

**STATE OF RHODE ISLAND  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**10/16/2015 PUBLIC NOTICE OF PROPOSED CATEGORY II CHANGE TO  
RHODE ISLAND'S COMPREHENSIVE 1115 WAIVER DEMONSTRATION**

In accordance Rhode Island General Laws 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) will seek federal authority to implement the following Category II Change to Rhode Island's Comprehensive 1115 Waiver Demonstration (project no. 11-W-00242/1):

**Reinventing Medicaid 2015:  
Coordinated Care Program Pilot**

As part of Governor Gina Raimondo's effort to reform Medicaid, the Working Group to Reinvent Medicaid issued an April report that recommended numerous initiatives to achieve financial savings in State Fiscal Year 2016. The Governor introduced those recommendations in a budget article entitled, "The Reinventing Medicaid Act of 2015." The Rhode Island General Assembly passed the Reinventing Medicaid Act in June.

As a result of the Act's passage, EOHHS is seeking federal authority to implement several changes to the Medicaid program. This Category II request will launch a pilot Coordinated Care Program. EOHHS envisions the care coordination occurring through new Accountable Entities. These Entities will be responsible to coordinate long-term services and supports as well as integrate physical and behavioral health. The program will effect up to 25,000 Medicaid beneficiaries in the first year. This change will yield an estimated \$3 million in savings to the state.

This proposed Category II change is accessible on the EOHHS website ([www.eohhs.ri.gov](http://www.eohhs.ri.gov)) or available in hard copy upon request (401-462-1965 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by November 15, 2015 to Darren J. McDonald, Executive Office of Health and Human Services, Hazard Building, 74 West Road, Cranston, RI, 02920, or [darren.mcdonald@ohhs.ri.gov](mailto:darren.mcdonald@ohhs.ri.gov).

In accordance with the Rhode Island General Laws 42-35-3, a hearing will be conducted to receive public testimony on the proposed Category II change if requested by twenty-five (25) persons, or by an agency or association having at least twenty-five (25) members. A request for a hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or disability in acceptance for or provision of services or employment in its programs or activities.

**Rhode Island Comprehensive Section 1115 Demonstration  
Project Number: 11-W-00242/1**

**Category II Change  
Change Name: Coordinated Care Program Pilot  
Change Number: 15-05-CII**

Date of Request	November 16, 2015
Proposed Implementation Date:	January 1, 2016

**Fiscal Impact:**

	<b>FFY 2016</b>	<b>FFY 2017</b>
<b>State:</b>	<b>\$0</b>	<b>\$0</b>
<b>Federal:</b>	<b>\$0</b>	<b>\$0</b>
<b>Total:</b>	<b>\$0</b>	<b>\$0</b>

**Description of Change:  
Attachment A**

**Assurances:  
Attachment B**

**Standard Funding Questions:  
Attachment C**

## Attachment A: Description of Change

Rhode Island's Executive Office of Health and Human Services (EOHHS) proposes to pilot an "Accountable Entity" program, beginning January 1, 2016. This Accountable Entity program will be administered through the Medicaid Managed Care (MCO) program, and will effect up to 25,000 MCO enrollees in State Fiscal Year (SFY) 2016, with the potential to expand to up to 65,000 enrollees in SFY 2017.<sup>1</sup>

As part of Rhode Island's Reinventing Medicaid Act of 2015, the state legislature directed EOHHS to seek federal authority for a so-called "coordinated care program" pilot in SFY 2016. The goals of the pilot are to test a new payment and delivery system model (an Accountable Entity or AE) aimed at improving quality of care, member experience of care, and total cost of care. The Accountable Entity or Entities will be responsible for the quality, member experience and total cost of care for an attributed population of MCO enrollees.

Rhode Island has a strong history of successful Medicaid managed care implementation with an established MCO infrastructure and a strong multi-payer medical home infrastructure (Care Transformation Collaborative). RIteCare members have access to broad networks of care, robust member services and supports and high levels of beneficiary responsiveness/ coordination. RI MCOs are nationally recognized as among the highest quality MCOs in the US.

