



Dual Eligibles – Payment and Delivery System Model Options July - September 2019 Stakeholder Discussions: Key Learnings

October 15, 2019

EOHHS currently operates a Medicare-Medicaid Plan (MMP) financial alignment demonstration in partnership with CMS and Neighborhood Health Plan of RI. The three-way MMP contract ends in December 2020. As such, EOHHS is assessing the payment and delivery system model options to serve the dual eligible population going forward. In July 2019, EOHHS embarked upon a stakeholder process aimed at gathering feedback to support the development of this solution. Over the course of July through September, EOHHS convened meetings with 35 stakeholder entities. Participating stakeholders included state agencies, health insurers, provider organizations, advocates, and members participating in the ICI Implementation Council. This document details key learnings from this initial stakeholder process. A full list of participating stakeholders is included in Appendix A; discussion materials are provided in Appendices B, C and D.

In summary, seven key themes emerged from these discussions:

1. Member Choice, Member Education and Options Counseling

There was general support and agreement regarding the program priorities as presented (see Appendix B); however, many stakeholders suggested that member choice should be added as an additional program priority. Some noted that choice amongst carriers is likely not sufficient; to the extent that many models come with network limitations, consumers may need choice amongst payment models.¹ One stakeholder commented that satisfaction with the MMP is high in part because it's a voluntary program – MMP is likely not the best option for everyone, and to the extent it became mandatory we may see satisfaction decline.² Additionally, different Medicare program options are confusing to members, and the broker driven marketing model of Medicare Advantage/DSNP plans may not always result in the most appropriate program selections by dual eligible populations. Many suggested that a broader Medicare/Medicaid options counseling function is needed; additionally, perhaps EOHHS could leverage an aligned DSNP model to direct/require Medicaid agency approval of DSNP marketing materials to promote member choice.³

2. Payment and Delivery System Models

Three distinct potential payment models were proposed as options for consideration (see Appendix C). No silver bullet emerged from these discussions; rather, there was general recognition that each potential model had pros and cons that required careful consideration. Specifically:

- **Most stakeholders expressed significant satisfaction with the current MMP program, and support for a MMP based program.** There was substantial consensus among providers and advocates that the MMP was working. Many acknowledged that the program had “its bumps” in start-up, but the program was currently operating smoothly. Most noted that the integrated benefit, or “single card” is of great value to members as it improves accessibility/ ease of navigating the system. Members participating in the ICI

¹ i.e. consumers may always need a FFS option to ensure access to out of state providers (e.g. Boston based specialists, snowbirds)

² States with mandatory programs have lower satisfaction, struggle with how to get people out of MMP when not appropriate

³ DSNP rules allow for states to place requirements on DSNP carriers, approve marketing materials

Implementation Council expressed strong satisfaction with the MMP, particularly noting the single card, no copays, and broad network access as important to them. HCBS providers, nursing home providers and advocates all expressed strong support, specifically commenting that this program allowed for timely access to much needed HCBS services, and that this was critically important to providers and members.^{4,5} Many expressed surprise that the state would consider alternatives, given their perception of strong current program performance. Many also noted that some of the longer-term goals of shifting to integrated care management, and value-based purchasing may simply be a “not yet,” not a “not happening.” However, the administrative burden of the three-way contract structure, and CMS program requirements on the state, plans, and providers was repeatedly acknowledged.

