The LEWIN GROUP

Administrative and Staffing Recommendations for Implementing the Global Compact

December 2008

Purpose and Process

- Goals of this engagement
  - To help position Rhode Island Medicaid to rebalance the long term care system and begin implementing the proposed 1115 waiver demonstration program in a short period of time
  - To recommend strategies for improving the administrative capability of the Medicaid agency to respond to consumer needs and preferences, monitor quality of care, and manage a global Medicaid budget
- Methodology
  - Reviewed Rhode Island Global Consumer Choice Compact Waiver
  - Reviewed organizational structure of EOHHS and its Departments
  - Conducted 20+ in-person interviews in Cranston with senior staff who oversee the full range of Medicaid activities; performed additional follow-up via telephone and email
  - Conducted telephone interviews with senior Medicaid staff in other states – Vermont, Oregon, Massachusetts

Critical Components of the Global Compact

- Global budget
  - Fixed allotment of federal contributions
- Long term care rebalancing
  - Right services, right time, right setting
  - Creation of an Assessment and Coordination Organization (ACO) to streamline intake and assessment processes and offer options counseling for people in need of long term supports
  - Consolidation of all existing home and community-based services (HCBS) waivers into a single 1115 demonstration
- Purchasing and payment reform
  - New methodologies for paying hospitals, nursing facilities, HCBS providers
  - Emphasis on leveraging Medicaid purchasing power to lower costs and improve performance
- Cross-department coordination under EOHHS umbrella
  - Program management / evaluation / quality assurance / fiscal stewardship

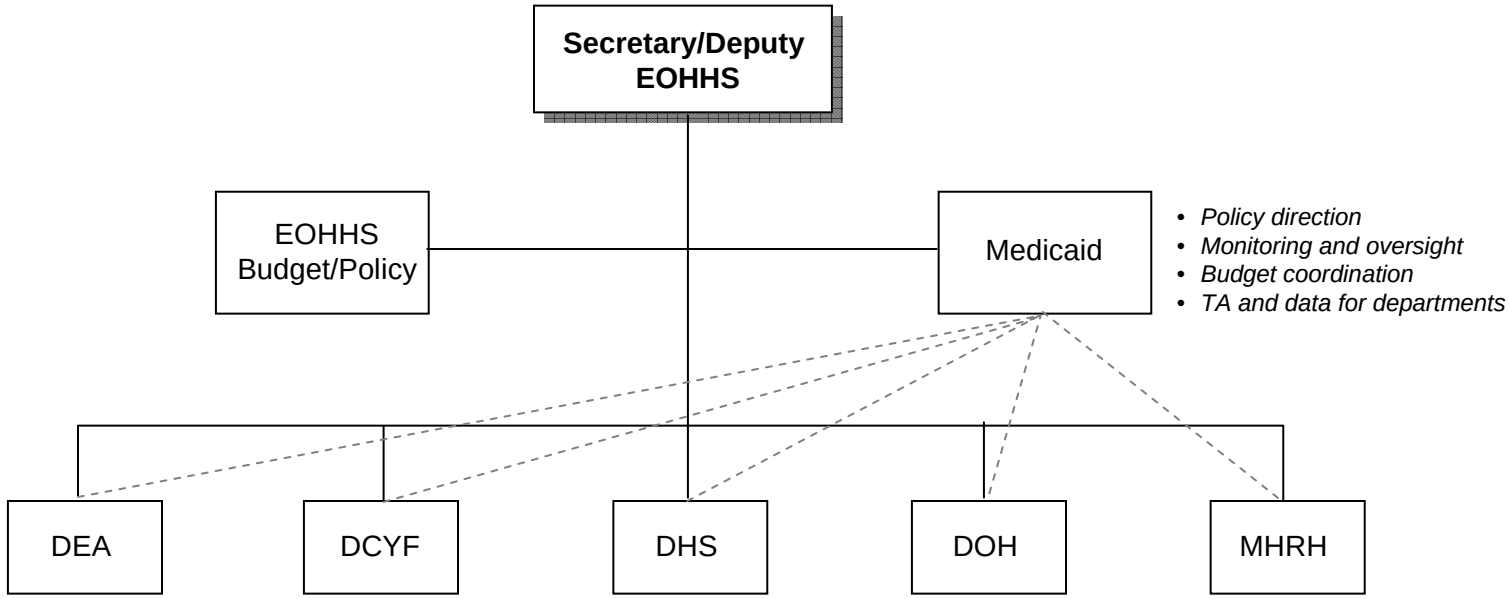
Rhode Island Medicaid SWOT Matrix

Strengths	Weaknesses
• Mature managed care and PCCM models • Relative to other states, less opposition to managed care from advocacy community • Current contractors (EDS, ACS) have strong foundation on which to implement new initiatives on a relatively quick timeline • "Choices" module a possible foundation for ACO • Small state with one service delivery area	• No clear, shared vision for operationalizing the ACO model • No strong budget mechanism to coordinate Medicaid policy/spending across EOHHS or to reward one agency for saving funds in another's budget • Medicaid funding permeates EOHHS, but Medicaid only provides limited policy leadership, oversight, technical assistance, and cross-department data-sharing • No party clearly responsible for HCBS capacity development envisioned in 1115 • Pervasive under-staffing decreases ability of staff to prepare for implementing reform or re-engineering processes • Retirements have significantly reduced the pool of institutional knowledge and experience
Opportunities	**Threats**
• Coordinating budget processes for Medicaid programs and functions to allow for better allocation of resources and opportunities to invest in one area to save in another • Repositioning Medicaid as a cross-departmental policy leader and technical assistance resource to departments	• Stakeholder antipathy toward the 1115 may lead to a tougher political environment • Reform is perceived as ephemeral when day-to-day operations are already under significant strain • Resistance from within • Continued budget shortfalls • "The world of unintended consequences can be large"

