



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

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EXECUTIVE SUMMARY

Overview

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

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

The Service Landscape

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

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

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

Foundations of an Integrated System

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

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

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

Evaluation of Options

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

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

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

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

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

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

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

Conclusions and Plan of Action

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

Phase 1 – January 2013

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

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

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

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

Exceptions/Exemptions

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

Phase 2 – January 2014

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

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

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

Phase III – July 2014 to 2015

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

Implementation Requirements

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

SECTION I: INTRODUCTION

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

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

Purpose of the Study

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

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

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

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

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

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

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

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

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

Organization of the Report

The report is organized in the following manner:

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

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

Section 4 introduces opportunities and sets forth model options.

Section 5 includes a summary and conclusions.

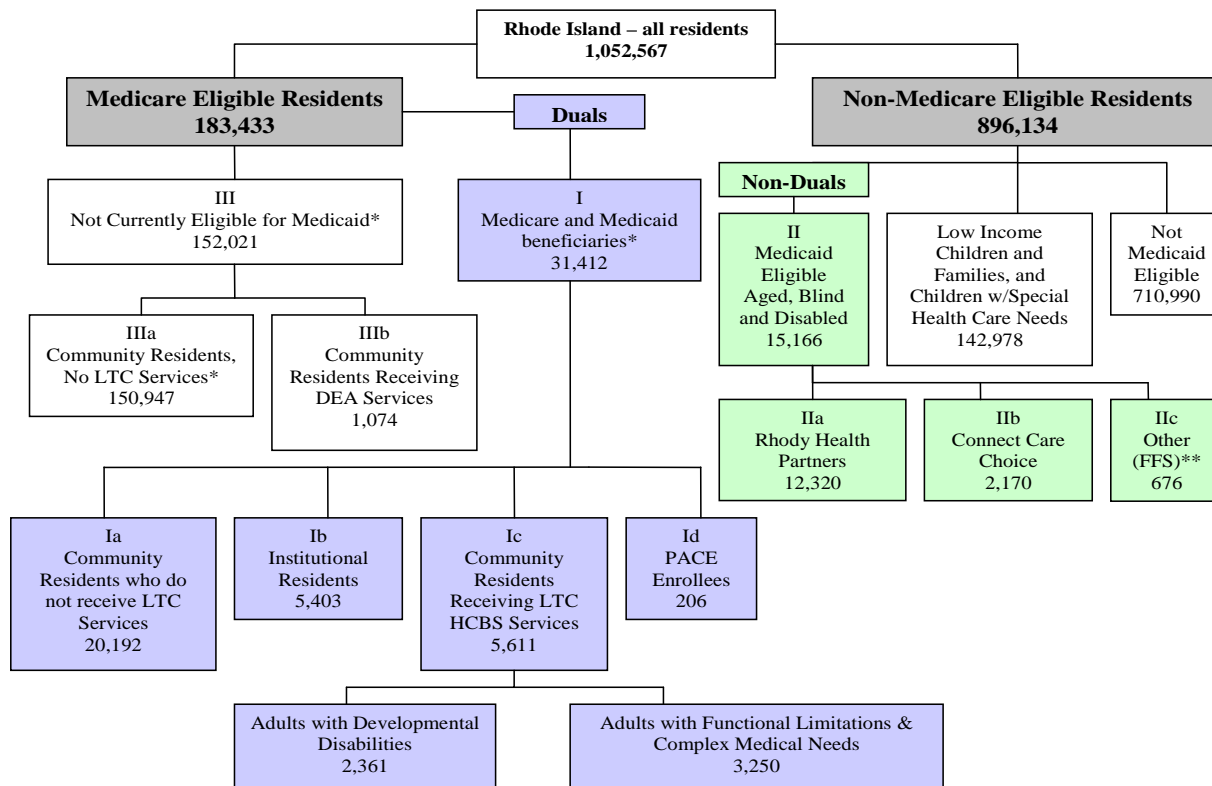
¹ Eligibility can be based on a diagnosis of end-stage renal disease or amyotrophic lateral sclerosis.

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

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

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

Figure 1. The Rhode Island Medicaid Population Profile



*

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

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

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

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

- The average number of dually eligible beneficiaries in Calendar Year 2010 (CY 2010) was 31,412³ or 17.1% of all Medicare enrollees (Figure 1, Box I, shaded blue).

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

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

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

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

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

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

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

During CY 2010, the dual eligible and the Medicaid-only population totaled an average of 46,578.⁴ As note earlier, beneficiaries in both groups have complex health care needs that are expensive to cover. A core goal for EOHHS is to provide a high quality, cost effective integrated system of care that addresses the needs not only of the adults and elders that are the focus of this study, but of all populations represented in *Figure 1*.

