
Primary Care	Connect Care Choice	Rhody Health Partners	Medicare Advantage and FFS	Medicare Advantage & FFS Rhody Health Partners	EOHHS/CMS/MCO Contract	PORI
Behavioral Health Care	Connect Care Choice in partnership with BHDDH licensed providers and other community-based providers	Rhody Health Partners in partnership with BHDDH	Medicare Advantage and FFS, including BHDDH licensed providers	Medicare Advantage & FFS Rhody Health Partners, in partnership with BHDDH	EOHHS/BHDDH/CMS/MCO Contract	PORI
Long-Term Services and Support	Purchase Care Mgt. & Service Integration in partnership with BHDDH for services for persons with developmental disabilities	Rhody Health Partners Expansion in partnership with BHDDH for behavioral health and services for persons with developmental disabilities	Purchase Care Mgt. & Service Integration in partnership with BHDDH for services for persons with developmental disabilities	Rhody Health Partners Expansion LTSS only in partnership with BHDDH for services for persons with developmental disabilities	EOHHS/BHDDH/CMS/MCO Contract	PORI

Blue = areas of program expansion  
 Yellow = existing programs

This document represents the state’s submission for participation in the CMS Demonstration of fully integrated care for full duals for effective enrollments beginning January 1, 2014. This document outlines the design elements for a fully integrated program for dual eligibles to comport with the CMS requirements, as described in Phase II Model II above (capitated arrangement). This document will outline the components of a fully integrated program, including the benefit design, the provider network requirements, and the elements of a care coordination program.

RI Medicaid intends to use this CMS opportunity to support and enhance state efforts with strengthening primary care and developing multidisciplinary teams that can oversee the integrated care of these individuals with complex care needs. The outcomes of this integration will be improved quality of life, the ability for a person to stay in their home for as long as possible and ease the transitions that occur in the delivery system over a person's life time. RI Medicaid will work with stakeholders to develop achievable performance metrics and incentivize care teams, patients and caregivers to change the ways they access and deliver care in the redesigned delivery system. The state believes this phased approach will better orient and prepare the state, the managed care organizations (MCOs), LTSS providers, beneficiaries, and caregivers for the State's participation in the CMS demonstration. The focus of this application is to describe a comprehensive and integrated delivery and payment model that meets the required standards and conditions for Rhode Island to partner with CMS in a demonstration for its dual eligible citizens, with effective enrollment beginning in January of 2014.

#### **A. Barriers to Integration to Address**

The Medicare and Medicaid programs were not designed to work together. Both programs operate separately and distinctly, leading to a fragmented financing system for providers who serve people on both programs, and uncoordinated care for the consumer. By design, Medicare funds primary, specialty, and acute care while Medicaid funds predominately long-term services and supports, including nursing home admissions. The impact of the fragmentation becomes most evident at critical moments when dual eligibles are transitioning from one care setting to another. For example, when a dual eligible client is discharged from a hospital to home, the discharge planning conducted at the hospital (Medicare funded) is often not well coordinated with the care plan for supports in the home (Medicaid funded) upon discharge. Few incentives, resources, or mechanisms for care coordination exist in the current fee-for-service (FFS) system.

This section addresses the barriers to integration that have existed for dual eligibles and their providers since the programs' inceptions in 1965. This CMS demonstration provides an opportunity for the financing of the two programs to align, resulting in improved quality of care for the dual eligible consumer. This demonstration seeks to eliminate the systemic barriers by accomplishing the following:

- Improving the coordination of care
- Aligning financial and quality incentives
- Improving health care system navigation for the member and provider

#### ***Improved Coordination of Care***

Without the proper coordination and discharge planning, dual eligibles are vulnerable to emergency department visits, readmissions to the hospital and nursing home stays that are potentially avoidable or unnecessarily lengthy. Dual eligibles do not currently benefit from a coordinated and integrated care team. This can result in unmet needs, or improper utilization of the health care system. The integration of Medicare and Medicaid funding streams will lead to more seamless care delivery and improve the quality of care, and access to care for beneficiaries covered by both programs.

### ***Aligned Financial and Quality Incentives***

A longstanding barrier to coordinating care for dual eligible individuals has been the financial misalignment between Medicare and Medicaid and the conflicting requirements for payers, providers, and beneficiaries. The financial incentives are not currently aligned to promote coordination between the two programs. This fragmentation has led to inefficiencies in the way care is paid for, the way providers render care, and the way beneficiaries access their care.

Currently, the majority of dual eligible beneficiaries receive Medicare and Medicaid services via the fee-for-service (FFS) system, in which providers are reimbursed for each service delivered. In this FFS system, providers are forced to operate in silos, with little incentive to coordinate primary care with behavioral health or LTSS. This demonstration offers the opportunity to discourage or eliminate cost-shifting between providers and payers.

Much work has been done nationally to develop evidence-based quality measures for dual eligibles receiving LTSS and those residing in the community without those supports. RI Medicaid will work with CMS and stakeholders to research the measures being used today, and to develop additional measures and benchmarks.

### ***Improved System Navigation***

The Medicare and Medicaid programs not only cover different benefits, but also have different administrative procedures and rules in place. These dichotomies leave dual eligibles to navigate a bifurcated system of benefits and rules with limited assistance and no single place for members and their caregivers to direct questions regarding their benefits, their provider networks, etc. Providers are often thrust into the role of care coordinator, spending hours determining which program to seek prior approval from to deliver services, which program to submit claims to, and which program to appeal to, if a provider does not agree with a benefit decision. Among other advantages, an integrated system administered through an MCO would allow members and providers to have a single source of information on benefits, billing, grievances and appeals, and general information.

Rhode Island's approach to integrating care for dual eligibles builds upon existing delivery system infrastructure in the state, and incorporates lessons learned from other state's programs and emerging best practices in the integration of care for dually eligible populations. It is the intent of RI Medicaid to frame, build, and transform the delivery system infrastructure by aligning the state's resources, CMS resources, and the Managed Care Organizations (MCOs) selected to serve the population by eliminating the barriers outlined above. Rhode Island is in a high state of readiness to integrate care for dual eligibles and views the CMS demonstration opportunity as one aligned with the state's goals and objectives.

## **B. Description of the Target Population**

This proposal focuses exclusively on full-benefit dual eligibles; meaning those Medicare beneficiaries who receive the full package of Medicaid benefits. Per direction from the CMS Office of Innovation, this demonstration will not include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualified Individuals (QIs). Those individuals who are dually eligible and are under 21 on the date the demonstration begins will be phased in as eligible for the demonstration upon their twenty-first (21<sup>st</sup>) birthday.

**Table 1. Target Population for Duals Demonstration**

	Age 21-44	Age 45-64	Age 65+	TOTAL
Individuals residing in institutional settings	52	455	5,364	5871
Individuals receiving LTSS in the community	143	730	2,118	2991
Individuals residing in the community with no LTSS	3,010	4,868	5,997	13,875
Overall Total	3205	6053	13,479	22,737

The target population described in Table 1 includes approximately 3722 dual eligibles that are currently enrolled in a Medicare Advantage Plan. RI Medicaid will work with CMS to design an enrollment process that allows for a seamless transition from fee-for-service to managed care that maximizes continuity of existing provider relationships. This seamless transition can be accomplished in many ways, and is described in more detail in future sections.

The American Community Survey, conducted by the Census Bureau, indicates that forty-three percent (43%) of dual eligibles in Rhode Island live at one hundred and thirty three percent (133%) or less of the federal poverty level (FPL). This survey also tells us that the majority of dual eligible beneficiaries are women and approximately forty percent (40%) live alone. This same survey also showed that while the type of disability among dual eligibles varies, approximately forty percent (40%) have a serious cognitive disability; almost half (46.7%) have a serious mobility limitation combined with difficulty living independently.

In Rhode Island, the dual eligible age group of 65 to 84 years is the largest cohort in the total population. Typically, those under 65 and those over 65 have differing patterns of needs and strengths. The non-elderly beneficiaries with disabilities tend to have lower incomes and qualify for Medicaid sooner than the elderly population. Because of their disabilities, they often have significant health problems, compounded by functional limitations and cognitive impairments, requiring supportive services to assist with activities of daily living (ADLs). The elder dual eligibles are poor, though not necessarily disabled. They have diagnoses and related expenditures for conditions such as diabetes, heart disease, lung disease, mental illness and Alzheimer’s disease.

A high percentage of elder dual eligibles in Rhode Island reside in long-term-care settings, primarily nursing homes. Nursing home spending is a key driver of Medicaid expenditures in the state:

- Rhode Island has 56 nursing home residents per 1,000 residents age 65 and over compared to the US rate of 38 per 1,000.
- For Rhode Islanders age 75 and over, the rate of nursing home residents increases to 104 per 1,000 compared to a US average of 78 per thousand.