Repositioning Medicaid

- When we began our work in September 2008, DHS was the single state Medicaid agency
  - Today, Medicaid is operating outside DHS/EOHHS and reporting directly to the Governor
  - State statute directs EOHHS to serve as the single state Medicaid agency
- Medicaid has evolved into an inter-departmental funding (and policy-driving) vehicle. Let's position it accordingly.
- Inter-departmental budgeting as a policy statement, not a math exercise
- Maintain role of EOHHS departments in administering programs and benefits
  - The Global Compact proposal sent to CMS is explicit on this matter
- Within Medicaid, organize around functions/objectives, not populations
- Inculcate the big policy objectives everywhere, not just in one division
  - Three big ones: rebalancing LTC; value-based purchasing; orientation toward monitoring, collaborating, and sharing data with EOHHS departments
- The next slide shows proposed new positioning of Medicaid within EOHHS
  - Staff currently administering the Medicaid program and staff involved in functional/medical eligibility and case management for A/D waiver would "move" from DHS to EOHHS

Proposed Medicaid & LTC Functions within EOHHS under the Global Compact



- *Managing HCBS delivery*
- *Quality and evaluation committees*
- *Potentially major ACO involvement*
- *High cost case review team*
- *Financial stewardship meetings*

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- *Financial eligibility*
- *Quality committee*
- *Financial stewardship meetings*

- *Quality and evaluation committees*

- *Managing HCBS delivery*
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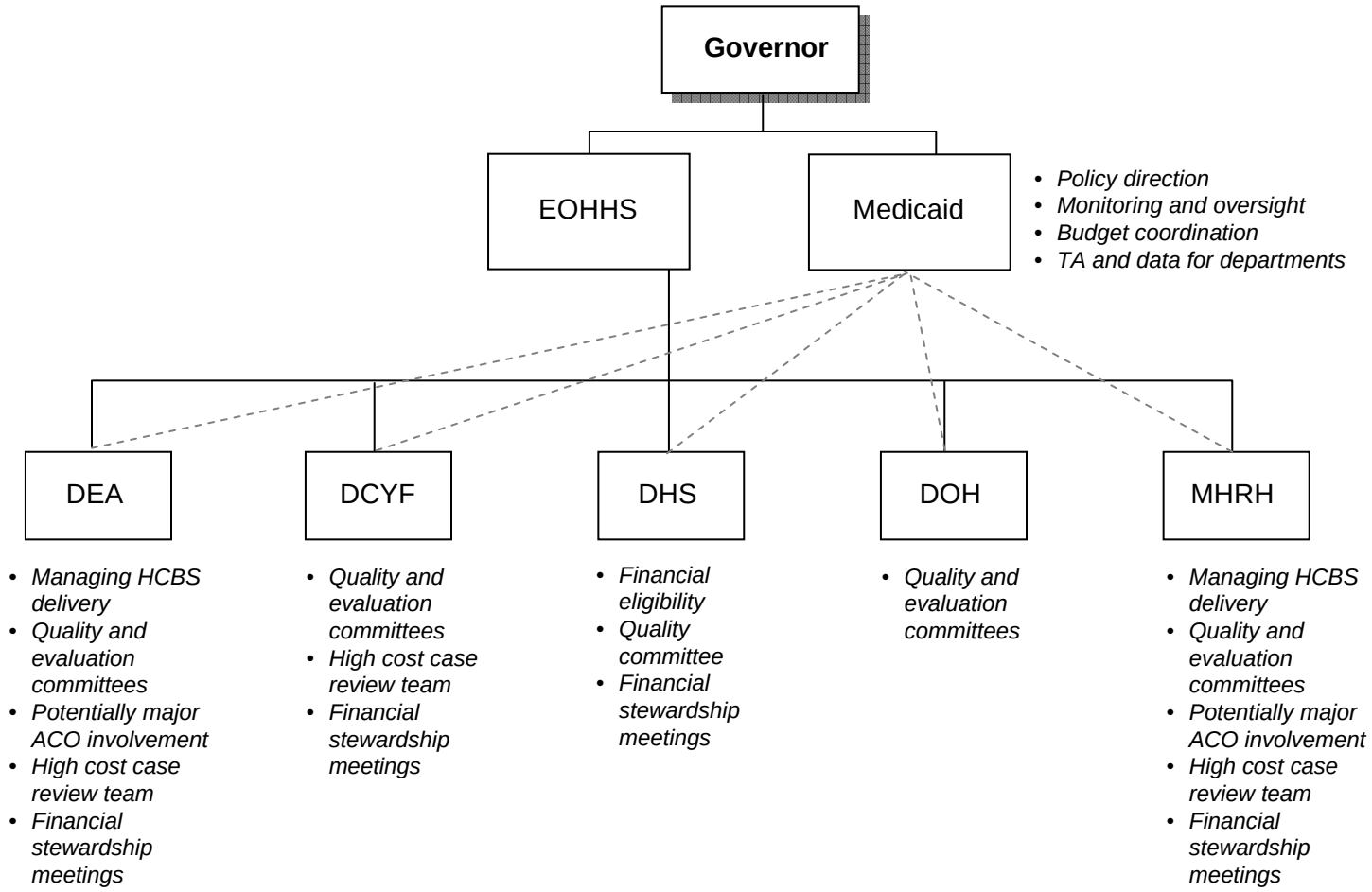
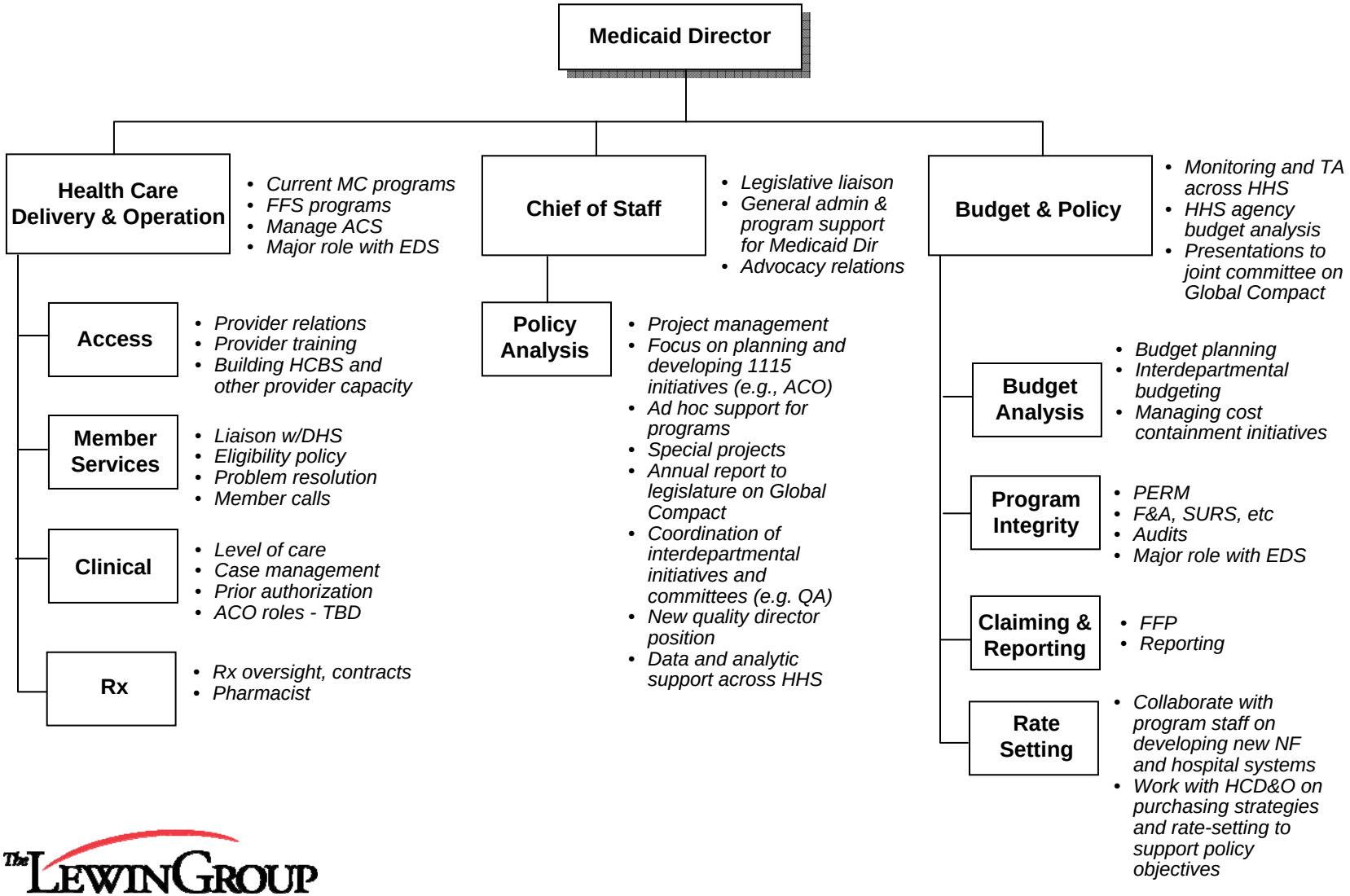
Proposed Medicaid & LTC Functions under the Global Compact, as Medicaid is Currently Placed

