Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration
11W-00242/1

Section 1115 Quarterly Progress Report

Period: October 1, 2009 – December 31, 2009

Table of Contents

Section I: General Information
Section II: Rhode Island Medicaid Eligibility
Section III: Goals of Demonstration
Section IV: Long-term Care Rebalancing
1. Ensure appropriate utilization of institutional services and facilitate access to community-based services and supports
Activity 1.1: Change the Clinical Level of Care Determination Process for Eligibility for Medicaid-funded Long-term Care from institutional to needs-based.
Activity 1.2: Remove Delegated Authority from Hospital Discharge Planners and Implement on-going Discharge Planner Education Initiative
Activity 1.3: Design and implement a Nursing Home Diversion project to identify individuals that could be discharged from the hospital to a community-based setting.
Activity 1.4: Design and implement a Nursing Home Transition project to identify individuals that could be transitioned from the nursing home to a community-based setting
2. Expand access to community-based services and supports
Activity 2.1: Develop a Preventive Level of Care
Activity 2.2: Expand Access to Shared Living to the Elderly and Adults with Physical Disabilities
Activity 2.3: Expand Access to Home Health Care
Activity 2.4: Expand Access to Assisted Living
Activity 2.5: Expand Access to Adult Day Services
3. Improve the coordination of all publicly-funded long-term care services and supports
Activity 3.1: Develop an Assessment and Coordination Organization that includes all agencies under the Executive Office of Health and Human Services
Activity 3.2: Address needs of high-cost utilizers
Activity 3.3: Revise Sherlock Plan
Section V: Medical Home and Care Management
1. Implement Mandatory Enrollment into Medicaid Managed Care
2. Promote Adoption of Medical Home Standards
3. Promote Adoption of Electronic Health Record
4. Promote Adoption of Managed Long Term Care
Section VI: Smart Purchasing
1. Implement competitive selective contracting procurement methodologies to assure the State obtains the highest value and quality of services for its beneficiaries at the best price.
Activity 1.1. Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Selective Contracting RFP
Activity 1.2. Shared Living Selective Contracting RFP
2. Develop and implement procurement strategies that are based on acuity level and needs of beneficiaries

Activity 2.1. Nursing Facility Acuity Payment
Activity 2.2. Hospital Outpatient and Inpatient Payment Methodology
Activity 2.3. Home Health Enhancements
Section VII: Quality and Evaluation
1. Quality Assurance and Improvement
2. Global Waiver Evaluation Plan
Section VIII: Communication
1. Global Waiver Task Force
2. Waiver Transition Notification
3. Nursing Facility Level of Care Communication
4. Website updates
Section IX: Cost Not Otherwise Matchable
Section X: Budget Neutrality and Allotment Neutrality
Section XI: State Plan Amendments and Waiver Change Requests

I. General Information

Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration
11W-00242/1

Initial Waiver Application Submitted: August 8, 2008

Initial Waiver Application Approved: January 16, 2009

Demonstration Project Implemented: July 1, 2009

Demonstration Expiration Date: December 31, 2013

II. Rhode Island Medicaid Eligibility

	September 2009 Count of Eligibles	**December 2009 Counts of Eligibles**
Aged	17,012	17,062
Disabled	26,122	26,352
BCCPT	546	270
QMBs, SLMBs, and QI 1s	5,011	5,201
Child and Families	122,236	125,911
Adoptive Subsidy	2,516	2,513
Foster Care	2,553	2,541
Children with Special Health Care Needs	8,348	8,468
Total	184,344	188,318

III. Goals of Demonstration

The Rhode Island Medicaid Reform Act of 2008 directed the State to apply for a "global" demonstration under the authority of Section 1115(a) of Title XIX of the Social Security Act. The goals of the Demonstration are promulgated in Section 42-12.4-2 of the General Laws of Rhode Island.

The Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration (Global Waiver) establishes a new Federal-State agreement that provides the State with substantially greater flexibility than is available under existing program guidelines. The State will use the additional flexibility afforded by the Global Waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting. In exchange for the increased flexibility and the opportunity to invest in Medicaid reform, the State will operate the Medicaid program during the Demonstration under a mutually agreed upon five-year aggregate cap of federal funds, thereby assuming a degree of financial risk with respect to caseload and per member per month cost trends.

Accordingly, Rhode Island now operates its Medicaid program under a single Section 1115 demonstration project with the exception of disproportionate share hospital (DSH) payments and payments to local education agencies (LEAs).[1] All Medicaid-funded services on the continuum of care are now organized, financed, and delivered under the authority of the Global Waiver. Rhode Island's Section 1115 RIte Care and RIte Share programs for children and families, the 1915(b) Dental Waiver (RIte Smiles), and the Section 1915(c) Home and Community Based Services waivers are included in the Global Waiver.

The Global Waiver has three major program goals:

1. To **re-balance the publicly-funded long-term care system** in order to increase access to home and community-based services and supports and to decrease reliance on inappropriate institutional stays.
2. To ensure all Medicaid beneficiaries have access to a **medical home**.
3. To implement **payment and purchasing strategies** that align with the programmatic goals and that ensure a sustainable, cost-effective program.

[1] Administrative expenses and phased-Medicare Part D contributions are also excluded from the five-year aggregate cap on Federal funds.

IV. Re-balancing of the Long-term Care System

Objectives and Supporting Activities:

1. Ensure appropriate utilization of institutional services and facilitate access to community-based services and supports

Activity 1.1: Change the Clinical Level of Care Determination Process for Eligibility for Medicaid-funded Long-term Care from institutional to needs-based.

Background:
Prior to the Global Waiver, clinical eligibility for long-term care services was based on an institutional level of care. Analysis of the acuity of persons in nursing homes in Rhode Island finds that many people have a low acuity and might be able to remain in the community, with the appropriate supports and services.

In order to ensure access to institutional services is limited only to those persons who are in need of that level of service, the State established a new Level of Care (LOC) for access to Nursing Facilities. The needs-based criteria were developed with input from providers and the community. In order to access Medicaid-funded long-term care, a person will need to have met either the highest or high LOC. If a person meets the highest LOC, he/she may access services in a nursing facility or in the community. If a person meets the high LOC, he/she may only access services in the community.

Individuals who were eligible for Medicaid long-term care and residing in nursing homes prior to July 1, 2009 will continue to be assessed at the institutional LOC.

Tasks completed for Period January –June 2009

A. New LOC assessment process developed and implemented:
   1. Referral comes to Office of Medical Review for LOC
      - Through the Long Term Care (LTC) field office
      - Through hospital discharge planners
      - Through nursing facility (NF)
   2. Existing Medical Assistance (MA) Eligibility status identified
      - Has community MA
      - Has LTC MA
      - Grandfathered Group
   3. Review clinical Information provided with referral
      - Hospital based information
      - MDS from Nursing Facility
      - MD form
   4. Complete clinical assessment tool / Level of Care Assessment for Long Term Care Services
      - Apply LOC criteria to assessment
      - Complete LOC worksheet-New Applicants for Level of Care for Long Term Service Worksheet.

- Determine LOC

5. Communicate LOC to referral source
    - Fax LOC authorization form
    - Send copy of completed assessment to Office of Community Programs for complex medical recipients for case management services and oversight
6. Insufficient clinical information to make LOC determination
    - On site visit to complete clinical assessment for hospital referrals
    - On site visit to Nursing Facility / or request for copy of MDS
    - On site visit to recipient's home
7. Clinical LOC not met
    - Written notification sent to MA recipient with appeal rights
    - LOC denial faxed to referral source and LTC office

B. New LOC Forms, worksheets, authorization, and referral forms developed and implemented:

1. Assessment Tools and Worksheets were developed based on:
    - Elements from Vermont's LTC Program
    - Includes recommendations from LOC stakeholder and Perry –Sullivan work groups
    - Mapped to NH MDS- Version 2
    - Mapped to the Department of Elderly Affair's (DEA) UCAT tool- pages 8 – 17.
2. Web- based software, OMAR, developed and installed on laptops for Office of Medical Review to complete assessments in offsite locations:
    - Electronic version of assessment tools
    - Information saved on server at EDS
    - Supports metrics and reporting capability

<u>Tasks completed for Period July –September 2009</u>

The activities, reported during January – June period outlined above, are either in the implementation phase or have been completed. In addition, the following tasks have been completed during this period.

