# RI EOHHS
# Managed Care Procurement Stakeholder Engagement Series

Integrated Dual Eligible Special Needs Plans, LTSS Services & New Core Contract Elements

RHODE ISLAND

# Public Meeting Sessions

| | | Dates & Times: |
|---|---|---|
| **Background** | • EOHHS Vision & Mission<br>• Upcoming Procurement for Medicaid Managed Care | |
| **Session 1: Member Choice & Plan Options** | • MMP Transition Plan<br>• Member Choice & Enrollment<br>• Procurement Timeline | Mon, April 24<br>4:00 PM |
| **Session 2: Contract Structure & Benefits** | • D-SNP Contract Requirements<br>• Covered Services<br>• Fiscal Considerations | Thu, April 27<br>4:00 PM |
| **Session 3: Service Delivery Models** | • Seamless Transitions<br>• Care Coordination<br>• Special Populations<br>• Quality & Value Based Payment<br>• Provider Network Capacity | Mon, May 1<br>4:00 PM |
| **Session 4: Core Contract** | • Delegation<br>• Primary Care Capitation<br>• Health Related Social Needs<br>• Certified Community Behavioral Health Centers<br>• Quality | Wed, May 3<br>8:30 AM |

# EOHHS Vision and Mission

**OUR VISION**

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

**OUR MISSION**

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

# Starting Point: Medicaid Managed Care in RI

**The Executive Office of Health and Human Services (EOHHS) administers Rhode Island's Medicaid program, which provides health care coverage for one-third of all Rhode Islanders**

- EOHHS is issuing a Request for Qualifications (RFQ) for a new Medicaid Managed Care Contract beginning July 2025
- **This process begins with a Request for Information (RFI) to hear feedback from Rhode Islanders regarding their needs and aims for the program**
- This work is building off the previous managed care contract RFI and RFQ released in March and November of 2021

### Who does the program currently serve?

- Rite Care: Children & Families
- Rhody Health Partners: Aged, blind, & disabled adults
- Medicaid Expansion: Expansion adults 19-64 years

### What services are currently provided?

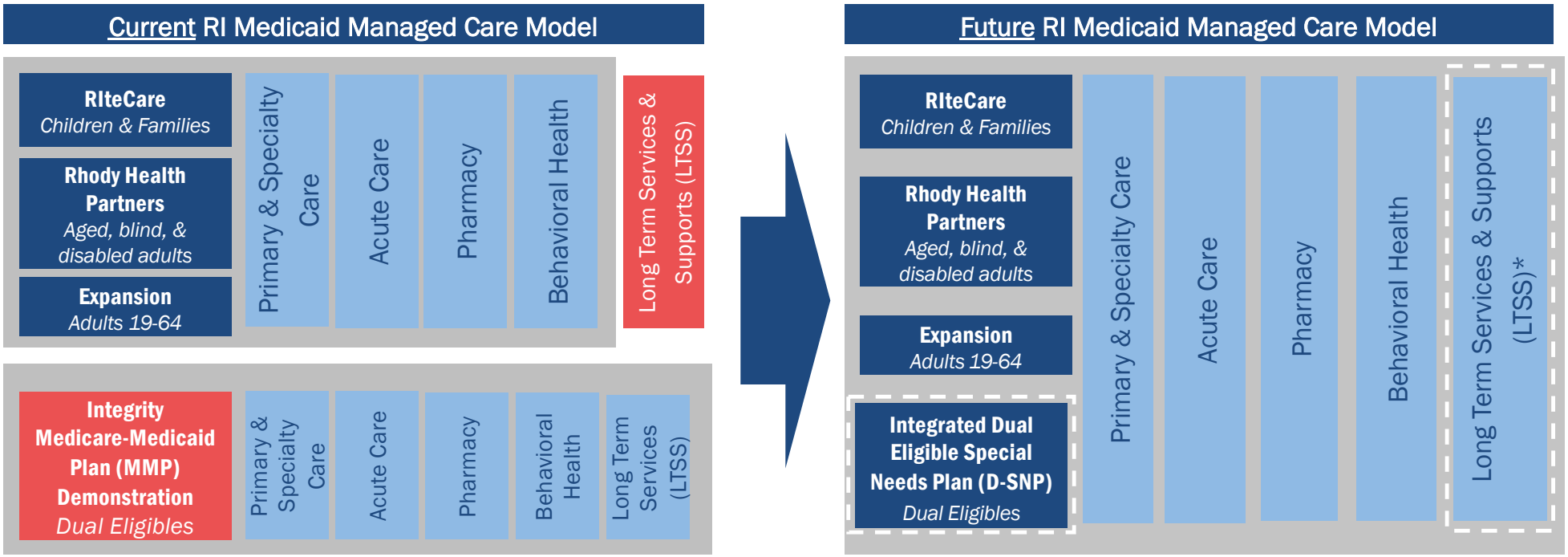
- Acute care
- Primary & specialty care
- Pharmacy
- Behavioral health services

### Which Managed Care Organizations (MCOs) does EOHHS currently contract with?

- Neighborhood Health Plan of RI
- Tufts Health Public Plan
- United Health Care Community Plan

# Where We Are Headed

**Single Procurement (including dual eligible populations) to align delivery systems; Bringing long term services and supports (LTSS) in plan**



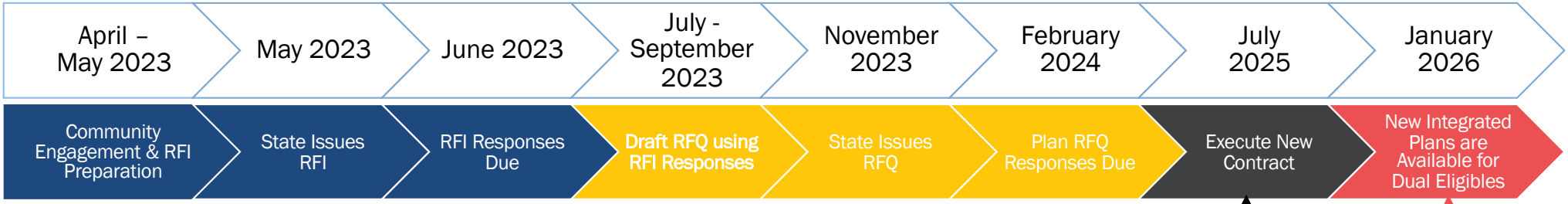

**Other Delivery Systems & Programming Outside of Integrated Model:** **FFS, PACE, Katie Beckett, Rite Share, Third Party Liability (TPL), DD Waiver Services**

**Note: HCBS/LTSS and nursing facility stays will be included in-plan and the state is seeking input on the nursing facility benefit length for Medicaid Only beneficiaries. Additionally, Intellectual and Developmental Disabilities (I/DD) waiver services will be carved out and provided FFS, as they are today.*

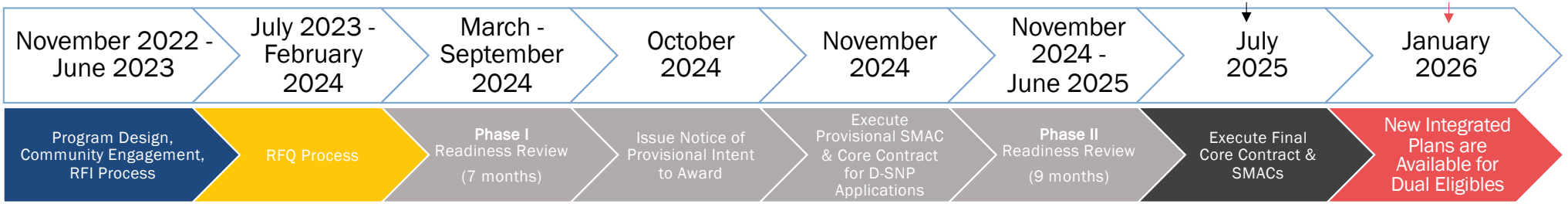
# Our Timeline

**This procurement will be based on extensive and ongoing stakeholder engagement, experience in Medicaid Managed Care, and experience with the MMP program.**

*Tentative RFI & RFQ Timeline*




*Tentative MCO Readiness Review & Contracting Timeline*



# MMP Transition - Learnings to Date

**In advance of submitting the MMP Transition Plan to CMS, EOHHS held community group sessions and one on one meetings to inform key considerations of the plan. August – September 2022 learnings included:**

