Duals Demonstration 2.0

Listening Session # 2

Topics for Discussion: Medicare Bidding Approach; Risk Sharing; Provider Payments; Value-Based Payment for Plans and Providers; Measuring and Incenting Quality

MassHealth Panel:

Corri Altman Moore - Director of Policy

Roseanne Mitrano – Director of Delivery Systems Operations

Elizabeth Goodman – Chief of Long Term Services and Supports

Elizabeth Larsen – Director of Policy and External Affairs - OLTSS

Deborah Daly – Strategy Analyst

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. MassHealth invited participants to send all questions or requests for Duals Demonstration 2.0 updates to the One Care email address: Onecare@state.ma.us.

Medicare Bidding Approach

Discussion Questions:

- What should MassHealth consider in transitioning from the current One Care Medicare financial methodology to the Medicare Advantage bidding methodology?
- How would this change impact plans, plan enrollees, network providers, or others?
- What should MassHealth consider in adding risk adjustment to the Medicaid rate-setting methodology for One Care and SCO?

Attendee responses:

Provider Representative

- Home healthcare providers experience financial problems when the cost of services for an enrollee exceeds the rates paid to the provider. This commonly occurs when rates do not equate to the costs associated with different care plans or levels of service. One example is having the same One Care rate for both day and overnight services, where the cost of delivering the overnight service is much higher.
- Providers struggle to remain cost effective while serving One Care members and need the rates to better reflect the different services moving forward.

MassHealth answer: ***The negotiated rates are between the SCO and One Care plans and each individual provider at this time. There is need to move towards more experienced-based rates.***

Plan Representative

- Medicare Advantage benchmarks which reflect primarily a population aged 65and over may be inappropriate for the Duals 2.0 population.
- The Duals 2.0 demonstration needs a consistent definition of Medicare versus Medicaid liability so all plan bids are on the same basis.

MassHealth follow-up question: ***Can you please expand on the Medicare versus Medicaid liability?***

- Integrated care may combine services traditionally labeled as either Medicare or Medicaid. There will need to be a clear consensus on the differences in liability to avoid confusion, so plan bids remain consistent.

Consumer Advocate

- Advocate envisions plans in SCO and One Care paying for non-traditional Medicare/Medicaid services – similar to the Flexible Services provided by some ACOs.

MassHealth answer: ***One Care does have additional services plans are required to cover beyond the traditional set of Medicare/Medicaid services. These services include behavioral health diversionary services, extended dental and vision services, care transition services, extended Personal Care Assistant services, Durable Medical Equipment (DME) services, home care services and Community Health Worker (CHW)***

services; SCO also offers a list of flexible or supplemental services. Not all of the services are built into One Care through rates or capitation though more of them are included than under Traditional Medicare or Medicaid. Some of these services would be considered discretionary services that the plan would provide based on a member's care plan.

Consumer Advocate

- The One Care chronic care model does not adequately reflect the One Care population. The current model does not accurately capture behavioral health costs and information especially if there is no specific diagnosis. Additionally, the Hierarchical Condition Category (HCC) Medicare risk adjustment program needs to be updated because it does not properly capture younger behavioral health information, especially when there is not a documented diagnosis.

MassHealth answer: ***CMS made positive changes to the HCC risk adjustment methodology in 2017. Additionally, CMS made further updates to the HCC model in 2018 reflecting a broader understanding of substance use disorders (SUD) and behavioral health and updating their risk adjustment to reflect the data.***

Provider Representative

- Will the Duals demonstration 2.0 allow One Care to have a Community Support Program for People Experiencing Chronic Homelessness (CSPECH) resource, similar to the program many SCO plans currently have?

MassHealth answer: ***Yes, this should be resolved and available for One Care before the new demonstrations begins.***

Provider Representative

- There is a need to incorporate learned information coming from PACE on how to offer services that are not clearly covered by Medicare or Medicaid.