- 910 Level of Care Assessments were completed
- Level of Care determinations: Highest category 630, High category 189, Preventive category 91
- Care Management Assessment Forms aligned across Departments
- Minor revisions were made to the forms
- Revisions made to web-based software
- Reporting metrics generated
- Additional enhancements to the web-based software have been identified and will be implemented in early 2010

<u>Tasks completed for Period October – December 2009</u>

The activities, reported during July – September period outlined above, are either in the implementation phase or have been completed. In addition, the following tasks have been completed during this period.

- 1,791 Level of Care Assessments were completed
- Level of Care determinations: Highest category 1,309, High category 392, Preventive category 90
- Care Management Assessment Forms aligned across Departments
- Minor revisions were made to the forms
- Revisions made to web-based software
- Reporting metrics generated
- Additional enhancements to the web-based software have been identified and will be implemented in early 2010
- Phase II Implementation strategy discussed, including ACO activities for High Cost Case Review, Information and Referral, LTC Options Counseling, LTC Financial eligibility, Medical Home, Provider Network/Special Programs, Purchasing/Rate Setting Strategies, Quality and Evaluation, Selective Contracting and Transitions from Children to Adult systems of care

Ensure appropriate utilization of institutional services and facilitate access to community-based services and supports

Activity 1.2: Remove Delegated Authority from Hospital Discharge Planners and Implement on-going Discharge Planner Education Initiative

Background: Prior to Global Waiver, hospital discharge planners had the authority to determine whether or not a person seeking Medicaid-funded nursing facility services met the clinical level-of-care. In an effort to ensure discharges from the hospital to the nursing home are appropriate, the State removed the delegated authority.

Tasks completed for Period January –June 2009

1. Worked collaboratively with Rhode Island Hospital and Miriam Hospital, hospitals with the highest number of discharges to nursing homes. Implemented a streamlined process that enables timely clinical determinations by State Office of Medical Review.

2. All hospitals trained on new processes.

3. The State will continue to work collaboratively with discharge planners to ensure resources are available to assist in appropriate discharges.

Tasks completed for Period July – September 2009

The following tasks have been completed during this period.

- Convened an all-hospital discharge planners training to review clinical criteria submission requirements
- Outlined schedule of implementation for the hospitals to begin submitting the clinical criteria
- Set forth delegated authority protocol for weekend discharge
- Outlined protocol for inpatient diversion discharge to a nursing facility

Tasks completed for Period October – December 2009

The following tasks have been completed during this period.

- Worked with targeted-hospital discharge planners to review clinical criteria submission requirements
- Implemented schedule for the hospitals to begin submitting the clinical criteria including 4 hospitals in October 2009, 4 hospitals in November and 5 hospitals in December 2009
- Implemented delegated authority protocol for weekend discharge
- Implemented protocol for inpatient diversion discharge to a nursing facility

1. Ensure appropriate utilization of institutional services and facilitate access to community-based services and supports

Activity 1.3: Design and implement a Nursing Home Diversion project to identify individuals that could be discharged from the hospital to a community-based setting.

Pilot project implemented at the Rhode Island Hospital by modifying the role of the on-site RN to identify Medical Assistant beneficiaries that could be safely discharged to a community setting. The RN will work with the hospital discharge planners, the DHS Office of Medical Review and the Providence LTC Social Worker to facilitate the discharge into to the community.

Tasks completed for Period January –June 2009

- Designed project components
- Modified role of the on-site RN at Rhode Island Hospital (RIH)
- Established the required LOC documentation to be sent to DHS
- Collaboration with RIH senior management and discharge planners/social workers
- Identified core group of Medicare certified Home Care agencies to accept referrals
- Created skilled visit criteria for safety and oversight
- Developed informational packets for community based services
- Integrated resources identified by Lt. Governor's Discharge Planner workgroup
- Identified on-site DHS diversion team RN and SW for LOC and eligibility
- Identified metrics for oversight, monitoring and cost savings
- Established data collection system
- Determined expected volume of diversions monthly-project savings
- Established a plan to implement the Nursing Home Diversion state-wide

Tasks completed for Period July –September 2009

- Reviewed the project components of the on-site RN at Rhode Island Hospital
- Determined expected volume of diversions monthly would not achieve the project savings to support the on-site RN.
- Reassigned the RN to the Connect Care Choice program
- Continue to develop a revised strategy for a Nursing Home Diversion project
- Redesign the program to incorporate elements based on the successful strategies employed by the Connect Care Choice and Rhody Health Partner case managers.

Tasks completed for Period October – December 2009

- Continue to develop a revised strategy for a Nursing Home Diversion project
- Redesign the program to incorporate elements based on the successful strategies employed by the Connect Care Choice and Rhody Health Partner case managers.

1. Ensure appropriate utilization of institutional services and facilitate access to community-based services and supports

Activity 1.4: Design and implement a Nursing Home Transition project to identify individuals that could be transitioned from the nursing home to a community-based setting

Tasks completed for Period January –June 2009

- Developed a scope of work and contract vehicle
- Completed necessary contracts
- Implemented contract including recruitment, hiring and training of staff
- Developed an assessment tool in collaboration with DHS NF LOC tool
- Developed information on HCBS, Assisted Living, Adult day in collaboration with DHS for Consumers and providers
- Developed marketing brochures, posters for program information with DHS
- Implement program on site at all nursing homes statewide
- Developed transition goals
- Developed metrics and data for tracking and outcome measures
- Developed and implemented program case management data base
- Developed cost savings metrics / produce monthly reports to DHS

Tasks completed for Period July –September 2009

- Monitored Nursing Home Transition activities
- Ensured accurate information on HCBS, Assisted Living, Adult Day Care for consumers and providers was being furnished
- Distributed marketing brochures, posters for program information
- Implemented program at all nursing homes statewide
- Nursing Home Transition services and the Nursing Facility Diversion program have resulted in 65 individuals being safely transitioned to a community setting
- Continue to monitor transition goals
- Monitored the Alliance's metrics and data for tracking and outcome measures
- DHS will incorporate the Nursing Home Transition responsibilities to the state staff in the Office of Community Programs and the Home and Community Care

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Nursing Home Transition services and the Nursing Facility Diversion program have resulted in 330 individuals being safely transitioned to a community setting
- Transition planning for the Nursing Home Transition responsibilities to the state staff in the Office of Community Programs and the DEA Home and Community Care underway

2. Expand access to community-based services and supports

Activity 2.1: Develop a Preventive Level of Care

Background: The State has identified a population who is categorically eligible for Medicaid, who have not yet met the highest or high clinical level, but who need a basic level of community-based support in order to keep them from meeting that clinical level of care.

Preventive LOC Criteria:

- Has a chronic illness or disability that requires, at a minimum:
- Supervision with 2 or more ADL's (bathing, eating, dressing, toileting, and ambulation/transfers) or
- Extensive or greater assistance with at least 3 IADL's (meal prep, laundry, shopping, and cleaning)

There must be no other person or agency available to perform these services. The criteria will be based on (1) a physician or other licensed practitioner's assessment and (2) a DHS caseworker or nurse's assessment.

The Preventive Level-of-Care Initiative provides the following services to categorically eligible Medicaid beneficiaries who meet the preventive level of care criteria:

- Limited CNA/ Homemaker Services- includes help with general household tasks such as meal preparation and routine household care. These services may be available when a person can no longer do these tasks on their own and has no other person available to help them. Limited personal care may also be available. Maximum hours available are 6 hrs per week for an individual or 10 hrs per week for a household with two or more eligible individuals.
- Minor Environmental Modifications- may be available to an individual to facilitate independence and the ability to live at home or in the community safely. They may include: grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, simple devices, such as: eating utensils, a transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles.

Tasks completed for Period January –June 2009

- Preventive LOC criteria developed and implemented
- Staff trained on new criteria and program.

Tasks completed for Period July –September 2009

- Preventive LOC criteria implemented for Phase I (minor environmental modifications/Homemaker/CNA)
- Continued staff training on new criteria and program.
- On-going planning and design for Phase II (Respite/ PT/OT)
- 90 individuals met the Preventive LOC and are receiving services

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Develop redesign of staffing assignments for the minor home modifications
- On-going planning and design for Phase II (Respite/ PT/OT)
- 90 individuals met the Preventive LOC and are receiving services
- Interdepartmental discussions and planning for Respite services

2. Expand access to community-based services and supports

Activity 2.2: Expand Access to Shared Living to the Elderly and Adults with Physical Disabilities

Prior to the Global Waiver, shared living was available to participants in the 1915(c) Waiver for Individuals with Developmental Disabilities. This initiative seeks to expand the shared living model to a greater number of individuals.

