Rhode Island Request for Information # 7611871 – Response Summary

In November 2020, the Rhode Island Executive Office of Health and Human Services (EOHHS) began an extensive stakeholder engagement process to gather feedback on the current $1.4 billion Medicaid managed care program and explore opportunities and innovations for improvements to align with Rhode Island's current initiatives and member needs. The following fundamental principles and policy goals were recognized during this process:

- Goal 1: Provide an opportunity for a fair and open market competition that provides choice among high quality health plans for Rhode Island Medicaid managed care enrollees.
- Goal 2: Promote innovative payment policies and reforms that transition away from fee-for-service (FFS), support accountable entity development, and increase alternative payment models (APMs) to incentivize better quality and more efficient delivery of health care services.
- Goal 3: Control the total cost of care (TCOC), increase risk taken on by managed care organizations (MCOs) and Accountable Entities (AEs), and increase budget predictability in the Medicaid Program while maintaining quality and access to care.

EOHHS conducted numerous listening sessions with state staff from EOHHS and other state agencies, MCOs, AEs, advocates, providers, and community organizations and received feedback from Medicaid enrollees. During these initial stakeholder feedback sessions, EOHHS heard several key themes:

- Improve the care management process to ensure adequate and timely interventions, especially for children with special health care needs, including children and families involved with the Department of Children, Youth and Families (DCYF) or the justice system.
- Options to improve integration of behavioral health services for all members, with particular focus on services for children.
- Ensure continuity of care for members in transition, such as those moving between FFS and managed care or from an acute care setting to a community-based setting.

- Modify or clarify roles and responsibilities between the MCOs and the AEs, including appropriate support for AEs by MCOs.

- Possible changes to the member/MCO enrollment process.

- Potential inclusion of new populations in managed care.

- Move from a risk corridor as the primary MCO risk mitigation strategy to more targeted risk mitigation techniques.

On March 2, 2021, the Rhode Island Department of Administration (DOA) on behalf of EOHHS issued Request for Information (RFI) # 7611871. The goal was to solicit informational responses from potential vendors and other interested parties to inform the managed care procurement for RIte Care, Rhody Health Partners and Adult Expansion populations. DOA accepted responses through March 30, 2021. The agency received responses from nineteen vendors, organizations, associations, and community leaders representing a cross section of respondents.

The RFI builds on the robust stakeholder engagement process started in November 2020 by gathering formal written input from potential vendors, providers, advocacy organizations and other interested parties in eight key areas:

1. Care and Service Coordination
2. Behavioral Health
3. Social Determinates of Health (SDoH)/Population Health/Health Equity
4. Value-Based Payments and APMs
5. Member Enrollment
6. COVID-19 Impacts/Telehealth/Data
7. MCO Financing and Comprehensive Risk
8. Other

EOHHS has carefully reviewed the RFI responses received, summarized those responses in the table below, and identified the following key highlights and areas of consensus among respondents:

Care and Service Coordination

- Deliver care management and service coordination in accordance with the consumer's choice and preferences. The most recommended approach is to pair the member with the provider who has an established relationship to the patient in order to optimize engagement and successful outcomes.
- Establish appropriate parameters to further support transparent and timely data sharing among and between EOHHS, MCOs and providers. All stakeholders should use the data flow to inform, support and track individual member, system, and programmatic performance to achieve EOHHS policy goals for the managed care program. In creating the data sharing infrastructure, the RI HIE, CurrentCare, should be leveraged, in accordance with federal privacy and interoperability standards.

Behavioral Health

- Implement systemic improvements at the state, MCO, AE, and provider levels to achieve an integrated system of whole-person care that addresses physical and behavioral health needs for children and adults. Providers should be well-versed in evidence-based care models including trauma-informed care, adverse childhood experiences, principles of recovery and empowerment, health literacy, and harm reduction. In addition, a service continuum assessment should address early identification, prevention and care transitions.

Social Determinants of Health (SDoH)/Population Health/Health Equity

- Support alignment of quality, operational, and financial incentives across MCOs, AEs and other providers, including community-based organizations. Support should build on current EOHHS and RI Department of Health's Health System Transformation Program (HSTP), Rhode to Equity, Health Enterprise Zones (HEZs), Care Transformation Collaborative Rhode Island (CTC-RI) and Community Resource Platform, and other strategies.
- Consider requirements for MCOs to have a health equity plan developed with member input to address internal and external anti-racism, implicit and unconscious bias training, staffing, quality, and financial incentives to reflect Black, Indigenous, and Persons of Color experiences.

Value-Based Payments and APMs

- Discourage exclusivity arrangements between AEs and MCOs. However, most respondents supported flexibility in value-based purchasing arrangements between MCOs, AEs and other providers to achieve the required outcomes while meeting providers where they are and advancing to more sophisticated arrangements over time.

Member Enrollment

- Contract with an independent enrollment broker for unbiased member outreach and education to facilitate active member choice among all available options. Outreach and education should be tailored to RI enrollees' cultural, linguistic, and literacy levels. Most respondents suggested requiring enrollees to select a primary care provider (PCP) at the point of managed care enrollment. Respondents also suggested membership distribution should be based on MCO competition with auto-assignment for enrollees that do not select an MCO equally distributed during initial contract years. In later contract years, auto-assignment should consider MCO performance on quality, member satisfaction and efficiency.
- Maintain members in their MCO for physical and behavioral health services when a non-dual member qualifies for long-term services and supports (LTSS) with additional requirements for coordination and communication to ensure continuity of care and coverage to ensure whole-person centered care. Future consideration for the inclusion of LTSS services within the managed care program should be thoughtful and deliberate and could be phased in over time or procured separately leveraging the current voluntary Medicare Medicaid Program (MMP).

MCO Financing and Comprehensive Risk

- Continue actuarially sound rate setting. Respondents note this is a key to the successful transfer of financial risk to MCOs. MCOs with demonstrated financial stability and experience should be well positioned to assume risk with additional mechanisms to recognize membership allocation and incentives for improved quality and member outcomes.

MCO Financing and Comprehensive Risk

- Respondents highly encouraged continued telehealth flexibilities, especially for meeting behavioral and SDoH needs of members.

The table identifies:

- The eight topic areas from the RFI.
- The specific RFI questions within the topic area.
- The number of respondents for each question within the topic area.
- A summary of the responses received for each question within the topic area.

I. Care and Service Coordination		
Question	**Number of Respondents**	**Summary of Responses**
1. Members with complex medical and social conditions often receive services from multiple programs administered by the MCOs, AEs and other providers. How should responsibilities be delineated when members are receiving care administered by MCOs, AEs, and/or other providers and outside programs to reduce duplication of effort, inefficiency, or incentive misalignment between the various parties to improve shared accountability for whole-person care while also improving health outcomes and controlling costs?	15	• Care management should be delivered as close to the patient as possible and supported by an appropriate or a full delegation of care management from MCOs to AEs/providers who demonstrate capabilities and capacity to accept this responsibility. Some recommended that AE/provider capability demonstration include demonstration of NCQA Case Management accreditation or NCQA Level III PCMH certification. Most respondents also supported flexibility for MCOs and AEs to develop the framework for appropriate delegation, with particular attention to those individuals with complex health and behavioral health needs. • To support care management delegation, several respondents expressed support for EOHHS development of appropriate parameters for data sharing among and between EOHHS, MCOs and providers. This also included a recommendation for member data sharing capacity through electronic medical record consent. • One respondent indicated care management should be maintained at the MCO level citing MCOs have the proven ability to manage care for their patients due to complete claims, utilization, staff, and financial resources to fully support care management activities. • Respondents also stressed flexibility should be coupled with clear accountability for outcomes and costs.
2. What recommended actions or best practices do you recommend EOHHS take to support effective care coordination between MCOs and provider entities that	15	• One respondent suggested using an independent Enrollment Broker to collect and update member contact information and administer a health risk assessment at enrollment, including SDoH elements, and share the results with the selected MCO as a best practice to streamline and facilitate the collection of necessary member information for effective care coordination.

