

Executive Office of Health and Human Services Memorandum

To: Theresa Vandergriff, Ascellon
Claudia Brown, CMS Project Coordinator
From: Ann M. Martino
Date: March 2, 2010
Re: Update on LTC Rebalancing Efforts and the Real Choices Systems
Transformation Grant II (STG)

The purpose of this memo is illustrate the important and changing role that the Real Choices System Transformation Grants (STGs I and II) have and will continue to play in Rhode Island's ongoing effort to rebalance the long term care (LTC) delivery system under the auspices of the state's innovative Global Consumer Choice Compact Section 1115 demonstration waiver (Global Compact Waiver or GCW). The goal is to show how the authority and flexibility of the GCW affords have enabled the state to pursue an array of rebalancing strategies that, though not contemplated when the STGs I and II were crafted, further the goals and objectives articulated in the STG strategic plan.

When the state was awarded both the RCSTG I and II, the framework for long-term care system reform was the Rhode Island Long Term Care Service and Finance Reform Act of 2006 (LTCSFR). This important law was the culmination of a near decade long process in which state officials joined together with key stakeholders to develop strategies to rebalance the long-term care system to ensure access to the right services, at the right time, in the right setting.

Whereas the LTCSFR set forth the basic goals of rebalancing and provided a financing scheme, the focus of the STGs was to support the design (I) and implementation (II) of a strategic plan for transforming these goals into measurable outcomes. For example, during the STG I period, the Executive Office of Health and Human Services (EOHHS) conducted a series of meetings with community stakeholders that led to development of the strategic plan. The three stakeholder groups that guided formulation of the plan – Access, LTC Finance and Quality – worked tirelessly over a period of months to establish LTC reform goals and objectives as well an array of strategies for achieving them. These elements of the strategic plan became, in turn, the basis for project deliverables for the STG II. In addition to grant deliverables, community stakeholders also developed a priority list for the use of funds under the LTCSFR.

The Nexus Between the GCW and the STGS I and II

While the STG II RFP was pending, state policymakers directed the leadership of the EOHHS to seek the federal waiver authority required to pursue comprehensive reform of the Rhode Island Medicaid program. Although the focus of this effort was transformation of the Medicaid program as a whole, the development of the waiver proposal was

informed significantly by the LTCSFR and the STG strategic plan. For example, the three central components of the waiver – LTC rebalancing, enhanced care management, and smart purchasing – incorporate many of the goals and objectives articulated by the three community stakeholder groups related to improving access to community based services, delaying the need for LTC through chronic disease prevention and management and eliminating the institutional bias in LTC through lasting finance reform.

However, as a Section 1115 demonstration, the Global Compact Waiver provides the state with a far more varied and efficacious set of tools for pursuing these and other STG and LTCSFR goals. Specifically, both as originally proposed and in the final form in which it was approved, the GCW affords the state the authority and flexibility under Title XIX to restructure the Medicaid program and in ways that allow RI to utilize a more aggressive and holistic approach to LTC reform than that set forth in the STG strategic plan and the LTCSFR.¹

The differences in approach between the GCW and the STG approaches to LTC rebalancing are thus a function of scope, not content. Even though the goals and objectives of the GCW are more far reaching (e.g., program wide) and the outcomes the state hopes to achieve considerably more ambitious (e.g., increase overall spending on home and community based services to 50% of the total LTC annual budget), the vision for LTC reform established in the STGs I and II remains the same. In this respect, the GCW rebalancing framework incorporates rather than supplants the STGs I and II. However, in changing the scope of the rebalancing effort, the GCW has altered how STG objectives are ordered and prioritized, the strategies used to achieve them, the relevance of STG II deliverables and, ultimately, how all these elements will be evaluated.

To illustrate the point fully, Table I provides an overview of the nexus between selected GCW and STG goals, objectives and strategies and the important role that STG II deliverables have and will continue to play in the rebalancing effort. The goal is show here more clearly how the STG and GCW reinforce and inform one another.