**Population Profile at a Glance**

- Living at or below the FPL
- Predominantly Female
- Live with serious cognitive and ambulatory disabilities
- Reside in the poorest households of Rhode Island
- Significantly more likely to live alone
- Need assistance with independent living, self care and direction
- Significant higher use of Nursing Homes than the national average

The lower acuity and longer lengths of stay for most nursing home residents contributes to an overall use of nursing homes in Rhode Island that is significantly above the national average.<sup>3</sup> Two recent studies conducted by Brown University in conjunction with the state's Real Choices System Transformation initiative indicate that the acuity level of nursing home residents is higher since the system rebalancing effort began in earnest under the Global Consumer Choice Compact Waiver in SFY 2010. Both studies note that if this trend is to continue further, efforts to transition beneficiaries back to the community must begin earlier in the beneficiary's institutional stay and be coupled with more intensive and ongoing service integration and coordination.

### C. Exempt Populations

As mentioned in Section II-B above, only full-benefit duals will be included in the demonstration. In addition, Rhode Island is proposing that services provided to certain individuals are not included for participation in the beginning of the demonstration. Services proposed for exclusion from the demonstration are long-term care services for adults with development disabilities and certain behavioral health services for individuals with serious and persistent mental illnesses (SPMI). During the first two years of the demonstration, RI Medicaid will explore the feasibility of including these services, in collaboration with the Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH). Expenditures associated with these services will not be included in capitated rates for the demonstration.

RI Medicaid will also consider exempting those individuals currently in hospice care at the time the demonstration begins. As new enrollees require hospice care, they will continue their enrollment in the demonstration.

**Table 2. Overview of the Demonstration Proposal Features**

<b>Target Population</b>	Full benefit Duals, age 21 and older
<b>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide</b>	27,894 SFY 2011 data
<b>Total Number of Beneficiaries Eligible for Demonstration</b>	22,737 Adults with Developmental Disabilities and Adults with Severe and Persistent Mental Illness (SPMI) not included
<b>Geographic Service Area</b> (Statewide or listing of pilot service areas)	Statewide
<b>Summary of Covered Benefits</b>	Medicare Part A, B, and D Medicaid State Plan and Waiver Services Additional Services
<b>Financing Model</b>	Capitated Payment Model
<b>Summary of Stakeholder Engagement/Input</b>	See Appendix A for individual key informant and stakeholder sessions conducted in advance of the required public notice period. See Appendix C for information related to Public Comment Period and Input Received
<b>Proposed Implementation Date(s)</b>	January 1, 2014 Enrollment Date

<sup>3</sup> Mor V, et. al., Prospects for transferring nursing home residents to the community. Health Affairs (Millwood). 2007, Nov-Dec; 26 (6): 1762-71. PubMed PMID: 17978396.

Note: Source data for Table A-1 is Medicaid Medical Information Systems (MMIS) database, State Fiscal Year 2010

### III. CARE MODEL OVERVIEW

#### A. Description of Delivery System

##### *Value-Based Purchasing through Contracts with Managed Care Organizations (MCOs)*

The primary mechanism for this demonstration will be secured via three way contracts between the State, CMS, and managed care organizations (MCOs), to include prospective blended payment for the provision of comprehensive, coordinated care of the eligible population for effective enrollments beginning on January 1, 2014. CMS and the State will solicit MCO interest in demonstration participation following finalization of a Memorandum of Understanding that will incorporate input received from both the State's and CMS' public comment periods.

RI Medicaid has provided preliminary Medicaid data to CMS for the purpose of establishing the baseline population and associated expenditures analysis to be used in modeling the demonstration savings potential. CMS and the State will jointly assess whether the savings assumptions underlying the payment model can be attained without disrupting the quality of care currently rendered to the duals population in Rhode Island. Upon mutual agreement of the savings target, between Rhode Island and CMS, demonstration specific actuarial analysis will be undertaken to apply rate and risk methodologies to then establish blended capitation rates and payment structures for the demonstration model.

Managed Care Organization (MCO) procurement and selection will be jointly administered by the State and CMS. The schedule will include release of the procurement opportunity, review of offerings received, selection, contract execution and readiness reviews. The MCO solicitation will include care coordination specifications, quality and outcomes performance targets, encounter data specifications and reports. The demonstration solicitation will also address and define health plan requirements for:

- Comprehensive and coordinated benefit package
- Access to a comprehensive provider network
- Care Coordination/Clinical Care Management program elements
- Member and provider services functions
- Quality assurance and medical management
- Other administrative requirements (e.g. grievances and appeals)

##### 1. Comprehensive and Coordinated Benefit Package

The MCOs will be responsible for providing and coordinating a comprehensive package of in-plan benefits. These benefits are described more explicitly in section B-ii, but will include the entire set of Medicare and Medicaid-covered benefits, including long-term services and supports (LTSS).

## 2. Access to a Comprehensive Provider Network

The MCOs will be required to offer a comprehensive robust network of providers. This robust network will include but not be limited to:

- Primary care providers, including federally qualified health centers
- Specialty providers
- Behavioral health providers
- Inpatient hospitals
- Ancillary providers (laboratory, radiology, etc.)
- Therapy providers (physical, occupational, speech)
- Nursing homes
- Home care providers
- Other LTSS providers (personal care attendants, etc.)

Contracted MCOs will be provided the necessary data to identify the providers that are currently being accessed by dual eligibles for both Medicare and Medicaid-covered services. Many of these providers may already be in the networks of the MCOs. If these providers are not currently in the MCO network, the MCO will make every effort to recruit and contract with those providers, prior to the start date of enrollment in the demonstration. Network providers will be required to meet the access standards outlined in the MCO contract specifications. These access standards will be jointly defined by RI Medicaid, CMS and stakeholder groups, and will align with Medicaid federal regulations.

All demonstration members enrolled in an MCO will be required to choose a primary care provider (PCP). The primary care provider will be the lead member of the interdisciplinary care team. The other health care practitioners on the interdisciplinary care team might include a service coordinator, a nurse practitioner, and a registered nurse, or physician's assistant; all with expertise in serving the demonstration population. The primary care provider will be required to integrate primary care and behavioral health for all enrollees. This integration can be accomplished by co-location of a behavioral health practitioner in a primary care office, the co-location of a primary care provider in a behavioral health practice, or an alternative arrangement. The PCP will ensure all routine medical screening (diabetes eye exam, etc.) in addition to routine screening for depression and other behavioral health conditions.

In addition to linkages with behavioral health care, it will be critical for PCPs to leverage the expertise of the LTSS care manager at the managed care organization. MCOs will be encouraged to work with the PCP sites that care for a high-volume of members who utilize LTSS to design innovative approaches to leverage this resource. This may include "rounds" with PCPs and LTSS case managers, co-location of the case manager on a periodic basis, or another innovation to be determined.

MCOs will be encouraged to contract with and include in their network, PCPs who have the capability to provide mobile or home based primary care (HBPC). HBPC has been shown to produce favorable outcomes and reduced expenditures in higher cost settings. In a pilot conducted by the Veterans Affairs Administration, enrollment into HBPC was associated with a 62% reduction in hospital days, a substantial reduction in ER visits, a 88% reduction in nursing home days, and a

net 24% reduction in total costs for the over 11,300 patients in the HBPC program<sup>4</sup>. Home-based primary care may include urgent home visits in order to avoid hospitalizations.

### 3. Care Coordination and Clinical Case Management

A central component to the MCO contract will be detailed requirements for conducting care coordination and clinical care management. These care coordination/care management programs will be tailored to meet the needs of the population (e.g. behavioral health focused, LTSS-focused, etc.)

Rhode Island's experience in implementing and managing programs for complex populations has taught the state that there are several key design features to consider when developing care coordination/care management programs. Care coordination programs for dual eligibles, regardless of the delivery system, must include the following:

- Early identification of “at-risk” members
  - Ability to identify emerging needs
  - Early warning systems
- A comprehensive needs assessment
- A personalized care plan
- Interdisciplinary care teams
- Information systems/technology to support the care team
- Decentralized decision-making and benefit flexibility

Whether these functions are developed inside an MCO contract, as described in this proposal, or procured through bundled purchasing arrangements in a managed fee-for-service system, the critical elements remain the same. Each of these elements will be described in detail in this section.

From our key informant interviews with other states, stakeholder input received to date, and a review of the literature, the Rhode Island integrated system of care for the dually eligible must be based on care management as the locus for integration; deploying strategies that meet the needs of the enrollees and improve the quality of care they receive by effectively building interdisciplinary provider capacity to deliver care that is person-centered. Care management must be focused on the whole person, and not just on their clinical needs. Assistance with overcoming social barriers to seeking care should be addressed as part of a plan of care. Long-term supports and services should be coordinated and work in tandem with the medical benefit. Similarly, many dual eligibles will need to access behavioral health services. The care management program should have tools and strategies in place to coordinate behavioral health with medical care (e.g. multi-disciplinary case conferences, etc.)

