



The Integrated Care Initiative Phase II

**RI Executive Office of Health
and Human Services**

September 2014



Presentation Overview

ICI Phase II/ Financial Alignment Demonstration (FAD)

- Background
 - National Landscape
 - Current Status of States
 - Impressions Based on State Experience
- Rhode Island FAD Plans to Date
- Overview of Draft MOU Contents
- Next Steps

FAD Background: National Landscape

- The Affordable Care Act of 2012 gives states opportunities to align financing and care for individuals with Medicare and Medicaid or “dual eligibles.”
- As a result of the ACA, CMS is seeking to address long-standing coordination barriers between Medicaid and Medicare.
- CMS’s planned Demonstrations to integrate care for dually eligible individuals features:
 - Either a FFS or capitated system;
 - Leverages combined Medicare and Medicaid funding and benefits and,
 - A CMS/State contract (for FFS model) or a three-way CMS/State/Health Plan contract (for capitated model).

Financial Alignment Demonstration, continued

- 15 states were awarded funding from CMS to develop FAD models
- Including money to process information with stakeholders – a key CMS requirement
- RI applied but was not awarded this grant
- Additional states developed FADs without CMS funding.

FAD Background: Current Status of States

State	Demonstration Type	Enrollment Effective Date
Arizona	Capitated Mode;	Not pursuing FAD as originally planned; currently exploring other delivery system options
California	Capitated	4/1/2014
Colorado	Managed Fee For Service (MFSS)	11/1/2013
Connecticut	MFSS	TBD
Hawaii	MFSS	Not pursuing FAD as originally planned
Illinois	Capitated	1/1/2014
Iowa	MFSS	TBD
Idaho	Capitated	4/1/2014 NOTE: Considering a delay due to inadequate plan participation – only one plan is currently in place
Massachusetts	Capitated	1/1/2014
Michigan	Capitated	7/1/2014
Missouri	MFSS	10/1/2012
Minnesota	Administrative Simplification	Not applicable

FAD Background: Current Status of States

State	Demonstration Type	Enrollment Effective Date
New Mexico	N/A	Not pursuing FAD as originally planned
New York	Capitated	7/1/2014
North Carolina	MFSS	TBD
Ohio	Capitated	4/1/2014
Oklahoma	MFSS	TBD
Oregon	N/A	Not pursuing FAD as originally planned
Rhode Island	Capitated	TBD
South Carolina	Capitated	7/1/2014
Tennessee		Not pursuing FAD as originally planned; pursuing integration through a D-SNP model
Texas	Capitated	1/1/2014
Virginia	Capitated	9/1/2014
Vermont	Capitated	9/1/2014
Washington	MFSS and Capitated	MFSS: 7/1/2014 Capitated: 5/1/2014
Wisconsin	Originally Capitated	Not pursuing FAD as originally planned

Rhode Island FAD Plans to Date: Goals

- Improves or maintains the health and quality of dual eligible beneficiaries' lives through care that
 - is person-centered and integrated;
 - is coordinated across medical, behavioral, long-term and psychosocial supports and,
 - attends to transitions of care from the hospital or nursing home back to the community.
- Focuses on re-balancing the long-term care and community-based systems.
- Aligns financial and quality incentives to improve care.

RI FAD Plans to Date: Goals (continued)

- Incorporates services provided through the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) including:
 - LTSS for adults with intellectual/developmental disabilities (IDD) and,
 - Intensive Behavioral Health Services for adults with serious and persistent mental illness (SPMI).

RI FAD Plans to Date: Who's Eligible in RI?

- Eligible population:
 - 28,000 dual eligibles
 - 79 percent live in the community (~23,000)
 - 21 percent live in nursing homes (~ 5,000)
 - Medicaid only adults with disabilities/chronic conditions with Long Term Services and Supports (LTSS).
- Excluded populations:
 - Partial Medicare, residents at Eleanor Slater Hospital, Tavares Pediatric, incarcerated individuals and individuals enrolled in hospice/end-of-life care on the program start date.

RI FAD Plans to Date: Phased Plan

- Rhode Island has a plan underway to rollout an FAD initiative in two phases:
 - Phase I: Delivery of services to dually eligible individuals with a greater focus on care integration within Medicaid services only.
 - Phase II: Movement to fully integrated Medicaid and Medicare services delivered by a single capitated health plan *subject to CMS and state timelines*

Also to include:

- LTSS for adults with intellectual/developmental disabilities (IDD) and
- Intensive Behavioral Health Services for adults with serious and persistent mental illness (SPMI).

Memorandum of Understanding - Contents

- A. Demonstration Authority
- B. Contracting Process
- C. Enrollment
- D. Delivery System and Benefits
- E. Participant Protections, Participation and Customer Service
- F. Integrated Appeals and Grievances
- G. Administration and Reporting
- H. Quality Management
- I. Financing and Payment
- J. Evaluation

A. Demonstration Authority

- RI intends to use the authority of the 1115 waiver to operate the program
- Additional Medicare authority is needed and is provided in the Code of Federal Regulation, as amended by the Affordable Care Act, as well as in existing Medicare Advantage provisions of the CFR

B. Contracting Process

- CMS and the State will sign a Memorandum of Understanding (MOU);
- CMS, the State, and Neighborhood Health Plan of Rhode Island will sign a three-way contract;
- CMS and the state will conduct a joint readiness review of the health plan (NHPRI).