Tasks completed for Period January –June 2009

- The State has establish shared living as a service for elderly and adult disabled clients who are Medicaid-eligible, unable to live independently and who meet the "high" or "highest" level of care definitions as delineated in the RI Global Waiver. Shared Living is a consumer-directed service.

- The State has issued a Request for Information.

Future activities:

- The State will issue a Request for Proposal (RFP) to selectively contract with one or more Shared Living Agencies. The Agency will be responsible for recruitment of host homes/caregivers, training of caregivers, safety of the host home, oversight and monitoring shared living services, provision of RN services as needed to ensure client health and safety, and development of the Shared Living Service and Safety Plan.

- Each Shared Living Service and Safety Plan will be uniquely tailored to meet the individualized needs of the client.

- The Caregiver will be responsible for 24/7 care and provision of services and supports to client, including meals, transportation, assistance with ADL's, etc.

- Anticipated Start Date of Contract: November, 2009

Tasks completed for Period July –September 2009

- The State has issued a Request for Information (RFI) to assist the state in developing and refining a procurement document for shared living. The state will then issue a Request For Proposals (RFP) to selectively contract with one or more Shared Living Agencies. The Agency will be responsible for recruitment of host homes/caregivers, training of caregivers, safety of the host home, oversight and monitoring shared living services, provision of RN services as needed to ensure client health and safety, and development of the Shared Living Service and Safety Plan.

- Anticipate contract award in January 2010

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Request For Information (RFI) responses received and incorporated into the Request For Proposal (RFP)
- Request For Proposal issued October 14, 2009
- Shared Living subcommittee established to establish workflow criteria, systems issues and evaluation criteria
- Shared Living Proposal received November 20, 2009
- Evaluation of proposals underway
- Anticipated contract award in March 2010

2. Expand access to community-based services and supports

Activity 2.3: Expand Access to Home Health Care

Tasks completed for Period January –June 2009

New criteria for Medicaid participating home health agencies have been developed and implemented.

In order for Home Care Agencies to participate in Medicaid, each agency must meet the following criteria:

- Be enrolled as a Medicaid provider and licensed by Health as a Home Care Agency
- Be Medicare certified or if not Medicare certified have a formal letter of agreement with a Medicare certified agency
- Participate in the "Enhanced Reimbursement Program"
- Provide evening, night, week-end and holiday Certified Nursing Assistant care and Provide 24 / 7 agency coverage for "no-shows, and problem solve with clinical staff for unexpected change in status of individuals and families they serve
- Provide intermittent skilled Registered Nurse visits as needed to monitor complex medical conditions and change in status, and bill Medicare when it is the prime coverage for dually eligible individuals
- Provide guarantee that the agency will provide all care and services as identified in the service / care plan and provide back up for staff call outs and no shows
- Collaborate with care management with the individual's Nurse Care Manager in the Connect Care Program; Rhody Health Partners: and the Office of Community Programs

Tasks completed for Period July –September 2009

New criteria for Medicaid participating home health agencies have been developed and implemented.

- Monitor utilization of intermittent skilled Registered Nurse visits as needed to monitor complex medical conditions and change in status, and bill Medicare when it is the prime coverage for dually eligible individuals
- Monitor Home Care agencies adherence to the Medicaid participation standards
- Monitor collaboration with care management with the individual's Nurse Care Manager in the Connect Care Program; Rhody Health Partners: and the Office of Community Programs
- Include information on Home Health Care services in marketing materials/communications
- Monitor Home Health Care services for the Preventive LOC beneficiaries

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Exploring reconfiguration of options for Home Health Care enhanced reimbursement
- Work with Home Health Care agencies to ensure network capacity for Rhody Health Partners managed care options

2. Expand access to community-based services and supports

Activity 2.4: Expand Access to Assisted Living

Tasks completed for Period July –September 2009

- Internal inter-agency workgroup formed to address various issues regarding Medicaid-funded services in Assisted Living: regulatory, quality of care; increased access; capacity and rate reform
- Met with Assisted Living Industry to gauge access issues
- State staff visited several assisted living facilities

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Met with the Assisted Living industry to discuss rate changes
- Discuss reimbursement strategies for Dementia unit in Assisted Living
- Discuss reimbursement strategies for SSI Assisted Living program
- Implement streamlined authorization and payment through the MMIS system

2. Expand access to community-based services and supports

Activity 2.5: Expand Access to Adult Day Services

Tasks completed for Period July –September 2009

- Members of Assessment and Coordination Organization and other State staff met with industry to fully understand scope of services provided by adult day.
- Developed plan for in-service training on adult day for State and contracted case managers

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Finalized plan for in-service training on adult day care services for State and contracted case managers
- Conducted in-service training on adult day care services for State and contracted case managers
- Exploring acuity-based payment reimbursement methodologies to address higher need beneficiaries (i.e. Alzheimer's, wound care, medication management)

3. Improve the coordination of all publicly-funded long-term care services and supports

Activity 3.1: Develop an Assessment and Coordination Organization that includes all agencies under the Executive Office of Health and Human Services

An inter-departmental long term care Assessment and Coordination Organization (ACO) has been established: to ensure consistency and uniformity in the administration of the publicly –funded long-term care system.

Tasks completed for Period January –June 2009

- ACO created and implemented
- On-going weekly meetings held
- Compiled inventory of current processes and tools for LTC assessment and care plan development
- Researched best practices for LTC clinical and functional assessment tools
- Integrated and continue to integrate work completed under the Real Choice Systems Change Grant
- Identified Information and Referral sources
- Developed Information and Referral strategy
- Determine process flowcharts and performance measures
- Recruited, hired, and trained RN staff for the Office of Medical Review (OMR)
- Created Office of Community Programs (OCP) to support community-based placements
- Integrated Preventive LOC with OCP
- Identified systems changes for eligibility (InRhodes) and MMIS
- Drafted and conducted the public notice of policy changes
- Developed education and training workplan for Nursing Facility LOC
- Developed materials and presentations for consumers, facilities and stakeholders
- Aligned efforts with Nursing Home Transition and Diversion initiatives

Tasks completed for Period July –September 2009

- ACO activities implemented
- Completed 910 Level of Care Assessments
- On-going bi-weekly meetings held
- Integrated and continue to integrate work completed under the Real Choice Systems Change Grant
- Implemented Information and Referral strategy
- Implement new business process flows and refined as needed
- Identified performance measures
- Reviewed analytics and metrics for performance measures
- Recruited, hired, and trained additional RN staff for the Office of Medical Review (OMR)

- Trained Office of Community Programs (OCP) staff to support community-based placements
- Integrated Preventive LOC with OCP
- Implemented systems changes for eligibility (InRhodes) and MMIS
- Conducted education and training workplan for Nursing Facility LOC
- Produced and distributed materials and presentations for consumers, facilities and stakeholders
- Aligned efforts with Nursing Home Transition and Diversion initiatives
- Analyzing revisions to the Assisted Living reimbursement
- Implemented consistent case management practices and tools for state staff
- Developed consistent home modification policy
- Developed consistent transition cost policy
- Initial planning for High Cost Case review
- Initial planning for cross departmental development of Respite services
- Formed an inter-agency group to assist dual-eligible beneficiaries transitioning from closed Special Needs Plans

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Continued to aligned efforts with Nursing Home Transition and Diversion initiatives
- Analyzing revisions to the Assisted Living reimbursement
- Implemented consistent case management practices and tools for state staff
- Implemented consistent home modification policy
- Implemented consistent transition cost policy
- Implemented planning for High Cost Case review
- Implemented planning for cross departmental development of Respite services
- Executed inter-agency group to assist dual-eligible beneficiaries transitioning from closed Special Needs Plans
- Continued planning for education and outreach
- Collaborate with DEA on the new activities planned for the ADRC, The Point

3. Improve the coordination of all publicly-funded long-term care services and supports

Activity 3.2: Address needs of high-cost utilizers

Tasks completed for Period July –September 2009

- Implement Inter-agency High-cost Case Review Working Group

Tasks completed for Period September –December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Work plan development for High-cost Case Review
- Strategies include predictive modeling solutions, establishment of a specialized Vent Unit, expansion of Connect CARRE to provide case management, incorporate targeted interventions (Communities of Care) for high utilizers under the managed care reprocurement, explore expansion of tobacco cessation
- Data needs identified

