2015

Report of the Working Group to Reinvent Medicaid

RECOMMENDATIONS FOR A PLAN FOR A MULTI-YEAR TRANSFORMATION OF THE MEDICAID PROGRAM AND ALL STATE PUBLICLY FINANCED HEALTHCARE IN RHODE ISLAND

JULY 8, 2015

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EXECUTIVE SUMMARY

This report builds on the foundation laid by the Reinventing Medicaid Act of 2015 to propose a transformative vision for Rhode Island Medicaid. In this Working Group's first report, we proposed a set of short-term cost-saving measures that were designed to be the first step on a path towards a payment and delivery system that promotes value, quality, health, and efficiency. Working with partners from the health care sector, the advocacy community, the business community at large, and the Executive Office of Health and Human Services, we now lay out a model for a reinvented publicly financed health care system in Rhode Island based on the following principles:

1. Pay for value, not for volume
2. Coordinate physical, behavioral, and long-term health care
3. Rebalance the delivery system away from high-cost settings
4. Promote efficiency, transparency, and flexibility

From these principles, we derive ten goals for Rhode Island's Medicaid program:

- **Goal 1:** Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members.
- **Goal 2:** Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- **Goal 3:** Maintain and expand on our record of excellence—including our #1 ranking—on delivering care to children.
- **Goal 4:** Maximize enrollment in integrated care delivery systems.
- **Goal 5:** Implement coordinated, accountable care for high-cost/high-need populations
- **Goal 6:** Ensure access to high-quality primary care.
- **Goal 7:** Leverage health information systems to ensure quality, coordinated care.
- **Goal 8:** Shift Medicaid expenditures from high-cost institutional settings to community-based settings.
- **Goal 9:** Encourage the development of accountable entities for integrated long-term care
- **Goal 10:** Improve operational efficiency

Each of these goals is accompanied by specific, measurable objectives that can serve as targets to achieve along the way towards the vision of a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with **Accountable Entities**, integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population. This will require **improved contracts with the MCOs** that require them to innovate in value-based purchasing strategies, including enhanced capacity for provider-level quality measurement, risk adjustment, and total

cost of care measures; shared savings and bundled payment methodologies; and innovative contracting strategies with hospitals, home care providers, and long term care facilities that align their financial interests and performance metrics with those of the accountable entities—while ensuring access to medically appropriate care. We also envision a system in which **case management and other member support resources are coordinated** and funded through the Accountable Entity, to ensure that care is focused, aligned, and timely, and that both medical and non-medical needs of our members are met and addressed.

Rhode Island has a strong foundation for reform in Medicaid. Our managed care programs are nationally recognized for their quality and effectiveness, and we have excellent partners in the provider community who have already begun to innovate in meaningful ways.

The vision set forward here is ambitious, as it should be, given the scale, impact, and importance of Medicaid. Rhode Island's leaders, including policy makers, health professionals, providers, community advocates and others, must not lose their passion for reform. Long-term, sustainable reforms must remain a top priority for the state, with a commitment to implementing those reforms and measuring progress along the way.

INTRODUCTION AND BACKGROUND

Rhode Islanders have access to some of the finest health care services in the country, but the health care they receive is often uncoordinated and fragmented. The health care delivery system is heavily weighted towards payment models that promote quantity, rather than quality, of services, and do not incentivize integrated, person-centered care. Patients with complex medical needs may see multiple health care providers, but those providers may not successfully communicate and coordinate with each other to ensure that the right care is provided at the right time and in the right setting. Providers are not typically given incentives to ensure that the patient experience is seamless and the overall outcome positive. In addition, the population served by the Medicaid program often faces challenges associated with social factors such as housing, food insecurity, and health literacy; challenges the current system is not fully equipped to address.

Medicaid provides an essential safety net and serves one out of four Rhode Islanders. Maintaining a strong Medicaid system is also an economic imperative for the state. Medicaid supports a healthier population, which provides businesses and employers with a healthier workforce and more predictability of publicly funded costs.

The old Medicaid model, however, is unsustainable. It relies too heavily on volume-based payment structures and does not include sufficient incentives for the delivery of, cost-effective, quality health care. Most health care services funded by Medicaid are still purchased, by the state or by a managed care organization, on a fee-for-service basis rather than through value-based payment structures that tie reimbursement to outcomes. Medicaid lags behind the private sector, which, although it is still primarily based in fee-for-service in Rhode Island, has begun small scale but meaningful efforts to shift away from paying for volume towards purchasing quality and value.

To this end, Governor Gina M. Raimondo appointed the Working Group to Reinvent Medicaid. In Executive Order 15-08, the Governor charged the Working Group to:

- Submit a report on or about April 30, 2015, of its findings and recommendations for consideration in the Fiscal Year 2016 budget
- Submit recommendations, no later than July 1, 2015, for a plan for a multi-year transformation of the Medicaid program and all state publicly financed health care in Rhode Island.

This document fulfills the second charge of Executive Order 15-08 and it builds on the recommendations offered earlier this year, which set a course for the successful passage of the Reinventing Medicaid Act of 2015.

It is necessary to transform Rhode Island's health care system to one that pays for the outcomes and quality care Rhode Islanders deserve, and that addresses the complex medical and social needs critical to achieving

improved health status. The reforms enacted as part of the Reinventing Medicaid process represent a first step towards addressing these challenges, and this report will build upon that foundation.

Prior to the Reinventing Medicaid Act of 2015 reforms, Rhode Island faced a nearly $200 million structural deficit. The comprehensive package of reforms enacted by the General Assembly achieve more than $70 million in state Medicaid savings without cutting eligibility and, more importantly, supports a shift towards a system that pays for outcomes and rewards quality and coordination. The reforms already in place establish the Hospital and Nursing Home Incentive Programs, which reinvest savings from fee-for-service reimbursement rate reforms to reward hospitals and nursing homes for providing better quality care and achieving better outcomes. The reform package also makes necessary investments and supports meaningful incentives to help Rhode Island achieve the elusive goal of rebalancing long-term care. In SFY2014, Rhode Island spent just $0.20 of every long-term care dollar on home- or community-based services (Executive Office of Health and Human Services, 2015). The Reinventing Medicaid Act expands access to assisted living and establishes new payment structures that give preferences to non-institutionalized settings like adult day health care.

Still, more needs to be done. The Reinventing Medicaid Act makes necessary, immediate reforms and positions Rhode Island to be a transformative national leader in Medicaid reform. It remains of compelling and immediate public importance that the state conduct a fundamental restructuring of its Medicaid program that builds on the reforms passed earlier this year, achieves measurable improvement in health outcomes for people and addresses the critical need to build a healthier Rhode Island.

Challenges in the current system

Costs in the Medicaid program can be thought of as a product of four factors:

- The number and characteristics of members covered
- The range and scope of benefits provided
- The unit cost of services
- The volume of services provided

Any effort to control costs must address one or more of these factors.