- **Stakeholder response to a DSNP model was more mixed, with specific interest among a subset of carriers and primary care providers/Medicare ACOs.** Most stakeholders acknowledged the importance of both a more sustainable financial model and an integrated solution – and were interested in exploring the financing mechanism under a DSNP, especially the more favorable Medicare rate setting adjustments available to carriers. There was a recognition that the DSNP model offers some distinct opportunities: EOHHS could leverage existing carrier investments in DSNP/Medicare Advantage plans, encourage/require Medicaid benefit enhancements, and reduce the administrative burden associated with the three-way MMP contract. Permanent authorization of the DSNP was cited as an assurance of program longevity that would encourage investment by some carriers and providers. While some thought the DSNP offered the opportunity to accomplish the same program goals without the administrative burden of a three-way contract; most were skeptical of the ability to achieve the same level of integration under an aligned DSNP model. Advocates also expressed concern regarding both the oversight model and the multi-state structure of DSNP contracts. Additionally, while some providers were highly supportive of the innovations underway by existing DSNP/Medicare Advantage plans who perhaps had a stronger organizational basis for value based purchasing models, many other providers cautioned that the plans who are currently participating in a DSNP model may rely on care delivery models that restrict member choice and the participation of all willing providers.
- **Stakeholders were generally less supportive of a FFS based model.** Behavioral health representatives and PACE expressed interest in moving away from a health plan based, capitated model – but most others expressed significant concerns about losing the payment flexibility, critical administrative funding, and benefit flexibility associated with managed care. HCBS providers and advocates raised concerns that the care coordination function, which is a health plan function in the MMP, and which is critical to any model’s success, could be effectively outsourced and separated from the payor – as effective care coordination would need to be linked to the ability to authorize access to services.⁶ Medicare ACOs raised concerns that value based purchasing models, which were often described as critical to any effective payment model, could not be meaningful in a traditional Medicaid/FFS payment system absent integration/alignment with Medicare, and that it seemed unlikely outside of managed care models.

3. Eligibility and Enrollment Processes

Many stakeholders raised concerns regarding the complexity of the current eligibility and enrollment process and delays as a significant barrier to any effective payment model. The complexity of/delays in the

⁴ Providers noted that under the MMP, the plan currently authorizes significant HCBS for dual eligible populations who are not waiver eligible - this authorization would likely not occur in a FFS structure; additionally, the plan currently provides valuable and timely support to providers seeking refined/additional authorizations for populations with complex health care needs. HCBS providers commented that “*when a member is in the MMP, I know I can call and get them the services they need.*”

⁵ The exception to this generally positive feedback came from BHDDH and the behavioral health community, many of whom did not see a significant value add to managed care for this population.

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current clinical level of care determination performed by the state coupled with the duplication between the state level of care determination and health plan service authorization was frequently noted.⁷

4. Care Coordination

There was significant discussion regarding the important role of care coordination for populations in need of HCBS/LTC services. Currently, under the MMP, this function is performed by the managed care plan, and most providers and advocates stated that this process worked well, particularly in terms of providing substantially improved and timely access to needed HCBS and LTC services. There was recognition that this care coordination function was not currently well aligned with primary care providers, and that more work needs to be done to create a care coordination model that connects primary care providers, HCBS providers, behavioral health providers and other social service providers to support populations with complex health care needs.⁸ There was also recognition that the primary caregiver for LTSS populations is often the HCBS provider and or specialist, as many of these members do not currently have a relationship with their primary care provider. It is therefore not clear where this role/care coordination function should reside. Many providers seemed to feel ill-equipped to play this role and were pleased with the health plan role under the current MMP structure. However, there was also general agreement that there had not been significant innovation in the care coordination model, nor implementation of value based purchasing strategies to date.

Care coordination was discussed distinctly relative to the SMI/SPMI and I/DD populations. In relation to the SMI/SPMI population, many stakeholders noted that care coordination most appropriately resides with CMHO and/or health home care coordinators who have unique competencies important to serving this complex population. BH providers generally saw less value in managed care, as care coordination through the MCO was typically seen as duplicative and less effective for this population compared to care coordination at the BH provider level. In relation to the I/DD population, many suggested a need for greater clarity in the delineation of roles and responsibilities and definition of care coordination processes, as there is currently no single point of coordination for the bifurcated medical and I/DD specific services this population utilizes.

