

Initial Report of the Working Group to Reinvent Medicaid

*Findings and Recommendations for
Consideration in the Fiscal Year 2016 Budget*

State of Rhode Island

May 1, 2015

Executive Summary

Rhode Island's Medicaid programs play a crucial role in the lives and health of the citizens of our state and in the state budget and economy. In order to ensure a sustainable future for Medicaid, Governor Raimondo assembled a group of 29 stakeholders--providers, insurers, advocates, businesspeople, and legislators--to outline a path for Medicaid in the years to come. This initial report lays out a set of recommendations for the Governor as she looks to close a \$190 million budget deficit in state fiscal year 2016.

The proposals contained in this report represent a starting point for moving these vital programs and resources towards a sustainable, modern, and effective future. The Working Group's recommendations fall into three major categories:

- Reforms to the payment and delivery system, to move away from the current fee-for-service model which pays for volume towards paying for value and quality. In many cases, these recommendations propose short-term reductions in reimbursements to providers, paired with a structure to move towards more effective and accountable models of care.
- Tools to strengthen the state's ability to root out waste, fraud, and abuse, ensuring that scarce resources are spent where they are needed most.
- Tactical improvements to the efficiency of the state's administration of these programs, ensuring that they operate effectively and leanly.

In her FY2016 budget submission, Governor Gina M. Raimondo proposed \$91 million in state Medicaid savings. Many of the Governor's initial line item proposals are included in this report. The Working Group proposes amendments to others, including reinvesting savings from payment rate reforms to create incentive pools that reward hospitals and nursing homes for providing higher quality and more coordinated care. Lastly, the Working Group identified a series of specific additional proposals that were not included in the Governor's initial budget submission.

These recommendations are presented to the Governor in the hope they are the beginning of a continuing conversation that will move Rhode Island's Medicaid programs into the future, and ensure that Rhode Island remains a leader in providing affordable, quality health care to all of its citizens.

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Introduction

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 does 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.

It is necessary to transform Rhode Island's health care system to one that pays for the outcomes and quality care Rhode Islanders deserve, rather than for the amount of services provided.

Nowhere is this more important than in the publicly funded health care system. The state has a moral and social responsibility as well as an economic imperative to provide its most vulnerable residents with access to quality health care. Medicaid provides an essential safety net and serves one out of four Rhode Islanders. Maintaining a strong Medicaid system is also an economic responsibility 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 state must ensure that Medicaid delivers high quality services, and they must be delivered at the greatest value to state taxpayers. As it is currently designed, Rhode Island's Medicaid model is not sustainable. It relies too heavily on volume-based payment structures and does not include sufficient incentives for the delivery of high value, cost-effective, quality health care. Currently, the majority of health care services funded by Medicaid are still purchased on a fee-for-service basis rather than through value-based payment structures. 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.

Rhode Island faces a serious structural deficit and significant annual fiscal constraints. While Medicaid spending is only one component of the state's structural deficit, and Rhode Island has contained cost growth below the national Medicaid and commercial average for healthcare¹, Medicaid spending still accounts for more than 30 cents of every state revenue dollar² and is the second highest cost per enrollee in the nation.³ Further, Rhode Island's age demographics and the

¹ Executive Office of Health and Human Services, *Rhode Island Annual Medicaid Expenditure Report for FY2013*. July 2014.

² House Fiscal Advisory Staff, *Budget as Enacted Fiscal Year 2015*. p769.

³ Kaiser Family Foundation, *State Health Facts. Medicaid Spending per Enrollee (Full or Partial Benefit)*, FY2011. <http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/>

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system's preference for institutional care result in the state spending 81 cents of every elder and adult-disabled long-term care dollar on nursing home care, 33 percent higher than the national average.⁴

These services represent a major cost to the state, but also a significant opportunity. Medicaid's role as a major health care payer means that innovations in publicly financed health care can help push the entire Rhode Island health care system in the right direction. Further, dollars spent on avoidable procedures and inefficient fee-for-service payment models are dollars that could be better invested in economic development priorities such as education, workforce training and infrastructure.

It is, therefore, of compelling and immediate public importance that the State conducts a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes for people and addresses the critical need to build a healthier Rhode Island.

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 first charge of Executive Order 15-08.

The Medicaid Program

Rhode Island's Medicaid program serves more than 250,000 Rhode Islanders. The Medicaid population includes low-income children and their families, adults with disabilities, elders, and children with special healthcare needs. The number of covered Rhode Islanders has continued to increase, with more than 65,000 added in the last two years alone, largely due to the addition of low-income adults newly eligible under the Affordable Care Act. Many Rhode Islanders rely on Medicaid coverage for essential, life-saving medical care. As the Working Group completed its evaluation, it paid special attention to protecting the state's most vulnerable residents.

The state's Medicaid program is projected to spend \$2,364.9 million in state fiscal year (FY) 2015.⁵ Medicaid is a federal-state partnership: the federal government pays over half of Rhode Island

⁴ S. C. Reinhard, E. Kassner, A. Houser, K. Ujvari, R. Mollica, and L. Hendrickson, *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. AARP, The Commonwealth Fund, and The SCAN Foundation. June 2014

⁵ Caseload Estimating Conference Consensus Estimate, November 2014.

<http://webserver.rilin.state.ri.us/housefinance/or/2014/November%202014%20Caseload%20Estimating%20Conference%20Report.pdf>

Medicaid costs. Still, more than 30 cents of every state dollar are spent supporting the Medicaid program: about \$913.7 million in FY2015.⁶

Rhode Island's average cost per Medicaid enrollee is the second-highest in the nation, behind only Alaska and significantly above many of our neighboring states. The state's eligibility criteria and scope of covered services are in line with neighboring states; it is largely demographics and excess utilization of health services that drive the state's increased costs: For example, approximately 15.5 percent of the state's residents are over 65 years old, including 2.7 percent over 85, compared to 14.1 percent and 1.9 percent nationally.⁷

Against this backdrop, the Working Group focused its attention on the areas of highest spend. In Rhode Island, the most costly seven percent of beneficiaries -- about 12,500 individuals -- are responsible for two-thirds of total spending.⁸ Some of the costs for this group are unavoidable -- these are individuals with very complex medical and behavioral health care needs. Still, it is clear that the existing Medicaid system is failing to support many of these members in a coordinated and cost-effective way. Addressing these institutional failures will most importantly improve the quality and dignity of the beneficiaries' lives, and also reduce costs for Rhode Island taxpayers. For example, the state can achieve both goals by helping an elder who would rather stay home than move to a nursing home but needs occasional assistance, or by providing primary care to a Rhode Islander who is constantly in and out of the emergency room.

The Working Group considered these and many other scenarios in its work.

Building from a Place of Strength

In Rhode Island, we have some very important building blocks already in place as we work to create an improved and more cost effective system:

- Excellent providers who are willing to be our partners in improving the Medicaid system;
- A nationally recognized system of primary care providers who can guide patients through complicated health challenges;
- Broad enrollment in managed care which can support improved coordination;
- Two Medicare accountable care organizations that are already bringing change to Rhode Island's health care system;
- Insurance companies serving Rhode Island's Medicaid population who share our goals of improving quality and affordability; and

⁶ Ibid.

⁷ U.S. Census Bureau, Population Division, *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2013*. June 2014. <http://www.census.gov/topics/population.html>

⁸ Executive Office of Health and Human Services, *Rhode Island Annual Medicaid Expenditure Report for FY2013*. July 2014.

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- Significant expansion in health insurance coverage over the past year, both through Medicaid and private insurance, that lessens the burden on providers of uncompensated care and allows people to receive care in the right place at the right time.

Our challenge is to build on this promising foundation. We have an enormous opportunity to transform our Medicaid funded services, and in doing so achieve our triple aim:

1. Improve the health of those we serve;
2. Improve quality of care; and
3. Lower cost.

Focus on Long Term Sustainability of Entire Health System

In July, the Working Group to Reinvent Medicaid will present a plan to the Governor for long-term transformation of Medicaid funding and services. This report focuses on ways that we can begin to move in the 2016 budget toward a more coordinated system, with enhanced efficiency and improved quality. This is an initial step, and it cannot incorporate all of the necessary long-term strategies for change. However, you will see in the following pages many steps toward a new system of administration and care delivery.

The Working Group has been guided by principles which will lead toward a sustainable and high quality program:

- Coordination of care across providers
- Elimination of waste, fraud and abuse in our system
- Transition away from paying for volume, towards the value of services in improving health
- A focus on meeting the needs of high utilizing, high cost patients in more cost effective ways
- Building transparency into a complex system and into its guiding policies and regulations
- Alignment of Medicaid improvements with our commercial insurers, public employee benefit purchasing and Medicare

We also recognize that using these guiding principles, Medicaid should participate in broader health care reform efforts. Many of these were articulated in a letter addressed to then Governor-elect Raimondo, Speaker Mattiello, and Senate President Paiva Weed in December 2014 by a group of Rhode Island health care leaders.⁹ They urge expansion of new payment models that reward value and patient-focused care, the imposition of a cap on percentage growth in health care cost for the state overall, as currently exists in Massachusetts, development of shared data systems that support collaboration, and an enhanced focus on eliminating waste in our system.

⁹ Letter to Governor-elect Raimondo, Speaker Mattiello, and Senate President Paiva Weed. 23 Dec. 2014. *RI Health Care Leaders Send Reform Recommendations to Raimondo and General Assembly Leaders*. Accessed 27 Apr. 2015. <http://www.whitehouse.senate.gov/news/release/ri-health-care-leaders-send-reform-recommendations-to-raimondo-and-general-assembly-leaders>

Coordination, Accountability and Innovation

The state cannot do this work effectively without examining how we administer our programs. In the Raimondo administration, there is a significant focus on coordination and accountability across government departments that administer Medicaid funded services. The Rhode Island Executive Office of Health and Human Services is assessing its internal policies and processes for effectiveness and efficiency and will be working to assure they are supportive of new approaches. Effective and rigorous contract management is crucial. It is also very important that state government work collaboratively with consumers, those who provide care and our managed care organizations so that we can be successful in meeting patient needs cost effectively.

There has also been a recognition that Rhode Island would benefit from additional resources to meet our goals. The Federal government, through innovative programs at the Center for Medicare and Medicaid Services (CMS), has grant opportunities to support change.

- We recently received \$20 million dollars through a **State Innovation Model** grant. These resources are designed to catalyze change in our payment and delivery system and the SIM implementation will be aligned with transformation in Medicaid, as well as other insurers.
- There is a **Delivery System Reform Incentive Payment Program (DSRIP)** opportunity that can provide funds to hospitals and nursing homes, assisting them in the transition to new payment and care delivery approaches.
- Rhode Island's current **1115 Waiver** also has additional potential to support changing our care delivery, responding to needs in our patients that are often driving high cost and utilization, but cannot be met under our current system.

