Medicaid MCO Procurement Stakeholder Series

April - May 2023 Stakeholder Discussions: Key Learnings

May 17, 2023

Purpose & Approach: The procurement process for Rhode Island's Medicaid Managed Care program is scheduled to begin in the fall of 2023 with a request for qualifications (RFQ). In preparation, the state is seeking both informal and formal feedback in two parts: Part 1: a facilitated public meeting series followed by Part 2: a request for information (RFI) regarding new elements of the managed care contract.

This document summarizes the learnings from Part 1: Facilitated Public Meetings. Faulkner Consulting Group (FCG) facilitated a series of four public meeting sessions with a range of stakeholders to hear concerns, considerations, and opportunities regarding new program elements. The goal of this process was to collect information to inform development of the RFQ, including model contracts, and future program design.

Sessions: Four public meetings were conducted over a two-week period to collect stakeholder feedback on specific managed care populations, programs, and policy decisions. The below table outlines the focus of each session and when each meeting took place. Participating stakeholders included state agencies, health insurers, provider organizations, advocates, and other interested parties. A full list of participating organizations is available in **Appendix A.**

Session Topic	Date & Time
Session 1: Member Choice & Plan Options • MMP Transition Plan • Member Choice & Enrollment • Procurement Timeline	April 24 4-5 PM
Session 2: Contract Structure & Benefits • D-SNP Contract Requirements • Covered Services • Fiscal Considerations	April 27 4-5 PM

Session 3: Service Delivery Models • Seamless Transitions • Care Coordination • Special Populations • Quality & Value Based Payment • Provider Network Capacity	May 1 4-5 PM
Session 4: New Core Contract Elements • Delegation • Primary Care Capitation • Health Related Social Needs • Certified Community Behavioral Health Centers • Quality	May 3 8:30-9:30 AM

Key Learnings: A summary of stakeholder feedback organized by Session is available below. Key takeaways for each topic area are **highlighted in Blue.** Detailed stakeholder input from each public meeting is available in **Appendix B.**

I. Member Choice, Plan Options and Enrollment Approach

Participants were presented with a background of the MMP transition to integrated D-SNPs, Rhode Island's vision, goals, and strategies for dually eligible individuals, future proposed plan options and approach to enrollment, and a high-level procurement timeline.

Member Choice and Plan Options

Strong support for maintaining the benefits of the MMP. Participants were collectively very supportive of carrying forward successes of the MMP to future integrated D-SNPs. Elements mentioned as most critical to maintain for member satisfaction included a single ID card, integrated care, and zero copay on prescriptions.

Importance of member counseling and education on plan options. There was general support for the proposed menu of plan and delivery system options, specifically maintaining a FFS option and promoting integrated care by eliminating the managed long term services and supports (MLTSS) option for members outside of integrated D-SNPs. Several participants raised the importance of educating members about their options due to the complexity of plan choices available and fear of decision fatigue for members. Maintaining Medicare Medicaid Enrollment (MME) Counselors, operating a benefit counseling hotline, and providing additional consumer support for when issues arise, were raised as strategies to mitigate concerns and support members in making informed choices. One participant also commented on the importance of oversight and standardization of Medicare/D-SNP marketing materials and tactics.

Enrollment Approach

Support for default enrollment and caution around the enrollment approach during the transition period. Stakeholders were generally in favor of the state's plan to pursue default enrollment into integrated D-SNPs for newly dually eligible members as the least disruptive option. Several also voiced concern about the enrollment approach in the period leading up to the transition to integrated D-SNPs. Specifically, if the state contract prevents enrollment into the MMP six months prior to the launch of integrated D-SNPs, Medicaid-Only members will be disenrolled from their managed care plans into Medicaid FFS, without an integrated Medicaid-Medicare option available. One participant encouraged the state to explore amending the MMP contract language to allow for continued enrollment, leaving one integrated managed care option available during this 6-month transition period.

Procurement Timeline

No major risks were raised with procurement timeline. Participants did not raise major risks or concerns with the procurement timeline. One participant encouraged the state to consider aligning the managed care contract period with the calendar year rather than the state fiscal year.

II. Contract Structure and Covered Services

Stakeholders were introduced to State Medicaid Agency Contracts (SMACs) and provided with an overview of the proposed benefit package for integrated D-SNPs.