¹ See the following documents for an overview: *Quarterly Report for Section 1115 Waiver* No. 11W-00242-1 July – September 2009
http://www.eohhs.ri.gov/documents/documents10/Global_Waiver_Report_July_Sept_09.pdf

Table I: Nexus Between Selected Global Compact Waiver and STG LTC Medicaid Reforms

Goal	GCW Objectives ²	GWC Evaluation Criteria (over 5 years of waiver)	Related STG Objectives & Strategies	Related STG Evaluation Criteria (over STG II grant period)	Relevant STG Deliverable and Impact
1. Access					
Improve access to LTC services and supports	4.1-4.1.2 Rebalance the state’s existing LTC system by increasing access to home and community based services (HCBS).	4.1.1. Change in number of admissions to LTC facilities paid by Medicaid. 4.1.2. Change in number and percentage of discharges from LTC to HCB settings. 4.1.3. Change in the average length of stay in LTC facilities 4.1.4. Percent change in average daily census of LTC facilities. 4.1.5. Rate of increase in	1.1 Provide awareness information and assistance of LTC options through: <i>1.1. Participant needs and experiences survey;</i> <i>1.1.2. Advisory stakeholder workgroup</i> <i>1.1.3 LTC web-based benefit screener to complement other resource/referral tools</i> <i>1.1.4. Discharge planner outreach and training.</i> <i>1.1.5 Development & dissemination of education materials on HCBS</i> <i>1.1.6. Resource Mapping</i>	1.1.1. 10% Increase in individual awareness of HCBS across the system. 1.1.2. 10% Increase in awareness of right to choose from among full range of services for which they are eligible. 1.1.3. Percent increase in utilization of LTC information and referral services 1.1.4. Provider/discharge planner knowledge and awareness of HBS	Survey of participant needs & experiences have assisted the state in identifying rebalancing priority areas and core HCBS. Recently completed snapshot survey provided baseline of beneficiary awareness of HCBS. Informs efforts related to STG II strategy 1.1.3 to 1.1.5. Access Workgroup and its successor the Global Waiver External Task Force (GWETF) – have played a critical role in

² The information contained here is derived from the following two sources: 1) *Proposed Evaluation Design for Section 1115 Waiver No. 11-W-00242/1*, prepared by the Executive Office of Health and Human Services, available at: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/GlobalWaiver/GW_Evaluation.pdf ; and 2) *RI Global Consumer Choice Compact 1115 Waiver Demonstration*, available at: <http://www.eohhs.ri.gov/global/documents/pdf/GlobalWaiverFinal1-09.pdf>

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		<p>cost of LTC in institutional settings.</p> <p>4.1.2.1. Change in volume of beneficiaries receiving one or more core LTC services in the HCB setting.</p> <p>4.1.2.2. Change in overall utilization of core HCBS.</p> <p>4.1.2.3. Change in distribution of beneficiaries receiving LTC in HCB v. institutional settings.</p> <p>4.1.2.4. Change in cost distribution for LTC in HCB v. institutional settings.</p>	<p>1.2. Streamline multiple eligibility processes</p> <p>1.3. Target individuals at imminent risk for institutional care</p>	<p>options pre-and-post training.</p>	<p>design/implementation of rebalancing effort.³</p> <p>Discharge planner training and education modules currently under development. Preliminary training to educate both groups about GCW process changes complete.</p> <p>Informational brochures for beneficiaries and families now in development with advice and assistance from GWETF members.</p> <p>Resource mapping, just finalized, provides a tool for assessing whether HCBS is capable of meeting demand as awareness grows of other LTC options. Critical for assessing of GWC objectives 4.1 and 4.1.2. and long-term</p>

³ Information about and for the Task Force is maintained on the EOHHS website at: <http://www.eohhs.ri.gov/global/documents/>

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					<p>impact of related evaluation criteria.</p> <p>Non-STG – Implementation in April 2010 of web-based RItE Resources – funded through Medicaid Transformation Grant – that provides real-time information about the availability of HCB and institutional LTC to public and providers</p>
	<p>4.1.3. Modify income and resource eligibility requirements for Medicaid funded LTC services to reduce institutional bias and eliminate variations across HCBS programs.</p> <p>(Includes consolidating all 9 Section 1915C waivers under GCW</p>	<p>4.1.3.1. Number of LTC applicants meeting the revised financial eligibility thresholds suing new spousal impoverishment rules.</p> <p>4.1.3.2. Number of LTC beneficiaries meeting new financial eligibility threshold choosing HCBS.</p>	<p>1.2. Streamline multiple eligibility processes –</p> <p><i>1.2.1. Select format for eligibility tool from existing models and modify as appropriate</i></p> <p><i>1.2.2. Incorporate recommendations of stakeholder groups</i></p> <p><i>1.2.3. Develop business process flow for LTC eligibility.</i></p> <p><i>1.2.4. Pilot triage tool</i></p>	<p>1.2.1. Number of beneficiaries receiving expedited services.</p> <p>1.1.4. Provider/discharge planner awareness of new rules.</p> <p>1.4.1.10% Increase use of full range of home and community based services</p>	<p><u>Important Note: STG objective 1.2.</u> Disparities in financial eligibility criteria and their application that existed at the time the STG strategic plan was developed have been minimized with the consolidation of the HCBS 1915 C waivers under the GCW.</p> <p>Revised financial eligibility criteria under GCW in accordance with stakeholder</p>