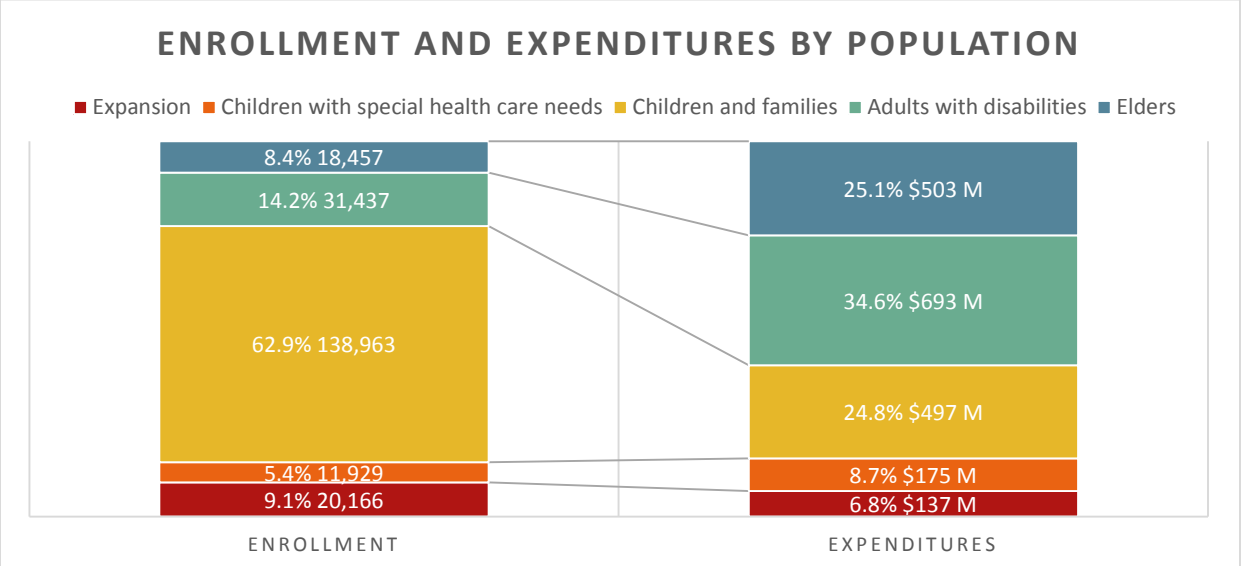
In the first report of this Working Group, we committed to proposing a set of short-term cost-containment strategies that held harmless the first two factors. We would transform Medicaid without constraining eligibility or reducing benefits. Looking toward the future, we reaffirm that goal of envisioning a sustainable and effective program that maintains a safety net for those same people who need and already have Medicaid, but serves them more efficiently and effectively.

The challenge and opportunity of Medicaid reinvention is to focus reforms on the highest need, highest cost populations and to both decrease the volume of high cost institutional and specialty care, and to shift the distribution of service volume to more low cost primary care, community-based behavioral health care and care management services. By better addressing some of the social determinants of health that result in poorer health outcomes and increased disease burden, overall costs can be contained. In the Rhode Island Medicaid program, this opportunity for savings can be realized by:

- avoiding or delaying nursing home admissions;
- reducing unnecessary hospital admissions and readmissions;
- reducing inappropriate use of the emergency department;
- enhancing access to and availability of comprehensive primary care;
- integrating behavioral health and substance use services with the primary care system;
- reducing the inappropriate use of high-cost services, including specialists and imaging; and
- purchasing laboratory, radiology and pharmacy services cost-effectively.

This strategy, if successful, has the effect of protecting both members and benefits, while improving health outcomes and lowering costs for the most vulnerable and complex populations.

Not all populations are equal, however; Medicaid spending varies widely by eligibility population within the program. In SFY 2014, per member per month (PMPM) costs ranged from $298 PMPM for low-income children and families, to $1,838 PMPM for disabled adults, $1,225 PMPM for children with special healthcare needs, and $2,270 PMPM for elders (Executive Office of Health and Human Services, 2015).

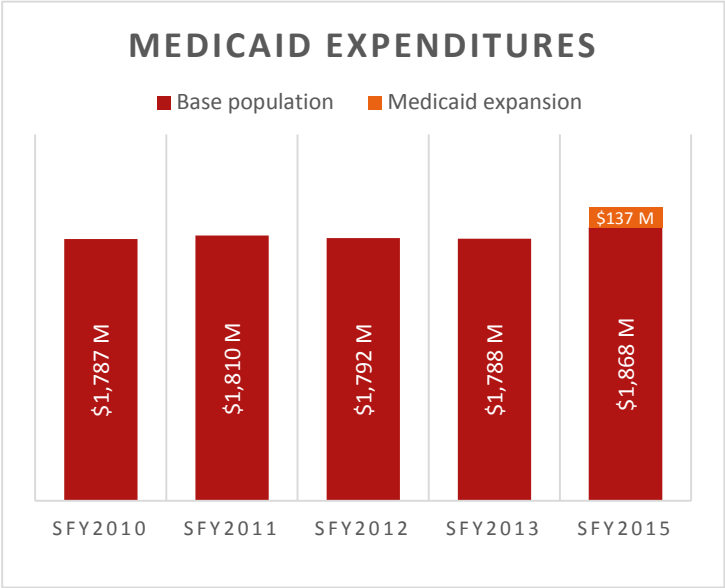


Overall Medicaid spending increased by 12.2% between 2010 and 2014, but nearly all of that increase is due to the addition of the (fully federally funded) Medicaid expansion population through the Affordable Care Act on January 1, 2014. (The national average Medicaid growth over the same period was 12.8 percent.)

Expenditures on the non-expansion population **grew by only 1.1 percent**.

Per-enrollee spending over the period 2010 to 2014 actually **decreased by 1.2 percent**. By comparison, Rhode Island commercial health insurance per member per month costs increased by 2.4 percent.

Spending for low income children and families (the RIte Care population) remained stable between 2010 and 2014 (PMPM costs shrank 0.3 percent over the five year period, although enrollment increased by 2.9 percent), and RIte Care



has provided some of the highest quality Medicaid Managed Care available in the country. In fact, the federal Centers for Medicare and Medicaid Services (CMS) recognized Rhode Island's RIte Care program as the highest-performing in the country on a set of core measures for children's health (Centers for Medicare and Medicaid Services, 2015).

These relatively healthy low income children and families constitute the majority of members in the Medicaid program (approximately 140,000 of 250,000 total members) but account for only 26% of spending. Conversely, although the elderly and disabled adults account for only 25% of Medicaid members, spending on their health care services comprised 64% of Medicaid spending in SFY 2013. PMPM costs for the elderly increased by 2.1% from 2009-2013, while spending for disabled adults declined by 2.5%. (These basic proportions and trends are common to nearly all state Medicaid programs.)

Neither the payment nor the delivery system have fully focused on the reality that a minority of socially and medically complex Medicaid members accounts for the largest percentage of spending. As a result, the largest opportunity for savings and improvements in inappropriate or unnecessary healthcare utilization rests with the same population. In order for any primary care and behavioral healthcare strategy to successfully reduce Medicaid spending, it needs to focus intensely on the medical and social needs of this fairly small population. Hospitals and long term care facilities are the two highest cost elements in the delivery system, and more efficient and effective use of these high cost services is an essential element of payment and delivery system reform. In addition, Medicaid needs to be designed to recognize that behavioral health and substance use disorders are highly prevalent in our members, and efforts to improve quality and control costs must focus on addressing these fundamental drivers of health behaviors and health outcomes.

The current payment and delivery system includes a number of elements that make it difficult to address the complex needs of these highly vulnerable members.

Financial incentives for hospitals, primary care providers, specialists and long term care providers are not aligned. The current fee-for-service system provides no incentive for providers to optimize primary, behavioral, and preventive care and minimize specialty, long term care, and inpatient services. Yet research has consistently demonstrated that primary care is associated with lower costs and better outcomes. Communication between hospitals and outpatient providers is difficult and sometimes impossible because of confusion regarding the responsible provider, and hospitals and outpatient providers do not have strong incentives to avoid unnecessary re-admissions. Inefficient scenarios repeat themselves daily throughout the system, and the current payment and measurement system offers no disincentives to inefficient use of high cost services. Despite a number of delivery system bright spots, such as a robust medical home movement, a high penetration of electronic medical records, a sophisticated Federally Qualified Health Center (FQHC) system, and the initial movement of long term services and supports into Medicaid managed care, this fundamental misalignment of incentives has not yet been fully addressed.