SECTION 2.1: FURTHER CHARACTERISTICS OF THE DUAL ELIGIBLE POPULATION

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

Population Profile at a Glance

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

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

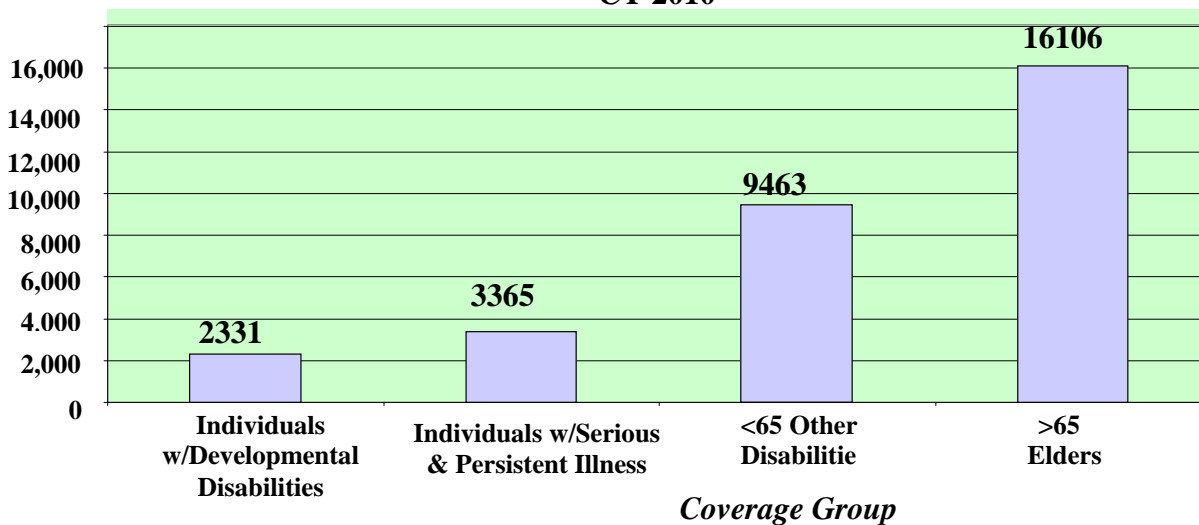


Figure 2. Rhode Island Average Dual Eligibles by Population Group, CY 2010, depicts four (4) population groups. In Rhode Island, 45% of the total Dual eligibles population is under the age of 65, qualifying for dual coverage due to SSDI disability status. Dual eligibles over the age of 65 are predominantly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

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

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

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

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

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

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

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

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

The lower acuity and longer lengths of stay for most nursing home residents contributes to an overall use of nursing homes in Rhode Island that is significantly above the national average.⁶ 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

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

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

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

SECTION 2.2: DIFFERENCES IN PATHWAYS TO MEDICARE AND MEDICAID ELIGIBILITY

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

Medicare Eligibility:

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

Medicaid Eligibility:

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

Medicare Savings Programs:

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

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

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

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

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

SECTION 2.3: MEDICARE AND MEDICAID BENEFIT COVERAGES

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

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

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

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

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

SECTION 2.4: CURRENT MEDICAID DELIVERY SYSTEMS FOR ACUTE CARE SERVICES

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

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

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

Medicare Advantage

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

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

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

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

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

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

SECTION 2.6: MEDICAID AND MEDICARE EXPENDITURES

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

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

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

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

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

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

SECTION 2.6.2: MEDICARE EXPENDITURES FOR DUAL ELIGIBLES

Figure 5 shows Medicare expenditures for Rhode Island dually eligible beneficiaries for the Calendar Year 2009⁸. Note that there are important Medicare expenditures that are not included in the data presented in *Figure 5*. First, expenditures for the 3,677 dual eligibles that are enrolled in Medicare Advantage plans are omitted. Second, Medicare Part D pharmacy benefits are also excluded. Combined, adding both would raise total expenditures by over \$100 million.

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

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

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

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

SECTION 3.0: CHARACTERISTICS OF A BETTER SYSTEM

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

SECTION 3.1: IMPROVEMENT OPPORTUNITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Domain 1: Outreach and Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Service Initiation:

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

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

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

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

Domain 3: Identification and Targeting

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

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

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

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

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

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

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

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

Domain 4: Robust Network of Health Care Services and Supports

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

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

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

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

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

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

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

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

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

Domain 5: Value Purchasing, Oversight and Continuous Quality Improvement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4.1: DELIVERY SYSTEM OPTIONS

EOHHS presents two primary pathways to follow:

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

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

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

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

Enhanced PCCM Models

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

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

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

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

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

FIGURE 8. PATHWAY FOR INTEGRATED SYSTEM REDESIGN

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

Capitated Models

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

The managed care model routes include:

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

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

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

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

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

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

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

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

SECTION 5: CONCLUDING REMARKS

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

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

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

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

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

APPENDIX A

Millie's Story

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

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

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

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

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

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

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

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

APPENDIX B

Successful Models of Care

Massachusetts' Senior Care Options

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

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

Commonwealth Care Alliance

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

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

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

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

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

Tennessee – Managed Long-term Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

¹⁰ VHA Handbook 1141.01, Home-Based Primary Care Program, January 31, 2007

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

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

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

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

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

APPENDIX C

EOHHS 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 D

SUMMARY of AFFORDABLE CARE ACT (ACA) OPPORTUNITIES

State Balancing Incentive Payments Program (SBIPP)

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

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

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

Money Follows the Person

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

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

Community First Choice Option

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

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

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

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

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

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

Health Homes Option

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

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

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

CMS Financial Alignment Demonstrations

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

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

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

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

More information can be found at:

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