Activity 3.3: Revise Sherlock Plan

The Sherlock Plan is Rhode Island's Medicaid Buy-In program for adults with disabilities who seek to gain or maintain employment while still maintaining health coverage. Enrollment in Program is very low and changes are necessary to increase enrollment and ensure it is a Program that meets the populations' needs

Tasks completed for Period July –September 2009

- Workgroup meetings held every month
- Recommendations developed
- Drafting of legislative and regulatory changes in process

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Explore a comprehensive long term support and service evaluation/assessment tool, with specific modules for medical, social and employment supports
- Explore opportunities in conjunction with ARRA

V. Medical Home and Care Management

Objectives and Supporting Activities:

1. Implement Mandatory Enrollment into Medicaid Managed Care

Under the Global Waiver, the State will continue to deliver primary and acute care services through the following systems:

Managed Care Organizations: *RIte Care, RIte Share Rhody Health Partners and PACE*
Primary Care Case Management Program: *Connect Care Choice, Connect Care*
Pre-paid Dental Ambulatory Health Plans: *RIte Smiles*

Care Management program enrollment is as follows:

Program	Enrollment as of 3/31/09	Enrollment as of 6/30/09
RIte Care	113,745	114,926
RIte Share	7,921	8,493
Rhody Health Partners	9,626	9,650
PACE	154	164
Connect Care Choice	1,947	1,931
Connect Care	160	168
RIte Smiles	39,607	41,616

The State created two managed care options for adults on Medicaid: Connect Care Choice (a primary care case management program) and Rhody Health Partners (managed care contract program). These programs began enrolling people in September of 2007 on a voluntary opt-out basis. Effective July 1, 2009, enrollment in one of these two programs is mandatory for the following categorically eligible[2] Medicaid clients:

- Clients over age 21
- Client with no other comprehensive health coverage (e.g. Medicare)
- Clients residing in the community (not in a nursing home or Eleanor Slater Hospital)

Mandatory enrollment will be phased in over two months. Half of the remaining fee-for-service Medicaid beneficiaries will be mailed letters in July for a September 1, 2009 effective enrollment date. The other half will be mailed letters in August for an October 1, 2009 effective enrollment date. Clients will have until December 31, 2009 to switch between Rhody Health Partners or Connect Care Choice. After January 1, 2010, clients will not be able to change options until open enrollment in January 2011. Clients may request an exception to this rule, but must demonstrate "good cause".

[2] Connect Care Choice does enroll medically needy clients

July – September 2009 Care Management program enrollment is as follows:

Program	Enrollment as of 6/30/09	Enrollment as of 9/30/09
RIte Care	114,926	116,865
RIte Share	8,493	9,102
Rhody Health Partners	9,650	10,383
PACE	164	158
Connect Care Choice	1,931	2,473
Connect Care	168	196
RIte Smiles	41,616	42,594

- Mandatory enrollment was phased in
- Letters were mailed in July for a September 1, 2009 effective enrollment date. and the other half were be mailed letters in August for an October 1, 2009
- Clients will have until December 31, 2009 to switch between Rhody Health Partners or Connect Care Choice.

October – December 2009 Care Management program enrollment is as follows:

Program	Enrollment as of 9/30/09	Enrollment as of 12/31/09
RIte Care	116,865	120,317
RIte Share	9,102	10,377
Rhody Health Partners	10,383	12,332
PACE	172	
Connect Care Choice	2,473	2,487
Connect Care	196	218
RIte Smiles	42,594	45,684

- Mandatory enrollment complete
- Implement protocols for review of Rhody Health Partners change requests and Connect Care Choice Change requests
- Monitor Rhody Health Partners care management reports and Connect Care Choice care management activities
- Exploring new initiatives including Managed Long Term Care and Communities of Care

V. Medical Home and Care Management

2. Promote Adoption of Medical Home

Tasks completed for Period July –September 2009

- Continued cooperative effort between Connect Care Choice and Chronic Sustainability Initiative
- Preparations for application to Centers for Medicare&Medicaid Services for Medicare Medical Home Initiative

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Explore adoption of Medical Home into managed care reprocurement
- Develop application to Centers for Medicare & Medicaid Services for Medicare Medical Home Initiative

3. Promote Adoption of Electronic Health Record

Tasks completed for Period July –September 2009

- Regular meetings with applicant for Regional Extension Center
- Initial work on P-APD; Submission expected by January 15, 2010

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Explore adoption of Electronic Health Record into managed care reprocurement
- Integrate with HIE activities under the DRA Medicaid Transformation Grant
- Continued voluntary enrollment of Medicaid beneficiaries in statewide current***care*** EMR

VI. Smart Purchasing

The State wants to continue to be a "smart purchaser" of services and care through "selective contracting" based on a competitive process that is market driven to assure the State obtains the highest value and quality of services for its beneficiaries at the best price. The state will contract with providers that meet, accept, and comply with the requirement, quality, and utilization standards that are consistent with the requirements of section 1923 of the Act. These standards are consistent with access, quality, and efficient and economic provision of covered care and services. Restrictions on providers will not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

Objectives and Supporting Activities:

1. Implement competitive selective contracting procurement methodologies to assure the State obtains the highest value and quality of services for its beneficiaries at the best price.

The state will contract with providers that meet, accept, and comply with the requirement, quality, and utilization standards that are consistent with the requirements of section 1923 of the Act. These standards are consistent with access, quality, and efficient and economic provision of covered care and services. Restrictions on providers will not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

Activity 1.1. Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Selective Contracting RFP

Rhode Island endeavors to contract with selected organizations/companies to supply DMEPOS products for Medicaid beneficiaries in the Medicaid fee-for-service program.

Currently, Medicaid-funded DMEPOS services may be provided through the State's managed care contracts with Medicaid managed care organizations or through the Medicaid fee-for service system. The RFP is targeted for DMEPOS provided through the Medicaid fee-for-service system.

<u>Tasks completed for Period January –June 2009</u>

- Conducted Analytic Assessment of each service/commodity
    - Identified the volume for code groups (e.g. walkers) and for each code within a group (e.g. E0130- rigid walkers) within groups based on HCPCS codes (CPT codes may be appropriate for other selective contracting efforts)
    - Identified the total and average unit costs for groups and each procedure code
    - Identified volume, total cost and average cost by providers

    - Identified volume, total cost and average cost by delivery/reimbursement system
    - Identified volume, total cost and average cost by population groups.

- Reviewed other selective purchasing efforts
    - Medicaid
    - Medicare
    - VA
    - Others as identified

- Determined specific parameters for selective contracting
    - Determined the specific code groups and procedure codes within a group to be included in the selective purchasing efforts
    - Determined the final setting, delivery/reimbursement system, providers and population groups to be included & excluded from the selective processing procurement
    - Determined pricing & bid strategy (e.g. DHS set rates or percentage discount based on past experience; vendor bid price for all items in RFP, for items within a product category, or only for items they choose to bid on; and alternative pricing mechanisms
    - Determined vendor organizational, certification, financial and QA requirements
- Determined potential bidders
    - Identified potential bidders
    - Contacted bidders notifying of potential procurement
    - Assessed potential bidders interest
    - Adjusted procurement strategy, if necessary
- Conducted Request for Bid (RFP) process
    - Drafted RFP
    - Worked with Department of Administration

Future Activities:

    - Post the RFP
    - Review bids
    - Hold oral presentations by venders, if appropriate
    - Prepare summary report on review panels evaluations
    - Recommend successful vendor
- Contract with successful vendors
    - Notify vendors
    - Prepare contract
    - Negotiate with vendor, if required
- Implement Contract
    - Work with vendor to assist in implementation
    - Prepare notices to providers and beneficiaries
    - Implement changes in MMIS systems
    - Notify other stake holders

- Conduct a "readiness review" of vendor and state operations to assure a smooth implementation and operation

Tasks completed for Period July – September 2009

- Conducted Request for Bid (RFP) process
  - Drafted RFP
  - Worked with Department of Administration to post the RFP in August 2009
  - Notified Interested parties
  - Received seventy-one questions regarding the RFP
  - Extended the bid submission twice
  - Drafted responses to the RFP questions
  - Planning for a Bidder's Conference in November 2009

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Conducted Bidder's Conference in November 2009
- DMEPOS subcommittee established to establish workflow criteria, systems issues and evaluation criteria
- DMEPOS RFP responses received December 3, 2009
- Evaluation of proposals underway
- Anticipated contract award in Spring 2010
- New initiatives identified for FY2010 and FY2011 include optimizing TPL, design eligibility system components, program integrity initiatives and review of hospital coding for ED.

