Integrated Medicare and Medicaid Services for Dually Eligible Beneficiaries in Rhode Island's Medicaid Program

Proposal for Transitioning from the Financial Alignment Initiative Demonstration MMP to A Comprehensive Program for Dually Eligible Medicaid Beneficiaries

Transition Plan
September 30, 2022

Table of Contents

1. Introduction and Background

Rhode Island is pleased to submit this Transition Plan to CMS to clearly affirm its intention to convert its Financial Alignment Initiative (FAI) Demonstration Medicare/Medicaid capitated plan (MMP) to a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)[1] and to outline its plan for doing so. Moving to a FIDE SNP for full benefit dually eligible beneficiaries (FBDEs) is part of Rhode Island's larger mission to foster and strengthen a community-driven, equitable, comprehensive, responsive, and high-quality health and human services system.

The underlying rationale for this initiative is to provide improved, equitable beneficiary experience and outcomes by addressing the lack of continuity and coordination of care resulting from the coverage and management of needed services for dually eligible beneficiaries in two different systems of care. Fragmentation between the two systems occurs at multiple levels. Fundamental is the differences in the services covered by Medicare and Medicaid. Medicare is the primary payer for most hospital, medical, and pharmacy services, while Medicaid pays for Medicare deductibles and cost sharing, and provides coverage of additional services, importantly including long term services and supports (LTSS).

FIDE SNPs represent the highest level of integration between the programs for members, for health plans, for providers, and for payers. The CMS Final Rule published on May 9, 2022, establishes multiple requirements to strengthen the integration of FIDE SNPs, including exclusively aligned enrollment, unified appeals and grievances processes, integrated member materials, administrative simplification in billing and payment for providers, and actuarially sound capitation rates to include Medicare cost-sharing.

Rhode Island believes that the Medicare-Medicaid integration achievable through FIDE SNPs will form the basis for continued, equitable improvement in the experiences and outcomes for the State's dually eligible beneficiaries.

This submission is triggered by the enactment of the Final Rule regarding rules and regulations for the Medicare program[2]. The Final Rule includes revisions to the Medicare Advantage program and to regulations related to dual eligible special needs plans (D-SNPs).

The Final Rule addresses the termination of the FAI Demonstration and provides a pathway for the transition of MMPs to become integrated D-SNPs. The FAI demonstration program is slated to terminate as of December 31, 2023. For Rhode Island this would mean that its present MMP program would need to close by the end of calendar year 2023.

However, in the Final Rule, CMS provides the opportunity for states to convert their MMPs to integrated D-SNPs noting that States: *"will need to convert all MMPs to integrated D–SNPs as early as possible, but no later than December 31, 2025. This timeframe reflects the perspectives expressed in public comments related to the time needed for a smooth transition*." [3] Under this provision a state can maintain its MMP until December 31, 2025, if it has provided CMS with a transition plan by October 1, 2022.

[1] Attachment A includes additional information on FIDE SNPs and updates to integrated D-SNP requirements from the May 9th Final Rule

[2] Final Rule – May 9, 2022 (Federal Register/vol. 87, No. 89/Monday/May 9, 2022/Rules and Regulations

[3] Ibid p. 27798

2. Required Elements of Transition Plan

The Final Rule outlines essential elements of an approvable Transition Plan.

Per the Final Rule the Transition Plan should:

a. Reflect each State's individual circumstances and outline the State's commitment to:
- Maximize integration attained through the capitated financial alignment demo and a seamless transition to integrated D–SNPs,
- Sustain dedicated ombudsman support without Federal grant funding,
- A stakeholder engagement process to promote collaborative discussion on the planning and implementation of the transition to integrated D–SNPs.

b. The transition plan should also identify specific policy and/or operational steps that need to occur to fulfill the commitments. These could include, but are not limited to:
- Executing Medicaid procurement and/or D–SNP contracting processes;
- Obtaining necessary State legislative or additional Medicaid authorities, if applicable;
- Identifying and executing system changes and processes to implement exclusively aligned enrollment.[4]

Each of these elements are addressed in turn in this submission of Rhode Island's Transition Plan.

The Transition Plan, specified herein, will allow for substantive public feedback and refinement over the coming months.

3. Rhode Island's Commitment to a Seamless Transition to an Integrated D–SNP Model

3.1. Rhode Island's Vision and Goals

Rhode Island is fully committed to maximizing the integration attained through the capitated FAI demonstration. RI seeks to accomplish this through transition to FIDE SNPs that will have a companion Medicaid managed care contract offered by the same parent organization as the FIDE SNP and that closely mirrors the benefits and performance requirements of the current MMP arrangement.

RI intends to transition its current MMP offered by a single health plan and contract with multiple FIDE SNPs to offer a broader array of options for the State's FBDEs. This will be accomplished by making the capitated model for duals a core component of Rhode Island's broader managed care program.

The terms and conditions of the current three-way MMP contract will be substantially carried forward in the State's contracts with integrated D-SNPs. The terms of the MMP contract have been developed in concert with CMS and provide the basis for a seamless transition. As appropriate, Rhode Island Executive Office of Health and Human Services (EOHHS) will also ensure that the additional requirements set forth in the Final Rule are incorporated. Further, and as is described in this paper, Rhode Island EOHHS intends to use the transition period to thoughtfully consider its approach to

[4] Ibid, p. 27798

extending a greater range of integrated service delivery and provider options for FBDEs. Rhode Island's vision for dually eligible beneficiaries supports RI EOHHS' overall mission and vision.

RI EOHHS
Mission: To foster and strengthen a community-driven, equitable, comprehensive, responsive, and high-quality health and human services system in Rhode Island.

Vision: Resilient, equitable, and just communities nurturing the health, safety, wellbeing, and independence of all Rhode Islanders.

Integrated Duals Program
Vision: Rhode Island envisions an integrated Medicare/Medicaid system that promotes member choice and enables vulnerable populations to access and navigate high-quality, equitable care and services with ease.

Preliminary Strategy: To achieve this vision, Rhode Island proposes:

1) **bringing LTSS as an in-plan benefit for all populations including for full benefit dually eligible (FBDE) beneficiaries.** This will be a program enhancement to existing arrangements, effectively creating a comprehensive Medicaid managed care plan with Managed Long-Term Services and Supports (MLTSS);

2) **requiring all Medicaid contracted health plans to offer a fully integrated dual eligible special needs plan (FIDE SNP) for FDBEs**, that integrates the provision and coordination of services between Medicare and Medicaid. For FBDEs who choose a FIDE SNP service delivery model, the comprehensive Medicaid managed care plan offered by the same parent organization will function as the aligned MLTSS plan to their chosen FIDE SNP, and;

3) **implementing a member choice and enrollment model for FBDEs that leverages unbiased enrollment counseling** to actively promote member choice of all options (comprehensive Medicaid managed care or fee-for-service (FFS)). If a member does not make an active choice, they will be auto-enrolled into the State's comprehensive Medicaid managed care plan, with an option to opt-out to FFS Medicaid.

Goals:
- Provide services in least restrictive, most comfortable, member preferred settings
- Improve member experience by reducing duplication and fragmentation
- Create the right financial incentives to deliver person-centered, efficient care
- Equitably improve health outcomes and quality of life for older Rhode Islanders & people with disabilities
- Enable members to seamlessly navigate continuous, coordinated care with fewer transitions

3.2. Context: The FAI Demonstration and Rhode Island's MMP

In 2011 CMS launched the Financial Alignment Initiative with the:

- *"…goal of improving outcomes and experiences for full-benefit dually eligible individuals while reducing costs for both States and the Federal Government. This State-Federal partnership is tested using authority under 1115A of the Act...*
- *Although the FAI includes two models, the model with the largest number of States participating is a capitated model through which CMS, the State, and health plans (called Medicare-Medicaid Plans or MMPs) enter into three-way contracts to coordinate the full array of Medicare and Medicaid services for members*
- *….CMS and States partnered with MMPs to create a seamless experience for beneficiaries, but MMPs operate as both MA organizations offering Medicare Advantage Prescription Drug (MA–PD) plans and Medicaid managed care organizations."*[5]

Along with eight other states, RI participated in the FAI, launching a three-way partnership among RI Executive Office of Health and Human Services, CMS, and Neighborhood Health Plan of Rhode Island (NHPRI). Participation in the FAI initiative has been a cornerstone of EOHHS' efforts to improve outcomes for dually eligible beneficiaries and strengthen long-term services and supports. Rhode Island's MMP demonstration was launched in July 2016 and has been managed and conducted in close coordination with CMS.

According to the Rhode Island Integrated Care Initiative: Combined First and Second Evaluation Report published by RTI International, **almost all participants in 2017-2018 focus groups were more satisfied with their coverage under the MMP demonstration than with their previous coverage**. Participants were largely satisfied with access to patient-centered care and patient engagement, and mentioned their single member ID card, care coordination, quality, and array of services as specific benefits of the MMP. Further, on a scale of 1 to 5, 95% of focus group participants rated their experience in the MMP as a 4 or 5. As of June 30, 2022 there were 12,915 members enrolled in the program, accounting for about 30% of dually eligible Rhode Islanders.

"My care coordinator [is] my guardian angel. She's there every second and every minute. I have a hard time getting to the things that I need for prescriptions and stuff…so she gets right on it. She's just there. She's my best friend." — Focus Group Participant (2018)

In ending the FAI demonstration, CMS comments in the Final Rule:

> *In the 10 years since the creation of the FAI, the integrated care landscape has changed substantially. Congress made D–SNPs permanent in 2018 and established, beginning in 2021, new minimum integration standards and directed the establishment of unified appeals and grievance procedures (which we tested through the MMPs). Changes in MA policy have also created a level of benefit flexibility that did not previously exist outside of the capitated model demonstrations, with MA plans increasingly offering supplemental benefits that address social determinants of health and long-term services and supports. These factors, in combination with*

[5] Ibid, p. 27715

the proposals discussed earlier in this final rule, offer the opportunity to implement integrated care at a much broader scale than existed when MMPs were first created.[6]

Rhode Island concurs that the current landscape offers important opportunities to build on the learnings of the MMP capitated model and to further strengthen the integration of services for dually eligible beneficiaries into its Medicaid managed care program.

3.3. Three-way MMP contract vs. FIDE SNP contracts

The current MMP arrangement, formed as part of the FAI Demonstration, is a three-way contract between Rhode Island EOHHS, CMS, and the participating Medicare-Medicaid Plan (MMP). As Rhode Island plans its transition from its current MMP program to a FIDE SNP-based arrangement it is important to note that CMS and State Medicaid pathways to certification and contracting follow parallel but distinct tracks. CMS is responsible for certifying Medicare Advantage Organizations (MAOs) and D-SNPs. A key condition for D-SNP certification is a State Medicaid Agency Contract (SMAC) outlining D-SNP responsibilities and requirements and a tightly aligned, companion Medicaid managed care contract (aka RI "Core" Contract). This is especially relevant to development timelines, as elaborated further in Section 7.2.

4. Rhode Island Starting Point

4.1. Overview of Medicaid Managed Care in Rhode Island

As of June 2022, the average monthly enrollment in Rhode Island's Medicaid program was 352,351. Of this total, duals (full + partial) represent 14% of total enrollment or approximately 51,000 people.[7]

Rhode Island has long embraced managed care as its delivery system of choice to provide access to high quality health services to covered populations in a cost-effective manner. Rhode Island's managed care program began on a mandatory-enrollment basis in 1994 with the start of RIte Care.

At the outset, the RIte Care program included carve-outs of various benefits and populations (e.g., behavioral health services; children in substitute care arrangements) and enrollment was targeted to children and family-related Medicaid-only eligibility groups. In the ensuing years RI's managed care program expanded to all Medicaid-only populations, including children in substitute care arrangements, SSI-eligible children and adults, and the expansion population authorized through the Affordable Care Act. The managed care benefit package has been progressively expanded to include the vast majority of Medicaid covered services.[8] This reflects the belief that the best opportunity for responsive and integrated care management is afforded by attentive state oversight of a comprehensive contract with an accountable managed care organization.

Rhode Island's managed care program is operated under the authority of its 1115a waiver (Waiver: Rhode Island Comprehensive Demonstration. Number: 11-W-00242/1); the waiver includes a waiver of freedom of choice of provider for individuals. Freedom of choice is maintained through a choice of

[6] Ibid p. 27796

[7] June 2022 Rhode Island Medicaid Managed Care Report, (42,454 full duals and 8,198 partial duals).