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	Section 1115 demonstration waiver.)		<i>through the Point (ADRC).</i>		<p>group recommendations (STG strategy 1.1.2). Additionally, received authority under the GCW to provide support for transitions (strategy 5.1.5), it as per stakeholder recommendation to improve access.</p> <p>Used business flow developed as part of strategy 1.2.3. to map out new eligibility process for changing IT systems, reorganizing staff into centralized Assessment and Coordination Unit, and promulgate rules and regulations required for implementation.</p> <p>Implementation of expedited services is under review in light of findings of the snapshot survey indicating</p>

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					low level of awareness. Goal is to revise current approach to improve utilization.
	<p>4. 2. Establish objective needs based level of care determinations for Medicaid LTC applicants and beneficiaries and establish access to selected “preventive” Provide LTC supports for community MA beneficiaries at risk for institutional level of care. Develop systems focusing on these needs that assist in determining ability of beneficiary to remain safely in home and community based settings.</p>	<p>4.2.1. Number of new applicants that meet revised level of care categories – highest and high (LTC) and preventive (community Medicaid at risk for LTC).</p> <p>Total at highest and high served in HCBS v. institutional settings.</p> <p>Total at preventive level that remain in HCBS overtime v. receive institutional based care</p>	<p>1.2. Streamline multiple eligibility processes -- Consolidation of long-term care clinical eligibility determinations in the Office of Medical Review</p> <p><i>1.2.5. Select format for assessment tool from existing models and modify as appropriate</i></p> <p><i>1.2.6. Incorporate recommendations of stakeholder groups</i></p> <p><i>1.2.7. Pilot clinical assessment tool</i></p> <p><i>1.2.8. Develop business process flow for LTC eligibility.</i></p> <p><i>1.2.9. Develop on-line data base for system-wide assessment</i></p> <p><i>1.2.10 Explore opportunities to improve</i></p>	<p>1.3.1 10% reduction of individuals with low care needs entering nursing facilities.</p> <p>1.3.2. 5% Increase number of people who return home following a post-acute stay</p> <p>1.1.1 to 1.1.4. As Above</p> <p>1.3.2 Percentage of individuals qualifying for expedited services.</p> <p>1.4.1.10% Increase use of full range of home and community based services</p>	<p>Clinical eligibility assessment tool and process instituted under GCW developed using STG strategies 1.2.5-1.2.8. STG II funded development of software (program is called OMAR) and hardware (laptops) for clinical eligibility staff to provide on-site assessments of need.</p> <p>Internal review by Office of Medical Review staff now underway. Also, STG study now using MDS to evaluate clinical level of need in nursing facilities is about to begin. This information will be used along with GCW evaluation criteria in 4.2.1. to determine identify low need beneficiaries and appropriate point to</p>

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			<p><i>expedited services provision in order to enable the temporary provision of specified HCBS.</i></p> <p>1.3.Target individuals at imminent risk for institutional care.</p> <p><i>1.3.1. Distribute info. packets for discharge planners for distribution to beneficiaries.</i></p> <p><i>1.3.2. Distribute info. packets about HCS to nursing facilities for distribution.</i></p> <p><i>1.3.3. Disseminate materials to and train providers in acute and sub-acute settings explaining HCBS options.</i></p> <p><i>1.3.4. Disseminate materials to and train discharge planners, family care givers, advocates, etc.</i></p>		<p>transition/diversions as well as overall efficacy of new process for determining clinical need.</p> <p>Materials for discharge planner training are in development as well as for providers and consumers.</p> <p>Clinical eligibility process developed in conjunction with the STG is being incorporated into the state’s Medicaid data warehouse – “CHOICES” – in accordance with STG strategy 1.3.5. In turn, this information will provide some of the data for assessing GCW objectives in this area (e.g., 4.2.1).</p> <p>Expedited services process is being reviewed to determine if benefits can be more effectively targeted at those at risk or qualifying for</p>

