State of Rhode Island

Alternate Non-Emergency Provider Network Grant Application

Abstract

The Rhode Island Medicaid program is committed to ensuring that beneficiaries receive the right mix of services, at the right time, in the least restrictive and most appropriate setting. Achieving this goal ultimately requires that Medicaid beneficiaries have ready access to a network of quality health providers that promotes primary care and a medical/behavioral home. One of the principal objectives of Governor Donald Carcieri's health care agenda addresses the "four cornerstones" of the federal government's health care reform agenda to improve Rhode Island's system of care by 2010 that focuses on wellness; a balanced delivery system; anywhere, anytime health care information, affordable health insurance, and smart state purchasing.

Toward these ends, the state embarked on a several initiatives that are designed to facilitate the adoption of improved primary care across payers and providers and implement a statewide health information exchange (HIE) with the capacity to improve health care outcomes for all Rhode Islanders, including Medicaid beneficiaries. To complement the current initiatives, the Rhode Island Medicaid program through this proposal is pursuing to build an alternative non-emergency provider network as tool for improving access to appropriate settings of care for ambulatory-sensative conditions that can be treated by primary care practitioner rather that treated in an emergency department setting.

The Executive Office of Health and Human Services, which oversees the all state Medicaid programs in Rhode Island, proposes a strategy to build an alternative non-emergency provider network that build on these on-going efforts to further its commitment to the right services, at the right time, and in the right setting. The concept has two distinct components, each of which is geared toward bringing the benefits of the right services in the right setting for beneficiaries with ambulatory sensative needs, complex acute and long-term care needs. The Medicaid Non Emergency Provider Network components are as follows: 1) Emergency Department Psychiatric Diversion Project and 2) RIte Care Emergency Department Utilization Project. The Rhode Island Non-Emergency Provider Network would build on the collaboration established between the RI Community Health Center Association and the Hospital Association of Rhode Island, the

efforts underway with the managed care health plans to reduce ED utilization, the established medical and behavioral health collaborative practice models, and recognized Child Psychiatry Access Project models. This proposal will improve the safety and quality of services, promote primary care, improve access to non-emergency care alternate settings, reduce Emergency Department overcrowding, expand the opportunities for beneficiaries to participate in and direct their own care, and reduce the incidence of and risk for medical errors and costly redundancies.

The implementation of these components will further Rhode Island's efforts in achieving the cornerstones of Value –Driven Health Care and access to the right care in the right setting. The proposal will result in transformation of the Rhode Island Medicaid Program by improving access, efficiency, transparency and accuracy. Funding sought under the grant will include project management, clinical support, reporting and survey development, and pay for performance. To this end, Rhode Island Medicaid is requesting a total of $4,200,000.00 over two years.

State of Rhode Island

Alternate Non-Emergency Provider Network

Grant Application

Project Narrative

Statement of Project/Need

Under the auspices of the Executive Office of Health and Human Services (EOHHS), Rhode Island Medicaid proposes a to develop an alternative Non-Emergency Provider Network to ensure access to "right care in the right setting" through the implementation of an Emergency Department Psychiatric Diversion project and RIte Care Emergency Department Utilization program. This will improve the safety and quality of services, improve appropriateness of emergency department utilization, reduce Emergency Department overcrowding, promote primary care, expand the opportunities for beneficiaries to participate in and direct their own care, and reduce the incidence of and risk for medical errors and costly redundancies.

In 2005, there were 382,243 ED statewide visits not resulting in an inpatient stay in an acute care or psychiatric hospital. The 2005 emergency department usage by Medicaid managed care beneficiaries (RIte Care) was the second leading payer with 19.1% of visits and traditional Medicaid Fee-For-Service accounted for 8.4% of the visits.[1] Thus, the total Medicaid visit represented 27.5% or 105,116 visits in 2005. The average 2005 Rhode Island Medicaid ER visits per hundred persons per year is 42.4[2] compared against the national average of 39.9 ER visits per hundred persons per year.[3]

---

[1] Health By Numbers, Utilization of Hospital Emergency Departments, Rhode Island 2005; Karen A. Williams, MPH, and Jay Buechner, PhD; Medicine & Health/Rhode Island; Volume 89, No. 12 (December 2006)