[8] Examples of services that continue to be in fee-for-service include dental care for adults and residential services and day supports for adults with intellectual and developmental disabilities.

two or more contracted managed care organizations (MCOs) and choice of provider within the MCO.

As Rhode Island's delivery system of choice, the large majority – 87% – of beneficiaries are enrolled in a capitated managed care arrangement. This includes 95%+ at any moment in time for children and families and for the expansion population. There are currently three participating MCOs: 1) UnitedHealthcare of New England, 2) Tufts Health Public Plans, and 3) Neighborhood Health Plan of Rhode Island.

Rhode Island's Medicaid program includes coverage of a comprehensive scope of mandatory and optional benefits. Rhode Island's 1115a waiver provides expenditure authority for demonstration benefits not otherwise available in the State Plan. Notably these include expenditures for the provision of core and preventive home and community-based services (HCBS).[9] Section 4.2 below provides details on benefits covered in managed care for duals.

4.2. Dually Eligible Beneficiaries in Managed Care

The picture of managed care enrollment for full duals is somewhat different than that of the overall Medicaid population. Where 87% of overall Medicaid beneficiaries are enrolled in a capitated managed care arrangement, only 40% of dually eligible beneficiaries are in a managed care plan.

As of June 30, 2022 there were 42,454 full duals in Rhode Island. Of these, 12,915 (30%) were enrolled in the MMP program with NHPRI. At present, NHPRI is the only plan participating in the MMP program, therefore, freedom of choice is maintained through a choice of managed care or fee for service, unlike for Medicaid-only beneficiaries, who have a choice of multiple managed care plans.

Table 1 presents the distribution of the FBDE population by delivery system and by certain characteristics.[10] Of the total population of 42,454 full duals, 59% are in FFS, 30% are enrolled in the MMP, less than 1% are in the PACE program, and the remaining 10% are in other managed care arrangements, primarily due to the public health emergency (PHE) during which Medicaid terminations have been paused.

Table 1 also provides a breakdown by residential setting, LTSS determination, adults with intellectual and/or developmental disabilities (I/DD), and seriously and persistently mentally ill (SPMI) diagnosis.[11] As shown below, 25,690 (60.5%) are non-LTSS, 5,727 (13.5%) are receiving LTSS in a home or community setting, 4,856 (11.4%) are in nursing facilities, 3,823 (9%) are diagnosed as SPMI, 1,785 (4.2%) are I/DD and 573 (1.3%) are receiving preventive home and community based services.

[9] Rhode Island's 1115a Waiver provides detail as to expenditure authority and covered benefits. Attachment B, Core and Preventive Home and Community-based Service Definitions, and Attachment C, Rhode Island Long-Term Services and Supports Assessment and Coordination Organization, describe core elements of Rhode Island LTSS/HCBS benefits.

[10] Duals Data Extract July 2022; Composed of Medicaid-Eligible members with full Medicaid benefits (i.e., excluding OHA Copay and QMB Only/SLMB/QI) who have a current TPL segment for Medicare, including Medicare supplemental, Part C, or FFS

[11] Note that for people with I/DD residential services and day support services are provided through fee-for-service.

Table 1. Full Benefit Dually Eligible Beneficiaries in Rhode Island, By Characteristic and Delivery System

	MMP	%	FFS	%	PACE	%	Other Managed Care*	%	Dually Eligible Total	Total %
Community, without LTSS	7,418	*57.4%*	13,984	*56.2%*	284	*82.6%*	4,004	*92.9%*	**25,690**	*60.5%*
Community LTSS	2,152	*16.7%*	3,499	*14.1%*	21	*6.1%*	55	*1.3%*	**5,727**	*13.5%*
Nursing Home / Hospice	697	*5.4%*	4,142	*16.6%*	15	*4.4%*	2	*0.0%*	**4,856**	*11.4%*
SPMI	1,540	*11.9%*	2,050	*8.2%*	17	*4.9%*	216	*5.0%*	**3,823**	*9.0%*
I/DD	912	*7.1%*	844	*3.4%*	0	*0.0%*	29	*0.7%*	**1,785**	*4.2%*
Preventive HCBS	196	*1.5%*	366	*1.5%*	7	*2.0%*	4	*0.1%*	**573**	*1.3%*
Total Duals	**12,915**	***100%***	**24,885**	***100%***	**344**	***100%***	**4,310**	***100%***	**42,454**	***100%***
% of Total	***30%***		***59%***		***1%***		***10%***		***100%***	

*Individuals are currently enrolled in Other Managed Care due to the public health emergency restriction which has paused terminations.

4.3. Covered Benefits for Duals in Managed Care

The MMP is Rhode Island's singular managed care program for FBDEs and includes a comprehensive benefit package. **Attachment B** provides an excerpt from the current MMP contract identifying covered services.[12]

Covered benefits include all Medicaid primary care and acute care benefits, home health services, nursing home services, medical supplies, equipment, and appliances, behavioral health, and LTSS. Coverage includes the Medicaid share of Medicare covered services, mental health and substance use disorder inpatient and outpatient and Assertive Community Treatment (ACT), and Long-Term Services and Supports.

There are limited services covered in Rhode Island Medicaid but excluded from the MMP contract.

- Section A.5 of the MMP contract (Attachment B) identifies the four services excluded from the MMP contract (i.e., residential services for I/DD enrollees, non-emergency transportation services, dental services, and home stabilization services)
- Section A.6 of the MMP contract (Attachment B) identifies six non-covered services (i.e., experimental procedures, abortion services, private hospital rooms (unless medically necessary), cosmetic services, infertility treatment, and medications for sexual or erectile dysfunction).

Rhode Island intends for the future FIDE SNP contract to mirror this listing of overall benefits, managed care contract exclusions and non-covered benefits with one refinement.

Rhode Island is proposing to match the MMP benefits package described above for the future state FIDE SNP with one refinement to carve out Nursing Home and Skilled Nursing Facility (SNF) care

[12] Contract excerpt is titled "Appendix A: Covered Services"

over 180 days per plan year, in line with the federal requirements for FIDE SNPs. Members who require nursing facility services for over 180 days will be disenrolled from their FIDE SNP and all services will be paid for and coordinated by Medicaid fee-for-service.

The current MMP covers 365 days of Nursing Home (NH) Care and Skilled Nursing Facility (SNF) Care, however research demonstrates under 6% of Medicaid eligible individuals in nursing homes for over 180 days, nationally, return to the community each year[13]. Rhode Island is undertaking substantial LTSS redesign efforts, with specific focus on strengthening community transition supports for long-stay NH residents. With these interventions, the State believes it can increase community transitions above 6%. RI intends to require a comprehensive assessment of each long-stay resident at 120-150 days to identify potential candidates for a successful transition to a community-based setting and initiate focused development of a transition plan.

On average, 2.5% (approx. 315 beneficiaries) of the MMP population fall into the category of having been in a residential nursing home setting for over 180 days[14]. The State is still considering whether MMP members will have nursing facility benefits over 180 days "grandfathered" into their future state plan benefits package or if this amendment will apply to all populations. This consideration will be a topic of discussion for stakeholder input during the design and implementation phase of the MMP transition.

4.4. Current Landscape of D-SNPs in Rhode Island

As of this submission there are no integrated D-SNPs in Rhode Island. The D-SNPs listed in Table 2 are coordination-only D-SNPs.[15] RI EOHHS has contracts/agreements with each of these health plans and meets with them on a periodic basis.

As noted in Section 3.3, all D-SNPs are required to operate under a State Medicaid Agency Contract (SMAC) signed by the State and D-SNP. SMACs list all requirements imposed on the Medicare Advantage Special Needs Plan by the State, including federal minimum requirements and additional state requirements to improve administrative, clinical, and financial coordination for enrollees. For calendar year (CY) 2023 SMACs, in addition to data sharing of admissions, discharges, and transfers (ADT's) to and from individual providers and SNF's, D-SNPs must meet the following Medicaid specific requirements:

- Must share their marketing strategies for new members and any member materials that provide information specific to Medicaid services with RI EOHHS prior to distribution (e.g., Annual Notice of Change, Evidence of Coverage, Summary of Benefits).
- Must provide care coordination of all benefits covered by Medicare and Medicaid, including LTSS, grievance and appeals, and are expected to participate in any RI Medicaid HCBS trainings for member-facing staff.
- Lastly (new for CY 2023), D-SNPs will be required to share Healthcare Effectiveness Data and Information Set (HEDIS) SNP measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data.

[13] Wenzlow, Audra T., and Debra J. Lipson. "Transitioning Medicaid enrollees from institutions to the community: Number of people eligible and number of transitions targeted under MFP." (2009).

[14] MMP NH percentage over 180 days based on average eligibles from the first 6 months of 2022.

[15] Note a portion of partial duals are currently being served through coordination-only D-SNPs.

Table 2. Coordination-Only D-SNPs in Rhode Island, June 2022[16]

Contract Number	Contract Name	Plan Name	Plan Type	Plan Enrollment
H0876	Commonwealth Care Alliance RI LLC	CCA Medicare/Maximum	HMO	12
H3113	Oxford Health Plans (NJ), Inc.	UnitedHealthcare Dual Complete	HMO	7,854
H4152	Blue Cross & Blue Shield of RI	BlueRI for Duals	HMO	1,102
H4699	Well Care HealthPlans of RI	Well Care Dual Liberty Open	Local PPO	269
H4699	Well Care HealthPlans of RI	Well Care Dual Access Open	Local PPO	309

4.5. Future Inclusion of Integrated D-SNPs in RI Procurement

Rhode Island will include full duals as one of the Medicaid populations in its upcoming procurement for its overall managed care program. Under the terms of this procurement a participating MCO will be required to offer MLTSS and a FIDE SNP.

RI anticipates that current RI Medicaid participating MCOs, coordination-only D-SNPs, and/or other health plans are potential bidders for future participation in its managed care program. This will then establish the basis for qualifying FIDE SNPs to be available for full duals.

5. Proposed Transition Plan and Implementation Approach

5.1. Plan Choice/Enrollment

As stated in Section 3.1, RI intends to enroll all FBDEs into comprehensive Medicaid managed care, with an option for beneficiaries to opt-out to fee-for-service. The primary aim is to improve care for Rhode Islanders, by implementing plan choice for duals in a manner that is most consistent with the current choice model, by maintaining a FFS option. This approach is being explored further and will be a primary topic for stakeholder input. In the future, as Rhode Island's managed care program evolves, the State may consider an exclusive managed care arrangement for FBDEs, as exists for Medicaid-only beneficiaries today.

Contractually, Rhode Island plans to integrate managed care arrangements for FBDEs under the umbrella of its overall Medicaid managed care program and re-procurement. Through this procurement model, EOHHS anticipates expanding managed care choices for dually eligible beneficiaries, by procuring contracts with two or more managed care organizations (each offering a comprehensive Medicaid managed care plan with MLTSS and a FIDE SNP), providing a choice of integrated plan options beyond what is currently available.[17]

[16] SNP Comprehensive Report 2022 06, https://www.cms.gov/

[17] Rhode Island's current MMP carrier, Neighborhood Health Plan of Rhode Island, is expected to participate in the states upcoming re-procurement to offer a FIDE SNP for its members to transition into. However, if NHPRI does not successfully bid on RI's re-procurement, MMP members will be transitioned to a comparable FIDE SNP, with CMS approval.

Enrollment Mechanisms[18]

As outlined in Table 3, Rhode Island intends to begin the enrollment process by prompting beneficiaries to make an active choice as to which plan they would like to transition to. The method of educating and counseling individuals on their choice options is outlined in Section 11 below. For members who do not make a choice, the State intends to implement transition and auto enrollment, with an option to opt out to FFS.

Table 3. Proposed Member Choice & Enrollment Model for Fully Dual Eligible Beneficiaries

		Member Choice Model
Member makes active choice	**All Duals**	• State promotes active member choice through unbiased enrollment counseling • **Choice of Model:** FIDE SNP, MLTSS or FFS • **Choice of Plan:** Carrier A, B, C
If Member does *not* make active choice	**MMP Duals (13,000)**	• **Enrollment transition (aka passive)** into NHPRI FIDE SNP (least disruptive) or a comparable FIDE SNP, should NHPRI not offer one • **Option to opt out** into another FIDE SNP, MLTSS or FFS

	FFS Medicaid Duals (29,000)[19]	• **Auto assign based on member's existing Medicare choice**
		  • If the member is in a Medicare health plan that also offers Medicaid in RI, auto assignment will be to that plan's MLTSS
		  • For all others, auto assignment to MLTSS will be random
		• **Option to opt out** into another FIDE SNP, MLTSS or FFS

New Fully Dual Eligible Beneficiaries		RI intends to pursue a **default enrollment** mechanism**,** with CMS approval, and is in the process of reviewing necessary considerations with ICRC, MMCO, and EOHHS enrollment specialists.