#### *a. Early Identification*

Detailed data is required in order for the MCOs to prioritize outreach efforts for initiation of their care management programs and supporting systems. MCOs will be provided with Medicare-

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<sup>4</sup> Edes, Thomas, Safe Transitions – Comprehensive Coordinated Care through VA Home Based Primary Care, October 4, 2010

Medicaid linked data sets covering a period of two years. This data will include, at a minimum, the following service utilization categories:

- Pharmacy
- Physician visits
- Inpatient stays (medical and behavioral)
- Behavioral health outpatient visits
- Ancillary services (laboratory, radiology, etc.)
- Other outpatient services, including emergency room and urgent care
- Long-term care services and supports – nursing home and community-based services, including waiver services
- Transportation Services

The MCOs will be expected to receive this data and analyze it using predictive modeling tools. This predictive modeling exercise would produce a risk score that would be used to prioritize outreach for engagement in the plan's care management programs. This historical data is also useful in creating a plan of care and in identifying areas of unmet need, as well as to identify the appropriate members of the interdisciplinary care team to engage the member in care management activities. For example, a 75-year old dually eligible individual living in the community with a history of ER visits with a primary diagnosis of substance abuse would be more appropriate for outreach by a team member with behavioral health expertise.

The MCO will be required to have a robust information system that is capable of detecting members in at-risk situations at the moment they occur. For example, critical to the success of the integrated care model overall is the ability to detect a non-scheduled inpatient admission in real-time. Once aware of this admission, the MCO would deploy a transitions coach (more details below).

RI Medicaid and CMS are in the process of identifying and collecting all relevant utilization and expenditure files in order to begin linking the historical Part A, Part B and Part D Medicare data with comparable Medicaid data.

*b. Comprehensive Needs Assessment*

Once enrolled in the MCO, a member of the care team will conduct a comprehensive needs assessment. A minimum set of requirements must be jointly specified by RI Medicaid and CMS for this purpose and all assessment tools for use by the MCOs would require RI Medicaid and CMS approval. Required elements under consideration for comprehensive assessment include:

- Medical history
- Functional status
- Mental health screen
- Screen for cognitive functioning and dementia
- Screen for alcohol and other drug use
- Screen for tobacco use
- Nutritional status
- Social service needs (heating, food insecurity, etc.)

- Housing
- Availability of informal supports
- Family structure and social supports
- Well-being (self-report)
- Self-identified areas of unmet need, such as transportation arrangements

The MCOs will have performance requirements for timely completion of an initial comprehensive needs assessment, as well as requirements for the ongoing assessment of enrollees needs. Ongoing assessment would occur:

- At least once every six months, or
- Quarterly for members who require complex care, or
- Whenever an enrollee experiences a major change that is:
  - Not temporary;
  - Impacts more than one area of health status; and
  - Requires interdisciplinary review or revision of the individualized plan of care

Within ten (10) calendar days of enrollment, the MCO will be responsible to initiate an initial telephonic outreach to welcome the member, conduct a brief health screen, and schedule the first home visit by a member of the interdisciplinary care team. For individuals residing in the community, this first home visit might occur within thirty (30) calendar days of enrollment in the delivery system. If a new member resides in an institution, this visit might be conducted within five (5) business days. The goal of this first home visit would be to conduct the initial comprehensive assessment and orient the new enrollee, their families and at home caregivers to the demonstration model of care.

*c. Personalized Care Plan*

Upon completion of the comprehensive needs assessment, the assigned lead member of the interdisciplinary care team works closely with the member and/or the family caregiver(s) to create a personalized care plan for each demonstration enrollee. This personalized care plan would include treatment goals and measures for individual progress towards those goals. The care plan would be whole-person focused and strengths-based. The care plan might pay particular attention to disease prevention and primary care/preventive care as well as health promotion and wellness activities. An example of a wellness activity may be attending a seminar on fall prevention or adjusting to changes in life roles. The care plan would promote self-direction and would reflect routinely scheduled adjustments and updates, especially as enrollees are transitioning between care settings. The MCOs will have contractual performance requirements in place for timely completion of the personalized care plan.

*d. Interdisciplinary Care Teams*

Once the comprehensive needs assessment is complete, and the care plan is developed, the lead care manager will assemble the MCO-based interdisciplinary care team. For clients who have a history of utilizing LTSS, or demonstrate need for LTSS during the comprehensive needs assessment, the lead case manager on the interdisciplinary team will be a clinician with specific expertise in the area of long-term care services and supports. This individual will be a resource with experience in different

kinds of LTSS needs and be familiar with other community resources. MCOs may choose to employ these individuals directly, or contract with a community-based organization that specialized in LTSS resources.

MCOs will be required to include community health workers/peer navigators as part of their integrated care teams. MCOs may either employ these individuals directly or contract with a community-based organization to provide this service. The use of peer navigators has been effective in other Rhode Island Medicaid programs in order to assist members with navigating the health care system, as well as overcoming social barriers to receiving care in the most appropriate setting (e.g. housing needs, heating assistance, food insecurity, etc.).

*e. Information Systems Support to Promote Safe Transitions*

The Managed Care Organizations will be required to have robust information systems, capable of detecting members in at-risk situations, preferably before and no later than at the time they occur. For example, critical to the success of the integrated care model overall is the ability to detect a non-scheduled inpatient admission in real-time. Managing care transitions across settings is a critical component to a successful care management program. RI Medicaid will require that a member of the care management team be solely responsible for coordinating managing the discharge plans for members being discharged from an acute care setting. This “Transition Coach” could be educated in the Coleman Transitions of Care Model and would be a fully recognized and participating member of MCO Interdisciplinary Care Teams. It would also promote specialization of systems and best practice interventions to meet the particular needs of the different population groups within the demonstration. Safe and Effective transitions require:

- Medication reconciliation and safe medication practices
- Patient and Caregiver involvement
- Person-centered Care Plans that are shared across the interdisciplinary care team
- Standardized and accurate communication and information exchanges between the transferring and receiving provider

*f. Decentralized Decision-Making and Benefit Flexibility*

Services integration is a primary goal of the demonstration, reflecting the reality that dual eligibles’ clinical needs are interdependent upon the full continuum of services being applied. The Rhode Island demonstration model can meet the complex and varied needs of the target population by decentralizing authority and promoting benefit flexibility. Allowing the MCO interdisciplinary care teams, in collaboration with the primary care provider team to make critical care decisions that support the person-centered approach to care delivery is a key feature of the demonstration model. RI Medicaid will consider locating the decisions as close to the delivery of services as possible while aligning incentives. In the Massachusetts Senior Care Options program, the Primary Care Team has the authority to make referrals and authorize services as needed, without seeking prior approval from the MCO. For example, care managers can authorize and arrange transportation to church for a depressed member who needs social interaction, or authorize a nursing home stay for respite purposes. Other examples include purchasing gym memberships for an overweight member, or reimbursing for acupuncture for a member with chronic pain. This flexibility will be explored in more detail with CMS and stakeholders.

*g. Other Requirements*

The MCO contracts will have additional requirements for their care management programs. These will include but not be limited to:

- Mobile Case Management –Home visits by the care management team lead are critical. Telephonic care management will not be effective for this complex population. Home visits allow for a more reliable assessment of a member’s medical, behavioral and social conditions.
- “Many Touches”. A successful care management program will include periodic home visits and re-assessments for routine monitoring, but will also have information support systems in place to detect a high-risk event at the moment it occurs (e.g. inpatient admission, nursing home admission, etc.). In addition to home visits, “touches” can take other forms including phone calls and mailings.
- Self-directed Services – for members who require long-term care services and supports, a self-directed approach could take the form of an agency model, in which the members selects a personal care worker (e.g. family member) or one that involves a fiscal employer agent, with whom the member contracts directly for personal care and attendant services. Appropriate guidelines for budgetary constraints and consumer protections could be taken into account.

MCOs may meet all of the contractual care management requirements by directly employing the individuals that make up the care team, or they may choose to purchase this function. For example, there are national companies that specialize in providing intensive primary care in home and facility settings. Case managers in the MCOs that subcontract with with these national companies can refer high-risk members who consent. A physician or nurse practitioner from from the subcontractor is assigned as the PCP. PCPs visit members in their homes, create care plans with them, and coordinate with case managers at the MCO to order services and coordinate other aspects of care. The expectation would be to provide 24/7 coverage to demonstration members. An additional expectation would be that between home visits, members can access nurses with any ongoing medical concerns.

#### 4. Enrollment Method

Rhode Island proposes that eligible duals be voluntarily enrolled monthly beginning with effective dates of enrollment for January 1, 2014, using a phased, opt-out model and provision for guaranteed access to established FFS providers and services for a period of time to allow for successful transitions. Enrollees can choose to opt out at any time, must be fully informed of their care options, including their ability to return to the Medicare FFS program at any time. The proposed model provides Rhode Island with more direct oversight of access and quality.

Member outreach and enrollment information will be jointly prepared for inclusion in Medicare’s 2013 Open Enrollment period. Dissemination of information and training will be conducted with stakeholders in advance of beneficiary notifications. RI Medicaid will work with various stakeholder groups to create a transparent enrollment process and enrollment materials that are understandable and respect members unique needs.

RI Medicaid will consider leveraging the The Aging and Disability Resource Center in Rhode Island, called The POINT, during the enrollment process. The POINT may operate as a consumer information and referral source to educate dual eligible consumers about the different delivery system models available to them, and offer non-biased enrollment counseling to assist consumers in selecting the best option for them.