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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.” Governor Raimondo tasked the group with conducting a comprehensive review of the state’s Medicaid program through detailed study and stakeholder engagement. The group would then offer advice to the governor based upon this analysis.

Working Group Membership

Dennis Keefe (Co-Chair) , Hospital Association of RI	Hugh Hall, West View Nursing Home
Ira Wilson, MD (Co-Chair) , Brown University	Cheryl Johnson, Textron
Peter Andruszkiewicz, Blue Cross Blue Shield of RI	Chuck Jones, Thundermist Health Center
Timothy Babineau, MD, Lifespan	Thomas Kane, AccessPoint RI
Antonio Barajas, MD, Physician	Linda Katz, Economic Progress Institute
Maria Fatima Barros, RN, Nursing Placement, Inc.	John Kelly, Meeting Street
Elizabeth Burke Bryant, RI Kids Count	Dale Klatzker, The Providence Center
Holly Cekala, RICARES	Elizabeth Lange, MD, Physician
The Honorable Louis DiPalma, First Vice Chair, Senate Committee on Finance	Maureen Maigret, RN, Senior Agenda Coalition of Rhode Island
Jon Duffy, Duffy Shanley	Peter Marino, Neighborhood Health Plan of RI
Stephen Farrell, United Healthcare of New England	The Honorable Joshua Miller, Chair, Senate Committee on Health & Human Services
Helena Foulkes, CVS Caremark	Patrick Quinn, SEIU
Diana Franchitto, Home & Hospice Care of RI	Sam Salganik, RI Parent Information Network
John Gregory, Northern RI Chamber	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 four occasions and convened town hall-style meetings across Rhode Island. Approximately 400 Rhode Islanders attended these town hall-style meetings.

Working Group Meeting Dates	Town Hall Meeting Dates
March 2, 2015: Department of Administration, Providence	March 16, 2015: Woonsocket Harris Public Library, Woonsocket
April 6, 2015: Department of Administration, Providence	March 18, 2015: Providence Community Health Center, Providence
April 22, 2015: Community College of Rhode Island, Warwick	March 23, 2015: Peace Dale Public Library, South Kingstown
April 30, 2015: Department of Administration, 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 to which working group members were assigned based on member's 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	
<p>Behavioral Health Work Stream (led by Director Maria Montanaro)</p> <ul style="list-style-type: none"> ● April 1, 2015 ● April 8, 2015 ● April 15, 2015 ● April 22, 2015 ● April 29, 2015 	<p>High Utilizer Work Stream (led by Ira Wilson)</p> <ul style="list-style-type: none"> ● March 30, 2015 ● April 2, 2015 ● April 9, 2015 ● April 16, 2015 ● April 23, 2015 ● April 30, 2015
<p>Delivery System Reform Work Stream (led by Dennis Keefe)</p> <ul style="list-style-type: none"> ● March 31, 2015 ● April 3, 2015 ● April 10, 2015 ● April 14, 2015 ● April 21, 2015 ● April 24, 2015 	<p>Long-Term Care Work Stream (led by Maureen Maignet)</p> <ul style="list-style-type: none"> ● March 31, 2015 ● April 3, 2015 ● April 9, 2015 ● April 16, 2015 ● April 23, 2015

Recommended Initiatives for FY2016

The Governor charged the Working Group to identify significant short-term savings that could be realized in state fiscal year 2016.

From the more than 250 proposals received through the Reinventing Medicaid public process, the Working Group has identified a list of 34 initiatives that achieve feasible savings in FY2016 and align with the overall goals of the process as laid out by the Governor. In total, these initiatives amount to a \$91 million reduction in state spending on Medicaid. (Including the federal share of Medicaid spending, this is in total a reduction of \$148.5 million from the program).

In general, the initiatives proposed below look to reduce cost and improve care by following at least one of the following strategies:

- Move away from fee-for-service payment models towards value-based purchasing arrangements;
- Eliminate unintended and counterproductive incentives that drive members into more expensive settings of care;
- Improve coordination of care across providers and systems;
- Continue Rhode Island's ongoing work to rebalance the long-term care system towards community settings;
- Simplify program rules and administration; and
- Maximize federal funding where possible.

The initiatives are grouped into three overarching themes:

Payment and Delivery System Reforms: initiatives that transform Rhode Island's Medicaid system into one which pays for quality and value, rather than volume, and promotes better quality of care and patient experience.

Targeting Fraud, Waste, and Abuse: initiatives that ensure Medicaid programs operate in compliance with state and federal law and regulation, and root out wasteful, unnecessary, or fraudulent spending and utilization.

Administrative and Operational Efficiencies: initiatives that streamline and improve state oversight of the Medicaid program.

The following sections list each recommended initiative in detail, including the anticipated budget savings in FY2016.

Payment and Delivery System Reform

The Working Group is ultimately concerned with transformational ideas for Medicaid that move Rhode Island from a system which pays for volume to a system which rewards quality and value and promotes patient experience. The initiatives in this section focus on approaches to move Rhode Island in this direction: coordination of care management through new programs and improvements in managed care, and investments in new services (such as home stabilization and addressing chronic inebriation) that reduce costs overall. Each of these initiatives holds not only immediate cost savings, but also the potential to bend the cost curve by moving the state's entire health care system away from fee-for-service care.

The Working Group fully expects reform to be a complicated and time-intensive process. To be successful, payment and delivery system reform must be a multi-payor, multi-provider effort. Mindsets and behavior throughout the state will need to shift towards patient-centered, value-based care.

The Working Group recommends these initiatives as a valuable step towards this goal:

1. Align Medicaid with commercial and federal value-based purchasing targets

The commercial insurance market is moving away from volume-based fee-for-service payments to models where providers are paid based on the value that they offer to the patients for whom they provide care. The U.S. Department of Health and Human Services has also established specific and aggressive targets for transitioning Medicare payments from volume-based to value-based approaches. Medicaid must mirror these trends.

Rhode Island should commit itself to have 30 percent of all Medicaid provider payments in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide, by December 31, 2016. That goal should increase to 50 percent by 2018. These alternative payment models may include accountable care organizations (ACOs), patient-centered medical homes (PCMHs), or bundled payment arrangements.

Additionally, following the federal model, EOHHS should require that 85 percent of fee-for-service payments to providers under Medicaid (whether paid directly by the state or through a managed care organization) have a component tied to quality and value by 2016. This goal should rise to 95 percent by 2018. These may include quality or performance incentive programs, or programs that penalize providers who do not meet quality metrics.

The Working Group recommends these targets be formally adopted in the FY2016 budget to commit the state to this path, but does not recommend that state budget savings be tied to this initiative in the short term.

2. Implement an incentive program to reduce unnecessary hospital utilization, funded by a 5% decrease in hospital payment rates

Under current law, hospitals will receive a rate increase in FY2016. Eliminating the planned rate increase and further reducing hospital rates by 5 percent would generate state savings that can be

invested in programs to reduce unnecessary utilization and improve quality. EOHHS projects savings of \$31.2 million (\$15.7 million in state funds) through this initiative. (Achievement of savings in the managed care products -- Rlte Care, Rhody Health Partners and Rhody Health Options -- will be accomplished through modifications to the capitation rate.)

The \$31 million saved would be re-invested in a hospital incentive program. Hospitals would have the opportunity to earn back a portion of the \$31 million by achieving defined performance goals that reduce unnecessary utilization and avoidable readmissions and improve coordination of care, thereby reducing overall costs. The incentive payments earned would be paid in September 2016, after the end of the state fiscal year, but still within the hospitals' fiscal year 2016. This incentive program will be designed to drive down unnecessary utilization and produce sustainable savings for taxpayers.

This initiative would save **\$31.2 million (\$15.7 million in state funds)**. Additional savings due to decreased utilization are also likely to accrue in FY2016—some of those savings are captured in the savings estimates of other initiatives that would reduce hospital utilization.

3. Implement an incentive program to reduce long stays and improve care quality and staffing in nursing homes

This initiative, which would impact both fee-for-service and managed care services, includes a 3.0% reduction in rates and the elimination of an inflation-related rate increase. Approximately half of the savings are associated with Rhody Health Options and will be achieved through a reduction in capitation rates. Additionally, the nursing home provider assessment will be increased from its current level of 5.5 percent of net patient revenue to the federal maximum of 6.0 percent.

The money saved would be re-invested in two nursing home incentive programs. The first program would measure discharges to the community and re-hospitalizations and offer incentive payments to facilities that achieve high ratings on both scores. The second would base incentive payments on achieving above-average scores on several quality metrics (which might include measures such as the use of anti-psychotic medications, the occurrence of pressure ulcers, energy efficiency, or staffing and retention levels). The payments would be made available in September 2016.¹⁰

Additionally, this initiative would also delay the scheduled October 1, 2015, rate increase to low-cost nursing home rates to FY2017, while EOHHS determines how this increase can be tied to the above-described quality incentives.

This initiative would save **\$26.7 million (\$13.3 million in state funds)**.

¹⁰ A proposal for how these incentives might be structured was presented to the Long Term Care Workstream of the Working Group by a representative of the American Health Care Association. The proposal can be read on the Working Group website, at <http://reinventingmedicaid.ri.gov>.

4. Increase hospital license fee to fund the inpatient and outpatient UPL supplemental payments

Hospitals currently receive supplemental payments based on their Medicaid inpatient and outpatient volume known as Upper Payment Limit (UPL) payments. These payments supplement some of the difference between Medicaid and Medicare hospital rates.

This initiative would fund these supplemental payments through an increase in the license fee paid by hospitals from 5.703 percent to 5.846 percent of net patient revenue. The additional revenue raised by the fee would be used to fund the state share of these payments, which is matched by the federal government.

This initiative would raise **\$11.2 million in state funds**.

5. Pilot a coordinated care program in partnership with a local provider organization

The state should pilot a new coordinated care program. The coordinated care program should rely on an established integrated delivery network including physicians, hospitals, and other providers, in coordination with our Medicaid managed care plans. The partner will be responsible for achieving better patient outcomes, higher patient satisfaction, and cost reduction through effective care coordination and integration.

This initiative would save **\$12.0 million (\$6.0 million in state funds)**.

6. Coordinate care management for those with severe and persistent mental illness (SPMI)

This initiative would create a population-based health home approach for persons living with a serious mental illness. The program will reduce medical, pharmacy and behavioral health expenses for the population by better coordinating their care. All members will be enrolled in an accountable health home, which will coordinate their care based upon their individual needs. Providers will be paid a capitated rate for care coordination and be incentivized for outcome measures and utilization.

This initiative would save **\$6.5 million (\$3.3 million in state funds)**.

7. Targeted programs for Medicaid high-utilizers living in the community

Community health teams (CHT) work as an extension of a primary care office to meet the social and behavioral needs of patients. They are a group of care providers such as social workers, community health workers, nurse managers, and others who can directly address social, behavioral, and environmental factors affecting health and health behaviors. The CHT is modeled after similar highly successful programs in Vermont, Maine, North Carolina, and other states.