5.2. Timeline of Transition

To accomplish coordinated Medicare and Medicaid plan enrollment, Rhode Island will align development of these plan options with the timeline for CMS's approval of Medicare Advantage Organizations and D-SNPs for a January 1, 2026 effective enrollment date for the MMP transition.

To ensure a smooth transition it is Rhode Island's intent to take a phased approach, beginning with:

- **Transition Phase I**
  Bringing LTSS services in-plan for Medicaid Managed Care Plans for Medicaid Only beneficiaries on July 1, 2025.
- **Transition Phase II**
  Opening Comprehensive Medicaid Managed Care Plans to fully dual eligible beneficiaries and thereby launching FIDE SNPs with aligned MLTSS plans to move all MMP members into their new plans (by active choice or transition enrollment) on January 1, 2026. FIDE SNPs and

[18] RI EOHHS acknowledges that Medicare requires freedom of choice, and therefore the state cannot auto-enroll beneficiaries into an integrated D-SNP or Medicare plan of any kind (e.g., FFS, Medicare Advantage, etc.)

[19] Includes FBDEs currently in Other Managed Care arrangements due to PHE

MLTSS plans will also be available for newly eligible duals and FFS duals to opt into at this time.

- **Transition Phase III**
  Begin enrollment and auto-enrollment of full duals outside of the MMP into their new plans, in phases by population over 12+ months following January 1, 2026.

Note, all transition and auto-enrollment mechanisms will only be pursued for members who do not make an active plan choice (as outlined in Table 3).

Table 4 below outlines how Rhode Island is planning to roll out this transition beginning July 2025.

Table 4. Phased Transition of Populations

Phases of Transition	Transitioning Population	Population #	Start Date
Transition Phase I: Launch of Comprehensive Medicaid Managed Care with LTSS in plan (MLTSS)	Medicaid-Only beneficiaries, eligible for LTSS	2,500	1-Jul-25
Transition Phase II: Launch of FIDE SNPs & MLTSS for entire duals population, and enrollment of MMP population	MMP population & other FBDEs who choose to opt-in	13,000	1-Jan-26
Transition Phase III: Phased transition to FIDE SNPs & MLTSS for select full dual FFS populations*	Medicaid FFS duals population[20]	29,000	TBD

***** Considerations regarding auto-enrollment and transition planning for select populations (e.g., long stay nursing home residents and IDD individuals) are under development and will be addressed as part of future stakeholder engagement

6. Procurement Process and Contracting

To achieve an integrated managed care system for duals, Rhode Island will initiate a comprehensive managed care procurement and contracting process, beginning tentatively in November 2023 as outlined below.

6.1. Comprehensive Managed Care Procurement

The full period covered by the procurement will be July 1, 2025 through June 30, 2030 for Medicaid MCOs and through December 31, 2030 for integrated D-SNPs.

- **July 1, 2025** will initiate the new contract period for all Medicaid-only beneficiaries within the new comprehensive Medicaid managed care program with LTSS offered as an in-plan benefit (MLTSS). The contract will be drafted such that 6 months into the contract period (January 1, 2026), MLTSS will be available for full benefit dual eligible beneficiaries.

[20] Includes FBDEs currently in Other Managed Care arrangements due to PHE

- **January 1, 2026** will initiate the new contract period for all D-SNPs and be the effective date for enrollment into integrated D-SNPs or MLTSS plans for MMP members, depending on the beneficiary's choice of delivery system for Medicare. At this time, opt-in enrollment to integrated D-SNPs and MLTSS plans will also be available for any FBDE outside of the MMP.

As mentioned, although there are Coordination-Only D-SNPs in Rhode Island, there are currently no FIDE SNPs. Potential bidders will need to be aware of the State's intentions and undertake the necessary steps to be ready to qualify as a FIDE SNP. The continuation of the MMP through the end of calendar year 2025 allows time for these multiple processes.

The Timeline in Section 7.1 provides a high-level view of Rhode Island's overall plan for the MMP transition. Section 7.2 includes a high-level timetable for alignment of RI EOHHS and CMS plan certification and contracting processes. Throughout the process Rhode Island will work in close coordination with CMS for joint State/CMS oversight and compliance.

6.2. Request for Qualifications Process

In November 2023, Rhode Island anticipates issuing a Request for Qualifications (RFQ) for its overall managed care program, including duals. The RFQ will include the requirement that successful bidders must be approved by Medicare as a FIDE SNP able to participate in open enrollment in the Fall of 2025.

The RFQ will delineate the full scope of work for selected applicants, including a Model Contract for Medicaid-specific performance requirements and a Model State Medicaid Agency Contract (SMAC) specifically addressing Medicaid's requirements for FIDE SNPs. Accepted proposers must agree to the contract conditions specified in the Model Contract or minimally identify specific exceptions for consideration by the State.

The RFQ development will build on learnings from stakeholder engagement, Rhode Island's past experience in procurement for Medicaid managed care, and on its experience with the MMP program. As noted previously Rhode Island will seek to carry forward, to the degree practicable, the specifics of the MMP contract.

RFQ Preparatory Steps:

- Incorporation, as appropriate, of key learnings from stakeholder process
- Crosswalk of MMP to FIDE SNP requirements to guide development of scope of work and model contract and ensure compliance with Medicaid and Medicare requirements
- Development of actuarially sound capitation rates to include Medicare cost sharing

Model Contract Program Elements include but will not be limited to:

- A comprehensive scope of services as stated in Section 4.3.
- Contractor responsibility to authorize, arrange, integrate, and coordinate the provision of all covered services for its enrollees.
- Requirements for ensuring exclusively aligned enrollment.

    - Enrollment is limited to full benefit dual eligible beneficiaries
    - FIDE-SNP and Medicaid service areas are aligned
    - Enrollment is limited to individuals for whom the plan also has Medicaid LTSS and behavioral health risk (FIDE SNP and Medicaid MCO state contracts are with the same legal entity)
- Requirement to maintain/establish an Enrollee Advisory Committee, which at a minimum must solicit input on ways to improve access to covered services, coordination of services, and health equity among underserved populations. Currently, all Rhode Island MCO's are required to have a member or enrollment advisory committee.
    - Rhode Island will consider implementing Committee requirements with respect to demographic representation and parameters for frequency and format through D-SNP SMACs.
    - The MMP has an active and robust member committee, the Integrated Care Initiative (ICI) Implementation Council, supported by a Charter and Bylaws[21]. This council is an advisory group to RI EOHHS that was started to help develop a high quality, effective health care program for seniors and adults living with disabilities who are eligible for both Medicare and Medicaid. The council has proven instrumental in maintaining and improving the quality of NHPRI's MMP and Rhode Island intends to continue supporting this committee.
- Inclusion of additional questions on Health Risk Assessment (HRA) to address key social determinants of health, including housing, food insecurity, and transportation.
- Requirement to establish a maximum out-of-pocket limit (MOOP) beyond which amount the D-SNP pays 100 percent of service costs.
- Administrative simplification for providers such that there is a single payor coordinating Medicare and Medicaid claim submissions for payment.
- Requirement to establish unified processes for plan resolution of appeals and grievances.
- Requirement for integrated member materials.
- Required coordination with CMS and RI EOHHS to promote joint CMS/State oversight. Current format and cadence of oversight meetings used for the MMP demonstration have proven successful, therefore Rhode Island's intent is to propose existing oversight mechanisms are continued.
- Requirement that plans must have a single CMS contract ID, such that carriers with D-SNPs in multiple states must have a separate contract for Rhode Island D-SNPs, with distinct requirements – enabling additional joint CMS/State oversight mechanisms.

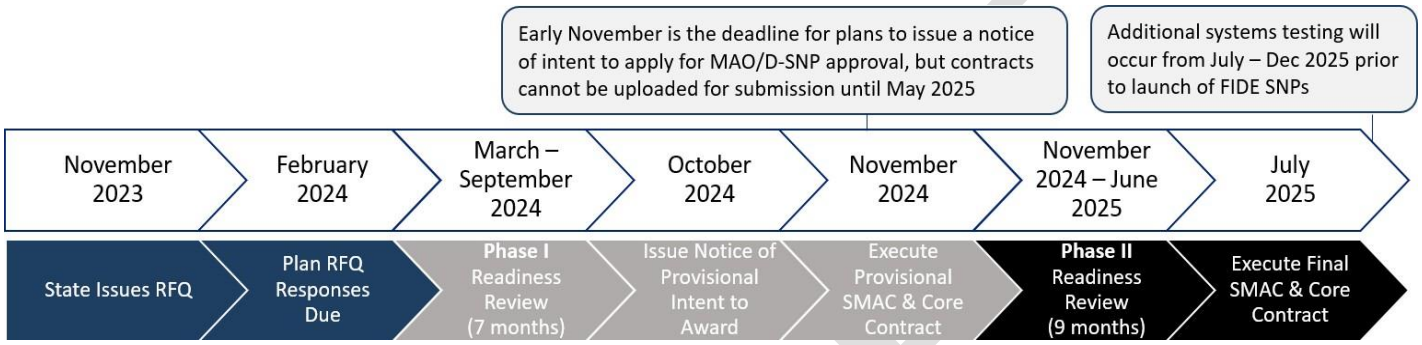
6.3. Readiness Review

For an initiative of this importance Rhode Island requires at least 12 months for a detailed readiness review of health plan carriers. Rhode Island has defined two distinct phases of Readiness Review in order for SMACs to be submitted to CMS and the RI EOHHS Medicaid Contract with MCOs (aka Core Medicaid Contract, Core Contract) to be finalized by the July 2025 deadline.

[21] Additional information on the ICI Implementation Council, including Charter and Bylaws can by found at https://eohhs.ri.gov/initiatives/integrated-care-initiative/ici-implementation-council

- Phase I Readiness Review: (March - September 2024, 7 months) is a provisional review and approval of procurement vendors to enable them to move forward with MAO/D-SNP application and execution of Provisional Core Contract and SMAC.
- Phase II Readiness Review: (November 2024 - June 2025, 9 months) is a formal, more extensive review period.

Figure 1. Rhode Island's Readiness Review Process & Timeline



Responses to a November 2023 RFQ will be due in February 2024. RI EOHHS will evaluate proposals and conduct a preliminary Phase I Readiness Review to identify qualifying submissions, potential deficiencies and areas needing further detail. Based on these evaluations, EOHHS will issue a Notice of Provisional Intent to Award to successful submitters. The work will then move to execution of provisional contracts, including any updates from the Model Contract conditions based on the initial Phase I Readiness Review, and provisional capitation rates based on more recent experience.

The Phase II Readiness Review will follow issuance of Notices of Provisional Intent to Award and will include but not be limited to:

- Status review of any deficiencies identified in Phase I Readiness Reviews
- Tracking any changes to corporate organization, personnel
- Network adequacy, particularly for critical Medicaid services
- Care management program and staffing
- Member services, materials, and communications
- Financial readiness
- Successful completion of FIDE SNP approval by CMS
- System readiness

7. High-level Transition Implementation Plan

7.1. Rhode Island Implementation Plan

Table 5 below provides a high-level overview of the transition implementation plan and timeline for this work. A more detailed timeline can be found in **Attachment C**.