Contract Structure

Collective interest in including SMAC requirements that promote alignment and standardization across FFS, MCOs and providers. Several participants advocated for a standardized set of questions for Health Risk Assessments (HRAs), some noting the benefits of having additional plan-specific questions that the state approves, with the aim being to consume that data in a consistent way across plans. One participant highlighted the need for SMAC terms that promote consistency regarding benefits, prior authorizations, care coordination and allowable utilization management policies across Medicaid and Medicare. While discussing how to best coordinate the efforts of required D-SNP Enrollee Advisory Committees with similar Medicaid committees, one participant recommended maintaining an ICI Implementation Council-like structure, where multiple voices can discuss the enrollee experience in a centralized forum.

Minimizing duplication and streamlining transitions. Stakeholders emphasized the need to minimize repeated assessments and duplicative questions as members move from plan to plan or between delivery systems, advocating that all MCOs, subcontracted entities, and providers use a common tool and have access to member assessments upon transition.

Considering a Rhode Island specific D-SNP contract with a single CMS contract ID. Stakeholders were asked for their thoughts on requiring D-SNPs to have a Rhode Island specific contract (i.e., a single CMS contract ID), such that health plans that operate D-SNPs in multiple states are required to have a contract that is unique to Rhode Island. One stakeholder noted potential benefits of a single CMS contract ID but encouraged the state to consider the possible impacts a single ID could have on skewing RI plan star ratings[1].

Covered Services

Encouragement to align covered services across populations, to minimize carve outs and to better define covered services. There was consensus among stakeholders that benefits packages for Medicaid-only and dually eligible members should be aligned with one another and that the more services that are carved out and provided FFS, the more disjointed the member experience will be. Feedback on specific covered services included:

- **LTSS Services:** Several participants emphasized the importance of more clearly defining what LTSS services will be brought in-plan for Medicaid Only populations. Additionally, there was consensus that Medicaid Only benefits should be aligned more broadly with those provided to dual eligible members in integrated D-SNPs (i.e., to expand coverage of nursing facility stays from 30 to 365 days per plan year). More explicit contract language regarding skilled vs custodial nursing facility benefits was also requested.

- **Preventive HCBS** was raised several times as a critical benefit for which a minimum scope and quantity of services should be more clearly defined for MCOs; creating a baseline requirement but allowing plans to provide additional hours of Preventive HCBS as they wish to better care for their members. One participant added that seemingly minor discrepancies in LTSS and preventive benefits between populations can result in impactful administrative burden, unnecessary complications in the member experience and caregiver experience, and lead to member confusion.

- **Dental and Transportation:** Multiple stakeholders highlighted transportation as a key benefit that should be better managed and funded and some suggested bringing this benefit in-plan. Dental was also mentioned as another service that could be brought in-plan and stakeholders encouraged the state to think of dental as an essential healthcare benefit.

General concerns were raised regarding behavioral health services – considering the member experience, adequate networks, and allowing MCOs to subcontract these services. Participants expressed concern regarding contract terms that permit MCOs to subcontract behavioral health services, noting that this structure can negatively impact the member experience and cause administrative burden on providers. One stakeholder also cautioned

[1] Currently, Medicare Star Ratings are applied at the D-SNP contract level and are a function of plan quality and performance metrics. If RI were to require a state specific contract with D-SNPs, this would mean star ratings would only reflect RI plan quality and performance, thereby decreasing the sample size of members contributing to these ratings. This could lower or increase star ratings as compared to ratings that are currently assessed for D-SNPs with contracts that span across multiple states. CMS advises that states consider the anticipated population size of each proposed D-SNP-only contract relative to minimum sample sizes and/or denominator requirements for applicable quality measures and surveys, particularly those used for the calculation of Star Ratings. Where concerns exist, CMS will work with the state to explore possible strategies for mitigation. https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf

against exclusionary diagnoses, highlighting the need for a broad provider network that allows members the flexibility to choose between an array of providers to select who suits them best, regardless of their diagnosis.

Risks around how plans are compensated for LTSS. Carriers noted a financial risk for integrated D-SNPs in how they are compensated for members that require LTSS and preventive HCBS. They stressed the importance of having a structure in place that allows plans to identify someone with emerging LTSS needs and clear requirements on the assessment for rate setting.

III. Service Delivery Models

Stakeholders were presented with a phased transition plan outlining key populations impacted with each phase, a full list of Medicaid covered service types to facilitate a conversation on provider network adequacy, and a payment incentive program for HCBS providers currently being piloted through the MMP.