The hospital and nursing home incentive programs instituted as part of the Reinventing Medicaid Act of 2015 are a first step towards addressing these challenges. Because 27 percent of Medicaid costs are from hospital care, and 20 percent from nursing home care, meaningful reforms can only be accomplished by reducing the unnecessary use of these services. Moving forward, designing a payment system that aligns with the system of care will be a necessary part of a reinvented Medicaid program.

Lack of systematic identification of "super-utilizers" and a focused effort to engage them in care. A small number of high-utilizing members account for a significant proportion of hospital and emergency department utilization, yet providers and payers do not routinely share information about who they are, and what services they are accessing. Medicaid has a managed care program that focuses on high emergency department utilizers, but health plans have struggled to reach and engage these members. In SFY 2015 EOHHS began requiring MCOs to systematically identify so-called "super-utilizers" and make focused efforts to engage them in care. Information about these members is also shared with providers and care managers. These efforts provides a foundation on which to build a system of care management and care coordination for these members within a system of accountability and outcomes measurement that rewards improvements in utilization and cost. Efforts such as the Camden (NJ) Coalition of Healthcare Providers have focused on identifying and concentrating resources on this population ("hot-spotting") with promising results (Truchil, 2014).

With the Reinventing Medicaid Act of 2015, Rhode Island has committed to a set of programs and initiatives that target interventions where they are needed most, at the populations that use (and require) the most care. Medicaid must work to strengthen this kind of approach, which will be critical in the years ahead.

Funding streams and delivery systems for behavioral and physical health care are not integrated. Services for members with severe mental illness (SMI) are administered and overseen by BHDDH, while physical health care services for the same population are provided through Medicaid fee-for-service or managed care. Even within Rhody Health Partners, the Medicaid managed care for these adults, behavioral health services are sub-contracted to another entity. At the delivery system level, attempts to integrate physical and behavioral health have begun, but have been hampered by the complexities of funding streams and the lack of explicit payment incentives to do so, the lack of measurement of health care outcomes, and the lack of accountability of any single entity for that population's total cost of care.

In general, physical and behavioral health providers are not held accountable for the outcomes of the care they provide, nor are they rewarded for outcomes that are better than average. This fragmentation results in challenges for both vulnerable members and their care providers, and in excessive costs. Emergency room visits for Medicaid members with SMI are excessive and have not improved, despite explicit incentives to the health plans. Communication between behavioral health and primary care providers is difficult, as is communication between hospitals and outpatient providers. Substance use disorder and recovery services

are functionally separate from the remainder of the health care system. This lack of coordination results in excessive hospitalizations and emergency department use, poor outcomes of care, and unnecessary costs.

The only way to significantly improve care for Medicaid members with both behavioral and physical health challenges will be to consciously coordinate the efforts of these currently disparate provider organizations. This report will recommend a fundamental restructuring of the payment and delivery incentives that currently allow this fragmentation to persist.

Lack of accountability for cost and quality. No single provider group is accountable for the total cost of care of a population, and there is no financial incentive for providers to seek out at-risk members who may not be accessing appropriate preventive or chronic care services.

Medicaid must transition to a model where providers have accountability for a member's total cost of care and for the quality of that care and the health outcomes it produces.

Lack of accurate, timely and actionable data on quality, cost and utilization. In the current system, even if a provider wished to be accountable for cost and quality of a population, they are hindered by a lack of systematic and consistent sharing of data on cost, quality, and utilization of their populations. Patient follow-up after hospitalization is critical to reducing readmissions, but information transfer from hospitals to outpatient providers is suboptimal. Referral decisions are made without information about the cost or quality of laboratory services, radiology, or specialty services that might alter referral decisions for a provider that was accountable for the total cost of care.

Medicaid must encourage and support the development and integration of robust systems to share and analyze health care data.

Inability to address social determinants of health that are not typically covered by health insurance: Lack of food, clothing, employment, or shelter can make it impossible for healthcare interventions to be successful, resulting in ineffective use of high cost interventions when lower cost provision of these basic needs could result in improved health.

Medicaid must support--and fund, where possible--a wider focus on non-medical interventions and social determinants that if resolved can often reduce utilization, lower costs and encourage healthier lifestyles. Close coordination with other relevant state agencies is critical to achieving this goal.

Fragmented, duplicative and poorly coordinated "care management" services. With the best of intentions, over the years a number of avenues for "care management" have developed within the Medicaid delivery system. These care managers may be based at a state agency, at the patient centered medical home, and the behavioral health home, a home care agency, a hospital, the managed care organization, or within a hospital or non-profit agency. Often, care managers are not aware of the existence or activities of other care

managers in the system. Responsibilities overlap and are unclear, and the training and role definitions for this workforce are neither specific nor consistent. Members are not always aware of how to access the care manager or what his/her role in their care should be, and care managers often have difficulty reaching and engaging the members most in need of their services. Finally, too much of the care management is provided remotely or telephonically, which has been shown to be less effective than care management located close to the point of medical decision making.

Medicaid must commit to breaking down barriers and eliminating duplication within the delivery system and improving coordination across the system.

Low health literacy and distrust of the healthcare system. Navigating the healthcare system is complex even for a highly educated, native English-speaking individual with adequate social supports. Many Medicaid recipients have limited English proficiency, low levels of education, and limited social supports, making follow-through on care plans a challenge. Such patients are sometimes labeled as “non-compliant” by the health care system, when in fact they face very difficult challenges in simply navigating the labyrinth of providers and other levels of the health care system. The concept of “community health workers,” or “peer navigators” is gaining traction nationally as a means of engaging members more appropriately in their care.

Investing in the development of this workforce has the dual advantage of both providing employment opportunities to qualified members of the Medicaid program, as well as improving appropriate use of medications, hospitals and emergency rooms by Medicaid members.

The Reinventing Medicaid Public Process

On February 26, 2015, Governor Gina Raimondo issued Executive Order 15-08 which established the "Working Group to Reinvent Medicaid." In the first phase of this work, the group conducted a comprehensive review of the state's Medicaid program. For the second phase, the Governor tasked the group with submitting recommendations for a plan for a multi-year transformation of the Medicaid program and all state publically financed healthcare in Rhode Island.

Working Group Membership	
• **Dennis Keefe** (Co-Chair), Hospital Association of RI • **Ira Wilson, MD** (Co-Chair), Brown University • Peter Andruszkiewicz, Blue Cross Blue Shield of RI • Timothy Babineau, MD, Lifespan • Antonio Barajas, MD, Physician • Maria Fatima Barros, RN, Nursing Placement, Inc. • Elizabeth Burke Bryant, RI Kids Count • Holly Cekala, RICARES • The Honorable Louis DiPalma, First Vice Chair, Senate Committee on Finance • Jon Duffy, Duffy Shanley • Stephen Farrell, United Healthcare of New England • Helena Foulkes, CVS Caremark • Diana Franchitto, Home & Hospice Care of RI • John Gregory, Northern RI Chamber	• Hugh Hall, West View Nursing Home • Cheryl Johnson, Textron • Chuck Jones, Thundermist Health Center • Thomas Kane, AccessPoint RI • Linda Katz, Economic Progress Institute • John Kelly, Meeting Street • Dale Klatzker, The Providence Center • Elizabeth Lange, MD, Physician • Maureen Maigret, RN, Senior Agenda Coalition of Rhode Island • Peter Marino, Neighborhood Health Plan of RI • The Honorable Joshua Miller, Chair, Senate Committee on Health & Human Services • Patrick Quinn, SEIU • Sam Salganik, RI Parent Information Network • John Simmons, RIPEC • Matt Trimble, St. Elizabeth Community