**B. Benefit Design**

At the core of the RI demonstration for duals, is arranging for an interdisciplinary team approach to care coordination and management for the full range of benefits available to dual eligibles with a person-centered focus. The benefit design for the full continuum of Medicare and Medicaid benefits includes the comprehensive range of primary, acute, prescription drug, behavioral health, and long-term supports and services. Although Medicare generally covers acute and post-acute care, primary and specialty care and prescription drugs while Medicaid generally covers acute care, primary and specialty care, behavioral health care and long-term services and supports, these covered benefits are not arranged, nor accessed in any coordinated or managed fashion, resulting in less appropriate, more costly, and likely poor health outcomes. All Medicare-covered Part A (inpatient, hospice, home health care), Part B (outpatient), and Part D (pharmacy services) and all Medicaid State Plan and waiver services are to be included in the capitated blended payment. The core requirement of the Managed Care Organizations is the delivery of all covered services so that the demonstration duals experience their coverage as a single, seamless and integrated system of care.

MCOs will be given the flexibility to substitute lower cost alternative services in order to avoid institutionalization or the use of higher cost services. These substitution services may avoid higher-cost more traditional services.

Additionally, certain non-emergency transportation and non-medical transportation will be included in the MCO benefit package. The restrictive rules in place for authorization of services by either Medicare or Medicaid will be eliminated and replaced by person-centered utilization review criteria at the MCO.

A specific breakdown of the covered benefits under consideration for the demonstration is described below in Figure 3.

**Figure 3. In-Plan Benefits for the Dual Eligible Demonstration**

Adult Day Health	Meals on Wheels
Ambulance (emergency)	Non-emergency medical transportation
Ancillary Services (lab, x-ray, etc.)	Nurse midwife services
Assisted Living	Nursing Home Care – Skilled and Custodial
Audiologist Services	Nutrition services
Behavioral health services (mental health and substance abuse)	Orthotic services and prosthetic services
Community Transition Services	Outpatient hospital
Consumer Directed Goods and Services	Outpatient surgical centers
Dialysis	Oxygen and respiratory therapy equipment

Durable Medical Equipment	Pharmacy, including over the counter medications
Environmental modifications	Personal care assistant services and homemaker services
Federally qualified health centers	Physician services
Independent Nursing Services (LPN)	Podiatry
Indian Health Centers	Private Duty Nursing
Family Planning	Rehabilitation and Rehabilitation Hospital Inpatient
Hearing Aids	Rural Health Centers
Home Health	Services of other practitioners
Hearing Aids	Shared Living
Hospice	Speech and hearing services
Inpatient Hospital	Therapies (physical, occupational, and speech)

### C. DESCRIPTION OF NEW SUPPLEMENTAL BENEFITS OR SERVICES

Rhode Island intends to use the combined capitation of Medicare and Medicaid funds to ensure the care coordination and management of the full spectrum of services are delivered in the most flexible, innovative and person-centered manner possible. Additionally, we expect to consolidate, to the greatest extent possible, all administrative processes required by both programs; including eligibility, outreach and education, customer service, fiscal accountability, grievances and appeals. By leveraging these functional efficiencies with the combined payment, Managed Care Organizations will have the flexibility to offer valued-added services beyond the mandated services beneficiaries are entitled to. In particular, creative alternatives to costly acute and LTSS will be encouraged with expanded and flexible use of community-based services, including alternative medicine/pain, wellness, and disease management practices.

As mentioned in a previous section, MCOs will be required to offer access to community health workers/peer navigators, either as direct employees or through a contract with a community-based organization. These individuals will support the primary care team and the interdisciplinary care management team by assisting members with self-management of chronic conditions, wellness coaching, delivery system navigation, and assistance with eliminating social barriers to seeking appropriate care. For people with behavioral health and substance use disorders, these individuals will be trained in a recovery/sober coaching model.

An estimated fifty percent (50%) of the target population for the demonstration have a co-occurring mental health and/or substance use disorder. MCOs will be required to develop a continuum of behavioral health care benefits, that range from the most restrictive setting (inpatient), to the least restrictive setting (office-based counseling) and everything in between (extended outpatient, partial hospitalization, etc.).

## **D. INTEGRATION OF EVIDENCE-BASED PRACTICES IN CARE MODEL**

As part of the state's planning process, in addition to the stakeholder forums convened within the State of Rhode Island, RI Medicaid conducted several key informant interviews with state leaders in Massachusetts, Vermont, North Carolina, and Tennessee to gain insights on models, best practices and key challenges in designing and developing care models for the dually eligible. RI Medicaid plans to conduct an analysis of available national guidelines and compare those with the evidence-based tools currently in use in our delivery system. This analysis will assist the State to identify and guide the incorporation of evidence-based practices into the performance requirements for accountable entities serving the demonstration population.

The managed care contracts will specify that the MCOs employ evidence-based clinical practice guidelines in decision-making, relevant to the conditions of members enrolled in the demonstration. However, the needs of dual eligible members are complex, and robust guidelines to inform decision-making are not currently available for all conditions. MCOs will be given the flexibility to develop those guidelines, in collaboration with clinical and consumer advisors.

## **E. CONTEXT OF OTHER MEDICAID INITIATIVES AND HEALTH REFORM**

As described earlier, Rhode Island views participation in the demonstration as part of its long term strategy and gradual approach to extend payment and delivery system reform to all Medicaid beneficiaries, including the dually eligible.

### **1. Existing Medicaid Waivers and/or State Plan Services**

The State of Rhode Island was granted an innovative 1115 waiver from the Centers for Medicare and Medicaid Services on January 16, 2009 for the period of 5 years. The authority granted by the Rhode Island Global Consumer Choice Compact (aka the Global Waiver) provides the State with greater flexibility to provide services in a more effective way and better meet the needs of Rhode Island Medicaid beneficiaries. In fact, the essence of the Global Waiver allows Rhode Island to restructure the Medicaid program to deliver "sustainable, cost-effective, person-centered, and opportunity driven programs by using competitive and value-based purchasing to maximize available service options" and "a results-oriented system of care."

Participating in this demonstration opportunity is befitting of the Global Waiver's purpose. During technical assistance sessions with CMS, we have briefly touched upon the topic of additional federal authority that may be required, particularly since the current waiver authority period will be terminating as the effective enrollments are expected to begin. RI Medicaid will continue to work with CMS to determine the appropriate and necessary modifications to the Global Waiver in order to implement the demonstration.

## 2. PACE and Medicare Advantage

### *PACE*

On average, 200 beneficiaries are enrolled in the state's fully integrated program for frail elders who are dually eligible beneficiaries – the Program of All-inclusive Care for the Elderly organization of RI (PORI). PORI is a provider-based Medicare and Medicaid managed care program that provides acute, chronic and long-term care. PACE is operated and funded through a three way agreement between CMS/Medicare, Rhode Island Medicaid, and PORI.

Under federal rules, to be eligible for PACE, participants must be age 55 or older, meet a nursing facility level of care, and live in the PACE organization service area. The PACE program features a comprehensive medical and social service delivery system in an adult day health center that is supplemented by in-home and referral services in accordance with participants' need. By coordinating and delivering a full spectrum of services, PACE helps enrolled beneficiaries remain independent and in their homes for as long as possible. During the summer of 2011 PORI received CMS approval to expand to a second site in Rhode Island.

RI Medicaid conducted a stakeholder meeting with PORI leadership early on in our planning process. RI Medicaid intends to fully support PACE as an option for duals, over the age of 55 years, in all available service areas during the demonstration period.

### *Medicare Advantage*

Approximately 3,677 RI Medicare beneficiaries are enrolled in Medicare Advantage Plans (also known as Part C) offered by Blue CHIP and United Senior Care of Rhode Island (30% in Blue CHIP and 70% in United). These enrollees receive care and coordination of all Medicare Part A and B services from the plans. RI Medicaid conducted stakeholder meetings with both of these plans and intends on providing Part C enrollees, who request authorization of LTSS (institutional or community-based) with the option of participating in the demonstration offering to receive the full array of services provided by demonstration participating plans. The enrollment approach for this group will be designed to be as least disruptive as possible to their existing delivery system.

## 3. Other State Payment/Delivery System Reform Efforts Underway

There are major initiatives underway both in Rhode Island and nationally to improve the coordination and integration of Medicare and Medicaid financed care. Rhode Island's participation in this CMS opportunity is viewed as an opportunity to strengthen and expand our existing and envisioned efforts to reform the state's delivery and payment of care to better serve our dually eligible residents. A summary of these delivery system and payment reform efforts are mentioned below.

### *Lt. Governor's Long-Term Care Coordinating Council*

The Long Term Care Coordinating Council was formed under RI General Law 23-17 to ensure the highest degree of quality and accessibility in caring for our elderly and disabled citizens, and in aiding

the families and loved ones who support them in their daily lives. By law, the council focuses solely on issues of long-term care.