Seamless Transitions and Care Coordination

Caution regarding the importance of clear processes and integration plans to support transitions between service delivery models - including the need for shared care coordination tools, and flexible enrollment periods to minimize (or avoid) member disruption. Participants expressed concern regarding populations transitioning during the first couple of years of the new contract period, beginning July 2025. Targeted concerns specific to each transition scenario are summarized below:

- **Transitions from FFS to managed care for LTSS services:** Multiple stakeholders expressed concern regarding disruption to individuals transitioning from receiving LTSS services through FFS to managed care. Participants requested that the state ensure protocols are in place to enable the sharing of prior care plans and goals, and more widely conveyed the need for a standardized set of care coordination tools across plans, providers, and care management entities including portal access, and conflict free case management tools. One stakeholder requested a continuity of care plan that requires the same level and quantity of preventive HCBS upon transition[2]. Carriers raised that members have been experiencing long wait times for clinical eligibility determinations with the state and expressed interest in providing their members with these assessments to help alleviate this bottleneck. To further assist members during this transition, participants advocated for flexible enrollment periods. One individual advocated for the state to have special enrollment rules, for Medicaid Only beneficiaries eligible for LTSS, that mimic those for dual eligible members; this was noted as an approach Massachusetts has implemented.

[2] Several participants raised concerns about preventive HCBS, specifically how the scope and quantity of these services currently vary between what is offered through FFS vs through the MMP. Some individuals may be getting 6 hours of preventive services in FFS but 10 hours in the MMP.

- **Transitions prior to the launch of integrated D-SNPs and default enrollment:** Stakeholders expressed concerns regarding transitions for newly dually eligible beneficiaries and all transitioning duals prior to the launch of integrated D-SNPs and default enrollment. They asked the state to consider policy solutions to best promote enrollment into integrated plan options during this period.

- **Enrollment and disenrollment due to Medicaid eligibility:** One stakeholder asked the state to consider the scenario when a member becomes eligible for Medicare but has not yet had their Medicaid redetermination complete, which does not always happen on a timely basis. These members may enroll into an integrated D-SNP but only be a dual for a short amount of time.

- **Full benefit dual eligible beneficiary (FBDE) transitions from Coordination Only D-SNPs (CO-DSNP):** Stakeholders were generally supportive of no longer allowing full benefit duals to enroll in coordination only D-SNPs to promote enrollment into more integrated plan options, however this raised the question of transitioning FBDEs out of the legacy D-SNPs. Participants questioned how the state could best streamline this transition to minimize member disruption[3].

Provider Network Adequacy, Quality and Value Based Payment Models

Promoting a sufficient HCBS provider network and creating standardized processes that allow MCOs to control quality. When stakeholders were asked about how to best ensure HCBS network adequacy, one participant suggested requiring MCOs pay providers at a minimum the FFS rate[4] and include any willing HCBS providers in their network, as is required under the Willing Provider Statute (R.I. Gen. Laws § 40-8.13-7) for licensed nursing facilities today. Carriers expressed concern that star ratings will now apply, therefore high-quality providers and member experience matter even more to the plan and there must be a mechanism to allow plans to drop poor performing providers. They emphasized the need for standardized provider assessments and processes to drop providers across carriers. One participant added that a lot of home care providers want to incentivize and create differentiation based on quality.

Support for the LTSS Alternative Payment Model (APM) Pilot with caution regarding populations measured. Participants provided positive feedback on the current APM for home care providers, agreeing with the current approach that measures should be evaluated using the "whole book of business", i.e., both managed care members and FFS members. Carriers agreed with the success of the model but cautioned that it is challenging to monitor/manage performance when measures are cross cutting across populations. They questioned how plans can validate data and be held accountable for a population they aren't responsible for. Others raised the need to increase reimbursement rates and protect the HCBS sector from negotiating with individual plans.

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[3] Participants and the EOHHS team discussed how the ease of FBDE transitions from coordination only D-SNPs is dependent on if the member is enrolled in a legacy CO-DSNP that successfully bids on the Medicaid contract and goes on to offer an integrated D-SNP. In this case, CMS would likely allow the CO-DSNP to "crosswalk" members into the corresponding integrated D-SNP. Members of CO-DSNPs that do not successfully bid on the contract would likely be disenrolled from their existing plans and need to actively make a new Medicare plan selection or be auto enrolled into Medicare FFS/Medicaid FFS.