I. Care and Service Coordination		
leverages the respective strengths of these organizations, particularly in a context in which MCOs, AEs and other providers that are bearing financial risk for a common population of members?		• Consistent recommendations from respondents centered on EOHHS setting expectations for MCOs, AEs and providers and holding them accountable for responsibilities in the managed care contract to support the movement to full risk. Responsibilities should include: o Seeking MCOs with demonstrated experience and a history of collaborative AE/provider engagement and support. o Considering providers beyond AEs who can effectively demonstrate abilities to manage care and TCOC. o Developing aligned oversight, governance, care model design, quality metrics, infrastructure, financial incentives, and data/information sharing requirements and tools within the MCO contract. • Respondents also commented that further requirements for providers and patient use of the RI HIE should be leveraged for improved data sharing to support care coordination. Several mentioned use of high-level population health data sets rather than individual level data for member risk stratification. • Several respondents reiterated patient care providers and coordinators should remain as close to the delivery of care to the patient as possible, stressing the patient/provider relationships as key, especially for those with complex physical and behavioral health needs. • To support full and consistent information sharing and effective care coordination, some respondents recommended comparing Rhode Island rules for sharing data, including behavioral health and substance use disorder information, to CFR 42 Part 2 rules.
3. EOHHS may consider an MCO contract requirement for care management and coordination functions to be delegated to AEs or primary care providers. What requirements would EOHHS need to have in place to ensure successful delegation of care management and care coordination to the AE and provider level, that preserves NCQA accreditation and ensures that resources are appropriately allocated to successfully take on	14	• Most respondents expressed support for appropriate or full delegation of care management from MCOs to the AEs/providers who demonstrate the capabilities and capacity to accept this responsibility. Some recommended that AE/Provider capabilities should include NCQA Case Management accreditation or NCQA Level III PCMH certification. Most of these respondents also supported flexibility for MCOs and AEs to develop the framework for appropriate delegation, with particular attention to those individuals with complex physical and behavioral health needs, and a focus on aligned measures, incentives, and outcomes. • To support care management delegation, several respondents expressed support for EOHHS development of appropriate parameters for data sharing among and between EOHHS, MCOs and providers. • One respondent expressed that care management be maintained by MCOs, citing MCOs' proven ability to manage care for their patients due to complete claims, utilization, staff, and financial resources to fully support care management activities. • One respondent recommended the enrollment broker be provided with detailed provider information (specialties, languages spoken, locations, etc.) for use in member choice counseling, as well as

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additional functions, including financial risk? Are there other functions that EOHHS should consider requiring MCOs to delegate to AEs or other providers?		centralizing provider credentialing processes by an NCQA-certified Credentialing Verification Organization to reduce administrative burden on providers who contract with multiple AEs/MCOs.
4. Describe best practices for the exchange of care management information and data between EOHHS, MCOs, AEs, and contracted and non-contracted care management entities and providers.	11	• Most respondents expressed support for continued movement toward information and data exchange and adoption of federal best practices standards to promote interoperability for shared care management information across multiple providers, MCOs, AEs and other entities. To further this movement, respondents recommended establishing a data exchange advisory committee to develop and expand RI's data sharing strategy. The strategy could leverage the HIE, CurrentCare, HealthFacts RI and other closed-loop referral tools in accordance with member privacy and preferences. • Respondents expressed support for standardized data elements, tools, and processes to ease the administrative burden for MCOs, AEs, providers, and members.
5. Are there policies or strategies EOHHS should adopt to improve the continuity and coordination of care for members who transition between coverage tiers, care settings, and/or the Medicaid managed care and FFS delivery systems (e.g., LTSS, Medicaid & Medicaid Plan, Dual Special Needs Plans)?	11	• Respondents recommend MCOs, AEs, and other providers align on real-time information and data sharing, agreed upon communication protocols, and standard care management protocols and processes to support continuity and coordination of member care. • EOHHS should as much information as possible on the member enrollment file and establish a statewide transition of care resource tool/repository for member assessments, care plans, authorizations, claims, and other relevant documents to facilitate member transitions. • EOHHS should collaborate with MCOs, AEs and other providers to establish clear transition policies and procedures for MCOs/AEs and providers to include identification of single points of contact for communication and documentation sharing among and between providers, enrollees, PCPs, and AEs to facilitate "warm-hand offs" with the member's care plan as the anchor for all providers' treatment strategies. • EOHHS should require a six-month continuation of existing service authorizations when members transition between MCOs and among delivery systems. • One respondent recommended EOHHS resume passive enrollment of new dual eligibles into the MMP, allowing the individual to opt-out of the MMP for other care delivery options. The respondent also recommended EOHHS maintain capitated delivery of acute and behavioral health services for Medicaid recipients eligible for LTSS, rather than transitioning to these services to FFS. • One respondent also recommended EOHHS modify or limit eligibility categories and/or streamline services across all eligibility categories to reduce coverage gaps.
6. Currently, individuals up to age 26 who are enrolled in	10	• Most respondents supported the integration of physical, behavioral, and dental health care under one entity for overall improved health and coordination. Some respondents recommended this could be

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the managed care delivery system receive dental services covered by one MCO. They may receive their other medical and behavioral health services from the same or a different MCO. What policies or strategies should EOHHS consider to improve the coordination and continuity of care for these individuals?		accomplished through contracting with a single Dental Benefits Manager, covering full adult and child dental benefits within the scope of the MCO contract, or implementing stronger coordination protocols. • One respondent cited dental access as an issue in the state and suggested implementing payment policies that support reasonable reimbursement for innovative delivery solutions, including telemedicine to reduce unnecessary dental emergency department utilization. • To drive further attention on integrated approaches to health, EOHHS should select annual quality improvement projects that bridge physical, behavioral, and dental health services.
7. Currently, individuals enrolled in an MCO who become eligible for LTSS are disenrolled from managed care. Should EOHHS consider maintaining these members in their MCO for acute and behavioral health care services? If EOHHS were to implement this approach, what should an MCO's strategy be for coordinating care between the physician and hospital (on the managed care side) and the HCBS service provider (delivering services on a fee-for-service basis)?	12	• Most respondents supported maintaining member in their MCO for acute and behavioral health services while continuing to provide HCBS services through FFS; however, EOHHS should explore including LTSS recipients in managed care, either by combining with the current MMP or developing integrated D-SNP provisions. Consideration for future inclusion of LTSS in MC should include changes to MCO requirements for skilled nursing facility coverage, including a separate appropriate rate cell to address the member's complex needs and cost savings associated with HCBS services. • Some commenters recommended EOHHS set requirements for improved coordination and communication if benefits and populations continue to be carved out of managed care. • A few respondents supported movement to full coverage for all beneficiaries and services if MCOs can demonstrate readiness and ability to operate a fully integrated program with appropriate financing and rates. • One respondent suggested AEs with full care management abilities be allowed to coordinate care for all members and all services like the Care @ Home model.

II. Behavioral Health		
Questions	**Number of Respondents**	**Summary of Responses**

II. Behavioral Health		

1. What best practices (including evidence-based practices) should EOHHS adopt in the MCO contract to integrate high-quality behavioral health, substance use disorder treatment services, and physical health across the care continuum for adults and children while maintaining consumer choice/person-centered care? What behavioral health performance measures should be included and how should EOHHS ensure consistent monitoring and evaluation of these measures?	15	• Respondents largely advocated taking an approach that integrates acute care with behavioral health, as well as other domains of wellness to ensure a whole-person centered approach to care. Specific recommendations for evidence-based practices recommended include:
		  ○ Motivational Interviewing
		  ○ Trauma Informed Care
		  ○ Medication Assisted Treatment
		  ○ Collaborative Care Models
		  ○ Cognitive Behavioral Therapy
		  ○ Several other nationally recognized standards/practices
		• Respondents suggested enhanced collaboration between EOHHS, BHDDH and other agencies, MCOs, as well as ongoing provider training and support will be needed to improve integration of services and care delivery.
		• Respondents supported value-based payment arrangements that incentivize MCOs/providers to find innovative solutions to better integrate BH and acute care.
		• EOHHS should consider additional assessments beyond depression screening and/or a single standard assessment for all behavioral health providers.
		• Respondents cited a need for greater programming and support for members with less intensive needs. Respondents also cited a need for transitional care management for members with low to moderate acuity.
		• Respondents encouraged continued use of telehealth services with reduced restrictions as per the pandemic.
		• Require the MCOs/AEs to hold the NCQA Certification in behavioral health Integration.
		• Establish clear contract language and requirements for provision of behavioral health services and data sharing related to these.
		• Ensure MCOs are compliant with behavioral health parity requirements.
		• Provider reimbursement rates should be reviewed regularly to ensure they are sufficient. Utilization review on a regular basis.
		• Reimburse providers for assessments and screening.

2. What do you see as the roles of MCOs, AEs, and primary care providers in person-centered/person-directed behavioral health, substance	12	• MCOs should support PCPs (AE and non-AE) in coordinating with behavioral health providers and the interdisciplinary care team for the member. MCOs should assist PCPs with integrated workflows, training, shared data. • MCOs should provide full, sustainable funding for Community Health Providers.

