September 1, 2016

Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare

First Annual Report

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FINANCIAL ALIGNMENT INITIATIVE ANNUAL REPORT: ONE CARE: MASSHEALTH PLUS MEDICARE

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CMS Contract No. HHSM500201000021i TO #3

September 1, 2016

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM500201000021i TO #3. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

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Executive Summary

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives. CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation (Walsh et al., 2013) and State-specific evaluations.

This report analyzes implementation of the Massachusetts capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative, called One Care: MassHealth plus Medicare (hereafter referred to as One Care) from its initiation on October 1, 2013 through the conclusion of Demonstration Year 1 on December 31, 2014. This period of the report includes both qualitative data as well as quantitative results based on Medicare encounter data and Minimum Data Set (MDS 3.0) nursing facility assessments. Complete Medicaid data were not available for analysis. To capture relevant information generated at the conclusion of the demonstration period or immediately afterward, this report also includes updated qualitative information through July 1, 2015 (i.e., it includes information from the June 2015 site visit).

Specifically, this report describes the Massachusetts One Care demonstration's approach to integrating the Medicare and Medicaid programs; providing care coordination to enrollees; enrolling beneficiaries into the demonstration; and engaging stakeholders in the oversight of the demonstration, as well as information on financing and payment. Data sources include key informant interviews, focus groups, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, plan-reported data submitted to CMS' implementation contractor, and other demonstration data. This report also includes data on the beneficiaries eligible and enrolled, geographic areas covered, and status of the participating Medicare-Medicaid Plans (hereafter referred to as One Care plans or MMPs). Then, it reports results on service utilization and results of targeted analyses related to enrollees, LTSS users, users of behavioral health services and special populations. Finally it presents data on various quality measures.

Demonstration Overview

The One Care demonstration is a capitated model of service delivery in which CMS, the Commonwealth of Massachusetts, and One Care plans enter into three-way contracts to provide comprehensive, coordinated care for eligible beneficiaries. Three MMPs participated in the demonstration for the period covered by this report. The demonstration operated in 9 of the Commonwealth's 14 counties. The One Care demonstration began on October 1, 2013, and was originally scheduled to continue until December 31, 2016. MassHealth and CMS have effectuated a 2-year extension to continue the demonstration through December 31, 2018.

Individuals eligible for One Care include full-benefit Medicare-Medicaid beneficiaries aged 21 to 64 at the time of enrollment who (1) are enrolled in Medicare Parts A and B and eligible for Part D and MassHealth Standard or MassHealth CommonHealth[1] and (2) have no other comprehensive private or public health insurance. Additional requirements for eligibility are described in later sections of this report. One Care is the only demonstration under the Financial Alignment Initiative to limit its enrollment to this age group.

The demonstration integrates the full array of functions performed by Medicare and Medicaid. This includes the processes required to determine demonstration eligibility and complete enrollment; the coordinated delivery of all medical, acute, pharmacy, and long term services and supports; joint oversight of the One Care plans; coordinated quality management processes and systems; and a coordinated grievance and appeals process. One Care also included new and expanded services which generally had not been previously available to One Care beneficiaries.

Care coordination is a central feature of the One Care demonstration. Plans are required to offer care coordination to all enrollees through a care coordinator or clinical care manager for all services included as part of the demonstration. For LTSS, plans are required to contract with community-based organizations (CBOs) to provide Independent Living and Long-Term Services and Supports (LTS) coordinator services; although not required, all enrollees have the right to the assistance of an LTS coordinator to coordinate LTSS. One Care plans are also responsible, through an interdisciplinary care team (ICT), for developing an individualized care plan (ICP) for each enrollee, which must reflect the enrollee's preferences and needs as well has how services and care will be integrated and coordinated among providers.

One Care included a formal framework for stakeholder engagement to support design and implementation, including the creation of a consumer-chaired implementation council to advise on demonstration design features and to ensure accountability and transparency throughout the demonstration. The design of One Care included a collaboration between MassHealth, the Implementation Council, and the University of Massachusetts Medical School, known as the Early Indicators Project. The partners conducted beneficiary focus groups and surveys to evaluate beneficiary experience, inform the demonstration design, and monitor its implementation.

Successes, Challenges, and Preliminary Findings

MassHealth officials, One Care plans, and other stakeholders voiced strong support for One Care and agreed that it was well designed to meet the needs of the population served. For the first time, adult Medicare-Medicaid enrollees under the age of 65 in Massachusetts are being offered care coordination services to help them access Medicare medical and pharmacy services, Medicaid services, and new community-based behavioral health services and community-based LTSS services.

[1] MassHealth Standard covers mandatory and optional State Plan populations. CommonHealth covers adults and children with disabilities who are not eligible for MassHealth Standard because their income is too high. Populations covered under MassHealth Standard and CommonHealth both receive State Plan services, either through direct coverage or premium assistance, or both.

Massachusetts embedded a formal stakeholder engagement structure and process into the design of One Care; stakeholder input has shaped many of the demonstration's design features and modifications made during implementation.

The financial structure of the demonstration proved to be a primary challenge during its implementation. MMPs participating in One Care experienced losses during the period covered by this report; one of those plans notified MassHealth and CMS in June 2015 of its intent to withdraw from the demonstration effective October 1, 2015.

Integration of Medicare and Medicaid

The One Care demonstration integrates Medicare and Medicaid into a unified set of benefits. To manage joint implementation of One Care, CMS and MassHealth formed the Contract Management Team (CMT). The CMT includes representatives from the MassHealth Provider and Plans unit, MassHealth's administrative office, CMS regional office Medicare and Medicaid staff, and representatives from the MMCO. MassHealth officials indicated that the team was essential in identifying issues, vetting policy options, and making decisions. At times, issues had to be escalated to higher levels of authority, particularly issues that had implications for CMS Medicare policy and management of Medicare Advantage plans at the Federal level. As Massachusetts was the first capitated model demonstration implemented under the Financial Alignment Initiative, many of the policy questions and alignment challenges that surfaced with One Care were new; some policy decisions made in Massachusetts were applied to other States.

In the One Care demonstration, Medicare-Medicaid beneficiaries have a single, unified process for enrollment into a managed care plan that provides the full range of medical, acute, LTSS, behavioral health, and pharmacy benefits. Beneficiary materials—including the member handbook, mailings, and member identification cards—have been unified for the enrollee as part of the demonstration. From the beneficiary's perspective, all the separate Medicare and Medicaid eligibility and enrollment functions have been coordinated, if not integrated, into a single process.

Integration of the many operational functions that control eligibility and enrollment between MassHealth, CMS, and the One Care plans has not been without its challenges. The operational and decision rules used in the MassHealth enrollment and eligibility systems did not align with those used by CMS, resulting in discrepancies in enrollment information among the various systems. CMS continues to collaborate with MassHealth to identify and remediate enrollment discrepancies. Integrating Part D presented particular challenges, in part because MassHealth officials and plans noted that policies and procedures for Medicare Part D pharmacy differ from policies and procedures that apply to all other covered services under the demonstration, including non-Part D pharmacy products.

MassHealth and CMS developed a set of demonstration-specific quality measures to assess performance of One Care. In addition, plans must collect measures as part of their Medicare Advantage plan requirements. Plans reported concerns about the number of measures and the redundancy of some measures. They also reported on the challenges of collecting the data, using the required formats and definitions, and the time required to develop some of the reports for this demonstration.

One Care plans receive three monthly capitation payments from CMS and MassHealth. CMS makes monthly payments reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. MassHealth makes a monthly payment reflecting coverage of Medicaid services. Although each plan receives three separate payments for services, they can blend these payments internally to cover the mix and array of Medicare and Medicaid services provided, and can leverage potential savings from one program to cover services in the other. They can also use the flexibility afforded by capitated payments to develop new service delivery models (as one plan did) or offer flexible benefits that meet the individual needs of members.

Successes, Challenges, and Preliminary Findings

Stakeholders reported an unprecedented amount of interagency and intra-agency collaboration and communication within the Commonwealth, within the Federal agencies, and across State and Federal boundaries in order to implement One Care. A collaborative partnership between MassHealth and CMS was critical to successful implementation, with the CMT playing a critical role in identifying issues, triaging decision making, and resolving complex policy and administrative questions.

The integration of eligibility and enrollment systems created significant challenges that required MassHealth to commit significant time and resources to develop Commonwealth-specific subsystems that would allow for successful interface. The plans experienced, first-hand, the complexity of integrating Medicare and Medicaid functions, with plans reporting the need to meet multiple reporting and other administrative requirements that did not fully align. Due to the relatively small size of One Care plans, it was challenging for them to establish comprehensive provider networks and negotiate rates with providers during early implementation, even though MassHealth placed a high priority on provider education, training, and outreach activities.

In addition, the three participating plans experienced losses during the period covered by this report, noting that Medicare and Medicaid capitation rates were inadequate to cover new costs associated with care coordination, additional benefits offered, and administrative start-up costs of the demonstration. In June 2015, one of the three plans notified MassHealth and CMS that it intended to withdraw from the demonstration effective October 1, 2015.

Eligibility and Enrollment

One Care beneficiaries can opt into the demonstration, be passively enrolled into a One Care plan (if there are at least two plans available in the area), and, at any time, disenroll from a plan or opt out of future passive enrollment into the demonstration. The One Care demonstration started with an initial period of opt-in only enrollment. During the time period covered by this report, there were four phases of passive enrollment and the continued opportunity for opt-in enrollment. The plans' capacity, initial performance, and interest in increasing the number of enrollees were taken into account when determining the number of beneficiaries to passively enroll.

Passive enrollment created many logistical, operational, and communication challenges for MassHealth, the plans, and beneficiaries. The large volume of enrollees during the phases of passive enrollment meant more cases that required the time-intensive process of reconciling

enrollment data between MassHealth and CMS. Processing enrollment files in a timely manner during passive enrollment in the demonstration's early stages produced challenges particularly because of discrepancies between the MassHealth and CMS systems. CMS worked closely with MassHealth to ensure that eligibility data were processed in the time frame required to ensure accurate effective dates. This close coordination between CMS and MassHealth was key and critical to reducing and minimizing enrollment discrepancies. Passive enrollment also created challenges for the One Care plans. During its initial phases, plans had to bring many functions and staffing to scale within a short period of time. Stakeholders generally supported more gradual growth of the demonstration to allow beneficiaries to affirmatively opt-in rather than to be passively enrolled in a plan, whereas MassHealth, CMS, and the plans recognized passive enrollment as an effective methodology to achieve adequate growth and scalability of the demonstration.

Once a member is enrolled in a plan, the plan is required to contact the enrollee and conduct an initial assessment within 90 days of the beneficiary's enrollment date. All three One Care plans have had difficulty locating enrollees to conduct the initial assessments, particularly those who had been passively enrolled. Some of these challenges were attributed to the population served by One Care, which includes a high prevalence of individuals with behavioral health needs and individuals experiencing homelessness. In other cases, these challenges were attributed to incorrect or changing addresses and phone numbers. Some beneficiaries reportedly were wary of being contacted by an unknown or unfamiliar organization, did not want to be contacted, or did not understand why they were being contacted. Although plans have made some progress, nearly 28 percent of enrollees could not be located as reported in the first quarter of 2015.

Successes, Challenges, and Preliminary Findings

The small number of plans participating in the demonstration limited the scale and reach of the demonstration; enrollment in the demonstration was low. Of the almost 100,000 Medicare-Medicaid beneficiaries eligible for enrollment in counties where One Care was available, approximately 17,700 beneficiaries were enrolled as of July 2015—about 18 percent of eligible beneficiaries. The three participating plans had different strategies for enrollment growth. MassHealth and CMS worked with the plans during the different enrollment phases to accommodate the varying growth strategies while also considering factors such as plan capacity and enrollee case mix. MassHealth officials and plans viewed passive enrollment as a necessary and important component of the demonstration, but it created unexpected challenges to plans in staffing, locating enrollees, and conducting assessments. Faced with the unexpected level of difficulty of finding and engaging members, MassHealth, CMS, and the plans worked collaboratively to share information and to devise creative approaches for finding and contacting enrollees. Based on survey results, beneficiaries who opted into the demonstration were motivated to join by the benefits or other features of the demonstration.

Locating enrollees after enrollment was a significant challenge for plans. Plans reported their greatest difficulty in reaching enrollees during passive enrollment periods. The waves of passive enrollment strained the plans and their ability to locate and assess enrollees in a timely manner, and plans had not anticipated the additional time, resources, and costs associated with finding and contacting enrollees. Plans also reported that allowing beneficiaries to enroll and

disenroll on a monthly basis limited the plans' ability to manage care and positively impact long-term outcomes.

Care Coordination

The use of care coordinators, clinical care managers, and community-based LTS coordinators are central features of the One Care model. For medical and behavioral health services, plans must offer care coordination to all enrollees through a care coordinator or, for members with complex needs, a clinical case manager. The One Care plans are required to contract with CBOs for the LTS coordinator role related to LTSS coordination. Before the One Care demonstration, enrollees had limited, if any, access to care coordination services.

One Care plans must complete a comprehensive in-person assessment within certain required timeframes. Plans were initially required to complete in-person reassessments annually, but this requirement was modified to allow for some telephone reassessments. Although there is no required assessment tool, One Care plans must assess for the 21 required domains outlined in the three-way contract. Plans reported that their ability to conduct timely assessments gradually improved over time, but they acknowledged the challenges of meeting the required time frames, particularly during early phases of passive enrollment when plans had higher volumes of enrollees requiring assessments. All One Care plans contracted with external vendors to conduct assessments, particularly during early implementation.

As part of the rate methodology for determining the Medicaid component of the capitated payment to the MMPs, MassHealth initially assigned all enrollees to one of four principal rating categories based on historical claims data. The different rating categories were based on need for facility versus community care, level of nursing or activities of daily living needs, and certain diagnostic criteria. Depending on an enrollee's assigned rating category, plans are required to complete an additional assessment using the MDS-HC, a proprietary clinical screening instrument. Note that the MDS-HC is different from the Minimum Data Set (MDS 3.0) nursing facility assessments mandated by CMS. MDS 3.0 data are used for the quantitative analysis in this report. The MDS-HC is used to assign a rating category for the enrollee that determines the level of payment to the plan. Plans reported that it was advantageous to complete the MDS-HC on all enrollees because MassHealth's initial rating assignments based on prior claims history did not always accurately reflect the enrollees' true needs.

One Care plans are responsible for establishing an ICT to coordinate the services needed by the enrollee. A primary responsibility of the ICT is to work with the enrollee to develop, implement, and maintain an ICP. Plans emphasized the role of the enrollee in developing the size and composition of the ICT and that ultimately the design was determined by enrollee choice.

The ICT must develop an ICP for each enrollee incorporating information from the comprehensive assessment. As designed, the ICP must be developed under the direction of the enrollee, and the enrollee must be at the center of the care planning process. Among other requirements, the ICP must reflect the enrollee's preferences and needs; it must include a prioritized list of the enrollee's concerns, goals, and strengths, and a plan for addressing concerns or goals. The ICP must also identify how services and care will be integrated and coordinated across health care, community, and social services providers.

Plans are required to offer care coordination to all enrollees through a care coordinator or clinical care manager if the person has certain complex needs. Because of the high number of individuals with behavioral health needs served by One Care, all plans noted the importance of addressing behavioral health needs in the care planning process. One plan delegated a portion of its care coordination responsibilities to outside entities.

Plans must offer enrollees the ability to have an LTS coordinator who is employed by a CBO to coordinate their LTSS needs. The CBOs include Aging Services Access Points (ASAPs), Independent Living Centers (ILCs), and Recovery Learning Communities (RLCs). The ASAPs are part of the elder services network responsible for providing information and referral and other services related to delivering home and community-based services (HCBS). The ILCs provide services such as advocacy, information and referral, and skills training to individuals with disabilities to help them live independently in the community. The RLCs are consumer-run networks that provide advocacy, information and referral, and peer support that focus on recovery and wellness for individuals with behavioral health needs.

The extent of services provided by the CBOs to plans varied. Plans also reimbursed the CBOs differently based on the service, ranging from a monthly fee to payment based on units of service. Some CBOs contracted with more than one plan. The role of the RLC in the delivery of LTSS, especially in providing LTS care coordination services, was added to the One Care design in response to stakeholder feedback regarding the behavioral health needs of the One Care population. Integrating the RLCs as part of the delivery system for LTS coordination services has been challenging; generally, RLCs have received fewer referrals than ASAPs or ILCs for LTS coordinator services.

MassHealth, plans and CBOs reported challenges for some CBOs in managing the high volume of referrals that occurred during phases of passive enrollment. CBOs reported that plans had different practices regarding the LTS coordinator's responsibilities following the LTSS assessment and participation on the ICT. MassHealth convened a workgroup during the first year of the demonstration to review the role and expectations for how plans were to be implementing the LTS coordinator.

The exchange of health information, especially behavioral health information that some beneficiaries do not want shared across providers, has been a particular area of focus in Massachusetts. Creating guiding principles and best practices around the sharing of behavioral health information was a primary focus of the One Care Implementation Council, in collaboration with MassHealth, the plans, and other stakeholders.

To facilitate care coordination, One Care plans are required to maintain a single, centralized, comprehensive record, known as the Centralized Enrollee Record (CER), that documents the enrollee's medical, prescription, functional, and social status. All three One Care plans made up-front investments in electronic documentation systems to meet these requirements. All One Care plans developed CERs that could be accessed by plan staff, but the extent to which information could be accessed, shared, or updated by external providers varied.

Successes, Challenges, and Preliminary Findings

MassHealth, plans, and stakeholders identified care coordination as the demonstration's greatest success. They reported that care coordination under One Care has benefitted enrollees and is widely viewed as a valuable service for connecting beneficiaries to new and previously existing resources and services. MassHealth and plans emphasized the importance of respecting enrollees' individual preferences and choices when providing care coordination, and they noted that there is no "one size fits all" care coordination model appropriate for the One Care population.

The LTS coordinator role is widely supported by stakeholders, providers, and plans, and is considered to be an important component of the One Care demonstration. The LTS coordinator role was designed to be flexible and person-centered, and to meet a broad range of enrollee needs, but the lack of clearly defined roles and responsibilities led to inconsistencies and confusion in implementation. It has been difficult for plans and CBOs to find the right balance between flexibility and structure for the LTS coordinator role. Plans and CBOs noted initial challenges in understanding each other's roles and responsibilities and in developing new relationships. Both needed to build capacity, because One Care plans had difficulty in meeting required timeframes for completing assessments, and CBOs lacked capacity to handle LTSS referrals, especially during waves of passive enrollment.

Beneficiary Experience

Improving the experience of beneficiaries who access Medicare- and Medicaid-covered services is one of the main goals of the demonstrations under the Financial Alignment Initiative. Many aspects of One Care are designed expressly with this goal in mind, including emphases on working closely with beneficiaries to develop person-centered care plans, delivering all Medicare and Medicaid services through a single plan, providing access to new and flexible services, and aligning Medicare and Medicaid processes. MassHealth and CMS recognized the importance of directly soliciting beneficiary feedback on their experience with One Care.

The RTI evaluation team also used qualitative and quantitative methods to assess the impact of the Massachusetts demonstration on beneficiary experience. These methods included conducting focus groups to gather insights from beneficiaries (RTI focus groups); conducting in-person interviews with Massachusetts demonstration staff during site visits and follow-up telephone interviews; and examining demonstration data available from other sources including CAHPS and data reported to the CMS Complaints Tracking Module and other sources on appeal and complaint data. One Care was also designed to solicit information about beneficiary experience through a variety of methods that helped inform implementation of One Care. In collaboration with the One Care Implementation Council and UMass Medical School, MassHealth monitored, assessed, and reported on early indicators of beneficiary perceptions of and early experiences with One Care as part of the Early Indicators Project (EIP). The EIP used multiple methods to gather qualitative and quantitative data from various sources, including focus groups (EIP focus groups) and surveys (EIP surveys).

Overall satisfaction with One Care. Both RTI and EIP focus group participants reported being satisfied with the demonstration overall. Although some RTI focus group participants reported initial apprehension when joining the demonstration, they reported being

satisfied with their plan and services. With some exceptions, even those participants who reported quality or access issues nonetheless expressed overall satisfaction. A few RTI focus group participants reported quality and access issues significant enough to them that their overall view of the demonstration was negative.

New or expanded benefits. A key design feature of One Care is that it offers new and expanded benefits to enrollees. Some RTI focus group participants attributed their satisfaction with One Care to the availability of these new services. According to a MassHealth-sponsored survey, a large majority of respondents who chose to opt into One Care reported that they hoped to gain access to dental and vision services. Other frequently mentioned services to which respondents hoped to gain access included LTSS, transportation services, behavioral health services, and care coordination. Although many participants in an RTI focus group described transportation as an important service for them, a number of participants voiced complaints and concerns regarding the quality of the transportation services provided under One Care.

Medical and specialty services. A combined set of Medicare and Medicaid benefits is offered as part of a single benefit package under the demonstration. Almost 90 percent of respondents to a State-sponsored survey reported having a primary care physician (PCP) under One Care. Of those respondents with a PCP, 84 percent had met with their PCP since enrolling in the demonstration, and overall satisfaction with their PCP was high—85 percent reported being somewhat or extremely satisfied (Henry et al., 2015). In addition, more than 80 percent of those survey respondents reported that their needs for prescription drugs, specialty care, and mental health services were being met. Several EIP and RTI focus group participants reported that being able to keep their same PCP was an important consideration in choosing to participate in the demonstration. During the evaluation's site visit interviews, One Care plans reported giving high priority to developing a provider network that preserved, where possible and desired, beneficiaries' relationship with their former PCP.

Care coordination services. Participants in EIP focus groups who had met with their care coordinators generally reported favorable experiences, as did participants of the RTI focus groups. Participants in RTI focus groups cited several reasons for their satisfaction: some found that care coordinators were able to connect them to new or additional services, and others felt having someone available to help them manage their care reduced stress and anxiety. Some RTI focus group participants voiced concern that care coordinators appeared to have high caseloads and that their care coordinators were too busy to return calls or provide assistance. A few participants also reported that their care coordinators did not listen to them.

LTS coordination services and LTSS. Findings from EIP and RTI focus groups, and a MassHealth-sponsored survey, highlighted beneficiaries' confusion about the LTS coordinator role. Several participants in both groups were unsure whether they had met with an LTS coordinator. Even participants who were receiving LTSS were not sure if they had met with an LTS coordinator and were not clear about who was responsible for implementing and monitoring those services. Several participants in both MassHealth and RTI focus groups expressed confusion and frustration around authorization and implementation of LTSS.

Beneficiary access to services. For the most part, respondents to an EIP survey and RTI focus groups reported that their needs for medical services were being met under One Care,

although participants reported unmet needs for oral/dental care and substance abuse services. Other than dental, focus group participants did not widely report access issues specific to a particular service. However, a few participants reported emergency room use due to access barriers—mostly an inability to schedule, or get transportation to, a same day appointment with their PCP. Some EIP and RTI focus group participants reported increased access to benefits under One Care, noting that One Care had reduced barriers and improved access to care.

Personal health outcomes and quality of life. Many RTI focus group participants reported that One Care had made a positive impact on their lives and was an improvement over their prior health care coverage; for some participants the differences were profound.

Experience of special populations. One Care was designed to meet the needs of younger (individuals under age 65 at time of enrollment) Medicare-Medicaid beneficiaries, including individuals with LTSS or behavioral health needs. Results of the CAHPS survey indicate that enrollees' experiences obtaining LTSS varied by plan, but generally respondents who indicated a need for in-home personal care assistance reported that it was usually or always easy to get through their plan. Approximately one-third of respondents in each One Care plan had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment. Experiences in this area also varied by plan, but the majority of respondents reported that it was usually or always easy to get or replace the medical equipment they needed through their health plan. More than 80 percent of respondents in each plan reported that it was usually or always easy to get treatment or counseling through their health plan.

Beneficiary protections. Beneficiary protections include, among others, complaint and appeals processes that provide an avenue for beneficiaries to seek redress when they have issues or disagree with decisions made by One Care plans or providers, and the availability of an Ombudsman Program to advocate for the beneficiary. The One Care Ombudsman Program (OCO) is an independent entity created through Federal funding that began operating in March 2014 to ensure adequate oversight of these beneficiary protections. Because One Care integrates Medicare and Medicaid services, data on complaints and appeals are compiled from a number of sources, including the OCO, One Care plans, MassHealth, and Medicare.

Complaints. After discussions with CMS, the RTI evaluation team identified four specific categories of complaints as important for the evaluation: inability to get an appointment with a PCP; inability to get an appointment with a specialist; excessive wait time for an appointment with the PCP; and excessive wait time for an appointment with a specialist. The average number of complaints across the three One Care plans was less than one complaint per 1,000 members in any quarter for any of the four specified complaint categories. The vast majority of complaints fell into the non-specific category. During the period covered by this report, complaints that came to the attention of MassHealth and 1-800-Medicare fell principally in the areas of benefits/access.

Appeals. CMS and MassHealth developed a coordinated appeals process that is detailed in the three-way contract. For calendar year 2014, One Care plans reported receiving a total of 231 appeals. Based on the first level of appeal, which involves a reconsideration of the decision at the MMP level by an individual who did not make the original decision, 129 (56 percent) had adverse outcomes (i.e., original determination upheld), 94 (41 percent) had fully favorable

outcomes to the beneficiary, and 8 (less than 1 percent) had partially favorable outcomes to the beneficiary.