[4] FFS is the required minimum rate payable by MCOs under the *Financial principles under managed care* statute (R.I. Gen. Laws § 40-8.13-5)

Suggestions for adapting and expanding the current APM. Stakeholders raised several recommendations for alternate APMs and expansions to the existing APM the state should consider, including: 1) Expanding to nursing facilities, as there are many established metrics in this area and there should be a standard set; 2) Expanding to institutions that provide adult day care and group homes; 3) Adapting to connect HCBS and primary care visits, with the caveat that the goal of the APM must be clear regarding improved quality rather than reduced cost as this could result in negative unintended consequences for dual eligible members.

IV. New Core Contract Elements

Delegation

Recommendations regarding Delegation of Care Coordination and Care Management Program activities to Accountable Entities (AEs) and providers – including MCO flexibility, population specific requirements, and more prescriptive funding guidelines.
Carriers requested flexibility from the state to use delegation at their discretion, noting they are well positioned to design programs for the populations they serve. Caution was advised against overly prescriptive requirements given the diverse populations represented in the core contract. Providers focused their input on how to tailor delegation requirements for specific populations and delineate (and fund) responsibilities among entities. Many suggested the state better define care coordination requirements for each population, including children, families and members without severe diagnoses who are often overlooked but can greatly benefit from care coordination – one participant referred to this group as the "giant middle". Participants also expressed concern that this delegated responsibility must be adequately funded and requested more prescriptive guidelines from the state on how care coordination and management funding should be allocated between MCOs and providers.

Primary Care Capitation

Primary Care Capitation Interest and Structural Considerations. Participants expressed general interest in and support for a PCP capitation model and offered specific suggestions regarding its design. Some participants cautioned that a PCP capitation that only covers primary care visits/services may be too limiting to have the intended effect on quality of care and utilization and that a global capitation model that includes care coordination might be a better alternative. Perspectives on risk adjustment varied – with participants generally supportive of/encouraging the use of risk adjustment but mixed opinions on how best to do so. Some cautioned that risk adjustment models often result in not enough money going to pediatricians and children; one participant suggested a model that requires spending be proportional to the size of the population, for example, if children are 25% of an AEs population, then 25% of the funding is spent on children. Others advocated that a global capitation model that is risk adjusted to the individual enables enough flexibilities to ensure dollars are well spent.

Health Related Social Needs

Mixed feedback regarding state standardization of Value-Added Services to support state specified priorities. Carriers advised against more prescriptive guidance from the state regarding value-added services, emphasizing the need for flexibility given the diverse contract population. Some participants added it could be helpful for the state to prioritize social issues and provide guidance regarding what types of services make sense for MCOs to work toward and for the state to fund. Housing security was raised as an issue that the state could to take the lead on, giving an example of an "all payor housing development pool" to mitigate fragmented efforts. One participant flagged that workforce issues are fundamental to being able to get the care to those who need it, starting with the state's short supply of primary care physicians.

Behavioral Health benefits and Certified Community Behavioral Health Centers (CCBHCs)

Importance of early access to the Certified Community Behavioral Health Center (CCBHC) Model Operations Manual. Participants emphasized the importance of getting a draft of the CCBHC operations manual as soon as possible, in advance of the launch of the program, to leave time for providers to transition to the new model. New billing methods and setting up attribution were two elements flagged as anticipated challenges. MCO involvement in the development of the manual was raised as being critical to success of the program. Clarification was requested regarding if the CCBHC program is focused on existing services or new services; one participant representing a designated collaborating organization (DCO) noted there are things being done today that need to be done better and that the scope should not be limited. Lastly, one participant questioned how DCYF and BHDDH are thinking about changes in their roles and responsibilities in this transition, highlighting that the services they manage and role they play with their providers can get between MCOs and members.

Concerns raised regarding behavioral health service definitions, alignment & coverage. One participant raised concerns regarding the way that DCYF-mandated services are currently defined by MCOs. Others flagged the need for the MCO service list to be aligned with the CCBHC service list. One participant questioned the decision to Included court ordered BH services as an in-plan benefit, noting that these services may not be medically necessary, and plans have limited control.

Quality

Support for aligned quality metrics and inclusion of member satisfaction surveys. Participants applauded the states success in aligning MCO and AE quality measures but noted there are still AE measures that are not aligned. Stakeholders encouraged the use of HEDIS measures as a standard practice (vs "homegrown" measures) and asked the state to consider stratifying measures for race/ethnicity. Member satisfaction and potentially provider satisfaction were raised as important measures that should be included in quality performance plans. However, participants highlighted challenges regarding member participation in the 60-question survey.