The RI Care Transformation Collaborative, an all-payor Medical Home initiative, is currently piloting two community health teams: one in South County and one in Pawtucket. Each community health team works collaboratively with CTC practices in that service area and health plans to identify high-risk patients. A number of other sites, including at least one Federally

Qualified Health Center (FQHC), have developed their own Community Health Team with separate funding.

This initiative would quickly bring the CHT effort to scale and develop an organized, Medicaid-wide approach to CHT implementation. CHTs are provided lists of high-utilizer patients by the managed care organizations (MCOs) and work from this list to pay special attention to those patients and collaborate with the Medical Home to address unmet needs. The result is improved utilization patterns, better health outcomes, and lower costs for some very complicated patients with specialized needs.

Additionally, EOHHS will implement an innovative home and health stabilization program that targets Medicaid beneficiaries who have complex medical or behavioral health conditions and are either homeless, at risk for homelessness or transitioning from high-cost intensive care settings back into the community.

The program focuses on the following Medicaid beneficiaries:

- Medicaid-eligible children and youth with behavioral health needs in the custody of the RI Department of Children, Youth, and Families (DCYF) who are at risk for or transitioning from institutionally based or residential treatment facilities, or congregate care; and the parent(s)/caretaker(s) of these children living in the community.
- Medicaid-eligible adults between the ages of 19 and 64 with serious behavioral health or physical conditions who are homeless or at risk of homelessness subsequent to military service, health treatment, or incarceration.
- Persons with disabilities, elders, and those who are transitioning from institutionally-based care who have a history of homelessness, would otherwise be homeless if not for the nursing home stay, or would benefit from this service upon transition to the community due to length of their stay in the institution.

Together, these initiatives would save **\$6.5 million (\$3.3 million in state funds)**.

8. Expand opportunities to encourage delivery of long term service and supports in the community

In 2006, State policymakers enacted the Medicaid “Long-term Service and Finances Reform Act” (R.I.G.L. §40-8.9-1) which declared, in part: “It is in the interest of all Rhode Islanders to...build a fiscally sound, dynamic long-term care system” that:

- Supports consumer independence and choice; the delivery of high quality, coordinated services; the financial integrity of all participants-purchasers, payers, providers and consumers; and the responsible and efficient allocation of all available public and private resources;
- Assures that rates paid for community-based long-term care services are adequate to ensure high quality as well as supportive of workforce recruitment and retention; and
- Improves consumers’ access to information regarding community-based alternatives to institutional settings of care.

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In the years since the Act became law, Rhode Island has launched multiple initiatives designed to further these and other reform goals including, most notably, the long-term services and supports (LTSS) rebalancing components of the Section 1115 waiver and, more recently, the Integrated Care Initiative (ICI). Although there are service areas where these efforts have achieved some measure of success, Rhode Island Medicaid LTSS beneficiaries continue to be more likely than their counterparts in neighboring states to be receiving services in higher cost institutional settings.¹¹

To make further progress toward rebalancing services to be provided in the community, Rhode Island should:

- Reform Medicaid LTSS eligibility criteria to encourage greater utilization of home and community based services (HCBS) options;
- Adopt payment strategies that expand the available affordable HCBS alternatives and reward healthy outcomes;
- Leverage all available dollars – from all federal, state and private sources – to ensure the fair and responsible financing of Medicaid-funded LTSS.

The criteria for the highest level of need for nursing facility care should be realigned to match the criteria used in Connecticut and Massachusetts. This would require a beneficiary at the highest level to require assistance with a minimum of three of the Activities of Daily Living (ADLs), with extensive assistance, or total dependence required for at least one ADL and some assistance required with the remaining two additional ADLs. In addition, a beneficiary must have one or more unstable medical, behavioral, psychiatric conditions or chronic/re-occurring conditions requiring nursing assessment and assistance on a daily basis.

Making this change will mean that fewer Rhode Islanders will be moving into nursing home settings for care. In narrowing access to nursing home care, the state must expand access to home and community based care as the alternative. It will not be sufficient to narrow access to nursing homes without expanding care options for home and community based services. There is a lower percentage of Medicaid LTSS beneficiaries in assisted living in Rhode Island and fewer licensed assisted living residences participating in Medicaid than in most other states in the region. Rhode Island's current Medicaid payment policies may be a major factor contributing to this trend: not only does the state pay considerably less per diem for assisted living services, but state-funded support that provides beneficiaries with assistance to pay room and board charges has declined significantly over the last 10 years.

To address this imbalance, the state should:

- use the state supplement to SSI – a vehicle already in place – to fund an increase the room and board cap through modifications to the state SSI supplement, and
- adopt an acuity-based payment strategy for assisted living services. The payment amount at each tier is tied to a flat base rate that increases along with additional hours for a range

¹¹ Reinhard, et al.

of other core, covered HCBS services – e.g., skilled nursing, behavioral health care, stabilization services, service coordination, etc.

To further increase the number of HCBS options open to Medicaid beneficiaries, the state should adopt the regulations necessary to license adult supportive housing residences. In 2009, the state enacted a law creating publicly or privately operated “adult supportive care homes” (R.I.G.L. 23-17.24-1) to provide “directly or indirectly, by means of contracts or arrangements” personal assistance, lodging and meals to between two and five adults. The law requires that such homes be licensed as nursing facilities, nursing care providers, assisted living residences or adult day services providers as well as “adult supportive care homes.” EOHHS drafted regulations implementing the law in 2011 that have not been adopted. As a result, EOHHS has not been able to offer LTSS Medicaid beneficiaries access to this unique HCBS alternative to nursing facility care. These regulations should be put in place and this rebalancing initiative fully implemented.

Medicaid-funded adult day health services provide a variety of health, social, and related support services to elders and persons with disabilities. This initiative will institute Medicaid certification standards, tie payment levels to acuity, scope of services, quality and outcomes, and will institute program oversight. (Note that this initiative does not apply to day services for individuals with developmental disabilities.)

Finally, the state should undertake a comprehensive assessment of eligibility criteria and rules that may give residents in nursing homes preferential treatment compared to those living in the community. Following this assessment, which should include a comparison to best practices in other states, the state should adopt new policies that do not financially penalize beneficiaries and their families who choose to remain in the community to receive their long term care services and supports. Furthermore, the state should implement expedited eligibility for long-term services and supports in appropriate situations.

Taken together, these initiatives would save **\$5.9 million (\$3.0 in state funds)**.

9. Improve management and coordination of care for children with special health care needs

In an effort to increase the efficiency of care and coverage for high-utilizing populations, EOHHS will integrate services for children with special health care needs into the continuum of care of the Medicaid Managed Care Organizations (MCOs). Services that have been out of plan for this population and will now be integrated into the MCO scope include Home Based Therapeutic Services (HBTS), Personal Services and Supports (PASS), and Respite care. Through the integration of these and similar services, this initiative will provide flexibility to the MCOs to provide more evidence-based, clinically appropriate, lower-cost services to children and adolescents.

In keeping with the principles of paying for value in the Medicaid delivery system and reducing waste, EOHHS will redesign the Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-Evaluation (CEDARR) Family Center package. This redesign will include a discontinuation of the

Family Care Plan Review, reduce the amount of health needs coordination services, as well as transfer direct service review functions of the CEDARR Family Centers to state staff. All of the recommended changes to the current approach for providing and coordinating services for children with special health care needs are focused on more seamless care coordination, less fragmentation for the children and their families and more efficiency in coordinating these now disparate programs.

This initiative would save **\$4.2 million (\$2.1 million in state funds)**.

10. Move towards bundled payment arrangements for maternity and childbirth, including NICU services

Medicaid payments for maternity services do not comprehensively cover all services related to childbirth leaving some high cost services in the fee-for-service realm. EOHHS will commit to developing a bundled payment for maternity, including pregnancy, birth, and post-partum care. Medicaid should also seek to develop a bundled payment model Neonatal Intensive Care Unit (NICU) services.

This initiative would save **\$3.8 million (\$1.9 million in state funds)**.

11. Refine FQHC incentive programs

This initiative would change the current Federally Qualified Health Center (FQHC) incentive program at Neighborhood Health Plan of Rhode Island to a shared savings model. In so doing, savings would accrue to the State either in the form of reduced utilization by FQHC members, or from reductions in the incentive paid to the FQHC.

This initiative would save **\$3.5 million (\$1.7 million in state funds)**.

12. Identify alternate settings for appropriate Eleanor Slater Hospital residents

Eleanor Slater Hospital is a state-run hospital. This initiative will establish community-based settings with an enhanced Medicaid group home rate to serve high-risk populations that do not require hospital services. These settings may then be used as an Eleanor Slater Hospital (ESH) step-down or diversion program, freeing up beds for patients who have been waiting for admission to ESH for long periods. Currently, there are 16 individuals awaiting admission to psychiatric beds at ESH. All but one of these patients is currently served in an acute care hospital at dramatically higher cost. In addition, there are 13 psychiatric patients in acute care beds at present who are candidates for discharge. However, due to a lack of clinically appropriate community settings, these patients remain in the hospital. Expanding the continuum of care for step down services will permit care to be delivered in the most clinically appropriate and cost effective setting, which is not happening now.

This initiative would save **\$2.0 million (\$1.0 million in state funds)**.

13. Eliminate automatic Graduate Medical Education (GME) funding

In 2014, Rhode Island established a \$1 million state-only pool to support graduate medical education at academic medical centers with level I trauma centers.

This initiative would eliminate that pool of funds and saves **\$1.0 million in state funds**.

14. Fund STOP program for chronic inebriation

This initiative will create a new Sobering Treatment Opportunity Program (STOP) in the upper level of Emmanuel House. The program will be an alternative to emergency room care for alcohol-dependent individuals who are frequent emergency room visitors and will produce immediate, short-term savings through reduced ER visits. More significant and sustainable savings are likely in long-term recovery for beneficiaries who now use the ER and other acute care services for all care in the absence of access to a more appropriate setting for care.

This initiative would save **\$1.0 million (\$0.5 million in state funds)**.

15. Develop a state policy around tele-health services

There are a number of innovative and potentially cost-saving opportunities that arise from the ability for health care providers to interact with and monitor their patients remotely. Medicaid should develop and promulgate a set of policies regarding tele-health and tele-medicine services, including clarifying what services can be provided with Medicaid funds.

Tele-health and tele-medicine services, appropriate implemented within best practice clinical protocols have shown meaningful savings in other states. Rhode Island's cost savings will need to be assessed and monitored as this initiative is brought forward. It is expected that this initiative will yield meaningful savings and better patient care, particularly for mobility-limited patients living in the community, in the FY2017 and FY2018 budget years.