[2] RI Department of Health

[3] National Utilization of Emergency Department Visits Per 100 Person: 39.9 Source: National Hospital Ambulatory Medical Care Survey 2003, Emergency Department Summary Tables 1,5,10,12,22 CDC http://www.cdc.gov/nchs/fastats/ervisits.htm. National Utilization of Emergency Department Visits Per 100 Medicaid Enrollee 81.0 Source: McCraig et. al., National Hospital Ambulatory Medical Care Survey 2003, Emergency Department Summary Advanced Data, Number 358, May 25, 2005, http://www.cdc.gov/nchs/data/ad/ad358.pdf.

The Rhode Island Executive Office of Health and Human Services (EOHHS) recently completed a comprehensive study of the state's Medicaid program that identified two service areas where implementation of the Non-Emergency Provider Network would assist directly in advancing its commitment to ensure that all beneficiaries receive the appropriate mix of services in the right setting. [4]

First, one of the most striking findings of the study indicated that emergency department (ED) utilization rates for Rhode Island beneficiaries were considerably higher than the national average across all payers. The greatest utilization of the ED measure in total dollars was in the population of children and families enrolled in the state's Medicaid managed care plan – RIte Care – which serves the largest portion of Medicaid beneficiaries. However, further analysis revealed that, on a per capita basis among unique users, the ED utilization rates and associated costs were the highest for a comparatively small number of adults with disabilities and elderly beneficiaries with complex health care needs.[5]

For example, ED expenditures across populations for the three year period including State Fiscal Years (SFY) 2004 through 2006 indicate that costs for RIte Care beneficiaries were widely dispersed: expenditures increased by 61 percent overall, but only by about 25 percent for unique users. By contrast, for the largest segment of the population of adults with disabilities (about 20,000 of 27,500 individuals), utilization was much more concentrated: Utilization for the entire population increased by 51 percent, but among the unique users in this group in SFY 2006, about 30 percent were responsible for 72 percent of ED expenditures during the year. (This figure excludes those beneficiaries who qualify for Medicaid as severely and persistently mentally ill (SPMI) and through the state's Developmental Disabilities/Mental Retardation HCBS waiver).[6]

Emergency Department utilization rates for the elderly population increased much more slowly from SFY 2004 to 2006, by 10 percent.[7] An earlier study on ED utilization found that a

---

[4] The study focused broadly on trends in service and case mix, utilization, payment rates by provider, and per beneficiary costs across populations and within coverage groups.

[5] Both populations combined elders and adults with disabilities represented about 24.6 percent of the total Medicaid caseload of 191,355 in SFY 2006. See EOHHS, *The Future of Medicaid in Rhode Island, (State of Rhode Island, EOHHS, June 2007).*

[6] Analysis based on an extract of claims data from the state's Medicaid Management Information System (MMIS) prepared for the EOHHS Medicaid study.

[7] Beneficiaries in transition includes elders who received ED services before/after nursing facility stay of three months or less.

significant percentage of beneficiaries in both groups had serious behavioral health conditions and were more likely to make repeated visits to the emergency room during the calendar year; most had no medical home and, as such, often relied on the ED as a primary care provider for their acute and chronic care needs.[8] Based on this study, the Department of Human Services (DHS) Center for Adult Health, convened an expert panel, that included administrative and clinical staff from DHS, the Department of Mental Health, Retardation and Hospitals, and Emergency Room Medical Directors from the major RI based acute care hospitals, to review the findings of the Emergency Department Psychiatric Utilization quality improvement project for the Fee-For-Service Adult population. The expert panel recommended strategies to implement emergency department diversion plan and discharge alternatives to improve access to current settings of care and reduce service gaps.[9]

The EOHHS Medicaid study noted that such an over-reliance on ED care was not unique to Medicaid beneficiaries; Rhode Islanders with commercial health insurance coverage have similar ED utilization rates, for example.[10] These trends suggest that the factors driving ED use are systemic, most likely a function of both patient and practitioner practices.