Critical incidence and abuse reports. One Care plans are required to report on the number of critical incidents and abuse reports as defined by CMS. Data reported by the plans indicate that the number and rate of critical incidents and abuse reports remained low in calendar Quarters 1 through 6 of the demonstration period.

Successes, Challenges, and Preliminary Findings

Findings from the RTI and MassHealth focus groups and MassHealth surveys generally indicate that beneficiaries are satisfied with One Care. For some One Care enrollees, the impact of the demonstration on their services and quality of life has been profound, as One Care has offered services and opportunities that were not available prior to the demonstration. A number of survey respondents and focus group participants expressed satisfaction with their care coordination services, although findings from One Care focus groups and surveys reflect confusion of the LTS coordinator role and access to LTSS. Survey respondents and focus group participants liked the new and expanded benefits offered under One Care.

Improvements in quality and access are still needed; some focus group participants expressed quality concerns with several One Care services, including with vendors under contract with the plans providing transportation, durable medical equipment, and homemaker services.

Feedback from the RTI and MassHealth focus group participants suggests that many beneficiaries are not aware of formal complaint and appeals processes or available resources to assist them when they disagree or have issues with the plans. Additional training and education appear warranted to ensure beneficiary awareness and access to complaint and appeal processes as well as to resources such as the OCO.

Stakeholder Engagement

Key informants expressed broad agreement that stakeholder engagement has been a critical component of the One Care demonstration from its inception and that the high level of engagement is a notable success of the demonstration. Massachusetts actively engaged a broad representation of stakeholders in the demonstration's planning, development, and implementation phases. The level of stakeholder involvement is widely perceived as unprecedented and meaningful to the initial demonstration design and operation.

Some of the more significant mechanisms for soliciting public feedback and exchanging information have been the meetings open to the public convened by MassHealth and the establishment of an Implementation Council. Significant stakeholder input was also solicited as part of the EIP, which gathered feedback on the beneficiary experience with early enrollment and implementation through surveys, focus groups, and other approaches.

The Implementation Council was established as a 21-member committee, at least 51 percent of whom were required to be consumer members. Membership included representatives from community-based organizations, providers, trade organization, and unions. Support staff to

the Council has been provided by the University of Massachusetts Medical School. The Implementation Council provided feedback on several aspects of the demonstration, including the enrollment processes, communication strategies, and financing structures. The Implementation Council developed subcommittees and work groups to address specific issues of broad interest. Demonstration workgroups included such topic areas as behavioral health privacy; quality; LTS coordination services; and encounter data. Composition of the workgroup membership depended on the issues being addressed.

Successes, Challenges, and Preliminary Findings

From the initial stages of design, stakeholders made it a priority to ensure that beneficiaries had a voice in the demonstration. Importantly, MassHealth and stakeholders have stayed focused on their mutual goals and commitment to the demonstration model even while some disagreements have persisted, for example, regarding the use of passive enrollment and the availability of service utilization, cost, and related financial data. Both MassHealth and stakeholders noted that trust and relationship-building takes time and effort, particularly while developing a new initiative such as One Care.

Financing and Payment

All covered Medicare and Medicaid services are paid on a capitated basis. One Care plans receive three monthly capitation payments from CMS and MassHealth. CMS makes a monthly payment reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. MassHealth makes a monthly payment reflecting coverage of Medicaid services. Two sets of services continued on a fee-for-service basis: targeted case management services and rehabilitation option services.[2]

Successes, Challenges, and Preliminary Findings

Even before implementing One Care, State officials, plans, and stakeholders had ongoing concerns about the adequacy of the Medicare and Medicaid capitation rates particularly during the start-up phase. Before the demonstration started, several plans that had applied to participate in the demonstration chose not to participate, citing concerns regarding the adequacy of the rates. A number of other factors contributed to financial challenges during implementation, including high start-up costs; high levels of unmet needs of new enrollees; difficulties in locating enrollees resulting in longer continuity of care periods; assignment of initial ratings categories not reflective of the enrollees' true needs; and impacts of the Part D reimbursement methodology.

Many plans and stakeholders voiced concerns that the Medicare and Medicaid capitation rates were not aligned with the care model, nor were they reflective of the needs of the dually eligible population younger than 65. In addition, plans reported that initial savings percentages applied to the capitation rates for the demonstration were overly optimistic, especially in light of the lead-up time required to fully implement the care model. In an open meeting on July 1, 2015, MassHealth shared information that indicated that plans were anticipating losses during the first

[2] In Massachusetts, targeted case management is provided by Department of Mental Health (DMH) staff for individuals with severe mental disabilities; it is provided by Department of Developmental Services staff for individuals with intellectual disabilities. Rehabilitation option services are provided through DMH.

18 months of the demonstration (October 1, 2013, through March 31, 2015).[3] CMS and MassHealth implemented a number of adjustments to the Medicare and Medicaid rate methodologies during this reporting period, which mitigated but did not eliminate losses. Even with these changes, one MMP announced its withdrawal from One Care in June 2015.

Service Utilization

The purpose of the analyses of service utilization is to understand Medicare service trends over time in the demonstration and comparison groups so that CMS, the Commonwealth, and stakeholders can understand the beneficiary characteristics of these groups and their utilization patterns before direct group comparisons are made in future reports that will provide the results of impact analyses. Complete Medicaid data were not available for this report to reliably identify those with any HCBS use in the demonstration period, so analyses on individuals eligible for the demonstration and One Care enrollees using any LTSS focus on only the small number of beneficiaries using LTSS nursing facility services (meaning only beneficiaries in nursing facilities as opposed to any other LTSS facility). Future Annual Reports will include analyses identifying HCBS users and their Medicare and Medicaid service use.

Populations analyzed in the report include all demonstration-eligible beneficiaries, as well as the following special populations: demonstration enrollees, those receiving any LTSS nursing facility care, those with any behavioral health service use in the last 2 years for an severe and persistent mental illness (SPMI), and seven demographic and health condition groups (age, gender, race, any disability, presence of Alzheimer's disease, hierarchical condition category (HCC) score category, and whether the beneficiary died).

Highlights of Quantitative Analyses of Utilization by the Demonstration-Eligible Population

- One Care enrollees were in poorer health than demonstration nonenrollees in Massachusetts, as indicated by higher percentages of beneficiaries with HCC scores between 1 and less than 2 (33 to 29 percent), a larger percentage of beneficiaries with SPMI (52 to 46 percent), and a larger percentage having disability as their original reason for Medicare entitlement (95 to 89 percent). An HCC score of 1.0 reflects costs for the average Medicare beneficiary.

- There were only slight differences in total, psychiatric-, and non-psychiatric-related inpatient admissions between One Care beneficiaries and those eligible beneficiaries who were not enrolled. Total inpatient admissions per 1,000 user months among those enrolled was higher than among those who did not enroll (183.2 vs. 167.8 visits). A similar pattern was observed across the different admission categories.

- Among those who were enrolled in the demonstration, a slightly lower percentage had emergency department (ED) use compared with those who were not enrolled (6.6 to 7.2 percent). But those enrolled in the demonstration with any ED visits had a

[3] Updates to this information based on data available outside the time frame of this report will be included in the second Annual Report.

higher number of visits per 1,000 eligible months than nonenrollees (244.0 vs. 207.5 visits).

- Among those not enrolled in the demonstration, a higher percentage had a primary care evaluation and management visit, compared with those who enrolled (49.1 to 41.8 percent). Among those with any use, those who were not enrolled had a higher rate of primary care visits per 1,000 user months relative to those who enrolled (984.6 vs. 909.6 visits).

- The use of Medicare home health services if any use was three to four times higher for enrollees than for nonenrollees.

- Demonstration-eligible beneficiaries with any LTSS nursing facility use in Massachusetts had modestly higher inpatient, ED, primary care, and behavioral health use than the comparison group.

- Medicare behavioral health utilization for those enrolled was approximately half that of those not enrolled. Given that the results presented are for Medicare data only, this lower utilization potentially may be due to higher Medicaid utilization for new behavioral health benefits in One Care.

- Results from quantitative analyses on various Medicare services show limited evidence of the demonstration's effect during the first demonstration year, partly due to initial implementation challenges but also due to the need for allowing adequate time for care interventions at the beneficiary level to affect service utilization; one of the expected outcomes of an integrated model of care includes reducing underutilization of community-based services and reducing overutilization of institutional care.

Quality of Care

MassHealth has extensive experience with managed care and the quality management systems necessary to oversee contract compliance and program performance. Implementation of One Care, however, has required both an expanded set of measures to define how quality will be assessed under an integrated Medicare and Medicaid plan, and the establishment of an oversight system, in collaboration with CMS. The One Care demonstration used quality measures and results of beneficiary feedback during the first year of implementation to monitor program performance.

Results on two groups of quality measures analyzed by RTI for this report are presented: selected Healthcare Effectiveness Data and Information Set (HEDIS) measures for calendar year 2014 and six quality measures developed by the RTI evaluation team. These include 30-day all-cause risk-standardized readmission rate; preventable emergency department visits per 1,000 demonstration eligible months; rate of 30-day follow up after hospitalization for mental illness; an overall composite measure for ambulatory care sensitive condition admissions per 1,000 eligible months; a chronic condition composite measure for ambulatory care sensitive condition admissions per 1,000 eligible months; and screening for clinical depression per 1,000 eligible

months. These six measures are reported for four different populations of interest: demonstration eligible beneficiaries (including both enrollees and nonenrollees without respect to enrollment status), enrollees vs. nonenrollees, demonstration eligible beneficiaries with any LTSS nursing facility use, and demonstration eligible beneficiaries with SPMI diagnoses. Early indicators show both successes and challenges in managing the care of One Care members.

Highlights on Quality of Care under One Care

- On the RTI evaluation's 30-day all-cause risk standardized inpatient readmission rate measure, enrollees had a lower percentage of readmissions than nonenrollees, which potentially may show the benefits of One Care.

- Although the measure for all eligible individuals for 30-day follow-up after hospitalization for mental illness calculated from Medicare claims showed little change over time, enrollees had much lower follow-up than nonenrollees. The enrollee population potentially had poorer health and/or the One Care demonstration had difficulty getting members under management. Conversely, enrollee needs were potentially met with some of the new behavioral health benefits that would not have been captured in this measure.

- Because Massachusetts enrolled beneficiaries incrementally over time and because MMPs had difficulty identifying and then finding beneficiaries in the community, One Care likely did not make substantial progress on care management until near the end of the first demonstration period. These findings are not surprising for a new demonstration. More time is needed for the demonstration to mature.

Successes, Challenges, and Preliminary Findings

MassHealth leveraged its experience in quality management of Medicaid managed care to the One Care demonstration. One Care has put into place a multi-faceted quality management system that uses multiple methods and stakeholders to assess program performance, as demonstrated though the operation of the CMT and initiatives such as the EIP. During implementation, however, plans indicated that the new extensive reporting requirements on quality measures were a major challenge and, for some plans, redundant. Many of the measures require data from the enrollee record in their calculation, which results in a time consuming manual collection process or the re-design of systems to allow for auto abstraction. Changes to data requirements on measures relating to the assessment process, care plan, and referral to LTS coordinators were seen as particularly problematic.

One Care plans also reported challenges in implementing measures and sought clarifying guidance from MassHealth and CMS on some measures. MassHealth noted the absence of national benchmarks against which they could measure One Care plan performance.

For most of the first year of implementation, emphasis was placed on developing the necessary structure and processes to support an integrated system of care, such as development of care coordination models. Maturation of the model will require a shift of emphasis to the outcomes of the care model and the identification of factors contributing to performance and identification of benchmarks for evaluating available data.

Conclusions

Overall, State officials and stakeholders indicated strong support for One Care and its integrated approach to service delivery for the population of Medicare-Medicaid beneficiaries served by One Care. Before the One Care demonstration, Medicare-Medicaid beneficiaries younger than age 65 were ineligible to enroll in Medicaid managed care. For many enrollees, One Care provided access to care coordination services for the first time as well as access to new and expanded benefits. A key element of the One Care demonstration is the use of medical care coordinators and, as appropriate, community based LTS coordinators to assess the enrollee's needs and facilitate access to and coordination of services within the medical, behavioral health, and LTSS systems.

Especially important to beneficiaries have been enhanced benefits, such as care coordination, LTSS, and dental services, not all of which were available to all enrollees prior to the demonstration. However, several focus group participants reported quality issues related to some of the services they received, including but not limited to transportation services. Stakeholders, beneficiaries, and plans provided examples of situations where One Care made a difference in the quality of life for beneficiaries and provided access to previously unavailable services. One Care has facilitated innovations not otherwise possible under the previous health care delivery system, such as the development of new community based programs by one plan to support enrollees with behavioral health needs as an alternative to institutional care.

Implementation of One Care has been challenging. It has required a substantial commitment of time and resources on the part of Commonwealth staff, and all parties experienced a learning curve that was particularly steep in Massachusetts because One Care is the first capitated model demonstration under the Financial Alignment Initiative. However, some of these challenges were mitigated by an unprecedented level of collaboration throughout the demonstration, as reported by MassHealth, CMS, plans, and other stakeholders.

In preliminary findings, One Care enrollees were in poorer health than demonstration nonenrollees in Massachusetts, partly because a larger percentage of enrollees had SPMI and had disability as their original reason for Medicare entitlement. Generally, enrollees were anticipated to cost more than nonenrollees, given their higher hierarchical condition category scores.

Some Medicare service use was higher for enrollees than nonenrollees, potentially because of health care needs for enrollees that had previously been unmet before the demonstration. For example, Medicare home health service use was three to four times higher for enrollees than for nonenrollees, and ED use was also higher among enrollees than nonenrollees for those with any use. Prior research has shown that Medicare-Medicaid enrollees tend to have poorer access to care, and thus may be underserved. Medicare behavioral health utilization for enrollees was approximately half that of nonenrollees. Given that the results presented are for Medicare data only, this lower utilization potentially may be due to higher Medicaid utilization for new behavioral health benefits in One Care.

Overall, results from quantitative analyses on various Medicare services show limited evidence of the demonstration's effect during the first demonstration year, in part because the One Care model needed more time for full implementation at a programmatic and operational level.

1. Overview

1.1 Evaluation Overview

1.1.1 Purpose

The Medicare-Medicaid Coordination Office and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

This Annual Report on the Massachusetts capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative, called One Care: MassHealth plus Medicare (hereafter referred to as One Care), is one of several reports that will be prepared over the next several years to evaluate the demonstration. CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation (Walsh et al., 2013) and State-specific evaluations.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness and/or substance use disorders, LTSS recipients). To achieve these goals, RTI collects qualitative and quantitative data from Massachusetts each quarter; analyzes Medicare and Medicaid enrollment, claims, and encounter data; conducts site visits, beneficiary focus groups, and key informant interviews; and incorporates relevant findings from any beneficiary surveys conducted by other entities. In addition to this report, monitoring and evaluation activities will also be reported in subsequent Annual Reports, and a final evaluation report.

1.1.2 What It Covers

This report analyzes implementation of the One Care demonstration from its initiation on October 1, 2013 through the conclusion of Demonstration Year 1 (i.e., October 1, 2013, through December 31, 2014). For this reporting period, qualitative and quantitative data based on Medicare claims and the nursing facility Minimum Data Set (MDS 3.0) are included. To capture relevant information generated at the conclusion of the demonstration period or immediately afterward, this report also includes updated qualitative information through July 1, 2015 (i.e., it includes information from the June 2015 site visit). It describes the Massachusetts One Care demonstration key design features; examines the extent to which the demonstration was implemented as planned; identifies any modifications to the design; and discusses the challenges, successes, and unintended consequences encountered during the period covered by this report. It

also includes data on the beneficiaries eligible and enrolled, geographic areas covered, and status of the participating Medicare-Medicaid Plans (hereafter referred to as One Care plans or MMPs). Finally, the report includes data on care coordination, the beneficiary experience, stakeholder engagement activities, and, to the extent that data are available, analyses of utilization, quality, and cost data and a section on special populations served.

1.1.3 Data Sources

A wide variety of information informed this first Annual Report of the One Care demonstration. Data sources were used to prepare this report, including the following:

Key informant interviews. The evaluation team conducted site visits in Massachusetts in April 2014 and June 2015. The team interviewed the following individuals either during the site visits or during follow-up phone calls: Commonwealth officials, including MassHealth (the Massachusetts Medicaid program) policy leaders, operations and contract staff, quality management staff, data staff, representatives from other Commonwealth agencies; officials from CMS' regional and central offices; representatives from all three One Care plans and from community-based organizations (CBOs), including the Independent Living Centers, Recovery Learning Communities, and Aging Services Access Points; stakeholders from the Implementation Council; and representatives from the One Care Ombudsman program and from Disability Advocates Advancing Our Healthcare Rights.

Focus groups. The RTI evaluation team conducted four focus groups in Massachusetts: two in Worcester on June 23, 2015, and two in Boston on June 24, 2015. A total of 29 beneficiaries participated in the RTI focus groups. Participants were assigned to one of two groups, based on whether they self-identified as having an Independent Living and Long-Term Services and Supports (LTS) coordinator. Each group included participants from at least two different plans, as well as a mix of individuals with self-reported medical conditions, physical/mobility issues, and behavioral health needs. All participants had been enrolled in a One Care plan for at least 9 months.

MassHealth, in collaboration with the Implementation Council and the University of Massachusetts Medical School, conducted four focus groups from December 2013 through April 2014, two in Worcester and one each in Springfield and Boston. Two focus groups were held in December 2013, one for English-speaking beneficiaries who chose to opt into One Care and the other for English-speaking beneficiaries who chose to opt out of the demonstration before enrollment. A March 2014 focus group was conducted for Spanish-speaking enrollees who were passively enrolled or chose to opt in. The April 2014 focus group solicited feedback from beneficiaries who were passively enrolled into the demonstration. A total of 26 beneficiaries participated in the focus groups.

Surveys. Medicare requires all Medicare Advantage plans, including One Care plans, to conduct an annual assessment of beneficiary experiences using the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. The 2015 survey for One Care plans was conducted in the first half of 2015 and included the core Medicare CAHPS questions, 10 supplemental questions added by the RTI evaluation team, and 9 supplemental questions added by MassHealth. Survey results for a subset of 2015 survey

questions are incorporated in this report. Findings are available at the One Care plan level only. Only results with more than 10 respondents across the three One Care plans are reported. Comparisons with findings from all Medicare Advantage plans are available for core CAHPS survey questions but not for the RTI or MassHealth supplemental questions.

MassHealth, in collaboration with the Implementation Council and the University of Massachusetts Medical School as part of the Early Indicators Project, conducted two surveys of One Care enrollees. The first survey, in English only, was conducted from December 2013 through January 2014 and surveyed 300 enrollees by telephone about their experiences during the initial enrollment period. The second survey was conducted from May through December 2014 and surveyed enrollees on a broad range of topics, including continuity of care, assessment and care planning, and LTS coordinator experience. A print survey was mailed to 6,000 enrollees; respondents were able to complete the survey in English or Spanish by mail, online, or by phone.

Demonstration data. The RTI evaluation team reviewed data provided quarterly by Massachusetts through the State Data Reporting System (SDRS). These data included eligibility, enrollment, opt-out, and disenrollment data, and information reported by Massachusetts on its stakeholder engagement process, accomplishments on the integration of services and systems, any changes made in policies and procedures, and a summary of successes and challenges.

Demonstration policies, contracts, and other materials. The RTI evaluation team reviewed a wide range of demonstration documents, including the Memorandum of Understanding (MOU) between CMS and Massachusetts (CMS and Commonwealth of Massachusetts, 2012; hereafter, MOU, 2012); the three-way contract between CMS, the Commonwealth of Massachusetts, and the One Care plans (CMS, July 11, 2013; hereafter, three-way contract, 2013); an addendum to the three-way contract executed in September 2014 (CMS, September 2014; hereafter, three-way contract addendum, September 2014); and a second addendum executed in January 2015 (CMS, January 2015; hereafter, three-way contract addendum, January 2015); Section 1115(a) demonstration documents; requests for proposals (e.g., for the One Care plans and the ombudsman program); Commonwealth regulations; documents on the CMS Medicare-Medicaid Coordination website (CMS, 2016); and other publicly available materials on the Massachusetts One Care website (http://www.mass.gov/eohhs/consumer/insurance/one-care) and the Massachusetts Executive Office of Health and Human Services (EOHHS) website (http://www.mass.gov/eohhs/), including meeting presentations, minutes, enrollment reports, and marketing materials.

Conversations with CMS and MassHealth officials. To monitor demonstration progress, the RTI evaluation team engages in periodic phone conversations with MassHealth and CMS.

Complaints and appeals data. Complaint (also referred to as grievance) data are from three separate sources: (1) complaints from beneficiaries reported by One Care plans to MassHealth, and separately to CMS' implementation contractor, NORC at the University of

Chicago (hereafter referred to as NORC);[4,5] (2) complaints received by MassHealth or 1-800-Medicare and entered into the CMS electronic Complaints Tracking Module;[6] and (3) complaints received by the Office of the One Care Ombudsman and reported to MassHealth and the Administration for Community Living,[7] the Federal agency that provides technical assistance to ombudsman programs for demonstrations under the Financial Alignment Initiative. Appeals data are based on data reported by MMPs to MassHealth and CMS' implementation contractor, NORC, for Core Measure 4.2 and the Medicare Independent Review Entity. Data on critical incidents and abuse reported to MassHealth and CMS' implementation contractor by One Care plans are also included in this report.

Although the perspectives of the three One Care plans—Fallon Total Care (Fallon), Commonwealth Care Alliance (CCA), and Network Health, now known as Tufts Health Unify (hereafter referred to as Tufts in this report)—are included, this report presents information primarily at the One Care demonstration level. It is not intended to assess individual plan performance, but individual plan information is provided where plan-level data are all that are available, or where plan-level data provide additional context to the discussion. The provider experience represented in this report is that conveyed by One Care plans, MassHealth, CBOs, and the other stakeholders listed above in data sources.

Analyses of service utilization and access to care and quality are based on Medicare claims data for Massachusetts and for a comparison group for 2 baseline years before the demonstration and for Demonstration Year 1 (October 1, 2013–December 31, 2014). The Nursing Home MDS 3.0 is also analyzed to evaluate nursing facility admission and use rates, characteristics of new entrants, and nursing facility quality. Special sections focus on people eligible for the demonstration who use LTSS nursing facility care (meaning only beneficiaries in nursing facilities as opposed to any other LTSS facility; Medicaid data were not available to reliably identify beneficiaries with home and community-based services [HCBS] use) and behavioral health services. ***Appendix A*** includes details on the methods used for comparison group identification; ***Appendix B*** contains additional information on analysis methods for MDS 3.0 data; ***Appendix C*** provides details on all population definitions and measures used in the analyses; and ***Appendix D*** provides a table listing the core, Massachusetts-specific, and quality withhold measures.

1.2 Model Description and Demonstration Goals

The goals of One Care are to alleviate fragmentation of care, improve coordination of services, enhance quality of care, and reduce costs. The demonstration's key objectives are to improve the beneficiary experience in accessing care, deliver person-centered care, promote

[4] Data are reported for calendar quarters January 1, 2014, through June 30, 2015.

[5] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans html.

[6] Data are presented for the time period October 1, 2013 through June 30, 2015.

[7] Data are presented for the time period January 1, 2014 through June 30, 2015.

independence in the community, improve quality, and eliminate cost shifting between Medicare and Medicaid (MOU, 2012, pp. 2–3).

According to officials at MassHealth, the demonstration design is based on the premise that improved care coordination; integration of physical, behavioral health, and LTSS; increased consumer engagement in care; and expanded access to enhanced community-based services will improve member experience and result in a more cost-effective and efficient delivery of services.

Integration of Medicare and Medicaid functions. The One Care demonstration integrates the full array of functions performed by Medicare and Medicaid. This includes the processes required to determine demonstration eligibility and complete enrollment; the coordinated delivery of all medical, acute, pharmacy, and long term services and supports; joint oversight of the One Care plans; coordinated quality management processes and systems; and a coordinated grievance and appeals process. Each enrollee receives a single insurance card that covers all of his or her Medicaid services (including LTSS and behavioral health services), Medicare medical and acute services (including physician and hospital services), and all of the individual's pharmacy benefits. Targeted case management services and rehabilitation option services are not included as part of the integrated One Care benefit, but they continue to be provided as part of the Medicaid fee-for-service (FFS) system. As in Medicare Advantage, Medicare hospice services continue to be provided as part of the Medicare FFS system.

Financial model. The One Care demonstration is a capitated model of service delivery in which CMS, the Commonwealth of Massachusetts, and One Care plans enter into three-way contracts to provide comprehensive, coordinated care for beneficiaries aged 21 to 64 at the time of enrollment, who are dually eligible for Medicaid and Medicare services. Each plan—referred to as a One Care Plan or an MMP—receives monthly capitated payments from Medicaid and Medicare to manage the care and services of enrollees.

Implementation. The One Care demonstration began on October 1, 2013, and was originally scheduled to continue until December 31, 2016. In July 2015, CMS notified the Financial Alignment States of the opportunity to extend their scheduled end date by 2 years. The Commonwealth and CMS subsequently effectuated an extension of the One Care demonstration by 2 years, through December 31, 2018.