- Stakeholders expressed general support for integrated care, a broad acknowledgment of the positive experience that MMP members have had, and a strong desire to see the benefits of the MMP continued in any future program.
- Specific benefits of the MMP that were emphasized by stakeholders included:
  - Integrated member materials and services
  - Integrated Care Coordination
  - The Integrated Care Initiative (ICI) Implementation Council
  - The Medicare-Medicaid Enrollment (MME) Counseling program
  - A Medicaid Fee for Service (FFS) option – outside of managed care

These are all elements that the State intends to keep after the MMP ends

- Stakeholders also expressed program design-related considerations including:
  - How to mitigate workforce challenges
  - Maintaining member choice
  - The importance of helping members understand the difference between Medicare choice and Medicaid choice
  - Mitigating member confusion that can come from having new plan options through education and unbiased enrollment counseling
  - Ensuring continuity of care and coordination of LTSS case management services for members with complex needs

# Session 1
# Member Choice & Plan Options

- MMP Transition Plan
- Member Choice & Enrollment
- Procurement Timeline

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# Starting Point and Goals

**In May 2022, the Centers for Medicare and Medicaid Services (CMS) announced that it would be sunsetting the MMP. Rhode Island is in the process of developing a replacement.**

## Starting Point: The MMP Demonstration

You may know the MMP as **Neighborhood INTEGRITY** or the Integrated Care Initiative **(ICI)** in RI. INTEGRITY

The MMP coordinates both Medicare and Medicaid benefits into **one, integrated delivery system** for eligible members.

The MMP began in July 2016 as **a demonstration program** in partnership with CMS, the state of Rhode Island and Neighborhood Health Plan of RI

MMPs promote **streamlined care for dual eligible members with one insurance ID card and better care coordination**. Providers only bill one insurance company for these members.

## Goal: To Carry Forward the Success

- On a scale of 1 to 5, **95%** of focus group participants rated their experience in the MMP as a **4 or 5**
- Participants were generally satisfied with access to patient-centered care and patient engagement.
- Members mentioned a single member ID card, care coordination, quality, and array of services as specific benefits of the MMP.

*"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)*

**Discussion Questions:**

1) What elements of the MMP are most important to maintain from a member perspective?
2) What elements of the demonstration should be modified to improve the member experience?

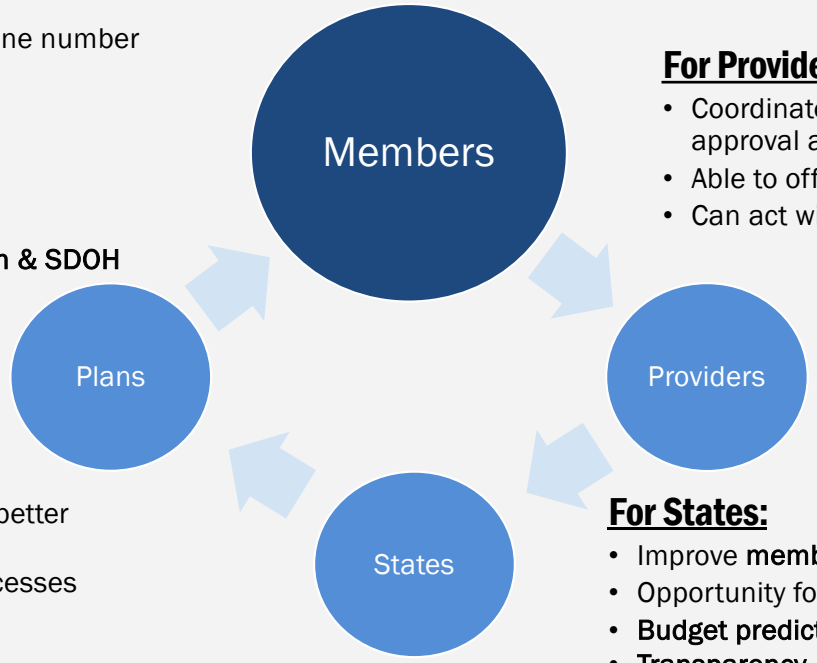
# Why Integrated Managed Care for Dual Eligible Members?

## For Members:

- **One communication**, one message, one phone number
- **Care coordination** with single case manager
- **Uniform** grievance and appeals
- **Integrated member materials**
- **Extended Provider Networks**
- **Extended Services**
- **Integrated Primary Health, Behavioral Health & SDOH** under one umbrella

## For Plans:

- Fully **integrated benefit structure**
- **Value based payment models** that promote better care
- Easier to **deliver member materials** and processes
- All **data is aggregated** under one plan
- **Fewer intermediaries**
- More opportunity for **financial incentive** from Medicare via frailty adjustments




## For Providers:

- Coordinate with **one administrative entity/** approval authority
- Able to offer a **more wholistic care plan**
- Can act with **fewer intermediaries**

## For States:

- Improve **member quality**/enable vision
- Opportunity for **administrative simplification**
- **Budget predictability**
- **Transparency**
- Opportunity to implement **contractual financial incentives** to **achieve State goals**

**Discussion Question:**

What are the potential risks and opportunities for an integrated Medicare/Medicaid model?

# Rhode Island's MMP Transition Plan

**In Rhode Islands upcoming RFQ the state intends to require all MCOs to offer an Integrated D-SNP and include LTSS as an in-plan benefit for all populations**

- In May 2022, the Centers for Medicare and Medicaid Services (CMS) announced that it would be sunsetting the MMP.
- CMS gave states the option to apply to extend their MMP programs for two additional years to develop replacement programs that incorporate the benefits of the MMP by submitting a transition plan by October 1, 2022.

- RI submitted a transition plan to CMS outlining its intent to:
  - Expand its Medicaid Managed Care program to include a new integrated program for dually eligible beneficiaries called an **Integrated Dual Eligible Special Needs Plan (D-SNP)** to replace the MMP, and
  - Include **managed long term services and supports (MLTSS)** as an in-plan benefit for all populations
- A copy of the Transition Plan can be found at [MMP Transition Plan | Executive Office of Health and Human Services (ri.gov)]

# MMP Transition: Vision, Goals, and Strategies

**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 & services with ease.**

## Goals

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

## Preliminary Strategies

- **Include LTSS as in-plan benefit** for all populations, including full benefit dually eligible beneficiaries (FBDEs)
- **Require all Medicaid contracted health plans** to offer an Integrated dual eligible special needs plan (D-SNP) for FBDEs
- **Implement a member choice and enrollment model** for FBDEs that leverages unbiased enrollment counseling to promote member choice of all options (Integrated D-SNP, Medicaid fee for service, or PACE)

*The most critical consideration is that members continue to receive benefits realized in the MMP, with as seamless a transition as possible.*

**Discussion Question:**

Do you have any feedback, questions, or consideration for the state regarding the vision, goals, and strategies?



*Note: Feedback collected during initial rounds of stakeholder engagement in the Fall of 2022 has been incorporated.*

Member Choice

# Medicare/Medicaid Options for Dual Eligible Individuals

## EOHHS anticipates four possible Medicare/Medicaid coverage options for dual eligible Rhode Islanders

| | | Medicare Options | | | |
|---|---|---|---|---|---|
| | | PACE | Medicare Advantage Integrated D-SNP | Medicare Advantage Non-Integrated Plan* | Medicare FFS/Other |
| Medicaid Options | PACE | Option 1 | | | |
| | Integrated D-SNP/ Aligned MLTSS | | Option 2 *(with choice of plans A, B, C)* | | |
| | Medicaid FFS | | | Option 3 | Option 4 |
| | | **Integrated Options** *strongly encouraged* | | **Non-Integrated Options** | |

**Note: Coordination-only D-SNPs will continue to be available for partial duals, but no longer an option for FBDEs.*

**Discussion Questions:**

- Are these the right options? Are there others you would anticipate?
- Should there be fewer or more?