For the RIte Care population, the project would focus on strengthening the managed care health plans' strategies to reduce ED utilization. Strategies will include conducting a participant survey of individuals to determine ***why*** they are using the ED instead of the PCP. These results will inform the alternate non-emergency provider network development and will be incorporated in member materials to improve education and outreach to change behavior. Additional efforts would include communication strategies with the PCPs regarding patient ED utilization for Ambulatory Care Sensitive conditions; PCPs question patients about inappropriate use of ER; and information about available non-emergency alternatives. RI would seek to build upon relationships established between RI Community Health Center and RI Hospital Association **c**ollaboration to have ED staff educate patients on primary care/ medical/behavioral health home sites and refer the patient to their PCP for follow up care. This collaboration aligns with the

[8] RI Department of Health and Human Services, Medicaid Research and Evaluation Project, "Behavioral Health Hospital and Emergency Department Services Utilization," (RI DHS, Division of Health Care Quality, Financing and Purchasing, December, 2003).
[9] RI Department of Human Services, Emergency Department Psychiatric Utilization Project Brief, August 2006
[10] Based on an analysis for the EOHHS study comparing ED and hospital the utilization and average lengths of stay for Medicaid v. non-Medicaid population in 2006.

principles outlined in the Report of the Community Hospital Task Force.[11] To address the issue of PCP access to consultations with psychiatrists, RI would seek to implement a network modeled on the Massachusetts Child Psychiatry Access Project (MCPAP).[12] RI's demonstrated success with the Performance Goals Program for the managed care health plan will provide the platform to develop additional Pay For Performance methodologies. The RI project may explore co-pays for non-emergency ED visits.

The Emergency Department Psychiatric Diversion project will focus on the Medicaid Fee-For-Service adult population through the creation of a network of behavioral health providers for adults, not served by the Community Mental Health Centers, as an alternative to the ED for non-emergency services. RI would seek to build relations with Community-based hospitals to explore feasibility of partnering to create alternative in-patient community site for alcohol detoxification and rehabilitation. RI would propose to integrate Psychiatric Nurse Case Manager(s) in the ED of the highest volume hospital emergency rooms to be on-site at peak hours of admissions. The Psychiatric Nurse Case Manager would provide referral and follow up for behavioral health, act as liaison back to primary care and community mental health centers as needed, and collect data on Psychiatric/Alcohol and Substance Abuse admissions including days of week and time. Additionally, RI would develop a workgroup with other insurers and the Allied Advocacy Committee for behavioral health collaborative practice networks to create additional alternatives to ED use for detoxification for all insurers.

Project Justification

The Rhode Island Medicaid program has a broad reach. In a state with a population of just over million, the program provides health coverage and services to upwards of 200,000 Rhode Islanders at any given point during the calendar year. As Medicaid is one of the principal payers and purchasers of health care in Rhode Island, the program is uniquely positioned to contribute to the statewide improvements in ED utilization.

The growth in ED utilization poses a unique set of challenges for the state, not only with respect to the attendant high costs of care, but also relative to the goal of providing the right care,

---

[11] Report of the Community Hospital Task Force, July 27, 2007

[12] Targeted Child Psychiatric Services: A New Model of Pediatric Primary Clinician—Child Psychiatry Collaborative Care From the Department of Psychiatry, Division of Child and Adolescent Psychiatry and Pediatrics, University of Massachusetts Medical School, Worcester, MA. Reprint requests and correspondence to: Daniel F. Connor, MD, Department of Psychiatry, University of Connecticut Health Care, 263 Farmington Avenue, MC 1410, Farmington, CT 06030-1410. Clinical Pediatrics, (June 2006)

at the right time, in the right setting, particularly for those beneficiaries with the most serious health needs. Of the greatest concern to the state is that a significant portion of the Medicaid beneficiaries served in these settings require primary rather than true emergency care services. In the ED in particular, treating health care practitioners do not typically have ready access to a patient's medical history when ordering and interpreting the results of these services. Such information, when available, is generally provided by fax or over the phone, both of which lend themselves to misinterpretations and errors. This situation can be, and often is, complicated further by the fact that many Medicaid beneficiaries without a medical home, seek care in a variety of different venues and by different providers as well as in multiple EDs.

