

Duals Demonstration 2.0

Listening Session # 1

Topics for Discussion: Provider Engagement and Networks, Service Authorizations, Grievances, Appeals, Care Management

MassHealth Panel:

Elizabeth Goodman - Chief of Long Term Services and Supports

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Introduction:

The MassHealth panel introduced themselves and provided a brief overview of current and proposed changes for each of the topics on the agenda before opening the topic up for discussion.

Provider Engagement / Networks

Discussion Questions:

- What would more effectively engage providers to participate in One Care and SCO plan networks?
- What discourages providers from participating in One Care or SCO plan networks? What mitigations would reduce or address these challenges?
- What is critical mass (percent of a patient panel) for a provider to participate?
- What would encourage network participation among Medicare ACO providers?
- How should creating choices in networks be balanced with contracting efficiently, particularly if few providers are geographically available?

Attendee responses:

Consumer Advocate

- The nationalization of Durable Medical Equipment (DME) is an issue. The quality of DME has decreased regardless of who the payer is – so this is not a provider issue.
- Consumers of DME would be better served through value-based purchasing that goes beyond the purchase of a product. Long-term relationships created by long-term contracts between the DME vendor, the plan, and the member would meet the needs of DME consumers better.
- There are limited vendors in the state that offer the transportation services that One Care members need. There are known capacity issues with services such as transportation. Allowing plans to contract with vendors such as Uber and Lyft may help.

Plan Representative

- It can be a challenge to balance ensuring members have vendor choices and ensuring that there are services available, this is especially true in rural areas. Thinking creatively about the time/distance requirements (for network adequacy) is required to meet member needs in rural areas. It's important to look where members go for medical care, and to consider transportation as part of this evaluation.

MassHealth follow-up question: *How would you judge the adequacy?*

- You can look to patterns of care and at the context of the network, using a broad-based approach to care that may be outside the formula (flexibility). Many members use an interdisciplinary team to meet their provider needs – an example of this would be a member in a rural area who uses a specialist for their primary care.

Consumer Advocate

- Quality of care should be considered when looking at available providers. It is not consistent across the board that all One Care members are getting person-centered care.
- Are people who address Social Determinants of Health (SDOH) such as food vendors considered “providers”?

MassHealth answer: *Any covered service or vendor in the contract is included in this.*

- A lot of the Long Term Services and Supports (LTSS) that One Care members need are not necessarily traditional LTSS but do include SDOH.
- Are providers who are in-network but who are not taking new patients included in Network Adequacy measures?

Provider Representative

- What risks does MassHealth expect providers to take? MassHealth should be clear and upfront with the financial constructs for Duals 2.0.

Service Authorizations

Discussion Questions:

- How could plans better link individualized care plans to the authorization process?
- What would improve transparency in these processes?
- What strategies could better balance person-centered processes with system efficiencies necessary to support enrollment at scale?

Attendee responses:

Consumer Advocate

- Want to be sure that the focus on person-centered goals continues as One Care grows. Focus needs to continue to be on what the member needs vs what the Plans need.
- Service authorization decisions should be transparent.

Plan Representative

- The current service authorization system is not that broken and doesn't need to be fixed.
- Different plans may have different utilization management and service authorization standards but are all subject to the same accreditation standards – so in general they ensure equity and fairness.
- SCO members come into the program from Fee for Service plans (FFS) with the same needs but with widely differing services. Utilization Management, if done well, ensures that people aren't getting different services for no known reason.

MassHealth follow-up question: *Can you resolve for inconsistencies in an environment of increasing automation?*

- A fully automated system probably would not work. You can use branched chain logic and have a nurse run the algorithm but then it usually goes to a physician for additional determination.
- You could create consistent ways to word and ask questions. There should not be a wide variety of questions asked anyway – it should be efficient and equitable.

Plan Representative

- Service authorization should be fully integrated with service and care planning but the Medicare Advantage service planning regulations for the standard Medicare Advantage populations make it challenging because they are hard to follow with the unique characteristics of the One Care populations.
- Plans must review all member service requests in view of the member's full service plan to make decisions that meet the member's needs.