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			<p><i>1.3.5. Expand capacity for eligibility and assessment information to be transmitted electronically.</i></p> <p><i>1.3.6. Institute presumptive eligibility.</i></p>		<p>preventive LTC services.</p> <p>The STG is supporting several ongoing efforts by the state to make information on HCBS options available across settings. Currently, information on HCBS is being provided in the nursing home setting by an outside contractor assisting in transitioning low care residents.</p> <p>Providers have received some training; though more targeted training is planned under the STG over the next six months.</p>
2. Quality Management					
The state is in the process of refining and adapting the	Meet or exceed existing quality improvement measures for all	4.3.4.1. How many beneficiaries and what proportion were enrolled in care management	1.4 Improve service delivery. <i>1.4.1 Resource mapping to determine capacity of</i>	3.1.1. Waiver Quality improvement measures will improve by 5% over the project period.	STG quality management activities are being coordinated with ongoing GCW efforts in this area.

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<p>comprehensive quality management strategy designed for the Rite Care and HCBS 1915 c waivers. Interagency team focusing on strengthening program integrity, incorporating modernization of IT systems, and enhancing monitoring activities with stakeholder input. The interagency group is using performance measures, many</p>	<p>Medicaid programs while revising to accommodate goals of the GCW.</p> <p>4.3.4. Promote the delivery of case management services for beneficiaries through organized systems of care that are accountable for quality.</p> <p>4.5. Improve client stability and functioning in the community.</p> <p>4.5. Assist elders and other adults with disabilities in maintaining optimum health and functioning in the least restrictive HCBS environment.</p>	<p>through Rhody Health Partners and Connect Care Choice as well as -- GCW evaluation criteria 4.3.4.2. -- care management options through other payers including Medicare.</p>	<p><i>selected HCBS</i></p> <p><i>1.4.2. Expand medical and financial resources for HCBS programs</i></p> <p>3. 1. Develop and implement a comprehensive quality management strategy consistent with the goals of the STG.</p> <p>3.2. Develop and routinely disseminate quality management reports to key entities and other stakeholders.</p> <p>3.3. Periodically evaluate the quality management strategy.</p> <p>3.4. Periodically evaluate program and participant outcome indicators</p>		<p>Dedicated STG staff is being hired for this purpose and will play a critical role in ensuring that each of the STG objectives and strategies are incorporated fully into the GCW plan. Certain elements of the quality management strategy for LTC balancing have already been incorporated into the GCW evaluation plan.</p> <p>Quality indicators have been incorporated into the LTC clinical assessment tool and will be tracked first through OMAR and then CHOICES when fully operational.</p> <p>Findings of snapshot</p>

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<p>developed in conjunction with the STG II, as well in-house and independent quality evaluation and management resources.</p>	<p>Provide all beneficiaries with a medical home that assures better outcomes and delays/prevents the need for LTC.</p> <p>Integrate and coordinate interagency efforts providing quality assurance and protective services to beneficiaries in the community</p>				<p>survey will be used to develop LTC satisfaction survey that builds on recently conducted survey focusing on acute care services for adults with disabilities and elders enrolled in Rhody Health MCO.</p> <p>Follow-up snapshot survey will assist in determining overall progress.</p> <p>GWETF stakeholder group is developing workgroup to assist in design of consumer satisfaction surveys.</p> <p>State is examining role of adult protective services in monitoring quality and</p>

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					<p>protecting safety in HCBS settings.</p> <p>Reports on rebalancing outcomes are being distributed to GWETF members on a monthly basis and being posted on agency websites.</p>
3. Finance					
	<p>Utilize flexibility under the GCW to purchase and pay for LTC services – smart purchasing – to advance rebalancing goals, encourage and reward quality, contain costs and assure access to the right services, at the right time and in the right setting.</p> <p>Utilize LTCFR funds to promote capacity</p>	<p>Change in utilization patterns as a result of implementation of acuity based payment system for nursing facilities that promotes HCBS alternatives.</p> <p>Change in capacity of selected HCBS alternatives as a result of rate restructuring that reflects level of need.</p>	<p>1.4 Improve service delivery.</p> <p><i>1.4.1 Resource mapping to determine capacity of selected HCBS</i></p> <p><i>1.4.2. Expand medical and financial resources for HCBS programs</i></p> <p>5.1. Develop and implement more effective payment methodologies</p> <p>Conduct comprehensive <i>5.1.1.Resource Mapping analysis and cost sampling across the</i></p>	<p>1.4.1.10% Increase use of full range of home and community based services.</p> <p>5.1.1. Develop an effective payment methodology that assists in rebalancing LTC spending by 5% from institutional to home and community based services</p> <p><i>Increase in \$\$ spent on HCB svcs</i></p>	<p>The STG Resource Mapping project, now completed, will play a critical role in assisting the state in determining where the demand for services will increase as the population ages. This is, as such, a crucial planning tool. The state is conducting a follow-up to the original cost reports prepared two years ago to determine whether current payment rates are adequate in several critical LTC services areas – e.g.,</p>

