

Implementation Council Conversation with CMS

Impacts of the One Care Model Transition from
Medicare-Medicaid Plan (MMP) to
Dual Eligible Special Needs Plan (D-SNP)

One Care Implementation Council Meeting

January 10, 2023

The Beginnings of an Ongoing Dialogue

- One Care will be transitioning from the current Medicare Medicaid Plan (MMP) status to a Dual Eligible – Special Needs Plan (D-SNP) over the next 3 years.
- IC wants to ensure that the One Care model continues to innovate integrated whole-person care and addresses existing barriers to innovation with the priority of increasing health equity, member quality of life, and community involvement.
- Today the topics of discussion are based on particular program features that are especially vital to the One Care member experience.

Topics for Discussion today

1. Benefits (45 minutes)
 - Medicare and Medicaid Benefit Integration
 - Prescription Drug Benefits
 - Flexible Benefits
2. Integration (15 minutes)
 - Integrated Definitions of Terms and Guidelines
 - Integrated Communication
3. Oversight (15 minutes)
 - Implementation Council Role
 - Quality of Care and Reporting
 - D-SNP Oversight
4. Enrollment (15 minutes)

The One Care Model of Care

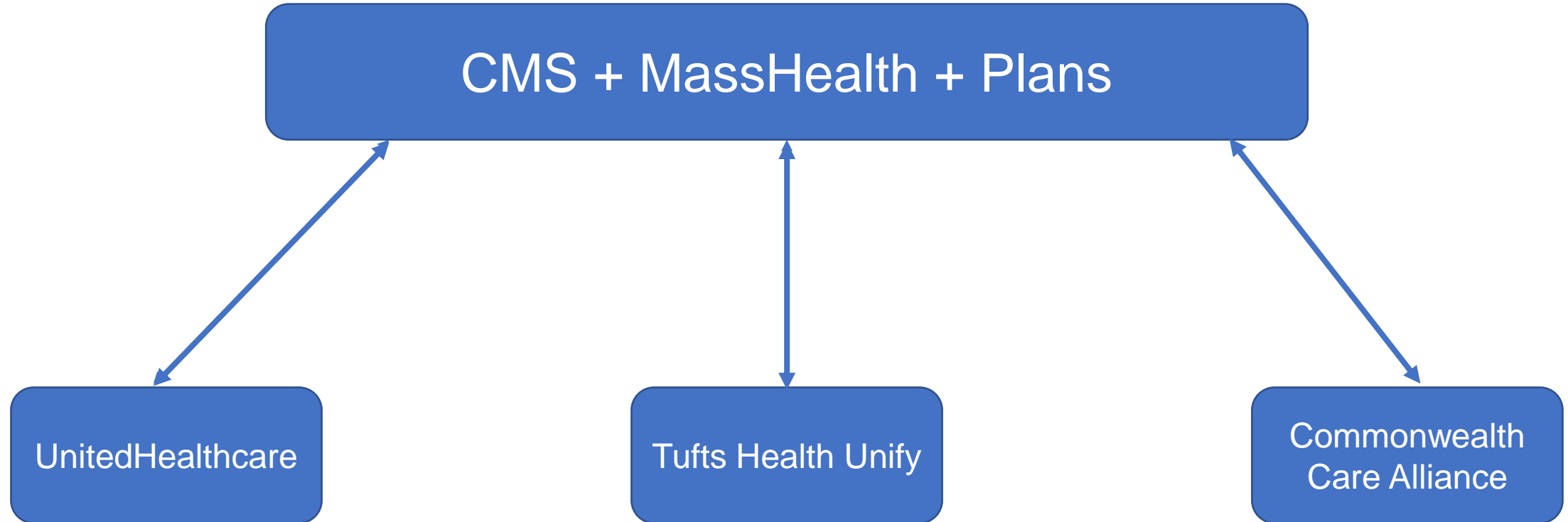
The goals of One Care include ensuring that members receive:

- care coordination to provide easy access to all available services
- high-quality integrated health care
- services that align with independent living philosophy and recovery principles to support their ability to live in the community