5. Specialized AEs, Provider Engagement and Value Based Purchasing

There was a strong interest among many providers in exploring some form of Specialized AEs and value-based purchasing models to support the dual eligible population. Many recognized the importance of increased provider engagement, and a movement away from fee for service provider payment as fundamental to any effective reform effort; however, this was offset by “reform fatigue” and a concern/skepticism that these reforms would truly move forward or “stick.” Many acknowledged the value of building VBP approaches within managed care, as managed care partners could more easily set up alternative payment models. However, many raised small numbers/low volume as a challenge to establishing APMs and recognized that the participation of multiple managed care plans could exacerbate this challenge. Some commented that the lack of innovative payment models under the MMP could be a function of timing, provider readiness and/or health plan expertise. Current Medicare ACOs strongly

⁷ Note: Minnesota separates level of care determination from eligibility determination – and delegates level of care determination to the plans. CMS requires that this delegation is based on state defined LOC determination template, and is coupled with careful oversight and frequent auditing to ensure appropriate access/use of services.

⁸ This challenge is consistent with national experience. As noted in a March 2019 study of care coordination models serving dual eligible beneficiaries, “Health plans continue to face care coordination challenges, though innovative solutions are emerging... Health plans continue to struggle to engage primary care providers (PCPs) in care coordination activities...” <https://www.macpac.gov/publication/care-coordination-in-integrated-care-programs-serving-dually-eligible-beneficiaries-health-plan-standards-challenges-and-evolving-approaches/>

encouraged models that integrated/aligned the Medicare and Medicaid funding streams – which seemed more feasible in a managed care environment. Some suggested that a pay for performance model, focused on key system performance metrics (e.g. rehospitalizations, ED use) would be a good place to start; perhaps such a model could be set up across payors to maximize volume, and be shared across provider types (HCBS providers, primary care/AEs).

6. Project Scope: Workforce Development

Multiple stakeholders cautioned EOHHS not to get too narrowly focused on the payment model – as none of this will succeed unless current workforce shortages and limitations are addressed. Specifically: existing home care waiting lists, geographic gaps in home care provider availability, a lack of community-based providers with expertise/capacity to serve populations with behavioral health needs, lack of HCBS career progression/certification/tiered rates, and a lack of step down/assisted living/other options “in between” home-based care and institutional care. These workforce limitations all substantially limit the program’s potential to keep people in the community – and all generally fall outside of the direct responsibility of any dual eligibles payment model.

7. Caution Regarding Transitions

Many stakeholders noted that significant investments have already been made in the MMP program and suggested that to the extent possible, it would be preferable to “fix” the MMP, as opposed to selecting a new model. Many stakeholders also cautioned that for the transition period, the state should give strong preference to the extension of the status quo vs. interim solutions that would result in changing the system multiple times. It was also noted that there is a limited window during which a member can be passively transitioned from one integrated solution to another, so limiting gaps between integrated solutions would be preferable. Consumer supports during this transition period will be essential.

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State Agencies

1. RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)
2. RI Department of Children, Youth & Families (DCYF)
3. RI Department of Human Services (DHS)
4. RI Executive Office of Health and Human Services (EOHHS) Staff
5. RI Office of Healthy Aging

Carriers

6. Blue Cross Blue Shield of RI
7. Neighborhood Health Plan of RI
8. Tufts Health Public Plans
9. United Healthcare Community Plan

Primary Care Providers, Accountable Entities and Hospitals

10. Blackstone Valley Community Health Center
11. Coastal Medical
12. Hospital Association of RI
13. Integra
14. Integrated Health Partners
15. Lifespan
16. Prospect Health Services
17. Providence Community Health Center
18. Wood River Health Center

HCBS and Long-Term Care Providers

19. Cowesett Home Care
20. Home Care Services of RI
21. LeadingAge RI
22. PACE
23. RI Partnership for Home Care
24. RI Assisted Living Association

Behavioral Health Providers

25. CODAC
26. Community Care Alliance
27. East Bay Community Action Program (EBCAP)
28. Newport Mental Health
29. Phoenix House
30. The Providence Center

