Integration of Care and Financing for Medicaid-Only and Medicare and Medicaid Eligible (MME)

RI Executive Office of Health and Human Services
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Services and Supports
Work Group Session 2

Workgroup Series Facilitators

EOHHS Representatives

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Community Facilitators

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- **Robert Cooper,** *Executive Secretary, RI Governor's Commission on Disabilities*

Welcome & Introductions

The Problem?

- Inadequate person-centered care coordination
- Lack of focus on primary and preventive care
- Long Term Services and Supports/Behavioral Health coordinated separately
- Fragmentation of benefits coverage leads to confusion and inefficiencies
- Cost shifting (Hospital and Nursing Facility)

Vision

- The State of Rhode Island will have an Integrated Health Care System for all Medicaid-only and MME members that will achieve improved health and well-being, better healthcare and lower costs.

Mission

- To transform the delivery system through purchasing person-centered, comprehensive, coordinated, quality health care and support services that promote and enhance the ability of Medicaid-only and MME members to maintain a high quality of life and live independently in the community.

What are we trying to achieve?

- Improve the integration and coordination of:
  - primary
  - specialty
  - hospital /acute
  - behavioral and
  - long term services and supports
- 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

Critical Elements for an Effectively Managed System

- Outreach and Information
- Identification of Risk and Emerging Needs to Target Efforts
- Robust Network of Health Care Services and Supports
- Value Purchasing, Oversight and Continuous Quality Improvement
- Strong Consumer Protections

Overview of Care Management

Optimal care management requires a combination of three basic types of activities:

1. A set of “high-touch”, person-centered, care management activities requiring direct interaction with the recipient and the care team.
2. Data collection, analysis, interpretation, and communication of data to the care team.
3. Monitoring and quality assurance of care management activities.

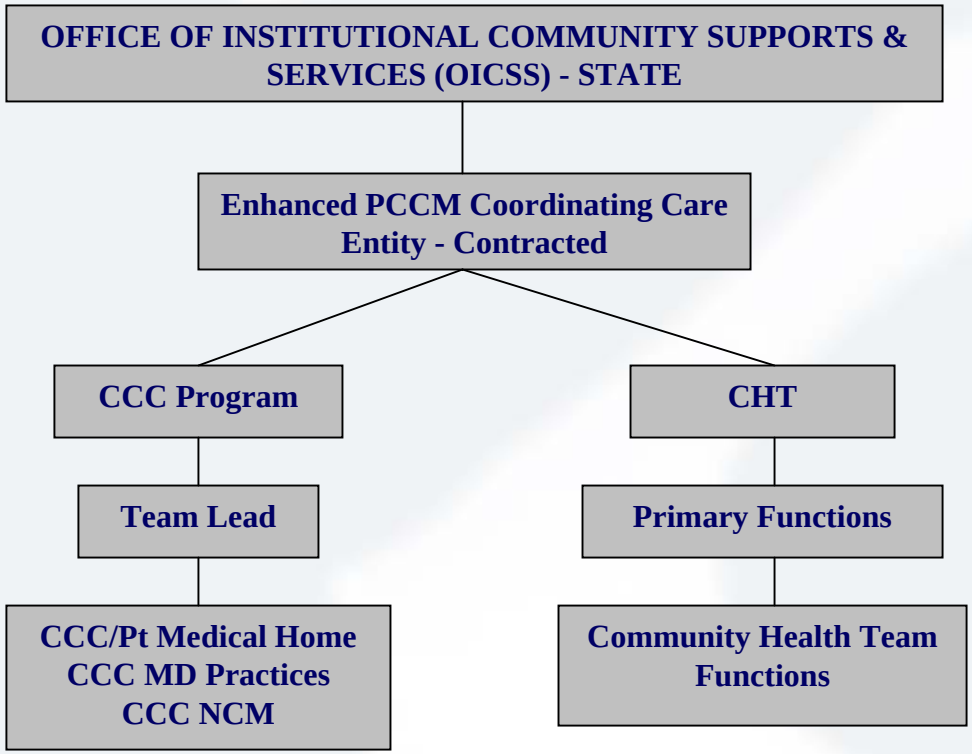
Key Care Management Goals

- Improve member health and quality of life
- Decrease care fragmentation
- Optimize resource utilization