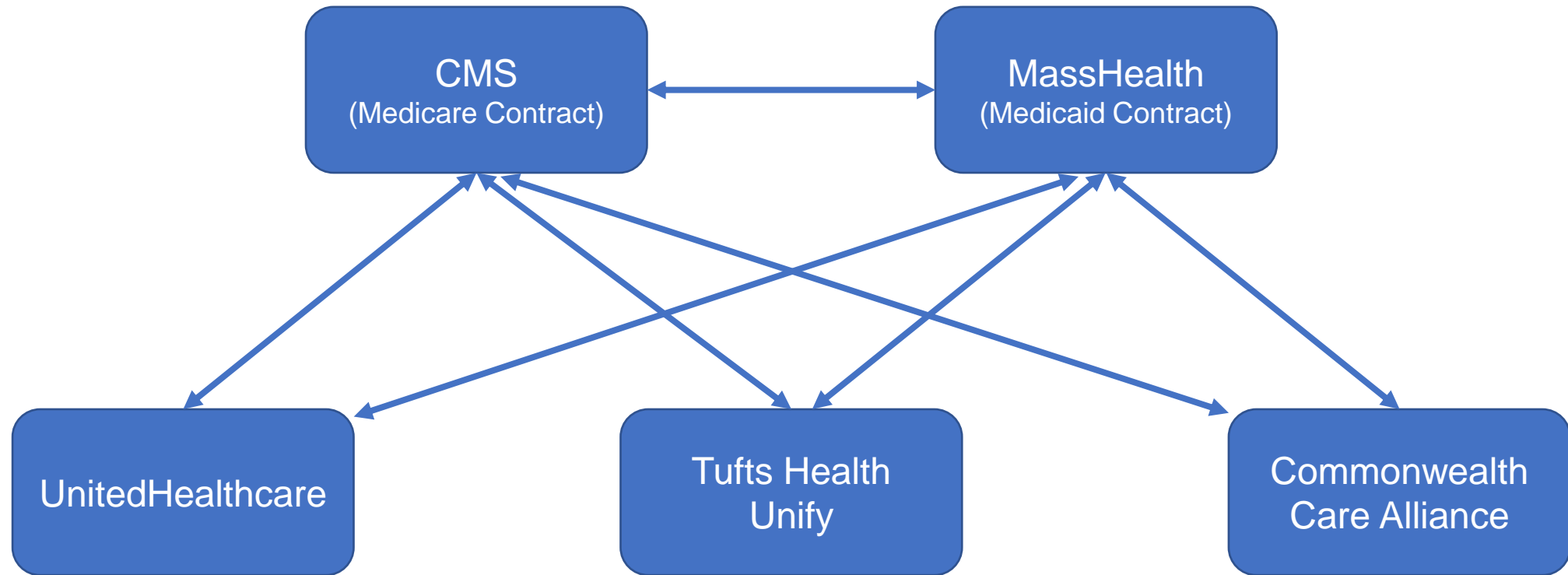
One Care plans are required to provide members:

- access to all services available to them through Medicare, Medicaid
- access to additional flexible benefits needed to meet care plan and independent living goals
- seamless enrollment and disenrollment processes as well as clear communication about that process

Current Model: Single Three-Way Contract



Dual Eligible Special Needs Plan (D-SNP)



Medicare and Medicaid Benefit Integration

Medicare and Medicaid Benefit Integration Examples

- A person in the hospital needs two ventilators when transitioning home. One ventilator is for home use, the other is portable to enable the person to navigate independently using their wheelchair in the community.
 - Under the most generous benefit provision, both pieces of equipment are authorized. The person can transition back to the community without languishing in the hospital waiting for appeals processes to run their course.
- A person needs a new wheelchair. The person's current and previous wheelchairs had elevating seats. The elevating seat is important to prevent exacerbation of the person's current condition and to support the present independent living goals.
 - What would be covered by Medicare?
 - What would be covered by MassHealth?
 - What will plans do to combine Medicare and MassHealth benefits seamlessly and ensure the plan utilizes One Care flexibly benefit as needed?

Medicare and Medicaid Benefit Integration Discussion

- How will CMS work with MassHealth to create a combined Medicare and Medicaid benefit package?
 - What would be covered by Medicare?
 - What would be covered by MassHealth?
- What does that combined benefit package look like to CMS? Will CMS work with MassHealth to create this benefit?
 - What would you expect a plan to enact by combining these two benefits? Where One Care will articulate additional benefits, how will the plans be able to approach that?
 - How will CMS support shared savings to help pay for these benefits?
 - How will this impact the seamless integration that protects against extended wait times for services and equipment?