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use disorder treatment, and primary care integration? What are the barriers that will need to be prioritized to improve client centered care and how should they be addressed?		• AEs should be responsible for monitoring overall treatment quality and costs of care for their members. Care management should be delegated by MCOs to AEs. • Include a psych prescriber in PCP clinics with payment incentives and training for the adoption of this practice. • Clarify the roles and responsibilities of PCPs, AEs, and MCOs in the contract. Provide a clear interpretation of 42 CFR Part 2. • Use a phased approach to implement Alternative Payment Models to incentivize flexibility and creativity in care delivery. Implement other payment incentives to encourage PCP completion of behavioral health/ substance use disorder screenings. • A respondent identified lack of shared assessments and data identified as a barrier to care. • Several respondents recommended continued use of expanded telehealth services for behavioral health to increase access to care.
3. What strategies or policies should EOHHS and its constituent agencies, such as the Department of Behavioral Health, Developmental Disabilities and Hospitals ("BHDDH"), and DCYF consider adopting to support and improve the integration of behavioral health at the provider level? What, if any, current state policies, operations, payment models or practices restrict this integration that should be considered for changes?	13	• EOHHS should take a stronger leadership role to convene all parties (e.g., BHDDH, DCYF, CMHOs, MCOs, AEs, IHH, providers and advocates) to set state-wide minimum standards for adequate and timely data sharing. • Establish common regulations to align agencies and establish standardized referral, communication, and coordination protocols between them to reduce siloes (between BHDDH and DCYF). Standardization should include four critical domains: clinical, operational, financial, and technological, plus a strategic framework to integrate care at the provider level. • One respondent suggested a statewide audit and strategic plan across medical and behavioral health to include DCYF, BHDDH, EOHHS and RIDOH in order to invest in successful models of care across departments, including identification of areas for direct Medicaid billing. • Conduct regular cross-agency meetings/Advisory Committee of MCOs, AEs, CBOs, and other stakeholders. • Improve communication and understanding of the array of available BH services. Expansion of services and care management for BH/SUD members with lower/moderate levels of severity is needed. • Implement trauma informed treatment practices, motivational interviewing, and cognitive behavioral therapy practices. • Adopt flexible payment models to encourage physical and behavioral health integration and inclusion of community health workers (CHWs), social workers (SWs), and other providers and support community-based care coordination.

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		• One respondent suggested EOHHS make a deliberate financial investment in behavioral health homes and provider operational infrastructure, which will assist the health homes in achieving sustainability.
4. EOHHS seeks to prevent situations in which members, including both children and adults, are "stuck" in acute behavioral health settings due to a lack of access to the full behavioral health continuum of care. What should EOHHS consider when setting requirements for MCOs to develop a child and adult behavioral health care continuum that serves members in the least restrictive, lowest cost, medically necessary environment? What suggestions can you offer to build and expand network and provider capacity to deliver the full continuum of behavioral health services (including treatment and recovery), in both the child and adult behavioral health service delivery system? What suggestions can you offer for adults and children with co-occurring disabilities (e.g., intellectual and developmental disabilities, autism, deaf and hard of hearing)?	14	• Adopt contracting practices that set fair and equitable rates for providers, especially competitive rates for pediatric psychiatrists. One respondent recommends establishing economic incentives for providers by benchmarking fee schedules and raising rates along with the development of educational programs to increase the workforce. • Include comprehensive community-based services in plan; many preventative and step-down services are currently only available to members in the DCYF system. • Incentivize MCOs to develop alternative step-down services and partial hospitalization/day programs for members. • One respondent recommended that BHDDH currently assess unused real estate to create much needed residential and community infrastructure to meet the current lack of capacity within the continuum of services for both adults and children. • EOHHS may wish to consider a prospective, global, population-based payment to AEs covering behavioral health and substance use disorder care management, supportive housing, transitional housing, and other forms of step-down care. EOHHS should also consider supporting the development of more crisis stabilization beds in the community outside the hospital system. • EOHHS should promote co-location of medical services in behavioral health residential treatment services and schools to keep members in the community. • One respondent recommended adding two significant missing services to the current continuum: 1. intensive and extended community and home-based treatment; and 2. a statewide mobile response system (Intensive Community Based Treatment) • Require MCOs use transition of care (TOC) teams with an identified single point of contact (SPOC) for the team and use evidenced-based utilization management tools such as InterQual/ASAM. MCOs should have the flexibility to offer value-add services or in-lieu of services to provide alternative behavioral health care options for both adults and children. • Leverage preventive services for children to keep them from progressing to State custody. Enhance MCO transition services to support child transitioning to adult systems, individuals moving from inpatient or justice system to community.

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5. Stakeholders sometimes comment that members receiving behavioral health services do not receive timely outpatient follow up and coordination when discharged from an acute care setting, leading to relapse or crisis that requires hospitalization or in some cases overdose death. What do you see as the role of MCOs, AEs, and primary care providers in proactively following up in these situations, acting as a stable touch point for these members?	15	• Several respondents recommended enhanced support for transitions of care that requires the MCOs to guide and encourage AEs, PCPs, and other providers to proactively engage with members following a hospitalization and require AEs to coordinate with behavioral health/ substance use disorder providers at discharge. AEs should schedule outpatient follow ups prior to member discharge. Interdisciplinary care teams should be convened, and member consent should be granted to share data between these providers to ensure the best possible care management and follow up.
		• Several respondents recommended:
		  ○ Increased rates and enhanced reimbursement for outpatient therapy and peer support
		  ○ Incentives for providers who meet quality measures.
		  ○ Adequate rates for providers serving children at all levels of care.
		  ○ Reimbursement to acute care and BH providers for collaborative discharge planning and coordination.
		  ○ MCOs partner with EOHHS to build comprehensive, recovery-focused crisis response teams.
		• Focus on health outcomes and quality rather than cost savings could better motivate providers.
		• Improve incentives for data sharing.
		• Bradley and Butler hospitals should be connected to CurrentCare HIE.
		• MCOs should provide a daily data feed to AEs to be shared with PCPs.
		• MCOs should consider other sources of clinical data to supplement their claims data, including electronic health records from clinics and hospitals, state immunization and disease registries, labs, and HIE data files.
		• Several respondents recommended continued use of telehealth services to increase access, as well as an Enhanced Transportation benefit provided for with PHSRI-AE.
		• EOHHS should continue enhancements to BH Link and mobile crisis units and the CurrentCare system.

6. How can MCOs incentivize behavioral health providers to improve medication management for individuals with a behavioral health disorder, especially with individuals who are often difficult to engage such as individuals with a substance	11	• Expand the eligible provider types and locations where medication management and reconciliation can occur to include pharmacist in both community-based retail pharmacies and those located in hospitals, FQHCs and CMHCs. Include a requirement that for every 4 medication management sessions with a BH provider, a PharmD provides an MTM session with the patient. • Additional training for providers in the use of MAT through Project ECHO and requirements for medication management and reconciliation during transition planning for children and youth leaving DCYF care and youth and adults leaving the criminal justice system.

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use disorder or a serious mental illness?		• Consider implementing models of care that include SUD and MAT to encompass AEs/MCOs/FQHC-type services; adopt co-located pharmacy services and collaborations between MCOs and CMHCs to share information. • Provide rate enhancements for medication management, incentives and reimbursements for additional screenings, joint/collaborative care coordination. Incentivize providers to create dedicated urgent appointment blocks, especially for members established within a provider's practice. • BH prescribers should be embedded as part of acute care/PCP practices. MCOs can train PCP offices in basic screening tools for BH/SUD. • Require MCOs to integrate PBM clinical programs with AEs and providers to achieve desired outcomes and ensure alignment. • One respondent suggested the revival of previously successful services such as Mobile Treatment Teams, Day Centers (PH/BH/SUD/SDOH) and increased housing options through a global population based prospective payment. • Increase tele-prescribing practices for initial prescriptions and refills of medications and urgent appointments in traditional and nontraditional settings (as allowed by state and federal law).
7. How can EOHHS ensure MCOs provide statewide uniformity in access to the public mental health system, so consumers and families aren't responded to in significantly different ways simply because of where they happen to live?	12	• Expansion of BH Link and mobile crisis delivery units and existing care facilities across the state to increase access to care. • All contracted MCOs should have contracts with all providers in the public mental health system for all levels of care, including crisis stabilization units, urgent care, outpatient, and acute care providers. Require MCOs to contract with all Rhode Island Community Mental Health Centers. • Standardize screening/assessment/triage and treatment protocols across the system of care, including the emergency room, adoption of clinical guidelines and the use of predictive analytics to identify high-risk members for outreach. Require MCOs to use and report on nationally recognized, evidence-based tools to screen individuals for BH needs (for example, the CAGE-AID for SUD and the PHQ-9 for depression). • Incentives for providers to work at the top of their licenses, consider expansion of screening by non-BH providers with MCO reimbursement. • Require MCOs to invest in areas outside of the AE structure to encourage BH provider participation and expansion. • Allow for infrastructure support needs or the ability for rate differentials to allow for travel time to deliver home based services in more rural parts of the state.

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		• Consider financial assistance that would allow members with BH diagnoses internet access to make better use of telehealth services. • Engage community groups and faith-based organizations to encourage members to access BH services when needed, further supporting a "no wrong door" approach to care. Improve cultural competency and language offerings within the BH delivery system. • One respondent suggested EOHHS make MCOs responsible for aligning with pre-release Medicaid enrollment process to ensure improved coordination from incarceration through re-entry into the community and continued development of comprehensive community-based care to support diversion from the criminal justice system.
8. How can EOHHS better align MCO program requirements with other programs offered by the Rhode Island's BHDDH, DCYF, and Department of Health ("RIDOH")?	10	• Establish EOHHS as the leader among other agencies, establishing a shared mission and vision amongst BHDDH, RIDOH and DCYF with clearly defined roles and responsibilities for each. Develop and communicate clear criteria for member program eligibility and benefits between agencies and the processes by which members may access services. Educate agency staff, MCOs and AEs on these programs, their criteria and access points. • EOHHS clarify the role and the decision-making authority of BHDDH in terms of Medicaid funded, in-plan services. • Establish regular cross-functional workgroups/collaborative meetings including representatives from all agencies, providers and MCOs. Smaller sub-workgroups could then be formed to focus on specific topics/initiatives.