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	and utilization of cost-effective LTC services.	4.3.2.3. Change in utilization patterns and/or outcomes for services purchased through selective contracting.	<i>service delivery spectrum</i> 5.1.2 Review payment methodologies, rates, and services, include private pay, Medicaid, Medicare and Medicare replacement for individual services. 5.1.3. Create rates that adequately cover long-term care supports based on cost report and resource mapping 5.1.4.Examine private-public financing strategies by incorporating incentives and developing programs to better utilize private funding sources for long-term support services, such as the Long Term Care Partnership 5.1.5. Promote institutional diversions and transitions to the community by developing	·Decrease in expenditures in institutional svcs ·Increased # of individuals accessing HCB services ·Decrease in utilization of institutional services	assisted living. An in depth assessment of HCBS payments structures has informed efforts thus far and assisted in assessing the feasibility of shifting to acuity based payment systems for an array of services. STG analysis of LTC and subacute specialty services has provided information used to evaluate current provider and MCO contracts and target areas requiring payment rate reform. Gap analysis of current Medicaid payment methodologies is also being conduct in conjunction with the STG. GWETF workgroups have prepared reports containing

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			<i>the financing mechanisms to assist with the institutional transitions of individuals to community based options.</i>		findings and recommendations related to public-private and third party payer strategies. These efforts included a review of the LTC partnership and assessment of its effectiveness. The reports are under review. A variety of reports related to LTC payments and services are prepared in conjunction with the budget process and distributed to stakeholders.
	4.3.3. Prevent or delay growth in beneficiaries requiring care in high cost venues by instituting Medicaid claiming for selected populations at risk and preventive	Through Medicaid funding for costs not otherwise matchable (CNOM) for elders: 4.5.3.1.Number of applicants that might have otherwise been unable to obtain HCBS.	1.3.Target individuals at imminent risk for institutional care.		

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	services using costs not otherwise matchable,	<p>5.5.3.2. Change in utilization of core HCBS for elders eligible through CNOM under the GCW.</p> <p>54.5.3.3. Extent to which utilization of preventive services for CNOM elders prevents or delays institutional care for at least six months</p>			

STG Rebalancing and the State Budget

The state's GCW became a reality as result of economic pressures that made Medicaid reform imperative. The choice to operate the entire RI Medicaid program under a single Section 1115 demonstration, and one with a five year spending cap, was more a financial decision rather than a programmatic one. In this regard, LTC rebalancing is a critical component of the GCW not only because the system lacked the capacity to respond to changing needs of many beneficiaries, but also because of the unprecedented growth in cost. Thus, although LTC finance reform is a goal of the STG rebalancing effort, many state policy makers consider rebalancing to be vehicle for containing program costs.

With these financial concerns in mind, state lawmakers imposed strict oversight and monitoring of GCW rebalancing activities. The State Budget Office also monitors rebalancing closely. Consequently, the Medicaid program provides the data contained in Table 2 to the State Budget Office on a monthly basis and to GCW Task Force members and legislators on a quarterly basis. The data collected and the analysis performed for this exercise has informed and been informed by several STG II activities and tasks and, most directly, those related to STG II objectives 1.2 and 1.3.

**Table 2: Nursing Home Transition/ Diversion
Budget Initiative FY 2010-FY2011**

M=monthly YTD=Year to date								
	July		December		January		February	
	M	YTD	M	YTD	M	YTD	M	YTD
NHT Transitioned	16	16	6	87	10	97	3	100
Savings	48960	48960	20310	281850	30600	312450	9630	322080
Diverted through Care Management⁴	0	0	0	34	14	48	unknown	
Savings		0	0	104040	75500	179540		
Diverted Through New Levels of care⁵	0	0	58	207	83	290	116	406
Savings		0	177480	633726	88893	722619	124236	846855
TOTAL	16	16	64	334	107	441		
Savings	48960	48960	197760	1019616	194993	1214609		
SAVINGS	Est	Actual	Est	Actual	Est	Actual	Est	Actual
Total	53 000	48,960	918,000	1,019,616	1,071,000	1,214,609	1,224,000	
	50	16	300	328	350	441	400	

Note that the focus is on nursing home level of care need as it was the initial target for the reform effort. A review and revision of the CFMR and hospital levels of care is now underway.