Member Choice

# Promoting Active Member Choice

**RI intends to promote active member choice supported by default enrollment for new dually eligible members to ensure continuity of care**

| | | |
|---|---|---|
| Member makes active choice | All Duals | • State promotes active member choice through unbiased enrollment counseling<br>• Choice of Model: Integrated D-SNP, alternate Medicare Plan/Medicaid FFS or PACE |

If Member **DOES NOT** make an Active Choice:

| | | |
|---|---|---|
| Current Dual Eligible Members | **Group 1:** NHPRI MMP Duals | • Enrollment into NHPRI Integrated D-SNP (least disruptive) or a comparable Integrated D-SNP, should NHPRI not offer one<br>• Option to opt-out to an alternate Integrated D-SNP, Medicaid FFS or PACE |
| | **Group 2:** Medicaid FFS Duals | • Remain in Medicaid FFS<br>• Option to opt-in to an Integrated D-SNP or PACE |
| New Dual Eligible Members | **Group 3:** Prior Medicaid Eligible, Newly Medicare Eligible | • RI intends to pursue a default enrollment mechanism* through which eligible Medicaid beneficiaries who become newly eligible for Medicare (new FBDEs) are enrolled into the Integrated D-SNP that aligns with their existing Medicaid managed care plan<br>• Option to opt-out to an alternate Integrated D-SNP, Medicaid FFS or PACE |
| | **Group 4:** Prior Medicare Eligible, Newly Medicaid Eligible | • Enrollment into Medicaid FFS<br>• Option to opt-in to an Integrated D-SNP or PACE |

**With CMS Approval*

## Discussion Questions:

1) What factors should EOHHS consider in designing and implementing a member education and outreach process to facilitate and encourage members to make an informed and active model selection?
2) What are the concerns, potential risks, and opportunities with this approach to enrollment?

Member Choice

# Phased Transition

**To ensure a smooth transition for all beneficiaries, Rhode Island is proposing a multi-year, phased approach. Timing is in development and will be a key topic for RFI input.**

| July 2025 | January 2026 | TBD |
|---|---|---|
| **Phase 1** | **Phase 2** | **Phase 3** |
| Bringing LTSS services* in plan for the **Medicaid Only population, eligible for LTSS** | Launch of integrated D-SNPs for the **MMP population & other Dual Eligible Members who choose to opt-in** | Implementation of Default Enrollment into integrated D-SNPs for **Medicaid Managed Care members who become newly Medicare eligible** |

**Discussion Questions:**

Is the proposed phased transition approach appropriate to manage enrollment and plan selection?
What factors should be considered?

**Note: Intellectual and Developmental Disabilities (I/DD) waiver services will be carved out and provided FFS, as they are today.*

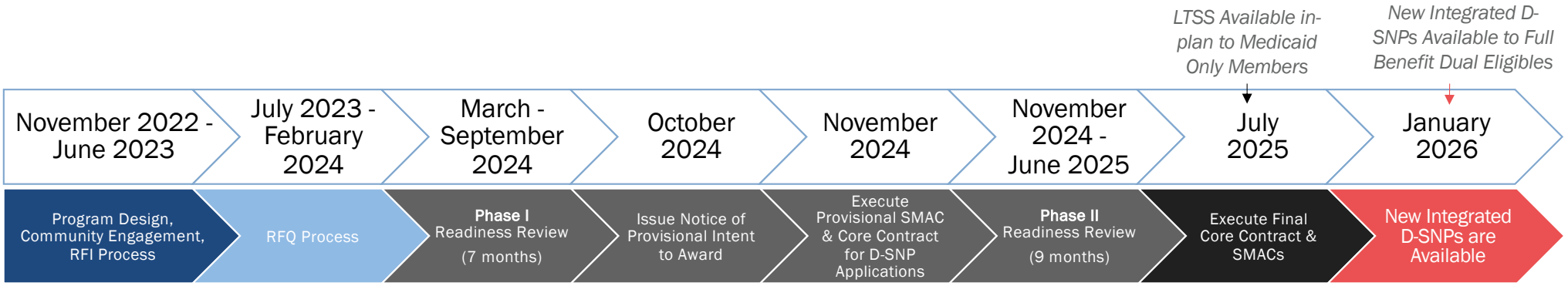
# Medicaid Procurement Timeline and Transition

**For a successful transition from the MMP to integrated D-SNPs, the Medicaid and Medicare procurement and authorization timelines must be in step with one another.**

- For an initiative of this importance, at least 12 months are required for a detailed readiness review of health plan carriers.
- Rhode Island has defined two distinct phases of Readiness Review to enable both contracts (SMAC & Core) to be finalized with CMS and EOHHS by their respective deadlines.
  - **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.

**Discussion Questions:**

1) Are there any concerns with following this timeline and meeting critical deadlines?
2) Any suggestions for how EOHHS can support this process?



# Session 1 Appendix

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Session 1 Appendix

# Impacted Population: Rhode Island Duals

**Currently about 42,000 Rhode Islanders are full duals, and only 30% of Rhode Islands duals are experiencing the advantages of an integrated Medicare-Medicaid model of care.**

Full Dual Eligible Members (42,454)

*By Medicaid Delivery System:*

| FFS* | MMP | Other |
|---|---|---|
| 24,885 (59%) | 12,915 (30%) | 4,310 (10%) |

PACE, 344 (1%)

*Includes members with FFS Medicare, Medicare Advantage, ACO, etc.

**Partial Duals**
**8,198**

This strategy is focused on the 42,454 full duals in Rhode Island and will not impact Rhode Islanders with partial dual coverage

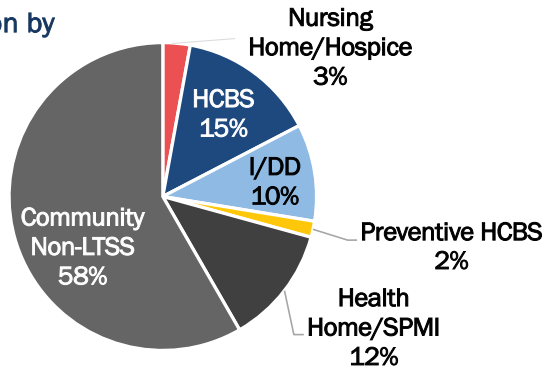
## Who does the MMP serve?

- A dually eligible individual is someone who is jointly eligible for both Medicare and Medicaid
- Dually eligible individuals are a high, complex need group
- 18% of MMP population are eligible for LTSS NH/HCBS – the MMP is the only managed care plan in RI with LTSS in-plan

**Glossary**

**LTSS** – Long Term Services and Supports
**NH** – Nursing Home
**FFS** – Fee for Service
**HCBS** – Home and Community Based Services
**I/DD** – Intellectually and Developmentally Delayed
**SPMI** – Severe and Persistent Mental Illness

MMP Composition by Sub-population (2022)




**Population Data Source:** June 30, 2022 Snapshot

# Session 2
# Contract Structure & Benefits

- D-SNP Contract Requirements
- Covered Services
- Fiscal Considerations

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# Intro to State Medicaid Agency Contracts (SMACs)

**States have D-SNP specific contracts that can include additional requirements to improve administrative, clinical, and financial integration for enrollees.**

- **SMAC Defined:** A contract between D-SNPs and state Medicaid agencies that lists all requirements imposed on the D-SNPs by the state, including federal minimum and additional state requirements to improve administrative, clinical, and financial coordination.
- **Examples of Medicaid specific SMAC requirements:**
  - D-SNPs 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, etc.)
  - D-SNPs 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.

**Discussion Question:**

- What Rhode Island specific SMAC requirements might the state consider to improve administrative, clinical and financial integration?
- Which should the state avoid/exclude?

# Additional SMAC Requirement Considerations

**In the May 9th, 2022 final rule, CMS set forth changes to D-SNP requirements – several of which provide opportunities to increase Medicare-Medicaid integration**

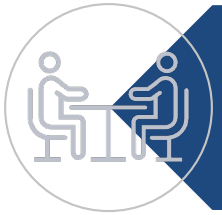
***New Federal Minimum Requirements:***

1) Requirement that D-SNPs include social determinants of health (SDOH) questions in their Health Risk Assessment (HRA), incorporate HRA results into individualized care plans, and consult with enrollees about unmet care needs
2) 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.*

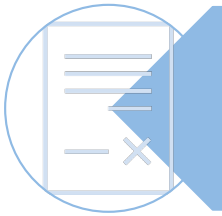
***Optional Requirements:***

3) EOHHS has the option to require plans to 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
   - *This would enable the State to leverage Medicare star ratings for D-SNP performance oversight, establish collaborative state CMS coordination of program audits, and would grant access to the CMS Health Plan Management System for oversight purposes.*

**Discussion Questions:**



1.) How can Medicaid HRA & D-SNP HRA questions and processes be aligned to minimize beneficiary and plan burden? To promote improved care coordination?