During the first 3 months of implementation, eligible beneficiaries could be enrolled only through an opt-in process. Starting in January 2014, beneficiaries in counties where at least two plans operated were passively (automatically) enrolled with the option to opt *out* before enrollment. Additional beneficiaries were passively enrolled in a One Care plan during four subsequent phases of passive enrollment that occurred before the conclusion of Demonstration Year 1 (i.e., December 31, 2014). Beneficiaries can opt into the demonstration and enroll at any time; and can disenroll at any time.

Massachusetts considered several factors in the assignment of beneficiaries to plans during these phases of passive enrollment, including the plans' capacity to serve new enrollees and the case mix or complexity of enrollees' service needs. (See ***Section 3, Eligibility and Enrollment***, for more information on enrollment.)

Eligible population. Individuals eligible for One Care include full-benefit Medicare-Medicaid beneficiaries aged 21 to 64 at the time of enrollment who (1) are enrolled in Medicare Parts A and B and eligible for Medicare Part D and MassHealth Standard or MassHealth CommonHealth and (2) have no other comprehensive private or public health insurance. Beneficiaries enrolled in any of the following programs also are eligible for the demonstration if they disenroll from the program and meet the other eligibility criteria: a Medicare Advantage plan; Program of All-Inclusive Care for the Elderly (PACE); Employer Group Waiver Plans, other employer-sponsored plans, or plans receiving a Retiree Drug Subsidy; or the CMS Independence at Home demonstration. Enrollees receiving HCBS waiver services or residing in an intermediate care facility for individuals with intellectual disabilities are not eligible to enroll (MOU, 2012, pp. 8–9).

One Care plans. To participate in the demonstration, One Care plans had to meet the Commonwealth's requirements set forth in the Massachusetts Request for Responses (RFR) (Commonwealth of Massachusetts and Center for Medicare and Medicaid Innovation, 2012; hereafter, RFR, 2012), as well as CMS' requirements outlined in the MMP application process and in multiple sets of capitated financial alignment model guidance. Massachusetts initially selected six plans to proceed to the joint CMS-MassHealth readiness review. Three of the plans withdrew before readiness review completion, citing inadequate payment rates relative to the programmatic requirements and covered services that they believed would result in losses. Had all six plans participated in their proposed service areas, beneficiaries would have had statewide coverage with four or more plans to choose from in most Massachusetts counties. With only three plans participating, only four of the nine counties where the demonstration operates had two or more plans participating during the period covered by this report, and about half of eligible beneficiaries reside in counties with just one plan.

The three plans selected to participate in the demonstration were CCA, Fallon, and Tufts. All three plans participated in the demonstration for the period covered by this report. In June 2015, Fallon notified MassHealth and CMS that it intended to withdraw from the demonstration as of September 30, 2015. Activities after this notification by Fallon, including transition planning and continuity of care processes, will be discussed as part of the next Annual Report.

Geographic coverage. The demonstration operates in 9 of the Commonwealth's 14 counties.[8] During the period covered by this report, two plans were available in Hampden, Hampshire, and Suffolk counties. All three plans operated in Worcester County. Only one plan was available in Essex, Franklin, Middlesex, Norfolk, and Plymouth counties (see ***Section 3*** for more information on geographic coverage of the plans).

Care coordination. A central feature of the One Care demonstration is the addition of care coordination services for medical, behavioral health, and LTSS. One Care plans are required to offer care coordination to all enrollees through a care coordinator or clinical care manager for medical and behavioral health services employed by or under contract with the One Care plan; for LTSS, care coordination is provided through an LTS coordinator under contract with a community-based organization (three-way contract, 2013, p. 31). One Care plans are also

[8] In Plymouth County, One Care is not available in the towns of East Wareham, Lakeville, Marion, Mattapoisett, Wareham, and West Wareham.

responsible, through an interdisciplinary care team, for developing an individualized care plan (ICP) for each enrollee, which must reflect the enrollee's preferences and needs as well has how services and care will be integrated and coordinated among providers. ***Section 4*** provides detailed information care coordination under One Care, including the roles and responsibilities of care coordinators and the LTS coordinators.

Benefits. Under One Care, eligible beneficiaries enroll in a single One Care plan that covers all Medicare and Medicaid services, as well as new and expanded services available under the demonstration. ***Table 1*** provides a list of these services. These include a set of new diversionary[9] behavioral health services that have been available to Medicaid-only beneficiaries enrolled in managed care but have generally not otherwise been a covered service for Medicare-Medicaid beneficiaries in Massachusetts; services expanded in amount, duration, or scope over Medicaid State Plan services; and new community-based services. ***Appendix E*** provides a complete list of services and service definitions.

Dental services covered by One Care are also broader in scope than those offered previously as part of the MassHealth FFS system; demonstration services encompassed preventative, restorative, and emergency oral health services. In addition, One Care expanded service delivery options for personal care services to include a choice of delivery through agency providers and through participant direction, the latter of which is available under the MassHealth FFS system.

Table 1
New and expanded services under One Care

New diversionary behavioral health services[1]
• Community Crisis Stabilization
• Acute Treatment Services for Substance Use Disorders
• Clinical Support Services for Substance Use Disorders
• Community Support Program
• Partial hospitalization
• Structured Outpatient Addiction Program
• Intensive Outpatient Program
• Program of Assertive Community Treatment
Expanded services[2]
• Durable medical equipment (DME): environmental aids and assistive technology and training in usage, repairs, and modifications.
• Personal assistance services (PAS): cueing and monitoring

(continued)

[9] Diversionary services are provided as alternatives to institutional care.

Table 1 (continued)
New and expanded services under One Care

New community-based services
• Day services
• Home care services (household tasks, personal assistance with ADLs)
• Respite care
• Peer Support/counseling/navigation
• Care Transition Assistance
• Home modifications
• Community health workers
• Medication management
• Non-medical transportation

ADLs = activities of daily living.

[1] Diversionary behavioral health services under One Care also include Psychiatric Day Treatment and Emergency Services Programs (24-hour crisis treatment services), which were previously available under the MassHealth fee-for-service system.

[2] Services expanded in amount, duration, or scope over Medicaid State Plan services.

SOURCE: Three-way contract, 2013, pp. 225–32 (Appendix B, Exhibits 3–4).

Flexible benefits. In addition to the covered benefits described above, a One Care plan may offer flexible benefits, as specified in the member's ICP, as appropriate to address the member's needs (MOU, 2012, p. 82). For example, plans reported providing special benefits or services to members such as gym membership, support to complete adult education courses, and headphones to block out noise for certain individuals.

New service delivery models. The new benefits provided under One Care and the capitation rate structure provide the opportunity and incentives for plans to create new service delivery options to meet the needs of beneficiaries. One of the plans, for example, opened its own new community-based programs to support those with behavioral health needs who would otherwise have been cared for in an inpatient setting (see ***Section 2, Integration of Medicare and Medicaid***, for more information on new service delivery models).

Stakeholder engagement. MassHealth implemented an extensive stakeholder engagement process to support the design and implementation of One Care. MassHealth holds regularly scheduled open meetings where staff present updates on the demonstration and provide enrollment and other data. These meetings began early in the demonstration design process and have continued. MassHealth created a consumer-chaired Implementation Council to advise on demonstration design features and to ensure accountability and transparency throughout the demonstration. Work groups were formed to address specific topical areas (e.g., LTS coordinator, quality, and encounter data). MassHealth also held beneficiary focus groups and conducted beneficiary surveys to inform the demonstration design and monitor its implementation (see ***Section 6, Stakeholder Engagement***).

1.3 Changes in Demonstration Design

The overall design of the care model within the One Care demonstration has not changed significantly since its implementation, although there have been several areas where MassHealth and CMS have provided guidance to the One Care plans and providers during implementation (e.g., the role and responsibilities of the LTS coordinator and the continuity-of-care provisions) and clarified reporting requirements (e.g., assessment completion time frames) (see ***Sections 3*** and ***4***).

Early in the implementation of One Care, MassHealth officials, plans, and stakeholders expressed concerns about the adequacy of the demonstration's rate structure. Based on preliminary data, all three plans initially showed potential losses, ranging from just under $1 million to over $36 million for Demonstration Year 1 (October 1, 2013 through December 31, 2014).[10] This information was presented by MassHealth at an Open Meeting in July 2015, shortly after the notice by Fallon of its intent to withdraw from the demonstration. Subsequent refinement of the cost data indicated that plan losses for Demonstration Year 1 ranged from approximately $460,000 to $18.4 million, with the reported revenue not including the interim risk corridor payment to two of the three plans and the final risk corridor payments for all qualifying plans.[11]

Several changes were made to One Care's rate methodologies as part of contract amendments executed September 10, 2014, and January 7, 2015. The percentage of savings withheld from the capitation rates was reduced for Years 2 and 3; the risk corridors that define the share of gains and losses shared by the plans, CMS, and MassHealth were expanded to provide a greater share of losses and gains by CMS and MassHealth; and the method used for "coding intensity adjustments" was revised to reflect the proportion of enrollees with prior Medicare or One Care demonstration experience. The high-cost risk pools that were established with the use of a withhold from each plan's rate were eliminated for 2013 and 2014 (three-way contract amendments, September 2014; and January 2015). In addition, MassHealth revised the method and timing of assigning members to Medicaid rating categories to allow for retroactive adjustment of payments when an individual member's assigned rate category changed (see ***Section 7, Financing and Payment***, for additional information).

1.4 Overview of State Context

MassHealth historically has used managed care as one of its primary strategies to improve care coordination and contain costs. Under its Section 1115(a) demonstration, MassHealth mandated Medicaid managed care enrollment for most of its Medicaid-only members. As of July 2012, almost two-thirds of MassHealth members were enrolled in managed

[10] The financial report noted that revenue categories did not include payment information for interim or final risk corridors, high-cost risk pool or quality withholds, or certain retroactive rating category adjustments; spending categories included incurred but not reported expenses, which were an estimate of costs that have been incurred for services provided during the reporting period, but that had not yet been billed or adjudicated.

[11] This financial data was presented at a May 2016 Open Meeting by MassHealth and was based on financial reports submitted to MassHealth by the plans for October 2013–December 2014, updated in October 2015.

care organizations or in the Primary Care Clinician Plan, a primary care case management program (EOHHS, September 30, 2013, pp. 1, 11).

Before the One Care demonstration, Medicare-Medicaid beneficiaries under age 65 had remained ineligible to enroll in Medicaid managed care and received their services through the existing FFS system under MassHealth and Medicare. Some may have received services in PACE or Medicare Advantage plans, although in Massachusetts, these programs primarily serve people aged 65 or older. This group of beneficiaries included those with the most complex conditions, highest costs, and in greatest need of care coordination and care management. They encompassed a high proportion of people with behavioral health needs and challenges who generally did not have access to the diversionary behavioral health services available to the MassHealth-only members with similar needs.

In the absence of One Care, Massachusetts did not have a mechanism to provide comprehensive care coordination and care management services to this population, nor a way to integrate Medicare and Medicaid payments and services. MassHealth officials reported that they were willing to invest in a care management model and expand community-based services if there were a way to capture and offset some of these costs with savings from reductions in the expensive acute care services provided by Medicare.

For a summary of predemonstration and demonstration design features for Medicare and Medicaid beneficiaries in Massachusetts, see ***Appendix F***.

MassHealth staff had significant experience in the design and management of managed care plans before the implementation of One Care, and MassHealth management leveraged existing expertise and knowledge where possible. Nevertheless, the One Care demonstration required building new teams and capacity to move it from the design phase to implementation.

Massachusetts also received substantial Federal funding that allowed it to significantly augment its internal resources. Massachusetts received an initial CMS contract award of $1.3 million to support the development of its original demonstration proposal, its stakeholder engagement process, and other outreach activities. After signing an MOU with CMS, Massachusetts also received an implementation grant of $9.3 million for Year 1 and $5.5 million for Year 2 to support infrastructure changes (e.g., enrollment interfaces and data warehouse modifications), internal staff positions to monitor and oversee the plans, and contracted services (e.g., enrollment counseling, ombudsman services, administration of surveys). One Care is managed under the terms of a three-way contract between CMS, the Commonwealth of Massachusetts, and each plan. A Contract Management Team, composed of MassHealth and CMS staff, oversees daily implementation of the initiative.

One Care is one of many reform initiatives that have been undertaken in Massachusetts, which has a long history of health care reform focused on ensuring access to affordable care, improving how care is delivered, and providing services in the most cost-effective manner. In 2015, under the leadership of its new Assistant Secretary, the Massachusetts EOHHS announced new priorities for MassHealth, including strategies to (1) improve population health and care coordination through payment reform and value-based payment methods; (2) improve integration of physical and behavioral health care; (3) scale innovative approaches for populations receiving LTSS; and (4) improve the management of existing programs. The proposed payment and

delivery system reform options included development of Accountable Care Organizations and Primary Care Medical Home models of care; the use of health homes and accountable care models for those with significant health and substance use concerns; the use and expansion of integrated care models (like One Care) for those with LTSS needs; and bundled payments for certain high-cost areas (SDRS, 7th Quarter).

1.5 Preliminary Findings

The following preliminary findings relate to the design features of the One Care demonstration. Findings specific to the implementation and administration of the demonstration will be discussed in the remaining sections.

Support for the One Care model has been strong. MassHealth officials, One Care plans, and other stakeholders strongly support One Care and agree that it is well designed to meet the needs of the population served. In the words of one MassHealth official:

> *We like the One Care model a lot and we think it's a high-value model for this population. From a model point of view we want to scale it. We really think it's the right model for this population.*

For the first time, younger adult Medicare-Medicaid enrollees in Massachusetts have access to care coordination services that help them to receive Medicare medical and pharmacy services as well as Medicaid community-based services. A hallmark of the One Care demonstration is the use of care coordinators and community-based LTS coordinators to assess the enrollee's needs and facilitate access to and coordination of services within the medical, behavioral health, and LTSS systems.

One Care offers access to valuable new services not previously available to Medicare-Medicaid beneficiaries in Massachusetts. These include new community-based behavioral health services that provide an alternative to inpatient psychiatric care, and other LTSS community-based services to help people live independently in their homes. As described in ***Section 5, Beneficiary Experience***, these services have positively affected the lives of One Care beneficiaries. According to one of the plans:

> *Our inpatient utilization for behavioral health has gone down and they [One Care beneficiaries] are using these outside diversionary services, the day programs. They've done a great job with that so that has been a big win for the program.*

Massachusetts has embedded a formal stakeholder engagement structure and process into the design of One Care. This includes the creation of a consumer-driven council of 21 members that provides ongoing advice to MassHealth; solicits input from stakeholders; and monitors the implementation of the demonstration. MassHealth has also committed to a participatory public reporting and meeting process with the goal of forging a transparent and collaborative relationship with stakeholders. Stakeholder input has shaped many of the demonstration's design features and modifications made during implementation.

The three participating plans reported experiencing financial losses during the period covered by this report. One of those plans notified MassHealth and CMS in June 2015 of its intent to withdraw from the demonstration as of September 30, 2015. The plans

reported that the Medicare and Medicaid capitation rates were inadequate during the period covered by this report. The calculation of the rates did not include the new costs associated with care coordination, the additional benefits offered, and the administrative or start-up costs of the demonstration. Three plans cited the rates as the reason for deciding not to pursue participation in the demonstration before implementation.

Results from quantitative analyses on Medicare data for various service types show limited evidence of the demonstration's effect during the first demonstration year. Several factors may be responsible, including the lack of sufficient Medicaid data for analysis and the need for adequate time to achieve operational implementation and impact of care interventions at the beneficiary level.

2. Integration of Medicare and Medicaid

The One Care demonstration integrates Medicare and Medicaid into a unified set of benefits. From the beneficiary's perspective, One Care is designed to integrate access to and delivery of services covered under both programs. From the perspective of MassHealth, CMS, and One Care plans, the integration of these programs depends on the alignment of policy, procedures, and systems at many levels.

This section provides an overview of the management structure that was created to oversee the implementation of the demonstration and discusses in greater detail the organization, geographic coverage areas, and enrollment experience of the three One Care plans that were selected to integrate and deliver the One Care benefits. It also provides a general description of the other functions (e.g., care coordination, eligibility, enrollment, quality management, and financing) that MassHealth, CMS, and the plans had to coordinate or integrate as part of the implementation of the demonstration. Later sections provide more in-depth discussion of the implementation successes and challenges associated with the integration of these functions.

2.1 Joint Management of Demonstration

Massachusetts and CMS entered into a Memorandum of Understanding (MOU) documenting their shared understanding of the design of One Care, how it will operate, and how the two parties will oversee and manage it (MOU, 2012). Similarly, the three-way contract articulates the One Care plan's role in implementing One Care, and aligning and integrating the delivery of Medicare and Medicaid-funded services (three-way contract, 2013). These documents define an integrated set of benefits, integrated financing for One Care through a combined rate, a single set of performance and quality measures for managing plan performance, and a range of other common standards and integrated rules for implementing One Care.

To manage joint implementation of One Care, CMS and MassHealth formed the Contract Management Team (CMT). The CMT includes representatives from the MassHealth Provider and Plan unit, MassHealth central policy office, CMS regional office Medicare and Medicaid staff, and representatives from the Medicare-Medicaid Coordination Office (MMCO). The CMT meets regularly to review demonstration status, discuss issues identified by MassHealth and CMS contract managers, and resolve, if possible, any outstanding items. The CMT also meets with each plan biweekly. During early implementation, these meetings focused on many of the enrollment and system interface issues between the plans, MassHealth, and Medicare. As implementation progressed, the meetings focused on the review of monitoring reports, customer service line calls, contract compliance, grievances and appeals, and performance improvement plans (State Data Reporting System 6th Quarter). The frequency of meetings and the agenda format have been revised during implementation to address the most pressing issues and to respond to the plans' needs.

MassHealth officials indicated that the team has been essential in identifying issues, vetting policy options, and making decisions. At times, issues had to be escalated to higher levels of authority (to the MMCO or national Medicare policy offices), particularly ones that had implications for national policy and management of Medicare Advantage plans at a Federal level.

Integrating Medicare and Medicaid systems has also required a high level of attention to operational details. For example, as discussed in ***Section 3, Eligibility and Enrollment***, integrated enrollment requires a coordinated process for confirming Medicaid and Medicare eligibility for One Care and ensuring that MassHealth, CMS, and the One Care plans have consistent, accurate, and up-to-date information on which beneficiaries are enrolled in each plan. Integration requires rules governing the flow of enrollment files from the enrollment broker to MassHealth to CMS to the plan, and the process for resolving inconsistency and problems across systems.

The challenges of integrating Commonwealth-level Medicaid policies, procedures, and systems with Federal-level Medicare policies, procedures, and systems introduced a high level of complexity in decision making and resolving problems across many parties at so many levels within the Commonwealth and CMS. One MassHealth official said it was "the hardest project that I have ever worked on." However, this same official reported that CMS, MassHealth, and other key stakeholders have been successful in creating a collaborative relationship:

> *I have never seen a project quite like this in terms of the layers of interaction, the layers of goodwill, and the layers of people who are really trying to do the best they can by its population. It has been a very difficult project, but the one thing that we have been able to count on is that people just want to help.*

Because Massachusetts was the first capitated model demonstration under the Financial Alignment Initiative implemented, MassHealth officials and CMS members of the CMT noted that many of the policy questions and alignment challenges that surfaced in Massachusetts were new, entailing more discussion and clarification than other demonstration States may have experienced. Some policy decisions made in Massachusetts were applied to other States, which were able to learn from Massachusetts's implementation experiences.

2.2 Overview of Integrated Delivery System

2.2.1 One Care Plans

To participate in the demonstration, One Care plans had to meet the Commonwealth's requirements set forth in the Massachusetts Request for Responses (RFR) (Commonwealth of Massachusetts and Center for Medicare & Medicaid Innovation, 2012; hereafter, RFR Integrated Care Organization, 2012); meet CMS requirements as outlined in the Medicare-Medicaid Plan application and multiple sets of capitated financial alignment model guidance documents;[12] and pass the joint CMS-Commonwealth readiness review (CMS, November 2012).

MassHealth and CMS entered into three-way contracts with Commonwealth Care Alliance (CCA), Fallon, and Tufts to serve as One Care plans. Massachusetts and CMS initially selected six plans to proceed to the joint readiness review stage. As noted earlier, before readiness review completion, three of the plans (Blue Cross Blue Shield of Massachusetts,

[12] See Centers for Medicare & Medicaid Services, Financial Alignment Initiative, Information and Guidance for Plans. Website. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans html.

Boston Medical Center HealthNet Plan, and Neighborhood Health Plan) decided not to pursue demonstration participation, citing concerns about the adequacy of the payment rates.

The organizations selected as One Care plans had varying amounts of experience working as either a Fully Integrated Dual Special Needs Plan (FIDE-SNPs), such as a Senior Care Options (SCO) plan; a Medicaid managed care plan; and/or as a Program of All-Inclusive Care for the Elderly (PACE). The SCO plans provide the full range of Medicare and Medicaid benefits through capitation, contracting separately with Medicare and Medicaid. ***Table 2*** provides a summary of the One Care plans' respective experience.

Table 2
One Care plans' organizational experience

One Care plan	Parent company	Nonprofit	National chain	Medicaid managed care plan (non-SCO)	SCO FIDE-SNPs	Total SCO enrollment[1,2]	Other Medicare Advantage plan	PACE
CCA	N/A	Yes	No	No	FIDE-SNP	5,466	No	No
Fallon Total Care	Fallon Community Health Plan	Yes	No	Yes	Parent company (NaviCare) FIDE-SNP	3,751	Yes	Yes
Tufts Health Unify	Tufts Associated HMO	Yes	Yes, parent company	Yes, integrated plan with medical and behavioral health services	Parent company (Tufts) FIDE-SNP	281	Yes	No

CCA = Commonwealth Care Alliance; FIDE-SNP = fully integrated dual eligible special needs plan; HMO = health maintenance organization; PACE = Program of All-Inclusive Care for the Elderly; SCO = Senior Care Options, a FIDE-SNP program.

[1] Senior Care Options is a voluntary program available to Massachusetts Medicare-Medicaid enrollees over age 65.

[2] CMS: Special Needs Comprehensive Report, 2014; data as of April 2014.

All three organizations had prior experience (either directly or through their parent company) as a Medicare FIDE-SNP under the SCO program; one of the plans had prior experience as a fully integrated (e.g., medical and behavioral health) Medicaid managed care plan; two of the plans' parent companies operate a Medicare Advantage plan, in addition to a SCO; and one of the plans had experience as a PACE program.

The three One Care plans had different strategies for enrollment growth. MassHealth and CMS worked with the plans during the different enrollment phases to accommodate the varying goals of each plan while also considering factors such as plan capacity and enrollee case mix. These different strategies and the different geographic areas served by the plans influenced the share of the One Care population served by each plan. As indicated in ***Table 3***, CCA had the greatest proportion (57 percent) of enrollees as of January 1, 2015. Fallon had the second-highest number of enrollees (32 percent). Tufts had 11 percent of the demonstration enrollees.

Table 3
Enrollees by plan as of January 1, 2015

One Care plan	Number of enrollees	% of total
Commonwealth Care Alliance	10,135	57
Fallon Total Care	5,740	32
Tufts Health Unify	1,992	11
Total	17,867	100

NOTE: Percentages do not total 100.0 because of rounding.

SOURCE: MassHealth, Enrollment Report, January 2015.

As indicated in ***Table 4***, of the three plans, CCA grew most rapidly; its enrollment increased from just over 1,000 enrollees in October 2013 to almost 10,000 enrollees a year later. Fallon also grew rapidly from fewer than 259 enrollees as of October 2013 to almost 6,000 enrollees a year later. Tufts chose to increase enrollment more slowly (including by having fewer enrollees assigned to it during phases of passive enrollment) and grew from 331 enrollees in October 2013 to approximately 1,400 enrollees a year later. By July 2015, enrollment in the three plans seemed to have stabilized.

Table 4
Enrollment in One Care plans, by quarter

One Care plan	Oct. 2013	Jan. 2014	July 2014	Oct. 2014	Jan. 2015	July 2015
Commonwealth Care Alliance	1,193	6,120	9,714	9,917	10,135	10,536
Fallon Total Care	259	2,570	7,551	6,110	5,740	5,373
Tufts Health Unify	331	816	1,571	1,438	1,992	1,762
Total	1,783	9,506	18,836	17,465	17,867	17,671

SOURCES: MassHealth, Enrollment Reports, October, 2013; January 2014; July 2014; October 2014; January 2015; July 2015.

The three plans operated in 9 of 14 counties in Massachusetts (Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester). CCA operated in all nine counties, Fallon operated in three counties, and Tufts operated in two (see ***Table 5***).

Table 5
Counties where One Care plans operate

	As of July 1, 2015		
County	**Commonwealth Care Alliance**	**Fallon Total Care**	**Tufts Health Unify**
Essex	X	—	—
Franklin	X	—	—
Hampden	X	X	—
Hampshire	X	X	—
Middlesex	X	—	—
Norfolk	X	—	—
Plymouth	X (partial)	—	—
Suffolk	X	—	X
Worcester	X	X	X

— data not available.

NOTE: In Plymouth County, One Care is not available in the towns of East Wareham, Lakeville, Marion, Mattapoisett, Wareham, and West Wareham.