Targeting Waste, Fraud, and Abuse

In addition to providing a quality system of care to some of Rhode Island's most vulnerable people, one of the highest priorities for the Executive Office of Health and Human Services is to be a responsible steward of public funds that support that mission. While the vast majority of Medicaid beneficiaries and health care providers are responsible users and providers of health care services, the state has an obligation to detect, root out, and prevent fraud, waste, and abuse that divert scarce resources from those who need them most.

These initiatives are designed to give the Office of Program Integrity within the Executive Office of Health and Human Services (EOHHS) the tools necessary to identifying and remedy vulnerabilities within the Medicaid financial oversight system and make Rhode Island a national leader in the use of claims analytics for verification of fee for service and managed care payments. The use of sophisticated predictive modeling will ensure timely identification of questionable medical claims. Electronic visit verification will ensure that home care services are delivered in a manner that allows the state to verify the time, place and manner of care delivery.

The working group recommends these initiatives as a valuable step towards this goal.

16. Improve claims analytics and tracking systems to catch waste, fraud, and abuse earlier

The state should develop predictive analytic capabilities to track and verify claims prospectively, working in concert with existing retrospective verifications. In particular, the recommended approach would examine claim errors and inconsistencies with provider payment reimbursement policies across claims processing and all related systems. Where the analytical tools detect a meaningful variance from the expected and predictable claims closer monitoring and verification can prospectively prevent the payment of unjustified or fraudulent claims.

In addition, this initiative would implement Electronic Visit Verification (EVV) to track personal care visits. EVV is a technological approach to verify visits at the point of care. Enhancing verification will crack down on abuse and ensure the state does not pay for services that are not actually delivered. Technology assisted verification systems are available which will enable payments to be verified at the point of service with little or no additional effort on the part of either the patient or the provider of care.

Taken together, this initiative would save **\$5.2 million (\$2.6 million in state funds)**.

17. Improve the timeliness and quality of communication with Medicare

This initiative would improve communication between Rhode Island Medicaid and Medicare to ensure that beneficiaries who are eligible for both Medicaid and Medicare coverage access Medicare coverage when available. For certain populations, the federal government pays some of the costs of healthcare through Medicare, but the state is still responsible for identifying and appropriately billing Medicare. Having the federal government reliably in the role of first payor through Medicare will generate significant savings in the partially state funded Medicaid program.

This initiative would save **\$2.0 million (\$1.0 million in state funds)**.

18. Enhance eligibility determinations

The Working Group recommends two initiatives to enhance eligibility determinations.

First, the state should explore the feasibility of contracting with an additional vendor for eligibility screening in order to reduce fraud. This enhanced verification is likely to lead to future year savings, though no savings are expected in FY2016. The Office of Program Integrity should issue a Request for Information (RFI) in the summer of 2016 to determine what additional verifications could be added to our existing application processes, and, based on the responses to the RFI, seek to contract with a vendor to add these verifications.

Second, the state should enhance existing residency verification processes. The state will expand verification to the full extent allowed under federal law by increasing the frequency and thoroughness of residency checks, including identifying members with significant numbers of out-of-state claims for medical services.

Residency verification would save **\$0.6 million (\$0.3 million in state funds)**.

19. Empower the Office of Program Integrity to issue subpoenas to support its investigations

Time is of the essence when dealing with financial documents and records, and providers are sometimes reluctant to provide timely documents. In a recent investigation which the EOHHS Office of Program Integrity referred to criminal prosecutors, the state was able to recover Medicaid money, but the amount would have been larger if the state could have subpoenaed more records and received those records in a timely manner in the course of the investigation. Granting subpoena power to the Office of Program Integrity will enhance the office's ability to recover funds paid for fraudulently and improperly billed claims.

This initiative would save **\$0.3 million (\$0.1 million in state funds)**.

Administrative and Operational Efficiency

The administrative and operational efficiency proposals focus on streamlining operations in the Executive Office of Health and Human Services and its managed care partners. These proposals also seek to align Rhode Island's policies with neighboring states. Specific initiatives include simplifying complex programs which suffer from fragmented administration at the state level, ensuring Medicaid gets the best price on purchases, working more effectively with federal partners, and closing loopholes in Medicaid regulations.

20. Improve the efficiency of managed care contracts

The majority of Medicaid beneficiaries receive health coverage through a managed care delivery system (such as RIte Care, Rhody Health Partners, or Rhody Health Options). This initiative would align risk-based managed care contracts with the core guiding principles for Reinventing Medicaid. Contracts will promote arrangements with providers that focus on paying for value, coordinate health care delivery across providers with a focus on high utilizers, work to align with other payors, and achieve further efficiencies in core administrative operations.

To better align Medicaid payment and purchasing strategies with other payors, the state should modify the risk/gain-share arrangement with the managed care payors to require the payors to take responsibility for more risk. This key change will bring Rhode Island's Medicaid MCO payment strategy in line with the successful policies in place in neighboring states.

Finally, the initiative also proposes reducing MCO administrative fees. The state pays managed care providers both a medical fee and an administrative fee. With the Affordable Care Act's expansion of Medicaid, the MCOs cover significantly more patients than in the past and thus collect more premiums. The administrative fee should be reduced in recognition of the MCO's newly achieved economies of scale created by the expansion of insurance coverage overall.

Together, these initiatives would save **\$12.1 million (\$6.1 million in state funds)**.

21. Increase Children's Health Account attachment point

This proposal will increase the amount raised by the Children's Health Account each year by increasing the cap from \$7,500 per child per service per year to \$15,000. The Children's Health Account is an assessment that the state levies on commercial health insurance carriers in Rhode Island. The assessment is designed to fund services provided to children who are covered by commercial insurance but are Medicaid eligible and require services that are not typically offered by commercial insurance. Because these children are already covered by commercial insurers the fund is created to acknowledge that, were it not for Medicaid, the commercial insurers would otherwise become potentially liable to pay for this care. The fund has existed as a public/private partnership for many years and this initiative expands the existing program.

This initiative will **raise \$5.5 million in state funds**.

22. Convert RICLAS homes to private sector operation

This initiative will convert the publicly-operated Rhode Island Community Living and Supports (RICLAS) group homes for individuals with developmental disabilities to privately run facilities as of January 1, 2016. This initiative will enable the transition of publicly operated group homes for individuals with developmental disabilities by migrating the existing homes to private sector operation so that the residents will not be disrupted. The partial reinvestment of funds now spent of public employee overtime will enable an upgrade to the compensation of private sector group home staff while still resulting in more cost effective operation of the group homes overall.

This initiative would save **\$4.0 million (\$2.0 million in state funds)**.

23. Streamline the Medicaid eligibility criteria

There are several methods a Medicaid applicant can use to qualify for services. This initiative focuses on streamlining the application process and maximizing access to federal funds for Medicaid coverage of Rhode Islanders. The state should prioritize the newly eligible for Medicaid adult expansion group for appropriate new applicants to avoid complicated age-, disability-, and asset-related criteria.

Some applicants qualify for Medicaid through the “medically needy” category, who become eligible due to their high medical expenses. Due to the current structure of this category, members fluctuate on and off the program every six months. Aside from the administrative burden and cost this creates, the current setup also makes effective care coordination impossible. The state should redesign this program to better serve the medically needy population. This initiative would produce modest immediate budget savings and more significant, sustainable savings in future years.

Together, these initiatives would save **\$1.5 million in state funds**.

Additionally, the state should evaluate its criteria for determining whether individuals qualify for Medicaid on the basis of a developmental disability, and whether those criteria differ materially from those of our New England peers.

24. Align hospital and community-based laboratory rates

The fee schedule for laboratory tests performed by a hospital is significantly higher than the community-based laboratory fee schedule. This initiative would align the payment rates for outpatient laboratory tests for community and hospital-based laboratories.

This initiative would save **\$2.4 million (\$1.2 million in state funds)**.

25. Operational efficiencies and administrative simplification

EOHHS will look for opportunities to streamline, consolidate, and simplify internal operations for Medicaid-funded programs across all agencies within the Secretariat. Many of these programs are fragmented in their administration due to a history of having been handled historically in various agencies and offices. When the Secretariat was created these disparate points of entry to

programs were not always rationalized, leaving the administration of some programs scattered across the EOHHS agencies. A good example is eligibility determinations and authorizations for services for long term services and supports which are being handled in multiple state agencies and offices, mostly due to historical anomalies. The time is right to rationalize program administration and designate a single point of eligibility determination and service authorization, along with a single point of accountability and a single set of program standards.

This initiative would save **\$2.3 million (\$1.1 million in state funds)**.

26. Evaluate and reform long-term care financial eligibility criteria and estate recovery policies

The state has established financial criteria for eligibility for Long-Term Services and Supports (LTSS) coverage under Medicaid. There are gaps in the current criteria which allow some applicants and their families to shelter assets in ways that have been eliminated in many other states. The state should review the estate planning limitations currently in state statute to bring rules in line with neighboring states and close loopholes that currently permit people with significant financial resources to transfer and shelter assets while accessing what should be a safety net program for those most in financial need.

This initiative is expected to save **\$2.0 million (\$1.0 million in state funds)**.

27. Align commercial insurance mandates with requirements of the Affordable Care Act

While the Affordable Care Act ended dollar limits on health benefits, however Rhode Island still allows private payors to limit early intervention and autism services to a maximum dollar value, with the state filling the gap and paying the rest. Under the current state system early intervention services carry a maximum limit of \$5,000 per child per year for the commercial insurers while autism services, specifically applied behavior analysis, are capped at \$32,000 per child per year for commercial insurers. This initiative will eliminate the maximum insurer cost ceiling on these services and the cost shift from commercial insurance to publicly funded Medicaid., consistent with the new patient protections in the Affordable Care Act. Commercial insurers will now pay for medically necessary services in the amount and duration that the child requires consistent with the requirements of parity laws and the Affordable Care Act prohibition on service caps.

The initiative would save **\$2.0 million (\$1.0 million in state funds)**.

28. Modify federally-qualified health center reporting to maximize CHIP revenue

Historically, the state has been unable to claim federal revenue for care provided to Children's Health Insurance Program (CHIP) beneficiaries delivered at federally-qualified health centers because specific member-level information was not available to bill for the federal payment. With enhancements to the submissions filed by each health center, the state will be able to identify which services are eligible for additional federal revenue.

This initiative would save **\$0.8 million in state funds**.

29. Improve the administration of home- and community-based services

This initiative would simplify the administration of Connect Care Choice Community Partners (4CP) and the Personal Choice Program. For 4CP, the state currently pays 17 separate primary care practices a monthly fee for enhanced care coordination. Instead, the state should move to a managed care model. The Personal Choice Program is a participant-directed program designed to provide in-home services and supports to adults with disabilities and elders. The state should move to an hourly case management rate from the current flat monthly rate.

In addition, the state should move to enhanced verification and automated collection of patient co-pays for these services. The state should also ensure agency-wide consistency in payment rates and eligibility determination for certain high-cost services (e.g., home care and residential services).

