Managed Care Procurement Stakeholder Engagement Series
Session 2: Contract Structure & Benefits
Public Meeting Notes

Monday, April 27, 2023
4:00 – 5:00 PM

Department of Labor and Training, 1511 Pontiac Avenue, Cranston, RI, 02920, Conference Room 73-1.

Facilitators/Organizers: Amanda Graziosi (EOHHS), John Neubauer (EOHHS), Mark Kraics (EOHHS), Debbie Morales (EOHHS), Jessica Brown (FCG), Lani Cooper (FCG), Min Tunkel (FCG)

Participants: Alice Msumba (Tufts), Amanda Graziosi (EOHHS), Betsy Dennegan (Lifespan), Catherine Taylor (AARP), Chantele Rotolo (EOHHS), Christina Amedeo (United Way), Christine Anderson (OHA), Christine Gadbois (Care Link), Corey McCarty (CCA Health RI), Debbie Morales (EOHHS), Erin Boles Welsh (Tufts), Garry Bliss (Prospect Medical), Heather-Rose Mattias (Care NE), Hector Rivera (EOHHS), Jan Word (NHPRI), Jeff Schmeltz (EOHHS), Jennifer Allen (Child + Family), Jess Brown (FCG), Jessica Stephens Burt (Child + Family), John Neubauer (EOHHS), Jordan Beaurert (AG's office), Kara Kurtis (Aetna), Katie Barrett (BCBSRI), Keavin Duffy (EOHHS), Kevin Cabral (Providence Community Health Centers), Kevin McKay (CCA Health RI), Kristin Harrison (Visiting Angels of RI), Lani Cooper (FCG), Lauren Morton (Molina), Leanna Moran (BCBSRI), Malorie Cannon (CCA Health RI), Marcy Reyes (CCA Health RI), Mark Cooper (NHPRI), Mark Kraics (EOHHS), Matthew Harvey (Integra), Melissa Campbell (RI Health Center Association), Melody Lawrence (BCBSRI), Mike Florczyk (UHC), Min Tunkel (FCG), Shamus Durac (RIPIN), Sophie Hansen (CCA Health RI), Stacey Aguiar (UHC), Susana Conklin (Providence Community Health Centers), Todd Farias (UHC), Tom Boucher (PACE), Tom Douglass (Providence Community Health Centers)

Agenda Item	Key Discussion Points
Welcome & Introductions	FCG and EOHHS welcomed participants to the public meeting and shared that the session would be an opportunity for the state to expand upon the Medicare-Medicaid Plan (MMP) Phase 2 transition plan and for participants to ask the EOHHS team questions and provide feedback in areas of the program design
Intro to State Medicaid Agency Contracts (SMACs)	• FCG began the discussion by defining State Medicaid Agency Contracts (SMACs) and sharing some examples of Medicaid specific SMAC requirements

	• What Rhode Island specific SMAC requirements might the state consider to improve administrative, clinical, and financial integration? What should the state avoid/exclude?
	  o It would be useful for consistency for beneficiaries to have the same marketing enhancements perhaps – we're seeing $150 gift cards to switch over to a plan, it's becoming an arms race for benefits. PACE can't keep up with it. Consistency across the board for marketing would be good.
	  o From a clinical perspective, there are differences in allowable utilization management policies and thinking about the language in SMACs specific to what you expect organizations to adhere to in terms of benefits. So you don't get a discrepancy between what Medicare and Medicaid is saying. Prior authorization, care coordination, it's a broad spectrum.
	• How can Medicaid Health Risk Assessment (HRA) and Dual Special Needs Plans (D-SNP) HRA questions and processes be aligned to minimize beneficiary and plan burden? To promote improve care coordination?
	  o Will it be one standardized question set between Medicaid and Medicare? We don't want to have to ask the same question in 4 different ways to a client or family member.
	  ▪ Where the state can minimize burden on the family and the plan it will. That kind of feedback is important to us.
	  ▪ And providers too, to make sure they have that kind of consistency.
	  o The state should consider requirements for a single entity assessment across all the plans – plans could have plan-specific questions in the SMAC, outside of the regular MDS (minimum data set) questions. And then you all could consume that data in a consistent way across D-SNPs. There's value in a single assessment requirement, then plan-specific questions the state approves, and then all-plan supplemental questions.
	  o Agreed, the same logic could apply to standard model of care. Plans could have the option to supplement on top and file with the state, so you would have insight into what the plans are doing. But there would be a minimal threshold.
	  o I would encourage the state to put the patient at the forefront. Something that's happened with MMP is that there are switches from plan-to-plan – patients get asked the same question as they churn through the system. Or having the patients interact with plans in a different way – there are so many programmatic requirements that we lose the patient point-of-view.
	• What contractual integration requirements should EOHHS consider regarding the coordination of D-SNP Enrollee Advisory Committees and Medicaid Enrollee Advisory Committees?
	  o If the state could require the DSNPs to each have their own advisory committee but have a structure like the Integrated Care Initiative or Mass Implementation Council – having multiple

	voices at the council to talk about what all enrollees are experiencing – some centralized forum to learn from the members is the way to go.
	• What do you see as the benefits, key risks, and considerations of state-specific DSNP only contracts?
	  o I could understand the benefits of having a RI-only contract ID. It's also very true that – there's a bunch of contract IDs that have been used to hide lower-star ratings so that the state can advertise higher-star ratings. If you were to carve it out, you should consider your contract oversight to make sure that doesn't work to the detriment of Rhode Islanders.
	  o A single contract ID could also affect plans in multistate contracts.