Appendix A: Public Meeting Participating Organizations

AARP
AG's office
BCBSRI
Care New England
CareLink RI
CCA Health RI
Child + Family
CTC RI / PCMH Kids
CVS Health / Aetna
EOHHS
Integra
Leading Age RI
Lifespan
Molina Healthcare
NHPRI
OHA
Opportunities Unlimited
PACE
Point 32 / Tufts
Prospect
Prospect Medical
Providence Community Health Centers
RI Health Center Association
RIEMHAC
RIPIN
Sherlock Center
UHC
UHC Dental
United Way
Visiting Angels of RI

Appendix B: Detailed Stakeholder Input by Session

Session 1: Member Choice & Plan Options

Topic	Stakeholder Feedback
Starting Point and Goals: The MMP Demonstration	• **What elements of the MMP are most important to maintain from a member perspective?** o Participants noted the single ID card, integrated care, and zero copay on prescriptions as elements of the MMP that members really like. • **What elements of the demonstration should be changed to improve the member experience?** o Flexibility for D-SNPs to provide different supplemental benefits was raised as an important consideration to ensure plans can best meet the needs of their members. o One participant emphasized the importance of maximizing freedom of choice of home care providers for members.
Why Integrated Managed Care for Dual Eligible Members?	• **What are the potential risks and opportunities for an integrated Medicare/Medicaid model?** o Participants raised concerns regarding challenges with the enrollment/disenrollment for members that go in and out of Medicaid eligibility, noting similar existing challenges within the MMP.
MMP Transition: Visual, Goals, and Strategies	• **Do you have any feedback, questions, or considerations for the state regarding the vision, goals, and strategies?** o Participants sought clarity regarding the requirement that all bidders offer an integrated D-SNP, questioning if the state had preference for a fully integrated D-SNP (FIDE SNP) over a highly integrated D-SNP (HIDE SNP) and if coordination only D-SNPs would still be available. o One participant raised a question regarding if the state would be pursuing standardized D-SNP models of care for integrated plans.
Medicare/Medicaid Options for Dual Eligible Individuals	• **Participants were shown a matrix of health plan service delivery options available for dual eligible members, depending on their Medicare and Medicaid choices. Are these the right options? Are there others you would anticipate? Should there be fewer or more?** o Several participants raised concerns regarding the number and complexity of plan choices available and fear of decision fatigue for members. o A few highlighted the need to maintain the Medicare-Medicaid Enrollment (MME) Counseling program, currently operated through United Way, to appropriately educate beneficiaries on their options. o A benefit counseling hotline/service and additional consumer support in case issues arise were also flagged as critical beneficiary support functions that the State should consider to support the transition to integrated D-SNPs.

	○ One participant noted a change from the original MMP Transition Plan that managed care (MLTSS) would not be available for dual eligible members who were not enrolled in an integrated D-SNP. There was consensus that the States' decision to eliminate the MLTSS option for duals made sense and would help promote the integrated option. ○ Clarification was requested regarding the eligibility of individuals with intellectual and developmental disabilities (I/DD) to enroll in integrated D-SNPs. (Note: The state clarified that individuals with I/DD are eligible and that IDD waiver services would continue to be provided FFS.) ○ One participant raised a question regarding the availability of existing Medicare supplemental plans for dual eligible individuals who enrolled in D-SNPs.
Promoting Active Member Choice	• **What factors should EOHHS consider in designing/implementing a member education and outreach process?** ○ Stakeholders raised concerns regarding the intensive/predatory marketing tactics from Medicare plans. ○ One participant highlighted the importance of educating members on all options available regardless of their existing plan choice. ○ One participant questioned if the state would be issuing another series of passive enrollment letters and when those letters would be sent.
Phased Transition	• **Is the proposed phased transition approach appropriate to manage enrollment and plan selection? What factors should be considered?** ○ Participants provided positive feedback on the state's plan to pursue default enrollment of Medicaid managed care members into integrated D-SNPs for newly dually eligible beneficiaries and also voiced concern about transitions for these members prior to launch of integrated D-SNPs and default enrollment. ○ One stakeholder asked the state to consider the scenario when a member becomes eligible for Medicare but has not yet had their Medicaid redetermination complete, which does not always happen on a timely basis. These members may enroll in a dual special needs plan but would only be a dual for a short amount of time.
Medicaid Procurement Timeline and Transition	• **Are there any concerns with following the States tentative procurement timeline and meeting critical deadlines? Any suggestions for how EOHHS can support this process?** ○ Participants requested clarification regarding when selected plans would be notified following RFQ Response submissions. ○ One participant encouraged the state to consider aligning the managed care contract period with the calendar year rather than the state fiscal year.