Together, these initiatives would save **\$1.4 million (\$0.7 million in state funds)**, with additional savings projected in future years.

30. Ensure Medicaid purchases “best price” drugs

The state should analyze the financial impact of carving pharmacy out of the managed care organizations by requiring a single pharmacy preferred drug list. A single list should allow the state to obtain the best price for its pharmacy purchases through supplemental rebates.

This initiative would save **\$1.0 million (\$0.5 million in state funds)**.

31. Ensure that hospice care is being provided appropriately and coordinated with other long-term services and supports

Hospice care in the Long Term Care environment is a benefit for all dually eligible residents. However, there is significant variation among and between the hospice providers in Rhode Island as it relates to the interpretation of hospice guidelines, particularly associated with hospice eligibility. EOHHS should encourage hospice providers to meet hospice eligibility guidelines, as evidenced by length of stay and live discharge rates. Additionally, professional palliative care services should be afforded to long-term care residents in need of pain/symptom management and/or goals of care discussions for those residents who are otherwise not eligible for hospice services.

This initiative would save **\$1.0 million (\$0.5 million in state funds)**.

32. Coordinate care for veterans

There are a significant number of veterans in Rhode Island who are eligible for VA Health Care. By formally recognizing VA Health Care (VAHC) as third-party coverage, care can be delivered through the VA where appropriate just as is done with other third-party insurance coverage now. The state should also continue to ensure that financial eligibility criteria for long-term care are aligned with VA policy. The state must continue to offer Medicaid coverage to eligible veterans who, for whatever reason, are unable to access to the services they need through the VAHC

system but better program administration will improve both the efficiency and the patient experience for veterans who have coverage in both programs.

This initiative would save **\$0.9 million (\$0.5 million in state funds)**.

33. Closure of two group homes

The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals will consider closing two group homes and transferring residents into other nearby homes. The state will be able to maintain more efficient staffing and reduce overall overtime. Additionally, the state will receive one-time income from the sale of the group home real estate.

This initiative would save **\$0.9 million (\$0.4 million in state funds)**.

34. Consolidate some services at Eleanor Slater Hospital

The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals should rigorously examine the benefits of consolidating and potentially privatizing services at the Eleanor Slater Hospital. This initiative will look at food and laundry consolidation (potentially with the Department of Corrections) and other potential efficiencies to achieve savings.

Together, this initiative would save **\$0.6 million (\$0.3 million in state funds)**.

Conclusions and Recommendations

In order to truly transform Rhode Island's Medicaid system, the state must have the fiscal foundation to make sustainable reforms. In many ways, this document should be seen as the starting point for transformative Medicaid reform. Our group offers these budget recommendations with an eye toward the future, fully aware that these proposals by themselves do not offer a transformative approach. It is, however, an essential and ambitious first step toward innovative, transformative change that, if we are successful, other states will seek to replicate.

These proposals, taken together, are a first step in the direction of a better, more sustainable Medicaid program. And they are essential to closing the state's \$190 million structural deficit, which is a barrier both to sustainable health care reform and the state's overall economic recovery.

The Reinventing Medicaid process has brought an unprecedented degree of openness, transparency, and reflection to Rhode Island's Medicaid budget and programs. Through the four public town-hall meetings, the members of the Working Group were able to hear firsthand what issues are most important to the Rhode Islanders who benefit from the Medicaid program, the health care professionals who provide services and the taxpayers who pay for the program. The providers, advocates, and stakeholders who participated in the Working Group's public sessions and work stream meetings have all benefited from the direct and candid exchange of data, ideas, and challenges.

Identifying a set of short-term savings of the magnitude contained in these recommendations was not an easy task. Not every member of the Working Group agrees with every initiative on this list: some of these recommendations represent painful cuts and difficult compromises. In putting forward this set of recommendations, we recognize the imperative to balance the state's immediate need for budget relief with the long-term system transformation that is required. Further, we are united by a belief and understanding that transformative change is never easy and that tough choices are necessary to lay a strong foundation for any kind of sustainable reform. We also share a belief that the state's current Medicaid model can be improved.

In proposing these initiatives for the FY16 budget, the Working Group includes the following recommendations:

1. Focus on reforms that push the healthcare delivery system in the direction of value-based purchasing and coordination of care, particularly between physical and behavioral health.
2. Invest in the resources, data, and tools necessary to measure the success of these and other initiatives.
3. Continue the effort to rebalance the long-term care system towards community settings, reserving institutional care for those who truly need it and cannot benefit from more community based alternatives.
4. Simplify program rules and administration, and eliminate regulations and oversight that impede innovation and experimentation.

Initial Report of the Working Group to Reinvent Medicaid

Above all, we urge Governor Raimondo and Secretary Roberts to continue the conversation that this undertaking has started. The diverse group of stakeholders who have gathered through this process represent a wealth of expertise and perspectives and they must remain engaged with the difficult task of implementing these reforms.

The changes to the Medicaid program that begin with the FY2016 budget will set the stage for a more successful and sustainable health care system for all of Rhode Island. During the coming months, the Working Group will develop a longer term strategy for reform, which we will present to the Governor in July. This vision will be for Medicaid services that meet the needs of our enrollees, many of them Rhode Island's most vulnerable residents, in a high quality and sustainable way. It will also be for a healthier state overall with Medicaid playing its important role as a major payer for services. The success of this effort over the coming years is crucial to the long-term health of Rhode Island's population and its economy.

Because of the Governor's personal engagement in this process and input from every imaginable stakeholder, Rhode Island is well positioned to be among the vanguard of states leading Medicaid reform to provide better care and better value for patients and taxpayers alike.

Table of proposed initiatives

Initiative	Total savings	State funds savings
Payment and Delivery System Reform		
1. Align Medicaid with commercial and federal value-based purchasing targets	<i>Future years</i>	<i>Future years</i>
2. Implement an incentive program to reduce unnecessary hospital utilization, funded by a 5% decrease in hospital payment rates	\$31.2M	\$15.7M
3. Implement an incentive program to reduce long stays and improve care quality and staffing in nursing homes	\$26.7M	\$13.3M
4. Increase hospital license fee to fund the inpatient and outpatient UPL supplemental payments	<i>State only</i>	\$11.2M
5. Pilot a coordinated care program in partnership with a local provider organization	\$12.0M	\$6.0M
6. Coordinate care management for those with severe and persistent mental illness (SPMI)	\$6.5M	\$3.3M
7. Targeted programs for Medicaid high-utilizers living in the community	\$6.5M	\$3.3M
8. Expand opportunities to encourage delivery of long term service and supports in the community	\$5.9M	\$3.0M
9. Improve management and coordination of care for children with special health care needs	\$4.2M	\$2.1M
10. Move towards bundled payment arrangements for maternity and childbirth, including NICU services	\$3.8M	\$1.9M
11. Refine FQHC incentive programs	\$3.5M	\$1.7M
12. Identify alternate settings for appropriate Eleanor Slater Hospital residents	\$2.0M	\$1.0M
13. Eliminate automatic Graduate Medical Education (GME) funding	\$1.0M	\$1.0M
14. Fund STOP program for chronic inebriation	\$1.0M	\$0.5M
15. Develop a state policy around tele-health services	<i>Future years</i>	<i>Future years</i>
SUBTOTAL: Payment and Delivery System Reform	\$104.3M	\$64.0M
Targeting Waste, Fraud, and Abuse		
16. Improve claims analytics and tracking systems to catch waste, fraud, and abuse earlier	\$5.2M	\$2.6M
17. Improve the timeliness and quality of communication with Medicare	\$2.0M	\$1.0M

Initial Report of the Working Group to Reinvent Medicaid

Initiative	Total savings	State funds savings
18. Enhance eligibility determinations	\$0.6M	\$0.3M
19. Empower the Office of Program Integrity to issue subpoenas to support its investigations	\$0.3M	\$0.1M
SUBTOTAL: Targeting Waste, Fraud, and Abuse	\$8.0M	\$4.0M
Administrative and Operational Efficiency		
20. Improve the efficiency of managed care contracts	\$12.1M	\$6.1M
21. Increase Children’s Health Account attachment point	<i>State only</i>	\$5.5M
22. Convert RICLAS homes to private sector operation	\$4.0M	\$2.0M
23. Streamline the Medicaid eligibility criteria	<i>State only</i>	\$1.5M
24. Align hospital and community-based laboratory rates	\$2.4M	\$1.2M
25. Operational efficiencies and administrative simplification	\$2.3M	\$1.1M
26. Evaluate and reform long-term care financial eligibility criteria and estate recovery policies	\$2.0M	\$1.0M
27. Align commercial insurance mandates with requirements of the Affordable Care Act	\$2.0M	\$1.0M
28. Modify federally-qualified health center reporting to maximize CHIP revenue	<i>State only</i>	\$0.8M
29. Improve the administration of home- and community-based services	\$1.4M	\$0.7M
30. Ensure Medicaid purchases “best price” drugs	\$1.0M	\$0.5M
31. Ensure that hospice care is being provided appropriately and coordinated with other long-term services and supports	\$1.0M	\$0.5M
32. Coordinate care for veterans	\$0.9M	\$0.5M
33. Closure of two group homes	\$0.9M	\$0.4M
34. Consolidate some services at Eleanor Slater Hospital	\$0.6M	\$0.3M
SUBTOTAL: Administrative and Operational Efficiency	\$36.1M	\$23.1M
TOTAL	\$148.5M	\$91.1M

Glossary

Activity of daily living (ADL): A routine activity typically performed without assistance. Examples include grooming, dressing, oral hygiene, transfer, eating, toileting, etc.

Community health teams (CHT): A team of health care professionals working with a patient to assess and guide the individual towards care in the medical, behavioral or socio-economic resources in the community and foster an environment that increases likely achievement of good health outcomes.

Comprehensive evaluation, diagnosis, assessment, referral, re-evaluation (CEDARR) program: A set of programs that provides information about services available for children enrolled in Medicaid who have disabilities or special needs. The program offers assessment and development of the individualized treatment plan; case management and coordination with the child's primary care provider; and direct services (home-based therapeutic services, KidsConnect Program, Personal Assistance Services and Supports, Respite Program).

Connect Care Choice Community Partners (4CP): A primary care case management program for adults with Medicaid coverage who have a disability or chronic condition. The program is based on a designated group of primary care practices which provide improved access to preventive and primary care with emphasis placed on teaching self-management skills and care management through nurse care managers and physicians.

Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH): A department under the Executive Office of Health and Human Services umbrella, BHDDH works to ensure access to quality services and supports for Rhode Islanders with developmental disabilities, mental health and substance abuse issues, and other chronic long-term medical and psychiatric conditions. The department's mission includes addressing the stigma attached to these disabilities as well as planning for the development of new services and prevention activities.

