



## **Stakeholder Workgroup Series Services and Supports: Final Recommendations**

---

### **I. Purpose/Goal**

#### **Overall Goal:**

To solicit recommendations from external stakeholders for the development of state contract procurement documents.

#### **Services and Supports**

To provide recommendations for defining the necessary requirements for creating a comprehensive provider network to address health care needs including but not limited to acute care, specialty, long term services and supports and behavioral health, help EOHHS define appropriate requirements for a responsive care management program (i.e. care models), and alternative benefits that may assist in keeping people healthy and residing in the community.

### **II. Methodology**

- From **July 9, 2012 – August 21, 2012**, the RI Executive Office of Health and Human Services (EOHHS)/Medicaid Program organized a series of workgroup meetings.
- Each workgroup met 3 times over this 7 week period.
- Each workgroup covered topics selected as imperative to the planning, development, implementation, and monitoring of these initiatives.
- The 3 topic areas selected were as follows:
  - Outreach and Information
  - Services and Supports
  - Oversight, Evaluation, and Continuous Improvement
- An invitational announcement letter/email was developed and sent to stakeholders for participation in the workgroup series in the weeks prior to the start of the meetings.
- Stakeholders were asked to forward workgroup invitation letters/emails to any other interested parties.
- In order to have well-rounded input, state representatives as well as topic experts from the community were selected as workgroup facilitators.
- An email listserv was developed to send continuous workgroup updates and workgroup handouts.

- All workgroup presentations and handouts were posted to the RI Executive Office of Health and Human Services website at [www.ohhs.ri.gov](http://www.ohhs.ri.gov) under “Integrated Care”
- An email box was set up at [integratedcare@ohhs.ri.gov](mailto:integratedcare@ohhs.ri.gov) for any questions and comments related to the Integrated Care Initiative

### **III. Summary of Input Process**

#### **Workgroup Session One Summary:**

At the first workgroup meeting, EOHHS staff provided an overview of the Medicaid Integrated Care Initiative, the purpose of the work group and an overview of two models.

An overview of the Medicaid State Plan and HCBS Waiver Services was followed by a discussion of unmet needs. The Stakeholders were asked to address the following:

- What are the areas of unmet need regarding services/benefits?
- What additional/supplemental benefits might EOHHS consider including in a managed long-term support and services benefit package?

Topics were arrayed by actionable items or “parking lot” items.

#### **Workgroup Session Two Summary:**

A recap of the Workgroup Session one included the compilation of the areas of unmet needs and the parking lot list. An interactive exercise took place where each of the workgroup members had an opportunity to prioritize the 17 areas that should be considered a focus for addressing the areas of unmet needs for the proposed Integrated Care models. The priority areas identified are outlined below. The remaining priority areas and parking lot items are outlined in Appendix A.

Priority Areas:

1. Medical and behavioral service coordination
2. Adult Day Care centers as medical home model (provide skilled services)
3. Expansion of home based services
4. Medication assistance & monitoring (Medpacking)
5. Remote monitoring of chronic illness (Telehealth)
6. Expedited Eligibility

An overview of the optimal care management requirements was presented by EOHHS staff:

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

The Key Care Management Goals were outlined:

1. Improve member health and quality of life
2. Decrease care fragmentation
3. Optimize resource utilization

Key components of the Care Management Process were outlined by EOHHS staff:

1. Comprehensive Needs Assessment
2. Plan of Care to Address Needs Identified
3. Coordination of Care/Implementation of the care plan
4. Transitional Care Planning
5. Risk Assessment/Identification of members who Need Care Management
6. Analysis of Care management Effectiveness and Appropriateness
7. Monitoring Outcomes
8. Technology to support Care management activities

The design models for the Enhanced PCCM model and the Managed Care Organization (MCO) Capitated model were discussed.

The Stakeholders were asked to address the following:

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

### **Workgroup Session Three Summary**

A comprehensive Data Analytics for the Integrated Care Initiative was presented that identified population characteristics, current patterns of utilization and costs, trends and opportunities for intervention.

The current Network Access standards for the Medicaid MCOs were presented. The current standards require the MCOs to establish and maintain a geographic network designed to accomplish the following goals:

- Offer an appropriate range of services, including access to preventive services, primary care services, and specialty care services for the anticipated number of enrolled in the services areas
- Maintain providers in sufficient number, mix, and geographic area
- Make available all services in a timely manner.