1. Implement competitive selective contracting procurement methodologies to assure the State obtains the highest value and quality of services for its beneficiaries at the best price.

Activity 1.2. Shared Living Selective Contracting RFP

Please refer to Section III Rebalancing Long-term Care for more general information on Shared Living.

Implementation Activities:

- Request for Information issued.

Future Activities:

- Issue a Selective Contracting RFP

Tasks completed for Period July –September 2009

- The State has establish shared living as a service for elderly and adult disabled clients who are Medicaid-eligible, unable to live independently and who meet the "high" or "highest" level of care definitions as delineated in the RI Global Waiver. Shared Living is a consumer-directed service.

- The State has issued a Request for Information (RFI) to assist the state in developing and refining a procurement document for shared living. The state will then issue a Request for Proposals (RFP) to selectively contract with one or more Shared Living Agencies. The Agency will be responsible for recruitment of host homes/caregivers, training of caregivers, safety of the host home, oversight and monitoring shared living services, provision of RN services as needed to ensure client health and safety, and development of the Shared Living Service and Safety Plan.

- Anticipate contract award in January 2010

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

- Request For Information (RFI) responses received and incorporated into the Request For Proposal (RFP)
- Request For Proposal issued October 14, 2009
- Shared Living subcommittee established to establish workflow criteria, systems issues and evaluation criteria
- Shared Living Proposal received November 20, 2009
- Evaluation of proposals underway

- Anticipated contract award in March 2010

2. Develop and implement procurement strategies that are based on acuity level and needs of beneficiaries

Activity 2.1. Nursing Facility Acuity Payment

The Rhode Island Legislature has directed the state to implement acuity based rates for nursing facilities. The current payment method bases rates on each facility's cost report. Different nursing facility residents require more or less resources depending on their health status and daily living needs. Facilities that care for resource intensive residents should receive a higher daily rate of compensation. Multiple studies have shown that acuity adjusted rates provide incentives to facilities to care for higher acuity residents.

Tasks completed for Period January –June 2009

- Reviewed how other States pay for LTC
- Reviewed options for Acuity adjustment in Rhode Island
- Conducted a facility wide census
- Conducted overview of rate setting process
- Reviewed RUG Grouper process
- Reviewed all resident census and acuity
- Compared facility acuity for all residents and Medicaid residents
- Reviewed cost report data
- Reviewed direct labor cost component by the facility case mix indices, to increase or decrease this portion of the rate, depending on the facility average acuity
- Designed data collection and analysis process
- Analyzed claims and cost report data
- Collected census data from all nursing facilities
- Matched census and MDS records, assign RUG categories
- Calculated acuity based rates based on provider data
- Identified workplan for training of providers
- Developed IT system changes implementation plan

Tasks completed for Period July –September 2009

- Matched census and MDS records, assign RUG categories (Feb and Sept 2009)
- Finalized acuity based rates based on provider data
- Set implementation date of January 15, 2010
- Finalized workplan for training of providers
- Implemented IT system changes plan
- Convened all-provider meeting on September 29, 2009 to review process to date and solicit feedback
- Acuity adjusted rates based on the relative acuity of each patient in each Nursing Facility, as well as the relative cost of nursing care in each facility
- Developed recommendations for short-term and long-term acuity adjustment to the per diem rate
- Developed a workplan for dissemination of information, public hearing requirements and final rate review process

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed.

2. Develop and implement procurement strategies that are based on acuity level and needs of beneficiaries

Activity 2.2. Hospital Outpatient and Inpatient Payment Methodology

The State will implement a revised outpatient payment methodology utilizing a simplified APC based on 100% of the Medicare rate. A Category 2 request has been submitted. The State anticipates an October 1, 2009 start date. On April 1, 2010, the State will implement an APR/DRG payment methodology for all of the hospitals in Rhode Island.

Tasks completed for Period January –June 2009

- Met with hospital administrators and trade group
- Developed IT system changes implementation plan
- Met with hospital billing staff to review new processes

Tasks completed for Period July –September 2009

Outpatient: On an interim basis, the Department will change its current payment method, a retrospective, cost-based method known as "Maxicap," to a fee schedule based on, but not identical to, Medicare Ambulatory Payment Classifications (APCs). DHS will assess future options for 2011

- Finalized interim plan to implement APC Fee Schedule with fees at 100% of Medicare, without many of the complexities of Medicare
- Conducted at detailed training for hospital administrators on September 9, 2009
- Produced Fact Sheet for the Outpatient APC payment methodology changes
- Monitored IT system changes implementation plan
- Working with a hospital finance advisory group on questions of payment policy, implementation and provider education
- Continue to analyze permanent option for 2011 payment method; two leading options include a comprehensive version of Medicare APCs or a method based on Ambulatory Patient Groups (APGs).

Inpatient: The Rhode Island Department of Human Services plans to move from a retrospective, cost-based method known as "Maxicap," to a new Medicaid method of paying for hospital inpatient services based on All Patient Refined Diagnosis Related Groups (APR-DRGs). Our goals are to implement a new payment method that is sustainable, increases fairness, reduces administrative burden, rewards economy and improves transparency. The target date is April 1, 2010, based on legislation passed by the 2009 Rhode Island Legislature.

- Developed interim plan to implement APR-DRGs Fee Schedule

- Conducted at detailed analysis of the Rate Year 2008 to project cost and projected impact to the individual hospital facilities
- Developed payment calculations and established DRG base price and update procedures
- Produced and distributed financial simulation at the stay-specific level for each hospital
- Created a DRG Calculator that is available to the hospitals to calculate expected payment. The excel spreadsheet does not assign the APR-DRG but it does show how the given APR-DRG will be priced in different circumstances
- Produced Fact Sheet for the Inpatient APR-DRGs payment methodology changes.
- Conducted a training on September 9, 2009 for hospital administrators
- Monitored IT system changes implementation plan
- Working with a hospital finance advisory group on questions of payment policy, implementation and provider education

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed.

2. Develop and implement procurement strategies that are based on acuity level and needs of beneficiaries

Activity 2.3. Home Health Enhancements

In 1999 the State established an enhanced reimbursement program for home health services. The purpose was to provide additional reimbursement when agencies met standards beyond those of minimal licensing requirements. The enhancements are applied to homemaker, personal care, homemaker/personal care and home health aide services. The specific enhancements include: Client Satisfaction; Continuity of Care; Worker Satisfaction; State Agency Accreditation; CHAP/Joint Commission Accreditation; Client Acuity; Staff Education Training; and Shift Differential.

In 2008, the State implemented an additional rate enhancement for home health care agencies as well as adult day care services. This rate enhancement was implemented under authority of the Long Term Care Service and Finance Reform Act, with the goal of promoting the expansion of home and community-based services. The State increased rates by 10% for homemaker, personal care, homemaker/personal care, home health aide and adult day care services. This rate increase was effective as of July 1, 2008.

Future Additional Enhancements

In order to further ensure increased capacity of home and community-based services as DHS moves to implement the Global Waiver, additional enhancements are under consideration. These include:

- Increased enhancement based on acuity (new acuity rating tool is under development)
- Increased enhancement for nights, weekends, holidays (further analysis needed)
- Home Health Care Agency Certification Standards will require all agencies to participate in the enhanced reimbursement program established in 1999.
- Selective contracting, which would establish higher rates based on an agency's ability to meet standards specified by DHS

Additional funds (amount TBD) are potentially available from the Long Term Care Service and Finance Reform Act to increase reimbursement for home health services for State Fiscal Year 2010.

Tasks completed July – September 2009

- The state is reviewing current acuity utilization trends of Home Health Care and Adult Day Care agencies
- Meeting with Assisted Living provider group to discuss acuity based strategies
- Reviewed preliminary report on Value Based Purchasing for Home and Community Based services.
- Reviewed RI Long Term Care Indicator Data, Hospital Discharge Data, Quality Indicators Data, Long Term Care Access, Quality and Health Status Indicators, Medicaid Long Term Care Trends and Long Term Care Inquiry and Hospital Data

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed.

- Reviewed final report on Value Based Purchasing for Home and Community Based services.