Department of Children, Youth, and Families (DCYF): A department under the Executive Office of Health and Human Services umbrella, DCYF works to assist families with their primary responsibility to raise their children to become productive members of society. The department works to fulfill its obligations to promote, safeguard and protect the overall well-being of culturally diverse children, youth and families and the communities in which they live.

Department of Health (DOH): A department under the Executive Office of Health and Human Services umbrella, DOH has as its primary mission to prevent disease and protect and promote the health and safety of the people of Rhode Island.

Department of Human Services (DHS): A department under the Executive Office of Health and Human Services umbrella, DHS works hand-in-hand with other resources in Rhode Island to offer a full continuum of services for families, adults, children, elders, individuals with disabilities and veterans. The department seeks to ensure families are strong, productive, healthy and

independent; adults and children are healthy and may reach their maximum potential; elders and individuals with disabilities receive a full continuum of services to enhance their quality of life; and veterans are cared for and honored.

Eleanor Slater Hospital: Eleanor Slater is a state hospital which provides intensive care to patients with long-term illnesses who are not in an acute phase, but require comprehensive long-term rehabilitative care. These patients typically have chronic disease which has left them with residual disability and require ongoing clinical intervention. The hospital also provides acute care services for its patients who develop an acute medical event and require close medical supervision.

Electronic Visit Verification (EVV): A telephone- and computer-based timekeeping system which electronically verifies when and where services are provided to clients, using telecommunications to record the time each service begins and ends.

Executive Office of Health and Human Services (EOHHS): Under state law, EOHHS serves as the principal agency of the executive branch of state government responsible for managing the departments of Health (DOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). EOHHS's mission is to assure access to high quality and cost effective services that foster the health, safety and independence of all Rhode Islanders.

Federally-qualified health center (FQHC): Organizations which receive federal grants under Section 330 of the Public Health Service Act (PHS), FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, among other benefits. FQHCs serve underserved areas or populations, offer a sliding fee scale, provide comprehensive services, and have an ongoing quality assurance program.

Home and community based services (HCBS): Services which allow individuals in need of long-term support to live safely at home or in the community. Services may include homemaker services, personal care/home health aides, personal emergency response systems, minor assistive devices, home modifications, case management, and assisted living. Services can be accessed at home, in an assisted living residence, or in a shared living arrangement

Integrated Care Initiative (ICI): A program to address the long-standing coordination barrier between Medicaid and Medicare, the ICI is being rolled out in two phases. Phase I began in November 2013 and involves a greater focus on care integration between Medicaid services. In Phase II, both Medicaid and Medicare services will be delivered by a single capitated health plan. The goals of the ICI are to improve the health and quality of beneficiaries' lives through person-centered and integrated care which is coordinated across medical, behavioral, long-term and psychosocial supports. In particular the ICI attempts to better attend to transitions of care from the hospital or nursing home back to the community.

Long-term services and supports (LTSS): Medicaid covers long term services and supports (e.g., nursing home care, home and community based services) tailored to meet the needs of people with chronic illnesses or disabilities who are unable to care for themselves for long periods of time.

Managed care organization (MCO): Any health plan, health maintenance organization, managed care plan, or other person or entity that enters into a contract with the state under which it is granted the authority to arrange for the provision of, and/or payment for, health care supports and services to eligible beneficiaries under the authority of the managed care contracts.

Office of Program Integrity: An office within EOHHS which ensures compliance, efficiency, and accountability within the health and human services programs administered by the State of Rhode Island by detecting and preventing fraud, waste, and program abuse and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws

Personal Choice Program (PCP): A participant-directed program designed to provide in-home services and supports to adults with disabilities and elders utilizing a “cash and counseling” model. The “cash” portion of the model consists of cash allowances made available to each participant to purchase and manage his/her personal assistance services. The “counseling” portion includes services provided to participants to help make informed decisions that work best for them, are consistent with their needs, and reflect their individual circumstances.

Personal services and supports (PASS): The PASS program assists children with disabilities and special needs and their families with daily life skills. PASS focuses on improving a child’s safety skills as well as the ability to accomplish the activities of daily life and participate in social situations. Services are provided in the child’s home or community setting by a direct support worker. Families may choose who is hired to work with their child and how PASS is delivered.

Rhode Island Community Living and Supports (RICLAS): RICLAS is licensed by the State of Rhode Island as a provider of services and regulated by the Office of Facilities and Program Standards and Licensure within the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, RICLAS supports adult men and women in a variety of homes, apartments, and day support services throughout the state.

Serious and persistent mental illness (SPMI): Mental illnesses with complex symptoms that require ongoing treatment and management, most often varying types and dosages of medication and therapy.

Executive Order 15-08**State of Rhode Island and Providence Plantations****Gina M. Raimondo****Governor****EXECUTIVE ORDER****15-08****February 26, 2015****ESTABLISHING THE WORKING GROUP TO REINVENT MEDICAID**

WHEREAS, Rhode Islanders have access to some of the finest healthcare services in the world, but the healthcare they receive is often uncoordinated and fragmented; and

WHEREAS, Rhode Island's Medicaid payment system often creates financial disincentives for the delivery of high value, cost-effective, quality healthcare; and

WHEREAS, the majority of healthcare services funded by Rhode Island Medicaid are still purchased on a fee-for-service basis rather than purchased based on patient health outcomes and pay-for-performance; and

WHEREAS, it is necessary to transform Rhode Island's healthcare system to one that pays for the outcomes and quality care Rhode Islanders deserve, rather than for the amount of services provided; and

WHEREAS, Rhode Island Medicaid per-enrollee costs are consistently among the highest in the nation; and

WHEREAS, Medicaid costs comprise approximately one third of the State's budget; and

WHEREAS, Rhode Island faces a serious structural deficit and significant annual fiscal constraints; and

WHEREAS, it is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes for people and addresses the critical need to build a healthier Rhode Island; and

WHEREAS, it is essential to rebuild Rhode Island's economy and, to do so, the business climate must be improved in part by establishing Rhode Island as a national leader in maintaining a healthy, skilled workforce, and by ensuring access to high quality healthcare at sustainable, predictable, and affordable cost; and

NOW, THEREFORE, I, GINA M. RAIMONDO, by virtue of the authority vested in me as Governor of the State of Rhode Island and Providence Plantations, do hereby order as follows:

A. Working Group to Reinvent Medicaid

Initial Report of the Working Group to Reinvent Medicaid

1. There is hereby established the Working Group to Reinvent Medicaid (“Working Group”) that shall exist for the purpose of advising the Governor.
2. The members and chairs of the Working Group shall be appointed by the Governor, shall serve at the pleasure of the Governor and shall include stakeholders with expertise in areas such as:
 - a. Healthcare delivery;
 - b. Healthcare insurance;
 - c. Healthcare workforce;
 - d. Healthcare policy;
 - e. Economics;
 - f. Business;
 - g. Consumer rights; and
 - h. Other relevant areas.
3. The Working Group shall engage and solicit input from a broad and diverse range of groups, organizations and individuals.

B. Cooperation with the Working Group

1. All departments, offices, boards and agencies of the State shall provide assistance and cooperation to the Working Group, including use of State facilities, which may be necessary to fulfill the purposes of this Executive Order.
2. All agencies of the State shall provide staff support necessary for the Working Group.

C. Duties and Purpose

1. The Working Group shall engage Medicaid stakeholders to conduct a comprehensive review of the Medicaid program and to make recommendations for short and long-term plans to transform Medicaid.
2. The Working Group shall recommend specific quality improvement and cost saving measures for redesigning Medicaid to meet the specific system transformation goals and cost savings for Medicaid spending to be set forth in the Governor’s Fiscal Year 2016 budget.
3. The Working Group’s review and recommendations shall address matters including, but not limited to:
 - a. existing programs in Rhode Island and across the country that have resulted in Medicaid savings and improved quality;
 - b. existing programs in Rhode Island that consume a disproportionate share of Medicaid dollars;
 - c. opportunities in the federal Patient Protection and Affordable Care Act to strengthen both the fiscal and care delivery models of Rhode Island’s Medicaid program;

- d. the utilization of Medicaid services by overall volume, site of service, and beneficiary group;
- e. new models of healthcare delivery to improve care management for beneficiaries with complex health conditions;
- f. existing regulations that are outdated, redundant, or hinder the modernization of the Medicaid program;
- g. potential cooperative efforts with the federal government to improve coverage, cost, and quality within the Medicaid program;
- h. the possible restructuring of Medicaid to achieve short-term solutions and long-term systemic changes; and
- i. recommendations for a plan for a multi-year transformation of the Medicaid program and all State publicly financed healthcare in Rhode Island.

4. The Working Group’s meetings shall be public meetings and shall be held in various locations throughout Rhode Island. Members of the Working Group may be assigned to specific committees, consistent with their areas of expertise and interest.
5. The Working Group shall provide parameters and mechanisms for the submission of proposals and recommendations by stakeholders and other interested parties. Such proposals shall be evaluated to determine if they can be feasibly implemented and, if so, the savings that may be realized from each proposal and recommendation.
6. The Working Group shall begin its work immediately. On or about April 30, 2015, the Working Group shall submit its report to the Governor of its findings and recommendations for consideration in the Fiscal Year 2016 budget.
7. The Working Group shall also submit recommendations for a plan for a multi-year transformation of the Medicaid program and all State publicly financed healthcare in Rhode Island. The Working Group shall submit these recommendations no later than July 1, 2015, at which time it shall terminate its work and be relieved of all responsibilities and duties pursuant to this Executive Order.

This Order shall take effect immediately.

So Ordered:

Gina M. Raimondo

Dated:

Public Comments on the Report

Written Comments

At the April 30, 2015, meeting of the Working Group, members of the group and of the public were invited to submit written comments on the draft report, for inclusion in the final version. Those comments received by the deadline are included below:

Sam Salganik, Rhode Island Parent Information Network

I write with respect to the recent CharterCARE global capitation proposal, a version of which appeared in the draft Working Group report circulated yesterday. Any reform proposal with potential to lower costs and improve quality by incentivizing better care coordination deserves careful attention. But this plan, which places medical providers at full financial risk for the cost of care, raises a host of important questions.

Dennis Keefe described the situation aptly at a recent Working Group meeting: The more that provider groups take on financial risks, the more that they start to look like insurance companies. For the insurance companies operating within the Medicaid program, we have spent decades carefully planning, crafting strong rules, and developing institutional capacity within the State and the MCOs to protect consumers and ensure a focus on quality. The results of that work include network adequacy and access standards, financial solvency oversight, appeal rights when services are denied, and meaningful quality targets. The April 20, 2015 memorandum from Kids Count to the Working Group attests to some of the impressive successes of our State's RIte Care program. When the risk-bearing entity is a provider group, however, little comparable planning work has yet been done, and little institutional capacity yet exists.