RI proposes to facilitate appropriate access to primary care for Medicaid recipients by developing access to alternative non-emergency providers in collaboration with PCPs and the hospitals. While several incremental diversion strategies have been developed and implemented, reductions in ED utilization have not been substantially realized. Preliminary information from the RI Community Health Center and RI Hospital Association utilization time study indicates that beneficiaries present at the ED for care when the Community Health Center was available to see patients. The data shows that 20% of health center patients in urban areas use the ED when the health centers are open; 70% of this 20% is for pediatrics. In suburban areas, the number appears to be about 12% with the predominance again in pediatrics (67%). That translates to approximately 18,779 people of which 12,978 (approximately 69.1%) are under 19 years old. A survey of 120 patients at one health center revealed that when questioned if the member used the ER in the last 30 days the affirmative response indicated that 15% were for pediatric patients, 11% for Adults and 9% for Ob/Gyn services.[13]

Critical to the success of the RI project is a survey of the members that present to the ED for non-emergency services. Results from the survey will be incorporated into the development of the non-emergency provider network. A key element of the successful use of the non-emergency network, once developed, is the message communicated by the PCP to the member about the availability of the resource and the responsibility of the member to utilize the available resource as an alternative to the ED. The collaboration with the hospital EDs remains a critical factor to successful implementation of ED diversion efforts. RI is well positioned to build upon successful statewide collaborative statewide initiatives made to date. It is anticipated that

[13] Data from the Rhode Island Community Health Center Association

additional funding under this grant will significantly enhance progress to improve efficiencies in the ED utilization and improvement in quality and access to care.

Specifically, the proposal to improve the access to alternatives to non-emergency providers is especially needed for beneficiaries in need of behavioral health services. For both the populations identified in this proposal, access to behavioral health services is a prevalent issue. PCPs are often not equipped to address the member's behavioral issues and may send the member to the ED for care. The RI proposal offers to address these issues by enhancing collaborative arrangements between PCPs and behavioral health providers.

Recent studies and reports estimate that up to 70 percent of children and adolescents with mental health problems do not receive timely access to appropriate services.[14] Rhode Island has faced and continues to face a significant shortage in available child psychiatrist. Reports speak to similar circumstances nationally. "While the small number of child psychiatrists is a historical issue with only about 6700 child and adolescent psychiatrists practicing in the United States compared to approximately 55,000 pediatricians and 78,000 family physicians (PCP's),"[15] Rhode Island joins other leading states in dealing with the problems that stem from lack of access to timely psychiatric evaluations for our most vulnerable youth. In an effort to provide timely access to behavioral health care and avoid crisis based care, this project proposes to develop a collaborative care model between our pediatric primary care clinicians and our child psychiatry network. This model, tailored after Massachusetts Child Psychiatry Access Project (MCPAP), will promote the use of consultation by developing a small but readily available psychiatric network able to respond in a timely manner to answer questions/concerns identified by the pediatrician/PCP. Consultation is provided to assist PCP with:

- Immediate phone access to expert consultation by a child psychiatrist or psychiatric nurse practitioner.
- Rapid access to a full psychiatric evaluation/consultation with a child psychiatrist or nurse practitioner.
- Rapid access to assistance with care-coordination/referral services for therapy and/or complex care needs.

---

[14] Responding to an Emergency for Children's Services, William Kanapaux; Behavioral Healthcare Tomorrow, (October 2003)

[15] Targeted Child Psychiatric Services: A New Model of Pediatric Primary Clinician—Child Psychiatry Collaborative Care From the Department of Psychiatry, Division of Child and Adolescent Psychiatry and Pediatrics, University of Massachusetts Medical School, Worcester, MA. Reprint requests and correspondence to: Daniel F. Connor, MD, Department of Psychiatry, University of Connecticut Health Care, 263 Farmington Avenue, MC 1410, Farmington, CT 06030-1410. Clinical Pediatrics, (June 2006)

- Rapid access to short-term behavioral interventions with a return to PCP for continued follow-up once medication management is stable.
- Education and knowledge transfer to primary care physicians.

With the difficulties of access to timely mental health specialty care contributing to greater ED use, our effort is to promote access to "the right care…intervening earlier not later…in the right setting" by supporting our pediatric primary care physicians and giving them access to the tools they need through timely access to psychiatric collaborative arrangements.