VII. Quality and Evaluation

1. Quality Assurance and Improvement

The State shall keep in place the existing quality systems for the programs that currently exist and will remain in place under the Global 1115 Waiver (RIte Care, Rhody Health, Connect Care Choice, RIte Smiles, and PACE). For its Home and Community Based Services System under the Global 1115, the State will utilize a QA/QI plan consistent with the Quality rubric utilized in the CMS 1915(c) Waiver Program that will assure the health and welfare of program participants. This QA/QI system will be based on the system utilized in the current aged/disabled waiver, number 0040.90.R5. Components must be added to the QA/QI to monitor and evaluate the health and welfare of the section 1115 expansion programs with limited benefit coverage.

2. Global Waiver Evaluation Plan

A Workgroup was formed to develop the Evaluation Plan. This Workgroup included representation from each of the EOHHS agencies that participate in the Global Waiver. The collaboration and commitment of the other EOHHS agencies was pivotal to the successful completion of the proposed draft.

A draft proposed Evaluation Design was submitted to CMS.

Lay-out of the Design:

Because of the innovative nature of RI's Demonstration Waiver, the Evaluation Design includes significant background about the Global Choice Compact Waiver, including the eligible populations, benefits, and service delivery systems as well as a thorough presentation of the proposed evaluation methodology. Because the Demonstration Waiver now organizes Medicaid services through a single waiver, the Design includes the following major areas of focus:

- ✓ LTC
- ✓ Rite Care
- ✓ Rite Share
- ✓ Extended Family Planning
- ✓ Focused Evaluations of Expansion Groups/CNOMs

For each of the major components of the Waiver, the proposed methodology delineates pertinent goals, objectives, and a series of evaluation questions accompanied by their proposed measures and data sources. Evaluation questions focus upon the number of beneficiaries served, the utilization of services, and associated costs, seeking to determine that individuals receive the most appropriate services in the least restrictive and most appropriate setting.

Tasks completed for Period July –September 2009

- Cross-department workgroup prepared an inventory spreadsheet, outlining the quality measures for the former 1915(a) waivers & the former 1115 waiver Status of Current Quality Measures
- Drafting Global Quality Waiver Measures including data collection methods, type of method, entity that performs, usual sample size, data collection frequency, findings reviewers and date preformed and next due date

Tasks completed for Period October – December 2009

The activities, reported during July – September period outlined above, are either on-going or have been completed.

VIII. Communication

The State has developed a comprehensive communication strategy to inform stakeholders and policy-makers about the Global Waiver. The Global Waiver communication strategy has three components: communication for consumers and families; communications for community partners and sister agencies; and communication for state and federal partners. The communication strategy includes a Choice Counseling program designed to provide beneficiaries and/or their representatives' information concerning the range of options that are available in Rhode Island to address a person's long-term care needs. This program will align with activities under the Choices MMIS project and the RIte ReSources initiative. To enhance transparency of information as we make system reform, the State is using a web-based project management tool, OnTrak, to ensure broadbased communications. The following communication activities have been accomplished.

Tasks accomplished January – June 2009

1. Global Waiver Task Force

The RI Global Waiver Implementation Task Force was established in state legislation to "work collaboratively with the executive office of health and human services and the department of human services to plan, design, and implement changes to the Medicaid program under the demonstration and to evaluate the impact of such changes and of the demonstration." (RI 2009—H 5112 Substitute C)

The taskforce is comprised of members of the Rhode Island community including consumers, advocates, and service providers representing the populations receiving services through Medicaid, including: "children and youth with special health care needs, adults and children with developmental disabilities, adults with serious and persistent mental illness and/or addiction disorders and children with severe emotional disturbance, adults with disabilities, adults age 65 and older, and low-income children and families."

The first meeting of the Global Waiver Taskforce was on May 12, 2009. Six workgroups were established, with members' self-selecting membership on at least one of the groups. State staff was assigned to each workgroup, and chairs were selected from the taskforce members. The workgroups and their charges include the following:

- Housing: How to increase housing options, including the expansion of supportive housing, available to Medicaid beneficiaries with long-term care needs; and the potential impact of increasing the minimum monthly maintenance needs allowance by $400 on Medicaid beneficiaries' ability to stay in the community.

- Employment: How to increase employment among Medicaid beneficiaries with disabilities; and how to support Medicaid beneficiaries with disabilities who are working.

- Long-term Care Insurance Partnership: A review of the program and recommendations on whether any program policy changes are needed in order to ensure cost-effectiveness; and how to increase public awareness of the Partnership program.

- Dual-Eligibles: How to better integrate and coordinate Medicare-funded primary and acute care with Medicaid-funded long-term care services and supports.

- Katie Beckett: How to incorporate a self-directed approach in the Program; and exploring the impact of a cost-sharing element.

- Medicaid Benefit Redesign: How to change the Medicaid benefit package to ensure services provided are the most appropriate and cost-effective. This workgroup was subsequently split into two groups, one focusing on Acute Care and one on Long-term Care services.

Global Waiver Task Force meetings will be held monthly. The taskforce is co-chaired by OHHS Policy Director Ann Martino and a community representative still to be confirmed. Meeting agendas include updates from the State on Global Waiver implementation activities and updates from the workgroup chairs and co-chairs on workgroup activities, as well as opportunities for public comment. All Global Waiver Task Force meetings are open to the public and minutes are posted on the OHHS website.

2. Waiver Transition Notification

Upon approval of the Global Waiver Project Number 11W-00242/1, the existing federal authority for all of the 1915(c) Waivers terminated effective June 30, 2009. DHS is required by federal law to provide notice to beneficiaries that the federal authority to operate the 1915(c) Wavier had terminated and that the federal authority is now under Section 1115 demonstration waiver.

Implementation Activities:

- Convened cross departmental team
- Drafted letter member letter and CMS correspondence
- Implemented the process for sending notification to recipients
- Sent notice to recipients
- Notified CMS
- Notified Stakeholders and providers

3. Nursing Facility Level of Care Communication

Medicaid has collaborated with other state agencies to: ensure that beneficiaries have access to the appropriate services; to streamline the intake and assessment processes; and to provide beneficiaries and their families with clear, concise, consistent, and accurate information about their care options. The state has created information on the new

Nursing Facility Level of Care for consumers, providers, external partners and interested parties. The State has completed an inventory of the all of the "points of entry" to the Long Term Care system and has identified the approach for accurate and timely dissemination of information. The State has developed a fact sheet, conducted trainings and has mailed information to numerous stakeholders.

4. Website updates

The State has updated the DHS and the OHHS websites with information pertaining to the Global Waiver. In addition, the websites are being redesigned to be user-friendly and updated with the most current information. The State is also reviewing the various websites maintained by sister agencies to ensure accurate information is available.

Tasks accomplished July – September 2009

1. Global Waiver Task Force

- Monthly meeting held with the large Global Waiver Task Force and the six workgroups. Topics discussed include:
  - Update on Global Waiver Implementation
  - Overview on the EOHHS Departments roles under the waiver
  - Rhody Health Partners
  - Connect Care Choice
  - Long Term Care Clinical and Financial eligibility
  - Real Choices Grant
  - Long Term Care Service and Reform Act (Perry Sullivan)
  - Budget Update
  - Workgroup Chairs & Co-Chairs Updates

2. Medical Care Advisory Committee

The Global Waiver and Medicaid regulations require the state to convene a Medical Care Advisory Committee. To meet the requirements, the state has:

- Convened a multidisciplinary clinical team Clinicians include: Primary Care Practitioners (geriatrics, pediatrics, family practice and internal medicine) a Psychiatrist, a Behavioral Health clinician, a Registered Nurse, the health plan Medical Directors a Pharmacists, a Dentist an ER physician, the Medicaid Medical Director and the Hospital Association of Rhode Island.
- Set a charter for the MCAC and meeting dates

3. Preventive Level of Care

Upon approval of the Global Waiver Project Number 11W-00242/1 Rhode Island was granted the permission to create a Preventive level of care for individuals who do not presently need an institutional level of care but will have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in an institution. The Communications workgroup created a Fact Sheet on the Phase I of the Preventive LOC services that was distributed to staff and made available on the website.

4. Nursing Facility Level of Care Communication

Medicaid has collaborated with other state agencies to: ensure that beneficiaries have access to the appropriate services; to streamline the intake and assessment processes; and to provide beneficiaries and their families with clear, concise, consistent, and accurate information about their care options. The state has created information on the new Nursing Facility Level of Care for consumers, providers, external partners and interested parties. The State has completed an inventory of the all of the "points of entry" to the Long Term Care system and has identified the approach for accurate and timely dissemination of information. The State has developed a fact sheet, conducted additional trainings and has mailed information to numerous stakeholders.

