Rhode Island Memorandum of Understanding: What Advocates Need to Know

Introduction

The Centers for Medicare & Medicaid Services (CMS) and the State of Rhode Island Executive Office of Health and Human Services (EOHHS) entered into a Memorandum of Understanding (MOU)[1] in July 2015 to pursue a dual eligible demonstration project. The MOU outlines the terms of what will eventually be a three-way contract between the federal government, the state and the selected health plan[2] that will provide integrated Medicare- and Medicaid-covered benefits to dually eligible individuals. The demonstration will run statewide, offering approximately 30,000 Medicare-Medicaid eligible individuals (dual eligibles) the opportunity to enroll.

When launched, the demonstration will represent full implementation of Rhode Island's *Integrated Care Initiative (ICI)*, which was designed to roll out in two phases.[3] Phase I of the ICI, began in November 2013, established the Rhody Health Options (RHO) Medicaid managed care program, called Unity.[4] In RHO, Medicaid members – including Medicare-Medicaid enrollees – enroll in a health plan that coordinates their Medicaid services, including long-term services and supports (LTSS). Under the newly signed MOU, a qualifying RHO plan, in this case only one plan is selected to serve – Neighborhood Health Plan of RI (NHP-RI). NHP-RI will be contracted to serve as a Medicare-Medicaid Plan (MMP) and will be called Integrity, to cover Medicare benefits in addition to the existing set of Medicaid benefits it currently offers dually eligible members, allowing for an integrated set of benefits for these enrollees.

This fact sheet provides consumer advocates with the basics on the MOU and key issues to monitor.

Enrollment

[1] See MOU: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/RIMOU.pdf
[2] In Rhode Island there will only be one health plan, the Neighborhood Health Plan of Rhode Island.
[3] See http://www.eohhs.ri.gov/IntegratedCare.aspx
[4] See http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RHO%20fact%20sheet%20%209-5-14.pdf

Highlights

- Eligible populations for enrollment include: the elderly, people with disabilities, individuals with intellectual and developmental disabilities (ID/DD),[5] and individuals with severe and persistent mental illness.[6]
- Enrollment into the ICI will begin with an active opt-in period and services for enrollees will begin winter 2016.[7] The opt-out or passive enrollment period will be phased in over the course of at least six months, post opt-in period. The opt-in period will be for people who are not currently enrolled in RHO (or Unity). The opt-out/passive enrollment will be for consumers who are enrolled in RHO.
- The state will use an intelligent assignment method for passive enrollment. This means the state will take into account continuity of providers and services, previous Medicaid managed care enrollment and historic provider utilization.
- Information about Program of All-inclusive Care for the Elderly (PACE)[8] will be provided in outreach and educational materials.

Cultural Competency & ADA Compliance

- All care must be provided in compliance with the Americans with Disabilities Act (ADA) and *Olmstead* decision. This means the MMP must contract with providers that demonstrate the ability to offer physical access and flexible scheduling.
- The readiness review process[9] will take into account that the participating MMP must require disability literacy training for its medical, behavioral and LTSS providers in ADA-compliance including concepts such as communication access, medical equipment access, physical access and access to program.
- Provider system records on provider and facility networks will include information on ADA accessibility of each provider office.
- The comprehensive functional needs assessments (CFNA) and wellness assessment[10] tool must include cultural and linguistic preferences of the enrollee.
- The MMP will ensure that the Interdisciplinary Care Plan (ICP) is written in a culturally and linguistically appropriate style that helps build the enrollee's health literacy, while considering the enrollee's overall capacity to learn and to self-direct his/her services.
- The MMP will have policies and procedures in place to conduct cultural competency and disability training to ensure that staff deliver culturally-competent services as well as oral and written enrollee communications. Cultural and linguistic training will be provided to all in-network providers, as well.