Session 2: Contract Structure & Benefits

Topic	Stakeholder Feedback
Intro to State Medicaid Agency Contracts (SMACs)	• **What Rhode Island specific SMAC requirements might the state consider to improve administrative, clinical, and financial integration? What should the state avoid/exclude?** o One participant suggested standardizing marketing gift rules for health plans. o One participant highlighted the need for SMAC terms that promote consistency regarding benefits, prior authorizations, care coordination and allowable utilization management policies across Medicaid and Medicare. • **How can Medicaid HRA and DSNP HRA questions and processes be aligned to minimize beneficiary and plan burden? To promote improve care coordination?** o Several participants advocated for a single assessment requirement, one standardized set of questions for Health Risk Assessments (HRAs), some noting the benefits of having additional plan-specific questions, outside of a tool such as the minimum data set (MDS), that the state approves, with the aim being to consume that data in a consistent way across plans. o Providers emphasized the need to minimize repeated assessments as members move from plan to plan, ensuring all MCOs and providers have access to member assessments upon transition. • **What contractual integration requirements should EOHHS consider regarding the coordination of DSNP Enrollee Advisory Committees and Medicaid Enrollee Advisory Committees?** o One participant recommended the state require DSNPs to each have their own advisory committee but have a structure like the ICI Council or Mass Implementation Council where multiple voices can talk about the enrollee experience in a centralized forum. • **What do you see as the benefits, key risks, and considerations of state-specific D-SNP only contracts?** o One stakeholder noted potential benefits of a single CMS contract ID but also highlighted that Medicare Star Ratings are applied at the contract level based on quality and performance, therefore challenges could occur with Rhode Island D-SNPs given the smaller pool of providers and participants, and encouraged the state to consider the potential a single ID could have on RI plan star ratings.
Covered Services	• **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?** o Several asked for the state to clarify its definition of LTSS for those services being brought in-plan for Medicaid Only populations and to align those benefits across dual eligible and Medicaid only populations. One participant added that minor discrepancies in LTSS benefits between populations can result in impactful administrative burden, unnecessary complications in the member experience and caregiver experience, and lead to member confusion. o Some participants expressed concern that the more services that remain carved out of plan benefit packages, the more disjointed the member experience will be.

	○ One carrier requested more explicit clarification regarding the definition of an extended nursing facility stay and expected plan coverage of skilled nursing services versus custodial services and when that transition from skilled to custodial occurs for members, through an amendment to contract language. • **What refinements to the MMP covered benefits would you recommend for the new integrated DSNP model?** ○ Multiple participants encouraged the state to consider bringing adult dental benefits in-plan, highlighting that plans are well positioned to provide this service if the states vision is to have the same plans run integrated D-SNPs as Medicaid Only plans. ○ General concern arose regarding behavioral health services, the member experience, and having a sufficient provider network. ▪ Stakeholders highlighted that member experience needs to be identical regardless of if MCOs are subcontracting these services or providing them in-house. ▪ One participant flagged subcontracting of specific services leads to administrative burden for providers. ▪ The state was cautioned against having any exclusionary BH diagnoses, with one participant emphasizing the need for members to feel cared for and have the flexibility to choose from an array of providers to find who best suits them without feeling limited by their diagnoses. ▪ One participant proposed requiring BH providers to take on a minimum number of Medicaid patients, similar to what is required of nursing homes. ▪ Another stakeholder cautioned against requiring MCOs to provide BH services directly or having BH providers take a minimum number of Medicaid patients, highlighting that concerns about an insufficient BH network is not unique to RI and these requirements would further limit the state's ability to identify and hold on to these providers. ○ Multiple stakeholders highlighted transportation as a key benefit that should be better managed and funded by the state.
Fiscal Considerations of Integration	• **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?** ○ Carriers noted a risk around how plans are compensated for members that require LTSS services. It was recommended to allow plans the flexibility to identify individuals in need of preventive HCBS or emerging LTSS needs, who may not be formally LTSS eligible and that the state have clear requirements on an assessment for rate setting. ○ One participant noted the importance to build an incentive regarding LTSS/HCBS rebalancing. ○ Mandating participating plans have an active presence in Rhode Island was also highlighted as a recommendation.