The LTCCC is not an independent agency, but rather brings the directors of the state's health agencies, concerned citizens, key legislators, medical professionals, and health care providers to the table to work together in addressing the unique challenges of long term care policy. Since high-quality long term care requires cooperation between health agencies, the families of those in need of care, and care providers, the Council provides a setting in which they can coordinate their efforts, and work together to explore new solutions to making care effective and affordable.

#### *Multi-Payer Demonstration Project*

The Rhode Island Chronic Care Sustainability Initiative (CSI-RI) is a community-wide collaborative effort convened in 2006 by the Office of the Health Insurance Commissioner to develop a sustainable model of primary care that will improve the care of chronic disease and lead to better overall health outcomes for Rhode Islanders.

CSI-RI is governed by a coalition of healthcare stakeholders, convened by the Office of the Health Insurance Commissioner, and managed by Health Progress, a quality improvement consulting organization. CSI-RI coalition members include payers, primary care providers, employers, state agencies, technical experts, and community organizations.

CSI-RI is focused on improving the delivery of chronic illness care and supporting and sustaining primary care in the state of Rhode Island through the development and implementation of the patient-centered medical home. The coalition's work has resulted in one of the nation's first nearly all-payer demonstrations of the medical home model of primary care. CSI-RI was selected as one of 8 states to participate in the Medicare Advanced Primary Care Practice Demonstration.

#### *Money Follows the Person (MFP) Demonstration*

Rhode Island was granted a MFP award in the amount of \$24,570,450 covering the period of April 1 of 2011 through July 26 of 2016 from CMS for a MFP demonstration project. MFP is designed to provide assistance to states to balance their long-term care systems and help Medicaid beneficiaries' transition from institutions to the community by providing responsive and person-centered home and community-based supports for a successful transition and continuance of care.

#### *CHCS Technical Assistance Initiative*

Rhode Island is participating in the CHCS Technical Assistance Initiative with other states to identify ways to rebalance and better manage the array of long term services and supports (LTSS) for Medicaid populations. This opportunity to interact with other states and learn from best practices will improve program development efforts.

#### *Rebalancing Long-Term Care System Request for Information (RFI)*

In the fall of 2010, DHS issued an RFI for input on strengthening Rhode Island's community-based capacity to support rebalancing the long-term care system and obtain guidance on developing an

array of programs and services to significantly increase the number of individuals with long-term care needs to live in their communities. DHS summarized the responses and organized the input received for incorporation into the proposed CMS demonstration model.

### *Health Homes*

Rhode Island became the second state in the nation to receive federal CMS approval on two state plan amendments to implement Health Homes. One Health Home is focused on children with special health care needs and the other is focused on individuals with severe and persistent mental illness (SPMI), receiving services at Community Mental Health Organizations (CMHO). Two-thirds of the individuals enrolled in the CMHO Health Home are dual eligibles. This demonstration proposal begins with an exclusion of SPMI clients, and using the first one to two years of the demonstration to analyze the potential impact of a CHP on these individuals. Lessons learned from the Health Home experience will be applied to this analysis.

### *All Payer Claims Database*

The All Payers Claims Database will serve as the central repository for all claims data for the State of Rhode Island. All Payer Data Claims Databases (APCDs) are large, statewide databases that systematically collect health care claims data from both private and public payers. Under a RI law enacted in 2008, the Rhode Island Department of Health was directed to establish and maintain an All Payer Claims Database. The law directs private and public payers to submit claims for health services paid on behalf of enrollees. This would include Medicare data.

## **IV. STAKEHOLDER ENGAGEMENT AND BENEFICIARY PROTECTIONS**

### **A. Stakeholder Engagement**

RI Medicaid embraces stakeholder involvement as an essential ingredient for success when developing and coordinating care initiatives for beneficiaries and has demonstrated the ability to work in partnership with stakeholders such as beneficiaries, providers, federal and state agencies, tribal partners, the general assembly, advocacy groups and community-based organizations. Each of these stakeholder audiences needs timely, clear and accurate communications about the demonstration model and the impact the model will have on them.

Stakeholders have a critical role in supporting RI Medicaid policy and model design decisions. Stakeholder support and desire to improve the current system will be leveraged throughout the planning and implementation process. RI Medicaid is committed to an open, transparent and accountable process with the diverse constituencies of Rhode Island stakeholders from planning through implementation of the demonstration program. RI Medicaid will also advocate for their involvement in the evaluation of the demonstration. RI Medicaid will establish meaningful beneficiary input processes that will aim to include beneficiary participation in the development and oversight of the program.

There is broad consensus among the varied stakeholders of Rhode Island that an integrated system of care for duals can improve quality, cost-effectiveness, and most importantly, outcomes for our

existing and growing beneficiary demands for Medicare and Medicaid services. RI Medicaid will continue to engage stakeholders to provide direct input and provide valuable insight in the identification of impacts, both positive and negative, the integrated care models will have on beneficiaries, costs and the overall goal to implement an intervention that will improve quality, coordination and cost-effectiveness for dual eligible beneficiaries. Rhode Island has the benefit of being a small state, where face-to-face meetings with state agencies and stakeholders are the rule and not the exception. This geographic proximity allows the state to build relationships and foster trust. As part of the state's planning efforts, beginning in the early fall of 2011, RI Medicaid convened and participated in stakeholder meetings with:

- **Managed Care Providers** experienced in delivering care to existing and proposed demonstration Medicaid populations including UnitedHealthcare, Blue Cross Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and The PACE Organization of Rhode Island)
- **Other Providers** representing providers serving the population (Home and Community-Based Services, Nursing Homes, Community Mental Health Organizations, Assisted Living Facilities, and Group Homes for people with Developmental Disabilities)
- **Rhode Island's** Long Term Care Coordinating Council, Global Waiver Task Force, and DEA Home and Community Care Advisory Committee; and
- **State Agency Representatives** of the Division of Elderly Affairs and the Department of Human Services long-term care Program and Case Management Staff.

RI Medicaid added a link on its website: <http://www.ohhs.ri.gov>, dedicated to informing the public of RI Medicaid integrated care activities and related information. Instructions for how to submit public comments are available at this site.

As part of preparing this demonstration proposal, RI Medicaid sought out comprehensive stakeholder input by conducting a 30-day Public Notice process and two Open Meetings according to Rhode Island General Laws. The comments and testimonies received are reflected in the minutes of the Open Meetings that can be found in Appendix C.

Under the Tribal Consultation Requirements Section 1902(a)(73) of the Social Security Act (the Act), a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services must establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Health Care Improvement Act (IHCA). This includes communicating on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. RI Medicaid has submitted a draft consultation process to CMS for approval.

To facilitate this ongoing communication, RI Medicaid identified a liaison to the Narragansett Indian Tribe, and in turn, the Tribe designated a liaison with RI Medicaid. RI Medicaid will communicate all program changes related to this demonstration via email, return receipt requested, to both the Tribe's primary and secondary contacts. Should the Tribe wish to discuss, question,

comment or provide input on this demonstration, they will respond to RI Medicaid within 14 calendar days, unless otherwise specified. A lack of response is considered an indication that The Tribe has no comment on the topic. The tribe also received the public notice announcement, and was invited to participate in the public meetings.

All stakeholder input received has informed the Rhode Island proposed design of this application to CMS. Specific input received from both formal and informal stakeholder engagement activities, reflected in this demonstration proposal includes:

<insert summary of stakeholder comments here>

Rhode Island has complied with all CMS requirements inviting public comment on the proposed demonstration program. The draft proposal was release for a thirty (30) day public comment period on April 26, 2012 and closed to public comment on May 25, 2012. Two large public meetings were held during this 30-day period to solicit stakeholder input. In addition to these two meetings, RI Medicaid’s vision for integrated care was outlined at the Global Waiver Task Force meeting on April 23, 2012. This task force is required in statute as a stakeholder oversight body that received periodic updates and information regarding the implementation of the 1115 Global Waiver. Attendees at the task force meeting include many of the stakeholders that RI Medicaid met with individually during the planning process, as well as additional individuals and organizations. The first public meeting was held on May 3, 2012 at the Arnold Conference Center in Cranston, and was attended by XXXX individuals. The second public meeting was held on May 15, 2012 at the DaVinci Center in Providence, and was attended by XXXX individuals representing a wide cross-section of stakeholders.

## **B. Beneficiary Protections**

RI Medicaid will work closely with CMS to articulate all beneficiary protection provisions in order that they are reflected in the joint contract specifications solicited from interested MCOs. Fundamental to protecting enrolled beneficiaries is ensuring competent and accessible networks of providers that are capable of meeting the diverse and varied needs of the demonstration populations. RI Medicaid is in the process of identifying the Medicaid providers that are currently serving the eligible demonstration population. Identified providers will be cross walked with the CMS database of providers serving the eligible demonstration population to identify “shared providers”. The list of “shared providers” will be reviewed with interested MCOs for the purpose of conducting a gap analysis to determine their existing network capacity to serve the demonstration population.

RI Medicaid will advocate for certain beneficiary protections; including that newly enrolled members be extended out-of-network continuity of care coverage by the participating MCOs for a minimum period of six months. During this time the CHP can pursue bringing those providers into their network and/or offering the member a provider with comparable or greater expertise in treating that member's individual needs. All network providers will need to accommodate ADA compliant physical accessibility standards and accommodate the communication needs of the enrolled demonstration population.