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[5] Certain services for the ID/DD populations are considered "out-of-plan" and will be through the Medicaid fee-for-service delivery system. See MOU Appendix 7 pg. 93.
[6] For more detail on eligible and non-eligible populations see MOU pg. 7.
[7] The MOU states opt-in services will begin December 1, 2015; however, the state is considering pushing the date back.
[8] To learn more about PACE see https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html.
[9] See Readiness Review Tool: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/RIRRTool.pdf
[10] For enrollees who reside in a nursing facility at the time of enrollment and do not have a desire to return to the community, the MMP must complete a Wellness Assessment within 120 days of enrollment.

- The provider handbook must include information on how to access language lines and resources for providers on how to provide culturally, linguistically, or disability-competent care.

Long-Term Services and Supports

Highlights

- The MOU lays out a strong statement in the demonstration goals about enabling individuals to "live independently" and self-direct their care, and to improve quality of life.[11]
- There are strong policy and practice provisions to promote rebalancing from nursing homes to community care, including:
    - The MMP must identify nursing facility residents on a quarterly basis who want to, or have the opportunity to, live in the community through a discharge opportunity assessment and conduct this within 30 days. Once identified, the MMP must develop a person-centered Community Transition Plan to support reintegration, including assignment of a transition care manager.
    - For those nursing facility residents who do not want to return to the community, the MMP must schedule a wellness assessment and complete it within 120 days.
    - There are several state-selected quality withhold measures that encourage rebalancing such as: nursing home diversion in year 1; and nursing home to community transition in year 2.
    - There are several quality measures that relate to rebalancing such as: long-term care overall balance measure, nursing facility diversion, and nursing facility transition measure.
    - The MMP will report on areas related to rebalancing from institutional to HCBS settings; further details will be outlined in the three-way contract.
- The MOU outlines strong continuity of care provisions[12]:
    - Enrollee can continue to received authorized services and see current providers for up to 6 months or until ICP is completed, whichever comes first.
    - The MMP must maintain providers at no less than the Medicare or Medicaid FFS rate.
    - The MMP must maintain necessary services for enrollees through either contracts or by single-case agreements to meet needs
- The MMP must include family member(s) in the care assessment and care team, if authorized by the consumer.
- The care plan for the enrollee includes[13]:
    - Measures to reduce risks without restricting the Enrollee's autonomy to undertake reasonable risks to achieve life goals

[11] See MOU pgs 1-2, 68-69.
[12] See MOU Appendix 7 pgs 94-95.
[13] See MOU Appendix 7 pg. 85-87.

- Interventions, including community living support needs, self-direction services and supports

- Other necessary interventions such as housing needs, legal and/or recreational services.

Care Delivery/Coordination Model

Highlights

- Enrollees will have access to care management services and care coordination services that fit their particular needs and will have access to a Lead Care Manager (LCM)[14], care coordinators and care management staff.[15]
- Those who are eligible for LTSS and others who are identified as high risk will get Intensive Care Management led by a LCM.
- The care management model[16] must be person-centered, based on an Interdisciplinary Care Plan (ICP) developed by the interdisciplinary care team (ICT)[17] and encourage residence in a community setting over institutional placement.
- The assessment process will have two main components: (1) an initial health screening (IHS) for those not eligible for LTSS and (2) comprehensive functional needs assessments (CFNA) for those who are eligible for LTSS or otherwise determined as high-risk.
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    - The IHS will be developed by the MMP and must be approved by the state. In the first six months of the demonstration, the MMP will be required to conduct the IHS over the phone within 180 days to those enrollees not eligible for LTSS or in the high-risk category.[18] After six months of operation, the MMP must conduct IHS within 45 days.

    - For enrollees who are eligible for LTSS and those determined to be at high-risk based on the IHS and other sources, the MMP must complete a CFNA (tool must be approved by the state) based on the following timeframes.

[14] Only consumers who have LTSS or are at high risk have a Lead Care manager. Consumers at low or moderate risk have "access to" a care coordinator or care manager.
[15] For more detail on requirements for lead care manager, care coordinator and care management staff see MOU Appendix 7 pgs. 79-82.
[16] See MOU Appendix 7 pgs. 68-70 for full list of objectives for the care management model.
[17] For more detail on the requirements for the interdisciplinary care team see MOU Appendix 7 pgs. 83-86.
[18] See MOU Appendix 7 pg. 72-73.