C. Enrollment

- Eligible populations will include all those currently eligible for Phase I
 - RI residents will full Medicare and Medicaid coverage
 - Medicaid-only clients with LTSS
 - Same exclusions apply (QMBs, SLMBs, QIs, Partial Medicare, residents at Eleanor Slater, residents at Tavares Pediatric, incarcerated individuals and individuals enrolled in hospice/end-of-life care on the program start date)
- EOHHS intends to conduct an opt-out enrollment process, phased over several months, for enrollees already in RHO.
- Because there are not additional health plans participating in Phase II, CMS will not allow an opt-out enrollment approach for all enrollees.

D. Delivery System and Benefits

- Shifting provider payments away from fee-for-service to other forms of reimbursement (pay-for-performance, bundled payments)
- Plans must provide full continuum of all Medicaid and Medicare covered services, including LTSS.
- Opportunity to include additional benefits
 - SBIRT
 - Peer supports
 - Pain management
 - Others??

E. Participant Protections

- The FAD is not mandatory – clients can opt-out
- Clients in Medicare Advantage would not be auto-enrolled, but would be offered the opportunity to enroll in the MMP during open enrollment
- Transition period – access out of network providers if currently in treatment
- Options counseling
- Ombudsman***
- Materials produced at no greater than 6th grade reading level
- Participant participation on MMP plan advisory boards
- No cost – sharing : RI will try to negotiate zero co-pays for pharmacy as part of the agreement
- No balance billing for any reason for covered services

F. Integrated Appeals Process

- Medicaid and Medicare have 4 levels of appeal, but they are different
- Timeframes also differ for Medicaid and Medicare
- This will be an area of focus for the CMS/EOHHS negotiations

Medicaid	Medicare
Health Plan Level 1	Health Plan Appeal
Health Plan Level 2	Administrative Hearing
External 3 rd level	Medicare Appeals Council
State Fair Hearing	Federal District Court

G. Administration and Reporting

- Develop CMS –state contract management team to conduct oversight jointly
- Part D oversight continues as CMS responsibility, with communication to the state as appropriate
- Consolidated reporting process for health plans
- Leverage existing state and CMS tools for oversight and monitoring, e.g. tracking of complaints, review of utilization reports, etc.
- Joint review of marketing materials by state and CMS

H. Quality Management

- Quality withhold measures specified by CMS and change with each year of the demonstration.
- Examples of CMS-specified measures include:
 - Nursing facility diversion
 - All cause readmissions
 - Certain HEDIS measures (follow-up after hospitalization for mental illness)
 - Fall risk reduction
- State specified measures – to be developed
- External Quality Review requirement with a Quality Improvement Organization (QIO)
 - Note – this is a current requirement in our Medicaid health plans

H. Quality Management, cont'd

- Core set of quality measures specified by CMS (there are many)
- Examples include:
 - Anti-depressant medication management
 - Screening for clinical depression and follow-up care
 - Care transitions
 - Breast cancer screening
 - CAHPS survey questions
- Other measures will be state-specified and are in development

I. Financing and Payment

- Medicare sets the A, B and D rates
 - Medicare rates are risk adjusted using a methodology currently used by Medicare Advantage – HCC
 - Part D rates risk adjusted using RxHCC
- States set the Medicaid portion of the rates
- Health plans would receive three payments – Medicare A/B, Medicare D and Medicaid
- Medical Loss Ratios and risk corridors are to be determined
- Savings percentages are to be negotiated and applied to the A/B and Medicaid rate, but not to the Part D rate
- Quality withholds look to be 1% in year 1, 2% in year 2, and 3% in year 3.

J. Evaluation

- CMS is funding an external evaluation, as required by the Social Security Act
- The state and health plans must submit all necessary and required data for this evaluation
- Data requirements are standardized across participating states and plans
- Qualitative and Quantitative components will be examined:
 - Experience of care
 - Costs by sub-population
 - Changes in patterns of primary, acute and LTSS use and expenditures
 - Administrative functions (e.g. enrollment, G&A)

Appendix 7 – Demonstration Parameters

- Enrollment approach outlined, including auto-assignment algorithm
- Model of Care outlined in detail – leveraging current RHO care management requirements:
 - Clients with LTSS at home have a lead care manager, comprehensive functional needs assessment (CFNA), person-centered plan of care with interdisciplinary team, and in-person quarterly visits by care manager (more frequent as needed)
 - Clients with LTSS in nursing homes have a lead care manager, comprehensive needs and discharge opportunity assessment, person-centered plan of care with interdisciplinary team, and bi-annual in-person visits (more frequently as needed)
 - Clients without LTSS are assessed for priority using predictive modeling, and receive a telephonic initial health screen. The initial screen will trigger members who need the CFNA.