So that disruption does not occur when dual eligibles transition to a new delivery system, the CHP will be required to honor all service authorizations in place at the time the client enrolls, for a

minimum period of six months. This will require not only Medicaid authorization data be transmitted to the CHP, but also Medicare authorization data transmission. RI Medicaid will work closely with CMS to ensure this data is available to the CHP when a member enrolls. No changes or reductions in care will be allowed until a comprehensive assessment is completed by the CHP.

RI Medicaid and CMS will jointly define a streamlined and unified process for all administrative functions governing the rights and protections of enrollees with regards to enrollment, transfers, disenrollments, grievances and appeals for incorporation into participating health plans internal processes and subject to oversight monitoring. All of these customer service functions will be critical components of evaluation during readiness reviews that will be jointly conducted by RI Medicaid and CMS.

To address the conflicting Medicare and Medicaid grievance and appeals requirements, RI Medicaid is advocating that the Medicare stricter timeframes and continuance of benefits during appeal be aligned with Rhode Island Medicaid processing standards. Medical necessity definitions also conflict. Under an ideal integrated care model, all of the administrative functions would be consistent; presented to and accessed by the demonstration population in a streamlined and unified way.

RI Medicaid ascribes to a “conflict-free case management approach” to ensure that service increases and decreases, substitutions, and alternatives in care plans are appropriate to the level and types of care needed and agreed to by the individual enrollees. We are exploring various options and strategies to embed a conflict-free case management approach in the demonstration model.

In conjunction with CMS, RI Medicaid will develop uniform/integrated enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech and vision limitations, and limited English proficiency.

In addition to the beneficiary protections described above, RI Medicaid will work with CMS to ensure the following:

- Meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model
- Privacy of enrollee health records and provide for access by enrollees to such records.
- All care meets the beneficiary’s needs, allows for involvement of caregivers, and is in an appropriate setting, including in the home and community.
- Access to all services in a manner that is sensitive to the beneficiary’s language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints/concerns appropriately.
- Beneficiaries are meaningfully informed about their care options.

### **C. Ongoing Stakeholder Engagement**

RI Medicaid is committed to continual solicitation and incorporation of stakeholder perspectives throughout our participation in the demonstration. RI Medicaid proposes that a “RI Duals Advisory Board” be formed with specific oversight responsibilities to meaningfully engage and convene stakeholders on a regular basis, in advance of, during implementation and ongoing phases

of the demonstration. Full participation of all stakeholders, most importantly the demonstration enrollees must be encouraged and actively sought using multiple and accessible modes of communication and meeting forum opportunities. The first charge of the board would be the development of a Stakeholder Engagement and Communications Plan proposal for stakeholder input and refinement.

In addition, RI Medicaid intends to solicit stakeholder feedback through focus groups and satisfaction surveys.

## **V. FINANCING AND PAYMENT**

### **A. State-level Payment Reforms**

An imperative first step in the design and development of the integrated model is to work with CMS to finalize the methodology for calculating shared savings. Improvements in the delivery system will deliver cost-savings in the short-term in areas that are traditionally services covered by the Medicare program (e.g. reductions in hospitalizations and ER visits). Longer-term savings will be realized in diverted or reduced nursing home stays, and delays in utilization of LTSS; services traditionally covered by the Medicaid program. The State will work with CMS to determine a mutually agreed upon shared savings estimate for the three years of the demonstration.

RI Medicaid will develop a capitated model in which both Medicare and Medicaid pay an actuarially sound, prospective, and risk adjusted “global” rate to MCOs for the delivery and coordination of the full continuum of contracted benefits and services to demonstration enrollees. This global capitated payment will allow for flexibility in many areas including but not limited to coverage decisions. When the capitated payments reach the MCOs, they are no longer linked to a specific payer source and are used to provide services in the way that best meets the each enrollee’s medical and social needs. For example, in order to receive payment for a skilled nursing facility stay, a three-day hospitalization will no longer be required. A blended capitation rate will necessitate a review of all Medicare and Medicaid coverage rules for appropriateness.

One of the financing and payment innovations under consideration by RI Medicaid is developing a “transitional capitation rate” to align and rebalance service delivery between institutional and community care settings. The transitional rate would allow community-based providers to retain a higher (institutionally-based) rate for a certain duration upon discharge from an institutional setting (e.g. 90 days) and conversely, the institutionally based providers would receive a lower (community-based) rate upon entry to the institution from the community for a certain period of time (e.g. 60 days). RI Medicaid will further examine and evaluate this payment innovation with stakeholders and CMS.

The process and timelines for design of financing and payment models is dependent on receipt of shared and linked Medicare and Medicaid data. When it becomes available, RI Medicaid will use linked and validated Medicare and Medicaid data (most recent available) to work with CMS on stratifying the profiles and rates for the demonstration population to align higher global capitation payments for higher risk and need of the stratified populations.

## B. Payments to MCOs

RI Medicaid has historical experience with enrolling people with disabilities into capitated managed care arrangements. Children with Special Health Care Needs (CSHCN) were enrolled on a voluntary opt-out basis in one MCO beginning in 2003. This enrollment became mandatory in 2009 when a second MCO became available. Rhody Health Partners, the capitated MCO program for adults with disabilities, began in April 2008 on a voluntary opt-out basis, and became a mandatory program in September of 2009. While not identical in need or service utilization to dual eligibles, the experience RI Medicaid has with rate setting for these groups lends some valuable “lessons learned” as the state embarks on a capitated model for dual eligibles.

As mentioned previously, RI Medicaid will work with CMS to obtain the necessary fee-for-service utilization and cost data for all members eligible for enrollment. In the state’s experience a minimum of three 12-month periods (e.g. calendar year, fiscal year, etc.) should be examined, in order to establish a viable trend. The historical data is then analyzed for trends in certain service categories, and assumptions are made regarding the effect managed care would have on those trends. For example, CMS and RI Medicaid may assume that with increased access to outpatient behavioral health care, the rate of behavioral health related inpatient hospitalizations would decline. This assumption has proved true in both the CSHCN and RHP populations.

Risk-adjusted rate setting is used in approximately 22 state Medicaid programs<sup>5</sup>, but limited data is available regarding the lessons learned from this approach to Medicaid rate setting. While the preferred approach, RI Medicaid recommends beginning the duals demonstration program by setting capitation rate categories based on historical utilization and trends, with the goal of identifying a risk-adjustment system by the close of the three-year demonstration.

Dual eligibles can be divided into groups, based on historical utilization, for purposes of capitation rate categories. For example, members who are permanently residing in an institution would be in a rate category, and members who reside in the community would be in a separate rate category. These groups could then be further subdivided based on other historical utilization or demographic factors (e.g. age, medical complexity, use of behavioral health services, etc.). RI Medicaid will work with CMS to determine the rating categories most appropriate for the members of the duals demonstration.

In addition to several rating categories, RI Medicaid should explore the potential to delay the requirement that MCOs accept full financial risk. The transition from fee-for-service to managed care for RI’s members has demonstrated a clear “wood working effect”. Long periods of pent up consumer demand for services leads to large spikes in utilization in the first one to two years of the improved access available through a managed care program. This “wood work effect” could result in large financial losses to the MCOs in the first years of the demonstration program. In a full risk arrangement, MCOs may choose to either reduce rates, deny access to services, or other equally dissatisfactory actions.

RI Medicaid proposes that for the period of the demonstration, the MCOs, CMS, and the State enter into a payment arrangement that aligns the interests of all parties. RI has been employing a

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<sup>5</sup> Dreyfus, T. and Davidson, E. “Risk Adjustment for Dual Eligibles: Breaking New Ground in Massachusetts”. Massachusetts Medicaid Policy Institute. January 2012

risk/gain share in its' managed care programs since the creation of RIte Care in 1994. This risk/gain share prevents the MCOs from experiencing large profits from participating in the Medicaid program and also protects the MCOs from major financial losses. CMS and RI Medicaid would agree upon the appropriate target medical loss ratio (MLR) and determine risk corridors on either side of that target MLR. In the case of large losses, the state/CMS would share in the losses. In the event of MCO financial gains, the state/CMS would share in those gains with the MCOs.

Other financing mechanisms to consider in the MCO contract are stop-loss provisions and reinsurance. The current Medicaid managed care program requires each participating MCO to hold a reinsurance policy with a carrier. In a reinsurance arrangement, the payer/insurer agrees to limit the MCO's financial exposure on high-cost cases (e.g. expenses for an individual in excess of \$100,000 per year). While reinsurance policies provide some financial protections for the plan, reinsurance does not conversely disincentive plans from enrolling more complex individuals.

Similarly, the state may consider including stop-loss provisions for certain services. Stop-loss provides another layer of financial protection for the plan and is often service specific for events that are not routine or are rare in nature (e.g. transplants in a non-disabled Medicaid population). The state may consider providing stop-loss coverage for certain services or event that are rare among dual eligibles.