Integrated Definitions of Terms and Guidelines

Integrated Definitions of Terms and Guidelines Examples

Terms that may have different definitions when One Care becomes a D-SNP:

- Medically Complex Populations
- Medical Necessity
- Determination of Need

Example

A person uses a high-end circulating mattress for eight years. The mattress was authorized after the person had been hospitalized twice in one year for decubitus ulcers. The person has not had a decubitus ulcer since the mattress was purchased. The mattress is no longer functioning properly and needs to be replaced.

Integrated Definitions of Terms and Guidelines Discussion

- Which definitions and guidelines (Medicare, MassHealth or existing One Care) do you expect plans to use in delivering care to members?
 - How will changes in the D-SNP definition of terms like **medical necessity** and **determination of need** impact member access to services at the right time, in the right place, by the right provider, and in the appropriate manner?
 - How will CMS reconcile the differences?
- How will prior authorization / utilization management processes change in the D-SNP model?
 - How will decisions be made under the D-SNP model?
 - Will the care plan still impact determination of need?
 - Will it continue to be seamless to the consumer?
 - Will services be delayed?

Integrated Communication

Integrated Communication Examples

- A person needs a root canal to preserve a front tooth. Medicare does not cover this service. One Care/MassHealth does cover this service.
 - Will the person and the provider receive multiple letters from the plan and Medicare with some letters containing denials and others containing approvals?
- Medicare model materials specify language that must be included in notices – such as information about copayments for services. One Care does not have any copays and including this language in notices to One Care members would be very confusing for members.
- One Care materials can advertise “no pay” to avoid confusion that exists in Medicare national template materials that imply out-of-pocket expenses.
 - To avoid this confusion, it is essential that CMS templates meet the population base needs of One Care members and are aligned with MassHealth templates created in collaboration with the IC.
 - CMS national templates must be adapted to reflect One Care rules.

Integrated Communication Questions

- How will CMS ensure seamless communication from the plan to members?
- Under the current contract, all communication between the plans and members is seamlessly integrated. Will this continue, or will members receive multiple mailings from their plans, CMS, or MassHealth?
- The IC worked with MassHealth to create language for Integrated Service Denial / Modification Notices. Will those notices continue to be used after the transition?

Prescription Drug Benefits

Prescription Drug Benefits Example / Discussion

- A person is prescribed Olanzapine by a provider to treat anorexia. Medicare does not cover the medication, but the medication is covered by MassHealth. However, when the person goes to the pharmacy, they are told that their health plan does not cover that medication.
 - How do we ensure member access to all Medicare and MassHealth covered drug benefits including over the counter medication benefits?

Flexible Benefits

Flexible Benefits Example

Flexible benefits are important to covering services for persons with high social determinants of health / (health related social needs), long term services and supports, and behavioral health needs.

Example

- Due to workforce shortages, people needing day habilitation services are left at home with no alternative services. It seems plans are not providing flexible benefits to address the unmet needs faced by these individuals. This is of particular concern for persons with complex social needs who may be experiencing isolation.

Flexible Benefits Discussion

- How will CMS ensure flexible benefits continue in a transparent way when One Care becomes a D-SNP?
 - What will they look like?
- Will CMS maintain rebalancing / shared savings for MassHealth to protect member access to services such as Flexible Benefits?
 - If no, what contracting mechanisms will CMS use to protect One Care members from cost-shifting contracting practices that will lead to reduced access to flexible benefits?
- How will flexible benefits be funded when One Care is a D-SNP?
 - How will CMS support shared savings to help pay for these benefits?

Implementation Council Role

Implementation Council (IC) Role Examples

- Consumer engagement is central to One Care Model and the IC is a key partner in reaching consumer voices.
- For years, MassHealth and the IC have worked closely to develop contract language that strengthens One Care member access to needed providers and services.
- The Care Model Focus Initiative (CMFI) was started by MassHealth to focus on opportunities for improvement that the IC has focused on including care coordination, LTSS denial process and oversight enhancements, member communications, and the LTS-C role.

Implementation Council (IC) Role Questions

- Will CMS work with MassHealth to include contractual provisions that require One Care plans to continue to engage with the IC? To reinvest a percentage of its earnings into financially supporting the IC?
- How will CMS support ongoing One Care innovations like those developed through the Care Model Focus Initiative (CMFI)?