2. ) What contractual integration requirements should EOHHS consider regarding the coordination of D-SNP Enrollee Advisory Committees and Medicaid Enrollee Advisory Committees?

3.) What do you see as the benefits, key risks, and considerations of state-specific D-SNP only contracts?

# Covered Services

**Rhode Island intends for the future Integrated D-SNP contracts to mirror the MMP managed care contract covered benefits, exclusions, and non-covered benefits**

## Enrollment of Populations with an Extended Nursing Facility Stay

*FBDEs:*

- Coverage of 365 days of stay in a skilled nursing facility
- Plans will receive a reduced rate after 180 days*

*Medicaid Only:*

- Currently members enrolled in RHP or Expansion are disenrolled from their MCO after 30 days in a skilled nursing facility because LTSS is carved out and paid FFS.

## Limited Services Covered for Medicaid only but carved out of the MMP Contract

*Services Carved Out/ Provided FFS for FBDEs:*

- Residential services for I/DD enrollees
- Non-emergency transportation services
- Dental services
- Home stabilization services

## Behavioral Health Services

*For FBDEs & Medicaid Only Beneficiaries:*

- Behavioral Health Services are a covered benefit that can be provided by the MCO or subcontracted.

**Discussion Questions:**

1) What are your concerns regarding the coverage of extended nursing facility stays for dual eligible members?
2) Should there be one aligned policy for nursing facility stays for both Medicaid Only and FBDE populations?
3) What refinements to the MMP covered benefits would you recommend for the new integrated D-SNP model?



*In a change from the Transition Plan, Rhode Island is no longer planning to disenroll dual-eligible individuals with nursing home stays over 180 days from D-SNPs

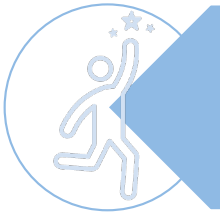
# Fiscal Considerations of Integration

**Value Add of Integration For Plans:**

- Fully **integrated benefit structure**
- Value based payment models that **promote better care**
- **Easier to deliver member materials** and processes
- All **data is aggregated** under one plan
- **Fewer intermediaries**
- More opportunity for **financial incentive** from Medicare via frailty adjustments

**Discussion Questions:**

1.) What contractual elements should Rhode Island consider to promote successful financial arrangements between the plan and the state?



2. ) What are the key success factors for plans seeking to participate in the Medicaid program and effectively serve dual eligible and Medicaid only populations?

3.) What specific concerns do you have regarding the profitability and sustainability of an integrated model and how might those concerns be mitigated?

# Session 2 Appendix

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Session 2 Appendix

# Excerpt of Draft SMAC Terms & Requirements

**SMAC Defined: Contract between D-SNPs and state Medicaid agencies that lists all requirements imposed on D-SNPs by the state, including federal minimum and additional state requirements to improve administrative, clinical, and financial coordination.**

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

1. Requirements for ensuring **exclusively aligned enrollment***
   - Integrated D-SNP enrollment limited to full-benefit dual eligible individuals (FBDEs),
   - who received their Medicaid benefits from the affiliated Medicaid Managed Care plan offered by the same parent company
2. Contractor responsibility to **authorize, arrange, integrate, and coordinate the provision of all covered services** for its enrollees.
3. Administrative simplification for providers - a **single payor coordinating Medicare and Medicaid claim submissions** for payment.
4. Requirement to establish **unified processes for plan resolution of appeals and grievances.**
5. Requirement for **integrated member materials.**
6. Required **coordination with CMS and RI EOHHS** to promote joint CMS/State oversight

# Session 3

## Service Delivery Models

- Seamless Transitions
- Special Populations
- Provider Network Adequacy
- Care Coordination
- Quality and Value Based Payment

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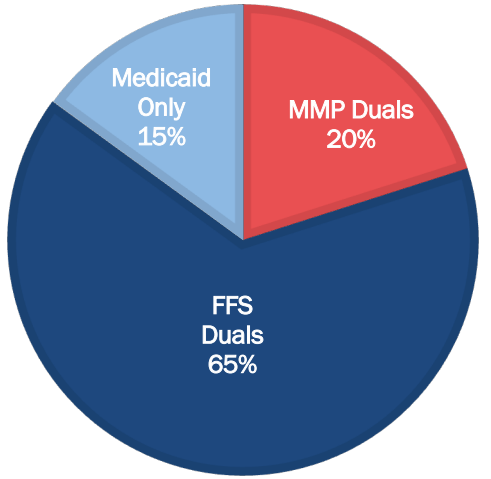
# Recap: Phased Transition

**To ensure a smooth transition for all beneficiaries, Rhode Island is proposing a multi-year, phased approach**

| July 2025 | January 2026 | TBD |
|---|---|---|
| **Phase 1** | **Phase 2** | **Phase 3** |
| Bringing LTSS services* in plan for the **Medicaid Only population, eligible for LTSS** | Launch of integrated D-SNPs for the **MMP population & other Dual Eligible Members who choose to opt-in** | Implementation of Default Enrollment into integrated D-SNPs for **Medicaid Managed Care members who become newly Medicare eligible** |

**Note: Intellectual and Developmental Disabilities (I/DD) waiver services will be carved out and provided FFS, as they are today.*

**RI Residents Receiving LTSS by Eligibility & Service Delivery Model**




Data: 2022 Avg Member Months

**On average across populations approx. 60% of individuals are receiving HCBS and 40% are receiving Nursing Facility/Hospice services**

# Seamless Transitions: Medicaid Only Population

- **Rhode Island is proposing a multi-year, phased approach, beginning with bringing LTSS services in-plan for Medicaid only individuals (non-duals)**

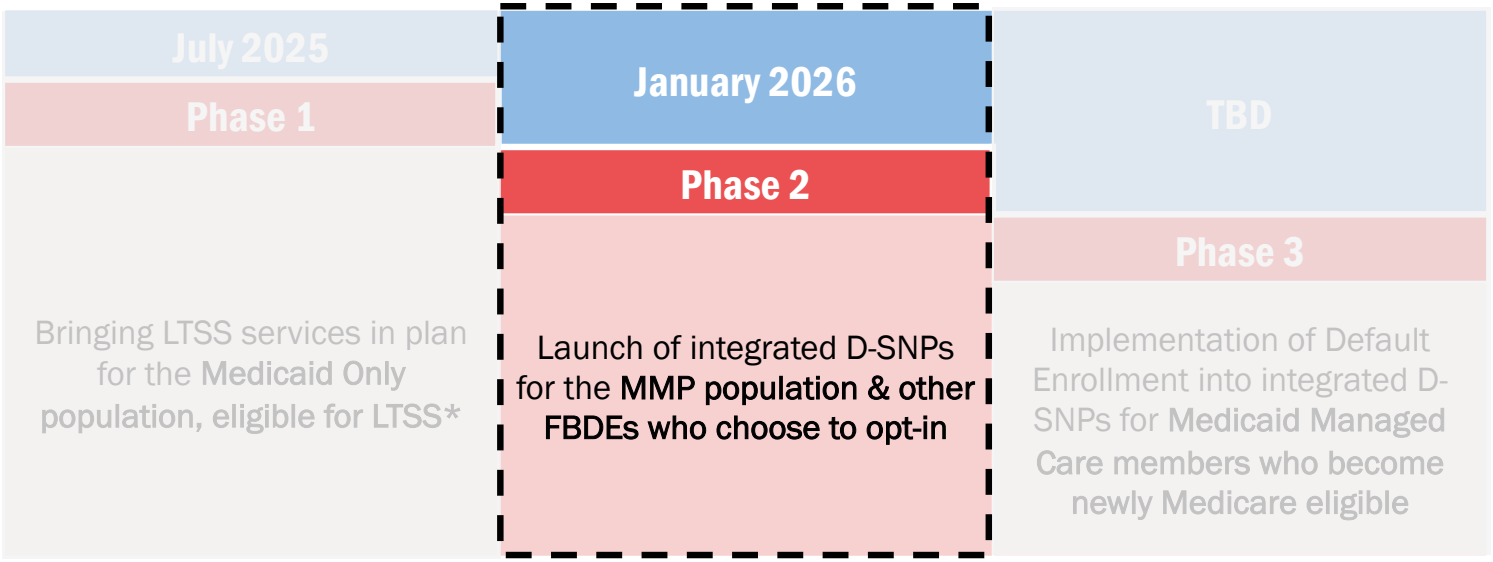
| July 2025 | January 2026 | TBD |
|---|---|---|
| **Phase 1** | **Phase 2** | **Phase 3** |
| Bringing LTSS services in plan for the **Medicaid Only population, eligible for LTSS** | Launch of integrated D-SNPs for the **MMP population & other FBDEs who choose to opt-in** | Implementation of Default Enrollment into integrated D-SNPs for **Medicaid Managed Care members who become newly Medicare eligible** |

**Discussion Question:**

How can EOHHS best manage the transition from fee-for-service to managed care LTSS services for the Medicaid Only population, to avoid gaps in services and disruption of existing provider/care manager relationships?