Consumer Advocate

- The risk adjustments for One Care members may be inappropriate when assessing under-coded One Care enrollees who have not been receiving proper treatment and therefore have low risk score.
- What determines a low or high risk adjustment?
- What is the assessment and treatment process for enrollees who have low risk scores because they have not been receiving treatment?

MassHealth answer: **Currently in *One Care MassHealth looks back at fee for service claim histories for an individual to determine a proxy rating category based as an estimate before they go through their comprehensive assessment process. This is the rating category that is used until the member has their full comprehensive assessment (within 90 days of enrollment). Medicare is a bit different. It takes some time for the risk adjustment to reflect an individual's level of complexity, but every plan's assigned rates are subject to an additional coding intensity offset. Early in One Care, we were able to negotiate to reduce the coding intensity offset since the population was enrolling from Medicare fee-for-service, although this reduction is not typically available now. The hope is that these things will not be needed once the rates shift to a system that is primarily based on the members' actual experience in the plans..***

Consumer

- Individuals with communication difficulties waste time dealing with interpreters and need more assistance. These individuals will require more time to understand and access medical information. Communication access is a right and should not be a burden.

Risk Sharing

Discussion Questions:

- What (if any) downsides should MassHealth consider in including a two-sided risk corridor in SCO?
- What other financial methodologies should MassHealth consider to assure the stability of One Care and SCO products until member enrollment reaches a minimum level for sustainability?
- What other approaches should MassHealth consider so that plans, CMS, MassHealth, and providers share in both risks and potential gains?

Attendee responses:

Provider Representative

- Currently, providers find the One Care rates and financial agreements do not reflect the cost of the services needed to care for the One Care population. How can providers deliver care under the current rates?

MassHealth answer*: The questions above focus on the financial relationship between the plans and CMS. However, the plans' individual relationships with their providers may affect the risk approach.*

- Often the provider is left unaware of the enrollee's needs following the comprehensive assessment because the provider does not have continuous access to the care plan. Providers need to be aware of the care plan to access the enrollee's overall condition and treatment needs.
- In the homecare environment is it possible for the nurse to see the care plan to better assess the overall needs of the enrollee?

MassHealth answer*: We are hearing that there is a need to add more transparency to the care planning process beyond the initial comprehensive assessment and care plan development. Are we correct in understanding that this recommendation includes increased communication between the plans and providers?*

- Providers struggle to ensure different levels of services in a cost effective manner. There needs to be a way to receive compensation for different types of care (such as 30 day or 60 day nursing visits). When does the provider need to get a prior authorization? There needs to be a better way to understand and process specific care questions and authorizations.

MassHealth answer*: The comprehensive assessments must take place within 90 days for One Care and within 30 days for SCO. Each plan has its own prior authorization requirements; please refer to the individual plan. MassHealth will look into solutions to strengthen communication between plans and providers.*

Plan Representative

- There is a need to look at risk scoring methodologies and evaluate stratification. Looking at risk mitigation should determine whether or not the rates are actuarially sound and whether or not the operational environment or the employment execution of the plan is consistent with how the rates are developed.

Consumer Advocate

- Symmetrical risk corridors tend to work better with smaller plans. Larger plans have more stability and it is harder to see the advantage of the symmetrical risk corridors when the plans have a higher level of stability.
- SCO currently has high cost protections in place. These protective measures are reasonably predictable and adding to them will require negotiating with CMS.
- The protections may make more sense for One Care to have, but it is difficult to analyze for SCO.

MassHealth follow-up question: *How large is large enough for a plan to be in order to reach the level of stability you mentioned?*

- Typically, plans with membership exceeding five thousand members is a comfortable range for the general population. These plans are more stable and rarely see the risks smaller plans would.

Provider Payments

Discussion Questions

- How can we balance the need for broader provider networks with the need for greater provider accountability and responsibility (i.e., deeper engagement with care teams)?
- Are there other mechanisms to encourage sustainable plan-provider network contracting that MassHealth should consider?
- How should creating choices in networks be balanced with contracting efficiently, particularly if few providers are geographically available?