SOURCE: MassHealth, August 17, 2015.

2.2.2 Provider Arrangements and Services

The three-way contracts require the plans to have a network that is adequate to ensure access to medical, behavioral health, pharmacy, community-based services, and long-term services and supports (LTSS) to meet the needs of the population, including physical, communication, and geographic access (three-way contract, 2013, p. 59). Accordingly, each One Care plan must have a contract with a Behavioral Health Provider Network. When emergency services are needed, enrollees may seek care from any qualified behavioral health provider (three-way contract, 2013, p. 38).

Plans are also required to ensure that best efforts are made to contact out-of-network providers and give them information on becoming in-network providers, including those providers who provide services during the 90-day continuity-of-care period during which time enrollees can continue to access their pre-demonstration providers and services. If the provider does not join the network, or if the enrollee does not select a new in-network provider by the end of the 90-day period, the plan chooses a provider for the enrollee. The plan can offer single-case out-of-network agreements with providers who are unwilling to enroll in the plan's provider network, are currently serving enrollees, and are willing to continue serving them at the plan's in-network rate of payment; plans are required to do so under certain circumstances (three-way contract, 2013, p. 61).

During early implementation, the plans reported needing to help the providers in their networks to understand the demonstration and the needs of the populations and services available. MassHealth and the plans offered ongoing webinars and learning collaboratives to explain the demonstration and to focus on specific topical areas. The plans reported varying

levels of provider engagement and willingness to participate in the demonstration, depending on area of the Commonwealth.

One of the plans reported that university-based providers and community health centers were familiar with the needs of the people served by the demonstration and were committed to helping with the initiative. In other instances, providers did not want to take more Medicaid patients, particularly in areas where there were fewer doctors. In areas with limited access to tertiary hospital care, at least one plan found it difficult to negotiate rates and engage the hospitals.

All three One Care plans contracted with medical providers on a fee-for-service basis. All the plans reported some degree of difficulty with the rates they were able to negotiate and pay providers for care of One Care members. In some instances, providers—particularly those providing specialty care—did not accept Medicare or Medicaid rates and required payments higher than the Medicare rates to be in the network. This was particularly true for dental care, for which it was difficult to get dentists to accept the fee schedule given that they typically can command the fees they want in the private market. In many instances the care needed is beyond routine dental care, and often the supply of oral surgeons and emergency dental care is limited. One plan reported losing a dentist who originally was in its network: "We recently had a dentist who we unfortunately overused because she said she was willing to see our members and saw our members and actually ended her contract. She's like, this is too much."

Another plan indicated that it contracted with and/or owned several medical practices (the plan refers to these as its "health homes") where either behavioral health had been integrated into primary care or where medical care was being integrated into behavioral health. This plan paid a care management fee to the practices to support this model and conducted learning collaboratives around a number of targeted quality metrics. The providers developed a quality improvement plan focused on certain clinical measures with support from the plan in the form of data and other information.

One of the plans discussed the potential for other types of risk sharing or alternative payment methods for providers but felt it needed more experience and volume before entering into such arrangements. The other plans had not entered into any such arrangements.

The One Care model provided the opportunity and incentive for One Care plans to develop or contract for new service delivery models. One plan developed new community-based programs for people with behavioral health needs who otherwise would be served in inpatient psychiatric settings. This plan opened two new units to provide community support programs and crisis stabilization units that could better serve these individuals. One unit opened in fall 2014 at a hospital that had an empty wing. The other unit, which opened in June 2015, is a 14-bed behavioral health stabilization unit that is an unlocked safe place where people can be treated without needing hospitalization. According to MassHealth and the plan, this was possible because of the flexibility provided by the capitated Medicare and Medicaid rates in the demonstration.

2.2.3 Training and Support for Plans and Providers

MassHealth developed an extensive number of webinars, educational sessions, and other trainings to support providers, community-based organizations, and the One Care plans during implementation of the demonstration. The University of Massachusetts Medical School was a significant partner in these endeavors. These educational and training activities covered a wide range of topics, including behavioral health, recovery, and peer support; promoting wellness for people with disabilities; the use of Independent Living and Long-Term Services and Supports (LTS) coordinators; how to talk about One Care; enhancing care to homeless individuals; reaching and engaging enrollees with mental health and substance abuse; self-direction; and the use of the Integrated Care Team.

2.3 Major Areas of Integration

2.3.1 Integrated Benefits and Enrollment

In the One Care Demonstration, Medicare-Medicaid beneficiaries have a single, unified process for enrollment into a managed care plan that provides the full range of medical, acute, LTSS, behavioral health, and pharmacy benefits. Member materials, including the member handbook, mailings, and member identification cards, have been unified under a common brand, One Care. A single organization is responsible for managing the enrollment process and fielding consumer calls and questions. From the beneficiary's perspective, all the separate Medicare and Medicaid eligibility and enrollment functions have been coordinated, if not integrated, into a single process.

Commonwealth officials and plans noted that Medicare Part D processes and payment systems remain largely unchanged under One Care. Under the demonstration, the One Care plans provide Part D drug coverage. The plans reported that the Medicare Part D payment structures and reimbursement methodologies remained the same under One Care as for plans providing Part D coverage outside of the demonstration. As discussed in ***Section 7***, ***Financing and Payment***, the plans reported very high pharmacy costs and experienced high receivable balances because of the lag in the payment reconciliation process. MassHealth officials reported a lack of transparency regarding the Part D operations from their perspective, and noted that "CMS has mountains to move every time they want to make a change." In addition, outside of the demonstration, stand-alone Medicare Part D plans continued to have separate processes for enrollment, continuity of care, and appeals. Despite the many separate Part D processes, CMS and MassHealth were able to resolve differences between Medicare Part D and MassHealth in mailing Part D notices to One Care enrollees and disenrollees. MassHealth was able to include information in one of its mailings that clarified information contained in Medicare Part D notices that some members were receiving.

As discussed in more detail in ***Section 3***, integration of the many operational functions that control eligibility and enrollment between MassHealth, CMS, and the One Care plans has not been without its challenges. The operational and decision rules used in the MassHealth enrollment and eligibility systems did not align with those used by CMS, resulting in discrepancies in enrollment information among the various systems. MassHealth had to develop specific reporting protocols for rejected enrollments and engage in a manual review and

remediation process. For the most part, beneficiaries have been shielded from these administrative complexities. MassHealth has had to develop subsystems and internal processes to ensure successful interface and transactions with the Medicare system. Throughout implementation, MassHealth and CMS have continued to work on ways to improve these processes.

2.3.2 Integrated Care Coordination and Care Planning

Under One Care, a single entity (the One Care plan) is responsible for coordinating all medical, acute, behavioral health, LTSS, and pharmacy benefits. Each plan is responsible for coordinating medical and behavioral health services through its internal care coordinator or clinical case manager; and for coordinating LTSS through an LTS coordinator, located at a community-based organization. Before the demonstration, most Medicare-Medicaid enrollees did not have access to any form of care coordination for medical and acute services, behavioral health services, or LTSS. Some beneficiaries aged 55 or older may have participated in PACE, and others may have been enrolled in a Medicare Advantage plan, but these numbers were small. Some members may have had case management services for their behavioral health needs, but otherwise services were not coordinated.

For One Care members, the demonstration provides a single point of contact and accountability for coordination of care. Furthermore, plans are required to conduct a comprehensive assessment of the full range of members' needs and preferences; to work with an Integrated Care Team to meet those needs; and to develop an individualized care plan for each member.

Section 4 provides a discussion of the roles and responsibilities of the internal care coordinators and the LTS coordinators, the use of the Integrated Care Team, as well as some of the successes and challenges faced during implementation.

2.3.3 Integrated Quality Management

In the One Care demonstration, MassHealth and CMS have developed a joint management structure for monitoring the One Care plans and the care they provide. MassHealth is responsible for day-to-day monitoring of the One Care plans and their contract compliance. As indicated above, the Contract Management Team, which includes representatives from MassHealth and CMS, provides the forum for discussion and resolution of issues and review of reports such as those from the customer call centers, monitoring reports submitted by the plans, grievances and appeals, and quality improvement plans. Many of these issues relate to quality monitoring processes and outcomes.

CMS developed a set of quality measures (referred to as core measures) that all Medicare-Medicaid Plans must report. In addition, MassHealth developed a set of State-specific measures that One Care plans are required to report. Plans are also required to collect additional measures as part of their Medicare Advantage plan requirements and submit ongoing monthly and quarterly reports that monitor compliance and other activities. Plans reported concerns about the number of measures and the redundancy of some measures. They also reported on the challenges of collecting the data, using the required formats and definitions, and the time required to develop some of the reports for this demonstration.

Section 8.4 provides a description of the quality management structures and measures for the One Care demonstration.

2.3.4 Integrated Financing

All covered Medicare and Medicaid services are paid on a capitated basis. One Care plans receive three monthly capitation payments from CMS and MassHealth. CMS makes monthly payments reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. MassHealth makes a monthly payment reflecting coverage of Medicaid services.

Although each plan receives three separate payments for services, they can blend these payments internally to cover the mix and array of Medicare and Medicaid services provided, and can leverage potential savings from one program to cover services in the other. They can also use the flexibility afforded by capitated payments to develop new service delivery models (as one plan did) or offer flexible benefits that meet the individual needs of members.

Section 7 provides more information on the integrated financing arrangements.

2.4 Successes

CMS, MassHealth and the One Care plans worked in partnership during implementation. MassHealth and CMS worked collaboratively to integrate or align Medicare and Medicaid policies and procedures for the One Care demonstration, including an integrated set of benefits, integrated financing, a single set of performance and quality measures for managing plan performance, and a range of other common standards and integrated rules for implementing One Care. The CMT has played a critical role in supporting the success of the One Care demonstration. The plans have acknowledged and appreciated the partnership with MassHealth and CMS. A representative from one of the plans had the following comments:

> *I would add that the State has been really collaborative in this and I think a lot of observers locally have found that has been a key difference in implementation of this program relative to other types of programs. CMS, too,…[has] been really very collaborative working with the plans to meet their needs.…they have been incredibly responsive to us and able to make changes on the fly that I don't know we've seen in other types of programs.*

One Care plans strongly support the goals of the demonstration. They recognize the value of providing an integrated set of benefits, coordination of LTSS and medical and behavioral services, and the potential to improve beneficiary outcomes.

MassHealth placed a high priority on provider education, training, and outreach activities. MassHealth contracted with the University of Massachusetts Medical School to develop webinars, trainings, and learning collaboratives aimed at the provider community and the broader public. These trainings and materials have been critical tools for sharing information about One Care with providers and the public and for building and supporting a common vision, mission, and understanding of the components of the demonstration among providers, community-based organizations, beneficiaries, and other stakeholders.

The integrated capitation payments allowed One Care plans to create new service delivery options. One of the plans used the financial flexibility provided by the integrated capitated Medicare-Medicaid payments to create new community support and crisis stabilization units that allow One Care beneficiaries to receive services in a community-based setting rather than be admitted to a hospital or other institution.

2.5 Challenges

The integration of eligibility and enrollment systems created significant challenges for MassHealth and CMS. MassHealth had to commit significant time and resources to develop Commonwealth-specific subsystems that would allow for successful interface and transactions between MassHealth and the Medicare eligibility and enrollment systems. MassHealth expressed the need for more training and a better understanding of the Medicare system; Medicare officials had to learn new processes, policies, and systems underlying the Medicaid program.

The plans experienced, first hand, much of the complexity of integrating Medicare and Medicaid functions. Although all three plans (or their parent company) had prior experience with Medicare, they all cited challenges with learning the One Care "business" and its reporting requirements as well as the Medicare requirements. One plan representative commented that the demonstration represents not one plan, but four: one for Medicare Parts A and B, one for Medicaid, one for One Care, and one for Medicare Part D. Regardless of whether this representation is entirely accurate, it reflects some of the frustration the plans feel in meeting multiple reporting requirements and understanding the different enrollment and disenrollment policies and notices, the grievance and appeals systems, and the contract requirements of each payer separately and for the One Care demonstration. As an example, One Care plans are required to submit duplicate sets of encounter data to both CMS and to MassHealth, using different formats to accommodate each reporting system.

The One Care plans had challenges during early implementation establishing comprehensive provider networks and negotiating rates with providers. For the most part, the One Care plans are small relative to other non-demonstration plans operating in the Commonwealth. Their size limited the ability of One Care plans to negotiate with providers and to influence their engagement in One Care. The plans worked to educate providers about the special needs of this One Care population and the advantages the demonstration offers to beneficiaries.

Medicare Part D processes remain largely unchanged. MassHealth officials indicated that the inner workings of Medicare Part D remain largely unfamiliar to them and that Medicare Part D continues to run as an independent program. Other than the coordination of enrollment, financing, benefits, and other policies related to Part D have not been integrated into the demonstration.

2.6 Preliminary Findings

Stakeholders reported that the amount of interagency and intra-agency collaboration and communication within the Commonwealth, within the Federal agencies, and across State and Federal boundaries in order to implement One Care was

unprecedented. One Care implementation illustrates the depth, breadth, and complexity of integrating the services and functions controlled by the two largest health care payers in the country: the Federal Medicare program and the State-administered Medicaid program. This required new interfaces between national and Commonwealth administrative systems that control national and Commonwealth-specific eligibility and enrollment; the creation of new managed care plans to coordinate and deliver a comprehensive array of medical, acute, and long-term services and supports; and the alignment of many systems that historically have operated independently (e.g., Medicare and Medicaid appeals; quality management and monitoring; financing and payment).

A collaborative partnership between MassHealth and CMS was critical to successful implementation. The CMT has been a critical vehicle for identifying issues, triaging decision making, and resolving complex policy and administrative questions. The CMT provides a platform for partnership with the One Care plans, and CMS and MassHealth are perceived as willing and collaborative partners.

The notice of withdrawal of Fallon Total Care from the demonstration was a major setback for One Care. Stakeholders interviewed immediately following Fallon's announcement to withdraw from One Care voiced deep disappointment about Fallon's announcement and expressed concern about the impact on its enrollees. Advocates were very motivated to be part of the conversation and to have a transparent process for communicating this news and the choices that would be available to Fallon enrollees and other stakeholders. They also worried that Fallon's withdrawal would be perceived as a failure of the demonstration despite the fact that many had worked hard to achieve a successful demonstration.

All three One Care plans reported experiencing losses during the period covered by this report. Challenges with the rate structure and concerns over expected losses deterred three plans from participating before implementation.

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3. Eligibility and Enrollment

Highlights

- Of the almost 100,000 Medicare-Medicaid beneficiaries eligible for enrollment in One Care, approximately 17,700 had enrolled as of July 2015.
- Although the majority of eligible beneficiaries live in counties where passive enrollment is permitted (i.e., at least two plans serving a county), passive enrollment has been limited by plan capacity. The Commonwealth has been phasing in enrollment to accommodate plan capacity, starting with beneficiaries in the lowest need rating category.
- Massachusetts conducted two surveys to understand factors influencing beneficiary enrollment decisions. Respondents who opted out reported concerns about losing an important provider or being satisfied with their current care. Those who voluntarily opted in cited access to additional services, care coordination and better health care, having a single health plan, and anticipated lower health care costs.
- The percentage of members whom the One Care plans could not locate to conduct health risk assessments as of the 90th day of enrollment was substantial, ranging from 20 to 35 percent per quarter.

3.1 Introduction

This section provides an overview of the enrollment process for One Care. Members can opt into the demonstration, be passively enrolled and then assigned to a plan (if there are at least two plans available in the area), and, at any time, disenroll from a plan or opt out of the demonstration. MassHealth staggered enrollment, particularly for those who were passively enrolled, during the first year of the demonstration. This section also describes the phases of enrollment and discusses the complexities of integrating the Medicare and Medicaid eligibility and enrollment systems. Once members are enrolled or assigned to a plan, each plan is required to locate members, contact them, and conduct an initial assessment. The challenges of finding members are discussed. Data on those enrolled and those who opted out are also provided.

3.2 Enrollment Process

3.2.1 Eligibility

Individuals eligible for the demonstration are full-benefit Medicare-Medicaid enrollees aged 21 to 64 at the time of enrollment who are enrolled in Medicare Parts A and B and eligible

for Part D; and those who are eligible for MassHealth Standard or MassHealth CommonHealth.[13] Individuals who turn 65 while enrolled in the demonstration may remain enrolled as long as they continue to be enrolled in Medicare Parts A and B, are eligible for Medicare Part D and MassHealth Standard, and have no other comprehensive private or public health insurance (Memorandum of Understanding [MOU], 2012, p. 8).

3.2.2 Phases of Enrollment

Beneficiaries could opt into the One Care demonstration or be passively (automatically) enrolled if they lived in a county where more than a single One Care plan operated.[14] During the passive enrollment process, eligible beneficiaries who have not otherwise opted into the demonstration are assigned to a plan based on their prior use of services and providers in a plan. Once assigned to a plan, beneficiaries are notified of the assignment and provided the opportunity to disenroll or to change plans at any time.

The One Care demonstration started with an initial period of opt-in-only enrollment. From January 2014 through December 2015, there were four phases of passive enrollment and the continued opportunity for opt-in enrollment. During each enrollment phase, MassHealth and CMS worked together to determine the number and groups of people to passively enroll. MassHealth has also used its rating categories for the Medicaid component of the capitated rate (***Table 6***) to stage enrollment.

Table 6
Medicaid rating categories

Facility Based Care (F1)	Long-term facility stay of more than 90 days
Community Tier 3 (C3)	Need for skilled nursing care and/or assistance with ADLs
• C3B	• With certain diagnoses (e.g., quadriplegia, ALS)
• C3A	• All others
Community Tier 2 (C2)	Chronic behavioral health diagnosis and high service need
• C2B	• With co-occurring substance abuse and serious mental illness
• C2A	• All others
Community Tier 1 (C1)	Not in F1, C3, or C2

ADLs = activities of daily living; ALS = amyotrophic lateral sclerosis (Lou Gehrig's disease).

NOTE: The subcategories C2A, C2B, C3A, and C3B were added effective January 2014; this change was anticipated and included in the three-way contract.

SOURCE: Three-way contract, 2013.

[13] MassHealth Standard covers mandatory and optional State Plan populations. CommonHealth covers adults and children with disabilities who are not eligible for MassHealth Standard because their income is too high. Populations covered under MassHealth Standard and MassHealth CommonHealth both receive State Plan services, either through direct coverage or premium assistance, or both.

[14] The following categories of beneficiaries are not eligible for passive enrollment in MassHealth: people enrolled in a Medicare Advantage plan, a Program of All-Inclusive Care for the Elderly, or a Medicare supplemental plan; and those individuals turning 65 in the next 6 months (MOU, 2012, p. 8).

In the first phase of passive enrollment, only those in the lowest rating category (e.g., people with the less acute care needs) were considered for inclusion in passive enrollment. In subsequent phases of enrollment, all beneficiaries, except those who were nursing facility residents, were included for passive enrollment. In the fifth phase of enrollment, only those in Suffolk and Worcester were included in the passive wave of enrollment, and beneficiaries were assigned to only one of the three plans; the other two plans did not participate in this phase of passive enrollment. ***Table 7*** shows the phases of enrollment in One Care.

Table 7
Phases of enrollment

Phase	Start date	Eligible population	Geographic area
1	10/01/2013	Opt-in only began.	All demonstration counties.
2	01/01/2014	Passive: Persons in the lowest rating category (C1) with less acute needs; assignment to plans based on prior use of primary care services; all eligible can opt in.	Passive enrollment: Hampden, Hampshire, Suffolk, and Worcester counties; opt-in enrollment: all demonstration counties.
3	04/01/2014	Passive: Persons in all rating categories except for facility-based care (F1); assignment to plans based on prior use of primary care, long-term services and supports (LTSS) or behavioral health; all eligible can opt in.	Passive enrollment: Hampden, Hampshire, Suffolk, and Worcester counties; opt-in enrollment: all demonstration counties.
4	07/01/2014	Passive: Persons in all rating categories except for facility-based care (F1); assignment to plans based on prior use of primary care, LTSS or behavioral health; all eligible can opt in.	Passive enrollment: Hampden, Hampshire, Suffolk, and Worcester counties; opt-in enrollment: all demonstration counties.
5	11/01/2014	Passive: Persons in all rating categories except for facility-based care (F1); all eligible can opt in. Beneficiaries were assigned to only one plan during this phase.	Passive: Suffolk and Worcester counties; opt-in enrollment: all demonstration counties.

MassHealth and CMS worked with the plans to determine the volume of beneficiaries to assign to each plan during each phase of enrollment. Both the plans' capacity and desire to increase the number of enrollees were taken into account when determining the number of beneficiaries to passively enroll. A single plan wanted to increase enrollment early in the demonstration to bring the model to scale sooner rather than later; a single plan chose to participate in the auto-assignment process incrementally, declining to participate in some waves of passive enrollment; another plan preferred smaller waves of enrollment. For a particular plan, it was important to take a slower approach to get the right staff on board and to have time for the significant learning curve associated with serving this new population.

For actual enrollment to align with plan targets, MassHealth and the plans had to consider and estimate multiple factors, including the number of notices that would be returned as undeliverable; the number of enrollees who might lose eligibility during the enrollment process; and the number of members choosing to opt out of participation, disenroll, or choose a different plan. Although MassHealth continued to learn with each phase of enrollment, estimating the number of people who would actually be passively enrolled under each had been an ongoing

challenge during the early periods of passive enrollment (State Data Reporting System [SDRS], 4th Quarter).

3.2.3 Impact of Passive Enrollment

Passive enrollment created many logistical, operational, and communication challenges for MassHealth, the plans, and beneficiaries. The large volume of enrollees during the phases of passive enrollment meant more cases requiring the time-intensive process of reconciling enrollment data between MassHealth and CMS. Many of the early operational challenges associated with integrating enrollment systems were resolved through the collaborative efforts of MassHealth, CMS, the Medicare-Medicaid Plans, and stakeholders, or were diminished during periods where passive enrollment did not occur.

Passive enrollment also created challenges for the One Care plans. During its initial phases, plans had to bring many functions and staffing to scale within a short period of time. MassHealth and CMS have worked to implement the process in a way that has been least disruptive to the beneficiaries and the plans. All the plans appreciated the opportunity to work with MassHealth and CMS to develop an individualized strategy for growth and scale.

For some beneficiaries, passive enrollment created suspicion and confusion. Beneficiaries who were passively enrolled did not always know they had been enrolled in a new health plan and were unfamiliar with the process of engagement and assessment.

The use of passive enrollment continues to be an area of discussion between MassHealth and stakeholders. Stakeholders wanted the demonstration to grow more gradually and to allow beneficiaries to affirmatively opt in rather than to be passively enrolled in a plan. Officials at MassHealth believe it is a way to bring the model to scale, provide new benefits and services to people in most need, and achieve improved outcomes for the greatest number of people. For plans, passive enrollment provides a level of volume that supports investments in the administrative and care coordination infrastructure necessary to implement the care model.

3.2.4 Integration of Medicare and Medicaid Enrollment Systems

MassHealth and CMS developed integrated enrollment materials for One Care. All eligible Medicare-Medicaid beneficiaries were sent an opt-in enrollment packet that included a cover letter, an enrollment guide (with tips for choosing a plan and ways to find out about a One Care plan's network, important phone numbers, and information about medications) and an enrollment decision form. The enrollment guide described how MassHealth and Medicare were offering an option for people with disabilities to get the full set of services provided by both programs from a single plan. It described the services that will be covered, who can participate, how to choose a One Care plan, how to sign up, and what will happen if you do or do not sign up. In the March 2014 mailing to members, a Part D insert was created explaining more clearly the implications for members' Part D benefits. This latter adjustment was to clarify the meaning of Part D disenrollment notices that beneficiaries received upon enrollment in One Care, which were causing confusion and anxiety (SDRS, 2nd Quarter).

MassHealth contracts with Maximus to act as an enrollment broker and to provide customer service. The enrollment broker prepares and manages mailings to potential enrollees;

enrolls and disenrolls members in One Care through MassHealth's and CMS' enrollment systems; and notifies One Care plans on the enrollment status. Enrollment in One Care requires confirmation of eligibility for the demonstration, which in turn requires confirming that the beneficiary meets Medicaid eligibility criteria as well as Medicare eligibility for Parts A, B, and D.

The process of confirming Medicare eligibility requires matching the beneficiary's identifying information collected by Maximus with Medicare enrollment systems. However, MassHealth and Medicare enrollment systems use different member name and date criteria to confirm eligibility. InfoCrossing, which validates a beneficiary's Medicare eligibility on behalf of CMS, uses more stringent criteria to verify member information than does the Massachusetts enrollment system. The inconsistent criteria cause enrollment transactions to be rejected. In some instances of a mismatch on demographic data (e.g., name, date of birth), CMS authorized MassHealth to bypass InfoCrossing in order to enroll beneficiaries known by MassHealth to be Medicaid eligible.

To facilitate the enrollment process, MassHealth conducted specialized training for Maximus call center representatives; developed internal escalation procedures to resolve issues; and conducted public meetings to keep beneficiaries and stakeholders informed (SDRS, 3rd Quarter). In collaboration with CMS, MassHealth worked with the State Health Insurance Assistance Program (SHIP), known in Massachusetts as Serving the Health Insurance Needs of Everyone (SHINE), to educate representatives and counselors on the One Care demonstration.[15] MassHealth and One Care plans also coordinated health and enrollment fairs across the Commonwealth to support in-person discussion and promote enrollment. Representatives from SHINE were available to answer questions and to help with enrollment (SDRS, 1st Quarter, 2013).