Enrollee Type	Timeframe for CFNA
Non-LTSS high-risk (living in the community)	15 days after IHS completion; in person and in enrollee's home
Community LTSS (living in the community, not enrolled in an RHO plan (opt-in individuals)	180 days after effective enrollment date during the first six months the demonstration is operating After six months of operation, assessment must be done no later than 15 days after effective enrollment date
Community LTSS (living in the community, currently enrolled in an RHO plan (opt-out individuals)	Any previous assessment done by RHO plan will be shared with care team within 30 days If prior assessment was conducted 180 days or more prior to demonstration enrollment, enrollee will be reassessed

- Comprehensive re-assessments must be done on an ongoing basis based on changes in an enrollee's condition or needs that call for a reassessment. [19]

Benefits and Provider Networks

Highlights

- The MMP must ensure that their provider networks are sufficient in number, mix, and geographic distribution to meet the complex and diverse needs of the enrollees.
- The MMP must adhere to Medicare requirements for network standards. This includes elements such as time, distance and/or minimum number of providers or facilities.
- The MMP must provide coverage to enrollees on a 24 hour per day, 7 days a week basis either directly or through enrollee primary care provider.
- Home and community based services must be available 24 hours per day, 7 days a week and in place within 5 days of a determination of need.
- Through the demonstration, enrollees will have access to all Medicare and Medicaid benefits including those available through 1115(a) demonstration waiver.
- The State and CMS can consider adding supplemental benefits in years 2 and 3 such as pain management, Screening, Brief Intervention and Referral to Treatment (SBIRT) and non-medical transportation.
- Certain benefits will be available to enrollees through Medicaid fee-for-service (FFS) rather than through the MMP benefits; these include dental and non-emergency

[19] For the list of reasons that call for reassessments and more detail on assessment process, see MOU Appendix 7 pgs.72-79

transportation services. MMP will be required to refer and coordinate the out-of-plan benefits.

Consumer Engagement

- MMP will be required to obtain enrollee and community input on issues related to program management and enrollee care through a range of approaches.
- MMP must establish at least one Enrollee Advisory Committee (EAC) that meets quarterly. The EAC composition will reflect the diversity of the demonstration population, including participation of individuals with disabilities, within the governance structure. MMP will also be encouraged to include enrollees on their board of directors.
- EAC members and ombudsman staff will be invited to participate in the State's ongoing stakeholder process, which will consist of a variety of feedback-gathering methods, including surveys, focus groups and regular meetings.

Financing and Payment

- The demonstration is expected to achieve savings of 1 percent in Year One, 1.25 percent in Year Two and 3 percent in Year Three. The savings for Year 3 will revert to 1.5 percent if Year 1 losses are more than 3 percent.
- The Medicaid portion of the capitated rate is determined by assigning each enrollee to a rating category. Medicaid will be using four rating categories.[20]

Rating Category	Rating Category Descriptions
1	Enrollees eligible to receive community or facility-based long-term services and supports[21]
2	Enrollees residing in the community who are *not* eligible to receive LTSS
3	Enrollees with Severe and Persistent Mental Illness (SPMI)
4	Enrollees with Intellectual or Developmental Disabilities (ID/DD)

[20] See MOU Appendix 6 pg. 47.
[21] This rating category is a blended rate that includes enrollees eligible for community-based and facility-based LTSS, and will reflect transition assumptions between the two LTSS settings.

- The quality withholds, where both payers (Medicare and Medicaid) withhold a percentage from capitation rate until the MMP demonstrates that it has met certain quality measures, will be 1 percent in year one, 2 percent in year two and 3 percent in year three.
- MMP will be required each year to meet the minimum Medical Loss Ratio (MLR) of 85 percent. CMS and EOHHS will use risk corridor tiers to address potential gains/losses by the MMP.