Consumer Advocate

- Service decisions must conceptualize a member's full needs.
- Equity is important. Service authorization decisions should ensure that everyone with similar needs has access to the same services within the context of their person-centered goals.

Consumer Advocate

- There needs to be a balance between standardization and a discussion when determining what services members have access to.
- The state has specific guidelines for different services, and those guidelines are very important and needed. There also needs to be an individualized conversation with a nurse or other practitioner – as diseases impact people differently.
- Fully automated service authorization determinations would be a disaster.

Consumer Advocate

- One Care services are prevention-oriented. The Care Plan includes things like quality of life and wellness goals and should not be undermined by a Prior Authorization process.
- Diagnosis driven authorization processes don't work for this population. For example, a person needed a machine to prevent pneumonia and the care manager had a very hard time obtaining it because the person didn't have a diagnosis of pneumonia.
- Plans need to be sustainable – it is clear that decisions will have to be made along the way.
- Algorithms are not value-free and "proprietary" algorithms can be a barrier to transparency.
- The "in-home use" definition used in service authorizations can be overly restrictive and contrary to the Olmstead decision.

Consumer Advocate

- Plan negotiations with providers can be "proprietary" as well and are also a barrier to transparency.

Phone Participant

- Will the questions and responses be posted online so that those who are on the phone can respond once they have had time to read the presentation and the comments?

MassHealth answer: *Yes, the presentation, agenda and notes from Listening Session # 1 will be posted on the Duals 2.0 website www.mass.gov/duals-demonstration-20. People can send comments and questions anytime to the One Care email address. The email address is: OneCare@state.ma.us*

Grievances

Discussion Questions

- What parts of the current processes are working well and most protective to members?
- What gaps exist in the current processes and how should MassHealth address them? (e.g. for members, providers, health plans, and others involved in the process)
- Where should members be able to submit grievances?
- In One Care, all grievances are documented in the Complaints Tracking Module (this is part of a CMS IT system). How is this supporting (or not) plans in resolving grievances?
- Suggestions to ensure grievance processes are transparent, accessible, and responsive to members?

Attendee responses:

Consumer Advocate

- Would like to see the SCO grievance process match the One Care grievance process.

Plan Representative

- Would like a broader net for grievances. It would be efficient if regulators had similar reporting mechanisms.

Consumer Advocate

- The Ombudsman is underutilized. Often grievances seem to be resolved informally through the care manager or care coordinator. It would be helpful to have data about issues people experience with vendors or services though. Perhaps this data can be gathered from

organizations on the ground who are hearing about these issues – such as disability organizations and health outreach workers.

MassHealth follow-up question: *Should there be more points of entry for SCO grievances?*

- There is not a need for more entry points officially, but perhaps there could be an emphasis on encouraging more members to report issues to the Ombudsman.

Consumer Advocate

- The grievance process in One Care usually works. It has not worked to resolve an issue with an inaccessible bathroom at a CCA medical provider office. The door in the bathroom does not self-close and this has not yet been resolved despite an ADA reasonable accommodation request and a grievance filed with the Office of Civil Rights.

Consumer Advocate

- A significant number of issues that the Ombudsman deals with are errors or misunderstandings, but, as a third party, the Ombudsman is able to facilitate communication between the member and other parties. The Ombudsman helps to alleviate the power differential.
- It feels like the grievance process has no consequence for the plan and therefore doesn't feel like an effective strategy. Also, if one party enters into a grievance in bad faith it will not be successful.

Consumer Advocate

- Paperwork should exist to explain to a member why they received a denial of services.

Appeals

Discussion Questions:

- What gaps exist in the current processes and how should MassHealth address them? (e.g. for members, providers, health plans, and others involved in the process)
- For which Medicare services is auto-forwarding most important, and why?
- Which Medicare services are most frequently (fully or partially) reversed in Medicare's external review process?
- Which Medicare services are more appropriate for a member or provider initiated second level external appeal?