Table 5. Rhode Island's High-level Transition Implementation Timeline

Implementation Tasks	Start Date	End Date	Description/Key Elements
Submission of Transition Plan	Jun 2022	Oct 2022	• Finalize and submit Transition Plan to CMS by Oct 1, 2022
State Budget and Funding	July 2022	Jun 2023	• Multi-year request for State admin & MME counselor support beginning SFY 2024 • Include request for full state funding for Ombudsman in Governor's budget for the period May 1, 2024 - December 31, 2025 • Governor's Budget Requested & Approved by legislature
State and Federal Authority	July 2022	Jun 2023	State Authority • Review existing legislative authority to identify potential technical changes needed to law • Propose any necessary technical amendments • Complete legislative action to establish authority June 2023, as needed Federal Authority • Submit application to CMS for renewal of 1115a waiver to carry forward authority within the existing waiver
Technical Assistance for Integration Efforts	July 2022	Ongoing	• Identify processes and system updates for implementing exclusively aligned enrollment with support from ICRC (complete feasibility testing of EAE) • Other technical assistance as identified
Phase II of Stakeholder Engagement	Nov 2022	Mar 2025	• Draft materials for stakeholder engagement • Cross agency staff workgroups • Survey of dually eligible beneficiaries • Stakeholder meetings • Issue Request for Information (RFI) • Receive, review responses • Develop summary of key learnings to prepare the RFQ
MCO Procurement (RFQ) Process	Apr 2023	Nov 2023	State Medicaid Procurement Process and Provisional Contract • Draft procurement document - Request for Qualifications (RFQ), including Model Contract with SMAC • Issue RFQ, including duals
MCO Phase I Readiness Review	Feb 2024	Nov 2024	• Receive and evaluate submissions • Begin Phase I Readiness Review • Issue Notice of Provisional Intent to award • Execute provisional SMAC & Core Contract for D-SNP applications
Member Choice and Enrollment	Oct 2023	Dec 2025	• Development of member communications strategy and materials to inform of choice • Communication, outreach, unbiased member choice counseling (MME) • Passive/default enrollment rules and system processes

Implementation Tasks	Start Date	End Date	Description/Key Elements
			• Enrollment files sent to MCOs • Oversight and approval of MCO marketing • Enrollment system testing period • Medicare & Medicaid Open Enrollment/choice
Operational Readiness	Jan 2024	Dec 2025	• Implementation of required system modifications • System testing
Final MCO Phase II Readiness Review and Contracting	Nov 2024	Jul 2025	Readiness Review and Execution of Final Contract • Conduct Phase II Readiness Review • Execute Core Medicaid Contract & SMAC prior to July 7, 2025

7.2. Alignment of Rhode Island and CMS Timelines for Implementation

For a successful transition from MMP to FIDE SNP, the Medicaid and Medicare procurement and authorization timelines must be in step with one another. Rhode Island will engage the Medicare-Medicaid Coordination Office (MMCO) for technical support in this area. A high-level timetable for Alignment of RI EOHHS and CMS Plan Certification and Contracted Processes is included in Table 6 below.

Points of critical alignment include:

- **Oct-Nov 2024**: Notice of Provisional Intent to Award and Execution of Provisional SMAC and Core Contract
- **Jul 2025**: Submission of SMAC to CMS and launch of LTSS in plan for Medicaid-Only beneficiaries
- **Oct-Dec 2025:** Pre-enrollment of MMP FBDEs
- **Jan 1, 2026:** MMP Transition to FIDE SNPs and MLTSS plans[22]

[22] Note, Table 4. Phased Transition of Dual Eligible Populations provides information on Rhode Island's intent to move additional full eligible dual beneficiaries into integrated managed care after MMP members are transitioned.

Table 6. High Level Timetable of RI EOHHS & CMS Alignment

	RI EOHHS Procurement	CMS D-SNP Certification Process
2023		
November	Issue RFQ for RI managed care for contract period July 1, 2025 - June 30, 2030. Includes:	No activity
	LTSS brought in plan for Medicaid Managed Care July 1, 2025	
	Enrollment into FIDE SNP/MLTSS January 1, 2026	
	RFQ includes model contract for full scope of work and contract components for Integrated D-SNP companion Medicaid contract (SMAC)	
2024		
February	Plan Responses to RFQ Due	
March	Evaluation of plan submissions & Phase I Readiness Review	
October	Issue Notice of Provisional Intent to Award	• Start of D-SNP Application Process • Release of NOIA for a new Integrated D-SNP contract application for CY 2026
November	Provisional SMAC & Core Contract for D-SNP applications are executed, Phase II Readiness Review begins	
2025		
January	Phase II Readiness Review continues and operational readiness preparation	• Model of Care submissions due • Deadline to submit a NOIA for CY 2026
May		Release of the CY 2026 D-SNP module for D-SNPs to upload required State Medicaid Agency Contract and Contract Matrices to HPMS.
June		• CMS conducts network adequacy reviews • Deadline for submission of CY 2026 bids
July	**Contract period/enrollment for non-duals and comprehensive Medicaid managed care/MLTSS begins**	**Deadline to upload required SMAC**
August	Ongoing operational readiness and systems testing	• Completion of CMS CY2026 bid review and approval • Deadline for organizations to complete plan connectivity data in HPMS to ensure timely approval of contracts • Contract execution deadline
September	Beneficiary communications for enrollment	All contracts fully executed
October	Plan marketing	• Plans can begin marketing • Annual election period begins
November	Pre-Enrollment of full duals in Integrated D-SNPs	
December		CY 2026 Annual election Period ends
2026		
Integrated D-SNP Enrollment Live (1-Jan-26)		

8. Stakeholder Engagement Process

Rhode Island is strongly committed to active engagement and collaboration with stakeholders in carrying forward this important transition. LTSS and delivery system transformation are long-term projects. Rhode Island took on this work in earnest with the initiation of its comprehensive 1115 waiver in 2009 and with its participation in the FAI capitated model beginning in July 2016. While progress has been made, more remains to be done. Rhode Island intends to continue to improve its capacity to recognize the needs of its beneficiaries as early as possible and promote coordinated supports to enable them to maintain positive health status and to continue to live successfully in community settings. A lynchpin is strong integration between Medicare and Medicaid along with effective deployment of home and community-based services attentive to social determinants of health.

The upcoming MMP transition to integrated D-SNPs is a major opportunity for Rhode Island to move forward. The State intends to build out integrated systems of care more comprehensively for the FBDE population. For those not choosing to enroll with an integrated D-SNP the MLTSS efforts will improve coordination. By incorporating integrated D-SNPs into Rhode Island's overall managed care program the State seeks to significantly bolster its delivery system for duals.

In getting to this point, RI has taken many steps. Much has been learned at multiple levels within the system. Through stakeholder processes the State is seeking to better understand the experiences, lessons, and recommendations of stakeholder groups as to realize maximum benefits of this transition for affected populations.

The stakeholder process will occur in two phases. Phase I, currently underway, is a short-term stakeholder process to support the development of this Transition Plan and inform key topics for future discussion. Phase II, slated to begin shortly after submission of this Transition Plan to CMS, is a deeper and more extended stakeholder engagement in the leadup period to design of the State's procurement.

8.1. Phase I Stakeholder Engagement Process – Leading to Transition Plan Submission

As part of its preparation for submission of this Transition Plan, Rhode Island identified key groups for engagement and held six group community engagement sessions and two one-on-one meetings. This activity took place over the period of late August through the end of September 2022 and included state agencies, consumers, carriers, providers, industry associations, advocates, and governmental leaders.

Table 7. Phase I Stakeholder Engagement Sessions

Stakeholder Category	Meeting Format	Attendees	Date Completed
State Agencies	LTSS Director's Meeting	Representation from State agencies including: • Department of Behavioral Health Developmental Disabilities and Hospitals • Executive Office of Health and Human Services • Department of Human Services • Department of Health • Office of Healthy Aging	8/19/22
Consumers	ICI Council Meeting	Consumers/Members	9/21/22
Carriers (Existing D-NSPs and Medicaid MCOs)	General Carrier Session	Tufts Health Plan United Well Care Commonwealth Care Blue Cross Blue Shield Neighborhood Health Plan	8/25/22
Providers, Advocates, Associations, Other	3 Broad Stakeholder Info Sessions	LTSS Providers, BH Providers, Medical Services Providers, Accountable Entities, Advocates, Provider Associations, NH Associations, and others interested parties	8/30; 8/31; 9/1/22
Meeting Format	**Attendees**		**Date Completed/ Scheduled**
One-on-one Sessions	Neighborhood Health Plan		8/23/22
	Secretary of the Executive Office of Health and Human Services		9/7/22
	Long Term Care Coordinating Council		To be scheduled
	Lt. Governor		To be scheduled
	Governor		To be scheduled
	AARP Policy Expert		To be scheduled

These meetings served to provide stakeholders with an introduction to the State's vision for integrated plans for duals along with preliminary thoughts as to how it might proceed. Descriptive materials and anticipated timelines were shared with each group to inform and to prompt discussion. A key area of discussion was to seek advice on the best way to proceed with stakeholder engagement for the longer-term process. A high-level summary of overall stakeholder learnings is provided below, and a detailed summary with key considerations for future stakeholder discussions can be found in **Attachment D**.

Overall Findings:

- Stakeholders expressed general support for the approach of integrated care, a broad acknowledgement of the positive experience that members have had with the MMP, and a strong desire to see the benefits of the MMP continued into any future program

    - Specific benefits of the MMP that were emphasized included integrated member materials and services, the ICI (MMP) Member Council, the MME Counseling program, and having a FFS option – all benefits that the State intends to maintain post MMP transition.
- Participants also expressed strong interest in being included in the ongoing stakeholder process
- Specific program design considerations raised by participants included:
    - How to mitigate workforce challenges
    - Maintaining member choice
    - Mitigating member confusion that can come from having new plan options through education and unbiased enrollment counseling
    - LTSS case management and continuity of care for members with complex needs

8.2. Phase II Stakeholder Engagement Process – Following Transition Plan Submission

Upon confirmation from CMS that Rhode Island's Transition Plan is approvable, the State will initiate its longer-term stakeholder process to gather feedback and recommendations and explore opportunities and innovations to strengthen the initiative.

Actions will include:

- **Conduct primary research (survey and/or focus groups) with dual eligible beneficiaries and caretakers** to better understand experiences, concerns, and recommendations.

- **Develop and issue a Request for Information (RFI)** seeking responses from interested parties. These might include consumers, advocates, LTSS providers, behavioral health providers, medical services providers, institutional providers, potential bidders, Accountable Entities, and others.

- **Convene regular, quarterly meetings** to keep all interested parties informed and up to date on the plan and progress.

- **Convene internal, cross-agency staff workgroups** to review the feedback received, the internal assessment of challenges and opportunities to make informed policy choices for the duals program.

A high-level schedule of these activities is included in Attachment C.

9. State Legislative Authority and Ombudsman Funding

9.1. Legislative Authority

RI EOHHS has conducted a review of current Rhode Island law to identify any legislative or regulatory concerns or updates that may need to be considered in pursuing a transition to managed care for LTSS benefits. Thus far an analysis of state laws related Rhode Island's authority to develop a multi-choice option for managed care and long-term care arrangements has been conducted and a policy brief has been presented to EOHHS Legal and Policy Departments.

RI Gen L § 40-8.5-1.1 permits RI EOHHS to implement managed care, inclusive of LTSS, for all medical assistance beneficiaries to ensure they have access to quality and affordable health care. RI Gen L § 40-8.13 (2021) requires that beneficiaries have the option to opt-out of a managed long-term-care arrangement, defined to include but not be limited to the MMP demonstration. RI Gen L § 40-8.13 (2021) is written primarily in reference to the MMP/FAI demonstration but could be more broadly applied to non-demonstration delivery systems, including but not limited to Managed Long-Term Services and Supports (MLTSS) plans and integrated D-SNPs.

For the launch of D-SNPs in January 2026, Rhode Island intends to offer dually eligible beneficiaries the option to opt-out of managed care, as is done today in the MMP. In the future, if Rhode Island moves toward requiring managed care for FBDEs, clarifying language would be needed in RI Gen L § 40-8.13 (2021). Potential amending language to RI Gen L § 40-8.13-2 regarding Beneficiary Choice for Long-Term Managed Care Arrangements has been forwarded to EOHHS Legal for consideration.

9.2. Ombudsman Funding

With the sunsetting of the FAI demonstration the federal grant that supports the Ombudsman program will expire as of April 30, 2024. Transitioning states are required to support the Ombudsman program until the termination of the MMP program with state funds or until December 31, 2025, with an approved Transition Plan. Further, the FAI demonstration has provided federal grant funding for Medicare-Medicaid Enrollment (MME) Counselors, and this will expire as of August 31, 2024. The MME Counseling program is not required to be maintained by states; however, RI has found this program to provide invaluable options counseling and support to dual beneficiaries and intends to sustain it beyond the end of the MMP demonstration.

To sustain these programs, RI EOHHS has included a multi-year funding request for both programs in their SFY 2024 budget request (July 2023 – June 2024). Ombudsman funding has been requested through the anticipated end date of the MMP demonstration, December 31, 2025, with the expectation that this program will sunset alongside the demonstration. MME funding has been requested with no definitive end date, as the State intends to expand this program and enhance its current role. This expansion will help facilitate a seamless transition for MMP beneficiaries and assist in educating all full duals in their future Medicare and Medicaid enrollment choices.