Executive Order 15-08 further directed that "the Working Group's meetings shall be public meetings and shall be held in various locations throughout Rhode Island." In compliance with this directive, the Working Group met on seven occasions and convened town hall-style meetings across Rhode Island. Approximately 400 Rhode Islanders attended these town hall-style meetings.[1]

Working Group Meeting Dates	Town Hall Meeting Dates
• March 2, 2015: Department of Administration, Providence • April 6, 2015: Department of Administration • April 22, 2015: Community College of Rhode Island, Warwick • April 30, 2015: Department of Administration • May 27, 2015: Department of Administration	• March 16, 2015: Woonsocket Harris Public Library, Woonsocket • March 18, 2015: Providence Community Health Center, Providence • March 23, 2015: Peace Dale Public Library, South Kingstown

[1] Minutes from these public meetings can be found at http://reinventingmedicaid.ri.gov

• June 24, 2015: Marriot Downtown Providence, Providence • July 8, 2015: Rhode Island Foundation, Providence	• April 1, 2015: East Bay Family Health Care Center, Newport

To facilitate the analysis of the state's Medicaid environment, the Working Group members also participated in four smaller topical work streams for the first phase to which working group members were assigned based on expertise. The work streams focused on behavioral health, long-term care, delivery system reform, and care for people who utilize a high amount of health care services.

Work Streams and Meeting Dates

Behavioral Health Work Stream	High Utilizer Work Stream	Delivery System Reform Work Stream	Long-Term Care Work Stream
(led by Director Maria Montanaro)	(led by Ira Wilson)	(led by Dennis Keefe)	(led by Maureen Maigret)
• April 1, 2015 • April 8, 2015 • April 15, 2015 • April 22, 2015 • April 29, 2015	• March 30, 2015 • April 2, 2015 • April 9, 2015 • April 16, 2015 • April 23, 2015 • April 30, 2015	• March 31, 2015 • April 3, 2015 • April 10, 2015 • April 14, 2015 • April 21, 2015 • April 24, 2015	• March 31, 2015 • April 3, 2015 • April 9, 2015 • April 16, 2015 • April 23, 2015

In addition to these meetings, there were five occasions on which working sessions were held for members of the Working Group and the general public. Each of these meetings focused on a particular thematic topic, operating as an extensions of the Working Group meetings for members particularly interested in a topic. These sessions were held in various locations and lasted for ninety minutes.

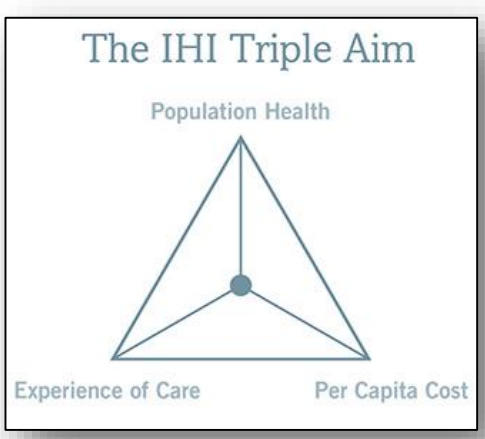
Working Group Additional Thematic Meeting Dates

- **Payment Methodologies**
  May 27, 2015: Brown School of Public Health, Providence
- **Accountable Entities and Payment Structures**
  June 3, 2015: Brown School of Public Health, Providence
- **Integrating Behavioral Health**
  June 10, 2015: EOHHS, Louis Pasteur Building, Cranston
- **Rebalancing the Long-Term Care System**
  June 11, 2015: Care New England, Providence
- **Quality Measurement**
  June 24, 2015: EOHHS, LP Building, West Wing, Cranston

PRINCIPLES AND GOALS FOR MEDICAID REFORM

As we look towards the future of Rhode Island's publicly financed healthcare programs, we recognize that above all we strive to achieve the "Triple Aim" for health systems, as articulated by the Institute for Healthcare Improvement (IHI):

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care (Institute for Healthcare Improvement, 2015).



All of the work of this Working Group and, indeed, of all of the health reform initiatives that have been convened over the past several years in Rhode Island, have this Triple Aim as the ultimate goal. In this report, we set forth four principles for Medicaid reform as the state begins to transform Medicaid into a system that is better optimized to achieve the Triple Aim. Under each principle, we identify a number of concrete goals that the state should commit to meeting over the next three to five years.

1. Pay for value, not for volume
2. Coordinate physical, behavioral, and long-term health care
3. Rebalance the delivery system away from high-cost settings
4. Promote efficiency, transparency, and flexibility

Principle 1: Pay for value, not for volume

The first principle recognizes that fundamental shift for Medicaid--and for all payers in the health care system--must be to create set of payment and care delivery frameworks that emphasize and incentivize value. By value, we mean that providers and provider systems are paid based on the quality (including efficacy, efficiency, and appropriateness) of the care they provide, rather than the quantity or volume of services provided. The National Business Council on Health defines value-based purchasing as:

> [A] strategy to measure, report, and reward excellence in health care delivery. Value-based purchasing involves the actions of coalitions, employer purchasers, public sector purchasers, health plans, and individual consumers in making decisions that take into consideration access, price, quality, efficiency, and alignment of incentives. Effective health care services and high performing health care providers are rewarded with improved reputations through public reporting, enhanced

> payments through differential reimbursements, and increased market share through purchaser, payer, and/or consumer selection (National Business Council on Health, 2015).

Value-based healthcare purchasing is a clear embodiment of the Triple Aim and seeks to create financial incentives for health systems to provide better quality and more effective care while reducing overall costs.

The Working Group emphasizes that quality is a critical component of value, and that quality care leads to better outcomes. Members of the working group cautioned that different providers are at varying levels of readiness to make a transition to value-based payments, and so any strategy must necessarily take these different starting points into account. The Working Group also cautioned the state to be mindful of the impact of any such change on patient access to care.

In line with this principle, the Working Group proposes the following goals for Rhode Island Medicaid:

GOAL 1: SUBSTANTIALLY TRANSITION AWAY FROM FEE-FOR-SERVICE MODELS TO A SYSTEM WHERE MEMBERS GET THEIR CARE THROUGH PROVIDER ORGANIZATIONS THAT ARE ACCOUNTABLE FOR THE QUALITY, HEALTH OUTCOMES AND TOTAL COST OF CARE FOR THEIR MEMBERS.

The last section of this report lays out a vision of a Medicaid program in which all members receive their care through an integrated provider organization that is accountable for a member's total cost of care. Recognizing that this transition will take time, the Working Group proposes a set of measurable goals and timelines to move Medicaid in Rhode Island toward paying providers based on the quality, rather than the quantity, of care they give patients.

Where appropriate, Medicaid should align these goals with the targets set forth for Medicare by CMS.

- **By 2018, at least 80 percent of Medicaid payments should have some aspect that is tied to quality or value**, whether through managed care organizations or directly from the state. This could include a quality withhold, a set of penalties for not meeting process or outcome metrics, a pay-for-performance incentive, or other structures.
- **By 2018, 50 percent of Medicaid payments should be made through an "alternative payment model,"** including payments to accountable care organizations, bundled payments, or others.
- Additionally, **by 2018, 25 percent of Medicaid members should be enrolled in an accountable integrated provider network**. These programs should first focus on the highest-cost, highest need members, such as those with severe mental illness or other behavioral health issues, developmental disabilities, children with special healthcare needs, etc.