# Seamless Transitions: Dual Eligible Population

- **Phase 2 will launch integrated D-SNPs with aligned MLTSS for the MMP population and other dual eligible members**

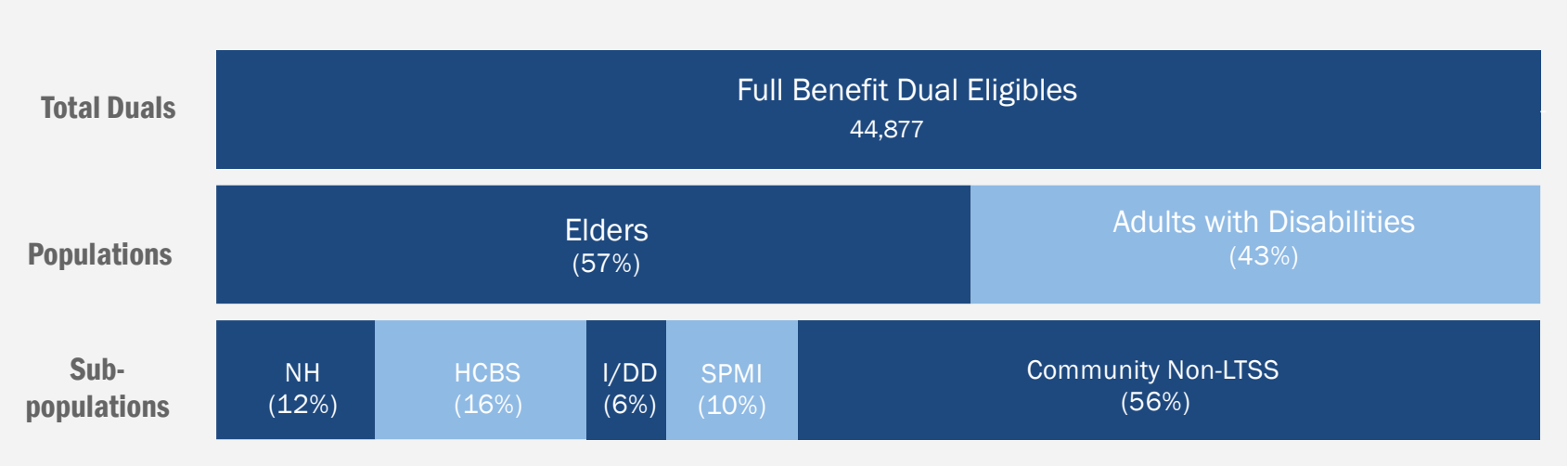



**Discussion Question:**

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?

# Special Populations

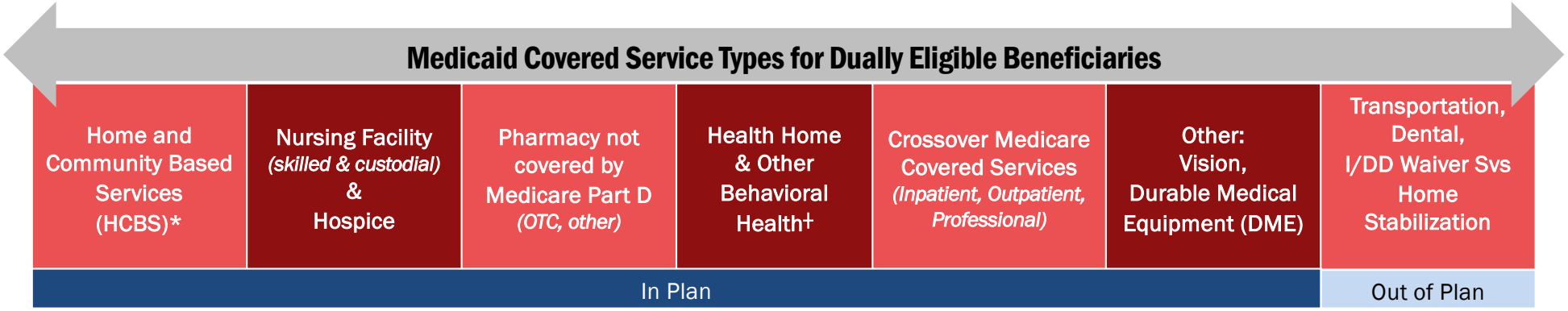
## RI's dual-eligible population includes multiple sub-populations of members with complex care needs




*Note, percentage of populations/sub-populations are based on 2022 enrollment data excluding dual eligible enrollees in managed care due to the PHE*

**Discussion Question:** What are the challenges specific to these populations that need to be addressed to ensure the population is well served in an integrated D-SNP model?

# Provider Network Adequacy




* *HCBS includes preventive services, home care, assisted living, group homes, adult day services, self directed care*

† *Other Behavioral Health includes mental health psychiatric rehabilitative residence, MH targeted case management, are other services not covered by Medicare Part B*

**Discussion Question:**

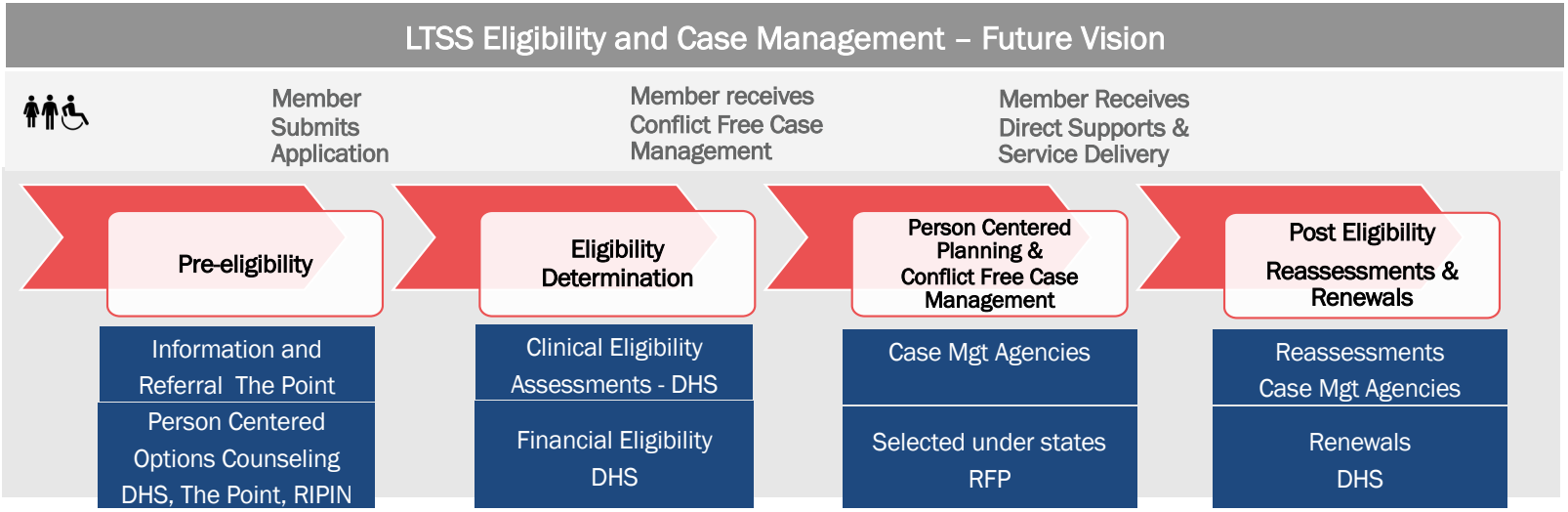
1) Where are the network gaps that you worry about for these services?
   - What provider network requirements would you want to be put in place to be sure members have access to these services?

2) How should EOHHS monitor the number and types of LTSS HCBS providers in MCO Networks to ensure network adequacy?