Rhode Island is evaluating options for how to sustain services provided by the Ombudsman program related to resolving member grievances and identifying opportunities for plan improvement, utilizing existing program infrastructure. Two existing programs have been identified as options to take on this role; 1) RI's MMP Ombudsman program currently operates within the Rhode Island Parent Information Network (RIPIN) Healthcare Advocate call and service center, which assists people covered by both Medicare and Medicaid with insurance denials and appeals, medical benefits, and billing and will continue to do so once the MMP program concludes,[23] and 2) the State also has a robust Long Term Care Ombudsman program which is extremely active and well utilized by RI residents. Future stakeholder discussions will help inform the best approach to embedding ombudsman services into RI's beneficiary support network.

[23] Additional information on RIPINs Healthcare Advocate call and service center can be found at https://ripin.org/services/services/

10. Federal Authority

With limited exceptions unrelated to dual eligible beneficiaries or managed care, Rhode Island operates its entire Medicaid program subject to the terms of its 1115a demonstration waiver (Rhode Island Comprehensive Demonstration. Number: 11-W-00242/1). Notably, the MMP program has been operating within the scope of this waiver in close partnership with CMS. A key feature of the 1115a waiver is the waiver of freedom of choice of individual providers. Within the current waiver, the waiver of freedom of choice applies to the delivery of LTSS and primary and acute care services that Medicaid pays for, and therefore permits the State to require Medicaid beneficiaries receive these services through managed care plans, should Rhode Island move in that direction for FBDEs in the future. The current waiver period expires December 31, 2023 and requires that the State must submit its application for an extension no later than December 31, 2022. To this end, Rhode Island is actively engaged in its work to submit its extension request in accord with that timeframe. Rhode Island will work closely with CMS to ensure that the language in the waiver renewal continues to support the transition plan as outlined.

11. Operational Readiness

11.1. Member Choice and Unbiased Enrollment Counseling

Rhode Island recognizes the importance of offering unbiased enrollment counseling so that dually eligible individuals can receive clear, comprehensive information about their integrated care options and have the ability to speak with a knowledgeable, unbiased expert. For this reason, the State intends to continue and expand the current Medicaid Medicare Enrollment (MME) Counseling program beyond the end of MMP. Rhode Island is currently assessing options and funding for how to best sustain this critical service and align with current No Wrong Door efforts (addressed in further detail in Section 11.4). In addition to support from MME counselors, RI EOHHS plans to implement a member communication plan to promote member choice that will include:

- Targeted notices to explain the transition to integrated D-SNPs/MLTSS, a beneficiary's health coverage options, and a phone number to call for help understanding options.
- Training for Patient Center Options Counselors working with members in need of LTSS, and others working directly with members such as SHIP counselors, Rhode Island Parent Information Network (RIPIN) Healthcare Advocates, Department of Human Services and HealthSource RI Call Centers.
- Broad Community Education to ensure providers, advocates, community organizations and others are aware and know how to direct members for help in answering questions about the transition and their options.
- A robust outreach and public education campaign targeting members, their families and caregivers.

For Rhode Islanders who do not make an active choice of plan, EOHHS intends to seek CMS approval and utilize enrollment transition and auto-enrollment mechanisms for its MMP and FFS dual populations, as outlined in Section 5.1.

Decisions regarding default enrollment for new dually eligible beneficiaries are under consideration and will be a topic of future discussion with stakeholders and the Integrated Care Resource Center (ICRC).

11.2. Exclusively Aligned Enrollment

The Final Rule for FIDE SNPs establishes multiple requirements to strengthen integration, including the requirement that all FIDE SNPs must have exclusively aligned enrollment (EAE) by 2025. Under this requirement, the State contract will limit D-SNP enrollment to FBDEs who receive their Medicaid benefits from the D-SNP, or an affiliated Medicaid Managed Care plan offered by the same parent company.[24] Requiring D-SNPs to enroll only members who are also enrolled in their aligned Medicaid plan ensures that Medicaid and Medicare benefits are provided in an integrated way through a single entity.

Exclusively aligned enrollment facilitates an integrated experience for beneficiaries and providers, which mirrors the integration achieved through Rhode Island's MMP. Some of these benefits include:

- Single ID card for or both Medicare and Medicaid benefits
- Comprehensive, coordinated benefits package
- Unified, plan level appeals and grievances processes
- Streamlined and integrated member materials
- More seamless care coordination under the same parent organization
- One customer service number
- Simplified provider billing

Additionally, exclusively aligned enrollment has been documented to provide benefits for plans, states, and federal payers, including[25]**:**

- One parent company is financially responsible for all Medicare and Medicaid benefits reducing incentives to shift costs across programs.
- A single parent company possesses all data on beneficiary service utilization and care experience. This facilitates better coordination and identification of opportunities to improve care, save money, and evaluate data on beneficiary experience.
- Fully integrated benefit structure, care coordination, and enrollee materials are easier for plans to design and deliver.

Rhode Island recognizes that there are several complexities to work through to implement exclusively aligned enrollment in a way that provides a seamless transition experience for current MMP members, FFS Medicaid FBDEs who chose to transition to an integrated model, or beneficiaries who become newly dual eligible. RI EOHHS has engaged early in discussions with ICRC and MMCO for technical assistance to better understand the key considerations, challenges and experiences of other states who

[24] Section 422.2 of final rule defines the term ''aligned enrollment'' as referring to when full-benefit dually eligible individuals who are enrolled in a D– SNP also receive coverage of Medicaid benefits from the D–SNP or from a Medicaid MCO that is: (1) The same organization as the MA organization offering the D SNP; (2) its parent organization; or (3) another entity that is owned and controlled by the D SNP's parent organization. When State policy limits a D–SNP's membership to individuals with aligned enrollment, § 422.2 refers to that condition as exclusively aligned enrollment

[25] ICRC https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_EAE_101_FINAL_5.4.22_0.pdf

have implemented different models and processes based on the State's particular circumstances. Rhode Island has established weekly recurring meetings with ICRC staffed by members of RI EOHHS operations and IT teams and appreciates this opportunity to receive technical assistance throughout the longer-term design and implementation of the program. Some of the initial considerations and decision points that have been raised thus far include:

Key Consideration: Determining the EAE Model

Based on conversations with ICRC, a key consideration that will impact how EAE is implemented is the model that Rhode Island pursues. Models are outlined below in Table 8.

Table 8. Models for Exclusively Aligned Enrollment

Model	Description
Aligned Medicare/ Medicaid Model	States that only contract with D-NSPs and Medicaid Managed Care plans that have the same parent company, and then requires those D-SNPs operate with EAE. When EAE is achieved using this model, the member has two integrated/coordinated plans – one for Medicare and one for Medicaid but offered through same parent company and required to work together to streamline members experience between two plans.
Direct Capitation Model	State pays D-SNP directly to cover all Medicaid benefits for all members instead of having member enroll in a separate Medicaid Managed Care Plan. Particularly useful in states that do not have Managed Care Program for Duals as it enables state to integrate care without having to build a managed care program to align with the D-SNP
D-SNP for Partials + Capitated or Aligned Model:	Separates D-SNP benefits packages for aligned and unaligned. Only some D-SNPs in the state operate with EAE and the others have Partial Duals or Duals with unaligned Medicaid/Medicare plan.

Considering Rhode Island's procurement approach and intention to provide a Managed LTSS plan for all dually eligible beneficiaries, conversations with ICRC have led RI EOHHS to consider the *Aligned Model*, where each D-SNP has a corresponding Medicaid Managed Care Plan. RI EOHHS is further exploring the system and process implications of the Aligned model with the ICRC technical assistance working group to confirm this approach. The State will be working with ICRC to develop a matrix of enrollment scenarios to understand system and business process implications, similar to the work that ICRC did with California.

Key Consideration: Learning from MMP Experience

As described in Rhode Island's CMS January 2022 Combined First and Second ICI Evaluation Report, implementing integrated enrollment processes and systems for the MMP demonstration presented one of the primary implementation challenges, and required significant resources to design, build, and implement. [26]

> The State also faced systems challenges in designing a new platform that would conform to Medicare managed care requirements such as allowing enrollees to request disenrollment through the last day of the month. This involved constructing an entirely new platform to allow for daily enrollment transactions with underlying logic that differed from all other State

[26] FINANCIAL ALIGNMENT INITIATIVE Rhode Island Integrated Care Initiative: Combined First and Second Evaluation Report January 2022

Medicaid processing. EOHHS estimated in 2017 that the build alone represented over 30,000 hours of staff time Additionally EOHHS also needed to develop interim business practices to accommodate design issues with the State's system. For example, automated business processes did not accommodate enrollment of beneficiaries who chose to opt into the ICI demonstration before the State identified them as part of an enrollment group. EOHHS staff developed interim manual processes to enroll beneficiaries who had not yet received an opt-in or passive enrollment letter. Although systems issues have improved over time, eligibility and enrollment processes have continued to be an area of significant challenge.[27]

Learning from the MMP experience, RI EOHHS has already begun the planning process for exclusively aligned enrollment given the scope of changes that will be required to system and business processes. Some key success factors for this planning include:

- Allocating sufficient resources and time for the design and implementation of the system build.
- Continuing weekly technical assistance calls with ICRC, MMCO, and members of EOHHS IT and Operations Teams who will be responsible for implementation.
- Bringing additional resources with Medicare experience and expertise in-house. RI intends to submit an application to Arnold Ventures in pursuit of this expertise.
- Aligning planning process with Rhode Island's MMIS re-procurement operational workplan to ensure the design of system requirements consider the needs of the MMP transition.

Key Considerations: Identifying the differences from today's processes

One of the fundamental differences from today's MMP enrollment process is that all states that have implemented exclusively aligned enrollment have chosen a "Medicare First" approach, in which a member chooses their Medicare, and the Medicaid follows. Although this is not required from a regulatory perspective, limiting D-SNP eligibility to individuals who are already enrolled in an affiliated Medicaid managed care plan through the same parent company as the D-SNP could reduce the number of beneficiaries who opt into the integrated D-SNP, as members would need to wait for the next Medicaid open enrollment period to make that change. Under the Medicare First approach, the member could be moved into the affiliated Medicaid plan whenever they elect to enroll in the D-SNP.

Example:

- Member is in Health Plan A's MLTSS plan and wishes to move to Health Plan B's Integrated Duals Plan
- If Medicaid enrollment leads, member would not be able to make this change until the next Medicaid Plan Change Opportunity.
- Medicare enrollment changes are allowed more frequently and therefore the member could make this transition more timely

The Medicare First approach represents a significant change from today's processes and will require substantial systems and business process changes.

Rhode Island MMP Voluntary Opt-in Enrollment Process Today:

1. On a monthly basis, the State runs a query to determine who is eligible for opt-in enrollment and issues a 30-day notice informing eligible enrollees.

[27] Ibid

2. Potential members (whether prompted by the 30-day notice, or from word of mouth) then apply for enrollment by:
    a. filling out a paper application and mailing it to ICI Enrollment
    b. using a telephonic app through the ICI Enrollment Call Center (hotline)
    c. calling or applying through Medicare directly, using 1-800-MEDICARE, or Medicare.gov.
3. The State submits transaction files to CMS systems and CMS sends the State and the MMP a Daily Transaction Reply Report (DTRR) of enrollment-related transactions. The State also sends the MMP a daily 834 file with enrollment transactions.
4. The MMP sends beneficiaries a welcome packet and integrated plan materials.

Table 9 below provides an example of how the processes may differ using an example shared by ICRC.

Table 9. State Example of Future D-SNP Enrollment Process

	Potential Future State (State Example using aligned model)
Step 1:	Member Enrolls in EAE D-SNP (through D-SNP, 1-800-MEDICARE, or Medicare.gov).
Step 2:	D-SNP verifies Medicare and Medicaid eligibility
Step 3:	D-SNP submits 834 file (showing beneficiary enrollment) to the state for review
Step 4:	State generates a modified 834 file and disposition file that are sent back to the D-SNP, confirming or rejecting enrollment, based on state Medicaid eligibility data
Step 5:	D-SNP sends final, approved 834 to State. State uses that file to generate EAE enrollment and capitation files for the next enrollment month.
Step 6:	State auto-assigns each D-SNP enrollee to the Medicaid managed care plan associated with their chosen D-SNP. Even continuing enrollments go through this process. State uses retroactive enrollment start dates when necessary to ensure that Medicaid managed care enrollment start date aligns with D-SNP enrollment start date
Step 7	D-SNP sends beneficiary welcome packet and integrated plan materials.