3.2.5 Contacting and Locating Enrollees

During the enrollment process, beneficiaries may opt into the demonstration and choose a One Care plan or be passively enrolled and assigned to a One Care Plan. Once a member is enrolled in a plan, the plan is required to contact him or her and conduct an initial assessment within 90 days of the beneficiary's enrollment date. During the initial enrollment phases, plans were actively engaged in trying to contact members.

All three One Care plans have had difficulty locating enrollees to conduct the initial assessments, particularly those who had been passively enrolled. Plan representatives attributed some of these challenges to the population served by One Care, which includes a high prevalence of those with behavioral health needs and those experiencing homelessness. In other cases, these challenges were attributed to incorrect or changing addresses and phone numbers. Some beneficiaries reportedly were wary of being contacted by an unknown or unfamiliar organization, did not want to be contacted, or did not understand why they were being contacted.

[15] CMS has provided funding opportunities for States participating in the Financial Alignment Initiative to support outreach and counseling activities through SHIP and the Aging and Disability Resource Centers for beneficiaries eligible for the demonstrations. Awards are for a 3-year period beginning with the date of the award. Massachusetts received $250,000 in March 2013.

During implementation, CMS provided additional guidance on how plans were to report this information. Specifically, CMS clarified that plans should report the number of members they were unable to locate after three attempts; and that they should document each attempt to locate the member, including the method used. They also encouraged the plans to continue beneficiary outreach after three unsuccessful attempts and to try to reach members via multiple methods, including phone, mail, or email; and to work with community organizations, network providers, and others to determine accurate contact information and promote member engagement (CMS, March 6, 2015).

Table 8 shows the percentage of members that the plans were unable to locate throughout the first five quarters of implementation. The percentage that they were unable to locate within 90 days has fluctuated from a low of 20 percent in the fourth quarter of 2014 to 35 percent in the third quarter of 2014 and has varied by plan.

Table 8
Percentage of members that One Care plans were unable to locate following three attempts, within 90 days of enrollment, by quarter

Quarter	CY 2014	CY 2015
Q1	28.6%	27.9%
Q2	26.6%	—
Q3	35.0%	—
Q4	20.0%	—

— data not available.

SOURCE: Excel spreadsheet 2015_06_15 MassHealth Tool Calculations 6-15-2015.

The challenges of finding enrollees made it difficult for plans to complete assessments in a timely manner (see ***Section 4***). A representative from one of the One Care plans had these comments:

> *We had 90 days to get that assessment done but sometimes finding them, we'd go to a parking lot thinking we were going to the home, so the address is wrong. So finding those individuals, finally getting them to do the assessment, complete it and submit it [is challenging]…*

Plans reported that the effort, staff time, and cost of trying to contact members, particularly in the population served by One Care, was not anticipated and contributed to higher-than-anticipated administrative costs, particularly in the early months of implementation.

MassHealth, CMS, One Care plans, and stakeholders worked collaboratively to share creative approaches for finding members and conducting outreach and education about One Care. Early in the demonstration, MassHealth identified strategies to increase awareness of the demonstration among behavioral health and other providers.

MassHealth participated in several outreach sessions targeting the behavioral health audiences to explain the One Care model and answer questions. Many of these providers have

been supportive of the One Care plans and have been invaluable in working with the plans to find hard-to-reach members. MassHealth also participated in events sponsored by Boston Health Care for the Homeless (BHCHP) and worked with BHCHP to increase awareness of One Care and to facilitate the eligibility verification and enrollment process. BHCHP also worked directly with the plans to locate hard-to-reach members (SDRS, 3rd and 4th Quarters).

The One Care plans also tried new ways to reach out to members. A One Care plan representative described some of the approaches used:

> *We found in the beginning, especially with large numbers and auto assignment, and even with opt-in enrollment, people may be…a little bit skeptical, concerned about why we're reaching out, why we wanted to meet with people face-to-face and do an assessment, etc. So we've learned ways to do that, to reach out to people early in the month. …We go to shelters, to workshops, Dunkin' Donuts, wherever people are and are comfortable seeing us, our outreach team will reach out to them.*

In fall 2014 MassHealth also implemented a provider communication plan to educate providers about One Care so they would consider contracting with these plans or educate their patients about the benefits of joining One Care. Other strategies included a direct mailing to providers; an email to providers; and information for provider associations to include in newsletters, bulletins, and updates to their members. They also placed ads in journals targeting primary care and behavioral health providers. MassHealth has continued to have discussions during its open meetings about options for increasing enrollment and retention in One Care (SDRS, 6th Quarter).

CMS was also able to make Medicare claims available to the plans so they can better identify enrollee-provider relationships and locate hard-to-reach members. In addition, MassHealth and CMS continued to adjust the passive enrollment process to enroll individuals with known relationships with providers in a plan's network (SDRS, 4th Quarter).

3.2.6 Enrollment Decisions

The Early Indicators Project, a collaboration among MassHealth, the Implementation Council, and the University of Massachusetts Medical School, conducted a telephone survey of One Care beneficiaries to assess perceptions and experiences during the initial enrollment period. A total of 300 beneficiaries were surveyed, representing three groups: beneficiaries who opted into the demonstration, beneficiaries who opted out, and beneficiaries who had not yet made a decision about enrollment. Of the 125 beneficiaries surveyed who chose not to enroll into One Care, 76 percent said they had opted out of participation because they were happy with their health care and One Care would not be as good; 69 percent indicated that they would lose an important provider; and 56 percent thought they would lose an important service. Among those concerned about losing an important service, 79 percent had concerns about losing access to a primary medical provider, such as a doctor or nurse practitioner; and 56 percent were concerned about losing a behavioral health or mental health provider (Henry et al., n.d.).

A later Early Indicators Project survey, conducted June 2014 to January 2015, was designed to capture member experiences and perceptions during the first months they were

enrolled in One Care (Henry et al., 2015). See ***Section 5, Beneficiary Experience***, for more information on this survey. The survey asked questions of those who had opted into the demonstration and those who had been passively enrolled. Of those who opted in, most found it easy to choose a plan (82 percent) and to enroll (87 percent); their primary reasons for enrolling were to get better health care (61 percent), additional services (51 percent), or better dental care (48 percent); to have one health plan rather than two (45 percent); to lower their costs for health care (36 percent); or to get a care coordinator (34 percent) or an Independent Living and Long-Term Services and Supports (LTS) coordinator (25 percent). The survey found that members who had opted into One Care "understood and were motivated to enroll by some of the unique features offered by One Care" (Henry et al., p. 21).

In some cases, it appears that beneficiaries are choosing to enroll for a short time only. Because beneficiaries may enroll and disenroll on a monthly basis, some plans reported that beneficiaries join the plan to get an additional benefit (e.g., dental) and then disenroll to go back to their preferred provider. For the plans, a disenrollment becomes a lost investment. A One Care plan representative explained the plan's problem:

> *Retention is so imperative in this program because again, when people come onto the program that's when you get the most expensive. They usually go in for all the new treatments, all effort and work and resources into the MDS and assessments and so on. Therefore, the longer we retain then the better in terms of our financials.*

3.3 Summary Data

As of January 1, 2015, approximately 17,900 beneficiaries were enrolled in the One Care demonstration, representing about 19 percent of the eligible population. The distribution of members by counties is displayed in ***Table 9***. The counties with the highest penetration of enrollment (Hamden, Hampshire, Suffolk, and Worcester) are also the counties where there were at least two plans operating and where beneficiaries were passively enrolled.

MassHealth reported that they did not have a specific enrollment goal for the demonstration. About half of the beneficiaries lived in counties with only one plan (Essex, Franklin, Middlesex, Norfolk, and Plymouth). As of July 1, 2015, approximately 17,670 were enrolled in the demonstration out of a total of 99,617 eligible beneficiaries (17.7 percent).

Table 9
Enrollment by county as of January 1, 2015

County	Eligible	Enrolled	Percent enrolled
Essex	14,386	931	6.5%
Franklin	2,045	72	3.5%
Hampden[1]	14,835	4,851	32.7%
Hampshire[1]	2,568	537	20.9%
Middlesex	17,699	1,235	7.0%
Norfolk	7,241	529	7.3%
Plymouth	6,825	419	6.1%
Suffolk[1]	15,198	4,170	27.4%
Worcester[1]	14,869	5,123	34.4%
Total	95,666	17,867	18.7%

[1] Counties with two or more plans.

SOURCE: MassHealth, Enrollment Report, January 2015.

3.4 Successes

Faced with the unexpected level of difficulty of finding and engaging members, MassHealth, CMS, and the plans worked collaboratively to develop various strategies to locate and contact enrollees. Early in the demonstration, MassHealth, the One Care plans, and other stakeholders realized that finding and contacting beneficiaries, particularly those who were homeless or transient, in the One Care demonstration was difficult. These stakeholders worked collaboratively to share information and creative approaches to find and contact members, including using medical and pharmacy claims data, and tracking enrollees through emergency department usage. To reduce reluctance or apprehension on the part of some beneficiaries to engage in the enrollment process, some plans met enrollees in a variety of locations, including shelters, workshops, and other locations outside of their homes.

MassHealth and CMS worked with the plans to manage passive enrollment volume to meet plan capacity. MassHealth and CMS recognized the need to tailor the assignment of beneficiaries during passive enrollment to align with the goals and capabilities of the plans. This approach allowed the plans to enroll members in a manner consistent with their goals for participation in the demonstration. This was particularly important because the plans had to make considerable investments in new infrastructures and administrative systems to meet the requirements of One Care.

Beneficiaries who opted into the demonstration were motivated to join by the benefits or other features of the demonstration. A survey of enrollees found that the primary reasons for enrolling were to get better care (61 percent), additional services (51 percent), and/or lower costs (36 percent). Other enrollees wanted to get a care coordinator (34 percent) or an LTS coordinator (25 percent). Most members who opted in found it easy to do so.

3.5 Challenges

Although plans have made some progress, the total percentage of enrollees who the plans were unable to locate remained high. As of the first quarter of 2015, the percent of enrollees not able to be located was 28 percent. The plans and MassHealth officials noted that enrollee contact information provided to the plans by MassHealth was not always current, especially for enrollees who were homeless or transient. Plans reported their greatest difficulty in reaching enrollees occurred during passive enrollment periods.

The plans had challenges developing internal capacity needed to meet the demonstration's requirements related to early enrollment and assessment processes. The waves of passive enrollment strained the plans and their ability to locate and assess enrollees in a timely manner. Many beneficiaries who were passively enrolled (e.g., people who were homeless) had not previously had prior contact with the health care system. The plans did not anticipate the additional time, resources, and costs associated with finding and contacting members.

Plans reported that allowing beneficiaries to enroll and disenroll on a monthly basis limited the plans' ability to manage care and positively impact long-term outcomes. Some plans reported that some beneficiaries enrolled in the demonstration to get a new benefit (e.g., dental) and then disenrolled in order to return to a regular provider. This was very disruptive to the plans, their financial planning, and their ability to provide comprehensive care management.

3.6 Preliminary Findings

MassHealth staff had to devote significant time and resources to align the MassHealth eligibility and enrollment systems with those of CMS and its contractors. MassHealth needed to develop multiple manual subsystems to successfully process enrollments and disenrollments. As of July 1, 2015, the interface issues had not been fully resolved.

The small number of plans participating in the demonstration limited the scale and reach of the demonstration. Enrollment in the demonstration was low—about 18 percent of eligible beneficiaries. Fewer plans than expected participated in the demonstration resulting in fewer choices for beneficiaries. Plans also chose different strategies for growth, with one plan seeking incremental growth over time. In counties where only one plan operated, the enrollment rate was under 10 percent. In counties with two or more plans, enrollment never exceeded 32 percent.

The One Care experience illustrates the challenges associated with passive enrollment for vulnerable populations. From the perspective of MassHealth officials, passive enrollment was a necessary and important component of the demonstration to bring the model to scale, meet the growth strategies of the plans, and achieve the greatest impact on the most people. MassHealth, CMS, and the plans also found it important to employ multiple phases of passive enrollment and to take into consideration the plans' capacity, initial performance, and growth strategies as part of this process. Passive enrollment also provided the volume necessary for plans to invest in the administrative and other infrastructure necessary to support the care coordination and other components of the care model. On the other hand, passive enrollment created unexpected challenges to plans in staffing, locating enrollees and conducting assessments.

4. Care Coordination

Highlights

- Care coordination was widely viewed as a valuable service for connecting beneficiaries to new and existing services, especially because many beneficiaries did not have access to care coordination as a covered service before One Care.
- Plans found during implementation that there was no "one size fits all" model for delivering care coordination to One Care beneficiaries because of enrollees' diverse needs and individual preferences.
- Some beneficiaries reported duplicative or multiple levels of coordination, resulting in a lack of clarity for beneficiaries around respective roles and responsibilities of different individuals coordinating their care.
- One Care was designed with stakeholder input to have community-based coordinators connect beneficiaries to long-term services and supports (LTSS). Although the Independent Living and Long-Term Services and Supports (LTS) coordinator role has been broadly supported, implementation has been challenging for MassHealth, plans, and providers.

4.1 Care Coordination Model

The use of care coordinators, clinical care managers, and community-based LTS coordinators are central features of the One Care model. For medical and behavioral health services, plans must offer care coordination to all enrollees through a care coordinator or, for members with complex needs, a clinical case manager. Enrollees needing LTSS are offered an LTS coordinator as a resource to help identify and coordinate those services. The One Care plans are required to contract with community-based organizations (CBOs) to provide the LTS coordination service, as described in this section. The care coordination components of the demonstration represent new services for this population; prior to the One Care demonstration, enrollees had limited, if any, access to care coordination services. This section provides an overview of the demonstration requirements related to the care coordination function, including assessment processes; use of Integrated Care Teams (ICTs) and the development of individualized care plans (ICPs); delivery of care coordination services; and the role of the LTS coordinators for enrollees needing LTSS.

4.1.1 Assessment

One Care plans must complete a comprehensive in-person assessment within 90 days of an enrollee's effective enrollment date, or whenever the enrollee experiences a major change that is not temporary or episodic, impacts more than one area of health status, and requires interdisciplinary review or revision of the care plan (three-way contract, 2013, p. 46). Initially, plans were required to complete in-person reassessments annually, but this requirement was

modified, as discussed in this section, to allow for some telephone reassessments. Although there is no required assessment tool, One Care plans must assess for the 21 required domains outlined in the three-way contract. Domain examples include medical and behavioral health conditions, functional status, employment and housing needs, care giver supports, food security, and transportation needs (three-way contract, 2013, pp. 46–9). Each plan developed its own assessment instrument covering these domains.

As part of the rate methodology for determining the Medicaid component of the capitated payment to the MMPs, all enrollees were assigned to one of four principal rating categories. The different rating categories were based on need for facility versus community care, level of nursing or activities of daily living (ADL) needs, and certain diagnostic criteria. Beginning January 2014, two of the four rating categories (C3 and C2) were divided into subcategories to more accurately reflect the intensity of service need. The One Care rating categories are defined in ***Table 10***. For new enrollees, MassHealth assigns a rating category based on available claims data.

Table 10
Definitions of One Care rating categories

Rating category	Tier	Definition
F1	Facility-based care	Enrollee with a stay exceeding 90 days in a skilled nursing facility, nursing facility, chronic hospital, rehabilitation, or psychiatric hospital.
C3	Community Tier 3 – High community need	Enrollee who has daily skilled need; two or more activities of daily living and 3 days of skilled nursing need; and individuals with four or more ADL limitations.
C3B[1]	Community Tier 3 – Very high community need	Enrollee meets the criteria of Community Tier 3 and has a diagnosis of quadriplegia, ALS, muscular dystrophy, or respirator dependence.
C3A[1]	Community Tier 3 – High community need	Enrollee meets criteria of Community Tier 3 and does not have diagnoses of people in C3B.
C2	Community Tier 2 – Community high behavioral health	Enrollee has chronic and ongoing behavioral health diagnosis that indicates a high level of service need.
C2B[1]	Community Tier 2 – Community very high behavioral health	Enrollee meets the Community Tier 2 criteria and has co-occurring diagnosis of substance abuse and serious mental illness.
C2A[1]	Community Tier 2 – Community high behavioral health	Enrollee meets the Community Tier 2 criteria but does not have diagnoses or characteristics of C2B.
C1	Community Tier 1– Other	Enrollee does not meet F1, C2, or C3 criteria.

ADL = activity of daily living; ALS = amyotrophic lateral sclerosis, often referred to as Lou Gehrig's disease.

[1] Rating categories implemented as of January 1, 2014.

SOURCE: Three-way contract, 2013.

Depending on an enrollee's assigned rating category, plans are required to complete an additional assessment using the Minimum Data Set-Home Care (MDS-HC), a proprietary clinical screening instrument. The MDS-HC assesses key domains of function, health, and service use and must be completed in–person by a registered nurse. Note that the MDS-HC is

different from the Minimum Data Set (MDS 3.0) nursing facility assessments mandated by CMS. MDS 3.0 data are used for the quantitative analysis in this report. The MDS-HC is used to assign a rating category for the enrollee that determines the level of payment to the plan. The MDS-HC is required for all enrollees except those assigned to a C1 rating (the rating for those with the lowest care needs, see ***Table 10***); the MDS-HC is required for enrollees assigned to the C1 rating only when a plan requests a change to a different rating category (three-way contract, 2013, p. 51). By contract, the MDS-HC must be completed within 6 months of enrollment for enrollees assigned to the C2 ratings; it must be completed within 90 days of enrollment for enrollees assigned to the C3 rating categories.

Although contract requirements for the comprehensive assessment and MDS-HC differ, plans reported that in practice they complete the MDS-HC for all initial enrollees, including those assigned to the C1 category, at the same time as they completed the comprehensive assessment. This practice began shortly after implementation because plans found that historical claims data used by MassHealth to initially assign the C1 rating did not always reflect the true level of need for those enrollees; consequently, it was advantageous to plans to complete the MDS-HC so that a different rating category could be established that more accurately reflected the costs of serving those enrollees. The financial implications of serving higher cost enrollees initially assigned to the C1 rating is discussed in ***Section 7, Financing and Payment***. For efficiency, one plan reported modifying its comprehensive assessment tool to cover only those required domains not already captured by the MDS-HC.

It has sometimes been challenging for One Care plans to complete initial assessments during the required timeframes, in part due to a lack of capacity during periods of high volume brought about by passive enrollment. Plans are required to report the percentage of members who have their assessment completed within 90 days of enrollment, including completion rates for enrollees who could be located and who were willing to participate in the process. ***Table 11*** reflects data for all plans and shows that rates for completing initial assessments increased during implementation of the demonstration. In the first calendar quarter of 2014, 56 percent of new enrollees had an assessment completed within 90 days; by the fifth quarter of the demonstration period, this result had increased to 84 percent of new enrollees who had timely assessments. Plans reported that that their ability to conduct timely assessments gradually improved but acknowledged the challenges of meeting the 90 day benchmark, particularly during early phases of high volume passive enrollment. As the table shows, plans completed timely assessments at lower rates during the periods of high enrollment (e.g., the first and third quarters of 2014).

As discussed in ***Section 3, Eligibility and Enrollment,*** One Care plans also had difficulty locating members. Even when located, some members were not willing to participate in the required assessment. To clarify the plans' reporting requirements, CMS issued guidance in March 2015 defining when an enrollee could be considered "unwilling to participate in an assessment." That category included enrollees who affirmatively declined to participate; those who were willing but asked for the assessment to be completed after 90 days; enrollees who were willing to participate but rescheduled the date, did not show up, or were subsequently non-responsive; and enrollees who agreed to the assessment but declined to answer most questions (CMS, March 6, 2015).

Table 11
Total percentage of enrollees whose assessment was completed within 90 days of enrollment

Calendar quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Assessment completed within 90 days of enrollment %	
		All enrollees	All enrollees willing to participate and who could be located
2014			
Q1	7,469	34.1%	55.8%
Q2	3,973	34.7%	56.8%
Q3	6,338	34.9%	59.9%
Q4	890	57.8%	92.9%
2015			
Q1	1,389	53.4%	84.3%

NOTE: Data are preliminary and have not been reconciled. Total number of enrollees reported on Table 11 differ slightly from those reported on Table 12 due to variation in the timing of when the data were actually submitted for the different measures. Plans receive updated information periodically about a member's enrollment status, so enrollment values can change for the same reporting period when they are pulled from the plan's systems at different times.

SOURCE: Medicare-Medicaid Plan–reported data for Core Measure 2.1,[16] MassHealth Tool Calculations as of December 15, 2015.

All One Care plans contracted with external vendors to conduct assessments, particularly during early implementation. One plan continued to rely on several different vendors, though it was still working toward the goal of completing assessments in-house with its own staff. Another plan reported that it still relied on a vendor primarily for completing required reassessments. The demonstration was designed to have the care coordinator participate in comprehensive assessments for care planning. Plans reported that this level of participation was always the goal, but that it was not always practical on the ground, especially if the assessment was completed by a contracted provider and not by the plan itself. Some stakeholders expressed concerns around the use of external vendors, questioning whether critical information was lost as part of the hand-off back to the plan.

In addition to initial assessments at the time of enrollment, plans are also required to complete annual reassessments of all enrollees (three-way contract, 2013, p. 46). In June 2015, MassHealth and CMS issued new guidance modifying some of the requirements regarding the reassessment process (Presentation at Open Meeting, June 8, 2015). A key change permitted plans to perform telephonic reassessments for enrollees assigned a C1 category, reducing the number of in-person assessments required of plans. In light of the challenges they faced in meeting assessment timeframes, plans viewed this as a favorable change that illustrated the level of collaboration with MassHealth and CMS to address implementation challenges encountered during the demonstration.

[16] The technical specifications for core measures are provided in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans html.

4.1.2 The Care Planning Process

The ICT

One Care plans are responsible for establishing an ICT to coordinate the services needed by the enrollee. A primary responsibility of the ICT is to work with the enrollee to develop, implement, and maintain an ICP. One Care plans must arrange to form and operate an ICT that respects the enrollee's needs and preferences. The ICT must consist of at least the enrollee's primary care physician (PCP); a behavioral health clinician, if indicated; the care coordinator or clinical case manager; and if applicable, the LTS coordinator (three-way contract, 2013, p. 29). Enrollees may also choose to have other individuals, such as family members or informal caregivers, as part of the ICT. In practice, plans have operationalized these requirements in different ways.

All One Care plans emphasized the role of the enrollee in developing the size and composition of the ICT. Plans reported that there was no single "one size fits all" approach that met the needs of all One Care enrollees. This was echoed by others, including stakeholders and MassHealth. As an official from MassHealth explained:

> *There's a perception out there that you must have a primary care physician, an LTS coordinator. Certain people think that an ICT team doesn't work unless you have 'xyz' on that team. What we've had to reinforce over and over and over again is member-driven decision making. The member gets to choose who he or she wants on their team.*

Some plans reported modifying their approach to developing the ICT based on information learned during early implementation. One plan reported that it learned that One Care enrollees did not always want, nor necessarily need, a full complement of people on their care team. The plan modified its original "full team for all" approach and started with a smaller team, with the enrollee and the clinical care manager working together to build the right care team. Although the enrollee was offered a full range of supports, the final team was driven by enrollee choice. As the plan noted:

> *I think it sounds great when everyone's talking about 'we want all these people to sit around a table and have an ICT,' but for the member, that's a lot…You always have that fine line of trying to coordinate to have this robust discussion, but at the same time folks have been much slower to get to the comfort level.*

There are no reporting requirements specific to the ICT to determine the extent to which enrollees, PCPs, or other providers participate on, or otherwise engage with, the ICT. In practice, MassHealth and the plans have emphasized an individualized design for the ICT. Beneficiary feedback regarding a team approach to the provision of care has been mixed. Some individuals who participated in the focus groups conducted by the RTI evaluation team reported that they felt as if they were part of a team; others reported confusion regarding the number and specific roles and responsibilities of people involved in their care. Some participants reported communication among their providers was working well; others reported little if any communication among their primary care, specialists, and plan. At least one participant noted

that although there was communication among providers, it was not a "fluid, natural team approach." Results from the focus groups are described in ***Section 5, Beneficiary Experience***.

The Individualized Care Plan

The ICT develops an ICP for each enrollee based on the results of the comprehensive assessment. The ICP must be developed under the direction of the enrollee, and the enrollee must be at the center of the care planning process (three-way contract, 2013, p. 51). Among other requirements, the ICP must reflect the enrollee's preferences and needs; it must include a prioritized list of the enrollee's concerns, goals, and strengths, and a plan for addressing concerns or goals. The ICP must also identify how services and care will be integrated and coordinated across health care, community, and social services providers.

As part of the demonstration, MassHealth required plans to track and report data on care plan development. Those data (see ***Table 12***) show that the percentage of enrollees with a care plan developed within 90 days of enrollment increased every quarter; for enrollees willing to participate and who could be located, the percent of completed care plans within 90 days of enrollment increased from 33 percent in Quarter 1 to 65 percent in Quarter 5.