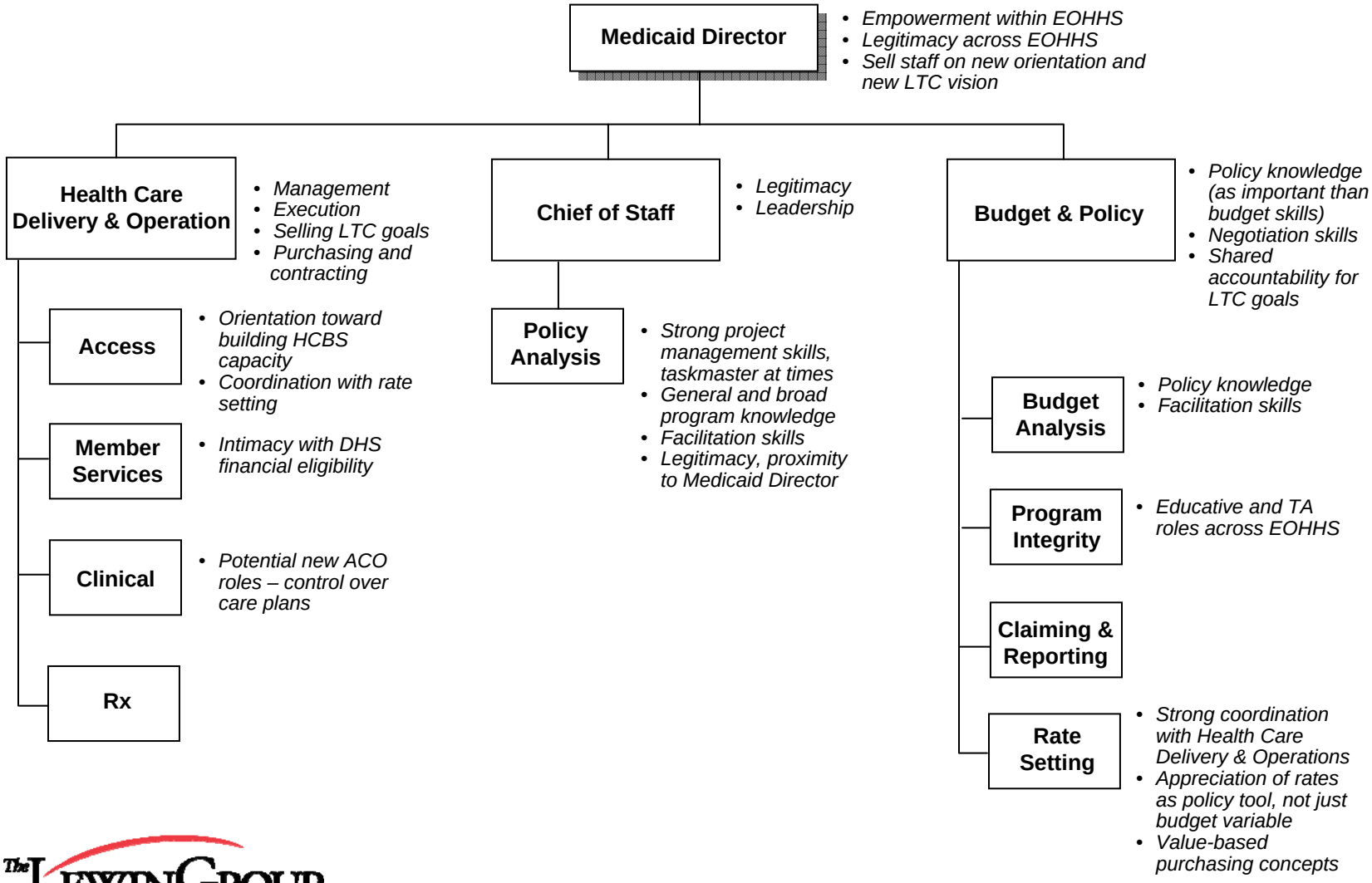
Regardless of where Medicaid is organizationally, the same inter-dependencies remain