Advocates/Other

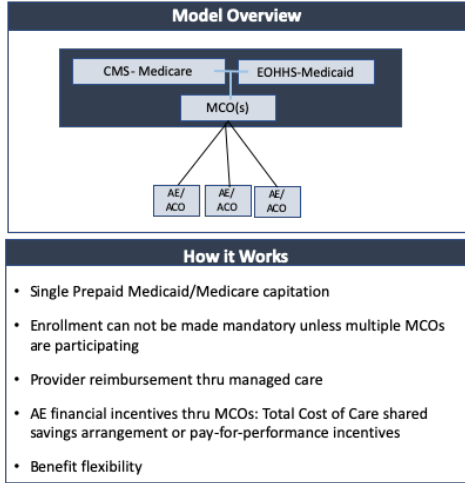
31. Economic Progress Institute (EPI)
32. ICI Implementation Council
33. RI Parent Information Network (RIPIN)
34. RI Organizing Project
35. The Substance Use and Mental Health Leadership Council of RI (SUMHLC)

1. **Integrated or aligned Medicare/Medicaid solution** that encourages use of Medicaid paid home and community based services (HCBS) to enable vulnerable populations to remain in the community, and benefits member experience
2. **Engage Provider Based Organizations as a partner** in supporting complex populations – transition providers away from FFS toward new alternative payment models that align financial incentives.
3. **Financially viable/sustainable solution** for EOHHS and our partners.
4. **Operational simplification + excellence**
 - Enrollment processing.
 - Provider billing/payment.
5. **Single solution supporting all dual eligible populations**, with limited program eligibility exclusions.

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Option 1: Modified MMP Program

Extend the current contract with modifications. E.g. MMP States: RI, CA, IL, MA, MI, NY, OH, SC, TX

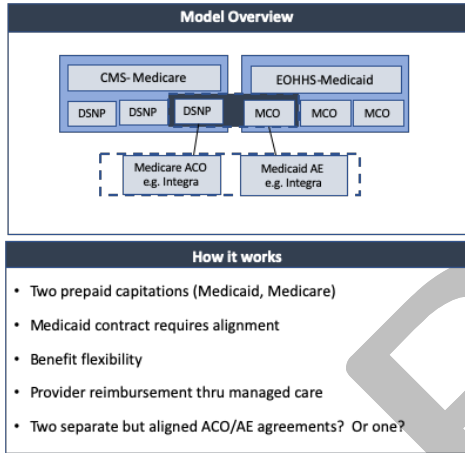


Key Success Factors	<p>The success of this model depends substantially on:</p> <ul style="list-style-type: none"> Solving technical challenges of integrated enrollment processes Negotiating CMS financial terms Negotiating mandatory/passive enrollment
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Discussion	<ul style="list-style-type: none"> What are the pros and cons of this option? How effectively does this option meet the needs of: <ul style="list-style-type: none"> Members? Plans? Providers? How well does this option respond to this project's priorities? <ol style="list-style-type: none"> Aligned Medicare/Medicaid - rebalancing potential and member experience benefits Engage provider based organizations as a partner Financially viable/sustainable for EOHHS and partners Operational simplification and excellence Single solution – limited program eligibility exclusions
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Option 2: Aligned D-SNP

Require Medicaid MCOs to offer a companion D-SNP product via core or separate contract E.g. Arizona, Minnesota, New Jersey

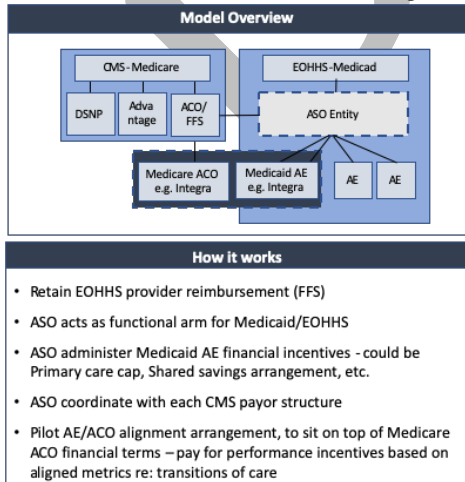


Key Success Factors	<p>The success of this model depends substantially on:</p> <ul style="list-style-type: none"> Accomplishing aligned enrollment via contracting and operations Instituting mandatory/passive enrollment Creating aligned provider contracts (AE/ACO)
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Discussion	<ul style="list-style-type: none"> What are the pros and cons of this option? How effectively does this option meet the needs of: <ul style="list-style-type: none"> Members? Plans? Providers? How well does this option respond to this project's priorities? <ol style="list-style-type: none"> Aligned Medicare/Medicaid - rebalancing potential and member experience benefits Engage provider based organizations as a partner Financially viable/sustainable for EOHHS and partners Operational simplification and excellence Single solution – limited program eligibility exclusions
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Option 3: ASO/AE Model with Aligned AE Pilot