Key Considerations: Challenges of Exclusively Aligned Enrollment to consider in the design

Rhode Island also participates in CMS-Maximus Quarterly Dual Eligible Work Group Meetings and will incorporate the learnings from the workgroup into the design process. Some of the challenges that have been identified via this workgroup and will be incorporated into RIs design process include:

- Setting up appropriate technical and programming processes to verify beneficiary eligibility to make an enrollment election and apply appropriate Medicare special enrollment periods
- Educating beneficiaries about the exclusively aligned enrollment process and implications of enrollment into a D-SNP for both Medicare and Medicaid benefits
- Designing systems to align with Medicare election periods/policies (initial coverage election period, annual election period, special enrollment periods)
- Considering how to enable Medicaid managed care plan enrollment changes if/when an individual enrolls into an integrated D-SNP outside of their annual Medicaid enrollment period
- Ensuring compliance with enrollment and disenrollment policies in 42 CFR 438.54 and 42 CFR 438.56[28]

[28] CMS Maximus Quarterly Dual Eligible Workgroup September 13th, 2022 PPT

11.3. Care Coordination and Continuity of Care

Rhode Island is committed to ensuring continuity of care for high risk, complex beneficiaries including those receiving LTSS services in a Home-and Community-Based or Nursing Home setting. The State will work closely with its partner agencies and Medicaid Managed Care Plans to identify potentially high-risk beneficiaries and ensure coordination with care management and between teams and providers. Should Neighborhood Health Plan of Rhode Island offer a FIDE SNP in the 2026 contract year, the transition for MMP members who choose to remain with NHPRIs integrated plan, should have minimal impact as the member's care plan and care coordinator will remain with NHPRI. For members who choose a different health plan, or should NHP not offer a FIDE SNP, processes will need to be in place to transition care plans and care coordination to the new plan.

Rhode Island intends to require FIDE SNPs to extend a continuity of care period of at least 12 months to honor existing care plans, prescription drug coverage and services, and allow members to receive care from existing providers, if providers are out of network.

11.4. Alignment with LTSS Re-design and No Wrong Door Policy Reform

Since 2019, Rhode Island has been pursuing a variety of LTSS reforms initiatives that are designed to make the system more person-centered, quality driven and resilient. These initiatives focus on a set of state-wide priorities that cover people, processes, and providers at every level of the LTSS system. One of the core LTSS initiatives is a multi-year plan effort to incorporate the person-centered principles and practices of the U.S. Administration of Community Living's No Wrong Door (NWD) reform policy for improving consumer access, expanding choice, and assuring quality.

Though NWD, the State has pursued an array of initiatives that are designed to improve system navigation and provide decision support, including:

- Launching a Person-Centered Options Counseling (PCOC) network
- Developing an information marketing and outreach strategy to expand awareness of HCBS alternatives.
- Further enhancing the consumer experience by standardizing and automating critical eligibility functions to expedite and eliminate inequities in access
- Implementing a robust system for person-centered planning and conflict-free case management across populations.

The next phase of NWD focuses on service delivery, coordination, and quality. The design and planning of the MMP transition to integrated D-SNPs will be tightly coordinated with the next phase of the No Wrong Door initiative and all LTSS re-design activities.

As outlined in the timeline in **Appendix C,** a working group will be established to bring together EOHHS staff involved in LTSS redesign activities and staff leading the MMP transition to document business processes for dually eligible beneficiaries in need of LTSS services, to ensure coordination and clarity of roles, responsibilities, and handoffs across managed care and FFS delivery systems in the areas of:

- Unbiased benefits counseling (Medicare/Medicaid)
- Person centered options counseling

- LTSS application assistance
- LTSS eligibility
- Person centered planning
- Conflict free case management

To do this effectively, will require looking at each possible transition scenario to determine where the processes may need to differ between scenarios and needs of the population. Additionally, business process work will include consideration of HCBS setting (Assisted Living, Self-Directed etc.) as well as needs of special populations, including I/DD and SPMI populations. Table 10 below provides the team's initial thinking on transition scenarios that will need to be considered as a starting point. The State anticipates this work to begin in October 2022.

Table 10: Draft Business Process Considerations for New D-SNP Implementation

		Business Process Needed to Ensure Seamless Transition						
Current Program	**Population**	**Unbiased Medicare/ Medicaid Benefits Counseling**	**PCOC**	**LTSSS Application Assistance**	**LTSS Eligibility**	**Person Centered Planning**	**Conflict Free Case Mgmt.**	**Re assessments**
Transition Population – Current Dually Eligible Beneficiaries								
MMP	LTSS-HCBS	`X	X	Already Eligible	Already Eligible	X	X	X
MMP	LTSS - NH	X	X	Already Eligible	Already Eligible	X	X	X
MMP	No LTSS	X	x	N/A	N/A	N/A	N/A	N/A
FFS	LTSS-HCBS	X	X	Already Eligible	Already Eligible	X	X	X
FFS	LTSS - NH	X	X	Already Eligible	Already Eligible	X	X	X
FFS	No LTSS	X	X	N/A	N/A	N/A	N/A	N/A
Post Transition – New Dually Eligible Beneficiaries *will further segment based on Medicaid choice - FIDE, MLTSS or FFS								
New Medicare	LTSS-HCBS	X	X	Already Eligible	Already Eligible	X	X	X
MLTSS New Medicare	LTSS - NH	X	X	Already Eligible	Already Eligible	X	X	X
New Medicare	No LTSS	X	X	N/A	N/A	N/A	N/A	N/A
New Medicaid	LTSS-HCBS	X	X	Already Eligible	Already Eligible	X	X	X
Newly Medicaid	LTSS - NH	X	X	Already Eligible	Already Eligible	X	X	X
Newly Medicaid	No LTSS	X	X	N/A	N/A	N/A	N/A	N/A
Post Transition – Existing Dual - Newly LTSS Eligible or in need of LTSS								
TBD	TBD	X	X	X	X	X	X	X

Attachment A: What is a FIDE SNP?

Brief Background on the May 9, 2022 Final Rule and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)

To provide an initial orientation for a reader seeking to become more familiar with the nomenclature for integrated SNPs this Attachment to the concept paper provides a brief overview of D-SNPs generally and FIDE SNPs more specifically. The Final Rule[29] notes:

> *Dual Eligible Special Needs Plans Special needs plans (SNPs) are M(edicare) A(dvantage) plans created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) that are specifically designed to provide targeted care and limit enrollment to special needs individuals. Under section 1859(b)(6) of the Act, SNPs restrict enrollment to certain populations. The most common type of SNP is a dual eligible special needs plan, or D–SNP, in which enrollment is limited to individuals entitled to medical assistance under a State plan under Title XIX of the Act.*
>
> *D–SNPs are intended to integrate or coordinate care for dually eligible individuals more effectively than standard MA plans or the original Medicare fee-for-service (FFS) program by focusing enrollment and care management on this population*
>
> *Federal statute and implementing regulations have established several requirements for D–SNPs in addition to those that apply to all M(edicare) A(dvantage) plans to promote coordination of care, including HRA requirements as described in section 1859(f)(5)(A)(ii)(I) of the Act and at 42 CFR 422.101(f)(1)(i), evidence based models of care (MOCs) as described in section 1859(f)(5)(A)(i) of the Act and at 42 CFR 422.101(f), and contracts with State Medicaid agencies as described in section 1859(f)(3)(D) of the Act and at 42 CFR 422.107. The State Medicaid agency contracting requirement allows States to require greater integration of Medicare and Medicaid benefits from the D–SNPs in their markets. (p. 27715 of Final Rule)*

FIDE SNPs were first authorized by the Affordable Care Act in 2010 and were permanently authorized in 2018. The HIDE (Highly Integrated Dual Eligible) designation was created in the Bipartisan Budget Act of 2018 to implement new requirements for D-SNPs first made available in 2021.[30] The May 9, 2022 Final Rule makes several revisions to the requirements for FIDE and HIDE SNPs in order to strengthen integration.

There are three types of D-SNPs for dual eligible beneficiaries presented in order of the level of Medicare-Medicaid integration.

- FIDE SNPs, or fully integrated dual eligible special needs plans

[29] Final Rule – May 9, 2022 (Federal Register/vol. 87, No. 89/Monday/May 9, 2022/Rules and Regulations
[30] Medicare Advantage dual eligible special needs plans. MACPAC.gov

- HIDE SNPs, or highly integrated dual eligible special needs plan
- Coordination-only D-SNPs

The Final Rule provides for the transition of a MMP to an integrated D-SNP and therefore applies to a FIDE or a HIDE SNP. The fully integrated FIDE SNP is the model most like the MMP and is RI EOHHS' preferred choice.

The Final Rule offers the following:

> *A. Improving Experiences for Dually Eligible Individuals*
> *1. Overview and Background*
> *Over 11 million people are concurrently enrolled in both Medicare and Medicaid. Beneficiaries who are dually eligible for both Medicare and Medicaid can face significant challenges in navigating the two programs, which include separate or overlapping benefits and administrative processes. Fragmentation between the two programs can result in a lack of coordination for care delivery, potentially resulting in: (1) Missed opportunities to provide appropriate, high-quality care and improve health outcomes; and (2) undesirable outcomes, such as avoidable hospitalizations and poor beneficiary experiences. Advancing policies and programs that integrate care for dually eligible individuals is one way in which we seek to address such fragmentation.4*
>
> *''Integrated care'' refers to delivery system and financing approaches that—*
> - *Maximize coordination person-centered coordination of Medicare and Medicaid services, across primary, acute, long term, behavioral, and social domains;*
> - *• Mitigate cost-shifting incentives, including total-cost-of-care accountability across Medicare and Medicaid; and • Create seamless experiences for beneficiaries. (Final Rule p..27714*

Page 27893 of the Final Rule provides the following amendments to 42 CFR Part 422, Medicare Advantage Program, of the Section 422.2 definition of the FIDE implemented through the Final Rule:

> *§ 422.2 Definitions.*
>
> * * * * *
> *Fully integrated dual eligible special needs plan * * * (2) Whose capitated contract with the State Medicaid agency requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a fully integrated dual eligible special needs plan (FIDE SNP) in the State, except as approved by CMS under § 422.107(g) and (h): (i) Primary care and acute care, and for plan year 2025 and subsequent years including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries; (ii) Long-term services and supports, including coverage of nursing facility services for a period of at least 180 days during the plan year; (iii) For plan year 2025 and subsequent years, behavioral health services; (iv) For plan year 2025 and subsequent years, home health services as defined in § 440.70 of this chapter; and (v) For plan year 2025 and subsequent years, medical supplies, equipment, and appliances, as described in § 440.70(b)(3) of this chapter; (3) That coordinates the delivery of covered Medicare and Medicaid services using aligned*

care management and specialty care network methods for high-risk beneficiaries;
* * * * *
(5) For plan year 2025 and subsequent years, that has exclusively aligned enrollment; and (6) For plan year 2025 and subsequent years, whose capitated contract with the State Medicaid agency covers the entire service area for the dual eligible special needs plan. (Final Rule, p. 27893)
* * *

Attachment B: Covered Services in Current MMP Contract

Appendix A. Covered Services

A.1 Medical Necessity: The Contractor shall provide services to Enrollees as follows:

A.1.1 Authorize, arrange, coordinate, and provide to Enrollee all Medically Necessary Covered Services as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.2.1 Prevent, diagnose, or treat health impairments;

A.1.2.2 Attain, maintain, or regain functional capacity.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Health Care Professional demonstrates is Medically Necessary.

A.1.5 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of Utilization Management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

A.1.5.1 Developed with input from practicing Health Care Professionals in the Contractor's Service Area;

A.1.5.2 Developed in accordance with standards adopted by national accreditation organizations;

A.1.5.3 Developed in accordance with the definition of Medically Necessary Services in Section 1.80;

A.1.5.4 Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.5.5 Evidence-based, if practicable; and

A.1.5.6 Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.6 The Contractor's Medical Necessity guidelines, program specifications and service components for Behavioral Health and Substance Abuse Treatment

Services must, at a minimum, be submitted to RI EOHHS annually for approval no later than thirty (30) Days prior to the start of a new Demonstration Year, and no later than thirty (30) Days prior to any change.