III. Social Determinants of Health/Population Health/Health Equity		
Questions	**Number of Respondents**	**Summary of Responses**
1. Describe how MCOs and providers can support efforts to reduce the impact of structural racism on members, including but not limited to social, economic, or geographic/	**16**	• Recommended EOHHS set forth requirements for MCOs to: o Develop a health equity plan with specific goals, a detailed approach to meet the goals, and measurements to evaluate progress and outcomes toward the goals. o Require annual top-to bottom implicit bias and anti-racism and unconscious bias training for their workforce and to attract and retain a more diverse, highly qualified workforce. o Provide at least one value-added service to target improved health that is separate and distinguishable from otherwise covered benefits or in-lieu of services.

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environmental disadvantages.		○ Build meaningful partnerships with community-based organizations (CBOs), Health Equity Zones (HEZs) and other agencies; and ○ Require use of closed-loop referral processes to ensure members' needs are addressed. • Respondents stressed the need for data and reporting to reflect race, ethnicity and language (REL) for members, and support the development of MCO incentives and reimbursement to encourage the use of available internal and external quality and operational data to identify and address inequities. Census and other geographic data may also be considered as a proxy for more specific member data. • MCOs should also be required to demonstrate how they use member/community feedback and information to design and implement policies and VBP incentives that address structural racism and other SDOH factors. • Several respondents encourage EOHHS to rebalance priorities toward improved public health outcomes and away from cost containment in order to drive further investments in SDOH and consider establishing a "Centering Anti-Racism" training program that would include provider CMEs.
2. How can MCOs identify and prioritize issues that disproportionately affect Rhode Island's Black, Indigenous, and People of Color ("BIPOC")?	**13**	• EOHHS should require all MCOs to: ○ Include BIPOC providers including FQHCs, CHC, CMHC, and CCBHCs and CBOs in their program designs and provider networks. ○ Engage and support community health teams and encourage these services within the core Medicaid benefit package. ○ Adopt and utilize a common Community Resource Platform. ○ Engage their Member Advisory Committees and demonstrate active involvement of members of diverse race, ethnicity, and cultures along with providers in shaping MCO interventions and approaches. ○ Include BIPOC in leadership and oversight positions; and ○ Use data analytics to identify and stratify beneficiaries by risk levels that also include race and ethnicity. • EOHHS should tie VBP financial and quality incentives for MCOs/ AEs and providers to support the adoption to the Community Resource Platform and development of tailored interventions and quality improvement measures and evaluation measures.
3. How can MCOs progressively work to identify their members' social needs and implement innovative strategies to address SDoH, including food insecurity, lack of housing, and interpersonal	**15**	• EOHHS should lead the following efforts to address SDOH, including food insecurity, lack of housing and interpersonal violence: ○ Adopt a standardized SDOH screening tool for providers and CBOs, focused on key state priorities. ○ Facilitate bidirectional transfer of meaningful, workable data, including critical SDOH data through use of a common referral platform.

III. Social Determinants of Health/Population Health/Health Equity		
violence in the context of the members race, ethnicity and culture?		○ Develop community partnerships and clear member expectations to set timeframes to address SDOH; and ○ Build an approach that rewards MCOs, AEs and providers for completing HRA/SDOH assessments, collaborating and providing financial support to CBOs to better integrate social services, reporting through use of Z-codes to reduce TCOC and help CBOs achieve adequate capacity. • One respondent recommended EOHHS consider an integrated Medicaid and SNAP application to support the capture of food security data. The respondent also recommended expanding the MCO 834 files to include SDoH fields for homelessness and risk for interpersonal violence to facilitate early identification and outreach by MCOs/AEs/providers.
4. What MCO contract requirements or policies should EOHHS consider to ensure MCOs are fully engaging with their members and putting the member at the center of their care? What requirements or policies should EOHHS consider to build trust between members and the healthcare system?	**13**	• Require all MCO to have NCQA Accreditation to include NCQA Population Health Management standards that require the use of data analytics for member risk stratification to better target needs and resources. • MCO co-location of staff, including community health workers (CHWs) and peer specialists, in neighborhood anchor organization such as churches, FQHCs, food banks, preschools, and community centers. • Add MCO requirements for robust member advisory councils and demonstration of how member feedback is shared up through the health plan leadership and policy making. • Require robust member education and engagement to promote primary care, preventive care and chronic care coupled with provider education regarding trauma-informed care (TIC), Adverse Childhood Experiences (ACEs), the guiding principles of recovery and empowerment, health literacy, and harm reduction. • Allow flexibility in modalities of care delivery and member engagement to include telehealth, social media, and other non-traditional methods.
5. What MCO contract requirements or policies should EOHHS consider to support providers in implementing care delivery strategies that are culturally relevant and foster respect, trust, and empathy?	**12**	• Recommend EOHHS, MCOs, AEs, and providers build on existing efforts (HEZ, CTC-RI) to develop and deploy a collective approach in providing culturally competent, trauma-informed care (TIC), training on DEI, ACEs, the guiding principles of recovery and empowerment, health literacy, and harm reduction. • Allow flexibility in modalities of care delivery, payment incentives and member engagement methods to include telehealth, use of diverse, multi-cultural/lingual CHWs, peer specialists, and recovery coaches to deliver localized, community-based care. • Provide member communications in member prevalent languages. • Require MCOs have Multicultural Health Care Distinction from NCQA.

III. Social Determinants of Health/Population Health/Health Equity		
6. A population-based approach to healthcare goes beyond the traditional biomedical model and addresses the importance of cross-sectoral collaboration in promoting the health of communities. What are best practices that EOHHS should implement to ensure MCOs identify and meet the unmet medical and behavioral healthcare needs in communities of color?	**13**	• Recommend requirements for MCOs/AEs to demonstrate collaborative relationships with local RI entities to include: RIPIN, CILs, AAA, RI Disabilities Council, MHA of RI, Housing authorities and other CBOs. Support information sharing and advocacy between these entities. • Require expanded use of diverse, multi-cultural/lingual CHWs, peer specialists, and recovery coaches to deliver localized, community-based care and use of in lieu of services (ILoS) to meet unmet needs. • MCO requirements for robust member advisory councils and demonstration of how member feedback is shared up through the health plan leadership and policy making. • Robust member education and engagement to promote primary care, preventive care and chronic care coupled with provider education regarding trauma-informed care (TIC), ACEs, the guiding principles of recovery and empowerment, health literacy, and harm reduction.

7. What suggestions can you offer for MCOs to play a greater role in creating housing opportunities for people who live with serious medical and behavioral health illness, and whose illness may require changing levels of intensity or support and care across their lifespan?	**11**	• Consider requirements for the development of medical respite and evaluation using the National Institute for Medical Respite Care's standards and tool kit as well as the national directory of operating MRC programs/facilities.
		• MCOs should:
		  ○ Dedicate housing coordination support staff to collaborate with organizations that offer permanent supportive housing services to link members to and help with applications or enrollment for state housing programs.
		  ○ Have the flexibility to use ILoS and value-added services to address housing needs, supports, and services for members.
		• Several respondents noted the lack of housing in RI is an issue and all state, local and private partners should collaborate to determine how best to develop health-related housing initiatives and funding.

8. How can MCOs strengthen the RI health care system to ensure it provides a comprehensive range of evidence-based practices and supports at the local community level? What evidence-based practices and services do you feel are important to add to the	**13**	• MCOs should build upon current EOHHS and RIDOH HSTP strategy, Rhode to Equity and use of Community Resource Platform as well as HEDIS, CAHPS, and OHIC Aligned Measure Sets. • MCOs should deploy advanced analytics to identify current or predicted gaps in network adequacy, and partner with AEs and providers to develop additional service capacity (e.g., non-medical transportation, crisis stabilization units, peer support, ACT, motivational interviewing, trauma-informed care, SBIRT, nurse family partnership, parents as teachers, play therapy, mobile integrated health teams with telemedicine capabilities; yoga/meditation; HARP-like programs to address Asthma; medically tailored meals, etc.) • EOHHS should seek to contract with MCOs with demonstrated experience: ○ Delivering evidence-based programs to a variety of member populations.

III. Social Determinants of Health/Population Health/Health Equity		
benefit plan to address the needs of adults and children in their natural environment?		○ Using evidence-based, person-centered, holistic, integrated models of care with demonstrated results. ○ Sharing compliant data among providers, members, and social services entities, such as use of interoperable data elements and open systems to facilitate collaboration of members' care and access to social service. ○ Using resources flexibly in the most effective way to achieve results. ○ Integrating all services, processes, and teams in the community to meet both member and provider needs. • Allow the flexibility for MCOs, AEs and providers to work together to develop innovative payment approaches to address member medical, behavioral, and health-related social needs.