Attendee responses:

Provider Representative

- It is best to assess providers on an individual basis and examine the region where they provide services. Networks and regions are important when assessing provider payments.
- Advantage Homecare Systems would like the One Care demonstration to be available in more geographic areas (especially Bristol County). The organizations currently provide services in Bristol County to SCO enrollees, but not to One Care enrollees.

MassHealth answer*: MassHealth hopes to achieve statewide coverage as part of the upcoming plan re-procurement.*

Consumer Advocate

- The discussion questions in the Provider Payments section are loaded with terms such as balance and efficient contracting. The current issue of provider networks being “unbalanced” is more about the networks not being adequate or broad enough and less about them lacking accountability.

Provider Representative

- There needs to be greater responsibility between providers and payers. Often it is difficult to engage with care managers after the initial assessment is concluded for service authorizations. It would be helpful to understand the communication requirements for plans to follow with their providers, especially related to direct communication between the enrollee’s care team and the provider. Cooperating more with care managers would be

helpful to better understand the psycho-social needs of each enrollee, which often inhibit outcomes.

MassHealth follow-up question*: Does your provider organization receive instructions or members' care plans, or have other communication from the plans?*

- The provider will do an assessment and then submit for prior authorization. The material is faxed or set electronically, after which point there is little to no direct communication. It would be helpful to know more information about other ongoing care to help with long term progress and compile similar findings. It would be especially helpful to have a person to call – like the care manager or care coordinator.
- Do most plans contract with bigger providers, such as Partners or other hospital affiliated providers? There is an apparent disparity between the reimbursement rates the larger hospital affiliated providers receive and those the free-standing / clinic providers receive.

Provider Representative

- The different levels of care should be taken into consideration when determining provider payments. For instance, there is a difference between day, and night care delivery, as well as 24-hours care. When determining provider payments rates it is essential to account for the difference to balance cost finances.

Value-Based Payments for Plans and Providers

Discussion Questions:

- How would additional incentives for VBP impact provider networks, both from the plan and provider perspective?
- Are plans and providers interested in VBP methodologies that include shared risk?
- Which (if any) existing Medicare and Medicaid VBP models should be considered to improve One Care and SCO performance?
- What other strategies should we consider to better engage Medicare ACOs in plan networks?

Attendee responses:

Provider Representative

- Will MCOs and ACOs affect the group adult foster care program?

MassHealth answer*: **Group adult foster care is one of the services One Care and SCO members can access today. Currently MassHealth is unaware of any discussion of value-based payments between group adult foster care providers and One Care / SCO plans; MassHealth is looking for any innovation ideas on the system.***

Plan Representative

- United Healthcare is interested in the value-based payment approach for One Care, specifically if it moves beyond value-based payments for behavioral health and long-term services and supports (LTSS) - towards quality of life value based goals.
- Would MassHealth consider, as part of the RFR, requiring specific value-based standards for behavioral health and LTSS in the contract for plans? It would be best if there is an understanding and a requirement for plans to do value-based purchasing with the entire provider community.

Provider Representative

- Plans needs to have a strong recommendation or mandate to implement value-based payments beyond acute and primary services.

Consumer Advocate

- Currently there are unique treatments behavioral health providers are offering, including art therapy and peer support recovery. These services would benefit from increased reimbursements and value-based payments for non-traditional services. The services are beneficial to add to the demonstration.

Provider Representative

- Many homeless folks have high service needs, especially the need for primary housing. Currently, there is a disconnect between quality of care and the types of innovations being administered to the population.
- Moving forward there needs to be greater quality measure metrics put in place for social determinants of health. The measurement structure should not be hyper sensitive to specific care services. Instead, the metrics should focus more on larger quality of life measures when analyzing the comprehensive care for each enrollee and focus less on small routine

testing. The metrics should incentivize providers to serve this high service need population instead of disincentivizing them.