Proposed Medicaid Structure and Functions



Proposed Medicaid Structure and LTC Success Factors



Rationale for the Proposed Structure

- How does this compare to other states?
  - The states that have had the greatest success promoting HCBS, decreasing nursing facility utilization, and still maintaining low levels of LTC cost increases all have different organizational structures. Endnote #1
  - We compare Rhode Island to Vermont and Oregon in greater detail on the following page.
- What are the other options?
  - We worked with other options for restructuring, but they would likely require longer planning and development phases than envisioned for implementation of the Global Compact.
  - One alternative: making a unit within Medicaid responsible for both financial and medical eligibility for Medicaid. These processes are already coordinated to some extent in field offices, but some states feel that ownership of the entire eligibility process in one place has been an important component of rebalancing.
  - Another alternative: broader reorganization of EOHHS agencies to consolidate LTC in one department. The new department would include most of DEA, a large part of MHRH, and numerous staff from Medicaid (e.g., 30+ LTC/adult services case workers). This is similar to the models in OR, VT, WA, WI. It integrates LTC delivery across population groups and funding streams. See Appendix A for a model of how this might look in Rhode Island.
- Why no dedicated LTC unit?
  - This effort needs to be organization-wide. We felt that a LTC unit might actually backfire by compartmentalizing a diffuse challenge. A LTC unit within Medicaid would still only represent a fraction of the operational activity, since many other programs and services are administered through other EOHHS departments.
- Is there anything magical about the proposed structure?
  - No. Implementing the Global Compact and rebalancing LTC can be achieved under a number of organizational structures. The most critical element in the organization, though, is broad buy-in and accountability for achieving RI's rebalancing goals. The Medicaid Director and other senior staff need to constantly reinforce those goals and make them a part of all decision-making and policy direction.
  - Public policy matters, too! Regardless of the administrative issues, success also depends on legislative, regulatory, and budget decisions to support the goals of the Global Compact.

Comparing RI to Other States

- Massachusetts -

- In 2004, Massachusetts began reorganizing its EOHHS agencies
- Medicaid was elevated to the EOHHS level
  - As a unit, Medicaid shrank/decentralized
  - Many Medicaid staff moved into the EOHHS operating agencies (e.g., LTC team moved to Elder Affairs)
  - It created many more "dotted line" relationships between Medicaid and the other agencies, more of a matrix management model
  - Spawned greater interagency collaboration
- Transition required a major investment of staff time, even for routine activities, when they moved into different agencies
- Strong executive leadership was essential to keep re-org moving
- Now "re-centralizing" some functions to Medicaid, still evolving today

- Vermont and Oregon -

- We interviewed officials in Vermont and Oregon – two states widely recognized as leaders in rebalancing LTC – to assess the investments they made as they implemented LTC reform
  - Vermont has pursued its most recent LTC reform with an 1115 demo, probably more similar to the RI Global Compact than any other in the U.S.
  - Oregon began LTC reform in the early 1980s, one of the first states to aggressively push HCBS alternatives to nursing facilities