Session 3: Service Delivery Models

Topic	Stakeholder Feedback
Seamless Transitions: Medicaid Only Population	**How can EOHHS best manage the transition from FFS to managed care LTSS services for the Medicaid Only population, to avoid gaps in services and disruption of existing provider/care manager relationships?** o Carriers expressed concern regarding long wait times for clinical eligibility determinations with the state and interest in providing their members with these assessments to help alleviate this bottleneck. o Multiple stakeholders expressed concern regarding disruption to Medicaid only LTSS eligible individuals and encouraged the state to have special enrollment rules that mimic those for dual eligible members. This was noted as an approach Massachusetts has implemented. o Stakeholders generally expressed the need for clear transition of care requirements. o Several carriers requested clarification regarding the proposed LTSS benefits covered in-plan, and specifically clearer definitions of custodial and skilled residential long-term care benefits.
Seamless Transitions: Dual Eligible Population	**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?** o Stakeholders identified the need for shared set of care coordination tools across plans, providers, and case management entities, and dedicated attention to newly dually eligible individuals prior to the launch of default enrollment as key factors to a successful transition into integrated D-SNPs in January 2026. ▪ Participants requested the state ensure protocols are in place to enable the sharing of prior care plans and goals, including portal access, and conflict free case management tools. ▪ Concern was expressed regarding the contractual obligation for enrollment into the MMP to pause during the last 6 months of the demonstration, noting this would limit access to integration for members.
Special Populations	**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?** o Several participants raised concerns about preventive LTSS services and how the scope and quantity of these services currently vary between what is offered through FFS vs through the MMP. Some individuals may be getting 6 hours of preventive services in FFS but 10 hours in the MMP. o One stakeholder requested a continuity of care plan that requires the same level of preventive HCBS care upon transition. o The state was encouraged to better define a minimum set of preventive benefits in the contract and allow plans to determine what they want to offer beyond that minimum. o Concerns were raised regarding a lack of sufficient LTC beds for individuals with SPMI not in the hospital. The state was encouraged to investigate how to create an improved continuum of care for this population.
Provider Network Adequacy	**How should EOHHS monitor the number and types of LTSS HCBS providers to ensure network adequacy?**

	○ One consideration was raised regarding a past RI statutory law that required MCOs pay the FFS rate at a minimum and include any and all willing nursing home providers in their network. Participants questioned if this rule could be applied to integrated DSNPs. ○ Carriers raised that star scores will now apply, so high quality providers and member experience matter to the plan and there must be a mechanism to allow plans to drop poor performing providers. Stakeholders emphasized the need for provider assessments and rules to drop providers to be clear and consistent across carriers. ○ One participant added that a lot of home care providers want to incentivize and create differentiation based on quality.
Value-Based Payment and HCBS VBP Program	**Participants were introduced to the LTSS Alternative Payment Model being piloted through the MMP and were asked whether and how to transition this program into an integrated D-SNP/MLTSS model. What factors should be considered?** ○ Participants provided positive feedback on the current APM for home care providers - agreeing measures should be evaluated using the "whole book of business", i.e., both managed care members and FFS members. ○ Carriers highlighted that it is challenging to monitor/manage performance when measures are cross cutting across populations and questioned how plans can validate data and be held accountable for a population they aren't responsible for (aka FFS beneficiaries). ○ Participants also raised the need to increase reimbursement rates and protect the HCBS sector from negotiating with individual plans. **Are there other APMs the state should contemplate?** ○ Stakeholders raised several recommendations for how the current APM could be expanded including: ▪ Expanding to nursing facilities, as there are many established metrics in this area and there should be a standard set. ▪ Adapting to connect HCBS and primary care visits, with the caveat that the goal of the APM must be clear regarding improved quality rather than reduced cost as this could result in negative unintended consequences for dual eligible members. ▪ Expanding to institutions that provide adult day care and group homes