Questions

This proposal raises a number of important questions. For example:

- What standards will be established to ensure that the contracted provider has sufficient capacity to handle the patient population? Who will be responsible for monitoring and enforcement?
- What access standards will be put in place, for example timeliness standards for appointments with specialists? Who will be responsible for monitoring and enforcement?
- How will enrollees be informed about the program and how it works? Would it be an opt-in program? If not, what opt-out rights would be in place?
- What will happen when a patient suspects that a provider is withholding appropriate care for financial reasons? In the MCO context, patients can access to well-defined a set of appeal rights that may not map easily onto this new landscape.
- How will the State ensure that the contracted provider has sufficient financial reserves to handle the new risks assumed?

- The proposal calls for patients to be able to access services outside of the "core network," but will that option be a reality when referrals from the core network PCP are required?
- If the providers outside the core network are paid the lesser of the MCO rates and Medicaid rates, as described in the CharterCARE proposal, will that payment be adequate to secure access to these services? This question carries particular importance in specialties, such as behavioral health, where we know that the Medicaid fee-for-service rates are inadequate to attract a sufficient network of providers.
- Does the core provider network have the capacity and experience to manage patients with complex medical conditions and disabilities?
- What quality, outcome, and patient satisfaction measures will be used, and through what process will the State define and report on those measures?

These are just a few of the important questions left open by the proposal. Without answers, it is hard to judge whether the plan will save money through better coordination, as promised, or merely through limiting access to needed care.

Recommendations

Clearly more details are needed before making formal recommendations, but we already know enough to outline some of what would be required to make such a proposal work:

- The State needs adequate legal authority and resources to monitor:
 - the adequacy of the core network,
 - access to care (both within and outside of the core network),
 - financial capacity of the contracted provider; and
 - the general market conduct of the contracted provider.
- The State should engage in a public process to define meaningful quality, access, and satisfaction metrics, for which the contracted provider should be held accountable.
- Enrollment in the pilot program should be opt-in. If the provider is indeed providing better, more coordinated care, then it should be easy to sell to enrollees. If enrollment is not opt-in, then enrollees need opt-out rights, exercisable at any time.
- Patients should have the right to a second medical opinion, from a non-core network provider, when they believe the core network provider is inappropriately withholding care or steering referrals. This second opinion should trump, subject to MCO utilization review.
- The State should gather public input and carefully consider what populations of Medicaid enrollees might not be well-suited for the program. Those populations should be excluded.
- The State should consider risk- and gain-sharing, at least in the early years of the program, to gather data and reduce financial risk.
- The State should create and fund an ombuds program to inform enrollees of their rights; to assist those who wish to opt-out, need to seek a second medical opinion, or have other complaints about the contracted provider; and to provide an organized feedback loop to the State on the performance of the program from the enrollees' perspective.

Initial Report of the Working Group to Reinvent Medicaid

Even with these protections in place, such a program still has vast potential to produce fiscal savings.

Conclusion

The global capitation proposal is an exciting one. There is an obvious need for better coordination in our medical system, and this payment model places strong incentives on providers to fulfill that need. But the proposal is based on a premise, probably a sound one, that financial incentives impact provider behavior. Keeping that premise in mind, a global capitation program needs carefully placed guardrails. Otherwise, there is a substantial risk that these incentives will create behavior that adversely impacts the 25,000 Rhode Islanders who will rely on the program to deliver necessary medical care.

Thank you very much for your consideration of these comments, and we look forward to discussing this with you in the future.

James Nyberg, Director, LeadingAge RI

As an association representing long-term care providers across the spectrum, LeadingAge RI appreciates the opportunity to comment on the final report of the Reinventing Medicaid Working Group. This report contains several important initiatives that we support, primarily the wide range of measures intended to promote home and community-based services and rebalance our long-term care system. In particular, the Working Group recommends rate reform for assisted living and adult day services, which is a critical need. The report also proposes rate reductions for nursing homes and the establishment of an incentive pool in which nursing homes could recoup the funding based on meeting quality-related measures. We understand the need for a new approach to paying for nursing home care, but note that the development of an incentive-based payment system needs to be done carefully using well-established and validated measures, and with appropriate stakeholder input. In addition, we are very concerned about the report's proposal to increase the bed tax on nursing homes to save \$4 million. This is a blunt instrument to achieve savings, and essentially amounts to a further cut to these providers. We look forward to working with the Administration and the General Assembly towards our collective goal of rebalancing our long term care system and improving its financial stability.

J. Michael Downey, President; Gerard E. O'Neill, Executive Director, RI Council 94 AFSCME

We are writing to express our concerns and opposition to several recommendations contained in the "Initial Report of the Working Group to Reinvent Medicaid." Rhode Island Council 94, AFSCME represents well over 750 employees who are members of Local 1293, Rhode Island Community Living and Supports; Local 1350, Medical Center; Local 2392, Medical Center Physical Plant & Management Services; and Local 2883, Department of Behavioral Health care, Developmental Disabilities, and Hospitals.

These employees work hard every day to provide a high level of care to some of Rhode Island's most fragile and vulnerable populations. Eleanor Slater Hospital/Pastore Medical Center cares for

patients who require acute care for serious psychological and/or medical conditions. Rhode Island Community Living and Supports (RICLAS) provide care for developmentally disabled residents in 28 group homes.

The specific recommendations in the report that RI Council 94 opposes include:

- 12. Identify alternate settings for appropriate Eleanor Slater Hospital residents - pg. 18
- 22. Convert RICLAS homes to private sector operation - pg. 23
- 34. Consolidate some services at Eleanor Slater Hospital - pg. 26

In order to preserve the quality of care and integrity of the facilities/homes where our members are employed, RI Council 94 must insist that:

- 1. All applicable articles, including 11.13 and 33, of the Master Agreement between the State of Rhode Island and Rhode Island Council 94, AFSCME, AFL-CIO are followed by the state.
- 2. The Workgroup Members keep in mind that the state facilities, residences, programs, and employees have also incurred cutbacks and made concessions during these difficult fiscal times.
- 3. If privatization is proposed for RICLAS and/or the Eleanor Slater Hospital, RI Council 94 may be compelled to pursue the process outlined in Rhode Island General Laws Chapter 148 - Privatization of State Services.

Privatization of RICLAS and/or the Eleanor Slater Hospital will eliminate hundreds of middle class jobs. RI Council 94 is willing to work with the administration to collaboratively identify savings and evolve our systems of care to benefit patients and residents.

However, at the present time without the necessary details/communications from the administration, RI Council 94 is opposed to the aforementioned proposals.

John C. Simmons, Executive Director, Rhode Island Public Expenditure Council

The work of your staff and of the Task Force was instrumental in developing a set of recommendations that will surely change the way Medicaid is provided in the state. I want to thank you and your staff for their work and commitment.

We support fundamental change in the Medicaid system and believe that the general direction of the work of the Task Force will provide change in the short-term as well as begin the discussion regarding the long-term impact of re-inventing Medicaid. Each proposal needs to be examined and more fully vetted, but changing the delivery system’s methodology and payment system, as contained in the set of proposals, will begin that process.

We have, however, several areas of concern with the broad impact of the proposal:

- 1. Capacity to Execute – With the large numbers of recommendations, along with managing the full set of services in Health and Human Services, the capacity to execute and implement the

recommendations becomes crucial. There needs to be a detailed implementation process undertaken to ensure that the budget reduction can be accomplished along with the agreed upon outcomes within the time frame allowed.

2. One-Time Solutions – We are concerned that several of the proposals could be considered as one-time spending reductions and do not structurally reduce spending or change the operations of major Medicaid providers. Careful metrics and measurements of success and how a possible return on savings to the providers can happen is necessary.

3. A Final Point – We need to have further discussions about what the future of our health care institutions will look like and how the transition to new ways of payment and delivery of services will occur. The proposed changes will require substantial modifications in the method of operations of the state's health care providers as well as the health care industry. We need to understand the nature of the changes and how they will impact the health care industry in our state and what it means to the people receiving care as well as those that provide the service.

Over the last two months, you, your staff and the Task Force have worked diligently to provide a series of recommendations that will reinvent the Medicaid System. I want to commend you and your staff for their commitment and work along with the members of the Task Force.

Senator Josh Miller

After working with both the High Utilizers and BH workstreams, I believe these categories and recommendations should be linked-- as 82% of high utilizers need BH services. The most effective model to care for this population is through an integrated community care model where the case management is directed by a BH provider with a capacity to tackle those with primary mental health/substance abuse issues who also have chronic medical diagnosis (diabetes, heart disease, asthma, for examples). The providers contracted should be selected on their ability, experience and capacity to expand while accepting patients with a complex diagnosis and an ability to work in RI communities with the highest levels of this population.

ER Diversion for the highly inebriated: This project should be implemented ASAP. The remaining concern is funding. An RFP has been awarded on a legislatively enabled 3yr pilot to The Providence Ctr. The remaining issue seems to be whether financing should be project based or paid per patient admitted. This unresolved issue may benefit by including RI Medicaid plans- Neighborhood and United, who will view ER Diversion as cost-avoidance; and by including investments from hospitals who may recognize ER diversion programs as a means to achieve goals related to the FY2017 performance incentive program. Both groups may understand the project based model as having potential to be adopted, in the near future, for other appropriate high utilizers, such as an urban mentally ill and/or an opiate addicted rather than alcohol addicted population. Three key components are important to emphasize -1. the upgrade of a current and appropriate facility (Emanuel House), 2. The use of compressive wrap-around services (access to treatment/recovery services, clothing/nutrition donations, employment/housing counseling, medical referral, Medicaid/insurance enrollment,) 3. The involvement of first responders (police/fire). In the case of the Providence pilot, they feel avoiding the use of a rescue is important

to cost savings and program effectiveness. To this goal, Providence Public Safety is committed to providing a vehicle to the program, as an option to avoid using the full-medical services and expense of using a rescue vehicle.

Providing a more appropriate response other than E-911 and a rescue vehicle, with trained street workers and a designated vehicle, is critical to the development of an effective diversion model for most priority populations (alcohol users, opiate addicted, mentally ill while also homeless) that may be developed in the future. First responders and ER doctors/nurses should be involved in identifying priorities for expansion of future diversions, what sectors have the most critical needs and would be best served in an alternative setting. This diversion concept could also be modified to concentrate on home based geriatric high utilizers, involving primary care providers as the patient destination.

Lastly, I wonder if the Medicaid Program will be estimating the need for more program, IT and contract management staff to oversee the implementation of the recommended reforms.

Comments from the April 30, 2015 Meeting of the Working Group

(Taken from the minutes of the meeting.)

Regarding Recommendation #1

Maureen Maignet: On number one, we've seen targets related to Medicare, but does the Office of the Health Insurance Commissioner (OHIC) have input on the commercial targets?

Sam Salganik: Would like to piggy back on top of Maureen's comment that I believe there is a lot to learn and work to be done in collaboration with OHIC and other groups.