Comparing Investments – VT and OR

Vermont	Oregon	Considerations for Rhode Island
Organizational Context		
Agency for Human Services (AHS) is the HHS umbrella agency. LTC is driven by the Department of Aging and Independent Living (DAIL), which merged with part of another agency to incorporate all disability services in 2005, simultaneous with 1115 implementation.	Department of Human Services (DHS) is the single state Medicaid agency. The Seniors and People with Disabilities Division within DHS administers all LTC programs for older adults, adults with physical disabilities and individuals with intellectual and developmental disabilities.	Unlike RI, both states have "integrated" models where a single agency manages the LTC system across populations
Care Coordination/Case Management		
New investment: For older adults and people with disabilities, brought level of care/medical eligibility process in house to a new team of RNs, giving DAIL more control over the intake and assessment process. The RNs also review the HCBS care plans developed by community agencies. They have driven down the cost of the average care plan through the review process. State determined an 'ideal' caseload for the RNs at a level that allows them to perform assessments and utilization reviews with enough flexibility to also work with providers and build relationships with hospital discharge planners.	*1980s investment:* When reform began, there was immediate focus on "relocating" existing nursing facility residents; 20 new state staff were hired for this work in 1982. *1980s investment:* Lots of training for state staff on HCBS options, who could be served in the community, who could transition out of nursing facilities *2008 re-investment:* Reassigned 26 FTEs from central office to field offices and AAAs as "diversion and transition coordinators." They are in and out of NFs daily, working with clients choosing to move back to the community. LOC and financial eligibility are managed by AAAs and local state offices. Public case managers do the LOC assessment and care planning, normally in a person's home. People are generally told immediately whether they are likely to qualify. Services are authorized as soon as all financials are completed. Case management of all LTC clients existed prior to the 1981 waiver and more were added as caseloads grew. State legislature supported additional staff, by formula, as they approved increased caseloads.	OR and VT have evaluated and monitored caseloads with much more rigor than Rhode Island. Our contacts in both states already had reports on caseloads; Oregon has contracted for major external evaluations as well. In RI, by contrast, there does not appear to be any routine tracking of Medicaid caseload levels for HCBS case managers. Unfortunately, the caseloads in OR, VT, and RI are like comparing apples and oranges, due to differences in their scopes of work. We can provide more info on both states upon request.

Comparing Investments – VT and OR, continued

Vermont	Oregon	Considerations for Rhode Island
Provider Capacity		
At start of *Choices for Care*, nearly half of participants were already in self- or surrogate-directed services, through which most beneficiaries choose friends and family as providers. Without that, there would be a struggle to ensure adequate HCBS provider capacity.	*1980s investment:* Provider recruitment has been both state and local responsibility. In the early '80s, the state reassigned about 15 staff statewide to help interested parties become adult foster home providers. Many NF staff also left to become adult foster care providers. Like VT, OR has a high percentage of beneficiaries who direct their own care and hire friends and family. *2008 investment:* recently created new "HCBS capacity developer" position to focus on building community provider capacity.	It is not clear that anyone today is charged with developing LTC provider capacity. We propose that role within Medicaid.
Project Management		
State created a Waiver Manager position, responsible for staff and project supervision; also managed the transition of the existing waivers into the 1115.	1980s strategy (and continuing today): Singular organizational focus on NF caseload, tracked on a weekly basis by region. At weekly meetings, top officials hold field managers accountable for the numbers.	The Oregon approach is straightforward but profound. In RI, it would need to include staff from DEA and MHRH.
HCBS Quality Management		
New investment: Quality assurance team is large, including ten quality improvement specialists. 1/3 of group were new staff, others came from disability and aging services. State was awarded a Quality Assurance grant from CMS parallel to 1115 Implementation.	For in-home services, quality monitoring is primarily through regular contact with case managers State and local agencies monitor community-based residential services (e.g., assisted living, adult foster care)	Advice from VT: Rather than dedicate staff entirely to quality, consider that these staff should also work in day-to-day waiver processes. This ensures a higher level of understanding of the complexity of program operation.

Top Priority Investments for Global Compact

Based on our analysis of the Global Waiver and assessment of the current administrative infrastructure, we recommend:

- Developing robust intake and assessment processes through the ACO
  - The nature of the investment will depend on the ACO model (discussed further on next page)
  - We believe this will require additional FTEs or contractors, whatever the model
- Strengthening case management, focused on helping people leave nursing facilities and avoid them altogether
  - Critical first step: assess current caseloads and establish a routine caseload monitoring process Endnote #2
- Focusing time and attention toward engaging current staff, achieving buy-in for new LTC goals and Medicaid orientation
  - Establish a formal plan for building internal support for rebalancing LTC
  - Work with key staff on the implications of the payer-to-purchaser transition; identify where staff need to develop new skills
  - Re-evaluate job descriptions and titles
  - Re-examine (or establish) written policies and procedures
  - Remain open to feedback and willing to accommodate diverse perspectives
- Developing and aggressively monitoring a master workplan
- Identifying and monitoring performance metrics; establishing accountability for achieving rebalancing goals
  - Example: Oregon's weekly reporting of nursing facility census
  - Need a reliable, timely source of NF census information
- We list other findings and considerations for RI in the supplemental materials at the end of this document

Operationalizing the ACO

- One of the primary vehicles for rebalancing LTC is through reforming the intake and assessment process for people in need of LTC services. The Global Compact describes a new Assessment and Coordination Organization as the centerpiece of this effort.
- Department directors across EOHHS are familiar with the ACO concept.
  - However, we found no consensus about how the ACO would be structured and what it would mean for the operating agencies.
  - Indeed, the directors appeared to be taking a very passive approach to development of the ACO (i.e., "Medicaid will have to figure that out"). It is not clear who will champion this cause.
- The ACO can conceivably take multiple forms. We describe three alternatives on the next page.
  - Decentralized government
  - Centralized government
  - Centralized private-sector vendor

Operationalizing the ACO (continued)