In defining what it means for a payment to be tied to value, and what constitutes an "alternative payment model," Medicaid should align with the work of the Office of the Health Insurance Commissioner (OHIC) wherever possible.

GOAL 2: DEFINE MEDICAID-WIDE POPULATION HEALTH TARGETS, AND, WHERE POSSIBLE, TIE THEM TO PAYMENTS.

The transition to value-based purchasing will, by definition, require a renewed focus on the measurement and reporting of healthcare process and outcomes. While the Medicaid program currently requires quality measurement and reporting from participating managed care organizations, and directly from some providers, there is not a clear set of measures and targets by which the program can systematically and over time monitor progress in quality of care and health outcomes. Further, current measures are focused at the health plan level and do not address specific measures for high need/high cost populations.

As a Model Test state for the State Innovation Model grants from the Center for Medicare and Medicaid Innovation, Rhode Island is currently engaged in a process of reviewing existing measurement strategies across the healthcare system, including in Medicaid. The goal of this process is to develop a set of aligned measures across commercial and publicly funded programs. In addition, Rhode Island is a grantee of the CMS Adult Medicaid Quality program, and as such has annually submitted a set of 26 core adult measures to CMS. As the co-convener of the Care Transformation Collaborative (formerly known as CSI RI), EOHHS has been involved in the development of a set of medical home-specific measures derived from electronic medical records and reported quarterly to a common measurement portal. Finally, the availability of the state's all-payer claims database provides an opportunity to derive claims-based quality and outcome measures across the population.

Building on these resources **by the end of SFY2016, the state should define a set of core quality, utilization and outcome measures by which to track the progress of the Reinventing Medicaid initiatives.** These measures should align, to the greatest extent possible, with commercial, exchange, and Medicare measures already in existence. Measures should build on existing systems already in place, as described above, and there should be adequate opportunity for the public to provide input into the development of the measure set. The measures should include a focus on high cost/high need populations, on behavioral health and substance use disorders, on patient-reported health status and outcomes of care, and on appropriate utilization of high cost services and settings.

GOAL 3: MAINTAIN AND EXPAND ON OUR RECORD OF EXCELLENCE—INCLUDING OUR #1 RANKING—ON DELIVERING CARE TO CHILDREN.

RIte Care program has been hailed as a national model, and in 2015 was recognized by CMS as the top performing Medicaid program in the country serving children. As we begin to make significant (and needed) changes in the structure of Medicaid programs in Rhode Island, it is critical to not lose sight of the successes the programs have achieved so far, and to ensure that these strengths are not eroded.

EOHHS must commit to continuing this legacy of success and aim to maintain a "top five" ranking in any future national assessment.

Principle 2: Coordinate physical, behavioral, and long-term health care

Waste and inefficiency enter a system when it is fragmented, duplicative, and uncoordinated. A reinvented Medicaid health care system should treat a whole person, not just one condition or characteristic. A patient-centered, rather than illness-centered, system will produce better health outcomes at a lower cost.

Members of the working group noted that integration among providers is difficult and must be carefully encouraged and supported. Incentives must be aligned across health care sectors, and cooperation and coordination may be labor-intensive at first.

Behavioral health is critical to providing effective cost-effective care to Medicaid members. In SFY2013, Medicaid spent nearly $500 million on care for the highest-cost enrollees.[2] Of these costs, more than 80 percent ($407 million) were for members who had a behavioral or neurologic diagnosis (Executive Office of Health and Human Services (2), 2015). The highest-cost Medicaid members have multiple co-morbidities, and their health and costs can only be improved by taking a coordinated approach.

Coordinated health care can also improve outcomes and reduce costs in long-term care. Involving primary care providers and supportive home care services as early and often as possible can help to delay expensive admission to a nursing facility. Proper coordination of care requires cooperation between primary care, social services, behavioral and specialty care, hospitals, rehabilitation centers, home health care, and other members of care team to ensure that needs are being met and not overlooked. Of course, focusing on initiatives that will allow seniors and people with disabilities to remain in their communities instead of in nursing facilities or other institutions will not only reduce costs; it will allow people to remain where they want to be—at least until they need the intensive care that a nursing facility provides.

New value-based payment systems must be focused on removing disincentives to care coordination, and on encouraging providers to work across existing divisions in the care delivery systems, and focused on leveraging health information systems to ensure quality, coordinated care. Through all of these services, it is critical that patients are empowered to participate in decisions about their health care, and that providers view their patients as partners with them in planning their health services and managing their health.

[2] Members with costs over $15,000 in a year but who did not live in nursing homes or other institutions.

GOAL 4: MAXIMIZE ENROLLMENT IN INTEGRATED CARE DELIVERY SYSTEMS

Managed care has been a success for the core RIte Care population, and Rhode Island has been effective in adding new populations and services under the managed care umbrella. Now it is time to expand the benefits of care coordination and management to other high-need or high-cost populations.

- **By 2018, 90 percent of Medicaid long-term care beneficiaries should be enrolled in a managed care program**
- **By 2018, 90 percent of Medicare/Medicaid dual-eligibles should be enrolled in integrated managed care**, which would link these two funding streams to ensure that an enrollee's long-term, primary, and hospital care are being managed and coordinated by an entity with financial accountability for the total cost of care.

GOAL 5: IMPLEMENT COORDINATED, ACCOUNTABLE CARE FOR HIGH-COST/HIGH-NEED POPULATIONS

As part of the fundamental effort to restructure the Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure, the Reinventing Medicaid Act includes path for moving behavioral healthcare services into an accountable structure where community mental health centers play a key coordinating role. As this approach begins to demonstrate success, this model should be expanded to all members with a diagnosis of severe mental illness (SMI) or severe and persistent mental illness (SPMI). **All Medicaid beneficiaries with an SPMI diagnosis should be enrolled in an accountable health home by 2018.**

GOAL 6: ENSURE ACCESS TO HIGH-QUALITY PRIMARY CARE

Research and experience has shown that access to, and utilization of, high-quality primary care can have a profound impact on health, especially for particularly vulnerable complex population, and can hold overall costs down by reducing the use of more expensive specialty or institutional services. To that end, objectives that promote primary care are key to the future of the Medicaid program.

A patient-centered medical home (PCMH) is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care (National Committee for Quality Assurance, 2015).

EOHHS and OHIC have convened a multi-payer PCMH initiative in Rhode Island since 2008, the Care Transformation Collaborative (CTC). This initiative brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high-quality, comprehensive accountable primary care. CTC began with five pilot sites and has grown to 73 practices serving over 300,000 Rhode

Islanders. The major health plans in RI, including Medicaid and Medicare, engage in a common contract with the practices that provides a supplemental per member per month payment to support enhanced care management and infrastructure build of becoming a PCMH. Practices can earn additional incentive payments for meeting benchmarks in clinical quality, utilization and patient experience. These incentive payments have driven improvement in quality measures since the beginning of the program.

In 2016, CTC will expand the transformation of primary care to practices serving children through PCMH-Kids. PCMH-Kids has selected 10 pilot sites that serve nearly 30,000 children, almost half of which are covered by Medicaid. The health plans will negotiate a contract with the pilot sites that is specific to the transformation needs of pediatrics. In particular, practices will be expected to build capacity for care coordination, with a focus on children and youth with special health care needs (CYSHCN). PCMH-Kids will also work to improve the collaboration and coordination with entities across the state that currently serve CYSHCN, including the state-designated health homes for CYSHCN: CEDARR Family Centers.