Pay for performance strategies can be effective in aligning quality incentives with reimbursement, and are described in more detail in Section F.

RI Medicaid will work closely with CMS and stakeholders to define the most appropriate reimbursement strategies for the MCOs.

#### **IV. EXPECTED OUTCOMES**

##### **A. Approach to Monitoring, Collecting and Tracking of Key Measures**

Rhode Island Medicaid has a comprehensive approach to oversight and management of its Health Plan contracts by performing oversight functions to ensure that all contractual standards are met and that ongoing strategic improvements in the program to further the goals of improving access to care, promoting quality and improving health outcomes while containing costs are collaboratively addressed, planned and undertaken with the plans.

Our existing approach to monitoring, collecting and tracking key quality metrics applies standards and procedures in MCO contracts to:

- Assess the quality and appropriateness of care and services furnished to all enrollees
- Identify the race, ethnicity, and language spoken of each enrollee
- Regularly monitor and evaluate the MCOs' compliance with these standards
- Identify any national performance measures that may be identified and developed by CMS in consultation with States and other relevant stakeholders
- Arrange for an annual external independent review of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract

- Identify an information system that supports the initial and ongoing operation and review of the State’s quality strategy
- Delineate standards for access to care, structure and operations, and quality measurement and improvement

Rhode Island Medicaid will require participating MCOs to submit a comprehensive series of standing quarterly monitoring reports on the duals eligible demonstration, which will be used for oversight and monitoring of the State’s managed care program. The findings from these quarterly reports will be analyzed with each Health Plan during the State’s monthly series of oversight and monitoring meetings. Receipt of this ongoing series of reports allows Rhode Island Medicaid to identify emerging trends, any potential barriers or unmet needs, or quality of care issues.

RI Medicaid would expect to expand and modify our current approach and tailor MCO requirements to advance integrated care for our duals population that:

- Hold MCOs accountable for the care they deliver
- Incentivize quality care and improved health outcomes
- Link payment incentives with quality metrics (pay for performance)
- Incorporates robust quality measurements, including satisfaction of the enrollees
- Tracks progress with comparative information and performance benchmarking.

In 1998, Rhode Island Medicaid launched its *Performance Goal Program*, which established benchmarks for quality and access performance measures. Rhode Island was the second State in the nation to implement a “pay-for-performance” (or “P4P”) program for its Medicaid managed care program. This program has been recognized by CMS and by America’s Health Insurance Plans (AHIP) for its innovation and positive impacts on quality.

Since the initial launch of the Performance Goal Program in 1998, Rhode Island’s Medicaid program has enrolled disabled adults and children with special health care needs into the State’s managed care delivery system. In response, Rhode Island’s Performance Goal Program has evolved over time, by incorporating externally audited performance measures that have established national benchmarks and adding an enhanced number of quality measures which focus on behavioral health and chronic care.

The Performance Goal Program marked its thirteenth year in 2011; over 40 quality improvement measures are now included. Currently, the Performance Goal Program includes a mix of HEDIS® and CAHPS® measures, as well as several Rhode Island-specific standards, with seven (7) major areas of focus:

- Member Services
- Medical Home/Preventive Care
- Women’s Health
- Chronic Care
- Behavioral Health Care
- Resource Maximization
- Care Management for Special Enrollment Populations

## **B. Potential Improvement Targets for Measure**

RI Medicaid specifically requested input during the Global Waiver Taskforce Stakeholder forums for input on prioritization of improvement targets for measure and evaluation. Input received and for further exploration with CMS includes:

- i. Live longer at home
- ii. Member satisfaction with the care received
- iii. Changes in utilization patterns
- iv. Changes in number of people who report feeling depressed or  
anxious
- v. Ability to perform activities of daily living
- vi. Member participation in wellness initiatives
- vii. Member engagement with care coordinator, peer navigator, etc.

RI Medicaid will work with various stakeholder groups to determine the most appropriate measures, tools to report those measures, and expected outcomes for each measurement. In many cases, significant health improvement may not be realistic. However, improvements in a member's ability to maintain living safely in the community would be an appropriate goal.

CMS recently released a set of Adult measure, most of which were focused on acute care indicators, and not long-term services and supports. RI Medicaid will continue to examine these adult measures for their applicability to the duals demonstration.

## **C. Expected Impacts**

The evolution of Rhode Island's Medicaid managed care programs reflect the State's commitment to provide accessible, coordinated, and quality services to eligible recipients while controlling program costs. Controlling program costs may be accomplished by reducing the cost of care, curtailing the use of high cost services, increasing program efficiencies, maximizing payer funds to rationalize the care provided and/or promoting the utilization of primary care services. It has been our experience that the actions and pathways taken to achieve any one of these goals have a synergistic effect on the other goals.

For dual eligibles, Medicaid is a significant payer for long term care services with annual expenditures of over \$700 million. A more fully integrated system of care, particularly through a coordinated relationship with Medicare, is expected to provide for both improved outcomes for the beneficiaries and greater cost effectiveness and balance of our long term care services and supports expenditures.

## **V. INFRASTRUCTURE AND IMPLEMENTATION**

### **A. Infrastructure and Capacity**

To implement this demonstration, RI Medicaid has assembled a team of professionals with years of experience in developing, implementing and monitoring Medicaid managed care programs. The following individual positions will compose the core project team:

<b>Role</b>	<b>Responsibility</b>
Program Manager	Oversight of all aspects of program implementation over the course of the demonstration project (e.g. 3-way contract development, procurement documents, rate setting, etc.).
Contract Manager	Develops and maintain relationships with contracted MCOs and perform ongoing quality oversight
Data Analyst	Support the team with analysis of Medicaid and Medicare utilization data
Financial Analyst	Support the core team and actuarial consultant with analysis for rate setting and ongoing financial monitoring.
Quality Specialist	Review and recommendation for quality metrics to be used during contracting as well as ongoing oversight.

The state operates an integrated staffing model, with the contracted staff working on site with the state staff. In addition to the full-time professional contracted staff, the contractor has an immediate pool of subject matter experts and the ability to deploy those resources and expertise to focus on a specific subject matter. This flexibility is a benefit that most state Medicaid programs do not have available to them.

Rhode Island Medicaid embraces a culture of quality improvement and data-driven decision-making. State and contracted staff together compose an analytic team that represent decades of experience in the design, development and management of public programs. The state receives and analyzes encounter data files from the contracted MCOs on a quarterly basis for all populations enrolled in managed care. Encounter data is used in a variety of ways, including rate setting, payment reconciliation, quality audits, utilization and cost trend analysis, and program evaluation.

State and contracted professional program staff utilize regular and ad hoc data reports to develop new programs and improve current programs. For example, early experience with children with special health care needs enrolled in managed care demonstrated increases in behavioral health inpatient utilization. This data was analyzed internally, jointly reviewed with the MCOs, and used to develop a continuum of outpatient behavioral health services for children, which has become a national best practice. Analysis of utilization patterns of disabled adults uncovered critical areas of unmet need and led to the development of Rhody Health Partners and Connect Care Choice.

In addition to the on-site state and contracted staff, the Medicaid program operates a research and evaluation unit. This research function is managed via a contract with the RI Medicaid Research and Evaluation Project. These researchers and evaluators are affiliated with Brown University and the RI Department of Health, allowing them access to a variety of data sets including hospital discharge data, vital records and statistics, the Current Population Survey (CPS), the Behavioral Risk Factor Surveillance System (BRFSS), and several others. On a quarterly basis this evaluation arm of Rhode Island Medicaid convenes analytic and program staff to review research reports and discuss how to utilize the data to improve the Medicaid program.

Rhode Island Medicaid requires several routine qualitative and quantitative reports from its contracted MCOs. Regular ongoing analysis of these reports guides program oversight, monitoring, and improvement. These routine reports include data on grievances and appeals, trends in informal

complaints, and high-cost cases. As part of the annual Performance Goal Program site visits, MCOs submit audited HEDIS scores to DHS, which are systematically compared with national benchmarks. These scores are shared with the state's EQRO (Independent Peer Review Organization, or IPRO), and used to develop the state-mandated quality improvement programs each year.

RI Medicaid staff is responsible for day-to-day oversight, as well as periodic reporting and site visits. Specific functions are outlined below.

- **Focused Performance Monitoring:** Responsibilities include monitoring compliance and contract performance, identifying areas for remediation, assisting in the development and implementation of corrective action plans, providing technical assistance to improve cost-effectiveness and assuring that health plans are incorporating changes in Federal and State rules and regulations.
- **Analytics:** Medicaid program requirements are complex and require reporting and analysis of timely information and data regarding the performance of each health plan. Health plans are required to submit information quarterly about financials, operations and service utilization through the encounter data system. RI Medicaid maintains and operates a data validation plan to assure the accuracy of encounter data submissions. The health plans are also required to submit a series of quarterly reports that provide information and actions taken regarding informal complaints, grievances and appeals, fraud and abuse investigations and care management functions. Staff utilizes data modeling techniques to assess the impact of current trends or alternative improvement strategies.
- **Ongoing Evaluation/Review of Program Priorities & Health Plan Performance:** RI Medicaid staff identifies strategies and develops recommendations for program improvements and assesses the feasibility and impact of potential changes in Medicaid to improve program operations.
- **Member Satisfaction Survey:** Member satisfaction surveys are conducted periodically to assess members' satisfaction with the access, timeliness, quality and the provision of care in an effort to identify specific measures to improve the delivery and administration of services.

