# One Care: MassHealth plus Medicare

# MassHealth Demonstration to Integrate Care for Dual Eligibles

October 17, 2014, 1:00-3:00PM

State Transportation Building

Boston, MA

# Slide 2

# Agenda for MassHealth Updates

* Network Adequacy
* Auto-Assignment Process
* Hard-to-Reach Enrollees
* Looking Ahead

# Slide 3

# Overview of One Care Network Adequacy Monitoring

* Readiness Review Process
* Medicare Adequacy Test
* MassHealth Adequacy Test
* Contractual Reporting
* Monitoring of network related complaints

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# Provider Network Readiness Review

* Mandatory before plans could begin accepting enrollments
* Plans had to pass
	+ Medicare network adequacy test, and
	+ MassHealth network adequacy test
* Plans were required demonstrate their capacity and ability to meet the provider network needs of members
* The provider network portion was just a part of the overall One Care readiness review conducted by MassHealth and CMS starting in 2012

## http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASS\_RR\_memo.pdf

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# The Medicare Network Adequacy Test

## Requirements:

* Plans must meet or exceed a minimum number of required provider and facility types (tests 32 provider types and 22 facility types ex. oncology, outpatient dialysis)
* Plans demonstrate at least 90% of their members have access to one or more required providers/facilities within a calculated time and distance

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# The Medicare Network Adequacy Test *(cont’d)*

## Method:

* Plans upload templates to CMS
* CMS runs the information through a system to evaluate data based on established requirements

## Frequency:

* During the readiness review and annually thereafter at Medicare’s discretion

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# The MassHealth Network Adequacy Test

## Requirements:

* Within a 15-mile or 30 minute radius from the Enrollee’s zip code of residence, each plan must have contracted with:
	+ At least two PCPs
	+ Two hospitals (when feasible)
	+ Two nursing facilities\*
	+ Two outpatient behavioral health providers
	+ A choice of two community LTSS providers per covered service\*
* Reasonable geographic coverage of all other provider types (ex. vision, transportation)

\**A choice of one provider may be offered with good cause and approval (ex. Lack of a certain provider type in the region)*

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# Additional Contractual Requirements and Reporting

## Method:

* Plans provide MassHealth with maps and provider lists demonstrating they have met the requirements

## Frequency:

* During the readiness review and annually thereafter

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# Additional Contractual Requirements and Reporting *(cont’d)*

## Plans Must Immediately Report:

* Any significant Provider Network changes

## Plans Must Annually Report:

* Provider turnover rates
* All out of network providers the plan has used
* An explanation of any trends regarding their use of out of network providers beyond the continuity of care period
* Action plan, next steps, and timeline around self-identified areas in need of improvement

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# Complaints Monitoring

* On a continuous basis, the One Care Contract Management team addresses network adequacy
concerns reported:
	+ Directly from members to MassHealth
	+ Directly from members to 1-800-Medicare
	+ From the One Care Ombudsman

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# Goals of Network Monitoring

* Ensure One Care members have access to adequate provider networks
* Have early warning of significant network changes
* Understand how many providers are leaving a plan’s network and why
* Identify and address potential weaknesses in a plan’s network or relationships with providers
* Create a dialogue between the plans and One Care contact management team around maintaining strong provider networks

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# Auto-Assignment Capacity Determinations

* MassHealth and the One Care plans collaboratively determine the number of auto-assignments:

1) Plan’s capacity to accept passive enrollments:

* + Readiness Review network capacity determination
		- Primary information source for first 3 rounds of auto-assignment
		- Plan staffing capacity
	+ Plan contract management reporting
		- Systems, staffing, appeals and grievances, service denial reports, etc.
		- Hard-to-reach enrollees
		- Assessment data reporting tool implemented late Spring 2014
			* Prior to Round 4, assessment statistics not available for planning

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# Auto-Assignment Capacity Determinations *(cont’d)*

2) Rating category

* + Plans’ enrollment distribution compared to the distribution in the eligible population
	+ Round 1: Individuals in C1 rating category only
	+ Rounds 2, 3, and 4: Individuals in C1, C2, and C3 rating categories