Given this important starting point, a key premise for Medicaid redesign in Rhode Island is that the existing MCO contract structure is "necessary but not sufficient." That is, the current model has some critically important strengths, but may not be structured to adequately address the next generation of managed care. Specifically, the "next generation of Medicaid managed care" must be able to meet the needs of the full population but must also have distinct competencies to recognize and address the special needs of high risk and "rising risk" sub groups. These populations of "high utilizers" account for only the 6% of Medicaid users but 65% of Medicaid expenditures. Two high priority capabilities for the next generation of Medicaid managed care are:

- *Priority 1: Integration and Coordination of Long term services and supports*  
Nearly half (45%) of claims expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with developmental disabilities.
- *Priority 2: Physical and behavioral health integration*  
Forty percent (40%) of claims expenditure on high cost users is on high utilizers. Among those living in the community, 82% of the expenditures for persons with over \$15,000 in payments for services were for persons with co-occurring mental health or substance and physical health needs underscoring the need for an integrated person-centered approach to care.

The proposed Accountable Entity (AE) structure is therefore intended to promote and support the development of a new type of entity equipped with the necessary characteristics and capabilities to achieve meaningful improvements in our systems of care, specifically targeting these high risk and rising risk subgroups. Key characteristics include:

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<sup>1</sup> Rhode Island's state fiscal year runs from July 1 through June 30.

- A multi-disciplinary capacity with a strong foundation in high performing primary care practices, effective integration between behavioral health and physical health, and with specialists and/or hospitals;
- Ability to manage the full continuum of care, including “social determinants.” An effective accountable entity will have the capacity, tools, authority to integrate and manage the full continuum of physical and behavioral health care, from preventive services to hospital based and long term/nursing home care;
- Analytic capacity to support data driven decision-making and real time interventions;

Such an infrastructure is intended to be developed within and in partnership with the existing MCO structure. As such, AEs would be responsible for the total cost of care of an attributed population capturing all Medicaid covered services that are included in EOHHS’ contract with MCOs for all attributed Medicaid populations enrolled in managed care. Services and populations reimbursed or covered by EOHHS in its fee for service program shall not be included. This program will thereby build upon the existing strengths in the current MCO model, enhancing its capacity to serve high-risk populations by increasing delivery system integration and improving information exchange and clinical integration across the continuum of care.

#### Role of the State:

Beginning in November of 2015, EOHHS will publish an application for AEs, along with the standards necessary for certification. Only state-certified AEs will be eligible to contract with Medicaid MCOs for the AE pilot. Eligible AEs will need to demonstrate a set of competencies and structural components that meet several EOHHS goals:

- Moving to value-based rather than volume-based purchasing
- Integrating physical and behavioral health
- Addressing the social determinants of health
- Focusing on high-cost, high-need beneficiaries
- Reducing inappropriate utilization of high cost/institutional settings such as hospitals, emergency departments, and nursing facilities

#### **Populations and Services:**

Two types of Coordinated Care Pilot are envisioned:

- Type 1 Coordinated Care Pilot: Total Population, All Services  
Authority to contract for all attributed populations, for all Medicaid services. A Type 1 pilot must include the following populations and services in the pilot and the calculations of the total cost of care:
  - All Medicaid populations enrolled in managed care; and
  - All Medicaid covered services that are included in EOHHS’ contracts with MCOs. Services that are reimbursed by EOHHS in its fee for service programs shall not be included.
- Type 2 Coordinated Care Pilot: SPMI/SMI Population, All Services  
Authority to contract for a specialized population, for all Medicaid services. A Type

2 pilot must include the following populations and services in the pilot and the calculations of the total cost of care:

- Must include a specific defined population - persons with SPMI or SMI; and
- Must include all Medicaid covered services that are included in EOHHS' contracts with MCOs. Services that are reimbursed by EOHHS in its fee for service programs shall not be included.

Applicants must specify if they applying as a Type 1 or 2 Coordinated Care Pilot.

### **Total Cost of Care Calculation and Quality Score**

The total cost of care calculation (TCOC) is a fundamental element in any shared savings and/or risk arrangement and requires careful analysis. Most fundamentally it will include a baseline or benchmark cost of care carried forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings pool, depending on the terms of the arrangement.