Model	Decentralized Gov't	Centralized Gov't	Centralized Private
Description	The current intake and assessment process stay largely unchanged (i.e., older adults go to DEA, people with DD go to MHRH), but all parties use a coordinated care planning process and shared IT platform.	EOHHS creates a new entity by taking staff involved in intake and assessment processes today (primarily from Medicaid, DEA, and MHRH).	EOHHS contracts with a private entity to manage the intake and assessment processes for all populations in need of LTC
Pro	+ Leverages existing strengths and relationships + Least disruption among ACO options	+ More administratively manageable	+ RI Medicaid has a history of successfully leveraging private vendors in long term, collaborative relationships
Con	- Easy to subvert - Highly reliant on a solid IT platform - This model presents managerial challenges and demands strong inter-departmental cooperation to work	- Staff today are not necessarily solely assigned to assessment and intake, complicating distribution of FTEs - Staff unwillingness to move - Potentially more disruptive to current staff than other options	- Requires consumers and stakeholders to interact with a new entity - Few firms have strong qualifications for serving all disability groups - Would be an expensive new contract without a clear funding source
Considerations	Will the "Choices" initiative be a robust enough platform for this process? Who will lead this process? Is there enough willingness from departments to cooperate?	Would this unit ever have the staffing necessary to be successful?	What hope is there to get authorization for a multi-million dollar contract in current fiscal environment? Potential 75% federal match for services through a QIO
More like	Oregon	Vermont	Maine (Goold Health Systems) Endnote #3

Interdepartmental Coordination

- Global Compact emphasizes interdepartmental coordination
  - See Appendix B for a matrix of interdepartmental committees referenced in the Global Compact and Lewin suggestions on leadership, membership, and frequency
- We recommend that new interdepartmental processes be formalized
  - Relying on voluntary, staff-level coordination alone is dangerous
  - Ultimately, coordination needs to happen at all levels of the organization
- Each interdepartmental committee needs
  - An authoritative chairperson
  - A facilitator with interpersonal skills
  - Mechanisms to promote participants' accountability and procedural transparency
    - Consider requiring attendance, posting meeting minutes to a shared drive, establishing written workplans, other mechanisms

Next Steps

- EOHHS and Medicaid need to decide on the ACO model
- Finalize the plan for staffing, administration, and reorganization for the Global Compact
- EOHHS executive staff meeting to discuss changes
- Revise inter-departmental MOAs
  - To reflect participation in inter-departmental activities related to Global Compact (e.g., quality committee), budgeting processes, and Medicaid roles in TA, data-sharing, etc.
  - It is an important step to formalize role changes for implementing the Global Compact
- Update Medicaid state plan with CMS to reflect new organizational structure for single state Medicaid agency Endnote #4
- Hire a permanent Medicaid Director
  - The sooner the better, of course – but cannot afford to delay critical decisions on implementing the Global Compact until someone new is on board
  - Have EOHHS department directors on interview panel
- Develop the organizational chart to a finer level of detail, clarify supervisory reporting lines
- Rhode Island must move with urgency, but success will not be immediate