Quality of Care and Reporting

Quality of Care and Reporting Questions

- How will CMS increase accountability to the current quality measures in the MMP contract? What quality measures other than CAHPS* will CMS be using to measure the quality of plan performance?
- How will CMS support MassHealth's member-focused quality of care framework, using the rating category structure?
 - Will D-SNPs be required to track member rating categories and services received, to ensure members are getting the level of services they require?
- How will CMS integrate MassHealth quality measures in the development of star rating requirements that go beyond CAHPS measures that are population appropriate to One Care?
- How will CMS ensure Medicare and MassHealth contracts have the necessary alignment to track approval and provision of services?

D-SNP Oversight

D-SNP Oversight Discussion

- Medicare Advantage plans get increased risk-adjusted rates for complex care populations but are not providing evidence of having to deliver services to these populations.
- Disability advocates are concerned that:
 - People eligible to receive services under the current risk adjustment rate are not getting the services they need
 - Capitation rates will be reduced in reaction to potential fraud, leading to reduced access to services for people who need higher level service.
- Advocates' concerns are heightened by:
 - Anecdotal evidence that plan utilization management processes do not always abide by the One Care “most generous payer requirement.” As a result, member DME, prescription, and other service requests are routinely modified or denied.”
 - Inability to track gaps in the actual provision of services from approved services.
- Plan capitated rates are based on risk categories. How will CMS ensure D-SNPs are addressing the needs of complex care populations at the level appropriate to the population’s risk scores?

Enrollment

Enrollment Questions

MassHealth or an independent broker should have the authority to communicate with potential One Care members and determine plan enrollment in consultation with the IC.

- How will CMS require plans network contracting practices to be based on provider quality and require plans to increase upper payment limits for providers tied to quality?
- What will CMS do to ensure the D-SNP annual enrollment cycle aligns with MassHealth's annual enrollment cycle?
- How will CMS work with the IC and MassHealth to remove the barriers impeding trust in Medicare Advantage plans and member willingness to enroll voluntarily in One Care when it becomes a D-SNP?

Discussion Topics for Future Discussions

- Integrated Appeals
- Integrated Medical Loss Ratio (MLR)
- State Medicaid Agency Contract (SMAC)
- Cost Shifting
- Financial Misalignment
- Defining the Care Coordination Role

Appendix

Integrated Appeals

Integrated Appeals Discussion

Appeals are an important concern of the IC to be discussed in more detail in another discussion.

- What will CMS do to ensure that members have an integrated appeals process to protect consumers from having to go through multiple appeal processes through CMS and MassHealth?

Integrated Medical Loss Ratio

Integrated Medical Loss Ratio Discussion

- How will CMS work with MassHealth to create a totally integrated D-SNP financially?
- How will CMS change its MLR calculation methodology to align with MassHealth MLR regulations to prevent cost-shifting from Medicare to MassHealth as spending on LTSS increases?

State Medicaid Agency Contract (SMAC)

SMAC Questions

- What steps will CMS take to maximize MassHealth's ability to build a contract that reduces misalignment between Medicare and MassHealth and increases transparency in its contracting practices with each plan and with MassHealth?
- What steps can CMS take to ensure the Massachusetts SMAC contains contractual integration including financially?
- How will CMS work with MassHealth to ensure the state's SMAC with plans include a requirement that plans reinvest profits into LTSS, and behavioral health services not covered by Medicare?
- SMAC Provisions: What will CMS do to ensure the Massachusetts D-SNP contains all One Care protections and innovations under the current MMP contract and support continuous innovation and integration that advances measurable improvement in health equity for dual eligible 21-64?

Medical Loss Ratio (MLR) / State Medicaid Agency Contract (SMAC)

- One Care plans cannot cost shift between Medicaid and Medicare since there is not blended MLR.
- Example
 - CMS could work with MassHealth to create actuarial sound MLR requirements that include plans providing evidence of billing for services provided to One Care members rather than relying on administrative data provided by plans as is customary.