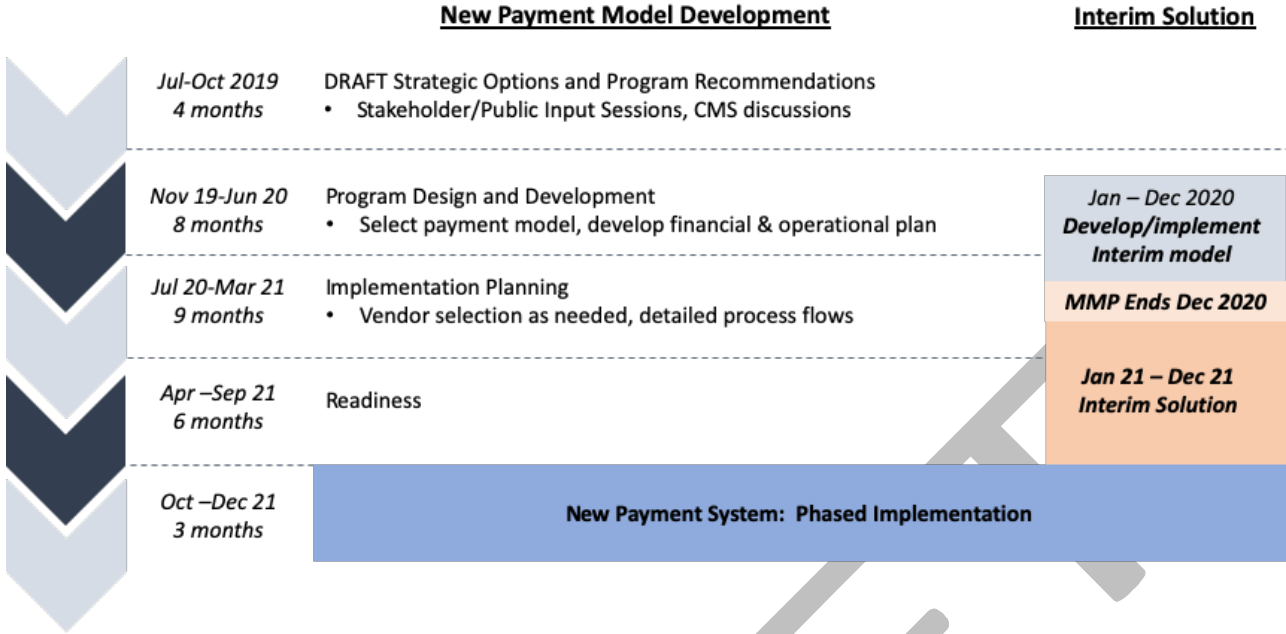
Medicaid only arrangement with ASO entity to administer the Medicaid duals program; plus financial alignment pilot with Medicaid AE/Medicare ACOs. E.g. "Connecticut plus"



Key Success Factors	<p>The success of this model depends substantially on:</p> <ul style="list-style-type: none"> Defining ASO responsibilities with sufficient authority Obtaining CMS approval and finding a willing AE partner(s) Contracting with an effective ASO partner
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Discussion	<ul style="list-style-type: none"> What are the pros and cons of this option? How effectively does this option meet the needs of: <ul style="list-style-type: none"> Members? Plans? Providers? How well does this option respond to this project's priorities? <ol style="list-style-type: none"> Aligned Medicare/Medicaid - rebalancing potential and member experience benefits Engage provider based organizations as a partner Financially viable/sustainable for EOHHS and partners Operational simplification and excellence Single solution – limited program eligibility exclusions
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APPENDIX D: TIMELINE AND PROCESS SUMMARY – DRAFT FOR DISCUSSION



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