A.1.7 The Contractor must offer Enrollees any additional non-medical programs and services available to a majority of the Contractor's commercial population, if any, on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon in writing by RI EOHHS and the Contractor, such as health club discounts, etc. The Contractor's Capitation Rate shall not include the costs of such programs and services.

A.1.8 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received RI EOHHS approval.

A.2 Covered Services: The Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All services provided under The Rhode Island State Plan, excluding those services otherwise excluded or limited in A.4, A.5 or A.6 of this Appendix.

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Pharmacy products that are covered by RI EOHHS and may not be covered under Medicare Part D, including:

A.2.5.1 Over-the-counter (OTC) drugs as specified by RI EOHHS.

A.2.5.2 "Miscellaneous" drugs for indications that may not be covered by Part D (dronabinol, megestrol, oxandrolone, somatropin); and

A.2.5.3 Prescription vitamins and minerals as specified by RI EOHHS.

A.2.6 Contractor is encouraged to offer a broader drug formulary than minimum requirements.

A.2.7 Value Add Services: services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate. Contractor is authorized to offer alternative services and value add services/equipment where such services are cost effective and clinically appropriate, including

interventions intended to address social determinants of health. The provision of value add services is not included in determining the Capitation Rate.

A.2.8 "In lieu of services or setting" are alternative services or settings that are not included in the State Plan or otherwise covered by the contract but are medically appropriate, cost-effective substitutes for State Plan services or settings included within a contract. EOHHS identifies the following services as those services, which the Contractor may provide to members without obtaining prior approval from EOHHS. If the Contractor seeks to provide cost-effective alternative services not listed below, it must obtain prior written approval from EOHHS.

A.3 Cost-sharing for Covered Services

A.3.1 Except as described below, cost-sharing of any kind is not permitted in this Demonstration.

A.3.2 Cost Sharing for Part D drugs.

A.3.2.1 Co-pays charged by the Contractor for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.3.2.2 The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

A.3.3 Cost Sharing for Medicaid Services.

A.3.3.1 For Medicaid services beyond the pharmacy Cost Sharing described here, the Contractor will not charge Cost Sharing to Enrollees above levels established under the State Plan.

A.3.3.2 The Contractor is free to waive Medicaid Cost Sharing.

A.3.3.3 For Enrollees who are residents of Nursing Facilities or receiving community-based LTSS, the Contractor may require the Enrollee to contribute to the cost of Nursing Facility or community-based LTSS care the amount listed for the Enrollee on the RI EOHHS 834 daily file, which will be transmitted daily to the Demonstration Plan.

A.4 Limitations on Covered Services. The following services and benefits shall be limited as Covered Services:

A.4.1 Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.4.2 Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).

A.5 Excluded Services. The following services are carved out of the Covered Services benefits. The Contractor agrees to coordinate and refer for these services as necessary.

A.5.1 Dental services (with the exception of those Oral Health services that appear in the table in A.7 below)

A.5.2 Non-emergency transportation services (Non-emergency transportation is coordinated by the Contractor).

A.5.3 Residential services for I/DD Enrollees

A.5.4 Home Stabilization Services

A.6 Non-Covered Services

A.6.1 Experimental procedures

A.6.2 Abortion services, only as provided under A.4.1 above.

A.6.3 Private rooms in hospitals (unless medically necessary)

A.6.4 Cosmetic surgery (please see A.2.2 and A.2.3)

A.6.5 Infertility treatment services (please see A.2.2 and A.2.3)

A.6.6 Medications for sexual or erectile dysfunction

A.7 Medicaid Covered Services

SERVICE	SCOPE OF BENEFIT (ANNUAL)
Inpatient Hospital Care	Up to 365 Days per year based on medical necessity. RI EOHHS shall be responsible for inpatient admissions or authorizations while the Enrollee was in Medicaid fee-for-service, prior to the Enrollee's Enrollment in Contractor's MMP. Contractor shall be responsible for inpatient admissions or authorizations, even after the Enrollee has been disenrolled from Contractor's MMP and enrolled in another health plan or re-enrolled into Medicaid fee-for-service, until the management of the Enrollee's care is formally transferred to the care of another health plan, another program option, or fee-for-service Medicaid.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid Covered Services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)
Physical Therapy Evaluation and Services	Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.
Physician Services	Covered as needed, based on medical necessity, including Primary Care, specialty care, obstetric and newborn care. Up to one (1) annual and five (5) gynecology visits annually to a network Health Care Professional for Family planning is covered without a PCP referral.
Care Management Services	Services that assist Enrollees in gaining access to needed Covered and non-Covered Services, as well as needed social, educational, and other services, regardless of the funding source for the services to which access is gained. LCMs and Care Coordinators are responsible for ongoing monitoring of the provision of services included in the Enrollee's ICP and other care plans. LCMs and Care Coordinators initiate and oversee the process of assessment and reassessment of the significant changes in client circumstances.

Family Planning Services	Enrollees have freedom of choice of providers of Family planning services.
Prescription Drugs	Covered when prescribed by a Health Care Professional. Generic substitution only unless provided for otherwise as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols.*
Non-Prescription Drugs	Covered when prescribed by a Health Care Professional. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation Supplies ordered by a Health Care Professional. Includes Medically Necessary nutritional supplements ordered by a Health Care Professional.
Laboratory Services	Covered when ordered by a Health Care Professional, including urine drug screens
Radiology Services	Covered when ordered by a Health Care Professional.
Diagnostic Services	Covered when ordered by a Health Care Professional.
Mental Health and Substance Use Disorder Treatment-Outpatient/ Inpatient	Covered as needed for all Enrollees. Covered Services include a full continuum of mental health and substance use disorder (MH/SUD) treatment, including but not limited to: community-based narcotic treatment; methadone, community- or hospital-based detox; MH/SUD residential treatment; mental health psychiatric rehabilitative residence (MHPRR); psychiatric rehabilitation day programs; Assertive Community Treatment (ACT); as described in in the following State documents: Integrated Health Homes Rhode Island SMI Program Description and Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program Provider Billing Manual; Integrated Health Home (IHH) as described in the following State documents: Integrated Health Homes Rhode Island SMI Program Description and Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program Provider Billing Manual; and services for individuals at CMHCs.

Home Health Services	Covered when provided at a beneficiary's place of residence, on his or her physician's orders as part of a written plan of care that the physician reviews every sixty (60) Days except for DME as specified at 42 C.F.R 440.70(b)(3). Nursing services, home health aide services and DME are required services. Physical therapy, occupational therapy, or speech pathology and audiology services are optional services the State can provide. Home Health services should not prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home Health services cannot be limited to services furnished to beneficiaries who are homebound.
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services (Section 2.8), or when authorized by a Contractor's Health Care Professional, or in order to assess whether a condition warrants treatment as an Emergency Service.
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Care Professional, up to 365 Days a year. All skilled and custodial care covered.
Services of Other Practitioners	Covered if referred by a Health Care Professional. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.
Podiatry Services	Covered as ordered by a Health Care Professional.
Optometry Services	Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two (2) years. Eyeglass lenses are covered more than once in two (2) years only if Medically Necessary. Eyeglass frames are covered only every two (2) years. Annual eye exams are covered for Enrollees who have diabetes. Other Medically Necessary treatment visits for illness or injury to the eye are covered.

Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by an Enrollee in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by an Enrollee in an outpatient hospital setting. *Oral Surgery:* Treatment covered as Medically Necessary, as detailed in the *Schedule of In-Plan Oral Health Benefits*.
Hospice Services	Covered as ordered by a Health Care Professional.
Durable Medical Equipment (DME)	Covered as ordered by a Contractor's physician as medically necessary, except if the DME qualifies as a residential service for I/DD Enrollees (see Section A.5 in this Appendix A).
Adult Day Health	Covered as needed based on Medical Necessity. Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult day health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult day health programs are for adults who return to their homes and caregivers at the end of the day.
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as defined in Appendix I and as referred by a Health Care Professional.
Group/Individual Education Programs	Including healthy lifestyles/weight management, wellness, weight loss, and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by a Health Care Professional.

HIV/AIDS Non-Medical Targeted Care Management for People Living with HIV/AIDS (PLWH/As) and Those That Are at High Risk for Acquiring HIV	Covered for Enrollees living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required steps such that all Enrollees are provided with an intake, assessment, and care plan. Health Care Professionals must utilize an acuity index to monitor Enrollee severity. Care Management services are specifically defined as services furnished to assist Enrollees who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted Care Management can be furnished without regard to Medicaid State-wideness or comparability requirements. This means that targeted Care Management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the State. Services may include but are not limited to; - Benefits/entitlement counseling and referral activities to assist eligible Enrollees to obtain access to public and private programs for which they may be eligible - All types of Care Management encounters and communications (face-to-face, telephone contact, other) - Categorical populations designated as high risk, such as sex workers A series of metrics and quality performance measures for both HIV Care Management for PLWH/As and those at high risk for HIV will be collected by Health Care Professionals and are required outcomes for delivering this service. The Contractor shall provide reporting on these services to RI EOHHS, at a frequency determined by RI EOHHS. Services do not involve coordination and follow up of medical treatments.

AIDS Medical Case Management	Medical Care Management services (including treatment adherence) are a range of patient-centered services that link Enrollees with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical Care Management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the Enrollee's and other key Family members' needs and personal support systems. Medical Care Management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: 1) Intake; 2) Assessment of service needs; 3) Development of a comprehensive ICP; 4) Coordination of services required to implement the ICP; 5) Monitoring the ICP to assess the efficacy of the plan; and 6) Periodic re-evaluation and adaptation of the plan as necessary over the time the Enrollee is enrolled in services. It includes Enrollee-specific advocacy and/or review of utilization of services. This includes all types of Care Management including face-to-face, phone contact, and any other form of communication. A series of metrics and quality performance measures for HIV medical Care Management for PLWH/As will be collected by Health Care Professionals and are required outcomes for delivering this service. The Contractor shall provide reporting on these services to RI EOHHS, at a frequency determined by RI EOHHS.

Court-Ordered Mental Health and Substance Abuse Treatment – Criminal Court	Treatment must be provided in totality, as directed by the Court or other State official or body (i.e., a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Contractor may conduct utilization review on the length of stay. The Contractor must offer appropriate transitional Care Management to persons upon discharge and coordinate and/or arrange for in-plan Medically Necessary Services to be in place after a court order expires. The following are examples of criminal court-ordered service that must be provided in totality as a Covered Service: • Bail ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of parole: Treatment is prescribed as a condition of parole by the parole board. • Condition of probation: Treatment is prescribed as a condition of probation • Recommendation by a probation State official: Treatment is recommended by a State official (e.g., probation officer, clinical social worker). • Condition of medical parole: Person is released to treatment as a condition of their parole, by the parole board.

Court-Ordered Mental Health and Substance Abuse Treatment – Civil Court	All civil (mental health court) court-ordered treatment must be provided in totality as a Covered Service. Contractor must follow all regulations promulgated pursuant to R.I. Gen. Laws §40.1-1 et seq., Behavioral Healthcare, Developmental Disabilities and Hospitals, and R. I. Gen. Laws §40.1-5 et seq., Mental Health Law, including R.I. Gen. Laws §40.1-5.5 et seq. Treatment may be ordered at the following facilities: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro Children's Hospital), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, community mental health centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than seven (7) Days, will be disenrolled from the Contractor's MMP at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or provided by a non-network Health Care Professional is not the responsibility of the Contractor. The Contractor must offer appropriate transitional Care Management to persons upon discharge and coordinate and/or arrange for Medically Necessary Covered Services to be in place after a court order expires. Civil court-ordered treatment can be from the result of: a) Voluntary admission b) Emergency certification c) Civil court certification
Telemedicine	As described in Section 2.4.1.10.1.
Opioid treatment program Health Home	Covered as needed for opioid dependent Enrollees who are receiving or who meet criteria for medication assisted treatment and have or are at risk for another chronic health condition.
Minor Environmental Modifications	Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers), and standing poles to improve home accessibility adaption, health, or safety.
Environmental Modifications (Home Accessibility Adaptations)	Physical adaptations to the home of the Enrollee or the Enrollee's Family that are necessary to ensure the health, welfare, and safety of the Enrollee or that enable the Enrollee to attain or retain capability for independence or self-care in the home and to avoid institutionalization, and are not covered or available under any other funding source. A completed home assessment by a specially trained

	and certified rehabilitation professional is also required. Such adaptations may include the installation of modular ramps, grab-bars, vertical platform lifts and interior stair lifts. Excluded are those adaptations that are of general utility, and are not of direct medical or remedial benefit to the member. Excluded are any re-modeling, construction, or structural changes to the home, i.e. (changes in load bearing walls or structures) that would require a structural engineer, architect and/or certification by a building inspector. Adaptations that add to the total square footage of the home are excluded from this benefit. All adaptations shall be provided in accordance with applicable State or local building codes and prior approved on an individual basis by the Contractor is required. Items should be of a nature that they are transferable if a member moves from their place of residence.
Special Medical Equipment (Minor Assistive Devices)	Specialized medical equipment and Supplies to include: (a) devices, controls, or appliances, which enable Enrollees to increase their ability to perform ADLs; and (b) Devices, controls, or appliances that enable the Enrollee to perceive, control, or communicate with the environment in which they live. All items shall meet applicable standards of manufacture, design, and installation. Provision of specialized medical equipment requires prior approval on an individual basis by the Contractor.