The RI proposal will be linked to on-going statewide initiatives. Specifically, the Rhode Island Department of Health was one of five states nationally to be awarded a demonstration contract from the Agency for Health Care Quality and Research (AHRQ) to create the infrastructure (connectivity) for a statewide HIE in 2005. Once implemented, the HIE will allow patients to have all their medical information shared electronically with their health care providers, regardless of where the care/services were obtained. In addition to significantly enhancing the HIE for Medicaid beneficiaries, RI is seeking funding under DRA Systems Transformation to establish RIte ReSources, a web based interface with real time provider availability and Medicaid service quality reports. These will allow discharge planners and other providers to have access to complete and timely information from across multiple medical records when treating and discharging a patient and will result in improving the quality, safety and efficiency of the state's health care system. This project also fully supports the Governor's health information technology health care priority entitled "Anywhere, Anytime Health Information" and the cornerstones of Value-Driven Health Care.

Project Goals and Outcomes

The successful development of a non-emergency provider network has numerous implications for many external partners as well as other state departments and internal programs. Improvements in the quality and efficiency of care provided will be realized in provider settings by having the necessary access to readily available non-emergency provider network. This will result in reducing errors in order to more appropriately use Medicaid dollars. Moreover, the goals of "anytime, anywhere health information" intersects with the state's on-going efforts to garner all available resources to ensuring all beneficiaries received the right services, at the right time, in the most appropriate setting.

The Goals and Objectives are as follows:

Goal I: RIte Care Emergency Department Utilization program will improve access to alternative non-emergency providers.

Objective Ia: By the end of twelve months, results from the member participant survey of individuals to determine why they are using the ED instead of the PCP are analyzed and included in the development of the network of non-emergency providers, including the implementation of provider and member communication strategies.

Objective Ib: By the end of eighteen months, a non-emergency provider network is established for RIte Care beneficiaries.

Objective Ic: By the end of eighteen months, a pediatric psychiatry access collaborative is established for RIte Care beneficiaries

Objective Id: By the end of eighteen months, feasibility is determined for implementation of co-pays for non-emergency provider services for RIte Care beneficiaries and enhanced payments for PCP after hour access for urgent care.

Objective Ie: By the end of eighteen months, a program quality evaluation and reporting plan is designed and implemented.

Goal II: Emergency Department Psychiatric Diversion project will establish non-emergency provider alternatives for adult beneficiaries.

Objective IIa: By the end of twelve months, the highest volume hospital emergency rooms are identified and a Psychiatric Nurse Case Managers is integrated on-site

Objective IIb: By the end of eighteen months, a network of behavioral health providers for adult beneficiaries is established.

Objective IIc: By the end of eighteen months, feasibility of partnering with community based hospitals to create alternative in-patient community site for alcohol detoxification and rehabilitation for adult beneficiaries is determined.

Objective IId: By the end of eighteen months, behavioral health collaboration practice networks are created and implemented to provide additional alternatives for ED utilization for adult beneficiaries, including pay for performance reimbursement.

Objective IIe: By the end of eighteen months, a program quality evaluation and reporting plan is designed and implemented.

The goals of this project and the Rhode Island Medicaid program align with those outlined in the Deficit Reduction Act (DRA) of 2005 to implement effective reforms to slow spending growth while growth while helping people get the care they need in a non-emergency setting. Rhode Island proposes using grant funds to facilitate appropriate access to primary care for Medicaid recipients by offering a delivery system of non-emergency providers that meet the needs of the beneficiaries and fosters a medical/behavioral home model of care that is focused on access and choice and provides quality and cost-effective care in a community-based setting. RI's proposal will dovetail with on-going statewide initiatives under the Governor Health Care agenda, specifically the implementation of a statewide HIE. Given the growth trends in ED utilization for non-emergency services, it is essential that the delivery system promote increased use of appropriate services, decreased avoidable utilization in ED settings of care, and be accountable for measuring and monitoring performance outcomes.