5. Website updates

The State has updated the DHS and the OHHS websites with information pertaining to the Global Waiver. During this reporting period, the redesigned websites were launched and are up to date with the most current information. The State is also reviewing the various websites maintained by sister agencies to ensure accurate information is available.

6. Choice Counseling Program

The State has tasked the Communication Workgroup to design, plan and implement a Choice Counseling Program to promote community based options for individuals needing long term care services. Efforts have begun to design the Choice Counseling Program. Efforts are being coordinated with the Real Choice Systems Transformation Grant activities.

7. Community Options Training

The State has begun to organize a community options training for hospital and nursing home discharge planners. This training will be videotaped and made available as a webcast.

<u>Tasks completed for Period October – December 2009</u>

The activities, reported during July – September period outlined above, are either on-going or have been completed. In addition, the following tasks have been completed during this period.

1. Global Waiver Task Force

Monthly meeting held with the large Global Waiver Task Force and the six workgroups.

- All workgroups have submitted recommendations to the Secretary for consideration
- Recommendations have been posted to the On-Trak project management website
- Realignment of Task Force with the Modernization (interagency re-engineering and realignment activities to strengthen the Medicaid program) efforts being explored

2. Medical Care Advisory Committee

- Presentation of Connect Care Choice program
- Presentation of Screen Basis Intervention and Referral to Treatment (SBIRT)
- Recommendation to add SBIRT code to Medicaid Fee Schedule
- Discuss strategies to rollout SBIRT in hospital EDs, Connect Care Choice practices and other interested physician groups
- Discussion of clinical programming with Medical Care Advisory Committee

3. Preventive Level of Care

- Communication strategies planned for additional services (i.e. Respite)

4. Nursing Facility Level of Care Communication

- Communication strategies on-going

5. Website updates

- Website updates on-going

6. Choice Counseling Program

- Choice Counseling development on-going
- Integrate with ADRC program initiatives and the Real Choice Systems Transformation Grant

7. Community Options Training

- Planning continues for a multi-pronged paper/video/website training in the spring 2010

- Integrate with rollout with Rite Resources, the electronic database of up-to-date community based resources

8. Lt. Governor Long Term Care Coordinating Council

- Present monthly updates on the Medicaid Global Waiver

IX. Costs Not Otherwise Matchable (CNOM)

Costs Not Otherwise Matchable (CNOM) represents costs that cannot be funded under the RI Medicaid State Plan. Upon approval of the RI Medicaid Global Waiver explicit authority was granted. This initiative allows the State Medicaid Agency (The Department of Human Services) to lead the effort in claiming specific health-related services for matching federal funds.

The purpose of including CNOM in the Global Compact Waiver is to demonstrate that the provision of Medicaid funded services to non-Medicaid eligible person's can delay and/or prevent the need for full Medicaid eligibility.

The following State Agencies manage programs that have been identified as CNOM eligible:

- The Department of Children, Youth and Families (DCYF)
- The Department of Elderly Affairs (DEA)
- The Department of Human Services (DHS)
- The Department of Health (DOH)
- The Department of Mental Health, Retardation and Hospitals (MHRH)
- The Office of Rehabilitative Services (ORS) (within DHS)

CNOM Eligibility and Service Groups

CNOM Eligibility Group	Demonstration Budget Population Group
Children and families in managed care enrolled in RIte Care Medicaid parents have behavioral health conditions that result in their children being placed in temporary State custody	Budget Population 8
Children with special health care needs who are 21 and under who would otherwise be placed in voluntary State custody-residential diversion	Budget Population 9 & Budget Services Group 4
Elders at risk of LTC	Budget Population 10
Adults with disabilities at risk for LTC who would otherwise not eligible for Medicaid	Budget Population 15
Uninsured adults with mental illness	Budget Population 16
Children at risk for Medicaid and/or institutional care	Budget Population 17
HIV positive individuals who are otherwise not eligible for Medicaid	Budget Population 18
Services billed to the Rhode Island Department of Health by the FQHCs for providing a limited benefit package for uninsured individuals	Budget Service 5

Tasks Completed for Period January-June 2009

1. Implementation of CNOM for the Global Waiver
    a. Provided technical support for each of the EOHHS agencies
    b. Provided technical assistance in the development and implementation of each budget population/service
    c. Developed an overall claiming manual
2. Budget Population 8
    a. Conducted an assessment of the population, services, providers, payment methods and current systems
    b. Coordinated and developed the requirements for changes in several systems, including InRhodes, RICHST and MMIS
    c. Collaborated with DCYF, DHS, Northrop Grumman and EDS to detail changes that must be implemented prior to claiming submissions
    d. Developed with DCYF the policies and procedures for implementation of final claiming methods
3. Budget Population 9
    a. Conducted an assessment of the population, services, providers, payment methods and current systems
    b. Coordinated and developed requirements for changes in several systems, including InRhodes, RICHST and MMIS
    c. Collaborated with DCYF, DHS, Northrop Grumman and EDS to detail changes that must be implemented prior to claiming submissions
    d. Developed with DCYF the policies and procedures for implementation of final claiming methods
    e. Provided technical assistance in the development of interim claiming solution for state fiscal year 2009
    f. Submitted claims to CMS for first and second quarter calendar year 2009
4. Budget Population 10
    a. Conducted an assessment of the population, services, providers, payment methods and current systems
    b. Assisted with the change from a co pay structure to a personal needs assessment
    c. Coordinated the MMIS system modifications with DEA and EDS
    d. Developed with DEA the policies and procedures for final claiming methods
    e. Provided technical assistance in the development of interim claiming solution for state fiscal year 2009
    f. Submitted claims to CMS for first and second quarter calendar year 2009
    g. Developed and implemented case management claiming methods
    h. Trained State staff and providers regarding process and procedures
    i. Provided assistance with the budget process for the services
    j. Developed the final claiming process

5. Budget Population 15
    a. Conducted an assessment of the population, services, providers, payment methods and current systems
    b. Coordinated the MMIS system modifications with ORS and EDS
    c. Developed the web-based eligibility system for streamlined claiming
    d. Developed with ORS the policies and procedures for final claiming methods
    e. Provided technical assistance in the development of interim claiming solution for state fiscal year 2009
    f. Submitted claims to CMS for first and second quarter calendar year 2009
    g. Trained State staff and providers regarding process and procedures
6. Budget Population 16
    a. Conducted an assessment of population, services, providers, payment methods and current systems
    b. Coordinated the MMIS system modifications with MHRH and EDS
    c. Developed web-based eligibility system for streamlined claiming
    d. Developed with MHRH the policies and procedures for final claiming methods
    e. Provided technical assistance in the development of interim claiming solution for state fiscal year 2009
    f. Submitted claims to CMS for first and second quarter calendar year 2009
7. Budget Population 17
    a. Conducted an assessment of the population, services, providers, payment methods and current systems
    b. Developed with DHS the policies and procedures for final claiming methods
    c. Provided assistance with development of financial attestation regarding income
    d. Submitted claims to CMS for first and second quarter calendar year 2009
8. Budget Population 19
    a. Conducted an assessment of the population, services, providers, payment methods and current systems
    b. Developed with DHS the policies and procedures for final claiming methods
    c. Submitted claims to CMS for first and second quarter calendar year 2009
9. Budget Services 4
    a. Conducted an assessment of the population, services, providers, payment methods and current systems
    b. Coordinated and developed the requirements for changes in several systems, including InRhodes, RICHST and MMIS
    c. Collaborated with DCYF, DHS, Northrop Grumman and EDS to detail changes that must be implemented prior to claiming submissions
    d. Developed with DCYF the policies and procedures for implementation of final claiming methods
    e. Provided technical assistance in the development of interim claiming solution for state fiscal year 2009

f. Submitted claims to CMS for first and second quarter calendar year 2009

10. Budget Services 5
    a. Conducted an assessment of the population, services, providers, payment methods and current systems
    b. Developed with DOH the policies and procedures for final claiming methods
    c. Submitted claims to CMS for first and second quarter calendar year 2009