MassHealth answer: ***MassHealth would like to achieve value-based payments and realize the measurements required to better define quality measures for serving diverse populations. The ACO program is a starting point, but new quality measurements and testing are needed - suggestions are welcomed.***

Plan Representative

- Commonwealth Care Alliance supports value-based payments. Commonly, providers want to engage in these types of payment structures, but do so cautiously because the payment structure may not support them enough. It is important to ask if there should be set payment levels for participation. There is a need to meet providers where they are. Some providers are equipped to service needs at certain payment levels and others are not. There needs to be a system in place to determine achievable metrics.
- Increasing numbers of behavioral health and LTSS contractors are interested in value-based payments. Taking a balanced approach to working with these providers is important. Prescribing percentages may create challenges for some providers and should be used cautiously.

MassHealth follow-up question: ***What are the specifics for educating and building capacity? Is it essential to require risks, where is the best place to start?***

- There is no need to roll out a specific mandate, as it is best to wait for providers to organize their capacities first. The ACO program will be a useful resource to learn from.

Plan Representative

- The high-touch One Care / SCO population requires many different resources. Providers need to build up their own networks before they will be at a point where they can take on financial risk.

Consumer Advocate

- Senior Whole Health is currently involved in value-based payment methodologies at the individual provider level and on the hospital level, with the Federally Qualified Health Centers (FQHCs). However, value-based payments are not for all organizations as it often involves critical mass.

- When considering the three avenues of value-based payment contracting: (1. Risk adjusted per-member per-month; 2. Quality measures; 3. Shared savings) it is important to caution against any one-size fits all mandate. Any mandate would need to consider each plan's member base, as well as their associated provider networks and their capabilities.

Measuring and Incenting Quality

Discussion Questions:

- What should MassHealth consider in developing One Care Stars (e.g., quality withhold, slate of quality measures tailored to population) for the population under age 65 with disabilities?
- How could MassHealth further align One Care and SCO quality measurement with the approaches and measures used in MassHealth ACOs, and incentivize improved quality across the MassHealth portfolio of products?

Attendee responses:

Consumer Advocate

- Is the Stars system solely for quality and payment reform or is it also a tool for consumer choice?

  MassHealth answer: ***The Medicare Stars system is also a tool for consumer choice. MassHealth has increased transparency requirements for MCO quality measures. Consistent with the Medicaid Managed Care rule MassHealth will be publicly displaying SCO HEDIS scores this year for the first time to support to increase transparency and support consumer choice.***

- Is there a way to align the measures present in the ACO program (for example the oral health screening measure) to One Care / SCO?
- Quality measures that look at social determinants of health are important. The ACO program is moving towards incorporating more of those quality measurements, and One Care and SCO should follow accordingly.

Plan Representative

- It is important to use a single vendor for the survey. Massachusetts providers are doing a lot of work incorporating ways to track and measure ACO quality measures. It would be good if the measures for One Care and SCO could align with the ACO measures to create a more uniform structure for providers.

Provider Representative

- MassHealth needs to better look at the ACO contract requirement for all plans to be accredited. Currently there are 28 accreditation measures**,** and only seven measures overlap with the ACO/MCO quality measures. MassHealth should attempt to align all the measures to provide the most beneficial resources for enrollees.

Consumer Advocate

- Keeping the number of quality standards to a finite set is important to allow for quality improvement. MassHealth should consider using existing quality measurement sets, that allow for both local and national comparisons. There should also be a rationale for why the each of the measurements were selected. This is different from the Stars system where the rationale and goals are much more ambiguous.
- It is best to utilize confidence intervals and then adjust them based on clinical and demographic factors. Aligning incentive models throughout the state is important, as well as having a cohesive measurement period for the programs.

Provider Representative

- There is a need to adjust for certain populations and move beyond clinical measurements. Some current metrics discount, or over-look, the tremendous work it takes to care for a severely disadvantaged population to bring the population to a more stable level of health. The metrics should account for the comprehensive care provided.