Any savings observed must be in light of defined quality metrics to help ensure that any cost savings that are realized are due to improved care and outcomes rather than denial of care. EOHHS will require that any agreement with an MCO will provide that an appropriate quality score factor be applied to any shared savings pool to determine the actual amount of the pool eligible for distribution.

The specific terms of the savings and risk transfer between the MMCO and the AE are at the discretion of the contracting parties. EOHHS does not intend to stipulate the terms of these arrangements but does reserve the right to review and approve them. <sup>2</sup>

#### 1. Member Choice

Members must have access to the right care, at the right time, and in the right setting. Applicants must provide assurance that the proposed AE will not limit or restrict beneficiaries to providers within the AE network. Accountable Entity provider relationships may not impact member choice and/or the member's ability to access providers contracted or affiliated with the MCO, including not requiring patients to obtain prior approval from a primary care gatekeeper or otherwise before utilizing the services of providers outside the AE network.

#### 2. Member Assignment/Attribution

##### a. Basis for Attribution

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<sup>2</sup> In addition to this EOHHS' requirement note that depending on circumstances transparency in such arrangements is specifically required in 42 CFR §438.6 Contract requirements 438.6(g) Inspection and audit of financial records -- Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans -- MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 436.6(k) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

Each participating AE must be assigned at least 5,000 members and up to 25,000 Medicaid members. Pilot applicants must identify the PCP practices that would be the basis for attribution of the population. These members will be either prospectively assigned by the MCO based on current PCP enrollment, or attributed based on a methodology consistent with the attribution guidelines described below.<sup>3</sup>

- b. Attribution guidelines – Attribution method may consider
  - i. Primary use of a PCP who is an identified member of the network
  - ii. If there is a demonstrated relationship with a CMHC and has received an SPMI or SMI service.
  - iii. Census track – member who is in a census track of a participating PCP (or CMHC) who has no identifiable primary source of care.
- c. Note – an organization can only be in one Medicaid shared savings program at a time.

### 3. MCO Capitation

The MCO retains the base contract with the state, and the MCO medical capitation will be adjusted for the anticipated savings associated with the pilot program. There will be neither gain-share nor risk-share between the state and the MCO for the pilot population.

### 4. Delegation of MCO required services

It is anticipated that successful development of an AE will include a new distribution of responsibilities between the MCO and the AE and that these will be identified in the written agreement between the parties. For this pilot, the following services may not be delegated:

- Network contracting
- Provider payment/claims processing
- Member services
- Grievances and Appeals

## **Qualifications for a Coordinated Care Pilot Entity**

AEs interested in participating in the Coordinated Care Pilot program must demonstrate evidence of readiness across the following required domains as specified below:

### **Domain 1: Responsible Entity and Governance**

The applicant must be a distinct corporate entity with defined responsibility for ensuring that the performance requirements of its certification and of its contract with an MCO are fully met. To the degree that the application is submitted on behalf of multiple partners collaborating on this project, a primary contractor must be clearly identified. Collaborative and contractual partnerships to achieve the goals of the pilot are permissible and encouraged, as appropriate, but the respective roles and responsibilities associated with these arrangements need to be clearly delineated.

A qualified AE shall have an adequate corporate structure to ensure that critical community participants are included in the leadership team of the Accountable Entity and that such

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<sup>3</sup> Ibid.

participants have the ability to influence or direct the integration of care and clinical practice to improve outcomes.

Each Care Coordination Pilot will be required to convene a Community Advisory Council, and must establish standards for publicizing the activities of the AE and the AE's Community Advisory Council, as necessary, to keep the community informed.

**Domain 2: Organizational Capability: Leadership and Management Structure**

A qualified Pilot AE must have a leadership and management structure that includes a Rhode Island based executive, a medical director who is board-certified and licensed in the State of Rhode Island, and a compliance officer. The AE must establish and maintain an ongoing quality assurance and process improvement program overseen by an appropriately qualified Rhode Island based health care professional

**Domain 3: Organizational Capability: Readiness to Develop and/or Provide an Integrated Multi-Disciplinary System of Care**

Qualified pilot AEs will have accountability for the total cost of care for a full spectrum of services as appropriate to serve the specified population. Coordinated Care Pilots must demonstrate that they have the capacity to develop and/or provide a full range of primary, specialty, behavioral health and care management services.