Demonstration Parameters, cont'd.

- Access standards and requirements for network adequacy
- RI intends to utilize existing LTSS access standards in the RHO program
 - PCP no more than 20 minutes driving time
 - LTSS community services in place 5 days after determination of need
 - Access to non-urgent care within 30 days of enrollment (not including annual physicals)
- Medicare benefits are subject to Medicare access standards
- For benefits that overlap (e.g. DME), access standards are those more favorable to the member
- When in doubt, default is to the more rigorous access standard – Medicare vs. Medicaid

Background: Ombudsman Requirements

- As part of the FAD, CMS requires that states develop and implement an Ombudsman Program to serve dually eligible individuals
 - Independent, conflict-free entity to serve as an ombudsman for participants
 - Free assistance in accessing care, understanding and exercising rights and responsibilities and in appealing adverse decisions made by their health plan including LTSS services

Background: Ombudsman Requirements

- Assistance includes:
 - Understanding benefits, coverage or access rules and procedures
 - Understanding and exercising participant rights and responsibilities
 - Making enrollment decisions
 - Accessing covered benefits
 - Resolving billing issues
 - Appealing MCO denials, reductions or terminations
 - Addressing quality of care issues
 - Ensuring the right to privacy and consumer direction
 - Understanding and enforcing civil rights

Background: Ombudsman Requirements

- The ombudsman must:
 - Be accessible to individuals telephonically and in-person
 - Be state funded
 - Have expertise in on-the-ground delivery of LTSS
 - Medicare experience is also essential
 - Be housed in an independent organization with an established record of beneficiary representation
 - Have credibility with the senior and disability communities and the capacity to foster formal links with both communities
- MCOs must:
 - Notify enrollees re: ombudsman services
 - Allow the ombudsman to participate in advisory committee meetings with MCOs and state officials
 - Maintain channels of access with senior officials with individuals at the MCO

Funding Opportunity: Key Information

- Credibility with beneficiaries
 - Serve as a problem-resolver when a Plan can't resolve an issue
 - Be conflict free
 - Be knowledgeable in areas relevant to the beneficiary
 - Be confidential
 - Be skilled in negotiation
- Accessible to beneficiaries
- Authorized to access information needed to investigate complaints
- Coordinated with other entities (e.g. SHIP, licensing and regulatory, civil legal services providers, other agencies)
- Capable of identifying trends and emergency issues
- Sufficient capacity of the State administrative agency or entity
 - *No later than six months after the award date*

Funding Opportunity: The State assures CMS that they will:

- Not divert resources from, or diminish the capacity of, existing consumer protection services
- Provide legal authority to the Ombudsman to ensure:
 - Access to beneficiaries and records
 - Confidentiality
- Coordinate efforts with the State Medicaid program
- Systematically use data to make improvements
- Follow three phases:
 - Planning
 - Implementation
 - Reporting
 - Management and Oversight

Funding Opportunity: Key Information

- Awards ranging from \$275,000 to \$3 million to each state over a period of three years
- Cooperative agreement awards within 45 days after the application due date
- 12-month budget periods
 - Continuation awards following demonstrated progress
 - Cooperative agreements w/ significant involvement from CMS
 - Significant data and reporting to CMS

Proposed Approach

- Phase I: Planning and development (NOT sequential)
 - Create staffing infrastructure under the Medicaid Office
 - Implement a stakeholder infrastructure for the purpose of planning and development under the Ombudsman grant
 - Refine and create a detailed strategy and work plan in collaboration with stakeholders
 - Conduct an RFP process
 - Develop an Outreach Plan
 - Develop curriculum and conduct training
 - Develop a reporting system
 - Research FAD ombudsman programs nationally

Proposed Approach

- Phase II:
 - Conduct member outreach
 - Deliver ombudsman services including ongoing technical assistance to CBOs
 - Monitor and oversee project
 - Provide cooperative agreement reporting
 - Develop sustainability plans

Proposed Approach

- Similar (but not identical) approach used in MA and CA
- Use of a Steering Committee for the program
 - Lt. Governor's Office
 - DEA
 - Medicaid
 - BHDDH
 - Provider groups
- Steering committee would assist in developing and executing the RFP and would assist in managing and improving the program over time

Proposed Approach

- Management and support provided by the Medicaid Office and contractors with robust and ongoing stakeholder input
- Focus on contracting with local community-based organizations through an RFP process to deliver ombudsman services
 - Some direct Ombudsman services from Medicaid (in cases where issues can't be solved by a CBO)
 - Conflict-free requirement for bidders
- A Medicaid Program Manager (along with staff and consulting resources) provides curriculum development, training, ongoing technical support, stakeholder management, reporting and continuous improvement of the CBO's service delivery



Questions

Website: www.eohhs.ri.gov (under “Integrated Care”)

Email us your questions at: integratedcare@ohhs.ri.gov