IV. Value-Based Payments and Alternative Payment Models		
Questions	**Number of Respondents**	**Summary of Responses**
1. EOHHS is interested in increasing the amount of financial risk that MCOs, AEs, and other providers take while jointly managing cost and quality of care for members. What strategies or policies should EOHHS consider to increase financial risk and accountability for cost and quality of care for members?	14	• One respondent cautioned that premium inadequacies in the managed care program should first be addressed before moving to a model in which providers must assume increased risk. Review and adjust rates as needed to account for "cost burden and variability." • Allow flexibility to leverage all-payer models in place of or in addition to the AE models to reduce variations of payment arrangements for the providers across payers and member populations to promote increased provider participation. Allow progressive/phased implementation of incentives/risk to meet providers where they are along the continuum. • Establish a VBP Advisory Committee; reward MCOs for helping providers advance to more sophisticated APMs over time and innovations in these models. • Align payment incentives and performance measures across the entire delivery system, encouraging providers to participate in multiple value-based programs. Promote quality-based incentives according to the Aligned Measures Set creating consistency across all MCOs and standardize to promote health information technology (HIT) implementation. • Transparency in quality measurement and assessment/assignment of risk is essential to all stakeholders. Understanding that AEs and MCOs are differently equipped to manage risk today, allow flexibility for these parties to negotiate assumption of risk between them; consider use of a Risk Bearing Provider Organization (RBPO) certification process. EOHHS would then be responsible for setting overall policy goals and requirements for outcomes without dictating specific approaches to MCOs/AEs.

IV. Value-Based Payments and Alternative Payment Models		
		• Allow for delegation of care management to AEs who can provide this service, but do not require liquid assets or reserves/reinsurance of AEs. FQHC-AEs should be exempt from risk requirements because they serve the uninsured. • Some respondents expressed concerns about deviation from the current model and the potential for squeezing out smaller providers or incentivizing the MCOs to reduce services as a result. • Timely, actionable data sharing is needed for these initiatives to be successful within the RI HIE. • One respondent suggested requiring MCOs/AEs to participate in the Medical Assistance Intercept System (MAIS) program as part of their assumption of greater risk.
2. What infrastructure, tools, and resources should MCOs provide to encourage and support primary care providers, AEs, integrated health delivery systems and other providers to take on greater accountability for improved members' health outcomes and total cost of care?	11	• Nearly all respondents indicated data systems and sharing are the biggest need in this area. Electronic data sharing, in real time, if possible, via provider portals and dashboards, to include performance data, assessments, attribution rosters, care plans, care gaps, encounter data, authorization information, SDoH gaps and resources, member satisfaction, utilization and cost reports, multi-disciplinary care team member information, medications and adherence rates, risk stratification and star rating for the providers. • Require flexibility within the MCOs' MIS systems, specifically noting EHRs and HIE connectivity as areas for further consideration. • Provide ongoing support to AEs and other providers, such as training on data/portal access, interpretation of data, etc. • Empower and support member use of online portals for data sharing and storage. • One respondent suggested requiring MCOs to provide tools/resources for VBPs to providers, to include tolls for population health, SDOH, quality and utilization review.
3. In addition to the AE program, what other value-based payment methodologies should MCOs be required or strongly encouraged to adopt?	12	• Align these efforts with Health Care Payment Learning & Action Network framework (HCPLAN) guidance including pay-for-infrastructure, pay-for-reporting, pay-for-performance/quality and linking arrangements to performance measures. Consider funding for provider administrative staff to outreach members as part of this. • Support providers with education and technical assistance to help them move into more advanced, risk-based payment arrangements over time. Provide funding for practice transformation. • Adopt consistent performance metrics and standards and align these with industry standards and best practices. Encourage flexibility in arrangements between MCOs and AEs. • Consider VBP arrangements to incentivize progress in housing needs and job-training initiatives. • One respondent encouraged EOHHS to use unclaimed shared savings bonuses (from AEs) to fund an MCO incentive pool for meeting health outcome performance measures.

IV. Value-Based Payments and Alternative Payment Models		
		• One respondent suggested requiring MCOs to participate in MAIS program. • One respondent also suggested EOHHS consider blended payments, episodes of care, and PCP and global capitation.

4. EOHHS is considering a delivery system that would enable AEs to contract with a single MCO to enable sufficient volume for risk-based contracting, as well as to support AE and MCO partnership that is customizable to the unique strengths and capacities of the AE and MCO. What are the benefits and challenges of an AE landscape that enables exclusivity? What impacts would such a change have on member access, quality, and financial viability of MCOs, AEs, and other providers?	12	• Most respondents were opposed to AE/MCO exclusivity arrangements citing:
		  ○ Confusion and reduced choice for members.
		  ○ Potential barriers to care/lack of access to acute care/BH providers in other networks.
		  ○ Inability of AEs to attain a large enough membership for sustainability.
		  ○ Lack of fair markets for AEs serving complex members.
		  ○ Strains on risk adjustment.
		• A few comments and considerations offered to support AE/MCO exclusivity arrangements included:
		  ○ Allowance for providers to manage the size of their patient panels within the limited number of MCO partnerships.
		  ○ Reduced administrative burden for providers, AEs, and MCOs.
		  ○ Opportunity for better payment arrangement to promote and improve care coordination and management of cost and services.
		  ○ Opportunity for MCOs to create tiered networks for AE members within AE-affiliated providers, allowing for incentives for patients to maintain care within the AE health system of providers.
		  ○ Creates a symbiotic partnership between the MCO and the AE that can ultimately improve quality of care for the member and align cost management strategies.

5. EOHHS intends to align quality and population health goals among MCOs, AEs, and other providers. What clinical quality measures should be prioritized in both the managed care contract and VBP arrangements to improve overall population health in RI communities, including communities of color and cultural and ethnic diversity?	14	• Encourage HEDIS and CAHPS measures that address health disparities and include SDOH and overall member well-being to include BH, birth outcomes, chronic disease management, housing/environment, medication management, obesity, stroke, potentially preventable events, children's health. • Consider alignment of measures across MCOs, AEs and Providers and consider alignment across all other payers in RI to reduce administrative measures. • In addition to these measures, one respondent suggested adding VBP approaches that directly align with three primary domains of Merit-based Incentive Payment System (MIPS)—quality, promoting interoperability, and improvement—with the fourth (cost) less applicable to these relationships. • Engage the members in communities of color in defining their own goals and measuring progress. • Require baseline care data before MCOs/AEs can attain shared savings benefits by setting realistic targets for increased access to care for communities of color and other underserved populations.

IV. Value-Based Payments and Alternative Payment Models		
		Suggested 3 years of baseline data and implementation of health equity dashboards for use by MCOs, AEs and other providers in these efforts. • Consider requiring AEs to meet federal CLAS standards.
6. What level of flexibility should EOHHS give to MCOs to design their own VBP arrangements, as opposed to requiring specific methods across all MCOs and providers? Should MCOs be able to develop the structure, payment methods, and quality measures for AEs? Are there ways to provide MCOs flexibility while minimizing provider abrasion and administrative challenges?	11	• Most respondents continued to offer recommendations that EOHHS allow for flexibility within MCO VBP arrangements to achieve the required outcomes while meeting providers where they are and advancing to more sophisticated arrangements over time. Focus on EOHHS-determined outcomes, rather than specific approaches to achieve these. • EOHHS would remain the primary driver of the EOHHS-MCO-AE Collaboration, developing an appropriate fee-schedule and in developing an actuarially sound rate structure. • One respondent cautioned against allowing MCOs flexibility, recommending standardization across payers to reduce complexity and provider administrative burden.
7. For any value-based payment arrangements adopted by MCOs (whether per an EOHHS requirement or not), should EOHHS or the MCOs be responsible for developing: a. The method for determining payment to providers (e.g., primary care capitation rates); b. The risk adjustment methodology (as needed for the methodology in question);	12	• Most respondents indicated support for allowing MCOs to be responsible for developing payment methods, risk adjustment, quality measures and accountability reports, though some stated EOHHS should maintain involvement and support/oversee these processes via data monitoring, particularly related to issuance of final performance reports. • A few respondents noted EOHHS should maintain responsibility for all functions described in this question, as EOHHS will do so more objectively than the MCOs. • One respondent advised that the AEs should determine the method for payment, with support from the MCOs, and that these parties could negotiate on quality and non-financial measures, with EOHHS ensuring the MCOs provide data to the AEs as needed.