Medicaid should seek to **align with the Office of the Health Insurance Commissioner's standards for PCMHs, which are to have 80 percent of primary care providers attain NCQA Level 3 recognition as a PCMH** with implementation of cost-containment strategies and demonstration of performance improvement on select quality metrics. The state should also continue to push ahead with expanding the reach of PCMH into the child/youth population.

GOAL 7: LEVERAGE HEALTH INFORMATION SYSTEMS TO ENSURE QUALITY, COORDINATED CARE

One of the most critical pieces to achieving a successful coordinated care health system is the proper use of available health information technology. Rhode Island is leading the way in supporting patients and providers with CurrentCare, a secure electronic network that gives authorized medical professionals access to their enrolled patients' most up to date health information, including lab results, medications, and hospital visits.

Nearly half of Rhode Islanders are enrolled, but the proportion for Medicaid members is considerably smaller (CurrentCare, 2015). Since Medicaid members tend to have complex health needs, it is especially important for providers to be able to share information about patient health to ensure that care is properly coordinated. The state should set as a target that **75 percent of Medicaid members will be enrolled in CurrentCare by 2018**. To achieve this goal, the state should also work collaboratively with the Rhode Island Quality Institute to enroll more providers. The broadening adoption of sophisticated electronic health record (EHR) systems will also help provide this kind of connectivity and data-sharing.

The state should also develop a strategy to provide Medicaid providers with the information they need on cost, quality and utilization in order to effectively manage their populations. Accountable, value-based care requires that providers have accurate, actionable information on which to base decisions and make

interventions. The state has a responsibility to work with our managed care organizations to ensure that this information is accessible to providers.

Principle 3: Rebalance the delivery system away from high-cost settings

Reducing unnecessary utilization will help to reduce costs and improve patient experiences, but it will also be necessary in some cases to increase the utilization of lower-cost, higher-value services. To this end, Medicaid needs to shift the balance of both services and payments away from high-cost settings (such as institutional or specialty care) toward lower-cost settings and services (like primary care and community-based services).

GOAL 8: SHIFT MEDICAID EXPENDITURES FROM HIGH-COST INSTITUTIONAL SETTINGS TO COMMUNITY-BASED SETTINGS

The most direct way to reduce expenditures and improve patient experience is to, whenever possible, provide necessary care early on in a low-cost, low-acuity setting and avoiding inappropriate or unnecessary use of high-cost institutional care. This means avoiding or delaying admissions to hospitals and nursing homes, and preferring primary care to emergency care.

Currently, roughly 80 percent of long-term care dollars spent on elders and adults with disabilities goes to nursing homes, a third above the national average. The Reinventing Medicaid act includes a number of initiatives to increase the use of home- and community-based services as alternatives to nursing facilities, where appropriate. EOHHS should build on these initiatives and adopt aggressive goals to rebalance this system:

- **By 2020, 50 percent of Medicaid long-term care spending on the elderly and disabled should be for home and community-based services**.
- **In 2016, 2017, and 2018, achieve year-over-year declines in hospital inpatient admissions per thousand members.**
- **In 2016, 2017, and 2018, achieve year-over-year declines in ED utilization.**
- OHIC requires commercial plans to spend at least 10.7% of total medical expenses on primary care. **Medicaid should aim to align with the OHIC primary care spending target by 2018.**

GOAL 9: ENCOURAGE THE DEVELOPMENT OF ACCOUNTABLE ENTITIES FOR INTEGRATED LONG-TERM CARE

There is potential to expand accountable entities beyond the traditional acute-care setting into long-term care as well. Currently, there are few organizations in the state capable of caring for elders as they progress through different stages of care needs: from home care, to independent living, to assisted living, to nursing homes.

Integration between long-term care entities could create the financial incentives to treat patients in the lowest-acuity setting and reduce costs while maintaining quality and patient experience. An accountable entity for long-term care would assume financial risk for a patient entering a low-acuity setting and remain accountable for that member. The accountable entity would have a financial incentive to ensure its patients remain in community settings as long as possible, leading to increased investment in independent living.

Principle 4: Promote efficiency, transparency, and flexibility

The reforms above will only be achievable in an environment that promotes and rewards flexibility and openness about the systems and structures that deliver health care to Rhode Islanders. Providers and health plans will need to be nimble, transparent, and efficient in order to succeed in a new Medicaid.

The same unquestionably applies to the state. The Medicaid program must be a responsive partner to health care providers and to enrollees. Transformation of Medicaid cannot happen without a transformation of EOHHS, the agency responsible for program implementation and oversight.

GOAL 10: IMPROVE OPERATIONAL EFFICIENCY

To succeed at reinventing Medicaid, EOHHS must **develop the resources and capacity within state government to adequately oversee its health care system partners** and drive system change. The Medicaid agency must be responsive and proactive. As recommended above, the agency should develop health outcome and system performance metrics to evaluate the success of these reforms and, crucially, be willing to change and invest in order to meet those goals.

One area where the state has an opportunity for improvement is in the timeliness of determinations of eligibility for Medicaid services. Performance varies widely among programs, and the roll-out of new eligibility systems creates a platform for improvement. **By the end of 2016, the state should commit to making 90 percent of eligibility decisions within 45 days, and 80 percent in fewer than 30 days.** It should be possible to meet this target for applications for long-term services and supports, and to exceed this target for simpler income-based applications (for programs like RIte Care). The Working Group encourages EOHHS to develop more specific and aggressive targets on a program-by-program basis.

Eliminating waste, fraud, and abuse is another key component of operating an efficient public program. EOHHS has a responsibility to ensure that systems are in place to identify and remediate unnecessary and improper spending. **In 2016, 2017, and 2018, EOHHS should commit to year over year increases in the number of activities, transactions, providers, service authorizations, and eligibility decisions reviewed or audited by the Office of Program Integrity.**

OUR VISION OF A REINVENTED MEDICAID PROGRAM

With these principles and goals in mind, we envision a Medicaid system that is more consciously and effectively organized towards achieving the Triple Aim: controlling costs, while improving health and the experience of care. In this section, we describe three key features of a future program.

Achieving the goals articulated above will set the state on a path toward this new reality of better care and better value. We anticipate that EOHHS and its stakeholders will work collaboratively to update the principles and goals as they begin to be implemented, and in response to input from insurers, providers, beneficiaries, and other stakeholders.

There are three key components to our vision of a reinvented Medicaid:

ACCOUNTABLE ENTITIES

In a reinvented Medicaid, integrated provider organizations will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population. Over time, beginning with high cost/high utilizing populations first, all Medicaid members will be attributed to an Accountable Entity, and eventually every member would be attributed to an accountable entity.

Payment to these entities will be based in part on performance on the health system metrics established by the State through the community stakeholder process. Below is a typical description of an Accountable Entity:

> Accountable care organizations (ACOs) are a health care payment model designed to reduce costs while improving quality. In an ACO, a group of providers is collectively held accountable for the overall cost and quality of care for a defined patient population. Patients are typically assigned to a primary care provider (or, in some cases, a specialist) who helps ensure that patients receive efficient, coordinated care.
>
> ACOs are intended to address concerns of both cost and quality through several mechanisms. These include encouraging better care coordination (for example, provider communication across care settings); providing incentives for prevention and management of chronic diseases (for example, increased focus on primary care; disease management programs); and reducing overutilization (for example, emergency department use). By incorporating meaningful performance measures, the ACO model is intended to ensure that cost savings come not from stinting on needed care, but rather through improving the quality of care.
>
> Despite these challenges, it is with this highly vulnerable group that ACOs may have the most potential to make notable gains in cost and quality and to reduce overall disparities. For example, work in Camden, New Jersey, has focused on meeting the needs of this set of highly vulnerable patients, making tremendous strides in reducing costs and improving patients' health outcomes. (Lewis, Larson, McClurg, Boswell, & Fisher, 2012)

In Medicaid accountable entities, it is important to avoid inadvertent financial disincentives that would discourage providers from caring for the most complex, high cost, and vulnerable members. Payments to accountable entities will need be risk adjusted to avoid "cherry picking" of healthier members, and to reward organizations which care for the most complex members. In addition, accountable entities will need to ensure that our current standards for access to care (including wait times) and other consumer protections are upheld.

