Managed Care Procurement Stakeholder Engagement Series
Session 3: Service Delivery Models
Public Meeting Notes

Monday, May 1, 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), Deb Faulkner (FCG), Olivia Burke (FCG), Jessica Brown (FCG), Min Tunkel (FCG)

Participants: Alice Msumba (Tufts), Amanda Graziosi (EOHHS), Barry Fabius (UHC), Beth Marootian (NHPRI), Carla Sabotino (Tufts), Carson Colmore (FCG), Catherine Taylor (AARP RI), Chantele Rotolo (EOHHS), Chrisina Amedeo (United Way), Christina Pitney (BCBSRI), Christine Anderson (OHA), Corey McCarty (CCA Health RI), Dan Hammond (Tufts), Dan Moynihan (Lifespan), Dave Boim (Molina Healthcare), Deb Faulkner (FCG), Debbie Morales (EOHHS), Desiree Otenti (Tufts), Garry Bliss (Prospect), Heather Mattias (CNE), Jessica Brown (FCG), John Neubauer (EOHHS), Kara Curtis (CVS Health / Aetna), Katie Barrett (BCBSRI), Kevin Cabral (PCHC), Kevin McKay (CCA Health RI), Lisa Fulchino (Tufts), Liz Adler (Integra), Marcy Reyes (CCA Health RI), Mariana Moore (Tufts), Mark Cooper (NHPRI), Mark Kraics (EOHHS), Matt Harvey (Integra), Melissa Campbell (RIHCA), Melody Lawrence (BCBSRI), Mike Florczyk (UHC), Mike Gossner (UHC), Olivia Burke (FCG), Robert Archer (Child + Family), Sam Salganik (RIPIN), Sarah Coutu (UHC), Shamus Durac (RIPIN), Sheila Santos (UHC), Sylvia Bernal (United Way), Stacey Aguiar (UHC), Stephanie Gill (CCA Health RI)

Agenda Item	Key Discussion Points
Welcome & Introductions	Faulkner Consulting Group (FCG) and EOHHS welcomed participants to the public meeting and shared that the session would be an opportunity to discuss service delivery model considerations for enhancements to the Medicaid Managed Care Contract.
Seamless Transitions: Medicaid Only Population	FCG explained the phased approach that the state is proposing, starting with bringing Long Term Services and Supports in-plan for Medicaid only individuals beginning July 2025 at the start of the new core contract period. • How can EOHHS best manage the transition from Fee For Service (FFS) to managed care LTSS services for the Medicaid Only population, to avoid gaps in services and disruption of existing provider/care manager relationships?

	○ Question from stakeholders: Is the intent that the state will still have a role in the approval process – and what will be the carrier responsibilities in deciding level of care (LOC)? ▪ The State will determine eligibility including the LOC of determination (both financial and clinical). The state is always the only entity that can do this determination and the annual redetermination, but information can be shared regarding the last comprehensive assessment. There will be some type of exchange. ▪ There is a long wait for clinical eligibility determinations with the state. Will this eligibility need to be redetermined for transitioning members? There may be individuals receiving FFS LTSS who will transition to managed care. Need to establish transition of care requirements. ▪ Hopefully the MCOs can help alleviate this bottleneck. ○ Question from stakeholders: Can we clarify what "LTSS services" means on this slide? ▪ LTSS is all HCBS (excluding IDD waiver services) and nursing facility stays for up to 30 days for Medicaid only beneficiaries and nursing facility stays for 365 days per plan year for dually eligible beneficiaries. However, the duration of covered nursing facility stays for Medicaid only beneficiaries is a topic the state would like stakeholder input on. ▪ FCG: When the state sends out the RFI, may be helpful to include a list of covered benefits that is included in the MMP contract, with a starting point for HCBS waiver services, and with the exception of the IDD waiver, to receive feedback. ▪ EOHHS: Yes, for example, the HAB/TBI waiver impacts a very small, specific population – some states don't include it – should Rhode Island? ▪ Carriers need clarity around custodial LT benefit vs. skilled benefit in a facility – we can look at the MMP contract, but we should be clearer about that.
Seamless Transitions: Dual Eligible Population	Phase 2 of the phased transition will be the launch of integrated DSNPs for the MMP population & other FBDEs who choose to opt-in, January 2026. The MMP comes to a close December 31, 2025. • How can EOHHS best manage the transition for existing MMP members and dual eligible members who chose to opt-in to Integrated D-SNPs to avoid gaps in services and disruption of existing provider/care manager relationships? ○ All DSNPs offer care management – every member has care management, an overall care plan, and we should think about the transition from whatever DSNP they are enrolled in to make sure continuity – and ensure protocols/requirements are in place to ensure sharing of prior care plans or goals – anything to help seamlessly support that member. ○ It's really important for continuity of care that plans, providers, case management agencies, all have the right set of tools. There are always going to be the extreme cases, for example, where the