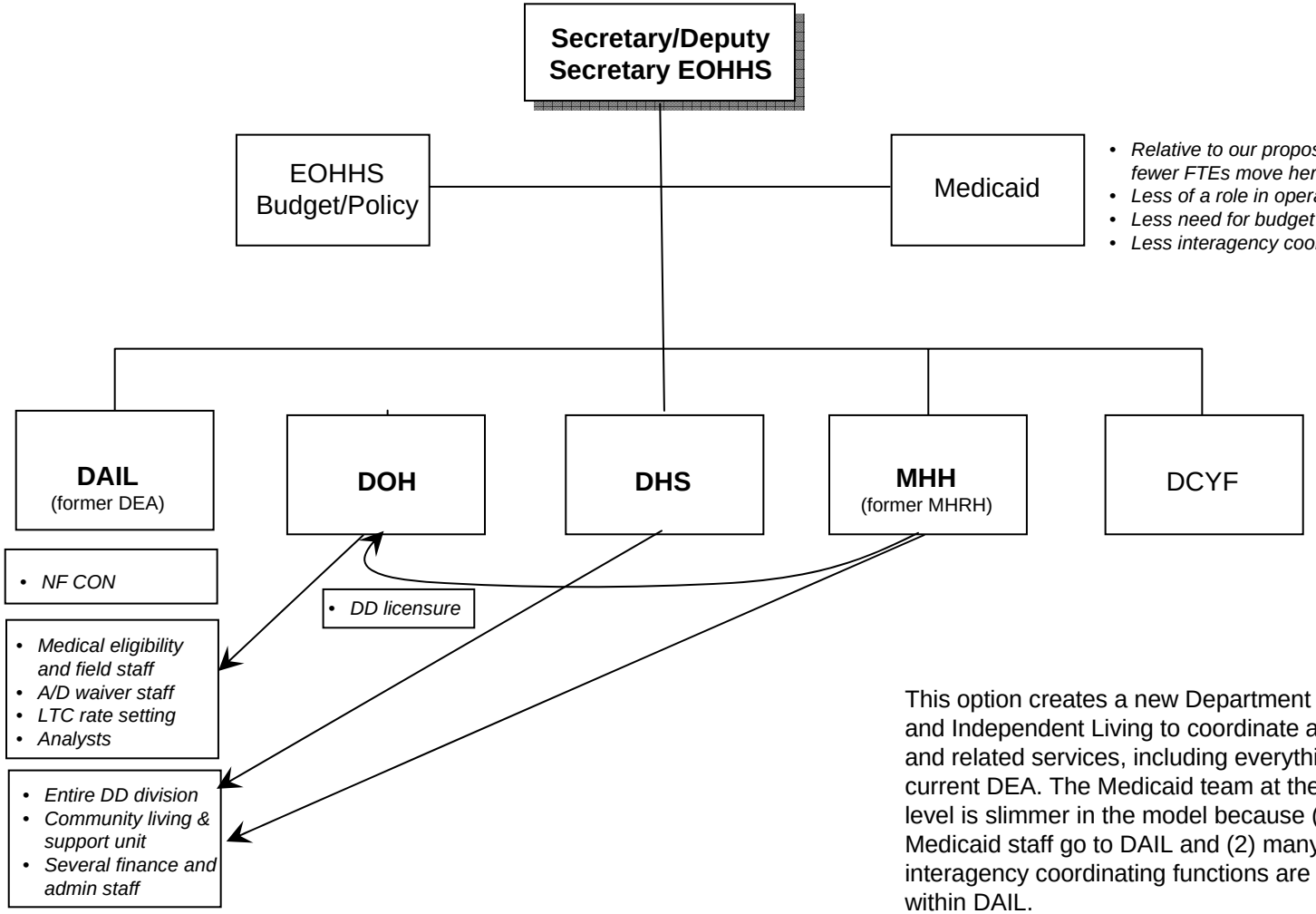
Endnotes

Endnotes

1. Lewin's analysis of national Medicaid data shows three states that have achieved high proportions of HCBS spending, decreased nursing facility utilization, and still maintained low levels of LTC cost increases (MN, WA, WI). All three have different organizational structures. We arrive at MN, WA, and WI with the following criteria for the period 1995 through 2005: (1) proportion of Medicaid LTC spending for HCBS of 30% or more; (2) decline in NF utilization per 1,000 people age 65+ of 25% or more; and (3) average per person increases in LTC spending for ages 65+ of less than 5.2%. Among the other states referenced in this presentation, MA meets criterion #3; ME meets criteria #2 and #3; OR meets #1 and #2; VT meets #1 only. For reference, Rhode Island shows a 10% proportion of HCBS in total LTC spending, an 11.7% decline in NF utilization per 1,000 people age 65+, and an average increase in per person LTC costs of 4.0% from 1995 to 2005.
2. Oregon has recently invested heavily in third-party review and analysis of caseloads for LTC case managers and other social service case workers. We can provide a copy of a report they commissioned in 2006 on assessing caseloads.
3. Maine pays Goold Health Systems $172 per assessment, plus other payments for related administrative tasks. Maine draws a 50% federal match on Medicaid-related assessments, although the assessment process also applies for some non-Medicaid LTC programs. Maine's total cost is approximately $3 million per year for 16,000 – 17,000 assessments. For more information directly from the Maine Office of Elder Services, contact Doreen McDaniel at 207.287.9213. In Rhode Island, contracting to a private entity would free up numerous staff (by our rough count, 20 FTEs) who current work on aspects of the medical/functional eligibility process. Logical redeployments for these staff members would include (1) oversight of the new contract, including review of initial care plans; (2) review of care plans by community case managers, like Vermont; (3) support for the financial eligibility staff to help resolve the current backlog; (4) providing direct case management – as many do now – with a smaller caseload; (5) assignment to specific nursing facilities to provide transition assistance to people who could return to the community; (6) quality assurance work to support interdepartmental QA efforts; (7) HCBS provider recruitment and capacity building.
4. 42 CFR 431.10 and .11 describe the requirements for the single state Medicaid agency and for describing it in the Medicaid state plan. 42 CFR 431.10(b)(2) requires a statement from the state attorney general on the legal authority for the single state agency.

Appendices

Appendix A
Alternative Structure: EOHHS with a LTC Department



- *Relative to our proposal in slide 6, significantly fewer FTEs move here from DHS*
- *Less of a role in operating programs*
- *Less need for budget staff*
- *Less interagency coordination (but still some)*

This option creates a new Department of Aging and Independent Living to coordinate all LTC and related services, including everything in the current DEA. The Medicaid team at the EOHHS level is slimmer in the model because (1) several Medicaid staff go to DAIL and (2) many of the interagency coordinating functions are conducted within DAIL.

Appendix B
Interdepartmental Teams from Global Compact

	Interagency quality team	Interagency evaluation workgroup	Interagency financial and utilization stewardship meetings	High cost case review team
Cite	*pg 66, 68 of 1115 request*	*pg 72*	*pg 78*	*pg 78*
Chair	Quality director (from Medicaid, under COS)	Medicaid policy analyst (from Medicaid, under COS) – until independent evaluator is in place	Medicaid director of budget & policy	Medicaid clinical rep
Members	Rep from ACS, DOH, MHRH, DEA, DCYF, DHS (eligibility), staff from Medicaid-run waiver	Reps from DOH, MHRH, DEA, DCYF, Medicaid program staff	From Medicaid: director of health care delivery & ops, COS, budget analysts; plus reps from MHRH, DEA, DHS, DCYF – maybe EDS if they are lead for producing data reports	Clinical reps from MHRH, DEA, DCYF, ESH; quality director (from Medicaid, under COS); ACO representatives
Goals	Develop quality plan to submit to CMS, develop interagency coordination strategy, monitor ongoing quality initiatives and report to EOHHS and dept directors, monitor critical incidents, annual public report, share data (including claims) with each agency	Set evaluation strategy for independent evaluator, perhaps lead procurement process for new evaluator, develop evaluation plan to submit to CMS	Coordinate budgeting, investment, and cost containment for Medicaid expenditures across EOHHS; monitor all Medicaid expenditures; manage new interagency budgeting "game" (pg 78 of 1115 request)	Identify strategies to cost-effectively manage high cost cases
Meets	Weekly until quality plan goes to CMS 120 days after approval, then either bi-weekly or monthly	Bi-weekly until eval plan goes to CMS 120 days after approval, then monthly	Monthly	Monthly