Estimated Impact on Medicaid Beneficiaries

As detailed in this proposal, the project will be implemented statewide with the focus population of children and families enrolled in the state's Medicaid managed care plan – RIte Care – which serves the largest portion of Medicaid beneficiaries (nearly 130,000) and elder and adults with disability (45,500 of the 186,964) beneficiaries covered by Medicaid. There are segments of both these populations with complex health needs who seek or require services in multiple care settings. The development of an alternative Non-Emergency Provider Network to ensure access to "right care in the right setting" through the implementation of an Emergency Department Psychiatric Diversion project and RIte Care Emergency Department Utilization program will improve the safety and quality of services, improve appropriateness of emergency department utilization, reduce Emergency Department overcrowding, promote primary care, expand the opportunities for beneficiaries to participate in and direct their own care, and reduce the incidence of and risk for medical errors and costly redundancies.

The benefits of this statewide project will address the primary care provider's ability to provide care for beneficiaries with behavioral health issues through the development of

partnerships with behavioral health collaborative practice site and the Psychiatry Access program. By implementing this project, RI will seek to build PCP access to the limited number of RI based psychiatric practitioners, and specifically child psychiatrists, to provide consultation and reduce the long waits for behavioral health appointments. This proposal combined with the on-going HIE initiatives positions RI to realize effective reforms to slow spending growth across populations due to the increased access to non-emergency provider settings, increased flow and exchange of information, the resulting reductions in medical errors and duplication, more efficient prescribing of medications, and improved health outcomes.

Magnitude of Transformation

The project promises to bring systemic change to the Medicaid program by increasing the availability of alternative non-emergency provider networks to improve economy, efficiency, transparency, and effectiveness of the health coverage and services provided to beneficiaries. By focusing on key populations where Medicaid ED utilization is high for non-emergency services, this project will provide a maximum impact on dollars and, most importantly, quality of care and transparency for Medicaid beneficiaries. As has been stressed throughout this proposal, the state is strongly committed to pursuing the "right care in the right setting " and to achieving the goal of providing every beneficiary with the appropriate mix of services in the right setting.

As previously stated, the EOHHS Medicaid study noted that such an over-reliance on ED care was not unique to Medicaid beneficiaries; Rhode Islanders with commercial health insurance coverage have similar ED utilization rates.[16] These trends suggest that the factors driving ED use are systemic, most likely a function of both patient and practitioner practices. This project will facilitate appropriate access to primary care for Medicaid beneficiaries, by understanding ***why*** the member is presenting to the ED, establishing the infrastructure for non-emergency provider networks, and creating efficiencies for collaborations between behavioral health practitioners and primary care providers. We believe that these changes will provide a statewide benefit across all payers.

Through the implementation of statewide initiatives, such as the HIE, a significant number of Medicaid beneficiaries stand to gain from the improvements in health and safety that the increased flow of data through the HIE promises to bring. Other initiatives include

enhancements in the MMIS under the auspices of the state's MITA initiative and expansions in Medicaid care management capacity through MMIS CHOICES are designed to complement and further these improvements for Medicaid beneficiaries in the community as well.

Description of Sustainability of the Project

As Medicaid is one of the principal payers and purchasers of health care in Rhode Island, the program is uniquely positioned to contribute to the statewide improvements in ED utilization. The Rhode Island Medicaid program has a broad reach. In a state with a population of just over million, the program provides health coverage and services to upwards of 200,000 Rhode Islanders at any given point during the calendar year.

As described in this proposal, RI seeks to establish an alternate non-emergency provider network that will meet the needs of the beneficiaries and the PCPs and stress the "right care at the right time." For both the RIte Care and Adult Medicaid populations, understanding why members present to the ED rather than the PCP will be critical to changing behavior. RI would seek to build upon relationships established between RI Community Health Center and RI Hospital Association **c**ollaboration to have ED staff educate patient on primary care/medical home sites and referral to PCP for follow up care. Additionally, the project will seek to establish strategies to address ED utilization for behavioral health issues that could be managed in an alternative setting. Once implemented, the benefits of the project will be sustained as the members will have access to the network of non-emergency providers and provider communications will be established to support utilization of the network

This proposal will align with statewide efforts of Rhode Island's health care sector through a public/private partnership that has been working collaboratively to create a vision for a high quality, safe, and efficient health care system. Specifically, the implementation of health information technology such as electronic health records (EHR), e-prescribing, the development of a health information exchange (the system for sharing patient information across provider settings) will augment the coordination of care in the primary care setting. In doing so, Rhode Island Medicaid expects to reduce costs, the risk of adverse events, and medical errors as well as improving health outcomes and further its commitment to ensure every beneficiary receives the right services, at the right time, in the most appropriate setting.