Stakeholders were asked to address the following questions:

- How can we apply access standards like these examples for members receiving LTSS?
- What access standards are appropriate for new entrants into the LTSS system?
- What are other ways to define access?
- (e.g. physical accessibility, providers with “disability competency,”etc.)

Stakeholder Feedback on the Network Access issues list is included in an Appendix B.

## IV. Final Group Recommendations

**Recommendation #1:** EOHHS should consider the top six priority areas identified by the work group when designing the comprehensive benefit package for both the capitated model and the enhanced PCCM model.

**Recommendation #2:** The care management processes and goals outlined by EOHHS are appropriate for designing effective and responsive delivery systems for Medicaid-only clients and MMEs who utilize long-term services and supports.

**Recommendation #3:** EOHHS should consider the unique needs and service utilization of elders and adults with disabilities who utilized long-term services and supports, in order to define appropriate network access standards. Items for consideration include the current Medicare skilled standards, with equal consideration given to the non-skilled needs of Medicaid members and MMEs.

## V. Conclusion

EOHHS will evaluate each of the recommendations above for inclusion in the LOI and in the pricing models.

There were several common themes and issues identified during the three workgroup sessions. These themes are listed below:

- Assessment and care planning should be in-person
- Coordination of care should be across services and settings
- Include “on-the-ground” early identification of emerging needs components
- Explore including rapid access to services in contractual requirements
- Include Peer Mentor/Peer Navigator in model design
- Increase Housing with supportive services and supply of low income housing
- Use data/technology to improve communication/coordination

- Explore reduction of barriers to eligibility and services
- Include respite for caregivers in the model design
- Require hospital discharge coordination before discharge

## APPENDIX A

### **Priority Areas Identified but not selected for prioritization:**

- Adult Supportive Care homes
- Eliminate co-payments for adult services and pharmacy
- Community Share Allowance (Implement \$400 allowance disregard)
- Identifying and resolving gaps
- Leverage organic or natural care supports/ augment, not replace
- Long term physical & occupational therapy / maintenance
- Memory support services
- Non-medical Transportation to decrease social isolation
- Personal care assistance training
- Work supports/Sherlock Plan
- Increase access to Assisted Living through rate or regulatory reform

### **Parking Lot Issues:**

- 2014 newly eligible adults
- Computer & system information sharing
- Dental
- Non-Medical Transportation
- Habilitation services (Essential Health Benefits Definition)
- Home modifications
- Increasing supply of registered nurses / compensation
- Involving Department of Health Regulators
- Long term care services 3 day hospital stay vs. observation
- On-line medical records
- Youth Transitions to Adult System
- Enrollment Approach/Strategy
- Current list of Medicaid providers
- Private financial assistance (Affect eligibility?)
- Co-Pay Program/CNOM
- Work force issues (e.g. RNs)
  - i. Reimbursement for travel (gas, tolls, etc.)
  - ii. Is PCA a workforce issue

## APPENDIX B

### Stakeholder Feedback on the Network Access issues is outlined below:

- Mirror access standards in both models
- Geographic standards for community LTSS?
- RN visit within 24 hours of going home?
- Home care agency allowed access to member while inpt.
- Coordination of skilled and non-skilled assessment
- Hold providers to the auth
  - Provide assurances of service delivery
  - Hold providers accountable weekends/nights
- Medicare standards – apply these (unless otherwise specified)
- Medicare home health payment rules are not flexible
  - Can't see same day as seen by ordering physician or PCP
- Hospital should contact home care agency for people on Waiver b/f discharge
- Build in transition/Coleman model to program
- Adjustable tables in doctor's office/mamography
- Person-centered solutions
  - A person knows what works for them
- Be trauma-informed
- Integrated chronic care specialists – critical component to care plan
- Openness to working with other family members
- Understand needs of people with dementia – all aspects (e.g. – allow staff person to accompany person to ER and stay until family comes)
  - Specialty docs need education
  - Gap for people with early onset
- State plan for Alzheimer's care
  - Co-expertise for people with DD
- Access to residential SA?
- Disease specific competency for direct care staff – para professional
- Staff education/training modules (e-mail Ellen)
- Respite for families
  - Safe haven