Supplemental Materials

Supplemental Materials
Staffing & Organizational Will for Reform

Key Findings

- Shortage of staff diverts significant attention from long-term goals to short-term crises and stresses the current workforce
- Institutional knowledge and experience is diminishing with large volume of retirements
- Contractors are relied upon heavily, both for expertise and as a hiring mechanism
- Managers are handling constituent issues because they do not have support staff

Considerations

- All signs point to a need for more FTEs across Medicaid/EOHHS
  - Are there opportunities for job reengineering to achieve greater administrative efficiency? Yes. But it is unlikely that they can be thoughtfully achieved by the people left to put out all the fires
  - Some states actually add staff to contain costs. Activities such as transitioning people out of NFs and monitoring program integrity should yield good return on investment
- Staff training would strengthen the organization for implementation of the Global Compact
  - Clinical staff (case managers, assessors, etc) should get training on HCBS alternatives, person-centered planning, and consumer direction (similar to Oregon in the 1980s)
  - Others will need training on value-based purchasing, CMS rules, contract management, managing IT. Consider:

Old Paradigm		Skill Required for Global Compact
Rates based on cost review	→	Link payment to outcomes
Pay any minimally qualified provider	→	Use financial incentives to drive efficiency and quality improvement
Funding is dedicated to specific programs/provider types	→	Empower consumers to make cost-effective decisions and direct their own care
Conduct quality reviews directly	→	Monitor, oversee, and provide TA for providers/health plans that are responsible for quality assurance

Supplemental Materials, continued
Finance, Budget, & Data

Key Findings

- No strong apparatus for coordination among departments
- Directors express willingness to work together but few incentives exist
- Accountability to individual budgets in each Department hinders potential for money-saving collaboration across program silos

Considerations

- Integrating budget and policy staff will promote closer collaboration and strategic budgeting decisions
- Medicaid director and budget staff need to help negotiate interdepartmental budget issues

- Data systems in Medicaid agency and in the individual Departments are operated in isolation
- Departments seem to crave more direct analytic support and information from the Medicaid agency (although it is not clear that they know exactly what they need or how they would use it)

- Diagnose the current barriers to information-sharing. If HIPAA is one, assign EOHHS legal counsel to clarify rules and help execute data-sharing agreements.

  Key staff across EOHHS may benefit from a Medicaid data summit to review what data are collected, how often, data limitations, and how this information might be leveraged to monitor and improve program performance.

- EDS can make changes necessary for proposed 1115 functions in reasonable timeframe

- If ACO is implemented in a decentralized model, the IT platform becomes crucial for success

Supplemental Materials, continued
Beneficiaries, Eligibility, & Case Management

Key Findings

- Many crucial elements of change are still undecided, especially the ACO model
- Department directors seem generally supportive of constructive change and well-versed in waiver's contents, but none are likely to be champions for implementation

- Processes for determining eligibility and performing case management functions are not well-coordinated or streamlined and differ across programs
- Medical/functional eligibility determinations for LTC are done by paper review instead of in person, thus yielding control of this aspect of eligibility and planning to providers
- Staff report increasingly long wait times for consumers' financial eligibility determinations

- Very high case management caseloads, mixed responsibilities for case managers

Considerations

- No indications that a decentralized ACO model would have strong buy-in from the departments; the model would demand strong EOHHS leadership

- There appear to be significant opportunities for workflow improvements and job reengineering in the Medicaid eligibility process

- Decisions on how the ACO will be operationalized will affect case management infrastructure
- Review current caseloads for case managers and establish a regular monitoring system
- Work with the budget office and legislature to establish a formula for automatically approving new FTEs based on changes in HCBS caseload
- Relocation of licensure function for developmental disability providers from MHRH to DoH may help

Supplemental Materials, continued
Additional Roles and Tasks and the Need for FTEs

- There are no reliable sources for comparative analysis of Medicaid staffing levels in different states.
- Medicaid staffing is not directly scalable based on state population. For many functions, smaller states need administrative effort similar to the most populous states.
- The Global Compact will create major new administrative responsibilities, but very few current responsibilities will go away.
- A detailed review of FTE needs is beyond the scope of this engagement, and would require time studies of RI-specific activities. Nonetheless, the scope of the new activities in the Global Compact suggests a need for a significant increase in administrative resources.
- The table below highlights a selection of the new tasks to implement the Global Compact.

New Roles/Tasks for Implementing the Global Compact	
New quality director	Selective contracting
New quality improvement functions (pg 68 of waiver)	Developing and managing new healthy choice accounts
New interdepartmental committees (see Appendix B)	Developing and implementing new eligibility rules
New legislative reporting (to joint committee on Global Compact and written annual report)	Major payment reform for hospitals, nursing facilities, and HCBS providers
Additional reporting requirements for CMS	New roles in building HCBS provider capacity
Implementing the ACO	Promulgating regulations and regulatory amendments

Acronyms Used Throughout This Report

- AAA – Area Agency on Aging
- A/D – Aged/Disabled
- ACO – Assessment and Coordination Organization
- CMS – Centers for Medicare and Medicaid Services
- COS – Chief of Staff
- DD – Developmental Disabilities
- FTE – Full-time Equivalent (Employee)
- HCBS – Home and Community-Based Services
- LOC – Level of Care
- LTC – Long Term Care
- MMIS – Medicaid Management Information System
- MOA – Memorandum of Agreement
- NF – Nursing Facility
- PCCM – Primary Care Case Management
- PWD – People With Disabilities
- QIO – Quality Improvement Organization
- RN – Registered Nurse
- ROI – Return on Investment
- TA – Technical Assistance