3) How can EOHHS encourage all stakeholders to better utilize telehealth and other technologies such as remote monitoring and e-consultation for assessments and delivery of services?
   - How can these new technologies and delivery mechanisms be used to provide the most appropriate care for people in the most appropriate setting?

# Care Coordination: Alignment with LTSS Re-design

- Rhode Island is currently engaged in an LTSS Modernization Project that incorporates the person-centered principles of the U.S. Administration of Community Living's No Wrong Door.
- The State is also working closely with federal partners to ensure all LTSS programs are fully compliant with federal requirements related to quality monitoring, person-centered planning, and conflict free case management




**Discussion Questions:**

What care coordination requirements should be specified by the state, and what elements of the care coordination approach should be left to individual MCOs?

- For example, should there be a consistent assessment tool used across all entities, and the same criteria for determining how many and what type of services to authorize in an individual's service plan?
- Should MCOs be required to contract with the same case management agencies participating in the state's CFCM network?
- What are the pros and cons of more or less state direction?

Quality & VBP

# LTSS Alternative Payment Model Pilot Program

**Rhode Island is currently piloting an optional payment incentive program for home and community-based service providers through the MMP.**

| | | | | |
|---|---|---|---|---|
| Program Goals | • Encourage and enable LTSS eligible and aging populations to live successfully in their communities<br>• Improve & ensure equitable access to home and community-based services (HCBS) that prevent LTSS eligible populations from needing institutional LTSS<br>• Foster a sustainable network of high quality HCBS providers that are equipped to meet the diverse needs of LTSS members | | | |
| Timeline and Structure | Pilot Program | **Phase 1:** Readiness | Jul – Dec 2022 | • Start-up funding for achieving program readiness milestones |
| | | **Phase 2:** Pay for Reporting | PY 1<br>CY 2023 | • Collecting & reporting data on a wide range of measures (e.g. employee retention, home care wait time, LTSS rebalancing ratio, etc.) that can inform program improvements, investments |
| | Full Program | **Phase 3:** Pay for Performance | PY 2 - 5<br>CY 2024 - 2027 | • Eligible to earn incentives based on attainment & improvement on measures |

**Discussion Questions:**

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

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?

# Session 4

New Elements of the Core Contract

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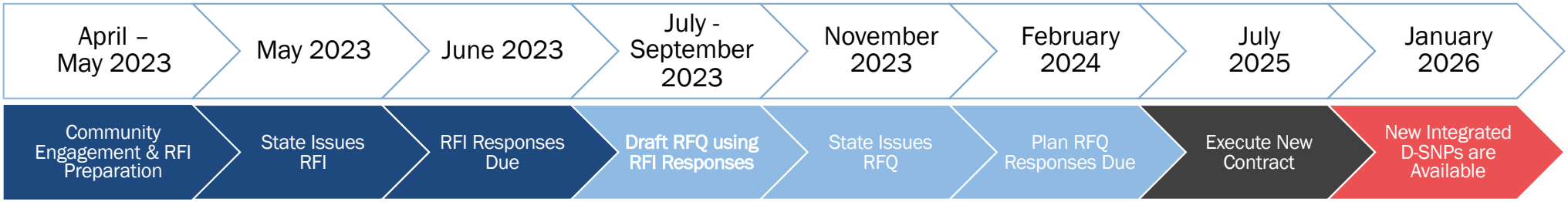
# Public Meeting Sessions

| | | Dates |
|---|---|---|
| **Background** | • EOHHS Vision & Mission<br>• Upcoming Procurement for Medicaid Managed Care | |
| **Session 1: Member Choice & Plan Options** | • MMP Transition Plan<br>• Member Choice & Enrollment<br>• Procurement Timeline | Mon, April 24<br>4:00 PM |
| **Session 2: Contract Structure & Benefits** | • D-SNP Contract Requirements<br>• Covered Services<br>• Fiscal Considerations | Thu, April 27<br>4:00 PM |
| **Session 3: Service Delivery Models** | • Seamless Transitions<br>• Care Coordination<br>• Special Populations<br>• Quality & Value Based Payment<br>• Provider Network Capacity | Mon, May 1<br>4:00 PM |
| **Session 4: Core Contract** | • Delegation<br>• Primary Care Capitation<br>• Health Related Social Needs<br>• Certified Community Behavioral Health Centers<br>• Quality | *Today's Session*<br>Wed, May 3<br>8:30 AM |

# Core Contract Elements Overview




- The Core Contract will be based on the model contract in the canceled 2021 MCO solicitation.
  - EOHHS appreciates the community feedback on those contract elements in the 2021 RFI.
- EOHHS is considering some new elements and refinements to the Core Contract.
  - There will be an opportunity for the community to provide feedback on all new elements and refinements in the May 2023 RFI.
- Today's session will focus on a few of these new elements and refinements to the Core Contract that particularly benefit from community dialogue and discussion.

# Core Contract New Elements

| Included in the Upcoming RFI | |
|---|---|
| **General** | • Program Brand<br>• Plan Assignment Rules |
| **Primary Care and Accountable Entities** | • Delegation of care management and care coordination<br>• Primary care capitation & Other Value Based Payment (VBP) Methodologies<br>• PCP Assignment<br>• Expanding comprehensive AE program to include dual eligible population |
| **SDoH, Population Health, and Health Equity** | • How to identify and meet unmet medical, BH needs for communities of color<br>• How to identify and address SDoH<br>• How MCOs can play a role in housing for individuals with serious illnesses<br>• How to increase sustainability of HEZs |
| **Quality Measurement, Data Sharing & Reporting** | • New quality measures/alignment of quality measures<br>• Electronic clinical data for quality measures<br>• Data acceptance threshold<br>• Data sharing/integration with out of plan benefits<br>• HRA data sharing between MCOs and SDoH providers |
| **New Benefits & Covered Services** | • HCBS<br>• Preferred Drug List approach and 340B claiming<br>• In Lieu of Services authority to address HRSNs<br>• CCBHC implementation<br>• Flexible mechanism for MLR |
| **Other Administrative Requirements** | • Refinements to Liquidated Damages for nonperformance<br>• Transparency and oversight of administrative expenditures |

## Today's Discussion

**Topic #1: Delegation**
of care management and care coordination

**Topic #2: Primary Care Capitation**
& Other Value Based Payment Methodologies

**Topic #3: HRSN**
Addressing Health Equity and Health Related Social Needs (HRSNs)

**Topic #4: Behavioral Health and CCBHC Implementation**

**Topic #5: Quality**
Quality Measures

# Accountable Entities and Primary Care

**The first two discussion topics will focus on planned refinements and potential future enhancements to support the AE program and primary care**

## Current AE Program

- Starting Year 6 of Accountable Entities (AE) program
- Certified Medicaid AEs and MCOs establish contracts to collaborate in managing **total cost of care** and **quality outcomes** for an attributed population
- AEs are an alternative payment model (APM). Part of RI's Health System Transformation Project approved in the 1115 waiver
- EOHHS has established certification standards and prospective AEs can apply for certification

## Planned Refinement: Delegation

- Contract requirement for care management and care coordination functions to be delegated to AEs or primary care providers.
  - To reduce duplication, unnecessary administrative expenses, and confusion among beneficiaries.

