

Rhode Island Executive Office of Health and Human Services

Integrated Care for Medicare and Medicaid Beneficiaries

A Demonstration Proposal to the Center for Medicare and
Medicaid Services

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I. EXECUTIVE SUMMARY

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

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

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

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

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

II. BACKGROUND

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

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

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

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

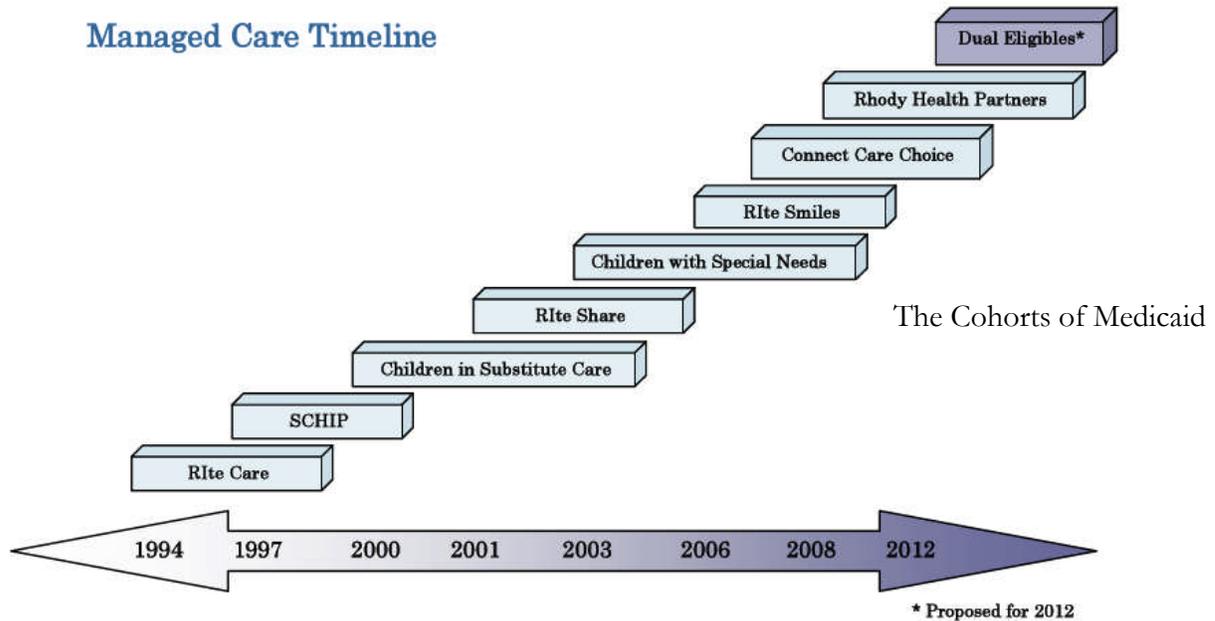
By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid Beneficiaries, the Executive Office of Health and Human Services (EOHHS) is directed to engage in a contractual arrangement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

Toward this end, this state issued a report¹ that focuses on the options for improving the way in which Medicaid eligible adults with disabilities and elders access health care services and long-term services and supports. Medicaid eligible adults with disabilities and elders represent about one quarter of the total RI Medicaid population, and just over 60 percent of total annual program expenditures. Although the service needs of adults with disabilities and elders do vary, the two populations share many common features. The beneficiaries in both groups tend to have very low incomes and limited assets. Many of these beneficiaries have multiple chronic conditions, one or more of which may result in a hospitalization or a nursing facility stay, and all require a mix of acute, sub-acute and long term care services. These services are often fragmented and difficult to navigate.

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

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

Managed Care Timeline

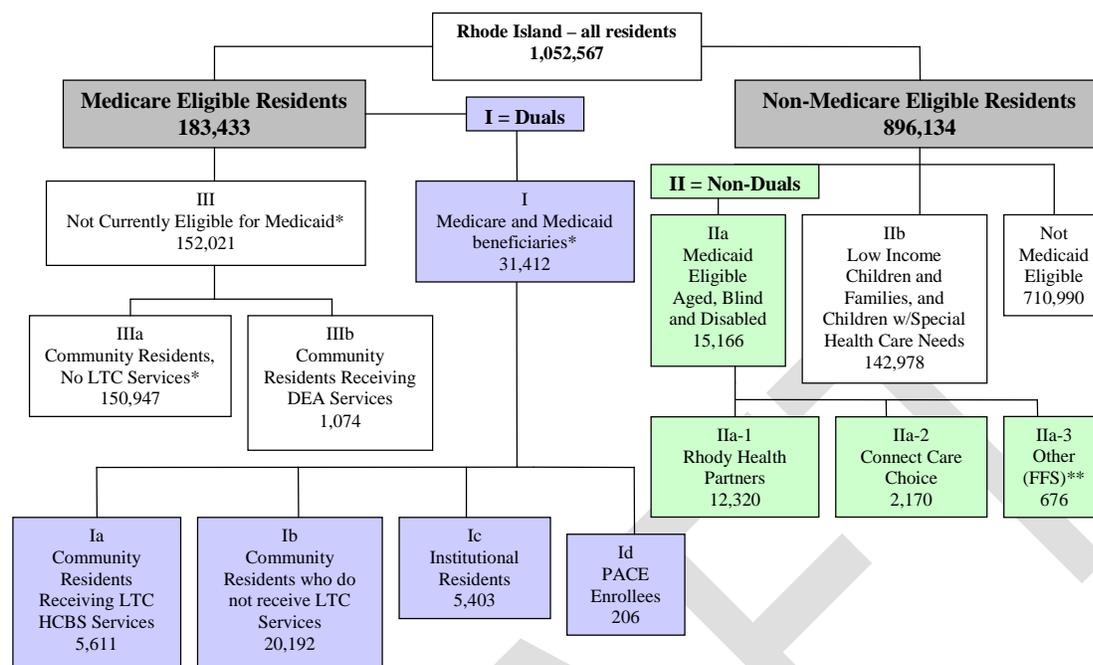


RI Medicaid is examining options to design and develop the delivery and payment systems to improve the quality, coordination and cost-effectiveness of services for Medicaid beneficiaries requiring long-term services and supports, including those who are eligible for both Medicaid and Medicare. As the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