Table 12
Total percentage of enrollees who had a care plan completed within 90 days of enrollment

Calendar quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Care plan completed within 90 days of enrollment %	
		All enrollees	All enrollees willing to participate and who could be located
2014			
Q1	7,447	18.0%	23.7%
Q2	3,977	25.8%	41.0%
Q3	6,330	24.8%	39.3%
Q4	886	37.0%	59.1%
2015			
Q1	1,398	48.1%	65.2%

NOTE: Data are preliminary and have not been reconciled. Total number of enrollees reported on Table 12 differ slightly from those reported previously on Table 11 due to variation in the timing of when the data were actually submitted for the different measures. Plans receive updated information periodically about a member's enrollment status, so enrollment values can change for the same reporting period when they are pulled from the plan's systems at different times.

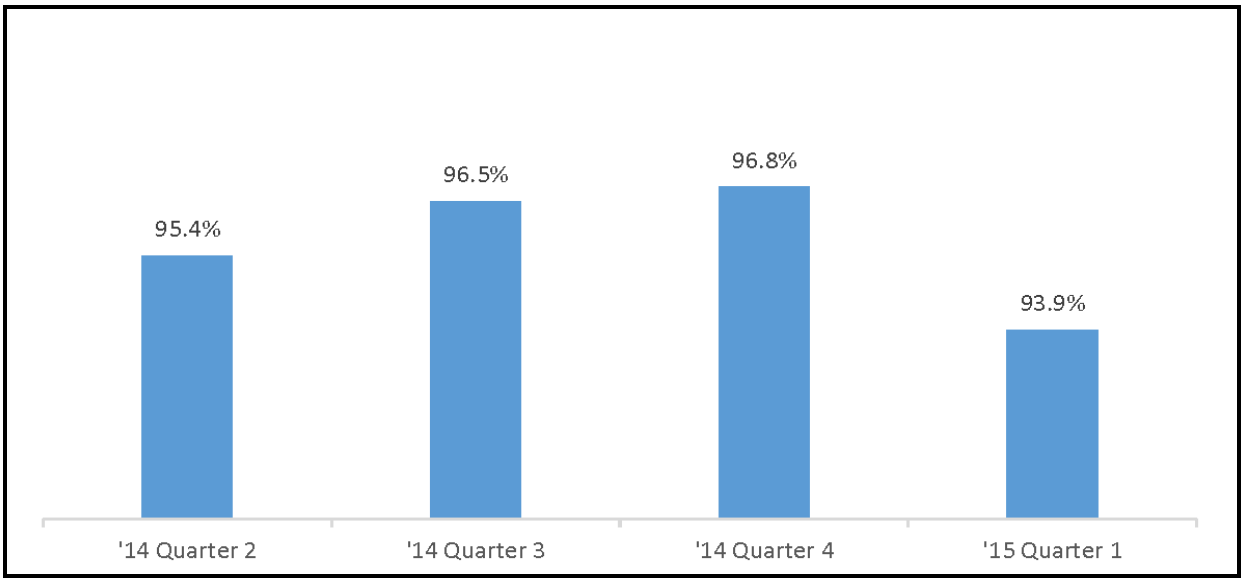
SOURCE: Data reported by Medicare-Medicaid Plans for State-Specific Measure 1.1, as of December 15, 2015.

Figure 1 indicates that of enrollees who had a care plan developed, a large majority had at least one documented discussion of a care goals. This particular measure is used to compute a quality withhold (see ***Section 7, Financing and Payment***). These data suggest that although One Care plans were challenged to develop care plans within 3 months of enrollment, enrollees had opportunities to discuss their care goals.

In a MassHealth-sponsored Early Indicators Project survey of One Care enrollees conducted from June 2014 through January 2015, two thirds (63 percent) of survey respondents

reported that someone from One Care met with them to assess their medical and other needs, but only slightly more than one-third (38 percent) reported having an ICP. Specific to their ICP, over one-third of respondents reported they did not know or were not sure if they had an ICP (35 percent) and a quarter of respondents (24 percent) reported that they did not have an ICP (Henry et al., 2015). These survey responses suggested that although One Care was designed to place enrollees at the center of the care planning process, enrollees may not have been engaged in or may not have understood the care plan development process. See ***Section 5, Beneficiary Experience***, for additional information.

Figure 1
Average percentage of enrollees with a care plan developed who had at least one documented discussion of care goals



NOTE: Percentages presented in this figure represent the average percentage of this measure across CCA, Fallon, and Tufts.

SOURCE: Compiled from data reported by Medicare-Medicaid Plans for State-specific Measure 1.2 as of December 15, 2015.

Care Coordination at the Plan Level

Plans are required to offer care coordination to all enrollees through a care coordinator or a clinical care manager if the person has certain complex needs (three-way contract, 2013, p. 32). The care coordinator acts as the enrollee's single point of contact with the One Care plan and the ICT. The care coordinator is expected to ensure that ICT meetings and calls are held periodically, monitors the provision and outcomes of services, and ensures that mechanisms are in place for communication with the enrollee to receive input and complaints (three-way contract, 2013, p. 31). Each plan developed its own approach to organizing and staffing care coordination.

Approaches to organizing and staffing care coordination. One plan assigned a medical nurse care manager to an enrollee, paired with a non-licensed individual, to act as the points of contact for the enrollee. Another plan created different levels of care coordination

based on the complexity of need reflected by the enrollee's assigned rating category. Because of the high number of individuals with behavioral health needs served by One Care, all plans noted the importance of addressing behavioral health needs in the care planning process.

One plan found that an interdisciplinary care team internal to the plan composed of social care management, medical care management, and behavioral health care management allowed for better cooperation in managing enrollees with comorbid conditions. The team was co-located and often co-managed cases. Some plans modified care coordination design during implementation based on the needs of the One Care population. For example, one plan implemented a single model for providing intensive care management to enrollees with complex behavioral health needs without differentiation based on medical needs. The plan changed its approach during implementation because it found that the care coordination needs of enrollees with complex behavioral problems who were otherwise medically stable differed from those of enrollees who had complex behavioral and medical needs.

Only one plan delegated any of its care coordination responsibilities to outside entities. This plan described delegation as being consistent with its overall mission of developing and building community support structures with the capacity and expertise to meet the requirements of members with behavioral health needs. The plan estimated that approximately 20 percent of its enrollees received care coordination services from primary care providers or behavioral health organizations. The plan found it advantageous to contract with organizations that already served One Care enrollees and to build on relationships that already existed. Reportedly, the plan and the external organizations found it more challenging than they initially expected to provide comprehensive care management services, particularly for the complex needs of the One Care population. As a result, the plan increased its reimbursement rates to contracted organizations and provided coaching to ensure that staff had the skills needed to integrate and support both medical and behavioral health needs. For example, the plan worked with behavioral health providers on approaches to improve influenza immunization rates, blood pressure control, and diabetes care. The plan and its contracted providers established learning collaboratives and worked closely together to share best practices.

Plans are required to report to the ratio of care coordinators to enrollees as part of core reporting requirements. The average across all plans for calendar year 2014 was 96 enrollees per one full-time equivalent (FTE) care coordinator. The ratio for individual plans ranged from 61 to 147 enrollees per FTE care coordinator.

Strategies and goals. Plans reported that care coordinators were able to link enrollees to new services and identify and address unmet needs through existing resources that the enrollee was not aware of and did not know how to access. Plans provided several examples, including the following:

> *One of the early people we saw was a woman who's quadriplegic living with her mother in public housing…. the head of the bed was being held up by a chair or something because it was broken. They didn't speak English, didn't know how to access a vendor. Their physician didn't know how to get them services. They were borrowing or getting donated supplies from neighbors and friends. They could*

have gotten that if they knew and understood the system, but what we do a lot of times is pave the way for people to access [needed services].

Some focus group participants reported improved access to services under One Care, with care coordinators connecting them to needed services such as dental and behavioral health services. One beneficiary reported accessing help was "just a phone call away" (see ***Section 5, Beneficiary Experience***).

As part of the care coordination function, all plans have developed strategies for supporting enrollees during transitions between community-based care services and inpatient hospital admissions, including enrollees hospitalized for behavioral health. Examples of these strategies include meeting with the hospital discharge team, providing home visits or intensive telephonic support, and ensuring community supports were in place prior to discharge. As discussed later in ***Section 8.4, Overview of Quality Structures and Processes***, plans are required to report the percent of enrollees discharged from an inpatient facility to home who had a transition record transmitted within 24 hours of discharge to their family and physician.

Coordination of benefits not covered by One Care. One Care did not include targeted case management services and rehabilitation option services as covered benefits under the demonstration. Targeted case management continued to be provided through the Department of Mental Health (DMH) and the Department of Developmental Services, and rehabilitation option services continued to be provided through DMH. Although not included as a covered benefit under One Care, targeted case management services are intended to be coordinated with the rest of the enrollee's care, with targeted case managers participating as part of the care team for coordination of services. DMH officials reported overall satisfaction with the degree of coordination between Medicare-Medicaid Plans (MMPs) and targeted case managers, noting that with the enrollee's permission, targeted case managers were engaged as part of the ICT and helped link enrollees to other mental health services not included as part of One Care. DMH officials expressed strong support for this model, reporting that the roles of the plan care coordinators and DMH's targeted case managers differed in several ways, including skill sets and scope of responsibility. As examples, DMH officials noted that care coordination under One Care generally offered a greater degree of clinical expertise than did targeted case management; they also noted that targeted case managers were able to provide an intensity of service required in some cases that an MMP would not be expected to provide (e.g., in forensic situations). Overall, DMH officials expressed strong support for the opportunities provided by One Care to further integrate care for individuals with behavioral health needs.

4.2 LTSS Coordination and the Role of the LTS Coordinator

Before One Care, most enrollees received Medicaid services through a fee-for-service system. Medicare-Medicaid beneficiaries had not been not included in other Medicaid managed care initiatives. Many One Care beneficiaries were also not eligible for existing 1915(c) home and community-based (HCBS) waivers; One Care also excluded individuals receiving HCBS waiver services from enrolling in the demonstration.[17] As a result, many One Care enrollees did

[17] HCBS waivers in Massachusetts include waiver services targeted for individuals with intellectual disabilities, acquired brain injury, frail elders, children with autism and waivers related to its Money Follows the Person demonstration.

not have access to the full range of LTSS—such as home modifications, peer support, and non-medical transportation services—before the demonstration. Before One Care, personal care services were available under the Medicaid State Plan only through a consumer-directed model. The design of One Care expanded options for personal care to include receipt of personal care and homemaker services through agency providers.

4.2.1 LTS Coordinator Service Organizations

The role of the LTS coordinator under One Care is provided by CBOs, which include Aging Service Access Points (ASAPs), Independent Living Centers (ILCs), and Recovery Learning Communities (RLCs). The ASAPs were established by Massachusetts legislation as part of the network of elder services providers responsible for providing information and referral as well as other services related to the delivery of home and community based services. The ILCs provide services such as advocacy, information and referral, and skills training to individuals with disabilities to help them live independently in the community. The RLCs are consumer-run networks that provide advocacy, information and referral, and peer support that focus on recovery and wellness for individuals with behavioral health needs. Legislation passed in Massachusetts codified the requirements for the provision of an independent community care coordinator and the role of the LTS coordinator in assessment and care planning (M.G.L., Ch. 118E, 9F(b)(1)).

Consistent with "conflict-free case management" principles,[18] the CBOs that provide LTS coordination may not be LTSS providers, but they are allowed to provide evaluation, assessment, coordination, skills training, peer support, and fiscal intermediary services (three-way contract, 2013, p. 33). Some ASAPs also managed provider networks that included LTSS providers. Because plan reimbursement to CBOs for these related services was permitted, one plan remarked that the LTS coordinator role was not conflict-free in the sense that CBOs were able to benefit financially from recommending LTSS that involved the CBOs' other services. The extent of service provided by the CBOs to plans varied, as discussed more fully in this section below. Plans also reimbursed the CBOs differently based on the service, ranging from a monthly capitated fee to payment based on units of service.

Enrollees must be given a choice between at least two LTS coordinators unless a plan is granted approval by MassHealth to offer only one, and plans must provide enrollees over the age of 60 the option to receive LTS coordination services through an ASAP. Plans are also required to contract with at least one ILC, where geographically feasible in the plan's service area (three-way contract, 2013, p. 33). Some CBOs contracted with more than one plan.

Generally, ASAPs and ILCs had organizational experience with the delivery of LTSS. For example, ASAPs provided LTSS care coordination in MassHealth managed care programs serving elders, and ILCs had a history of providing support to MassHealth members who self-directed their personal care services. The role of the RLC in the delivery of LTSS, especially in providing LTS coordination, was added to the One Care design in response to stakeholder feedback regarding the behavioral health needs of the One Care population. Integrating the RLCs as part of the delivery system for LTS coordination services presented a number of challenges.

[18] "Conflict free case management" refers to separating the assessment and service authorization functions from direct service provision, to avoid conflict of interest in the service authorization and service provision processes.

One agency that decided not to participate in One Care to provide LTS coordination services reported "[the role of the LTS coordinator] requires case planning, treatment planning, and some degree of assessment and notes, and [that] is not consistent with a peer role." Another RLC strongly supported a peer model for providing LTS coordination and employed LTS coordinators who were certified peer specialists in recovery. The RLC recognized that there were challenges in implementing this model because RLCs tended to be structured differently from each other, often with staff who did not typically have the breadth and depth of knowledge needed to refer enrollees to the full array of community resources and services offered under One Care (for example, personal care services). The RLC felt this model could be successful, but that it would take time to fully evolve. In general, plans reported contracting with small numbers of RLCs to provide LTS care coordination services.

4.2.2 Referral and Assessment Process for LTSS

Plans must provide information about the LTS coordinator to all enrollees, and must offer an LTS coordinator to all enrollees within 90 days of an enrollee's effective date of enrollment. Plans must also make an LTS coordinator available during comprehensive assessments for enrollees assigned certain rating categories indicating a need for LTSS (specifically, the C3 and F1 ratings) and for any other enrollee who requests it (three-way contract, 2013, p. 34). Other circumstances, such as a contemplated admission to a facility or hospital, also require plans to make an LTS coordinator available. During site visit interviews, some stakeholders expressed concern as to whether appropriate referrals were happening; one CBO contrasted the design of One Care with another managed care model in Massachusetts where the CBO received a referral and screened every enrollee as a requirement of the program, which it felt resulted in a more transparent referral process. To monitor activities, MassHealth developed a data collection tool for offering LTSS coordinators, offering referrals to LTS coordinators and beneficiary refusals of LTS coordinator services.

Plans and CBOs experienced implementation challenges related to the referral process for LTSS. Plans and MassHealth reported concerns that CBOs lacked capacity to meet the referral volume. Although some CBOs noted that the total number of LTSS referrals was not as high as originally anticipated for the demonstration as a whole, they reported several difficulties in managing the volume of referrals occurring during phases of high-volume passive enrollment. One CBO described it as "sheer chaos." CBOs reported challenges in planning and hiring staff given the fluctuations in enrollment and referral volume. Adding to their challenge, CBOs reported receiving referrals for enrollees they could not locate. As described in ***Section 3, Eligibility and Enrollment***, plans encountered similar difficulties. As one CBO explained:

> *The major reason in the beginning [plans] were trying to deal with us is that a lot of times we were the ones they were asking to find the people…They couldn't find the people and they were asking us to go out and find them.*

CBOs reported that they sometimes received referrals from plans and other providers with just an enrollee's name and phone number. Several CBOs reported that it was not unusual for phone numbers to be wrong (one estimated the number at 20 percent), and had concerns that other relevant information about the enrollee was not always provided by plans to CBOs. When enrollees were located, the LTS coordinator was sometimes the enrollee's first contact with One

Care. In some cases, the enrollee had never heard of One Care and had limited if any understanding of why they were being contacted by the CBO.

One Care plans are required to report the number of enrollees referred to an LTS coordinator, including enrollees assigned a rating category indicating a high likelihood of LTSS needs. The rating categories most indicative of LTSS need were those assigned to enrollees with a long-term facility stay of over 90 days (F1) and those in the community needing skilled nursing or assistance with ADLs (C3). These rating categories are more fully described above in ***Table 10***. ***Table 12*** shows the percentage of enrollees with F1 or C3 rating categories who had a referral to an LTS coordinator within 90 days of enrollment. During Quarter 1 of calendar year 2014 (CY2014) through Quarter 1 of calendar year 2015 (CY2015), based on averages for the demonstration as a whole, the percentage ranged from 30 percent to 65 percent with the lowest percentage (30 percent) of referrals occurring during Quarter 1 of CY2014. ***Table 13 s***hows the percentage of enrollees with a F1 or C3 rating category who met with an LTS coordinator within 90 days of enrollment. Based on averages for the demonstration as a whole, the highest percentage (21 percent) of these enrollees who met with their coordinators occurred in the second calendar quarter of 2014.

Table 13
Total percentage of enrollees who had a referral or meeting with an LTS coordinator

Calendar time period	Eligible members with skilled or personal care needs,[1] or a facility stay of more than 90 days[2] who have a referral to an LTS coordinator %	Eligible members with skilled or personal care needs,[1] or a facility stay of more than 90 days[2] who have met with an LTS coordinator %
Q1, 2014	30.4%	3.8%
Q2	65.4%	21.0%
Q3	56.4%	19.4%
Q4	60.6%	14.7%
Q1, 2015	41.9%	13.0%

[1] These members are rating category C3, which requires enrollees to have certain skilled or personal care needs.

[2] These members are rating category F1, which requires enrollees to have a facility stay of more than 90 days.

[3] Calculation based on quarterly data reported by plans to MassHealth as of December 15, 2015.

NOTE: The demonstration-wide total is based on the RTI evaluation team analysis of quarterly data reported by plans to MassHealth as of December 15, 2015. Data are preliminary and have not been reconciled.

The CBOs reported that the LTS coordinators conducted face-to-face assessments of enrollees using an LTSS needs assessment tool as required by each plan. This assessment was geared toward identifying the enrollee's needs and wants for LTSS and the availability of other community resources. CBOs reported that each One Care plan requires using a different LTSS assessment tool, with differences in protocol. In some cases, the LTS coordinator was present at the comprehensive assessment conducted by the One Care plan, as described above, but generally LTS coordinators reported meeting with enrollees separate from that process.

Based on the assessment, the LTS coordinator submits a recommended LTSS plan to the One Care plan for approval. The demonstration was designed to provide flexibility in defining LTSS in order to meet the individualized needs of the enrollees. For example, the three-way contract defines LTSS as a "wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives" (three-way contract, 2013, p. 10). Some CBOs reported that they initially understood the LTS coordinator would be able to recommend innovative or atypical services (e.g., gym memberships) based on the identified needs of enrollees, but these CBOs reported that plans generally developed a set list of allowable services. The degree of flexibility appeared to vary across plans, with some plans noting the financial implications of broadening the benefit too widely.

If a need for personal care services was identified, an additional evaluation was conducted by a registered nurse (RN) to establish the enrollee's eligibility for personal care services and allowable hours of service. CBOs reported that plans generally adopted the existing eligibility guidelines used by MassHealth in its Medicaid State Plan Personal Attendant Care program. One plan completes its own RN evaluation whereas the other two plans generally referred to a CBO with experience in making this determination. As designed, the demonstration included cueing and supervision as of part of personal care services. There were conflicting reports from MassHealth officials, plans, and CBOs as to whether these particular services were being offered or provided to enrollees.

4.2.3 Participation of the LTS Coordinator on the ICT and Service Monitoring

As designed, the LTS coordinator is expected to "participate as a full member of the ICT for all Enrollees with LTSS needs, at the discretion of the Enrollee" (three-way contract, 2013, p. 34). This includes representing the LTSS needs of the enrollee; providing education on LTSS to the ICT; arranging and coordinating the authorized LTSS with agreement of the ICT; and monitoring the provision and functional outcomes of LTSS as deemed appropriate by the ICT (three-way contract, 2013, p. 34). MassHealth training materials referenced the LTS coordinator as part of the care team and as assisting with coordination and monitoring of LTSS.

The extent to which the One Care plans actively engaged the CBOs in the full range of assessment, coordination, and monitoring activities varied across plans. CBOs reported inconsistent practices across plans in terms of communication and on-going participation with the enrollee following the completion of the LTSS needs assessments. In some instances, CBOs and plans reported strong working relationships and information sharing; in other instances those roles and responsibilities were evolving. Several CBOs reported that they were not always clear on their role following the assessment, particularly relating to arranging, coordinating, and monitoring services. CBOs reported instances, for example, where they submitted recommendations for LTSS but never received information back from the plan about service authorization or whether the CBO was expected to have an ongoing role.

Some CBOs reported that the inclusion of an LTS coordinator as part of the care team as initially envisioned by One Care was more the exception than the rule. Several CBOs emphasized that all three One Care plans operated very differently (e.g., one plan generally included the LTS coordinator as part of the team; another did not). Some CBOs described that

procedures across plans were unique and at times opposite from one another, adding to the confusion around roles and responsibilities and practices around information sharing. One of the CBOs contrasted the Centralized Enrollee Record (CER) systems of two plans, reporting one had "great access" for the LTS coordinator whereas another did not, hindering their ability to participate as a team member.

MassHealth convened a work group during the first year of the demonstration to review the role and expectations for how plans were to be implementing the LTS coordinator role. This included discussion of when to offer the LTS coordinator service, how to describe the service to members, and reasons why enrollees were refusing the LTS coordinator. To address these issues, MassHealth developed a webinar training for providers and plans about the LTS role, an enrollee's right to access an LTS coordinator, what an LTS coordinator is, and how to request an LTS coordinator. They also developed a handout for enrollees—using common language—that explained the LTS coordinator role (State Data Reporting System Quarters 2, 3, and 4). As part of monitoring activities, MassHealth developed a data collection tool for offering LTS coordinators, referrals to LTS coordinators, and beneficiary refusals of LTS coordinator services. Regardless of inconsistencies in implementation issues described above, support remains strong for maintaining an LTS coordinator role as part of the demonstration (interviews with MassHealth officials, One Care plans, CBOs, and stakeholders).

4.3 Information Exchange

4.3.1 Behavioral Health Privacy

The exchange of health information, especially behavioral health information that some beneficiaries do not want shared across providers, has been a particular area of focus in Massachusetts. As described in ***Section 6, Stakeholder Engagement***, a work group was formed to address the tensions existing between the privacy rights of individuals and the goals of the demonstration to reduce system fragmentation and better integrate care. One of the plans described its strategy to educate members about the importance of sharing medical and behavioral health information with their providers. In discussing this issue with its enrollees, the plan provided examples, such as coordination of prescription medications for drug interactions, to help illustrate the value of sharing information across providers but noted that "at the end of the day the member still controls those decisions."

4.3.2 Centralized Enrollee Record

To facilitate care coordination, One Care plans are required to maintain a single, centralized, comprehensive record, known as the CER, that documents the enrollee's medical, prescription, functional, and social status (three-way contract, 2013, p. 57). The CER includes certain required elements such as enrollee-identifying information; demographic information; service documentation; communication needs; documentation of comprehensive assessments; and medical records and reports. The CER must be available and accessible at all times to manage communication and information flow regarding referrals, transitions, and care delivery. One Care plans reported making up-front investment in electronic documentation systems to meet these requirements.

All One Care plans reported developing CERs that could be accessed for use by plan staff, but the extent to which information could be accessed, shared, or updated by external providers and enrollees varied. One plan reported that it implemented the contract requirements regarding the CER very broadly and created a CER system that could be accessed by external providers and enrollees as well as by the plan itself to meet the contract requirements. Enrollees could register to access the CER, which provided them electronic access to their records. Another plan created a CER that providers external to the plan could access, but that enrollees could not access.

Generally, plans reported that the external CER was not accessed by beneficiaries or providers to the extent that they had hoped, in part because of the additional administrative burdens to health care and community providers in terms of time and resources. One plan reported that providers sometimes viewed working with the plan's CER as an "extra step" in the sense that it was another place where information needed to be recorded. For providers who did not use electronic health records, entering information into the CER was particularly onerous and duplicative. Some CBOs, while noting inconsistencies across plans in terms of access and use of the CER, emphasized the importance of the CER in coordinating the care of enrollees. Both plans and CBOs reported that when the CER was used by everyone involved in the enrollee's care, it facilitated communication and increased the sense of being "part of the team."

As described in ***Section 8.4, Overview of Quality Structures and Processes***, MassHealth conducted on-site reviews of the CER to ensure plan compliance with contractual requirements. Commonwealth staff reported that One Care plans implemented different systems but that, even with variations, they were generally impressed by the amount of information contained in each plan's CER.

4.4 Successes

Beneficiaries were connected to new services through care coordination. The delivery of care coordination to One Care enrollees has been viewed by many key informants, including the plans, as the greatest success of the demonstration. They cited several reasons, including the fact that One Care enrollees did not have access to this service prior to the demonstration. Care coordination has connected beneficiaries not only to the new services available for the first time under the demonstration but also to other existing community resources. One plan emphasized the benefits available to health care providers serving the enrollee, stating that care coordination should not be viewed as "another level of bureaucracy" or "just another prior authorization" but as support also for providers (for example, ensuring enrollees keep medical appointments).