11. Implementation of CNOM for the Global Waiver
    a. Provided technical support for each of the EOHHS agencies
    b. Provided technical assistance in the development and implementation of each budget population/service
    c. Monitored overall claiming in accordance with the claiming manual
12. Budget Population 8
    a. Reviewed the assessment of the population, services, providers, payment methods and current systems
    b. Coordinated and developed the requirements for additional changes in several systems, including InRhodes, RICHST and MMIS
    c. Collaborated with DCYF, DHS, Northrop Grumman and EDS to detail changes that must be implemented prior to claiming submissions
    d. Monitored the DCYF policies and procedures for implementation of final claiming methods
13. Budget Population 9
    a. Reviewed the assessment of the population, services, providers, payment methods and current systems
    b. Coordinated and developed requirements for additional changes in several systems, including InRhodes, RICHST and MMIS
    c. Collaborated with DCYF, DHS, Northrop Grumman and EDS to detail changes that must be implemented prior to claiming submissions
    d. Monitored the DCYF policies and procedures for implementation of final claiming methods
    e. Provided technical assistance in the development of a claiming solution for state fiscal year 2010
14. Budget Population 10
    a. Reviewed the assessment of the population, services, providers, payment methods and current systems
    b. Assisted with the change from a co pay structure to a personal needs assessment
    c. Monitored the MMIS system modifications with DEA and EDS
    d. Monitored the DEA policies and procedures for final claiming methods
    e. Provided technical assistance in the development of a claiming solution for state fiscal year 2010
    f. Submitted claims to CMS for first and second quarter calendar year 2009
    g. Monitored case management claiming methods
    h. Trained State staff and providers regarding process and procedures
    i. Provided assistance with the budget process for the services
    j. Monitored the final claiming process

15. Budget Population 15
    a. Reviewed the assessment of the population, services, providers, payment methods and current systems
    b. Coordinated the MMIS system modifications with ORS and EDS
    c. Monitored the web-based eligibility system for streamlined claiming
    d. Monitored the ORS policies and procedures for final claiming methods
    e. Provided technical assistance in the development of a claiming solution for state fiscal year 2010
    f. Trained State staff and providers regarding process and procedures
16. Budget Population 16
    a. Reviewed the assessment of population, services, providers, payment methods and current systems
    b. Coordinated the MMIS system modifications with MHRH and EDS
    c. Monitored the web-based eligibility system for streamlined claiming
    d. Monitored the MHRH policies and procedures for final claiming methods
    e. Provided technical assistance in the development of a claiming solution for state fiscal year 2010
    f. Submitted claims to CMS for the third quarter calendar year 2009
17. Budget Population 17
    a. Reviewed the assessment of the population, services, providers, payment methods and current systems
    b. Monitored the DHS policies and procedures for final claiming methods
    c. Implemented the financial attestation regarding income
    d. Submitted claims to CMS for the third quarter calendar year 2009
18. Budget Population 19
    a. Reviewed the assessment of the population, services, providers, payment methods and current systems
    b. Monitored the DHS policies and procedures for final claiming methods
    c. Submitted claims to CMS for the third quarter calendar year 2009
19. Budget Services 4
    a. Reviewed the assessment of the population, services, providers, payment methods and current systems
    b. Coordinated the requirements for changes in several systems, including InRhodes, RICHST and MMIS
    c. Collaborated with DCYF, DHS, Northrop Grumman and EDS to detail changes to claiming submissions
    d. Monitored the DCYF policies and procedures for implementation of final claiming methods
    e. Provided technical assistance in the development of a claiming solution for state fiscal year 2010
20. Budget Services 5
    a. Reviewed the assessment of the population, services, providers, payment methods and current systems
       Monitored the DOH policies and procedures for final claiming methods

Tasks accomplished July – September 2009

Under the federal authority granted by CMS, the state has claimed approximately $10 million dollars in Cost Not Otherwise Claimable (CNOM). The state continues to perform the activities outlined above.

Tasks accomplished September – December 2009

The state continues to perform the activities outlined above.

X. Budget Neutrality and Allotment Neutrality

Under the terms of the Global Waiver, the State is subject to a limit on the amount of Federal Title XIX funding that it may receive on selected Medicaid expenditures during the demonstration period. The budget neutrality cap is for the Federal share of the total computable cost of $12.075 billion for the five-year demonstration period.

Section XIII of the STCs, "Reporting Expenditures Under the Demonstration", identifies the requirement that all Demonstration expenditures claimed must be reported quarterly on separate forms CMS-64.9 Waiver and/ CMS64.9P. Twenty-four separate Form CMS-64.9 Waiver and/or 64.9P Waiver are to be submitted for each of the identified Budget Populations (1-19) and for Budget Services (1 – 5).

Budget neutrality shall be enforced by CMS over the life of the Demonstration, rather than on an annual basis. However, cumulative targets for each year of the Demonstration are contained in Paragraph 93 of the STCs.

Attached is a revised Budget Neutrality summary for the quarter ending March 31, 2009, the first calendar quarter of the Demonstration, second calendar quarter ending June 30, 2009 and third calendar quarter ending September 30, 2009. The summaries identify all expenditures included within the Demonstration for the January 1, 2009 –September 30, 2009 period. Expenditures for DSH, the phased-down Part D contributions and LEA payments are not subject to the budget neutrality agreement and are excluded from this report. The attached spreadsheet reflects $646,993,942 cumulative expenditures below the expenditure target cap from January 1, 2009 through September 30, 2009.

The Budget Neutrality spreadsheet is structured to identify:

I. Total Expenditures Subject to Budget Neutrality
II. Cumulative Expenditure Target
III. Cumulative Results

The STCs identify a Cumulative Expenditure target by Demonstration Year. For the purpose of presentation in this report, the Demonstration Year 1 Cumulative Target of $2.6 billion is divided into four equal amounts of $650 million per quarter.
The revised total expenditures of $404,904,076 are reported for the January 1, 2009 – March 31, 2009 quarter. It has been agreed with CMS that the reporting period for the financial component of the Demonstration commenced January 1, 2009 rather than the January 16, 2009 date of the Demonstration approval letter. The total expenditures of $467,204,301 are reported for April 1, 2009 – June 30, 2009. The total expenditures of $430,897,682 are reported for July 1, 2009 – September 30, 2009.

Note that expenditure reporting for the Budget Neutrality summary is presented in four sections. Section I identifies expenditure lines for each of the nineteen Budget Populations and five Budget Services in the Demonstration, Section II identifies the expenditure target, Section III details the actual expenditures and Section IV reflects the Surplus/ (Deficit).

Tasks accomplished for July – September 2009

- Revised Budget Neutrality summary for the quarter ending March 31, 2009, the first calendar quarter of the Demonstration
- Calculated second calendar quarter ending June 30, 2009
- Calculate third calendar quarter ending September 30, 2009
- The state has achieved Cumulative results of $646 million dollars below the cap

Tasks accomplished for September – December 2009

- Calculate fourth calendar quarter ending December 31, 2009
- The state has achieved Cumulative results of $853 million dollars below the cap

XI. Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted during this Quarterly Operational Report period January 16, 2009 – June 30, 2009:

Request Type	Description	Date Submitted	CMS Action	Date
Category 1	CMAP Rebate	07/09/2009		
Category 2	Acute Stabilization Unit	06/16/2009		

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during this Quarterly Operational Report period July 1, 2009 – September 30, 2009:

Request Type	Description	Date Submitted	CMS Action	Date
Category 1	CMAP Rebate	07/09/2009	Approved	
Category 2	Acute Stabilization Unit	06/08/2009	Approved	10/30/2009
Category 2	Hospital Outpatient APC methodology	08/14/2009	RAI Received DHS response received Approved	1/7/2010
Category 2	Emergency Department Limit on Visits	08/14/2009	Denied	
Category 3	Pregnant Women with incomes between 185% and 250% FPL	07/09/2009	Approved	12/9/2009
Evaluation Plan	STC required Global Waiver Evaluation Design plan	07/20/2009		

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during this Quarterly Operational Report period October 1, 2009 – December 31, 2009:

Request Type	Description	Date Submitted	CMS Action	Date
Category 1	CMAP Rebate	07/09/2009	Approved	
Category 2	Acute Stabilization Unit	06/08/2009	Approved	10/30/2009
Category 2	Hospital Outpatient APC methodology	08/14/2009	RAI Received DHS response received Approved	1/7/2010
Category 2	Emergency Department Limit on Visits	08/14/2009	Denied	
Category 3	Pregnant Women with incomes between 185% and 250% FPL	07/09/2009	Approved	12/9/2009
Evaluation Plan	STC required Global Waiver Evaluation Design plan	07/20/2009		