---

[16] Based on an analysis for the EOHHS study comparing ED and hospital the utilization and average lengths of stay for Medicaid v. non-

Evaluation Plan

The Rhode Medicaid program will comply with the statutory reporting requirements including the submission of the SF-269a and the progress RI is making in the establishment of an alternative non-emergency service provider network. The project will also include a performance evaluation of the project to include 1) cost benefit comparison of Medicaid ED services before and twelve months after the implementation of the non-emergency provider network based on claims information, 2) a review of PCP billing for after hour services before and after implementation and 3) a review of data collected in ED for Psychiatric/Alcohol and Substance Abuse admission billing of behavior health consultations for the period six months before and after integration of on-site nurse case manager. In addition, the state will track and monitor each project deliverable and performance objective as identified in the "Project Goals and Outcomes."

Description of Project Implementation Readiness

Rhode Island is well positioned to implement the project. Rhode Island has been actively engaged in identifying performance improvement activities to curb utilization in the ED. RI would propose to procure the services outlined in this proposal. Based on our experience, we believe that this will take approximately three months. The tasks/timeline that demonstrates RI's readiness to implement the project is outlined below.

Medicaid population in 2006.

Implementation Tasks/Timeline

Task Name	12/07	03/08	06/08	09/08	12/08	03/09	0609	0909
Goal I: RIte Care Emergency Department Utilization program will improve access to alternative non-emergency providers.								
By the end of twelve months, results from the member participant survey of individuals to determine why they are using the ED instead of the PCP are analyzed and included in the development of the network of non-emergency providers, including the implementation of provider and member communication strategies.								
By the end of eighteen months, a non-emergency provider network is established for RIte Care beneficiaries								
By the end of eighteen months, a pediatric psychiatry access collaborative is established for RIte Care beneficiaries								
By the end of eighteen months, feasibility is determine for the implementation of co-pays for non-emergency provider services for RIte Care beneficiaries and enhanced payments for PCP after hour access for urgent care								
By the end of eighteen months, a program quality evaluation and reporting plan is designed and implemented.								
Goal II: Emergency Department Psychiatric Diversion project will establish non-emergency provider alternatives for adult beneficiaries.								
By the end of twelve months, the highest volume hospital emergency rooms are identified and a Psychiatric Nurse Case Managers is integrated on-site.								
By the end of eighteen months, a network of behavioral health providers for adult beneficiaries is established.								
By the end of eighteen months, feasibility of partnering with community based hospitals to create alternative in-patient community site for alcohol detoxification and rehabilitation for adult beneficiaries is determined.								
By the end of eighteen months, behavioral health collaboration practice networks are created and implemented to provide additional alternatives for ED utilization for adult beneficiaries.								
By the end of eighteen months, a program quality evaluation and reporting plan is designed and implemented.								

VIII. *Budget*

The grant amount that is requested to fund the project is $ 4,200,000.00. As reflective of the proposed project schedule, the estimated funding for Federal fiscal years 2008 and 2009 is $1,800,000.00 and $ 2,400,000.00 respectively.

Line Item	Description	Estimated Funding Requirement – Federal FY' 2008	Estimated Funding Requirement – Federal FY' 2009
Personnel/ fringe benefits		n/a	n/a
Contractual cost	Project Management and Technical Leadership	$975,000.00	$1,050,000.00
	Clinical Support	$200,000.00	$275,000.00
	Project Survey	$125,000.00	$75,000.00
	Sub-total	**$1,300,000.00**	**$1,400,000.00**
Travel		$0.00	$0.00
Supplies		$0.00	$0.00
Equipment		$0.00	$0.00
Other Cost	Pay For Performance	$500,000.00	$1,000,000.00
	Sub-total	**$500,000.00**	**$1,000,000.00**
	Total	**$1,800,000.00**	**$2,400,000.00**