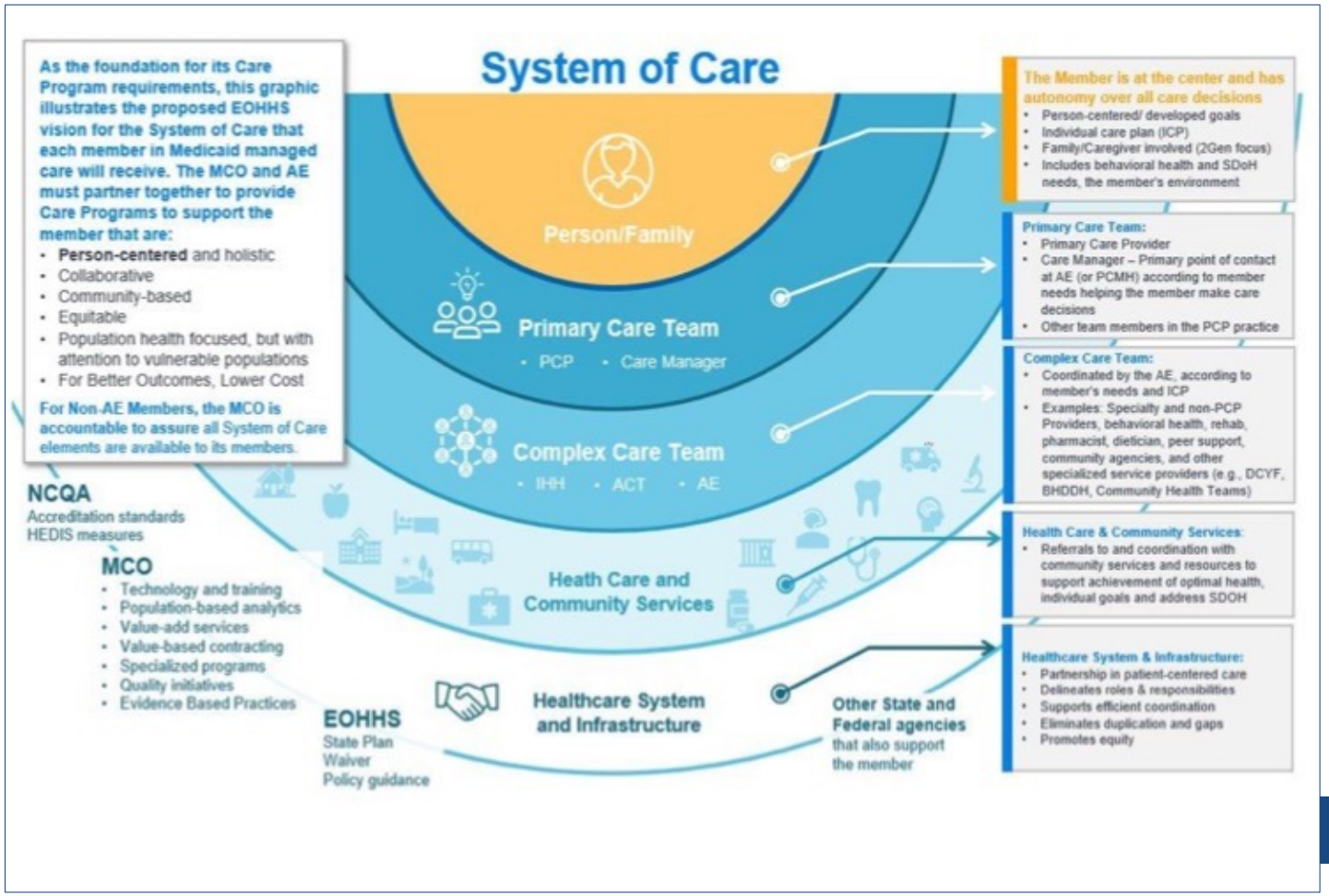
Discussion Topic 1

## Potential Future Enhancement: Primary Care Capitation

- Development of a Primary Care Capitation program
  - To give providers flexibility and financial incentives to support whole-person care and tailor delivery to individual member needs.

Discussion Topic 2

# Care Coordination & Care Management Delegation




## Discussion Questions

EOHHS plans to require care management & care coordination functions be delegated to AEs or primary care providers. See model contract language in canceled RFQ.

1) How can EOHHS promote delegation?
2) How should requirements be tailored for specific populations?
3) For members with complex medical and social conditions, how to delineate responsibilities?

# Primary Care Capitation

## Rhode Island is considering a Primary Care Capitation (PCP) Program

### Why Primary Care Capitation?

- Support a whole-person care approach. **Expanded care team to coordinate care** for medical, BH & social needs
- Providers can **tailor care delivery** to meet member needs,*(e.g., phone, email, patient portal, remote monitoring).*
- Partner with providers to more **effectively identify and address HRSN & BH**
- **Measure and address disparities in care** to promote health equity
- **Provide Budget predictability & support delegation** - EOHHS anticipates that in a PCP program, care coordination & care management funding in the MCO capitation would be appropriately shared with AEs and providers

### State Examples:

- **Medicaid Models: Colorado** (practice selected hybrid PBP model) & **MassHealth** (below)
- **CMMI models:** CPC+, Primary Care First and ACO Reach Programs
- **Multi-payor initiatives** in WA and CT also offer valuable examples

### Case Study: MassHealth

| | |
|---|---|
| **Base Payment** | **Primary care population-based payment (PBP)**<br>• Capitated payments for defined services<br>• Tied to a 3-tiered practice classification<br>• Includes care management funding |
| **Additional Payment Components** | *At the ACO level:*<br>• Health Equity P4R/P4P<br>• Quality P4P<br>• TCOC Shared Savings/Risk Model |
| **Other Notable Program Features** | • Primary care PBP **embedded in ACO model**<br>• Tied to **tiered practice capabilities;**<br>• **+ funding** to support enhanced care delivery |

### Discussion Questions

- Are there specific models that EOHHS should consider?
- Any key risks and opportunities?
- What other VBP methods should MCOs be required or strongly encouraged to adopt?

# Key Definitions

**Health Related Social Needs (HRSN)**

- Includes factors like housing instability, food insecurity, and exposure to intrapersonal violence that drive health care utilization and health outcomes

*Source: Center for Medicare and Medicaid Services*

**Social Determinants of Health**

- The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.

*Source: World Health Organization; Centers for Disease Control and Prevention*

**Health Equity**

- The absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation)

*Source: World Health Organization*

# CMS Health Equity and HRSN

**CMS has prioritized advancing health equity and released a Framework for Health Equity with 5 priority areas**


To address health disparities, CMS has encouraged states to leverage 1115 waivers to promote whole person care and address unmet health related social needs. 19 states have approved 1115 waivers with HRSN provisions.

- **California:** Under *CalAIM*, managed care plans will provide Enhanced Care Management and Community Supports, also referred to as "in-lieu of services" (ILOS), to high-need beneficiaries, including recuperative care and short-term post-hospitalization housing services.
- **North Carolina:** *Healthy Opportunities Pilots* address housing instability, transportation insecurity, interpersonal violence, and toxic stress for a limited number of high-need managed care enrollees who meet health and social risk factors.
- **Arizona:** Through *H2O Program*, enrollees who are homeless or at risk of being homeless and meet clinical and social risk criteria are eligible for temporary housing for up to 6 months, utility costs, housing navigation, housing deposits, accessibility modifications, etc.

# Rhode Island: Health Equity and HRSN

## Major Barriers

**Major barriers** that impact the equitable delivery of care and member health outcomes:

- Access to transportation
- Housing security
- Food security
- Translation supports
- Technology enabled care
- Behavioral health access
- Extended care hours
- Disability access
- Cultural competency
- Workforce diversity

## Examples of EOHHS Efforts to Date

**Unite Us Community Referral Program (CRP):** Support AEs in systematically screening for members' HRSNs, referring to appropriate community resources, & coordinating service delivery & follow up with CBOs.

**Health Equity Zones (HEZ)** – Investing in place-based, community-led collaborations to build healthier, resilient communities and address disparities.

**Certified Community Health Workers (CHW)** – Coverage of CHW services. CHWs often have similar cultural knowledge, health conditions, life experiences as the populations they serve. Help link members to timely health care & social services.

**Support and Services at Home (SASH) Program** – Two-year pilot providing site-based services (in partnership with Housing Authorities & Affordable Housing Providers) to support elders living independently at home

## Discussion Questions

- What additional actions should EOHHS and MCOs take to address health equity and HRSNs?
- Are there specific needs (e.g. housing, medically tailored meals) 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 added services to address these needs?

# Certified Community Behavioral Health Centers (CCBHCs)

## CCBHC Program Overview

- **Goals:** Improve community health outcomes, reduce health disparities, and support providers in delivering higher quality, more sustainable services.
  - Jointly supported by **CMS and SAMHSA**. Expands on Community Mental Health Organization (CMHO) framework.
- **Services included:** outpatient MH & SUD treatment, primary care screening and monitoring, case management, psychiatric rehabilitation, peer and family support services, assertive community treatment, intensive community-based treatment for veterans/armed forces members.
- **Prospective Payment System:** RI has selected the PPS-2 Model, which is attribution based.

**Fall 2022**
Infrastructure Grant Program

**Spring 2023**
Provider Certification

**Fall 2023**
Operations Manual Release

**February 2024**
Implementation thru Managed Care

## Discussion Questions

- What are the opportunities and risks in the implementation of the CCBHC model?
- What enhancements to the model do you recommend to help us address behavioral health needs and address health disparities
- As EOHHS develops the Operations Manual, what technical specifications should we consider for attribution, billing and quality program requirements?