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

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

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



The data in Figure 1 describes the overall population in Rhode Island, and provides some detail on the subset of Rhode Islanders who are eligible for Medicare, eligible for Medicaid, and eligible for both programs. The shaded box Ia illustrates that the majority of dual eligibles in Rhode Island reside in the community, and are not yet connected with the long-term care system. Of these roughly 26,000 dual eligible individuals who presently reside in the community without home and community-based services (HCBS, Fig 1., Box Ia), approximately 4,000 of them are persons with severe and persistent mental illness (SPMI). Also within this group of community-based dual eligibles, RI estimates that upward of ten percent (10%) are at increased risk for needing home and community-based supports within two years². Effective identification and preventive services could help delay this and other costly acute episodes.

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

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

² Based on historical utilization patterns

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

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

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

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

January 1, 2013

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

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

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

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

Pathway #2: Capitated Model

Phase I: January 1, 2013

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

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

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

Phase II: January 1, 2014

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

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

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

Blue = areas of program expansion
 Yellow = existing programs

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

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

A. Barriers to Integration to Address

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

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

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

Improved Coordination of Care

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

Aligned Financial and Quality Incentives

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

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

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

Improved System Navigation

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

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

B. Description of the Target Population

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

Table 1. Target Population for Duals Demonstration

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

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

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

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

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

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

Population Profile at a Glance

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

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

C. Exempt Populations

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

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

Table 2. Overview of the Demonstration Proposal Features

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

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

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

III. CARE MODEL OVERVIEW

A. Description of Delivery System

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

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

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

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

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

1. Comprehensive and Coordinated Benefit Package

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

2. Access to a Comprehensive Provider Network

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

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

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

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

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

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

net 24% reduction in total costs for the over 11,300 patients in the HBPC program⁴. Home-based primary care may include urgent home visits in order to avoid hospitalizations.

3. Care Coordination and Clinical Case Management

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

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

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

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

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

a. Early Identification

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

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

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

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

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

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

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

b. Comprehensive Needs Assessment

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

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

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

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

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

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

c. Personalized Care Plan

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

d. Interdisciplinary Care Teams

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

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

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

e. Information Systems Support to Promote Safe Transitions

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

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

f. Decentralized Decision-Making and Benefit Flexibility

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

g. Other Requirements

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

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

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

4. Enrollment Method

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

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

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

B. Benefit Design

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

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

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

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

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

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

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

C. DESCRIPTION OF NEW SUPPLEMENTAL BENEFITS OR SERVICES

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

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

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

D. INTEGRATION OF EVIDENCE-BASED PRACTICES IN CARE MODEL

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

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

E. CONTEXT OF OTHER MEDICAID INITIATIVES AND HEALTH REFORM

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

1. Existing Medicaid Waivers and/or State Plan Services

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

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

2. PACE and Medicare Advantage

PACE

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

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

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

Medicare Advantage

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

3. Other State Payment/Delivery System Reform Efforts Underway

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

Lt. Governor's Long-Term Care Coordinating Council

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

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

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

Multi-Payer Demonstration Project

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

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

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

Money Follows the Person (MFP) Demonstration

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

CHCS Technical Assistance Initiative

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

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

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

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

Health Homes

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

All Payer Claims Database

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

IV. STAKEHOLDER ENGAGEMENT AND BENEFICIARY PROTECTIONS

A. Stakeholder Engagement

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

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

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

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

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

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

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

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

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

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

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

<insert summary of stakeholder comments here>

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

B. Beneficiary Protections

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

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

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

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

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

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

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

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

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

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

C. Ongoing Stakeholder Engagement

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

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

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

V. FINANCING AND PAYMENT

A. State-level Payment Reforms

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

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

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

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

B. Payments to MCOs

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

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

Risk-adjusted rate setting is used in approximately 22 state Medicaid programs⁵, but limited data is available regarding the lessons learned from this approach to Medicaid rate setting. While the preferred approach, RI Medicaid recommends beginning the duals demonstration program by setting capitation rate categories based on historical utilization and trends, with the goal of identifying a risk-adjustment system by the close of the three-year demonstration.

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

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

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

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

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

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

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

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

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

IV. EXPECTED OUTCOMES

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

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

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

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

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

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

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

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

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

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

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

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

B. Potential Improvement Targets for Measure

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

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

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

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

C. Expected Impacts

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

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

V. INFRASTRUCTURE AND IMPLEMENTATION

A. Infrastructure and Capacity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Time Line and High Level Work Plan

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

Figure 4. Duals Integration High Level Time Line/Milestones

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

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

VI. FEASIBILITY AND SUSTAINABILITY

A. Potential Barriers and Challenges and Mitigation Strategies

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

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

B. Statutory and Regulatory Changes Needed for Implementation

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

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

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

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

C. State Budget Authority Needed for Implementation

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

D. Scalability and Replicability

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

E. Letters of Support

All Letters of Support can be found in Appendix B.

VII. ADDITIONAL DOCUMENTATION (AS APPLICABLE)

RI Medicaid will provide additional documentation at CMS' request.

VIII. INTERACTION WITH OTHER HHS/CMS INITIATIVES

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

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

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

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

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

Appendix B – Letters of Support

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Appendix C – Notes from Stakeholder Meetings

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