- Please provide any additional strategies, considerations, or approaches MassHealth should consider ensuring external appeals processes are transparent, accessible, and responsive to members.

Attendee responses:

Plan Representative

- Hearings at the Board of Hearing (BOH) can be 6 months after a denial of services. This is very difficult for members and for plan.

Plan Representative

- Having appeals for Medicare benefits at the MassHealth BOH seems like it might be a mismatch because these are very different benefits with very different experts.
- Medicare Advantage holds SCO to the Stars incentives. These are awarded by comparing plans across the country against each other – on different things including appeals data. If SCO appeals are done through a BOH process this could hurt SCO plans.
- Currently Medicare Part D is not auto forwarded for appeal – only Medicare Part C is. It has been found that most lidocaine denials are overturned on appeal. If Medicare Part D claims start to be auto forwarded this also would have an impact on Massachusetts lidocaine prescription costs – as there will presumably be an increase in lidocaine prescriptions that are covered and therefor filled, on appeal.

MassHealth follow-up question: *Would a Medicare Independent Review Entity (IRE) understand MassHealth benefits such as a well-visit? Does the IRE look at MassHealth benefits generally?*

- That would generally be reviewed by the MassHealth BOH.

Plan Representative

- The Medicare IRE doesn't understand Medicaid services and often doesn't look to see if a person is covered by both Medicare and Medicaid. A common example is the electric hospital bed that Medicare doesn't cover but Medicaid does.

Consumer Advocate

- The general elderly Medicare population is very different than the population of people with dual eligibility. The Stars incentive program is probably not a good system to measure quality for the "duals" population.

- The One Care appeals process (allowing members to appeal to both Medicare and Medicaid at the same time – for Medicaid/Medicare services) helps to ensure that the One Care program adheres to the “least restrictive” ADA rule.
- Recommend that One Care continue to provide this protection – and maintain the current appeal process and recommend that the current One Care appeal process be extended to SCO.

Consumer Advocate

- BOH hearing officers don’t always know what One Care is.

Plan Representative

- IRE offers online case files. It would be helpful if BOH had more online and technology access and abilities.

Care Management

Discussion Questions:

- In some cases, plans have delegated care management functions to community-based provider organizations
- What is working well and not working well for this kind of approach?
- What qualifications or expertise are important in delegated entities to effectively provide comprehensive care management?
- What guardrails should MassHealth consider for these kinds of approaches?

Attendee responses:

Plan Representative

- One Care and CCA have already overcome a lot of scale issues as the program has grown over the past demonstration.
- The Home Health Model is a good model for working with Community-Based services to de-medicalize care and to focus on Social Determinants of Health as well as the Social Influences of Health. This is a very personalized and person-specific health care model. The Home Health Model understands and accounts for the psycho-social, behavioral health and

primary care needs of the consumer. The rest of the team needs to identify and treat the medical gaps.

Consumer Advocate

- One Care de-medicalized the needs of people. Important aspects such as Independent Living philosophy and the Recovery Model should be maintained. One Care members should have the right to have anyone they need on their care team – and the Primary Care Provider might not always be the quarterback for all care teams.

Plan Representative

- Worked in the past for an Illinois MMP (Medicare-Medicaid Plan) that decided to leverage partnerships with community-based organizations (CBO). It was difficult to make sure that all the CBOs were complying with care management regulations.

Plan Representative

- Integrated care is an important aspect of One Care. There is a large population of consumers who don't like to go to their Primary Care Provider but who are willing to have other providers in their home. It's important for the team to work together.
- Some Primary Care Providers are resistant to relationships with Behavioral Health and typically only share the consumers' medication list and diagnosis with the behavioral health team.

Plan Representative

- Care management problems do not exist in the integrated provider care offered by the PACE plan.
- Do not want the SCO / One Care focus to marginalize the PACE program. To reduce the risk of this would like to have the opportunity to partner around enrollment.

Consumer Advocate

- The Long Term Supports Coordinator (LTS-C) in One Care and the Geriatric Services Support Coordinator (GSSC) in SCO are both highly effective at getting services to consumers to address social determinants – or social influencers – of health.