Components of Care Management Process

- Comprehensive Needs Assessment
- Plan of Care to Address Needs Identified
- Coordination of Care/Implementation of the care plan
- Transitional Care Planning
- Risk Assessment/Identification of Members Who Need Care Management
- Analysis of Care Management Effectiveness and Appropriateness
- Monitoring Outcomes
- Technology to support Care Management activities

Enhanced PCCM Model Design



Enhanced PCCM Model Design
Community Health Team Functions

Care Management/Care Coordination Functions:

- Communicate with PCP for a holistic approach to care
- Focus on care coordination for services funded through Medicare
- Facilitate housing supports
- Coordinate transportation
- Conduct person-center assessment and service plan for LTSS
- Conduct home visits and intermittent telephonic contact
- Provide Community Health Care Worker / Peer Navigator
- Identify & refer to community social supports and resources
- Provide Geriatric Specialist Coordinator (non-clinical) consultation
- Psychiatric Clinical Nurse Specialist consultation
- Coordinate and monitor early warning system to identify risk and coordinate response
- Coordinate service authorization with state as needed
- Coordinate supports for family caregivers
- Obtain, track, measure and report quality of care and safety
- Ensure registration with the RI Special Needs Emergency Registry

Enhanced PCCM Model Design
Community Health Team Functions

Transition Functions:

- Assist with transition services – collaborate w/ Connect Care Choice RN
- Facilitate housing supports
- Pharmacist for medication reconciliation & issues
- Assure post-discharge plan medication management adherence
- Consultation with Certified Occupational Therapy Assistant (COTA)

Enhanced PCCM Model Design
Community Health Team Functions

Chronic Disease Coordination Functions:

- Communicate to CCC RN for PCP & medical issues
- Provide Health & Wellness coaching
- Provide linkages to community prevention and treatment programs
- Assist w/ individuals attaining personal goals & support
- Coordinate end of life supports

Enhanced PCCM Model Design
Community Health Team Functions

Hospital/Nursing Facility Coordination Functions:

- Nursing facility inpatient management for non-skilled care
- Provide Nurse Practitioner (Geriatric) for NH member management & transition
- Provide Nurse Practitioner (Disability) for NH member management & transition

Capitated Model – Purchasing Overview

Initial Risk Assessment

Identification of people "at risk" using predictive modeling tool

Purchase of Clinical Functions

- Periodic re-assessment of risk
- Care plan development and monitoring
- Medical and/or BH chronic care management
- Service authorization and monitoring of services that corresponds with care plan
- Discharge planning for safe transitions between settings
- Coordination with primary provider (PCP or specialty care)

Purchase of Social/Community Support Functions

- Service coordination/care coordination
- Connection with social supports (housing, transportation, etc.)
- Coordination of medical and LTSS needs (mobility, homemaker, assistance with ADLs and IADLs)

Potentially use "Community Health Teams" to perform this function

Capitated Model – What else are we purchasing?

- Comprehensive network of quality providers (medical, BH, LTSS), including home-based primary care
- Service accessibility
- Comprehensive Benefit Package
- Benefit administration and Claims adjudication
- Member services
- Grievance and appeals
- Quality assurance and utilization review
- Budget predictability

Discussion Questions

- What are the key interventions that are needed to keep people living healthy in the community?
- Are these the components of an effective care management system?
- What, if anything, is missing?

Questions can be directed to:

Email: integratedcare@ohhs.ri.gov

How We Will Keep You Informed

RI Executive Office of Health and Human Services website "Integrated Care" section

All public documents will be posted to this site:

http://www.ohhs.ri.gov