Session 4: Core Contract Elements

Topic	Stakeholder Feedback
Care Coordination & Care Management Delegation	**How can EOHHS promote delegation? How should requirements be tailored for specific populations? For members with complex medical and social conditions, how to delineate responsibilities?** o Some participants requested clearer contract language regarding if delegation is required and others requested flexibility for plans to decide when delegation made sense for specific populations. o Stakeholders requested the state better define care coordination requirements per population, cautioning that without clearer guidelines money will be spent on the high spenders and not on children and families or members without severe diagnoses "the giant middle", where these services can be valuable. o There was agreement among carriers they are well positioned to design programs for the populations they are serving, cautioning against the use of overly prescriptive delegation requirements for the diverse population represented in the core contract; suggesting the state provide flexibility to delegate at MCO discretion. o Additional suggestions regarding delegation for the state included: AEs should be NCQA accredited to contract for delegation; the state should define the outcomes it's looking for rather than setting targets; the state should delegate funding if it's going to allow MCOs to contract directly with providers; and the end goal should be to define one care manager for members with complex needs.
Primary Care Capitation	**What are the key risks and opportunities regarding primary care capitation? Are there other specific models the EOHHS should consider? What other value-based payment (VBP) methods should MCOs be required or strongly encouraged to adopt?** o Participants cautioned that a PCP capitation that only covers primary care visits/services may be too limiting to have the intended effect on quality of care and utilization and that a global capitation model may be a better alternative. o Concerns were raised regarding the administrative burden on PCPs that can result from the state being overly prescriptive. The Mass Health PC Capitation Model was used as an example of burdensome admin complexity. o Additional participants suggested: ▪ Including care coordination in the primary care capitation, at a minimum, sharing concern about limiting the capitation to only a small portion of the total dollars spend. One participant highlighted that for this model to be successful plans and providers need to keep quality data and aggregate it. ▪ Including CCBHCs as part of the value based arrangement with AEs ▪ A global cap model that is risk adjusted to the individual and enables flexibility to best ensure dollars are being spent well. ▪ A method that ensures money is spent on all populations, I.e. if children are 25% of an AEs population, then 25% of the funding is spent on children. There was specific concern around not enough money going to pediatricians

Health Equity & Health Related Social Needs (HRSN)	**What additional actions should the state and MCOs take to address equity and HRSNs? Are there specific needs that EOHHS should prioritize? Should EOHHS pursue in-lieu-of services (ILOS) authority in managed care programs to address HRSNs? How can EOHHS encourage supplemental benefits and value add services to address these needs?** o The state was encouraged to provide ample flexibility to plans regarding value add services because populations within the contract are so diverse. o Some participants added it could be helpful for the state to prioritize social issues and determine what services make sense for MCOs to work toward and for the state to fund. Housing security was raised as an issue that the state could take the lead on, giving an example of an "all payor housing development pool" to mitigate fragmented efforts. o One participant flagged that workforce issues are fundamental to being able to get the care to those who need it, starting with the state's short supply of primary care physicians.
Certified Community Behavioral Health Centers (CCBHCs)	**What are the opportunities and risks in the implementation of the CCBHC model? What enhancements to the model do you recommend to help the state address BH needs and disparities? As the state develops the Operations Manual, what technical specs should we consider for attribution, billing, and quality program requirements?** o Participants emphasized the importance of getting a draft of the CCBHC operations manual as soon as possible, in advance of the launch of the program, to leave time for providers to transition to the new model. New billing methods and setting up attribution were two elements flagged as anticipated challenges. o One participant representing a designated collaborating organization (DCO) expressed confusion regarding if the CCBHC program is for existing services or new services, noting there are things being done today that need to be done better and the scope should not be limited. o MCO involvement was raised as being critical to success of the program.
Behavioral Health Services	**Where are the most significant gaps in BH service capacity and access? Are there significant operational or administrative barriers impacting the member experience? Beyond CCBHCs, what payment and/or service delivery reforms might EOHHS consider?** o One concern was raised regarding the lack of coverage of DCYF-mandated services the way they're currently defined by managed care organizations. A participant flagged the need for the MCO service list to be aligned with the CCBHC service list. o Bringing court ordered BH benefits into plan was flagged as a concern, noting services may not be medically necessary and plans have limited control. o One participant questioned how DCYF and BHDDH are thinking about changes in their roles and responsibilities in this transition, highlighting that the services they manage and role they play with their providers can get between MCOs and members.
Quality	**What are the key considerations about a new quality strategy and the alignment of quality measures?**

	○ Participants applauded the states success in aligning MCO and AE quality measures but noted there are still AE measures that are not aligned; they encouraged the use of HEDIS measures as a standard practice (vs "homegrown" measures) and asked the state to consider stratifying measures for race/ethnicity. **Should member satisfaction be measured as part of a quality strategy?** ○ Stakeholders advocated for member satisfaction, potentially also provider satisfaction, to be included in quality performance plans but highlighted the challenge of getting members to fill out a 60-question survey, noting subpar response rates. ○ One participant noted they would continue to advocate to NCQA to streamline member surveys.