IV. Value-Based Payments and Alternative Payment Models		
c. Any quality or non-financial measures; d. The data and reports necessary to support accountability for improved members' health outcomes and total cost of care.		
8. What value-based payment methodologies or other strategies should EOHHS consider to improve the quality and coordination of care delivery for members requiring: a. Behavioral Health services; b. Long-Term Services and Supports; c. Pediatric care and other child and family services; and d. SDoH.	12	• **Related to BH Services**: use of APMs to encourage PH/BH integration and coordination between inpatient and outpatient providers, intensive community based BH services applicable across the member's lifespan, rebuilding the 2703 Health Homes for BH, global capitation with full population-based payment for BH services, behavioral therapy, exercise, and nutrition along with BH treatment could be part of a VBP arrangement, shared savings expansion (specifically, outpatient), and data sharing. • **For LTSS**: MCO incentives for investing in HCBS workforce to recruit and retain providers, VBP arrangements tailored to LTSS providers by provider type, which could incentivize providers with additional bonus payments for meeting a variety of suggested quality metrics, implementation of global capitation with full population-based payment, monitoring frequency of PCP referrals to LTSS services, and identifying opportunities for intervention to promote person-centered coordination. • **For pediatric care/child/family services**: Recommendations for the continuation and expansion of the CTC "PCMH Kids" cohort in addition to incentives for PCPs, FQHCs and BH providers to increase access to non-standard office hours, including via telehealth, consider a payment mechanism for pediatric community health teams to coordinate care between their primary pediatric provider and all others serving the member, allow schools and day cares to assess children for ACEs for pediatric care, global capitation, monitor frequency of referrals for services. • **Regarding SDOH**: references the MassHealth Community Health Partners/risk adjusted model of care and encourages and incentivizing universal SDoH screening/closed loop referral systems. Recommendation that EOHHS establish strategies and target investments in upstream factors to address SDOH at the statewide level, while also requiring MCOs/AE to directly invest in SDOH. Adopt use of IMAT/flat files and make data available to parties online, consider reimbursing for social care services through Medicaid like North Carolina's Healthy Opportunities or California's In Lieu of Services within CalAIM.

V. Member Enrollment		
Questions	**Number of Respondents**	**Summary of Responses**
1. In order to provide enrollees with an opportunity to make an informed choice amongst all contracted MCOs, EOHHS is considering an open enrollment process. The open enrollment would require **all** members to actively select an MCO following the procurement, with impartial member choice counseling available. 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 MCO selection, thereby reducing MCO auto-assignment? Should AE and primary care provider education and selection be considered as part of the MCO enrollment process at initial or open MCO enrollment?	12	• Most express support for use of an Enrollment Broker to meet all state and federal regulations for independent member choice counseling. • Early implementation of a diverse member outreach strategy that is available by phone, in person, mail, text, online to include a "live chat" feature for both on-line and mobile applications ensuring messaging to members is consistent across all formats, including language preference and member literacy. • Members should be consulted and engaged in the design and development of the outreach and education strategy. • Require coordination between enrollment broker and HSRI to address member needs and reduce confusion if members move between Medicaid and exchange coverage programs. • Develop and implement member decision making tools that consider provider participation, current medications, and value-added benefits and services. • Most respondents expressed support for PCP selection at the time of MCO enrollment. Several respondents felt that AE selection at the point of enrollment would be complex and that more education about AEs is needed in order to move to a more AE-centric enrollment. • Consider requirements for attributed AE be included in addition to PCP on member ID cards. • Support for an open enrollment for all members was mixed. Some respondents supported an open enrollment that is supported by an independent choice counselor, but other respondents felt that this could disrupt care and be a challenge for members, especially those with low literacy or those that are non-English speaking. One respondent recommended existing members receive notice that they will be re-enrolled with their existing plan, if available, unless they take action to select another MCO during the open enrollment period.
2. For members who do not make an active MCO selection during initial and open enrollment periods, EOHHS applies an auto-assignment algorithm to assign members to an MCO.	10	• The main factors that should be taken into consideration include the ability to keep families and case members together, as well as previous provider, PCP relationships, prior enrollment with an AE or MCO, and MCO capacity. • Most respondents did not recommend AE/MCO exclusivity relationship citing the small Medicaid population and market in RI as not being conducive to this type of policy and concerns regarding the current consolidation in RI's system of care that could limit member access to services/facilities and overall choice.

V. Member Enrollment		

EOHHS currently uses a weighted algorithm that assigns members to among contracted plans. EOHHS may consider changes to the auto-assignment process to assign members to higher performing MCOs (e.g., MCOs with higher quality and member satisfaction ratings, expanded access to care, high financial performance, and AE affiliations). What factors or metrics should EOHHS consider when auto-assigning members to an MCO?		• Several respondents recommended that minimum enrollment thresholds be established for new entrants that focus on demonstrated RI experience and partnerships to assist BIPOC, and that consideration be given to equal distribution of membership across all MCOs.
		• Auto-assignment recommendations included:
		  ○ Distribution of members based on strength of MCO network, existing provider relationships and investments in CBO/Programs.
		  ○ Plan equity and market share equality.
		  ○ Assigning members to the plan with the lowest enrollment unless change would disrupt AE or provider alignment.
		• Once the initial market is well established, future auto-assignment considerations could include regional HEDIS performance, CAHPs scores, and compliance on administrative and access measures.

3. Currently, upon determination of Medicaid eligibility, individuals select (or are auto assigned to) an MCO. MCOs attribute their members to an AE based on primary care provider selection or provider utilization data. If EOHHS considers changing the process to require members to select (or be auto assigned to) an AE upon determination of Medicaid eligibility and then make an MCO selection based on AEs who are contracted with the MCO, what are the benefits of this alternative approach?	12	• Most respondents supported the selection of an MCO vs. an AE and to include requirements for MCOs to help their members find the best AE at the time of enrollment, citing AE confusion and lack of enrollee education regarding AEs. Respondent suggested requiring MCOs' consideration of AE enrollment could be something considered in the future after additional education is provided by the MCO regarding AEs. • One respondent recommended EOHHS either standardize benefits or provide the option to select either an AE or MCO. • Some respondents reiterated concern regarding the potential for AE/MCO relationship exclusivity, citing the small Medicaid population and market in RI as not being conducive to this type of policy.

V. Member Enrollment		
What are challenges to this alternative and how could EOHHS mitigate these challenges? Are there other approaches that EOHHS should consider to encourage members to choose their own AE?		
4. Some states implement enrollment caps including minimum and maximum sizes for each MCO. Should EOHHS implement similar rules around membership size that would potentially restrict the total number of Medicaid enrollees any one (1) MCO can have? What factors should EOHHS consider when determining the total number of enrollees each contracted MCO should have?	9	• Support for minimum enrollment thresholds was mixed and included the following: ○ Equal distribution of membership across all MCOs by the time of contract award in order to accept full risk and achievement of TCOC targets. ○ Consider a maximum and minimum size for enrollment in each MCO as part of a revamped approach to enrollee distribution for those who do not affirmatively select an MCO. ○ Caps create disruption in the market and limit member choice. ○ All vendors, including any new entrant, should have the ability to earn membership based on merits of their performance and not on systematic manipulation. ○ Any minimum membership target for MCOs should be in partnership with actuarial experts. • Auto-assignment recommendations included: ○ Distribution of members based on strength of MCO network, existing provider relationships and investments in CBO/Programs. ○ Plan equity and market share equality. ○ Assigning members to the plan with the lowest enrollment unless change would disrupt AE or provider alignment. • Once the initial market is well established, future auto-assignment considerations could include regional HEDIS performance, CAHPs scores, and compliance on administrative and access measures. • One respondent also recommended EOHHS limit the number of MCOs to ensure viability.
5. What steps should EOHHS take to manage care transitions between the FFS delivery system and managed care to ensure continuity of care for individuals who choose or are assigned to a new MCO due to EOHHS'	11	• Respondents cited the following key drivers for improving continuity and coordination of care during transitions: ○ Real-time bi-directional data sharing, to include care/treatment plans, SDoH data, prior authorizations, claims, prescriptions, and clear communication protocols. ○ Establishing continuity of care policies and procedures. ○ Extended (6-month) authorizations for non-network providers/medications. ○ LTSS/HCBS service plans and assessments. ○ Extension of FFS 60-day transition period to 6 months.

V. Member Enrollment		
redistribution of the membership?		○ Including detailed information on the 834 enrollment files transmitted from EOHHS to the MCO, including care management flag, race, ethnicity, language, program eligibility, contact information (address, phone, email), and preferred providers. • EOHHS should look to best practices from other states to including NC, GA and TX.
6. There are several Medicaid eligibility groups who do not receive services through the managed care delivery system, e.g., non-duals with long-term service and support needs, Medicare-Medicaid individuals (dual-eligibles). Should EOHHS consider including any of these additional eligibility groups in managed care? If so, please describe which eligibility groups should be considered for inclusion and the timeframe for transitioning these groups to managed care.	13	• Respondents recommended detailed and consistent outreach to educate members, including an online tool for LTSS provider identification that would also allow enrollment. Also consider aligning Medicaid and Medicare eligible individuals into a single health plan based on the member's active Medicare enrollment choice. • Most respondents commented that an integrated, person-centered model of care management for all Medicaid covered services delivered through a single coordinating source is the most effective model. However, EOHHS should consider this transition deliberatively and cautiously. • Most recommend EOHHS consider a staggered implementation to integrate LTSS and the duals population into an MLTSS program a year or two after the next iteration of Medicaid Managed Care goes live, to give the MCOs enough time to get established with less complex populations and establish contracts and relationships with LTSS providers, and for EOHHS to solicit stakeholder and advocate feedback on shaping the program. This could include maintaining non-dual members who quality for LTSS in their MCO for medical and behavioral health services with strong care coordination requirements for LTSS and other FFS covered benefits. • Some supported the movement to include all populations and services in current planning as long as actuarially sound and risk-adjusted rates were applied. Including these populations in managed care will improve their health outcomes and quality of life and will allow the state to achieve budget predictability. • EOHHS should continue with the current Medicare-Medicaid (MMP) model in addition to expanding the Medicaid Managed Care program to provide an integrated plan option for non-dual individuals with LTSS needs. This will facilitate the alignment between the goals of VBP transformation in the Medicaid and Medicare Programs.