Covered Services	• FCG explained that the state intends for the future Integrated DSNP contracts to mirror the MMP managed care contract with regards to benefits, exclusions, and non-covered benefits – with minimal exceptions
	• What are your concerns regarding the coverage of extended nursing facility stays for dual eligible members? Should there be one aligned policy for nursing facility stays for both Medicaid Only and FBDE populations? What refinements to the MMP covered benefits would you recommend for the new integrated DSNP model?
	  o Could the state clarify which Long Term Services and Supports (LTSS) would be in-plan for Medicaid only?
	  ▪ When EOHHS is talking about LTSS we're talking about a few different things - coverage of nursing facility stays of 30 days has been a standard of care in the core contract. Expanding the duration of this benefit is being considered now. Additionally, comprehensive Home and Community Based Services are being brought in-plan.
	  o So the state would consider leaving Skilled Nursing Facility (SNF) care carved out of LTSS for Medicaid Only beneficiaries?
	  ▪ For this specific rule, yes.
	  o The state should be clear on its definition of an extended NF stay – a skilled NF provides skilled services, so we should be clear when a member becomes custodial and – at what point does that 365 day timer start? We need clear definitions around what an "extended NF stay" is.
	  o Question regarding dental - I understand that the state has been working on putting adult Medicaid dental in a managed plan. Would that be a separate plan or carved out?
	  ▪ The state hasn't considered Dental in the work for this procurement, but maintains flexibility to determine if that should be a separate contract.
	  ▪ If the vision is to have the same plans run the integrated D-SNPs as the Medicaid Only plans, if the plan is required to build and maintain a dental benefit, then they're well

	positioned to have a dental benefit in the adult Medicaid piece. There's a great opportunity there. o One piece that I would caution, more about LTSS – things that feel minor about fully integrated and Medicaid only, can be very large admin deficiencies, but also the member experience and caregiver experience. They would look at it like "why does my mother have this, and I don't" etc. We run into a lot of issues where we see slight differences but the member experience can be very impacted. o Thinking about one card managing everything, it'll be far better for a fragile population, that would be a wise thing to do, to have it under one card. o Home stabilization is a really important benefit – carving it out of plan may not be the most effective way to serve a population. The more benefits are carved out, the harder it is. o Regarding the MTM transportation system –maybe this is an opportunity to better provide that service. ▪ I would really like to echo that point about transportation – it's such a need, we are providing it ourselves without any subsidy from the state. The state should be providing it. o My understanding is that the difference between FIDE and HIDE is the BH integration. We had anticipated that the model would prioritize having that in-plan in a concrete sort of way. But this idea that BH can be subcontracted could mean a lot of different things. And a slide on Monday, we were talking about, even in that FIDE/HIDE distinction, it would still be under the plan umbrella. ▪ One of the central benefits, and something that's come up in the success of the MMP, is having seamless transition in the care coordination. Even if something is delegated out, it doesn't really feel like that from the enrollees perspective. ▪ Today for the MMP, they do subcontract with an organization for their BH services. But from a member perspective, the plan is still "on the hook" from a contractual perspective, to the state. A member shouldn't be noticing any sort of discrepancy due to subcontracting. There is one-plan that does it in-house, is there a benefit of having it integrated rather than subcontracted? o The state should also consider the provider perspective, it's another type of admin burden –it's very challenging. o Will there be exclusionary diagnoses used? We work with older adults, and I want to make sure they're getting the best coverage they can get, I don't want them to feel excluded because of their diagnosis. And also – will it be siloed from plan to plan, or will it be that we can provide info with releases? If someone is not happy with one provider, can they go to the next?

	○ Similar with what we do in NF, I would love to see BH providers, where if they're practicing with the state – they have to take a certain number of Medicaid patients, it's hard to find BH providers that work for certain individuals. Also, it's important that BH services and dental are on the same level as any other healthcare need – we worry a lot about physical needs, but less about BH and dental. ▪ Having a sufficient BH network is not unique to RI, providing BH providers that take Medicaid – but by limiting to exclude any delegated components or requiring that they take a certain number of Medicaid, it would be very hard to find enough providers for that, with both of those limiting factors.
Fiscal Considerations of Integration	• FCG gave an overview of the value add of integration for plans, including fully integrated benefit structures, the promotion of better care, easier to deliver member materials, and more. • What contractual elements should RI consider to promote successful financial arrangements between plan and state? What are the key success factors for plans seeking to participate in the Medicaid program and effectually serve duals and Medicaid Only populations? What specific concerns do you have regarding the profitability and sustainability of an integrated model and how might those concerns be mitigated? ○ One risk to think about for integrated DSNPs is how they're compensated for members that require some sort of LTSS services. So making sure there's structure in place with some flexibility – some individuals that get HCBS but maybe not formally LTSS eligible – how that plays out for a DSNP can significantly affect the financing. Other states have made clear requirements on an assessment for rate setting for members in a DSNP – that allows plans to identify someone with emerging LTSS needs. That's real member impact. ○ It's important with financing to build an incentive regarding rebalancing. ○ Regarding Medicaid & Medicare (integrated Medicare Advantage) plans, if they are benefiting from state or federal dollars, UnitedWay would love to see them have a presence in RI. Medicare plans especially, they can be picked as a prescription plan or dental plan in RI – I'd love to see a mandate to have a presence in RI.
Closing Remarks	• FCG reminded participants of future public meeting sessions • EOHHS asked for public comment before ending the meeting. No comments received.