Preventive Services

Homemaker	Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home. Homemakers shall meet such standards of education and training established by the State for the provision of these activities.
Physical Therapy Evaluation and Services	Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.

Respite	Temporary caregiving services given to an Enrollee unable to care for himself/herself because of the absence or need for relief of those persons normally providing the care. Respite services can be provided in the Enrollee's home or in a facility approved by the State, such as a hospital, nursing facility, adult day services center, foster home, or community residential facility. An Enrollee qualifies for these respite services if he/she requires the services of a professional or qualified technical health professional or requires assistance with at least two (2) ADLs.

Long Term Services and Supports

Homemaker	Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.
Meals on Wheels (Home Delivered Meals)	The delivery of hot meals and shelf staples to the Enrollee's residence. Meals are available to Enrollees unable to care for their nutritional needs because of a functional dependency/disability and who require this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.
Personal Emergency Response (PERS)	An electronic device that enables certain Enrollees at high risk of institutionalization to secure help in an emergency. The Enrollee may also wear a portable "help" button to allow for mobility. The system is connected to the Enrollee's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center, as specified by RI EOHHS. This service includes coverage for installation and a monthly service fee. Health Care Professionals are responsible to insure the upkeep and maintenance of the devices/systems.
Skilled Nursing Services (LPN Services)	LPN services provided under the supervision of a registered nurse. LPN services are available to Enrollees who require interventions beyond the scope of certified nursing assistant (CNA) duties. LPN services are provided in accordance with the nurse practice act under the supervision of a registered nurse. This service is aimed at Enrollees who have achieved a measure of medical stability despite the need for chronic care nursing interventions.

Community Transition Services	Community transition services are non-recurring set-up expenses for Enrollees who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the Enrollee is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable an Enrollee to establish a basic household that do not constitute room and board and may include: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings, and moving expense; set-up fees or deposits for utility or service access; and services necessary for the Enrollee's health and safety and activities to assess need arrange for and procure needed resources. Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the Community Transition Plan development process and clearly identified in the Community Transition Plan and the Enrollee is unable to meet such expense or when the services cannot be obtained from other sources. They do not include ongoing shelter expenses, food, regular utility charges, household appliances, or items intended for recreational purposes.
Residential Supports	Assistance with acquisition, retention, or improvement in skills related to ADLs, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the Enrollee to reside in their own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance (where applicable), or upkeep and improvement.
Day Supports	Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the Enrollee to attain or maintain their maximum functioning level and are coordinated with any other services identified in the Enrollee's LTSS Care Plan.
Supported Employment	Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by individuals receiving services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

RIte @ Home (Supported Living Arrangements-Shared Living)	Personal care and services, homemaker, chore, attendant care, companion services, and medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Supported living arrangements are furnished to Enrollees who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an Enrollee receiving supported living arrangements, since these services are integral to and inherent in the provision of adult foster care services.
Private Duty Nursing	Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law and as identified in the LTSS Care Plan. These services are provided to an Enrollee at home.
Supports for Consumer Direction (Supports Facilitation)	Focuses on empowering Enrollees to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the Enrollee through the service planning and delivery process. The facilitator counsels, facilitates, and assists in development of a self-directed care plan which includes both paid and unpaid services and supports designed to allow the Enrollee to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the self-directed care plan are temporarily unavailable.
Self-Directed Goods and Services	Self-directed goods and services are services, equipment or Supplies not otherwise provided through LTSS or through the Medicaid State Plan that address an identified need and are in the approved self-directed care plan (including improving and maintaining the Enrollee's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services and/or promote inclusion in the community; and/or the item or service would increase the Enrollee's ability to perform ADLs or IADLs and/or increase the person's safety in the home environment; and, alternative funding sources are not available. Individual goods and services are purchased from the Enrollee's self-directed budget through the fiscal intermediary when approved as part of the self-directed care plan. Examples include a laundry service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove due to their disability. This will not include

	any good/service that would be restrictive to the Enrollee or strictly experimental in nature.
Financial Management Services (Fiscal Intermediary)	Payroll services for Personal Choice program Enrollees; responsible for all taxes, fees, and insurances required for the Personal Choice program Enrollee to act as an employer of record; manage all non-labor related payments for goods and services authorized in the participant's approved spending plan; assure that all payments made under the Demonstration comply with the Enrollee's approved spending plan and conduct criminal background and abuse registry screens of all Enrollee's employees.
Senior Companion (Adult Companion Services)	Non-medical care, supervision and socialization, provided to a functionally impaired adult Enrollee. Companions may assist or supervise the Enrollee with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Companions may also perform light housekeeping tasks, which are incidental to the care and supervision of the Enrollee. This service is provided in accordance with a therapeutic goal in the LTSS Care Plan.
Assisted Living	Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Personalized care is furnished to Enrollees who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to Privacy. Living units may be locked at the discretion of the Enrollee, except when a physician or mental health professional has certified in writing that the Enrollee is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the

	door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The Enrollee retains the right to assume risk, tempered only by the Enrollee's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each Enrollee to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services
Personal Care Assistance Services	Provide direct support in the home or community to Enrollees in performing tasks they are functionally unable to complete independently due to disability, based on the LTSS Care Plan and/or the self-directed care plan. Services include: • Enrollee assistance with ADLs, such as grooming, personal hygiene, toileting bathing, and dressing • Assistance with monitoring health status and physical condition • Assistance with preparation and eating of meals (not the cost of the meals itself) • Assistance with housekeeping activities (e.g., bed making, dusting, vacuuming, laundry, grocery shopping, cleaning) • Assistance with transferring, ambulation, and use of special mobility devices Assisting the Enrollee by directly providing or arranging transportation (If providing transportation, the personal care assistant must be verified as having a valid driver's license and liability coverage).
Rehabilitation Services	Physical, occupational and speech therapy services may be provided with Health Care Professional orders by RI DOH licensed outpatient rehabilitation centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the Enrollee requires specialized rehabilitation services not available from a home health or outpatient hospital provider.

Attachment C: Multi-Year Transition Timeline

Available in attached excel document titled *Attachment C – Multi-Year Transition Timeline*

Attachment D: Phase I Stakeholder Learnings

Overall Findings:

- Stakeholders expressed general support for the approach of integrated care, a broad acknowledgement of the positive experience that members have had with the MMP, and a strong desire to see the benefits of the MMP continued into any future program
- There was universal interest in understanding the details of the program design and the managed care procurement process and timeline
- Participants also expressed strong interest in being included in the ongoing stakeholder process and helping to inform design

Topic	Key Comments, Concerns & Questions
Maintaining Benefits of the MMP & Incorporating Lessons Learned	• Across all sessions there was support for the submission of the Transition Plan to enable the extension of the MMP and transition to integrated DSNP plans • Many participants noted the benefits of the current MMP and the importance of retaining its popular features in any future model *"The integrated experience is so crucial to consumers. Having integrated member services, care coordination, unified review and appeals."* *"We encourage EOHHS to maintain the aspects of the MMP that made it popular and successful in the future duals model Rhode Island develops… we would strongly encourage EOHHS not to commit to anything which would undercut those successes, such as through encouraging plans with limited provider networks or locking all duals into a single model."* • Participants brought up the need to incorporate learnings from previous or existing programs for dually eligible populations and/or previous stakeholder engagement work. Suggestions and comments included: • Consider how to address current problems within the MMP, such as beneficiaries who are on a wait list for home care leading to re-admissions and hospitalizations. • Consider how D-SNPs are working in Rhode Island and what the consumer experience has been with those programs • Be sure that the lessons learned from the RHO transition are incorporated into planning *"I would encourage EOHHS to look at work done over the past 18 months through provider events. There are materials out there about the way this model can work in partnership with deep rooted community organizations."* *"How are lessons learned from what went well and did not go well with the RHO transition going to be incorporated? How will the state make sure they don't repeat the same mistakes/build on the learnings?"*

Topic	Key Comments, Concerns & Questions
	• One MMP member asked about if an NHP supplemental benefit called the Papa Pals program was going to continue to be available. • There was sentiment that the ICI Council has provided a great forum for feedback and people would like to see this continued *"I don't think you guys can get any better. Yesterday I was interacting with a lot of insurance companies, and they were telling me about the other programs and benefits. In my head, I was thinking about my ICI council meeting. Integrity has is going on… I know this step is going to make it even better, so thank you."*
Program Design and Transition Process	Considerations and questions around specific elements of the program design and the roll out of the integrated DSNPs included: • Health plans emphasized the importance of having a phased transition with a significant pre-enrollment period (~6 months) • Importance of collecting race and ethnicity data across all duals populations in order to evaluate program equity and improve access to integrated plan options for underserved Rhode Islanders. • Understanding how moving toward managed care for members with LTSS will impact case management *"How will this impact the conflict free case management network? Will plans be required to have agreements with the same CM entities selected by the state?"*
Member Choice and Enrollment Counseling	• Participants emphasized the importance of member choice, while also cautioning the confusion that comes with having too much choice *"With increased choice, it becomes even more important to help members understand the changes and counsel them around plan choice"* *"Biggest concern is member churn; members often struggle with what options they have and accidentally opt out of the MMP. Worry is access to care when there are options that members don't understand."* • Health plans and advocates alike stated the important role that unbiased enrollment counseling will play to help members make informed choices and avoid confusion throughout the transition • Members and State agencies expressed support for the continuation of the Medicare Medicaid Enrollment (MME) Counseling program, which plays a critical role in educating members on their enrollment options • Concerns were raised regarding passive enrollment and what this means for member choice • Many stakeholders expressed the importance of retaining a traditional Medicaid FFS option for duals and maintaining choice of providers *"Could this lead to less choice of providers for members? For example, you can't guarantee that a plan will include all assisted living residences."*

Topic	Key Comments, Concerns & Questions
	• Considerations were raised regarding the PACE program and the importance of providing the opportunity for members to select that plan if it is the right fit
Special Populations	Stakeholders raised questions about how special populations such as I/DD and Partial Duals fit into the transition timeline and program design. Comments included: • Interest in how and when I/DD population would be considered for inclusion in this program • Importance of coordination with BHDDH regarding the consent decree and ensuring there is alignment on the strategy in advance of any public information being shared • Questions around about how this program will impact partial duals • Importance of aligning the program design and planning with the states ongoing LTSS redesign initiatives
Workforce Challenges	• Workforce considerations were raised across the various stakeholder segments, primarily focused on the importance of increasing the capacity of workforce/CNAs to meet a potential increased demand and acknowledgement that the demand exceeds the capacity • One participant raised the concern that if home care agencies are required to become Medicare certified it could limit the number of agencies and further limit the availability of services. *"When we started the MMP, NHP allowed all providers to contract with them. Are there plans by the state to make sure that all and not just Medicare providers are allowed into the system? Because if they are not, you won't have the number of CNAs you need to serve."*
MCO Procurement (RFQ) Process & Timeline	There was interest in how the new integrated D-SNPs fit into the overall managed care procurement picture including: • A desire to understand how this initiative dovetails with the RFP for Managed Care and whether there would be one single procurement or a separate procurement for the duals program • Questions around if the RFI will pertain to the entirety of the state Medicaid model or will be limited to the MMP transition and future integrated D-NSPs • Questions about whether AEs are intended to be a part of this strategy • A desire to understand the RFQ release timelines *"The timeline presented by CMS, even with an extension through 2025, is aggressive, and we are hopeful that EOHHS will utilize all of the time and resources provided to ensure a successful transition."*