The state also tracks closely, the settings where diverted/transitioned beneficiaries are receiving LTC services and the difference in monthly costs. For example, all 10 of the beneficiaries discharged from nursing homes in January returned to their primary residences with services. The average difference in cost is estimated at about \$30,000 per resident per month. The state is able to perform this level of tracking on a routine basis largely as a result of the work done in conjunction again with STG II objectives 1.2 and 1.3 and the related deliverables. (See Table 1)

Additionally, the state also regularly evaluates the impact of the new process for determining institutional level of care need. Table 3 shows the total number of clinical assessments and levels of need of new applicants for LTC completed by the Office of Medical Review staff from July 1, 2009 (the GCW implementation date) through to January 2010.

Table 3: Level of Need Nursing Home Clinical Eligibility Assessments July 2009 – January 2010									
LOC	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Total	Percentage
Preventive –limited LTC services	24	19	47	40	29	28	6	193	6.8%
High Need		35	152	126	103	166	15	597	21.1%
Highest Need	50	143	437	431	386	507	82	2,036	72.0%
Total	74	197	636	597	518	701	103	2,826	100.0%

The state uses the data developed for Table 3 to measure progress toward rebalancing goals by comparing LOC assessment outcomes and placements to the pre -STG and GCW LOC baselines. Thus far, the state has found that the majority of beneficiaries determined to have the highest level of need are choosing institutional v. HCBS settings, and appropriately so. An STG I task, recently underway, using the MDS to analyze the clinical needs of new v. established Medicaid nursing home residents will assist the state greatly in determining whether the new assessment process and the resulting placements are furthering long-term rebalancing goals.

STG Rebalancing and LTC Financial Reform

A final, but no less important, area in which the STG II plays a crucial role in ongoing rebalancing efforts is with respect to implementation of the Rhode Island Long Term Care Service and Finance Reform Act of 2006 (LTCSFR). The goal of the Act is to establish global budgeting for publicly funded LTC to ensure that some of the savings from reductions in LTC costs in institutional settings are reinvested in HCBS.

The STG strategic plan, developed by many of the stakeholders that pushed for enactment of a LTC global budget, incorporated many of the principal objectives of the LTCSFR. Tasks completed in conjunction with the STG have, thus, influenced significantly decisions about how best to reinvest rebalancing savings. Preliminary resource mapping, completed in conjunction with the STG I, identified key HCBS that were under-capacity due to low rates – e.g., adult day services. STG II cost reports and related rate analysis review activities (see Objective 5.1) provided supporting documentation and, as such, influenced the decision of the state to allocate LTCSFR rebalancing to increase payments to several of these providers.

Since implementation of the GCW began in July, the state has been reviewing a number of other financial reforms related to payment for institutional v. HCBS LTC services. Again, STG II tasks and deliverables are informing these decisions. For example, the STG II report analyzing payment strategies for HCBS shows how changes in the payment rate structure for assisted living services may affect supply and demand; likewise, the STG II report on subacute and specialty care services has made the state aware of capacity issues on the institutional side that may arise as a result of rebalancing over the long-term. Both of these works and planned follow-up through the STG II will have an impact on whether LTCSFR funds are reinvested in these areas.

The just completed full-scale STG II resource mapping project includes a model that will allow the state to project demand for HCB and institutional LTC in a much more systematic way. As indicated in Table 1, the state views this model as an important tool for transforming the goals of LTC financial reform into a concrete reality.

Conclusion

The months since the STG II was awarded to Rhode Island have been challenging due to not only external factors – e.g., economic downturn and the fiscal pressures resulting thereof, but unprecedented internal change as well – e.g., multiple changes in agency leadership, reorganizations, staffing declines, etc. Despite this fact, this has also been a time period in which the state has identified and taken advantage of the opportunity to pursue system transformations on a number of levels. As I hope this memo makes clear, the STGs have played an integral role in this sometimes disjointed and disorganized change process.

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