- **Provider Network and Profile**  
The Pilot will be able to identify a strong complement of providers participating in its proposed delivery system with particular emphasis on high performing primary care practices (e.g., the number and type of primary care providers and provider sites of its delivery system and which of them have been accredited as Patient Centered Medical Homes, behavioral health providers, specialists, hospitals, community health supports, others). Note this capacity may exist in concert with that of a participating managed care organization that, for example, has contractual arrangements with a broader network of providers than is resident within the applicant structure.
- **Integrated Multi-Disciplinary System of Care**  
A central goal of EOHHS in this initiative is promoting the development of Accountable Entities with the capabilities to play central roles in transforming system of care for Medicaid eligible populations. EOHHS understands that this is a process of furthering capabilities that are in various stages of development; and applicant pilot entities are unlikely to have in place the full set of organizational competencies necessary to be successful. To that end, successful applicants will describe the critical organizational and/or clinical practice actions they would seek to undertake to enable them to most effectively impact on the health outcomes for populations they propose to serve.

**Domain 4: Minimum Population Served – Linkage to Provider Network**

Minimum volume thresholds are important to ensure that entities can reasonably be held accountable to the total cost of care. Absent a minimum volume of Medicaid eligibles, variations in cost associated with individual high cost cases cannot be adequately managed. As

such, EOHHS requires that certified Accountable Entities be responsible for the total cost of care associated with a minimum of 5,000 unique Medicaid enrollees.

As of September 2015 just over 244,000 Medicaid eligible were enrolled in Medicaid managed care plans. These include children and families in Rite Care, children with special health care needs, adults with disabilities in Rhody Health Partners or Rhody Health Options, and adults without dependent children (Expansion population). With a reasonable degree of accuracy the applicant Entity will be able to identify the segments and size of the population served by the system of care included in the proposal. EOHHS anticipates that the primary method of attribution will be use of a primary care provider in the network or use of behavioral health provider for individuals with SPMI or SMI.

**Domain 5: Data and Analytic Capacity**

Data capacity is central to the ability of the organization to effectively recognize short and long term utilization and cost patterns for the population and to identify critical points of intervention for individuals. The pilot AE will need to have the ability to monitor and understand utilization and cost data and will need access to real time or near real time data for coordination of care for individuals. Beyond data alone, the entity will need to have the analytic capacity to effectively use that data to inform care. Such data capacity may be resident within the applicant entity or provided in part by another party, e.g. an MCO. Development of effective data capacity remains an ongoing challenge throughout the health care system. The applicant entity will be able to describe its plans for data and analytic capacity.

**Attachment B: Assurances**

**The State assures the following:**

- This change is consistent with the protections to health and welfare as appropriate to Title XIX of the Social Security Act (the Act)
- The change results in appropriate efficient and effective operation of the program, including Justification and Response to Funding Questions
- This change would be permissible as a State Plan or Section 1915 Waiver Amendment and is otherwise consistent with sections 1902,1903,1905,and 1906, current federal regulations , and CMS policy

### Attachment C: Standard Funding Questions

1. Section 1903(a)(I) provides that Federal matching funds are available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local government entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (ie., general fund, medical services account, etc.)

**Providers receive and retain the total Medicaid expenditures claimed by the State. No portion of the payments is returned to the State, local governmental entity, or any other intermediary organization**

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation were not used by the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditures and State share amounts for each Medicaid payment. If any of the nonfederal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify the total expenditures being certified are eligible for Federal matching funds in accordance with 42CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
  - (i) A complete list of the names of entities transferring or certifying funds;
  - (ii) the operational nature of the entity (state, county, city, other);
  - (iii) the total amounts transferred or certified by each entity;
  - (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
  - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

**The State share is funded through general revenue funds appropriated by the legislature for this purpose.**

3. Section 1902(a)(30) requires that the payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type .

**No supplemental or enhanced payments are made.**

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

N/A

5. Does the governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable cost of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

**No governmental providers receive payments that in the aggregate exceed their reasonable costs of providing services.**