Linda Katz: From a process perspective, this is the first time we have seen these targets and we haven't vetted these numbers. It may be better to discuss in our longer term discussion along with OHIC.

Peter Andruszkiewicz: I agree that there is a tremendous opportunity. Medicaid and commercial insurance should put all our efforts behind a single method for how we pay. BCBSRI is committed to essentially eliminating fee-for-service by 2018.

Ira Wilson: In the high utilizer work stream we kept coming back to the idea of all payer models, and what we can do to coordinate in the state to be a role model for providers.

Regarding Recommendation #2

Peter Marino: Are payers at the table to talk about those metrics?

Dennis Keefe: I think so; we welcome the conversation. I think we are all beset by a myriad of metrics and indicators and any way we can be more transparent and work together we all would strongly support that.

John Simmons: How will the state handle the budget in FY2017? Do you restore the funding? Is this one-time savings?

Dennis Keefe: I think everything gets reset at the end of the fiscal year: see how hospitals did and open a whole new discussion when we see where we end in '16 and what the challenges are for '17. There is a leap of faith here, crossing budgetary years, and I get that.

Secretary Roberts: The plan is to drive the trend down by designing the metrics around appropriately lowering utilization. We should meet that 5% target by managing utilization, and look at the coming year with an entirely different Medicaid number if what we are planning here is effective. I think we will be using some of those dollars to drive change and adjust hospital spend.

Dennis Keefe: This is modeled after the value based purchasing program in Medicare, and in Medicare it restarts every year. They look back at how successful it was, and look forward to new targets and always seek to improve.

Peter Marino: I agree that having a good incentive helps to move us all towards good change. This initiative is on the right path.

Regarding Recommendation #3

Maureen Maigret: Because this will be done by cuts in FY2016 I would ask that quality checks be put in nursing homes to ensure that quality in these homes remains as good as it has been.

Regarding Recommendation #5

Sam Salganik: This proposal raises concerns as provider groups are taking on more and more risk. I just have a million questions about how this would work if now the providers were to be fully at risk. I have submitted a letter to the Secretary already and will happily send it around to all.

Linda Katz: On a process note, this proposal was not vetted at any work stream meeting, and I would strongly urge that this be taken out of the recommendations.

Secretary Roberts: It is correct this is a late recommendation – this general approach was talked about but not with this particular dollar amount attached to it. We have discussed accountable entities, so what is the approach? This implementation phase will be a collaborative process as well, and our Managed Care Organizations are still our primary partners in our systems of care. We have two ACOs in the state now and BCBSRI is participating in an accountable entity, and there are in fact protections as part of our managed care structure. You are correct that there are many unanswered questions on how this would be created. These are all recommendations for consideration by the Governor.

Linda Katz: I appreciate that and agree that the approach was heard, but I am concerned that the specific proposal was not allowed to be vetted.

Maureen Maigret: I share the concerns, and I also question the ability to do this in the short term. While I'm not opposed to the idea in principle, I question if it should be on the short term list

Senator Miller: I have been present while this and many similar ideas have been presented and I think it is appropriate that this is proposed; however, we need a watchdog to ensure that

coordination and not denial of care is what will save money. I think this has been done and it can be done.

Patrice Cooper (United): I feel this aligns a lot with the first proposal.

Peter Marino: I also have concerns about the timelines on this initiative. I have also seen some very aggressive proposals around this. Accounting for it as part of the FY2016 menu may be premature.

Elizabeth Burke Bryant: I wanted to say that there has been a lot of agreement that coordinated care at the provider level is very important to reform efforts. I circulated a memo on successful efforts to build up on, including the success of the RIte Care program and the work of the state to build up a Medicaid managed care program to build up quality and care for children and families. We need to have the time to really look at what is working well, and build on that. I agree the timing may be too aggressive on this.

Senator DiPalma: For each of initiative that I know will come before Senate Finance, I will ask, what are the assumptions? For example: timeline, do we need CMS approval, is there government agency involvement, etc. What kinds of investments need to be made? Corollary: what are the risks? If the initiative is to invest in community-based services to keep people at home, if that investment isn't made, it is a risk. The assumption is that we will bolster community health. If that's not done, it's a risk. These questions don't need to be answered today, but in hearings these will need to be asked. I want to help and support and answer what these are to ensure success: What are the three to five key assumptions and key risks that have to be addressed to ensure achieving the savings there?

John Simmons: Does the office have the capacity to do the thirty some-odd items here? My concern is if you put \$90 million of recommendations all hinged on execution, you need the timelines, the estimates, the capacity. One way or another we will need to answer these soon.

Secretary Roberts: We are developing a work plan over the next 30 days to deliver on the items you touched upon.

Peter Andruszkiewicz: Another lens to place on this is what could be or should be piloted or tested, and then assess if the pilots are successful. It could be wasteful to wait a whole year and then review for '16, and then start new ideas in '17 – let's try to phase in recommendations.

Regarding Recommendation #6

Dale Klatzker: It's nice to have a behavioral health initiative in the top ten list. It's critical to improve the care for this population, and to meet the various organizations in the state where they are for their current level of operation. I certainly support this.

Linda Katz: Nice to see some proposals that were developed when the waiver was renewed come to fruition here--such as the SOBRA proposals and health at home--those were both initiatives that many people had worked on, and it is great to see them come up now and come to fruition.

Regarding Recommendation #9

Initial Report of the Working Group to Reinvent Medicaid

John Kelley: On Recommendation #9, I want to ask if we are moving to getting out of CEDARRs? If we are, why not just do it all and be done with it? I am concerned about leaving a system that barely exists and creates more issues.

Tom Kane: I agree with John [Kelly's] statement on CEDARRs. Also, it is very difficult for patients to get into PASS and I think that should be looked at as well. I think getting rid of that duplication can save money.

Regarding Recommendation #11

Chuck Jones: The incentive program represents revenue coming to health centers, and there are strict targets for quality. So going back to the conversation from the beginning of the meeting, we need to pair cost reductions with investments in tools and infrastructure. I have no problem with incentive programs, but we need to be careful about the impact of a 5 percent cut in Medicaid revenue.

Regarding Recommendation #12

Dale Klatzker: On Recommendation #12, I think this is a great initiative, long overdue.

Dennis Keefe: I applaud the state for looking at this, and specifically Director Montanaro for taking this on. We have a number of patients at Butler who have been in their beds for over a year, and that is just one example. It is a significant problem, and I want to call that one out as an example of how working together we can fix things that affect member organizations in an effective way.

Regarding Recommendation #14

Dale Klatzker: As Senator Miller knows, we have been working on this for a while, I think this is a grand slam for the system: it's a difficult population, that we need to do a better job engaging and working with. This is one where we truly can save money.

Senator Miller: Also on Recommendation #14, and including Recommendation #2, the hospitals may look at this as a point of investment to use as a structure, to help manage the readmissions of addicted populations.

Regarding Recommendation #15

Tom Kane: I know that this needs more assessment, but incorporating telehealth is a big part of meeting people where they are, getting health to people where they are.

Elizabeth Lange: Building on the telehealth part and the fact that we have a strong PCMH movement in this state, I think somewhere it should be stated that incorporating telehealth into PCMHs would be very helpful

Linda Katz: I wanted to note that all have done a tremendous amount of work in a short time. We did acknowledge that both the system of care for kids in DCYF custody and the care for those with Developmental Disabilities have not been drawn into this whole process. Want to be sure we are doing the same data dives and thoughtful approaches to think about doing care there.

Director Montanaro: Not just looking at it, already working on it – part of a robust transformation in that system.

Linda Katz: I just think we should acknowledge in the report that is happening.

Secretary Roberts: And DCYF is engaged, although not yet ready at this level. We are in active conversation with them.

Regarding Recommendation #16

Tom Kane: On Recommendation #16, is there any impact on timeliness of payments? And on where does that information go? It seems troubling if it goes to state and not to providers.

Bruce McIntyre, EOHHS Director of Program Integrity: We want people to know that they won't be subject to post payment audits and move forward with a system to allow them to proceed with business.

Tom Kane: Also when a provider shows up at a home and no one there, how is that documented?

Bruce McIntyre: We have discussed a number of different options, such as geo-tracking on a cell phone, voice recognition, a transponder, etc. We need to sit down with all those options and chose the route that makes the most sense.

Regarding Waste, Fraud and Abuse Generally

Senator DiPalma: Based on what other states have done, how might these waste, fraud and abuse initiatives compare in terms of savings? Have we looked at what other states have invested?

Bruce McIntyre: I am happy to respond as head of program integrity for EOHHS. We have attempted to conservatively estimate based on the experience of other states. There is a bit of a wild card because we are on the forefront of doing some of the computer-based analytics in this space. We have limited experience to draw data. Massachusetts has something similar, and we are basing it off Massachusetts a bit.

Senator DiPalma: The Attorney General's office has expanded its investigative ability in some situations. We could work with the AG's office to see what else could be done.

Bruce McIntyre: For Medicaid fraud, the AG has civil investigative authority. This is something very different. We want the ability to move quickly to see where things stand. Then, we can our results over to the AG.

On Recommendation #18

Linda Katz: I think we should step back and ask whether there are problems in terms of verification. This initiative is directed at consumers, not at provider fraud. We have just built a system for HealthSourceRI and EOHHS to verify this information. I don't think we should look to spend money where we do not know there is a problem.

Hugh Hall: I was pleased to hear that expedited community eligibility is being looked at. In our world the application process can take four months to a year; any reduction would be a big help.

On Recommendation #20

Peter Marino: We look forward to having many conversations on this initiative. I would argue that NHP is a very strong organization on this and I think it will be a good discussion.

Patrice Cooper: I would just echo Peter's comment, we understand that all of us were asked to take cuts and we appreciate that, but we look forward to conversations.

On Recommendation #21

Peter Andruszkiewicz: There's an implication that this recommendation leads to savings. I feel that is a misnomer. This is not a savings but rather an incremental fee paid by privately insured people in the state. Last year, the legislature changed the way this was paid, and one criticism by the opponents of the legislation was that this might become a tree to put things on. I feel it has become just that. We would suggest this comes off the list.

Secretary Roberts: I was not here last year for the conversation on children's savings account. These are privately insured people for whom Medicaid is paying for their services. The account is a means of moving the cost back on private insurers, but I agree that this is an area that should have further discussion.

On Recommendation #23

Tom Kane: I'm concerned with changes in eligibility. The report mentions other New England states. I think there can be a problem with covering people while subject to a federal lawsuit. Other states do not have the same consent decree. In other states, you need to realize that some individuals are still living in institutions whereas that may not be the case here. When doing a comparison, we need to do so for the whole picture, not just the savings.

On Recommendation #33

Sen DiPalma: I recognize the work of DCYF. I see this recommendation and realize that for the long term perspective we are looking at group homes. Kids are getting the wrong services at the wrong time, etc. and part of that is due to the structure of group homes.