Year 1	Risk/Reward	Year 2	Risk/Reward	Year 3	Risk/Reward
Greater than 5% gain/loss	MMP would bear 10% risk/reward; 90% share by EOHHS and CMS	Greater than 6% gain/loss	MMP would bear 10% risk/reward; 90% share by EOHHS and CMS	Greater than 7% gain/loss	MMP would bear 100% risk/reward
Between 1.5%-5% gain/loss	MMP would bear 30% of the risk/reward; 70% share by EOHHS and CMS	Between 2%-6% gain/loss	MMP would bear 30% of the risk/reward; 70% share by EOHHS and CMS	Between 2.5%-7% gain/loss	MMP would bear 30% of the risk/reward; 70% share by EOHHS and CMS
Between 0-1.5% gain/loss	MMP would bear 100% risk/reward	Between 0-2% gain/loss	MMP would bear 100% risk/reward	Between 0-2.5% gain/loss	MMP would bear 100% risk/reward

Key Issues to Watch

- **Passive enrollment:** The State is working on an intelligent assignment process for passive enrollment, but does not offer details on how this will be implemented. The three-way contract should specify that the State will take into account previous provider relationships and LTSS needs and usage in assigning enrollees to the MMP.
- **MMP capacity/competency:** The readiness review process must ensure that the MMP has the capacity and competency to provide LTSS, including the self-direction option, and to determine how it will provide supports to consumers to facilitate self-direction.
- **Cultural competency:** The language in the MOU on cultural competency is a step in the right direction; CMS and the state should incorporate stronger requirements in the three-way contract to ensure MMP compliance so that services are delivered to enrollees in a manner preferred by them.[22]

[22] For recommendations on enhancing the cultural competency requirements see: Miles to Go: Progress on Addressing Racial and Ethnic Health Disparities in the Dual Eligible Demonstration Projects.

- **Person-centered care:** Although the MOU says care must be person-centered, few of the policies empower the consumer. CMS and the state should include in the three-way contract stronger language around:
    - The definition of LTSS. Currently the definition is narrow and does not include specifics like training providers on independent living and recovery philosophies.[23]
    - The assessment process, which must be conflict-free and explicitly include consumer goals.
    - The care plan and care team, which must be led by the consumer. The MOU states that the consumer is a "collaborator" along with family, caregivers, PCP and other providers, led by the Lead Care Manager (LCM). Qualifications of the LCM should include independent living and LTSS experience and should be spelled out further in the three-way contract.
- **Financing:** There are several concerns related to the financing and payment mechanisms:
    - While the savings expectations are lower than in MOUs from other demonstration states, it is still an area of concern given there is no backup evidence for the expected savings target. Also, given the experiences of the other demonstrations thus far, we know that it takes time to make a new system of care work. CMS and the State should consider lowering or eliminating the first year savings target.[24] CMS and the state should make available data from Phase I about savings – to help inform the savings targets for Phase II.
    - The State should expand Medicaid rating categories to better account for the complexity of beneficiaries' needs and the costs associated with those needs. For example, category 1 assumes transitions between community and facility-based LTSS, but the three-way contract should specify how this will favor community supports and services. The State should also consider dividing categories 1 and 2 for the elderly and disabled in order to account for the unique complexities of each group.
    - It is encouraging to see risk corridors applied to all three years of the demonstration. Again, given the complexity of the population and the time it takes for the MMP to build its capacity and competency, we urge that in year three losses great than 7 percent do not put 100 percent of the risk on the MMP, but, rather, are shared with CMS and the State.

~ Leena Sharma, Senior State Advocacy Manger, Voices for Better Health

[23] The readiness review tool states that the MMP must have policies and procedures in place for this kind of training however it needs to be enforced through the three-way contract.
[24] In the Massachusetts demonstration, CMS and the State made two addendums to the contracts related to financing to provide protection and stability to health plans. See: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2015/150320-masshealth-presentation.pdf