As a core component of its contract monitoring and oversight program, the State requires that MCOs submit detailed files quarterly of all claims paid for services rendered to their enrollees, referred to as "encounter data". This claims-based information contains details as to the specific services received by individuals during any unique episode of care. Among other data elements, it identifies the provider of services, the date of the encounter, the specific services provided to the member, the reason for the encounter, the amount billed for those services, and the amount paid by the health plan to the provider.<sup>6</sup>

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<sup>6</sup> Encounter data submissions have been a consistent CMS requirement in every Medicaid managed care program nationwide. Historically, the primary purposes behind the development of Encounter Data

Through analytic review, the encounter data is validated within and across the health plans for reasonableness and for consistency across time periods. Analysis of encounter data is performed regularly as part of health plan oversight and monitoring of health care quality, utilization, costs and trends in any of these areas. It therefore is a core part of the analytical component to the financial oversight provided by the State.

The State has recently entered into an agreement with JEN Associates, Inc., a pioneer in the development of sophisticated methodologies for the analysis of national healthcare data. This agreement provides Rhode Island Medicaid with Medicare utilization and expense data for our dual eligible beneficiaries. State and contractor analysts have received user training on this database. The data will be for multiple analytics in this project including developing risk profiles of the population. Also, the State’s fiscal agenda, Hewlett Packard (HP) has the capacity to integrate Medicare data with Medicaid data via crossover claims analysis. In addition to the data from JEN, the state intends to enter into a data sharing arrangement with CMS to obtain real-time Medicare claims data. Simultaneously the state will approach the Medicare Advantage plans operating in RI, to discuss entering into a data sharing arrangement with them for dual eligibles enrolled in their plans.

**B. Time Line and High Level Work Plan**

Figure 4 below provides a list of key milestones and dates associated with those milestones, for implementing fully integrated care for dual eligibles.

**Figure 4. Duals Integration High Level Time Line/Milestones**

Submit Demonstration Proposal to CMS	May 30, 2012
Stakeholder Engagement	April - June 2012
Memorandum of Understanding with CMS	July 2012
Joint Procurement	April-May 2013
Plan selection	June 2013
MCO Readiness Assessment	July-August 2013
Member Materials Development	August-September 2013
Notice to Members	October 1, 2013
Enrollment Effective Date	January 1, 2014

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reporting related to program management and service utilization review, access to care measures and the like – detailed financial information was a secondary consideration, and even there, the data were intended primarily to assist in capturing broad cost trends rather than to capture precise accounting information. Because of this, the financial information contained in encounter data files does not directly mirror information in the MCOs’ financial statements or other sources. Among the sources of variation from financial statements are the following: claims adjustments after the original claim is reported; non-claim specific payments, recoupment’s and other transactions such as pharmacy rebates, settlements, performance incentives, reinsurance costs and recoveries, sub-capitation and the like.

## **VI. FEASIBILITY AND SUSTAINABILITY**

### **A. Potential Barriers and Challenges and Mitigation Strategies**

CMS proposed an extremely aggressive time frame for implementation of this demonstration project. This challenge is mitigated by allowing Rhode Island to begin enrollment in the demonstration on January 1, 2014. RI Medicaid looks forward to continued discussion with CMS regarding this time frame.

Prior to entering into a memorandum of understanding with CMS, RI Medicaid will seek to have a thorough understanding of the shared savings arrangement. At the time of the drafting of this proposal, savings estimates had not yet been shared. The state will work closely with CMS to complete this analysis and arrive at a mutually agreed upon savings estimate. Sharing a linked data set of Medicare and Medicaid data with the MCOs will be a critical implementation step. This linked data set does not yet exist, but the state will work closely with CMS to submit the appropriate data requests, and secure data sharing agreements, in order to receive Medicare data in a timely way.

### **B. Statutory and Regulatory Changes Needed for Implementation**

The Governor's enacted state fiscal year 2012 budget included the following language:

By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid Beneficiaries, the Department of Human Services was directed to engage in a contractual arrangement for the expansion and integration of care management strategies by July of 2012 for Medicaid-only beneficiaries and for individuals dually eligible for Medicaid and Medicare.

This language provides RI Medicaid with the appropriate statutory authority to implement the demonstration program. In addition, any changes to the RI Compact Global Consumer Choice 1115 Waiver must be approved by the General Assembly. RI Medicaid will seek this legislative approval prior to submitting waiver category change requests to CMS.

RI Medicaid is currently researching the changes that will be necessary to RI Medicaid Rules and Regulations. All necessary Rules and Regulations will be updated and promulgated prior to the enrollment for the demonstration.

### **C. State Budget Authority Needed for Implementation**

Rhode Island received budget authority in the Governor's enacted state fiscal year (SFY) 2012 budget. No additional budgetary authorities are needed at the state level.

### **D. Scalability and Replicability**

Rhode Island Medicaid will begin enrollment in the demonstration on a state-wide level on January 1, 2014. Therefore, additional scalability is not necessary.

## **E. Letters of Support**

All Letters of Support can be found in Appendix B.

## **VII. ADDITIONAL DOCUMENTATION (AS APPLICABLE)**

RI Medicaid will provide additional documentation at CMS' request.

## **VIII. INTERACTION WITH OTHER HHS/CMS INITIATIVES**

The goal of *Partnership with Patients* to reduce hospital admissions by twenty percent (20%) is well aligned with the goals of this demonstration proposal. RI intends to improve coordination of care for dual eligibles by addressing many of the elements of safe, effective and efficient care transitions identified in the *Partnership with Patients*. Dual eligibles will have access to an array of services that will improve care coordination including; a comprehensive needs assessment, a personalized care plan, interdisciplinary care teams, information systems and technology that will support the care team and decentralized decision-making and benefit flexibility. With the assistance of the care teams, dual eligibles will experience improved outcomes including a reduction in hospital admissions, which will result in helping the twenty percent (20%) reduction goal of the *Partnership for Patients Initiative*.

A central component of successful integration will be to ensure access for all beneficiaries. RI Medicaid is committed to serving the needs of the dual eligible population, including providing materials, identifying service providers and ensuring access of information to those who have limited English proficiency. MCO's will be required to provide information and materials in relevant languages and provide access to primary care and care teams who are culturally competent. Interpretation services will also be a requirement. These components align with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*.

The *Million Hearts Campaign* will strive to prevent one million heart attacks and strokes in the United States over the next five years. RI Medicaid will aid in the prevention of heart attacks and strokes through its care coordination and management, more specifically around its personalized care plans for dual eligibles. These care plans will include treatment goals and measures for an individual's progress towards these goals. The care plan would be whole-person focused and strengths-based. The care plan will pay particular attention to disease prevention and primary care/preventive care as well as health promotion and wellness activities. An example of a wellness activity may be attending a seminar on healthy eating and exercise. The care plan would promote self-direction and would reflect routinely scheduled adjustments and updates, especially as enrollees are transitioning between care settings. These activities and services will assist in improving the cardiovascular health of dual eligibles.

**Appendix A. List of Stakeholder Meetings and Key Informant Interview in 2011.**

<b>RI Medicaid Stakeholder Meetings and Key Informant Interviews through December 22, 2011</b>	
<b>Date</b>	<b>Key Informants and Stakeholder(s)</b>
September 16, 2011	United Healthcare
September 22, 2011	Blue Cross Blue Shield
October 5, 2011	Commonwealth Care Alliance (CCA) of Massachusetts Lois Simon, COO
October 7, 2011	Program of All Inclusive Care of the Elderly of Rhode Island (PORI)
October 11, 2011	DEA Program Staff
October 31, 2011	Mass Senior Care of Massachusetts Scott Plumb, Senior Vice President
November 8, 2011	DEA Case Management Team
November 9, 2011	Key Informant Interview with State of Vermont Julie Wasserman and Bard Hill, Agency for Health Services (AHS)
November 10, 2011	Key Informant Interview with North Carolina Denise Levis and Angela Floyd North Carolina Community Care of North Carolina (CCNC)
November 16, 2011	Neighborhood Health Plan of Rhode Island and Rhode Island Health Center Association Policy Makers Breakfast on Dual eligibles
November 22, 2011	DEA Home and Community Care Advisory Committee
November 23, 2011	Key Informant Interview with State of Tennessee Patti Killingsworth, Assistant Commissioner, Chief of LTC, Bureau of TennCare
November 28, 2011	Global Waiver Task Force
December 1, 2011	Deb Castellano, Chief Casework Supervisor, DHS Long-Term-Care
December 1, 2011	Home and Community-Based Services Trade Associations and Advocates
December 13, 2011	DEA Academy
December 14, 2011	Long-Term-Care Coordinating Council

**Appendix B – Letters of Support**

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**Appendix C – Notes from Stakeholder Meetings**

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