The design of the LTS coordinator role was widely supported. The LTS coordinator role is widely supported by stakeholders, providers and plans, and is considered to be an important component of the One Care demonstration. Although a number of implementation issues have arisen in connection with the LTS coordinator role, stakeholders and others remained committed to the concept to ensure that LTSS needs of One Care enrollees receive adequate attention and support. The role is also seen as important to introducing independent living skills and recovery model services to One Care enrollees (One Care Implementation Council Annual

Report, 2013). One stakeholder described the LTS coordinator role as the "crown jewel" of the demonstration.

A high level of collaboration was demonstrated among stakeholders. There has been a high level of stakeholder collaboration on a number of issues affecting the delivery of care coordination to enrollees. For example, a broad array of stakeholders, including MassHealth, the plans, the Department of Mental Health, the Office of Behavioral Health and members of the Implementation Council, developed strategies to share behavioral health information. The establishment of a separate work group to develop materials relevant to clarifying the LTS coordinator role was another example of collaboration.

4.5 Challenges

Given enrollee privacy concerns, sharing behavioral health information across providers has been a challenge for some plans in integrating care. Plans noted the challenge of integrating behavioral with medical health and, in particular, the balance that existed between safeguarding a beneficiary's right to privacy and the demonstration's goal of creating a fully integrated care model. This reflected some enrollees' preference to be selective about which providers had access to their behavioral health records and information. Plans were developing strategies to address this issue, primarily through improved communication with enrollees and by providing examples of how sharing information among providers could benefit their care. The development of guiding principles around sharing behavioral health information was a primary focus of advocacy groups and the One Care Implementation Council.

Plans needed to gain the trust of the beneficiaries. One Care plans mentioned that it was essential to gain the trust of beneficiaries in order to better achieve integration of care for members with behavioral health needs. Plans reported that beneficiaries were not always willing to accept assistance or to allow information to be shared across providers. Plans noted that gaining the trust of enrollees will take time and effort, especially as many enrollees have not had this type of assistance before. One plan noted:

> *There's a 70 percent comorbidity of the medical and behavioral, and so there's a natural distrust in general. 'Why do you want to do an assessment? Does that mean you're going to take something away? I don't want you to come in my house.' It's a learning curve for individuals to help them understand what this is and how actually they probably have benefits they haven't even known they can tap into, and if they were to participate in the program, we could help them get that.*

Confusion exists among beneficiaries regarding different care coordination roles. Many One Care beneficiaries transitioned from having no care coordination at all to receiving multiple levels of care coordination, including medical, behavioral and LTSS. Some participants of One Care focus groups (see ***Section 5, Beneficiary Experience***) reported confusion as to the various people and roles.

The LTS coordinator role lacked clarity as implemented. It has been challenging to find the right balance between flexibility and structure for the LTS coordinator role. As one of the plans noted:

> *It's hard to be really prescriptive about [the LTS coordinator role] because someone with a mental health issue might want someone from a recovery learning center, and it may be a different skill set and different need than that member needs, as opposed to somebody with a physical disability in an independent living center. There was an attempt to allow for individualization of the role, which leads to some lack of clarity in the role.*

It has taken time for plans and CBOs to establish relationships. CBOs and plans noted initial challenges in understanding each other's roles and responsibilities. One CBO reported that it received referrals from care coordinators for housing and other resources that it could not provide, but that enrollees expected to receive. The CBO reported that additional training for care coordinators and LTS coordinators would be beneficial. One plan offered a similar perspective, reporting that the plans and LTSS providers spent the first year learning about each other's capabilities and establishing an effective collaboration.

Plans and CBOs needed to build capacity. One Care plans have had difficulty meeting required timeframes for completing assessments, and CBOs have lacked capacity to handle LTSS referrals, especially during waves of passive enrollment when the volume of referrals has been particularly high. Responding to those referrals with existing staff and resources presented challenges for several CBOs.

4.6 Preliminary Findings

Care coordination has benefitted enrollees in a variety of ways and is widely viewed as a valuable service for connecting beneficiaries to new and previously existing resources and services. One focus group participant said that navigating the system before One Care was like trying to get through a "metal, steel wall," but One Care changed that: "But this way, it's like they just call you up and say 'do you need this? Do you need that?' They [the care coordinators] are awesome." Other focus group participants mentioned that having someone to call when they had a question or issue helped to reduce stress and anxiety, and that the care coordinators seemed to genuinely care about them and wanted to help. As one plan noted:

> *What the program is bringing is helping to really align individuals to understand and maximize the resources and benefits available to them in a single approach. And to have all of it coordinated in a way that allows them to try to live as independently as possible. Examples would be where a member was somewhat isolated, living in a remote area, did not have access to phone or transportation, wasn't getting the treatment she needed, wasn't able to be independent. By working with the care management team and understanding what the challenges were, we were able to get her phone service, make sure she had electricity, food, got resources in place. We have a therapist who comes to her house because she can't get out to the therapist. We've been able to coordinate in a way that she can feel safe and independent where she's living. That's the success of the program.*

There is no "one size fits all" care coordination model appropriate for the One Care population. Regardless of the care coordination delivery model implemented by the plan, MassHealth and plans recognized the importance of respecting individual preferences and choices of the enrollees in the operation and composition of the care team. MassHealth and the plans described composition of ICTs as being member-specific; as one of the MassHealth contract managers reported, there is variation in ICT development because it is "a member driven program." No reporting requirements specific to the ICT determine the extent to which enrollees, physicians, or other providers participate in, or otherwise engage with, the ICT.

Many stakeholders noted the need to increase member understanding and, importantly, trust of the care coordination system. One MassHealth official said that although he had seen care coordination and a team approach result in better outcomes for some beneficiaries, it was important to remember that "initially getting [care] coordinated is really to get the member on board first, because if they can't get the member on board it's going to be very difficult for them to even talk about a care plan and how we can address all of [their] needs." One plan noted that "pushing" care coordination on some enrollees was counter-productive, and, in those cases, the plan needed to learn how to slow their approach down to better match the enrollees' level of comfort and choice for involving other people in their care.

Although considered an important service for beneficiaries, the LTS coordinator role has been challenging to implement. The LTS coordinator role was designed to be flexible, person centered, and to meet a broad range of enrollee needs. However, the lack of clearly defined roles and responsibilities led to inconsistencies and confusion in the implementation of the position across plans and CBOs. Inconsistent practices were reported specific to the assessing, authorizing, implementing, and monitoring processes for delivery of LTSS. As described in ***Section 5, Beneficiary Experience***, the findings of beneficiary surveys and focus groups generally reflected confusion and a lack of understanding by enrollees about the core functions of the LTS coordinator.

5. Beneficiary Experience

Highlights

- Most enrollees reported overall satisfaction with One Care as reported through surveys, focus groups, and stakeholder interviews.
- Focus group participants often attributed their satisfaction to the availability of new or expanded benefits and to the assistance and support provided through care coordination. Focus group participants also voiced quality concerns about some of the new or expanded One Care services and expressed the need for Medicare-Medicaid Plans (MMPs) to hold their service vendors more accountable.
- Findings from surveys and focus groups indicated a lack of clarity around the roles and responsibilities of people assisting or coordinating care at the plan level and for long-term services and supports (LTSS).
- Findings from focus groups suggest that participants were not always aware of their rights or of the resources available to them when they had a complaint or disagreed with a decision about their services.
- The number of complaints filed with the MMPs increased each quarter during calendar year 2014. The MMPs reported a total of 558 complaints in the last quarter of Demonstration Year 1 when enrollment in One Care was near 18,000. A different pattern was seen in the first level appeals filed with MMPs, where the number of appeals rose from 57 in the first quarter of calendar year 2014 to 102 appeals in the second quarter, only to decline in the subsequent two quarters.

5.1 Introduction

Improving the experience of beneficiaries who access Medicare- and Medicaid-covered services is one of the main goals of the demonstrations under the Financial Alignment Initiative. Many aspects of One Care are designed expressly with this goal in mind, including emphases on working closely with beneficiaries to develop person-centered care plans, delivering all Medicare and Medicaid services through a single plan, providing access to new and flexible services, and aligning Medicare and Medicaid processes.

This section highlights findings from various sources that indicate the levels of satisfaction with One Care overall; satisfaction with new or expanded One Care benefits; satisfaction with medical and specialty services; satisfaction with care coordination services; satisfaction with Independent Living and Long-Term Services and Supports (LTS) coordination services; experience with access to care; and impact on personal health, well-being and quality of life. This section also provides information on beneficiary protections, data related to complaints and appeals, and critical incident and abuse reports.

5.2 Methods and Data Sources

The Commonwealth and CMS recognized the importance of directly soliciting beneficiary feedback on their experience with OneCare. MassHealth, in collaboration with the One Care Implementation Council and UMass Medical School, monitored, assessed, and reported on early indicators of beneficiary perceptions of and early experiences with One Care as part of the Early Indicators Project (EIP). The EIP used multiple methods to gather qualitative and quantitative data from various sources, including focus groups and surveys.

The RTI evaluation team also used qualitative and quantitative methods to assess the impact of the Massachusetts demonstration on beneficiary experience. These methods included conducting focus groups to gather insights from beneficiaries; conducting in-person interviews with Massachusetts demonstration staff during site visits and follow-up telephone interviews; and examining demonstration data available from other sources including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and data reported to the CMS Complaints Tracking Module (CTM) and other sources on appeals, grievances, and complaints data. Data sources include the following:

MassHealth-sponsored focus groups (EIP focus groups). As part of the EIP, four focus groups were conducted in several locations across Massachusetts. A total of 26 beneficiaries participated. The groups were recruited based on different criteria: beneficiaries who opted into One Care (December 16, 2013, in Boston); eligible beneficiaries who chose to opt out of One Care (December 19, 2013, in Worcester); beneficiaries enrolled in One Care who were Spanish-speaking (March 31, 2014, in Springfield); and beneficiaries who were passively enrolled into One Care (April 28, 2014, in Worcester).

MassHealth-sponsored surveys (EIP surveys). As part of the EIP, the State conducted two surveys. The first was a telephone survey conducted December 2013 through January 2014. Telephone interviews were conducted with 300 One Care enrollees about their perceptions and experiences during the initial enrollment period (Henry et al., n.d.). The second survey was conducted May through December 2014 (Henry et al., 2015). A total of 6,000 beneficiaries were mailed a written survey with the option to complete the survey by telephone or on-line. The overall response rate was 32 percent (1,933 respondents).[19] The survey was conducted in English and Spanish. Enrollees were asked 38 core questions in eight major domains ranging from assessment and care planning, service delivery, and overall perceptions of One Care.

RTI evaluation focus groups (RTI focus groups). RTI conducted four focus groups as part of the evaluation of the One Care demonstration: two in Worcester on June 23, 2015, and two in Boston on June 24, 2015. A total of 29 One Care beneficiaries participated in the focus groups. Participants were assigned to one of two types of groups, based on whether or not they self-identified as having a LTS coordinator. Each group included participants from at least two different plans, as well as a mix of individuals with self-reported medical conditions, physical/mobility issues, and behavioral health needs. About half of the focus group participants reported their race as White, with the remaining participants self-reporting as African-American

[19] Due to variations in survey sampling rates and response rates across the plans, the survey responses were weighted to ensure that the reported statistics represented the One Care population as a whole.

or Hispanic. To ensure that participants had an adequate amount of experience to draw upon, all participants had been enrolled in a One Care plan for at least 9 months. Each session was between 90 and 120 minutes in length.

RTI stakeholder interviews. RTI conducted stakeholder interviews in June 2015 with MassHealth officials, One Care plans, the One Care ombudsman, community-based providers, and members of the Implementation Council to obtain their perspective on beneficiaries' experiences with One Care.

CAHPS survey. Medicare requires all Medicare Advantage plans, including One Care plans, to conduct an annual assessment of the experiences of beneficiaries using the standardized CAHPS survey instrument. The 2015 survey for One Care plans was conducted in the first half of 2015 and included the core Medicare CAHPS questions, 10 supplemental questions added by the RTI evaluation team, and 9 supplemental questions added by MassHealth. All survey questions include a 6-month look-back period.

Survey results for a subset of 2015 survey questions are incorporated in this section. Findings are available at the One Care plan level only. Only results with more than 10 respondents across the three One Care plans are reported.

Complaints and grievances data. Complaint and grievance data are from three separate sources: (1) complaints from beneficiaries reported by One Care plans to MassHealth, and separately to CMS' implementation contractor, NORC;[20] (2) complaints received by MassHealth or 1-800-Medicare and entered into the CMS Complaints Tracking Module;[21] and (3) complaints received by the Office of the One Care Ombudsman (OCO) and reported to MassHealth and the Administration for Community Living (ACL).[22]

Appeals data. One Care plans are required to report all requests made by beneficiaries to appeal plans' decisions to deny, limit, terminate, or suspend a service or procedure. One Care plans report appeals data (e.g., decisions to deny, limit, terminate, or suspend a service or procedure) to MassHealth and NORC. Data used in this report are for the period January 1, 2014, through June 30, 2015. CMS' contractor, Maximus, compiles data received by the Independent Review Entity (IRE), which is responsible for reviewing appeals of One Care plans' unfavorable decisions in response to beneficiary complaints. These data are reported for the period January 1, 2014, through July 31, 2015.

Critical incident and abuse reports. One Care plans are required to report to MassHealth and NORC[23] on the number of critical incidents and abuse reports related to beneficiaries. Data are presented in this section for the time period from January 1, 2014, through June 30, 2015.

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[20] Data are reported for calendar quarters January 1, 2014, through June 30, 2015.
[21] Data are presented for the time period October 1, 2013, through June 30, 2015.
[22] Data are presented for the time period January 1, 2014, through June 30, 2015.
[23] The technical specifications for core measures are provided in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans html.

5.3 Impact of the Demonstration on Beneficiaries

This section summarizes the findings of focus groups, beneficiary surveys, and stakeholder interviews reflecting beneficiary experiences with service delivery and quality of life under One Care. Beneficiary experiences related to the early enrollment process, including experiences of beneficiaries who chose to opt in, opt out or who were passively enrolled, are discussed as part of ***Section 3, Eligibility and Enrollment***.

5.3.1 Overall Satisfaction with One Care

Enrollees and focus group participants generally reported satisfaction with One Care. The first EIP survey, conducted during the third and fourth months of implementation, found that 43 percent of enrollees reported experiencing a change in service since enrolling in One Care, and of those, 73 percent reported the change as positive (Henry et al., n.d.).[24] In the second EIP survey, which began almost a year after implementation, 80 percent of enrollees expressed satisfaction (extremely or somewhat satisfied) with their plan, and almost 82 percent reported satisfaction with the services they received under One Care (Henry et al., 2015).[25] Less than 2 percent of enrollees surveyed planned to disenroll from the demonstration, and over 83 percent indicated an intent to remain in One Care.

EIP focus group participants enrolled in the demonstration also reported being satisfied with the demonstration overall. One participant who had been passively enrolled remarked: "I have been hearing some negative comments about [One Care plan], but so far my experience with them has been surprisingly good." Another participant reported: "Any concerns I have had, they have addressed them immediately. They made phone calls for me and got things straightened out."

Several participants in the RTI focus groups were also generally positive about One Care. Although some focus group participants reported initial apprehension when joining the demonstration, they reported being satisfied with their plan and services. As one participant described, "So like I said and I'll say it a thousand times: this is the best health care I've ever had... I've had [other health plans]. This blows them all away…I have never had a plan that is so wonderful." Another participant stated that "[before One Care] I might have had a complaint. I don't have any complaints with the situation I have now. None at all. I can do cartwheels because I am so happy."

Some of the RTI focus group participants felt that plans lacked capacity to keep up with the number of enrollees, resulting in care coordinators being overburdened and challenged to respond to beneficiary questions and concerns. As one participant described, "[My care coordinator says] 'I want to get with you, but I can't, I am so busy…I'll call you every once in a while just to make sure everything is okay. If anything's not okay, call 9-1-1. Other than that, I'm busy.'" Another participant expressed frustration with a similar situation: "They need to hire more people so one person doesn't get 95 people. That's not fair saying I can't get to you because of my workload. That's not my fault. I need you." A few focus group participants felt that rapid growth contributed to reported quality issues, particularly with vendors under contract

[24] http://www.mass.gov/eohhs/docs/masshealth/onecare/eip-survey-1-report.pdf
[25] http://www.mass.gov/eohhs/docs/masshealth/onecare/eip-survey-2-report.pdf

with the plan to provide services to beneficiaries, especially LTSS such as transportation services and medical equipment suppliers and expressed frustration that plans did not hold vendors more accountable for improved service delivery. In discussing quality of vendor services, one participant noted: "Part of the reason why all these problems are happening is because they shoved too many people into the program with a lot of huge problems and all of a sudden this thing grew. It just grew too quickly...I just picture all these people in their office trying to keep up with everything." For the most part, however, these participants still expressed satisfaction with One Care overall: "Like I said, I've already mentioned [the problems I've had]. Again, it's better than it was."

Some RTI focus group participants reported issues accessing care that were significant enough that their overall view of the demonstration was negative. One participant no longer had access to a medication that was covered before One Care and described her experience with One Care as "Stressful mentally. Physically, you don't have the same quality of life… I'm afraid to move because it's going to hurt." One participant reported being discharged from a hospital without time for adequate recovery: "I wasn't ready to go home…I wasn't comfortable…but I had no choice…They said 'Your insurance says you have to leave, you need to leave.'" A few reported overall dissatisfaction with One Care based in part on quality of their coordination services, including the lack of responsiveness and failure to provide timely answers and information. However, for the majority of participants any challenges they had accessing specific services or obtaining care did not impact their overall satisfaction with One Care.

Participants in the EIP focus groups who liked the demonstration were concerned that One Care might change for the worse or not last long. One participant remarked: "[In the past], when one's got something good, they come and POOF!" The 2015 RTI focus groups took place immediately following the announcement by Fallon that it intended to withdraw from the demonstration. Consequently, focus groups participants in areas served by Fallon expressed concern about this change although most had been unaware of this news until hearing it during the focus group discussion.

Stakeholders interviewed by the RTI evaluation team included the OCO, an independent entity created to ensure adequate oversight of beneficiary protections that began operating in March 2014. The OCO also tracks complaints received from beneficiaries regarding quality, access or other aspects of One Care. Information regarding the number and types of complaints received by the OCO is discussed this section below.

As noted in Section 5.2, the 2015 CAHPS survey for One Care plans was conducted in the first half of 2015. One domain of the CAHPS survey relates to beneficiary satisfaction of health plan, personal doctor, specialists, and drug plan. When asked to provide an overall rating (on a scale of 1 to 10 with 10 being the best) of their One Care plan, most survey respondents ranked it as a 9 or 10. As shown in ***Table 14***, most survey respondents indicated they had a favorable view of their health plan. A higher proportion of survey respondents enrolled in Commonwealth Care Alliance (CCA) were satisfied with their drug plan; that is, they rated their drug plan a 9 or 10 than in Fallon and Tufts (76 percent, compared to 71 and 62 percent, respectively). A majority of respondents (94 to 98 percent to 85 percent) in each One Care plan reported that their plan usually or always treats them with courtesy and respect.

Table 14
CAHPS results: Beneficiary overall satisfaction

CAHPS survey item	Commonwealth Care Alliance	Fallon Total Care	Tufts Health Unify
Percent rating health plan 9 or 10 on scale of 1 (worst) to 10 (best)	70% (N=324)	62% (N=204)	62% (N=189)
Percent rating drug plan 9 or 10 on scale of 1 (worst) to 10 (best)	76% (N=324)	71% (N=205)	62% (N=185)
Percent reporting being usually or always treated with courtesy and respect	98% (N=163)	94% (N=84)	98% (N=90)

5.3.2 New or Expanded Benefits

A key design feature of One Care is that it offers new and expanded benefits to enrollees. These benefits include diversionary health services, expanded Medicaid services, and new community LTSS. (See ***Appendix E*** for a complete list of services and service definitions.) Some RTI focus group participants attributed their satisfaction with One Care to the availability of these new services. One participant noted: "I am really happy with the plan because they have so many things they do offer. Right now I don't need many of those things, but in the long run I probably will… You could hardly get anything before."

According to the first EIP survey, a large majority of respondents who chose to opt into One Care reported that they hoped to gain access to dental and vision services. Other frequently mentioned services to which respondents hoped to gain access included LTSS, transportation services, behavioral health services, and care coordination.

Similarly, EIP and RTI focus group participants mentioned several specific demonstration services as being important, including dental services, non-medical transportation and other LTSS, enhanced vision services, homemaker and other in-home care, and specialized medical equipment. The elimination of co-pays on prescription drugs was another important feature of One Care according to most participants in both the EIP and RTI focus groups: "My co-pays [on medications] have dropped down to nothing…so that is a big savings for me" (RTI focus group). Regarding dental services, one participant noted: "Dental has improved. Before all they would do is pull your teeth. Now they'll fill it. They give you cleanings" (RTI focus group).

Participants also reported some flexibility in authorized services. For example, participants noted that their personal care attendants were able to provide services during hospital stays, which would typically have been denied as a duplicate service. Another participant received specialized contact lenses in addition to glasses, stating: "[The providers] were absolutely stunned because I guess no one has ever gotten [contact lenses] covered before" (RTI focus group).

EIP and RTI focus group participants also mentioned that transportation, both non-urgent medical and non-medical, was an important benefit under One Care. In the EIP survey, almost 40 percent of respondents reported a need for non-urgent medical transportation and just over 33

percent reported a need for non-medical transportation (Henry et al., 2015). Although many participants in the RTI focus group described transportation as an important service for them, a number of those participants also voiced complaints and concerns regarding the quality of the transportation services provided under One Care. Participants in EIP and RTI focus groups noted that many of the issues they experienced were related to the quality and performance of vendors hired by the plan to provide the transportation service. Examples included no-shows or late rides; confusion around pick-up or drop-off locations; and inadequate vehicles for accommodating wheelchairs and individuals with disabilities. As a result of such poor service, one participant noted: "I don't even get the ride anymore. I don't depend on it" (RTI focus group).

5.3.3 Medical and Specialty Services

A combined set of Medicare and Medicaid benefits is offered as part of a single benefit package under the demonstration. Benefits include coordination by the One Care plans of all medical services, including primary care, behavioral health, specialty, and prescription medications. Almost 90 percent of EIP survey respondents reported having a primary care physician (PCP) under One Care. Of those respondents with a PCP, 84 percent had met with their PCP since enrolling in the demonstration, and overall satisfaction with their PCP was high—85 percent reporting being somewhat or extremely satisfied (Henry et al., 2015). In addition, more than 80 percent of those survey respondents reported that their needs for prescription drugs, specialty care, and mental health services were being met.

Several EIP and RTI focus group participants reported that being able to keep their same PCP was an important consideration in choosing to participate in the demonstration. During the evaluation's site visit interviews, One Care plans reported giving high priority to developing a provider network that preserved, where possible and desired, beneficiaries' relationship with their former primary care physician. According to results of the CAHPS survey, approximately two-thirds of beneficiaries surveyed in all One Care plans (range of 65–72 percent) reported having the same doctor before enrolling in One Care.

Table 15
CAHPS results: Beneficiary experience with medical services (including specialists)

CAHPS survey item	Commonwealth Care Alliance	Fallon Total Care	Tufts Health Unify
Percent reporting that they had the same doctor before enrolling in One Care	72% (N=325)	69% (N=200)	65% (N=168)

Although most participants of the RTI focus groups reported satisfaction with their primary care providers, some expressed dissatisfaction with the manner in which their doctors treated them, disagreements over treatment, and poor communication. Participants also provided mixed feedback regarding their satisfaction with the quality of communication between and among providers. Some participants felt that their primary care provider and specialists had a team approach and communicated well with each other; other participants reported that their primary care provider or care coordinator did not have current information about the

participants' medications, treatments, and in one case, a hospitalization. For example, one participant noted: "My primary care doesn't know too much about my psychiatric [medications]." Another participant noted: "My specialists and my primary care are all on the same system but they're not on the same picture…they've got [medications] on [the system] that I had three years ago that I've never had again." One participant described improvement in this type of situation: "My medication list isn't always current with [the plan] or my specialist because they don't always communicate with one another. That's a big issue. I was able to [have providers coordinate care] when I asked them to communicate. It works out amazingly well, and the coordination between them does work."

Notably, participants in both the EIP and RTI focus groups reported concerns that medications covered previously were no longer available to them under One Care. Participants clearly expressed that the inability to access these medications had significant negative impact on their quality of life, both physically and mentally. Participants mentioned a range of medications and medical supplies, some available over the counter and others not, that had been covered services prior to One Care. Examples offered by participants included lidocaine patches for pain management, prescription cough syrup, medication for migraines, and post-surgery nasal spray. Generally, participants did not appear to be aware of their ability to file a complaint or appeal in these cases and were not familiar with the services of the One Care Ombudsman Program.

5.3.4 Care Coordination Services

Care coordination is a central component of the One Care demonstration intended to ensure comprehensive assessment of enrollees' medical, behavioral health, and LTSS needs, and to coordinate services across the various service systems and providers. Delivery of care coordination under One Care, including delivery systems and models, is discussed in ***Section 4, Care Coordination***. This section focuses primarily on beneficiaries' experiences with care coordination.