# Behavioral Health Services

| Managed Care Contracted BH Services |
| --- |
| General Rehabilitative Services |
| Mental Health Targeted Case Management |
| HCBS for Children |
| Intermediate Services |
| Acute Services |
| Long Term Residential Program |
| Opioid Treatment Program (OTP) Health Home |
| Court Ordered Behavioral Health Benefits |
| Care Coordination and Discharge Planning |

## Discussion Questions

- Where are the most significant **gaps in Behavioral Health service capacity** and access?
  - What steps can EOHHS and managed care plans take together to best address these gaps?
- Are there significant **operational and/or administrative barriers** impacting the member experience with Behavioral Health Services delivered through managed care?
  - What steps can EOHHS and managed care plans take together to best address these barriers?
- Beyond CCBHCs, what **payment and/or service delivery reforms** might EOHHS consider?

# Quality

## Current MCO Quality Program

**Pay for Performance (P4P) Program includes 10 2021 HEDIS Performance Measures:**

1. Medication Mgt for People with Asthma
2. Comprehensive Diabetes Care, including: HbA1c control,** Eye exam (retinal) performance,** and Kidney health evaluation for patients with diabetes (KED)
3. Controlling High Blood Pressure**
4. Breast Cancer Screening**
5. Cervical Cancer Screening
6. Follow Up - Hospitalization for Mental Illness
7. Adolescent Well-Care Visits
8. Combination measure that mirrors AE measure of Child & Adolescent Well-Care Visits (3-11 years and total)**
9. Childhood Immunization Status
10. Prenatal and Postpartum Care

## EOHHS Planned Refinements

- **New Quality Assessment and Performance Improvement Program (QAPI),** with new requirements for quality improvement for state-contracted MCOs.
- **Measures** aligned with the AE quality measures and with the quality measures of the Office of the Health Insurance Commissioner (OHIC).
- The Quality Program will include a **Pay for Performance** component (P4R in Year 1), funded through a withhold, tied to individual measure performance vs. benchmarks

## Discussion Questions

- *What are the key considerations about a new quality strategy and the alignment of quality measures?*
- *Should member satisfaction be measured as part of a quality strategy?*

# Session 4
# Appendix

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# Care Coordination and Care Management

## Key Definitions

| Term | Definition |
|---|---|
| Care Program Design and Planning | • Includes activities to coordinate Care Program functions with and delegate Care Program functions to AEs and other program participants, including data analytics, HRAs, and referrals |
| Health Risk Assessment (HRA) | • Determines members' needs for and access to medical and health-related social services and supports; whether risk factors indicate a need for CM or CCM |
| Care Coordination | • The deliberate organization of members' care activities between two or more participants to facilitate the appropriate delivery of Health Care Services and supports.<br>• Care Coordination participants can include members, their families, and caregivers; AEs; patient-centered medical homes, health homes, community health teams |
| Care Management (CM) | • A team-based, person-centered approach designed to improve Members' health and situational health-related needs (as documented in an ICP) by facilitating access to clinical and non-clinical services<br>• Situational needs include time-limited episodes of instability, such as following an acute medical event (e.g., heart attack, sepsis, surgery, high-risk pregnancy) or gaining selfcare) |
| Complex Case Management (CCM) | • Includes evidence-based coordination services for Members with multiple or complex conditions in accordance with NCQA standards<br>• Include comprehensive initial assessment and development of an ICP with Member/family input; delineation of available services and resources; ongoing monitoring and follow-up |

# Program Examples: Primary Care Population-Based Payment

**CMMI and State Medicaid programs offer instructive examples for integrating primary care population-based payment.**

| | CMMI Multi-Payer Primary Care Payment Reform Demonstrations | | CMMI Medicare ACO Model | State Medicaid Models | |
|---|---|---|---|---|---|
| | CPC+ | Primary Care First | ACO REACH | MassHealth ACO Program (1115 waiver) | Colorado (SPA) |
| | Track 2 | Risk Group 3-4 | Professional | Primary Care ACO | APM 2 |
| Base Payment Model | • **Hybrid primary care population-based payment, with FFS reduction** – upfront payment for % of expected payments for E&M services for attributed members; **practice selected hybrid payment ratio** | • A **flat visit fee** that compensates practices for in-person treatment;<br>• A **primary care population-based payment,** practice risk group adjusted | • **Hybrid primary care population-based payment, with FFS reduction** of at least 10% (and incrementally higher reduction standards over time for participant providers, up to 100% in Year 3) | • **Primary care population-based payment**: capitated payments for defined primary care services, tied to a 3-tiered practice classification based on care delivery and structure/staffing requirements | • **Hybrid primary care population-based payment, with FFS reduction -** prospectively paid partial PMPM, based on **practice selected hybrid payment ratio** (can be 0% cap) |
| Incremental Payments | • **Care management fee** (PMPM) – supports augmented staffing and training/ historically nonbillable services<br>• **Pay for performance** (PMPM): prospectively paid, retrospectively reconciled incentive tied to patient experience, clinical quality, and utilization (hospital and ED) | • **Chronic care management** services included in PBP<br>• **Performance-based adjustment (with downside):** up to 50% upside; 10% downside incentive to reduce costs and improve quality (tied to Acute Hospital Utilization or Total Per Capita Cost, with a quality gateway) | *At the ACO level:*<br>• **Total Cost of Care Shared Savings/Risk** Model**:** up to 50% savings/losses | • **Care management funding:** enhanced PMPM funding included in primary care PBP<br>*At the ACO level:*<br>• **Health Equity P4R/P4P**<br>• **Quality P4P**<br>• **Total Cost of Care Shared Savings/Risk** Model with 3 risk track options (100%, 70%, 60% savings/losses) | • **Shared savings for 13 different chronic condition episodes** of care with benchmark prices; 50% savings (upside-only) |
| Other Notable Program Features | • **Focus on practice infrastructure, "wrap-around" primary care services, flexibility** to support comprehensive care/ delivery of nonbillable services through the primary care PBP | • Substantial **focus on promoting flexibility in care delivery, reducing the need to bring patients into the office** (supports services by email, phone, patient portal, etc.)<br>• **TCOC shared savings/risk-like model adapted** for primary care practices | • Primary care PBP **embedded in ACO model**<br>• Strong **focus on advancing health equity** and bringing the benefits of accountable care to underserved communities; incorporates a range of equity advancement strategies | • Primary care PBP **embedded in ACO model**; ACOs required to implement for network practices<br>• Payment tied to **tiered expectations of practice capabilities; additive funding** to support enhanced care delivery<br>• **FQHCs receive PMPM** | • **PMPM option for FQHCs**<br>• **PMPM reconciliation** ensures providers don't get paid less under the APM, vs. FFS ("no risk" if quality thresholds are met)<br>• **Chronic condition-based** TCOC model |

# Behavioral Health Services Details

| Details of Select Managed Care Contracted Services (not a complete list) | |
|---|---|
| General Rehabilitative Services | • Assessment and diagnostic evaluation; Psychological & neuropsychological assessment & evaluation; Developmental evaluation; Psychological testing;<br>• Individual, family, couple, and group therapy;<br>• Crisis intervention<br>• Medication treatment, evaluation, and management. |
| HCBS for Children | • Applied Behavior Analysis (ABA); Adolescent Residential Substance Use Treatment;<br>• Personal Assistance Services and Supports (PASS); Respite Services. |
| Intermediate Services | • Partial Hospitalization (PHP)/Day Treatment/Intensive OP Treatment (IOP) (for children, adults);<br>• Enhanced OP Services (EOS) (for children)/Community Psychiatric<br>• Supported Treatment (CPST) (for adults);<br>• Assertive Community Treatment (ACT) (for adults);<br>• Health Homes for Children services (for children);<br>• Peer Recovery Specialist services (for adults) and Family Support services (for children);<br>• Integrated Dual Dx Treatment for SUD Services (for adults);<br>• Center of Excellence Program (COE) Medications (for adults |
| Acute Services | • Inpatient Acute Hospitalization; Acute Residential Treatment Services (ARTS);<br>• Observation/Crisis Stabilization; and<br>• Emergency Service Intervention; including mobile crisis services. |
| Long Term Residential Program | • SSTAR Birth Residential Program;<br>• Mental Health Psychiatric Rehabilitative Residence (MHPRR);<br>• Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-A). |