	member makes the enrollment decision, and then immediately ends up in the hospital with a stroke – for those cases, we will need to think through the tools and information sharing – making sure that the right players have access into the right system to know if the member is LTSS eligible, and what service plans are in place. "Tools" referring to portal access, CFCM tools, the connective tissue to know service plan. o For initial enrollment, that'll cover the populations that come in, but what about annual enrollment? At least the first year should have liberal plan change rules and not lock people in. ▪ With integrated D-SNPs, the state can't dictate enrollment, duals have special election periods allowing them to change on a quarterly basis. The federal Medicare rules dictate this. ▪ The state is unsure if CMS will allow additional flexibility to the state to allow folks to transition. Medicare choice drives Medicaid selection so duals will be able to change between integrated D-SNPs and into FFS on a quarterly basis, as it stands. ▪ What about the Medicaid-only population – can they have more flexibility? Disruption can occur for the Medicaid only LTSS eligible individuals - the state could have the special enrollment rules mimic duals. This is present in Massachusetts. o Those that hit Phase 1 on July 1st and then hit Phase 2 and become dually eligible – the state welcomes thoughts about how to manage transitions prior to the launch of default enrollment. ▪ Enrollment into MMP will stop within the last 6 months of the demonstration, at least from the MMP side – is that appropriate? NHPRI voiced some concern with this approach as some may want a fully integrated option. ▪ New duals could be excluded from participating in duals program until 1/1/26 – for ease of operation, they could stay in Medicaid FFS – is that best for the member? ▪ We should be considering the beneficiary experience.
Special Populations	Rhode Island's dual eligible population includes many subpopulations with complex care needs – what are the challenges specific to these populations that need to be addressed to ensure the population is well served in an integrated DSNP model? • Some individuals may be getting 6 hours of preventive services in FFS – but in the MMP they may be getting 10 hours. If members transition from the MMP to another integrated DSNP we want to maintain what is in the best interest of the member. A continuity of care plan should require the same LOC upon transition. • Preventive services should be better defined in the contract. If someone might benefit from these services, plan can initiate that; plans always have flexibility to provide additional services as value add, above what is in the contract if it's beneficial to the member.

	• There is a dearth of LTC beds for individuals with SPMI not in the hospital – how should we create a continuum of care for BH and add hospital LOC capacity? ○ The state asked that stakeholders review the service requirements and offer suggestions via the RFI.
Provider Network Adequacy	Medicaid covered service types for dually eligible beneficiaries are all in plan with the exception of transportation, dental, I/DD waiver systems, and home stabilization. Where are the network gaps that you worry about across services? How should EOHHS monitor the number and types of LTSS HCBS providers to ensure network adequacy? How can EOHHS encourage stakeholders to better utilize telehealth and other technologies? • At the start of the MMP, RI statutory law required that MCOs pay FFS rate at a minimum and include any and all willing HCBS providers in their network. Could we do this same rule for integrated DSNPs – have the state require the MCO pay a minimum of the FFS rate and include all the state contracted providers? • We also want the networks to be high quality – there are efforts to promote quality, a lot of home care providers who want to incentivize or even create differentiation based on quality – want members to go to high quality providers, not just any provider. • Star scores will now apply, so quality and member experience matters to the plan – they won't want to keep poor performers. There must be a mechanism to allow them to drop providers, and those rules need to be clear and consistent across carriers so that there is a consistent way the providers are being evaluated, and a consistent way plans can exclude a provider. • However, also need to set a reimbursement rate at a minimum – want to protect that sector from negotiating with individual plans.
Value-Based Payment and HCBS VBP Program	The LTSS Alternative Payment Model is being piloted through the MMP - EOHHS is considering expanding the LTSS APM program dependent on initial results and pilot program learnings. Questions addressed to participants included: 1) As EOHHS considers whether and how to transition this program into an integrated D-SNP/MLTSS model, what factors should be considered? 2) This is an optional program – how can EOHHS best encourage provider participation and engagement? 3) Are there other types of APMs that EOHHS should consider as part of an integrated D-SNP/MLTSS model? 4) Are there additional policies or strategies EOHHS should adopt to improve the quality and coordination of care for FBDE and Medicaid Only individuals receiving LTSS under the new integrated D-SNP/MLTSS model?

	• There is concern that this HCBS VBP program is only available to managed care program providers – measures are only on the managed care side. There are ways to come up with measures and encourage high quality across the whole book of business.
	  o Olivia Burke, FCG explained that it is set up that way – measures are across the participating home care providers' whole book of business. There seemed to be a lot of folks agreeing that this is a really good way to do it – and it should stay that way as transitions to DSNPs occur.
	  o The only challenge is that it's hard for the plan to monitor/manage impact due to plans if measures are crosscutting FFS and managed care.
	• Regarding encouraging high provider participation it depends on the size of the "carrot" and what the risk is, as to how successful the program will be. It needs to be adequately funded to work.
	• After the pilot is over – would the MCO be potentially expanding the VBP program?
	  o Even if we allowed every plan to participate, reporting is across all populations – there is a concern that plans can't validate the data.
	  o It sounds like the state is doing a good job, aligning measure sets, working across providers and across payors, and having simple, straightforward, meaningfully-aligned measures – which makes success metrics easier to report and track.
	  o Expanding the VBP program puts more pressure on carrot size – looking ahead to all payor quality. How can the plan be held accountable to a population they are not responsible for? Need to be paid for that.
	• Are there other APMs the state should contemplate?
	  o Raise reimbursement rates.
	  o Seems like the state should consider nursing facilities as their next generation – there are already a lot of metrics in the NF area, and there should be a standard set.
	  o Would love to see about a connection between HCBS and primary care visits, home care to primary care. There should be an effort to make that connection.
	  o Need to tie primary care to this space and be very clear about the goal of the APM –it is likely the goal to improve quality, but the state should be careful about any APM in this duals space that is intended to reduce costs. Especially in the LTC space, need the broader continuum – can't do TCOC model in the duals space.
	  o Institutions that provide adult day care, and group homes – what about VBP in those arenas? Other provider types who service individuals – some of whom are duals – who receive home care *and* go to a day care center end up aging into group homes. Can we create a pathway for these providers to participate?

Public Comment	• EOHHS asked for any public comment. No comments received.