3) Projected number of opt-outs and cancelations

* + Assumptions about how many auto-assignments would result in enrollments
	+ Round 1 experience informed Round 3
	+ Round 1 & 2 experience informed Round 4

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# Timeline for Auto-Assignments

Four months lead time prior to auto-assignment effective date:

* Member data analysis
	+ Collaboration with plans
	+ Systems processing
	+ Member mailing process
	+ Members receive notices 60 days and 30 days prior to effective date
* For Round 1, planning September 2013
* For Round 2, planning December 2013
* For Round 3, planning March 2014
	+ 90-day assessment period for Q1 enrollees ended March 2014
* For Round 4, planning July 2014
	+ 90-day assessment period for Q2 (Round 1) ended June 2014

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# Intelligent Assignment

* During planning period, One Care plans send an updated provider file to MassHealth
* MassHealth uses (MassHealth and Medicare cross-overs) claims history and plans’ provider network files to match individuals to a One Care plan
* Match criteria
	+ A visit since 7/1/2012 to a provider identified by plan as a PCP
	+ Services provided on 3+ separate dates of service since 7/1/2012 by a behavioral health provider
	+ Services provided on 3+ separate dates of service since 7/1/2012 by an LTSS provider
	+ For members with claims activity but no PCP match to any plan, opportunity for a One Care plan to establish a PCP relationship

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# Enrollees who are Hard to Reach

* The volume of “hard-to-reach” enrollees has been higher than anticipated
	+ Other states have shared similar concerns
	+ Most hard-to-reach people are enrolled through auto-assignment, but some enrolled through self-selection
	+ For members not utilizing care, plans don’t have provider relationships to leverage connections
	+ Some people are experiencing homelessness or living in temporary housing, and may not receive information
	+ Some members may not read or understand notices
	+ Limited options to update members’ demographic information in MassHealth’s system

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**Enrolllees who are Hard to Reach (cont’d)**

* Plans have identified and shared with MassHealth some effective ways of finding harder-to-reach members, including
	+ Using claims history and Rx data to reach out to providers
	+ Working in collaboration with contracted behavioral health provider networks, group adult foster care, behavioral health caseworkers, health home staffers, and other providers to locate members
	+ Sending a “PCP not assigned” letter, or a “PCP assigned” letter – sometimes this results in a call back
	+ Partnering with pharmacies and leaving a “please contact us” card for members when a script is filled
	+ Calling members early in the month before cell phone minutes run out on prepaid phone services
* MassHealth is interested in discussion on this topic and ideas from the Implementation Council on other ways to try to find hard-to-reach members

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# Looking Ahead

* Data Reporting
	+ In November, MassHealth will present draft layout of plan data in response to the Implementation Council’s September 2014 request for additional data reporting
	+ Timeline for data reporting from various sources
	+ EIP workgroup reviewing in-depth results from Survey 2, Cohort 1
* Encounter Data
	+ MassHealth presented on Encounter Data at the September 2014 Implementation Council meeting
	+ Data will be reported from October 2013 start
	+ Ex: Community vs. Facility-based LTSS utilization; hospital utilization; expansion service utilization
	+ MassHealth requests suggestions from the Implementation Council on what we should look at when we begin receiving encounter data.

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# Looking Ahead *(cont’d)*

* Behavioral Health
	+ MassHealth is interested in hearing from the Implementation Council challenges and opportunities around meeting the behavioral health needs of enrollees (e.g., members unwilling to engage in care planning process)
	+ MassHealth understands that the Council has requested that the plans present on this topic in November
* Enrollment Data
	+ MassHealth releases monthly enrollment reports to the stakeholder email list and posts on the One Care website (under “News and Community”)
	+ EIP Monthly Enrollment Reports contain additional detail, tables, and graphics (also available on One Care website)
	+ MassHealth welcomes suggestions on what kind of enrollment data the Implementation Council wants to hear about in MassHealth’s Updates at the monthly meetings.

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## Visit us at www.mass.gov/masshealth/onecare

## Email us at OneCare@state.ma.us