Payments to accountable entities may begin as fee-for-service with shared savings and transition over time to capitated payments with opportunities for reward based on overall quality and cost performance. The payment structure to these entities will need to be designed to support the full integration of primary and behavioral healthcare and care management services, and accountable entities will be required to provide these services in an integrated fashion. Accountable entities must also integrate with community organizations that can take advantage of a flexible funding stream in order to address social determinants of health: housing, employment, food security, transportation and substance use disorder recovery.

For primary-care led accountable entities, MCOs would continue to contract directly with hospitals, specialists and LTC providers to provide services to their members. However, a critical component of this strategy would be the requirement that MCOs include in their contracts with hospitals and specialists strategies that tie their financial incentives to the performance of the Accountable Entities. Hospitals, LTC providers and specialists serving the Medicaid membership would also stand to gain financially, or minimize their losses, when the system begins to eliminate the inappropriate use of these services. Without this linkage between the success of the accountable entity and the incentives for other providers the Accountable Entity will struggle to engage and change the behavior of these high cost provider systems. Such incentives will encourage communication between providers, shared accountability for quality metrics, and a patient centered rather than a provider centered approach to services.

NEXT GENERATION MANAGED CARE

In states where accountable care is being implemented in Medicaid, some have employed the vehicle of managed care, some have contracted directly with accountable entities, and one (Minnesota) has done a combination of the two. Given our State's strong managed care programs, and our multi-year investment in an effective managed care oversight structure, it is logical for Rhode Island to begin its move towards accountable care through the vehicle of Medicaid managed care.

This means a re-engineering of the managed care contracts, and a deliberate and focused effort to maximize the members and services included in managed care contracts. This also implies that with the shift to accountable care, Medicaid managed care organizations will need to develop new competencies in order to provide the State with the services it needs. In addition, with the MCO requirement to share accountability, and eventually financial risk, with accountable entities, payments to MCOs should over time move away from

complex systems where certain services and costs are not covered to a model where the MCO and its accountable entities take on full risk for the populations covered.[3]

Next generation MCOs will need to innovate in value-based purchasing strategies. This includes enhanced capacity for provider-level quality measurement, risk adjustment, and total cost of care measures; shared savings and bundled payment methodologies; and innovative contracting strategies with hospitals, home care providers, and long term care facilities that align their financial interests and performance metrics with those of the accountable entities.

Effective care management and care coordination are foundational elements of a re-designed delivery system. Care managers can educate and engage members in their healthcare, and ensure that they are connected to the social services necessary to address their broader healthcare concerns. Current MCO contracts contain strong requirements for care management and disease management of members. Evolving research in patient-centered medical homes and care management indicates that care management is most effective when it is fully integrated into the care delivery team, provided in a culturally competent manner, and there is open and unfettered communication between care managers and healthcare providers. The new delivery system will focus on ensuring that culturally competent care management teams are available to high need members on site with the accountable entity, and as such may gradually shift this responsibility out of the managed care organization.

On the other hand, MCOs in the new environment will need to gain new competencies. In particular, as MCOs shift their care management and disease management efforts to the accountable entities, they will need to establish mechanisms to hold them responsible for care management activities. MCOs will need to become expert at producing, analyzing, and feeding back to accountable providers the data they need to manage their populations. Experience with the Medicare Shared Savings ACOs has shown that without actionable, timely data, providers are unable to effectively engage in activities to control costs and use services more appropriately. This includes data on quality and cost of hospital and specialty care, real time data on hospitalizations and emergency department use, and provider-level measures of performance on quality, utilization and member experience. Primary care-based accountable entities will need support in data collection, analysis and use, and it is logical for MCOs to develop this competency and support the accountable entities in their population management efforts.

[3] Current carve-outs include NICU, Hepatitis C drugs, transplants, behavioral health services, services for children with special health needs, group homes, DD services, and DCYF-funded services. Risk share/gain share corridors require the state to share in MCO losses/gains above 1% of premium

A ROBUST AND SPECIALIZED CARE MANAGEMENT AND COMMUNITY HEALTH WORKFORCE

Community health worker and clinical care management teams located within the accountable entity, integrated with the primary care and behavioral health providers, and funded through the same payment stream are a critical component to successful management of complex populations. This workforce needs to be developed, trained, and employed in the accountable entities. This new workforce would include specialized care managers for members with particularly complex issues such as: behavioral health, substance use, long term care, developmental disabilities, chronic care, and children with special healthcare needs. This requires a consolidation and streamlining of Medicaid-funded care management resources into the accountable entity with appropriate contractual accountability.

This workforce should be drawn whenever possible from the communities in which Medicaid members live and will be of similar ethnic and socio-economic backgrounds. Licensed clinicians will serve as care managers for members with predominant medical and behavioral health needs, with support in outreach and engagement by community health workers. Linkages to social service agencies and supporting member self-management will be predominant responsibilities. Workforce development should focus on identifying and cultivating Medicaid members who can be trained to serve in this workforce.

Investments in cultural competency among providers is key to reducing health disparities, and the delivery system should continue to invest in medical interpreters, bilingual/multilingual staff, and other resources.

High-level transition plan

The creation of Accountable Entities to serve the highest need Medicaid populations will not happen overnight, and it will require investment. **Rhode Island should seek federal authority to support that investment, in resources, funding, and technical assistance, through a Delivery System Reform Incentive Payment (DSRIP) program.**

One use of DSRIP funds will be to support the hospital and nursing home incentive programs described in the first report from this working group and enacted as a part of the Reinventing Medicaid Act of 2015 in the SFY2016 budget. EOHHS will work with providers to define a set of metrics that are tied to incentive payments for meeting benchmarks designed improve quality and reduce long-term costs (see #2 below). These payments, however, will only constitute one aspect of Rhode Island's DSRIP approach.

Working with the State Innovation Model (SIM) steering committee, EOHHS should define a multi-year delivery system transformation plan focused on incentivizing, supporting, and evaluating Medicaid accountable entities in Rhode Island. At a high level, that plan must include:

- Defining the desired population health outcomes, and proposing to link provider payments to those outcomes;
- Identifying the highest need and highest cost populations who should be targeted for first involvement with an accountable entity;
- Adopting proportional spending targets for institutional, inpatient, and specialty care services that are lower than the SFY2015 baseline, and spending targets for primary care, behavioral health care, and care management services that are higher than the SFY2015 baseline.

The transition from a fee-for-service healthcare delivery system to an accountable, total-cost-of-care system, will happen incrementally. The multi-year DSRIP plan should follow these steps:

Phase 1: Structure

Convene a workgroup to adopt a definition of an Accountable Entity, including the governance, contracting, and financial characteristics. Through a DSRIP waiver, Rhode Island should seek to make available planning and implementation funds to providers (or groups of providers) to make investments in information systems and other infrastructure necessary to form an accountable entity. Payments could be made to providers who achieve certain infrastructure benchmarks by demonstrating readiness against a set of criteria defined by the state.

The metrics to evaluate the success of Phase 1 (and to which the DSRIP payments would be tied) are structural in nature, including: what an accountable entity consists of, what services must be included, what community partners should participate, etc.