VI. COVID-19 Impacts/Telehealth/Data		
Questions	**Number of Respondents**	**Summary of Responses**
1. What programmatic flexibilities adopted during the COVID-19 pandemic should be continued beyond the public health emergency?	13	• Continue increased use of technologies such as Zoom, telehealth, phone visits, asynchronous visits, and remote patient monitoring. Consider providing members with technology/tools needed for digital engagement (tablets, etc.). • Relax restrictions on services such as medication refills without service limitations. • Continue payment for services provided via telehealth under sustainable rates, including for BH.
2. What have you learned through responding to the public health emergency that we should incorporate into an MCO contract? What opportunities do you see for continuing positive trends (for example in emergency department utilization)?	11	• Recommendations include: o Incorporating controlled reimbursement for MCO-sponsored device and connectivity distribution programs in future state plan amendments. o Having MCOs replicate the current Care Transformation Collaborative of Rhode Island (CTC-RI) Community Health Team (CHT) system of service delivery. o Continuing expanded/flexible policies for telehealth and form a collaborative workgroup/Telehealth Advisory Council to ensure continued communication in this area, including EOHHS, MCOs, and providers. o Encouraging contracts that incentivize community-based alternatives to skilled nursing facility (SNF) stays. o Increasing coordination for BH community/crisis interventions. o Establishing Health Equity dashboards and enhanced connectivity and data sharing between MCOs and providers. • Noting disproportionate impact of the pandemic on communities of color, one respondent advised annual quality initiatives to address health disparities, 1115 waiver authority to reimburse for CHWs, care coordinators and/or medical assistants deployed as front-line caregivers. • Business continuity plans must account for mitigation of emergency on employees, community partners, and stakeholders, as well as members and providers.
3. How can EOHHS and MCOs better support providers in preparing for future public health emergencies?	11	• Provider structural/flexible funding to support provider response to PHEs. • Allow MCOs flexibility to anticipate and deploy necessary measures outside of normal operations in an emergency. • Provide MCOs standard preparedness checklists for PHE situations addressing access to care and communication plans. • Encourage MCOs to deploy nurses for follow ups where possible to free up physicians for emergency care. • Consider deployment of an electronic referral platform for SDOH needs. • Explore partnering with NACHC to expand FQHC use of telehealth.

VI. COVID-19 Impacts/Telehealth/Data		
		• Facilitate PPE donations to providers. • Encourage partnership with AT&T for increased broadband for providers. • Conduct post-PHE workgroup meetings to identify lessons learned and document for future.
4. Describe the strategies an MCO might employ to help EOHHS address the negative budgetary impacts of the economic downturn while maintaining a person-centered, value-based delivery model.	7	• Continue use of telehealth as during the pandemic. • Allow MCOs flexibility to provide interventions to address poverty, including job training, housing, food and other HRSNs. • Move FFS populations into managed care and implement aggressive VBP arrangements; reinvest in access/health equity and delivery systems. • EOHHS should provide MCOs with as much information as possible in advance to avoid having members' coverage lapse due to incomplete redetermination paperwork or other communications barriers. • Make considerations for the fixed costs provider agencies are responsible for, especially in delivering evidence-based services. • Continue strong fraud, waste, and abuse monitoring and remediation.
5. How can EOHHS encourage all stakeholders (e.g., MCOs, providers, members, caregivers, advocates) to better utilize telehealth and other technologies 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?	10	• EOHHS should develop a quality performance improvement project (PIP) aimed at increasing access to telehealth tools; support staffing to assist members and others in the use of telehealth. • The state should also invest in lower cost Wi-Fi for low-income individuals, as well as cell phones and telehealth. • Partner with CBOs, broadband companies, municipal governments. to increase access to technology to support telemedicine. EOHHS should also promote the Federal Communications Commission Emergency Broadband Benefit once start date has been announced. • Convene a workgroup dedicated to timely data exchange, standardization of data between parties. • Consider adding home-monitoring technology to the list of in lieu of services as a diversion service for ED and inpatient hospital care. • Engage with multiple stakeholders in the community to promote equitable use and access to telehealth technologies.
6. How can EOHHS ensure MCOs are using and sharing complete, accurate, and actionable data with contracted medical providers	8	• Suggests establishing timely or real-time access to a central source of member data for all stakeholders either within or aligned to the Medicaid Management Information System (MMIS). • Increase transparency and reduce duplication in data. • Set contract requirements for data sharing with LDs for failure. • Data should include member rosters, claims that allow TCOC and utilization to be trended over time, monthly care gaps, monthly performance, and outcome reports.

VI. COVID-19 Impacts/Telehealth/Data		
and AEs to enhance care quality and delivery?		• Conduct centralized audits of data completeness by MCOs on a regular basis. • Increase use of the HIEs to further comprehensive data transmission and leverage them to respond to public health and population health needs. • Research other state data sharing resources.
7. How can data sharing between MCOs, AEs, and EOHHS be enhanced or modified to improve the cost and quality outcomes in the AE program?	8	• Work toward point of service cost transparency. • Require all state vendors providing services or goods to Medicaid members to have BAAs and share member data with Medicaid MCOs. • Facilitate bidirectional data exchange with HIEs. • Recommend EOHHS actively encourage and incentivize providers, including hospitals and facilities, to establish and maintain connectivity to CurrentCare and use EHRs and HIT. • Support the addition of SDoH data to IMAT.
8. What policy levers should EOHHS consider as part of the MCO procurement to advance Rhode Island's Health IT Roadmap?	6	• Use and expansion of synchronous, asynchronous, remote patient monitoring, and device-based information sharing telehealth modes through expanded incorporation in the State Medicaid Plan for all methods and reimbursements. • Consider an infrastructure investment to create a clearinghouse for AEs, MCOs, IHH and other CBOs to identify member attribution. This will improve care coordination and collaboration. • MCOs should form multidisciplinary IT policy teams and meet with providers and their teams regularly to review processes, evaluate efficiency, and collaborate on solutions. • Develop a unified approach to health IT portals. • Continue migration toward IMAT implementation. • Consider policy revisions to improve implementation of population health management initiatives and enable mainstream HIT use, and payment parity to sustain meaningful use of data exchanges.

VII. MCO Financing and Comprehensive Risk		
Questions	**Number of Respondents**	**Summary of Responses**
1. EOHHS is interested in ensuring that program administration funding is used in the most efficient manner. Please provide suggestions and information related to approaches for EOHHS to consider to assist with managing	9	• There was some support for a transition to full risk and elimination of risk corridors, but elimination be coupled with additional MCO quality withholds tied to appropriate outcomes that align with state-based goals and initiatives. • Several respondents expressed support for continued net neutral risk adjustment mechanisms to ensure that those MCOs with the highest risk members are appropriately compensated, citing that this would reduce need for -/+ MLR. • Respondents cited administrative care management and quality activities as key components of the MLR numerator to encourage program innovation. • Further recommendations for managing administrative expenses/load included:

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administrative spending amounts while encouraging innovative investment in the Rhode Island Medicaid managed care program.		○ Dividing administrative expense data into HCQI (CM/medical management, IT to reflect innovative investments) and general administrative costs (claims processing, call center, finance). ○ Less focus on how administrative funding is spent and more on how well MCOs are efficient and providing adequate funds to administer the program, investing in innovation, and accomplishing EOHHS' performance targets/goals. ○ Consideration of a 6-8% administrative load as the general standard within Medicaid managed care rates and supports MCO innovation investments. ○ Consideration of a comprehensive review and streamlining of administrative aspects of the program including, but not limited to, AE program oversight and operational reporting. • One respondent suggested authorization and contracting can be done at the provider level to reduce administrative costs. • One respondent advocated for fewer AEs and more concentrated AE-MCO infrastructure. • One respondent suggested that EOHHS develop a form of financial credit for long-term health-related investments by MCOs in underserved communities.
2. EOHHS is interested in increasing the amount of financial risk that MCOs should take in our contract structure, for example by reducing or eliminating the risk- and gain-share corridors that exist in the current contract. What strategies can EOHHS consider to facilitate a successful transfer of financial risk from EOHHS to the MCOs? What strategic or operational approaches could MCOs adopt to succeed without a risk corridor while not sacrificing quality of care for members?	10	• Most respondents stressed the need to ensure capitation rates are actuarially sound. • Respondents generally supported the removal of risk corridors, but recommended EOHHS consider the following: ○ Increase the amount of the at-risk quality withhold tied to outcomes along with risk adjustment to provide premiums to those MCOs with high-risk members in a net neutral way to the state. ○ Aligning risk and care management. ○ Adding other populations into managed care, which could require continuation of a risk corridor specifically to address the population, e.g., LTSS population. ○ Adjust base rates and establish standard fee schedules. ○ Ensure sufficient membership scale across MCOs in order to accommodate risk sharing. ○ Implement additional risk-mitigation mechanisms, including high-risk stop loss, concurrent risk adjustment, and right-sized risk corridors. ○ Request MCOs provide supplemental encounter submissions to improve clinical documentation, reduce administrative burden for providers by reducing the need for provider claim adjustments, and enable the submission of additional diagnosis beyond the current 10-diagnosis limit. ○ If risk and gain-share corridors are removed, provide allowances for a 5% difference between the pricing/capitation rate MLR and the minimum MLR of 85%, to allow the MCOs to retain

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		surplus in good years to offset losses in bad years yet achieve the target pricing MLR over the long run. ○ Provide an adequate risk margin/underwriting gain in the capitation rates. • A few respondents advised against elimination of risk corridors and suggested expanding them from the current levels to match industry benchmarks citing risk share/gain share has helped to save costs and improve patient outcomes. • Further recommendations centered on allowing permissible flexibility or a phased approach around risk-sharing arrangements between the MCO and AE to allow the MCO and AE to move toward meaningful risk-bearing at the pace that best suits the partnership's needs and goals.
3. EOHHS recognizes the importance of MCOs maintaining sufficient Risk Based Capital ("RBC") levels. Please provide information related to how MCOs or EOHHS can balance safeguards for MCO solvency and allow for cost effective financing of the program.	6	• Contracts should be with MCOs who have demonstrated fiscal stability. • EOHHS should meet with current and potential contractors to discuss and agree on the upper and lower bounds of risk-based capital (RBC) and other reserves that will best meet the State's goals of ensuring MCO solvency and enhancing cost effective program financing, both initially and annually based on financial results of each MCO. • Respondents cited best practice levels for RBC at 350% -500% as the industry standard for Medicaid MCOs to protect against insolvency and ensure continuity of benefit coverage and provider payments. • One respondent noted the shift in risk arrangement may necessitate higher RBC reserves. • After program implementation, EOHHS should require MCOs that have poor financial results to produce a plan to restore at least break-even performance and then monitor financial performance quarterly. EOHHS should also require these MCOs to monitor and report on market aggregate performance on an annual basis to retrospectively evaluate actuarial soundness of funding and, in the event of funding shortfall, make timely adjustments.
4. It is common for MCOs to purchase reinsurance coverage to reduce risk associated with low frequency, high-cost events. Please provide input related to the potential for additional MCO contracting requirements related to specific level(s) and/or type(s) of reinsurance coverage.	6	• EOHHS should set requirements for parental guarantees, MCO surety bonds, and establishing solvency standards that confirm participating MCOs and their parents, affiliates and subsidiaries have not filed (or had filed against them) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee or assignee for the benefit of creditors in the last 10 years. • EOHHS should meet with MCOs to discuss reinsurance coverage requirements. • MCOs should have the flexibility to determine its need for reinsurance, but excess-of-loss coverage limits (reinsurance) should be at least $5M. • Require MCO reinsurance to cover a large portion of costs for members whose annual claims totals exceed $1 million. • Distribution of initial enrollment equally across MCOs is important to distribute risk across all MCOs. • EOHHS should consider programs like the Hepatitis C Program that has limited or no risk to the plan for high cost, low frequency events.

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5. Pharmacy pricing, contracting, and transparency have become a topic of discussion for Medicaid programs across the country. Please provide suggestions for EOHHS's consideration related to policy changes that could assist with controlling pharmacy costs while increasing quality, accountability, and transparency of the pharmacy benefit in the Rhode Island Medicaid managed care program.	6	• Respondents offered EOHHS the following polices and processes for consideration to address quality, accountability, and transparency within the RI pharmacy benefit: ○ Establishing pharmacy benchmark reports by population and diagnosis. ○ Requiring transparency of ownership of PBMs and MCO-owned pharmacies to demonstrate equal payments across all pharmacies in-network by to including required reporting of ingredient costs to NADAC or other benchmarks to ensure prices are not inflated inappropriately. ○ Forbid mail order prescriptions but allow for 90-day refills. ○ Meet with MCOs to identify and develop solutions related to high-cost, breakthrough, and other financially challenging drugs new to market. ○ Require stand-alone Medicaid pharmacy contracts between pharmacy providers and pharmacy benefit managers (PBMs). ○ Allow for the substitution of biosimilar drugs and referenced biologic drugs at the point of sale, similar to generic substitution for brand. ○ Prohibit 340B contracted pharmacies from using 340B-purchased stock to bill Medicaid claims and require 340B covered entities to submit their 340B acquisition costs when billing Medicaid claims. ○ Allow MCOs to develop pharmacy payment methodologies, including risk share arrangements for specialty care and specialty drugs, and reimbursement of pharmacists for hemoglobin A1C, blood pressure, and medication-assisted smoking cessation counseling. • One respondent noted improving medication adherence, engaging members in care management, addressing under- and over-utilization of services, avoiding potential drug interactions, and integrating medical and pharmacy claims would further support EOHHS' commitment to reducing administrative burden, lowering pharmacy costs, and increasing transparency. • One respondent also mentioned support for state-based and northeast coalition efforts to reduce drug price increases. • EOHHS could continue the reinsurance model for high-cost drugs, like the Hepatitis C Program. • Respondent's comments were mixed regarding carve out of high cost or any drugs from the managed care program.
6. EOHHS recognizes that MCOs may utilize subcontracting relationships for meeting the requirements of the Rhode Island managed care program. In addition, EOHHS	7	• Respondents offered the following approaches to increase transparency and accountability of MCO subcontractors: ○ Require MCOs to disclose all material subcontractors regardless of relationship with the MCO and conduct pre-delegation, implementation, and ongoing oversight in accordance with NCQA Health Plan standards with reports to EOHHS on the results, especially before performing work.

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recognizes that some of these subcontracted entities may be related entities (owned by the same parent company as the MCO). Please provide information related to approaches EOHHS could consider that would increase the transparency and accountability of these relationships.		○ Require MCOs to have written agreements with all subcontractors that fulfill state and federal Medicaid managed care program requirements and make those agreements available to EOHHS for inspection. • Respondents also recommended MCOs disclose their ownership status for any subcontractors, PBMs, utilization review agents, or others and limit the rates paid to these related entities to no more than the actual costs for such services (or a variation thereof that limits the profit on such services) similar to the Medicare "related party" rule, and further disclose the associated payment and profit for each related entity each year.

VIII. Other		
Questions	**Number of Respondents**	**Summary of Responses**
1. EOHHS is considering rebranding of the managed care program serving the current RIte Care (children and families, including children with health special health care needs and in substitute care), Rhody Health Partners (qualified aged, blind, and disabled adults), and Medicaid Expansion (adults nineteen to sixty-four years of age) populations. Do you have recommendations on the brand name EOHHS could consider for this program?	4	• Recommends using RIte Care for the entire Medicaid program, noting the positive reputation and current name recognition associated with that term. • Other suggested names: ○ Care in Action ○ CareWorks and CareWorks Kids ○ TeamHealth ○ Generation Healthy ○ Rhode Island First Health Plan ○ "My Health" Plan or "Your" Health Plan ○ Healthy Me
2. Is there any other feedback that you would like to provide on the current or	6	• Increase transparency in communication regarding quality and rates and improve engagement with providers. • Strengthen oversight of MCOs and increased oversight of agencies by the Secretary.

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future program that we should consider?		• Support for an enrollment algorithm that allows for member choice. • Support for redistribution of membership across MCOs. • Suggestion that procurement be delayed allowing for more stakeholder engagement and assessment of federal COVID funding. • Carve in LTSS population and adopt a blended rate.

EOHHS will use the information gathered from the stakeholder process and this RFI to make future policy and programmatic decisions to be incorporated in a formal RFP. EOHHS intends to issue the RFP in the summer of 2021, selecting up to three (3) vendors for new contracts with an operational start date of July 1, 2022.

On March 20, 2021, EOHHS made available (via U.S. mail, online e-mail correspondence, social media outreach and posting on the agency website) a survey to obtain further input from current Medicaid managed care enrollees regarding the services and care they receive through the Medicaid managed care program. EOHHS intends to continue seeking input from stakeholders, pending the release of the RFP, to identify additional innovations and opportunities for improvement within the current managed care program.

The survey can be accessed here: https://www.surveymonkey.com/r/Rhode_Island_Medicaid_Member_Survey