Financial Topics for Future Discussion

- Medicaid and Medicare capitation rate setting processes must reflect a consumer-informed actuarially sound process and support a person-centered, whole-person model of care
- Must reconcile the MLRs against a joint MLR across MassHealth and Medicare
- Must establish risk-sharing corridors to monitor and set policy on plan profits and losses
- Must develop a methodology for accounting for cost shifting, from Medicare to MassHealth

Additional High-Level Concerns and Questions:

- **CMS's Role:** Has CMS conducted a comparative assessment of its role and administrative responsibilities under the current program compared to the new program? Will CMS invest in more oversight of this new program?
- **Whole-Person Care:** What is CMS's role to ensure that One Care members receive population appropriate whole person care that advances health equity? Has CMS conducted a review of the implications of the new program on members' benefits from the whole-person perspective envisioned in One Care? Now separate from Medicaid, will CMS consider ways to modify its Medicare benefit administration to align with Medicaid's independent living and recovery principles that preserve key elements of the One Care model?
- **A Transparent Dashboard:** Will CMS create a dashboard to measure the impact of this new demonstration on members to include but not be limited to a review of the patterns and trends in key Medicaid and Medicare measures across the states, including member LTSS use, inpatient and ED use, MLRs, and plan margins?

#	MMCO Goals	Status on One Care	Questions for MMCO
1	BENEFITS. Providing dual eligible individuals full access to the benefits to which such individuals are entitled to under the Medicare and Medicaid programs.	Access to a single set of benefits	How will CMS support shared savings to help pay for these benefits? Will CMS work with MassHealth to create a combined Medicare and Medicaid benefit package? What does the combined benefit package look like to CMS? How will CMS support shared savings to help pay for these benefits?
		Access to flexible benefits	How will CMS protect flexible benefits?
		Complex care needs	How will CMS ensure that D-SNPs address the needs of the complex care populations since they receive risk-adjusted payment rates to do so? Are there elements of Chronic Condition Special Needs Plans (C-SNPs) that should be explicitly cited in the new FIDE SNP?
		Prescription Drug Benefit	How will CMS ensure member access to all Medicare and MassHealth covered drug benefits including OTC benefits How will CMS protect flexible benefits?
2	ACCESS. Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.	Integrated Appeals	What will CMS do to ensure that members have an integrated appeals process?
		Integrated Communication	Will CMS ensure seamless communication from the plan to members? And, how?
3	QUALITY. Improving the quality of health care and long-term services for dual eligible individuals	Quality of Care and Reporting	What makes current One Care quality measures unique? Will CMS support MassHealth's member-focused quality of care framework, using the rating category structure? How will CMS integrate MassHealth quality measures in the development of star rating requirements that are population appropriate to One Care?
4	MEMBER EXPERIENCE. Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.	IC Role	Will CMS require plans to pay for the IC?
		Enrollment	Will CMS require plans network contracting practices to be based on provider quality and require plans to increase upper payment limits for providers tied to quality?

#	MMCO Goals	Status on One Care	Questions for MMCO
5	REGULATORY CONFLICTS. Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs	The purpose of the blended payment is to reduce regulatory conflicts that lead to reduced answers to adequate, appropriate services	What mechanisms can CMS leverage to ensure One Care is totally integrated and not just fully integrated?
		Creating SMAC contracts is a complex undertaking. While states are developing these plans can market nonaligned products for dual eligible populations.	Will CMS disallow plans from enrolling new members in non-aligned duals products while MassHealth creates SMAC contracts?
		MMPs today have to submit separate Medicare and Medicaid encounter claims.	Will MassHealth take active steps to increase actuarial soundness of capitated rates by requiring plans to submit utilization data in addition to encounter data and, require alignment between actuarial soundness standards between CMS and MassHealth to hold plans to a higher level of transparency and actuarial sound capitated rates.
6	CARE CONTINUITY. Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.	The Care Model Focus Initiative (CMFI)	How will CMS support ongoing One Care innovations like those developed through the Care Model Focus Initiative (CMFI) that strengthen contract requirements to ensure plans provide population-appropriate care coordination and other contract requirements that improve member experience and strengthen continuity of care to ensure effective transitions of dual eligible individuals between different settings?
7	COST SHIFTING. Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.	One Care plans cannot cost shift between Medicaid and Medicare since there is a blended MLR	How will CMS change its Medical Loss Ratio (MLR) calculation methodology to align with MassHealth MLR regulations to prevent cost-shifting from Medicare to MassHealth as spending on HCBS and LTSS increases? How will CMS work with MassHealth to ensure the state's State Medicaid Agency Contract (SMAC) with plans include a requirement that plans reinvest profits above the MLR R&B invested back into HCBS, LTSS, and behavioral health services not covered by Medicare?
8	QUALITY. Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.		