Phase 2: Process

Convene a workgroup to define a set of healthcare delivery operational (process) metrics that reflect the desired changes in the healthcare system. These might include reductions in ED utilization, long stays in nursing facilities, and unnecessary hospital admissions/readmissions, or increases in primary care utilization and pharmaceutical adherence. Rhode Island will seek to make available DSRIP-funded incentive payments to providers who meet these targets.

Phase 3: Outcomes

Convene a workgroup to define a set of population health outcome metrics that reflect the desired changes in the healthcare system, in line with the four principles articulated above and the Triple Aim. Rhode Island should seek to make available DSRIP-funded incentive payments to providers who meet these targets.

The incentive payments envisioned here should be thought of and designed as a *transitional funding stream* as providers transform themselves into entities that are able to take on accountability for the total cost of care for their attributed members, including assuming financial risk. In the long term, providers will have to

streamline their operations, reduce costs, and align incentives to prosper in an environment where overall healthcare spending decreases.

Note that this transformation needs to affect all providers who service Medicaid members, including those who provide long term services and supports. Rhode Island must aim to be a nationwide leader in developing a sustainable model for accountable long-term care, in which home and community-based providers and nursing facilities are able to collaborate to responsibly manage the total cost of care (acute and long-term) for a member. This may require the development of LTC-specific DSRIP programs.

CHALLENGES AND BARRIERS

Achieving such radical transformation of a $2 billion program will not be easy: transformative change to vital programs like Medicaid ought not to be easy. However, leaders in Rhode Island, including policy makers, health professionals, providers, community advocates and others, must not lose their passion for reform.

Long-term, sustainable reforms must be a top priority for the next legislative session and the state must make a commitment to implementing those reforms and measuring progress along the way. Through that effort, the state must also be aware of the key challenges that may threaten Rhode Island's progress and slow - or even derail - the shift of our Medicaid system from one that pays for volume to one that rewards outcomes, coordination and value.

Some of the key challenges that the state should be aware of include:

- Cautious reluctance from some quarters of the provider community to commit to sweeping change, especially change that is threatening to an existing business model
- The need for a substantial investment in new provider capacity and infrastructure
- A recognition that EOHHS may need to invest in additional capabilities or resources to drive this transformation

There are also areas that this report was unable to address, that should be the focus of future attention. These include:

- A comprehensive plan for including oral health care as an important component of overall health.
- Ensuring coordination among the different state agencies involved in long-term health system planning (OHIC, Department of Health) and clarifying the role of EOHHS.
- Recommendations for evaluating and possibly restructuring services for children with serious emotional disturbances, currently administered by the Department of Children, Youth, and Families.

CONCLUSION AND RECOMMENDATIONS

Rhode Island has a unique opportunity to redesign the Medicaid program for the next generation to encourage more effective, more affordable, and more patient-centered care. Rhode Islanders already have access to some of the finest health care services in the country, and we hope to build on that success. Like health care systems throughout the country, Rhode Island's health care delivery system is heavily weighted towards standard fee-for-service payment models. Medicaid reflects the state health system overall, serving one out of every four Rhode Islanders. In addition to health conditions, the Medicaid population often faces social factors which the current system does not address.

We have proposed ten goals for the Medicaid program, designed to move the program towards a new structure based on Accountable Entities delivering high-quality, high-value care. To a large degree, our recommendations hinge upon additional coordination between payors, providers, physicians, and patients.

- **Goal 1:** Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members.
- **Goal 2:** Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- **Goal 3:** Maintain and expand on our record of excellence—including our #1 ranking—on delivering care to children.
- **Goal 4:** Maximize enrollment in integrated care delivery systems
- **Goal 5:** Implement coordinated, accountable care for high-cost/high-need populations
- **Goal 6:** Ensure access to high-quality primary care
- **Goal 7:** Leverage health information systems to ensure quality, coordinated care
- **Goal 8:** Shift Medicaid expenditures from high-cost institutional settings to community-based settings
- **Goal 9:** Encourage the development of accountable entities for integrated long-term care
- **Goal 10:** Improve operational efficiency

EOHHS should develop and publish specific metrics to track the progress and success of the Reinventing Medicaid initiative, including both the first phase of Medicaid savings, and the longer-term reforms identified in this report. We also recommend that EOHHS continue to maintain a robust stakeholder engagement process to gather input from relevant experts on each of these issues as well as hold the state accountable for each goals. Although the Working Group itself will formally disband with the issuance of this report, there are existing stakeholder groups that can be informally charged with monitoring and supporting this transformation.

We hope that these long-term Medicaid reforms will spark a conversation extending beyond publically financed healthcare. Previous waves of public health reform have spread from the public sector to cover all payors, public and private. This is an exciting time for health reform, with a number of innovative approaches being pioneered across the country. We hope to see Rhode Island at the forefront of health reform.

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SUMMARY OF PRINCIPLES AND GOALS

Principle 1: Pay for value, not for volume

- **Goal 1:** Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members.
  - By 2018, at least 80 percent of Medicaid payments should have some aspect that is tied to quality or value
  - By 2018, 50 percent of Medicaid payments should be made through an "alternative payment model"
  - By 2018, 25 percent of Medicaid members should be enrolled in an accountable integrated provider network.
- **Goal 2:** Define Medicaid-wide population health targets, and, where possible, tie them to payments.
  - By the end of SFY2016, the state should define a set of core quality, utilization and outcome measures by which to track the progress of the Reinventing Medicaid initiatives
- **Goal 3:** Maintain and expand on our record of excellence - including our #1 ranking - on delivering care to children.
  - EOHHS must commit to continuing this legacy of success and aim to maintain a "top five" ranking in any future national assessment.

Principle 2: Coordinate physical, behavioral, and long-term health care

- **Goal 4:** Maximize enrollment in integrated care delivery systems
  - By 2018, 90 percent of Medicaid long-term care beneficiaries should be enrolled in a managed care program
  - By 2018, 90 percent of Medicare/Medicaid dual-eligibles should be enrolled in integrated managed care
- **Goal 5:** Implement coordinated, accountable care for high-cost/high-need populations
  - All Medicaid beneficiaries with an SPMI diagnosis should be enrolled in an accountable health home by 2018
- **Goal 6**: Ensure access to high-quality primary care
  - Align with the Office of the Health Insurance Commissioner's standards for PCMHs, which are to have 80 percent of primary care providers attain NCQA Level 3 recognition as a PCMH
- **Goal 7:** Leverage health information systems to ensure quality, coordinated care
  - 75 percent of Medicaid members will be enrolled in CurrentCare by 2018

Principle 3: Rebalance the delivery system away from high-cost settings

- **Goal 8:** Shift Medicaid expenditures from high-cost institutional settings to community-based settings
  - By 2020, 50 percent of Medicaid long-term care spending on the elderly and disabled should be for home and community-based services.
  - In 2016, 2017, and 2018, achieve year-over-year declines in hospital inpatient admissions per thousand members.
  - In 2016, 2017, and 2018, achieve year-over-year declines in ED utilization.
  - Align with the OHIC primary care spending target by 2018.
- **Goal 9**: Encourage the development of accountable entities for integrated long-term care

Principle 4: Promote efficiency, transparency, and flexibility

- **Goal 10:** Improve operational efficiency
  - Develop the resources and capacity within state government to adequately oversee its health care system partners
  - By the end of 2016, the state should commit to making 90 percent of eligibility decisions within 45 days, and 80 percent in fewer than 30 days.
  - In 2016, 2017, and 2018, EOHHS should commit to year over year increases in the number of activities, transactions, providers, service authorizations, and eligibility decisions reviewed or audited by the Office of Program Integrity.