EIP survey results show that approximately 51 percent of enrollees reported they had met with their care coordinator. Of those who had met with a care coordinator, 91 percent were satisfied (extremely or somewhat) with their care coordinator (Henry et al., 2015). Similarly, participants in the EIP focus groups who had met with their care coordinators generally reported favorable experiences, as did participants of the RTI focus groups. Participants in RTI focus groups cited several reasons for their satisfaction: some found that care coordinators were able to connect them to new or additional services, and others felt having someone available to help them manage their care reduced stress and anxiety. Many participants felt that their care coordinators seemed to genuinely care about them and understand their needs. Examples of participant comments are included below:

> *It's a lot smoother for me now. It doesn't bring anxieties. Before, you'd be talking to somebody, and they'd switch you to somebody else… [Now] I talk to [my care coordinator]. They take care of everything (RTI focus group).*
>
> *They go over your meds, they go over your services, what do you need, what can we do for you, so forth and so on. So it's a review of your health care…they come*

to you so in that point, the meshing of the MassHealth and Medicare is a good thing (RTI focus group).

People definitely do care about you with One Care—how many times has anyone from Medicare met you or MassHealth? It shows [the One Care care coordinators] care that much more (RTI focus group).

Some RTI focus group participants voiced concern that care coordinators appeared to have high caseloads and that their care coordinators were too busy to return calls or provide assistance. One participant remarked that care coordinators were very busy: "I feel like if you contact them, you feel like you're bothering them." A few participants also reported that their care coordinators did not listen to them: "They hear us, but they don't listen."

By design, One Care enrollees may have multiple people coordinating their care. As discussed in ***Section 4, Care Coordination***, plans have implemented different models of delivery for care coordination, including one One Care plan that contracts out this function. Some EIP and RTI focus groups participants found contacts with multiple people involved in their care to be confusing. In the early EIP focus group consisting of 26 beneficiaries passively enrolled in One Care, about half of the participants appeared to understand the care coordination role whereas others indicated confusion about the role. In one case, a participant reported that in the first four months of enrollment, their care coordinator had changed four times. Several participants in the RTI focus groups described multiple people involved in their care. In some cases, participants reported being unsure whether or how the people they spoke to or met were connected to One Care nor did they always understand the purpose of the contact or visit. As one participant remarked, "I've seen so many people in the last 6 weeks: four or five. It's hard for me to keep track of who is who" (RTI focus group). Often, participants identified with people by their name rather than by their job title or position.

One Care plans are expected to coordinate medical services for enrollees with complex conditions or who are cared for by multiple providers. As discussed above, focus groups participants reported mixed feedback on the extent to which this was happening. Responses to the CAHPS survey indicated that less than half (between 37 and 47 percent) of respondents in each One Care plan reported that anyone from their health plan, doctor's office, or clinic helped them coordinate their care among doctors or other health providers, with the highest percentage from Fallon Total Care (47 percent) (see ***Table 16***). Of these individuals, 33 percent of beneficiaries in Tufts Health Plan, 47 percent in Fallon Total Care, and 54 percent in CCA reported being "very satisfied" with the help they received to coordinate their care. Over half of all respondents for each One Care plan (range of 51–61 percent) indicated that they usually or always received information that they needed from their plan.

Table 16
CAHPS results: Beneficiary experience with care coordination

CAHPS survey item	Commonwealth Care Alliance	Fallon Total Care	Tufts Health Unify
Percent who had anyone from their health plan, doctor's office, or clinic help them coordinate their care among doctors or other health providers	44% (N=302)	47% (N=194)	37% (N=162)
Of those who used care coordination, the percent who were "very satisfied" with the help from the One Care plan or doctor's office in coordinating their care	54% (N=130)	47% (N=90)	33% (N=60)
Percent reporting that health plan gave them information they needed	61% (N=162)	51% (N=85)	56% (N=90)

5.3.5 LTS Coordination Services and LTSS

Under One Care, enrollees are offered an LTS coordinator who is independent of the plans to coordinate LTSS needs. The role of the LTS coordinator is discussed above in ***Section 4, Care Coordination***. The current section provides a description of beneficiaries' experience with the One Care LTS coordinator.

Results of the EIP survey showed that almost 42 percent of respondents reported being offered an LTS coordinator, 23 percent said they were not offered an LTS coordinator, and 30 percent were not sure or did not know (Henry et al., 2015). The authors of the EIP survey report drew three key conclusions from their findings, two of which related directly to the need for improvement in the LTS coordinator role. The first recommendation related to the need to educate and engage beneficiaries in understanding the role and benefits of working with an LTS coordinator and the second related to development of strategies to ensure adequate capacity and consistent referral processes (Henry et al., 2015, p. 68).

Findings from the EIP and RTI focus groups also highlighted beneficiaries' confusion about the LTS coordinator role. Several participants in both groups were unsure whether they had met with an LTS coordinator. Even participants who were receiving LTSS were not sure if they had met with an LTS coordinator and were not clear about who was responsible for implementing and monitoring those services. Although attempts were made to assign participants in the 2015 RTI focus groups to different groups based on whether they self-reported as having an LTS coordinator, this was difficult to accomplish because beneficiaries did not know whether they had a LTS coordinator. Thus, there was a mix of beneficiaries in both groups, some receiving LTSS and some not, with many participants not recognizing or being sure about meeting or communicating with an LTS coordinator.

Several participants in both the EIP and RTI focus groups expressed confusion and frustration around authorization and implementation of LTSS. A few participants reported that they had been approved for LTSS but never received the services. Examples of the services in question included home modifications and in-home care. Some participants reported that it was the responsibility of the One Care plan to contact the vendor for services; one participant

believed it was the responsibility of the beneficiary to contact a vendor directly. A few participants reported quality issues with their in-home services, including alleged theft and dissatisfaction with worker performance; there did not appear to be a consistent understanding among the participants as to who was responsible for monitoring these services and to whom these incidents should be reported. Several participants reported that much of the information they had received about LTSS was confusing; this included verbal information received from plans and providers as well as written materials. For example, one participant reported receiving four pages of paperwork about LTSS and "couldn't make heads or tails of it," and subsequently decided to refuse the service (RTI focus group).

Focus group participants receiving LTSS described the value of those services to their mental and physical well-being. Some of the services included non-medical transportation, home modifications, specialized medical equipment, and in-home personal care and homemaker services. Other LTSS needs identified by respondents of the EIP survey included community integration services; day program services; and assistive technology (Henry et al., 2015). Generally, focus group participants who reported having specific difficulty getting the LTSS services they wanted were told of the denial of service over the phone; they reported that they did not receive written denial letters or information about the appeals process or the One Care Ombudsman Program (RTI focus groups). Two participants reported being told they were ineligible for LTSS because they were not 65 years old, even though One Care serves only individuals younger than 65 years of age at the time of enrollment.

Responses to the CAHPS survey (see ***Table 17***) indicated that about one-quarter of respondents needed someone to come into their home to give them home health care or assistance. Of these individuals, there was a difference among One Care plans in the percent who reported that it was usually or always easy to get the personal care or aide assistance at home through their care plan (from 68 to 82 percent). Nearly one-third of respondents had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment. Of those individuals, enrollees in CCA were more likely (78 percent) to report that it was usually or always easy to get or replace the medical equipment they needed through their health plan, compared to 60 and 62 percent in the other One Care plans.

Table 17
CAHPS results: Long-term services and supports

CAHPS survey item	Commonwealth Care Alliance	Fallon Total Care	Tufts Health Unify
Percent who needed someone to come into their home to give them home health care or assistance	23% (N=320)	28% (N=203)	29% (N=171)
Percent who reported it is usually or always easy to get personal care or aide assistance at home through their care plan	73% (N=70)	82% (N=54)	68% (N=47)
Percent who had a health problem for which they needed special medical equipment, such as a cane, wheelchair or oxygen equipment	32% (N=324)	31% (N=201)	35% (N=169)
Of those who report needing it, percent who report it is usually or always easy to get or replace the medical equipment they needed through their health plan	78% (N=96)	60% (N=55)	62% (N=55)

5.3.6 Beneficiary Access to Care

For the most part, respondents to the EIP survey reported that their needs for medical services were being met under One Care (see ***Table 18***).

EIP survey respondents reported higher unmet needs for oral/dental care (21.8 percent) and substance abuse services (17.7 percent) than prescription medications (2.6 percent), specialty care (7.9 percent), or mental health services (9.8 percent). Consistent with these findings, several participants in the RTI focus group discussed difficulties in locating dental providers in their areas. Some participants reported needing to change dental providers because their current providers did not participate in One Care. Other than dental, focus group participants did not widely report access issues specific to a particular service. However, a few participants reported emergency department use due to access barriers, mostly due to an inability to schedule, or get transportation to, a same day appointment with their primary care provider.

Table 18
EIP survey: Service needs and use of medical services

Medical services	Need met very well	Need met somewhat	Need not met at all
Prescription drugs	88%	9%	3%
Oral/dental care	45%	22%	22%
Specialty care	66%	21%	8%
Mental health services	70%	15%	10%
Substance abuse	70%	7%	18%

SOURCE: Henry et al., 2015, pp. 45–6.

Some EIP and RTI focus group participants reported increased access to benefits under One Care. As discussed above, some participants attributed this to their care coordinator and the availability of new or expanded services. Others reported that One Care had reduced barriers and made accessing care easier. Examples included being able to receive services in-home rather than in an office setting, and having someone able to help arrange transportation to appointments. For example, one participant who refused to return to a psychiatrist after poor experiences before One Care was now seeing an in-home psychologist. The participant decided to give the psychologist a chance, in part, because the plan brought the psychologist to the participant's house so that they could meet each other. Because of this situation, the participant said One Care "has given me hope."

Although the CAHPS survey asked many questions about the ease of access to urgent care, specialists, and other providers, responses were statistically too low to report. The CAHPS survey indicated that the percentage of enrollees who needed any treatment or counseling for a personal or family problem ranged from 30 percent to 42 percent across the One Care plans. Over 80 percent of these individuals in each One Care plan reported that it is usually or always easy to get the treatment or counseling they need through their health plan. Access to behavioral health services was not reported as an issue during RTI focus groups; for some participants, One Care increased access by offering behavioral health services in their homes as an alternative to office visits.

MassHealth included several questions related to accessibility issues in the doctor's office. For example, of particular concern to individuals with physical disabilities is the availability of assistance to access an examination table for a complete exam. Between 65 and 70 percent of respondents enrolled in each plan reported they were usually or always examined on the examination table when they visited their personal doctor's office (see ***Table 19***).

Table 19
CAHPS results: Beneficiary experience with access to services

CAHPS survey item	Commonwealth Care Alliance	Fallon Total Care	Tufts Health Unify
Percent who needed any treatment or counseling for a personal or family problem	42% (N=313)	36% (N=203)	30% (N=166)
Of those who reported needing it, percent who report it is usually or always easy to get the treatment or counseling they needed through their health plan	86% (N=129)	83% (N=70)	83% (N=47)
Percent who reported they were usually or always examined on the examination table when they visited their personal doctor's office	65% (N=325)	65% (N=191)	70% (N=169)

5.3.7 Personal Health Outcomes and Quality of Life

A key goal of One Care is to positively impact health outcomes and quality of life for beneficiaries. Some findings in this area can be inferred from reports of overall satisfaction of

One Care. More specifically, however, many RTI focus group participants reported that One Care had made a positive impact on their lives. As one participant explained:

> *"[One Care] has given me hope…I think [the One Care plans] are trying to get you the best you can be. And maybe that's savings in the long run instead of just 'This happens and deal with it, and that happens and deal with it'" (RTI focus group).*

Many of the focus group participants reported that One Care was an improvement over their prior health care coverage, and for some participants the differences were profound. One individual described it as "the difference between living in bed and being able to live" (RTI focus group). According to interviews with advocacy groups and stakeholders, One Care had also allowed some beneficiaries to return to the workforce, although none of the RTI focus group participants mentioned this when asked how One Care had impacted their quality of life.

For some beneficiaries, One Care has offered the first opportunity to receive some of the LTSS services provided under the demonstration. One focus group participant reported:

> *They've [One Care plan] given me equipment that would have been denied to me under the old system, even though the doctors said they were medically necessary. They've been able to get those things to me, and it's been the difference—I'm not exaggerating this—between life and death. In the old system, I wouldn't have access to these things. Right away as soon as One Care started, they said 'You need this. We're going to get you these things.' That's such a big change (RTI focus group).*

Effective communication with one's doctor is a key factor in achieving personal health outcomes. Although as noted above, some focus group participants reported poor communication with their PCP as an issue, the vast majority of respondents to the CAHPS survey (84–90 percent in each One Care plan) indicated that their personal doctor usually or always understands how health problems affect their day to day life (see ***Table 20***).

Table 20
CAHPS results: Beneficiary experience with personal health outcomes

CAHPS survey item	Commonwealth Care Alliance	Fallon Total Care	Tufts Health Unify
Percent reporting that their personal doctor usually or always understands how any health problems you have affect your day to day life?	90% (N=322)	84% (N=195)	87% (N=167)

5.3.8 Experience of Special Populations

This section summarizes the beneficiary experience for One Care special populations, including individuals with LTSS or behavioral health needs, and racial/ethnic or linguistic minorities.

One Care is the only demonstration under the Financial Alignment Initiative that limits eligibility to adults younger than age 65 at the time of enrollment, many of whom have behavioral health and LTSS needs. Results of the CAHPS survey indicated that CCA had a higher percentage of people who needed any treatment or counseling for a personal or family problem (42 percent compared to 30 and 35 percent of Tufts and Fallon enrollees, respectively). Over 80 percent of respondents in each One Care plan reported that it is usually or always easy to get the treatment or counseling they need through their health plan. Participants in the RTI focus groups expressed something similar; some participants suggested that One Care increased access by offering behavioral health services in their homes as an option to office visits.

Relevant to LTSS, about one-quarter of respondents to the CAHPS survey reported that they needed someone to come into their home to give them home health care or assistance. Enrollees' experiences obtaining these services varied by plan (see ***Table 21***). Of respondents indicating a need for in-home assistance, a higher proportion of Fallon enrollees (81 percent) reported that it was usually or always easy to get the personal care or aide assistance at home through their care plan than did those enrolled in CCA (73 percent) or Tufts (68 percent). Approximately one-third of respondents in each One Care plan had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment. Experiences in this area also varied by plan. Of the respondents needing special equipment, CCA enrollees were more likely (78 percent) to report that it was usually or always easy to get or replace the medical equipment they needed through their health plan, compared to 60 percent of Fallon enrollees and 62 percent of Tufts enrollees.

Table 21
CAHPS results: Beneficiary experience among special populations

CAHPS survey item	Commonwealth Care Alliance	Fallon Total Care	Tufts Health Unify
Percent who needed any treatment or counseling for a personal or family problem	42% (N=313)	36% (N=203)	30% (N=166)
Of those who reported needing it, percent who report it is usually or always easy to get the treatment or counseling they needed through their health plan	86% (N=129)	83% (N=70)	83% (N=47)
Percent who needed someone to come into their home to give them home health care or assistance	23% (N=320)	28% (N=203)	29% (N=171)
Percent who reported it is usually or always easy to get personal care or aide assistance at home through their care plan	73% (N=70)	82% (N=54)	68% (N=47)
Percent who had a health problem for which they needed special medical equipment, such as a cane, wheelchair or oxygen equipment	32% (N=324)	31% (N=201)	35% (N=169)
Of those who report needing it, percent who report it is usually or always easy to get or replace the medical equipment they needed through their health plan	78% (N=96)	60% (N=55)	62% (N=55)
Percent who reported they were usually or always weighed when they visited their personal doctor's office	91% (N=322)	87% (N=191)	92% (N=168)
Percent who needed an interpreter to help them speak with doctors or other health providers	7% (N=315)	10% (N=205)	# (N=163)

= Sample size too small (greater than or equal to 10).

A large majority of respondents reported they were usually or always weighed when they visited their personal doctor's office (87, 91, and 92 percent of respondents enrolled in Fallon, CCA, and Tufts, respectively). Five to 10 percent of respondents in each One Care plan reported needing an interpreter to help them speak with doctors or other health providers.

5.3.9 Beneficiary Protections

The One Care demonstration was designed to "ensure that strong protections of enrollee health, safety, and access to high quality health and supportive services are in place." (Commonwealth Proposal, February 2012, p. 23). Protections include, among others, complaint and appeals processes that provide an avenue for beneficiaries to seek redress when they have issues or disagree with decisions made by One Care plans or providers, and the availability of an Ombudsman Program to advocate for the beneficiary. The OCO is an independent entity created through Federal funding[26] to ensure adequate oversight of these beneficiary protections that began operating in March 2014. As part of its responsibilities, the OCO provides information and outreach to One Care beneficiaries, receives and investigates complaints, and identifies systemic issues and opportunities for improvement. This section describes the numbers and types of beneficiary complaints and appeals received about One Care. Because One Care integrates Medicare and Medicaid services, these data have been compiled from a number of sources, including the OCO, the One Care plans, MassHealth and Medicare.

Complaints

Beneficiaries have the option of submitting a complaint (also known as a grievance) to their One Care plan, MassHealth, Medicare, or the OCO. Complaints or grievances are defined to include "dissatisfaction with any aspect of the contractor's or provider's operations, activities, or behavior, regardless of whether remedial action is requested" (three-way contract, 2013, p. 9).

Most often, beneficiaries submit complaints directly to their One Care plan. Plans are required to develop a system to log complaints and to track all actions and final resolution pertaining to each complaint. On a monthly basis, plans must report to MassHealth and to NORC (CMS' implementation contractor) on the status of all outstanding complaints. Complaints involving "medical provider errors" must be reported immediately to both MassHealth and CMS, and must be resolved within 3 business days (three-way contract, 2013, p. 65). Early in implementation, MassHealth officials expressed concern that plans were not reporting complaints that were resolved on the spot; since then, the CMT has clarified that all complaints, regardless of complexity, are to be tracked.

Beneficiaries may also file complaints directly with MassHealth or 1-800-Medicare. MassHealth or Medicare document the details of a complaint in the CMS CTM, which is used to communicate with the One Care plan when resolution requires plan action (CMS file, June 8, 2012).

[26] CMS and the ACL have provided funding opportunities specific to States participating in the Financial Alignment Initiative to support the development of ombudsman services to assist beneficiaries participating in the demonstration. Awards were made for 12-month periods. The ACL administers the Duals Demonstration Ombudsman Technical Assistance Program for participating States. Beginning in March 2014, Massachusetts was awarded a total of $554,675 covering two award periods.

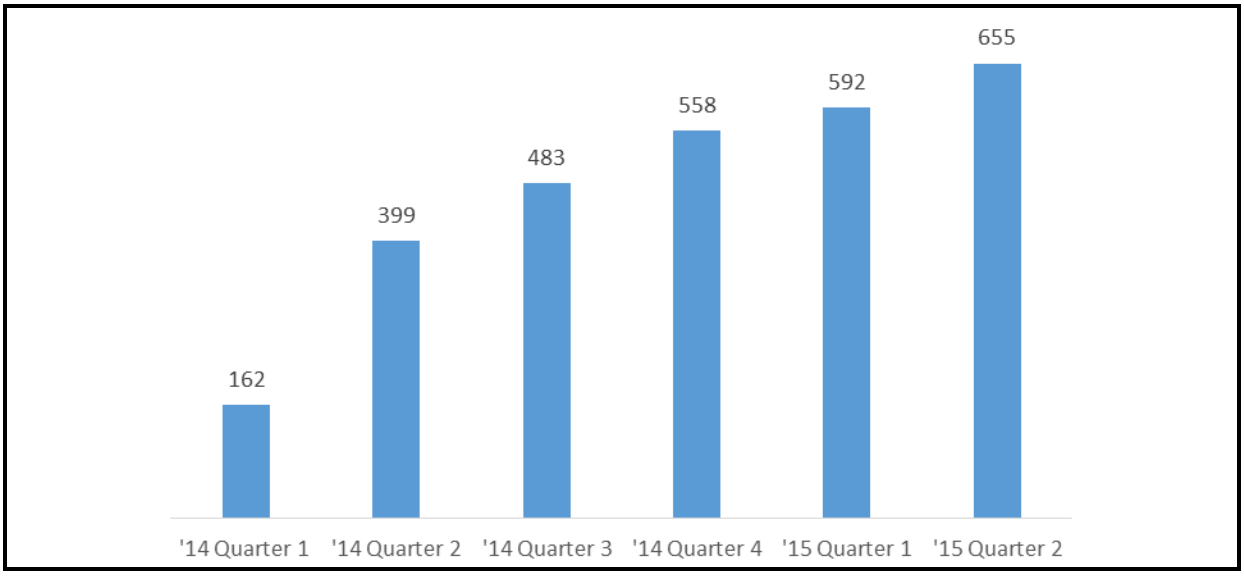
In addition, beneficiaries may file complaints with the OCO, which is required to maintain a system for documenting and tracking complaints. On a monthly basis, the OCO reports aggregate data on all complaints by category and status to MassHealth; on a quarterly basis, data are reported to NORC and the ACL, the Federal entity contracting with CMS to provide technical assistance to ombudsman programs under all demonstrations (interview with MassHealth officials, 2015). According to CMS guidance, the OCO enters complaints into the CTM that come directly to its office but which the OCO is unable to resolve (telephone conversation with CMS, September 16, 2015).

Following is a summary of complaint data received from each of the three previously discussed sources: (1) data reported by One Care plans on complaints made directly to them; (2) data reported on the CTM for complaints received by MassHealth and 1-800-Medicare; and (3) data reported by OCO on complaints made directly to its office. Reporting periods vary across these sources. Some, but not all, sources report complaint data per 1,000 beneficiaries, thereby accounting for changes in enrollment. Also, the rates of complaints in some areas are extremely small (e.g., less than one complaint per 1,000 beneficiaries) and are therefore not included in this summary.

Complaints Received by One Care Plans

Figure 2 shows the number of complaints filed by One Care plans for 6 calendar quarters of implementation, January 1, 2014, through June 30, 2015.

Figure 2
Total number of complaints across plans, by quarter: January 1, 2014, through June 30, 2015



SOURCE: Medicare-Medicaid Plan–reported data for Core Measure 4.2: Calendar Year Quarters, January 1, 2014, through June 30, 2015.

As shown in ***Figure 2***, complaints increased each quarter over this period as enrollment also increased. Across these six quarters, a total of 2,849 complaints were filed with One Care

plans. One Care plans are required to separately report to NORC on the number of complaints in four specific categories: inability to get an appointment with a PCP; inability to get an appointment with a specialist; excessive wait time for an appointment with the PCP; and excessive wait time for an appointment with a specialist. All other complaints are grouped into the category of "Complaints related to areas not measured by the demonstration." The average number of complaints across the three One Care plans was less than one complaint per 1,000 members in any quarter for any of the four specified complaint categories. The vast majority of complaints (98–99 percent, depending on the quarter) fell into the non-specific category (data not shown).

Complaints Received by the One Care Ombudsman

Complaints filed directly with the OCO are reported to MassHealth and the ACL as part of the demonstration's efforts to monitor plan complaints.

Because the OCO's ability to receive and assist with complaints is dependent on beneficiary awareness of its services, the OCO has engaged in public outreach through presentations, mailings, media, and networking. The OCO reported that lack of knowledge about One Care has been a significant challenge. To facilitate effective communication, the OCO employed a dedicated Spanish bilingual ombudsman and required disability cultural competence training for all its staff (OCO Report to the Implementation Committee, March 13, 2015). OCO representatives noted that some plans have been better than others in informing their enrollees of the OCO, and that outreach and training has been needed for One Care plans to ensure that the plans provide beneficiaries with appropriate information about the OCO's services.

Enrollees who are aware of the OCO may use this avenue to report complaints. The OCO began operations in March 2014. ***Table 22*** provides a summary of complaints received by the OCO over five quarters from April 1, 2014, through June 30, 2015; these are the most recent data available.

Table 22
Number and type of complaints received by the One Care Ombudsman: April 1, 2014–June 30, 2015

Complaint category	2014 QTR 2	2014 QTR 3	2014 QTR 4	2015 QTR 1	2015 QTR 2	Total
Medicaid eligibility	4	0	0	0	0	4
Benefits/access	10	31	27	27	17	112
Customer service	1	0	3	10	33	47
Enrollment	3	2	0	2	2	9
Payment/claims	0	7	8	7	11	33
Total—number	18	40	38	46	63	205

SOURCE: Administration for Community Living, Quarterly Data Reported by OCO, Section C – Complaints Issue Category/Subcategory for Complaints Received.

Data reported in ***Table 22*** show that the total number of complaints throughout the reporting period remained very low. Across most quarters, almost half of all complaints pertain to benefit and access issues.

During the RTI interviews, OCO representatives reported that during early implementation of the demonstration, its staff assisted beneficiaries in correcting errors in eligibility due to system compatibility issues and data entry errors that resulted in denials of service, commonly for pharmacy benefits. In some cases, the OCO helped beneficiaries get reimbursed by plans for out-of-pocket expenses that should have been covered by the plans, including transportation and durable medical equipment expenses.

Data on Complaints Received by MassHealth and 1-800-Medicare

As described above, beneficiaries may file complaints directly with MassHealth or 1-800-Medicare. The most current data available at the time of this report on the number and nature of those complaints cover the period October 2013 through June 2015 and are shown in ***Table 23***.

Table 23
Number and category of beneficiary complaints filed with MassHealth and 1-800-Medicare:
October 1, 2013–June 30, 2015

Category	Number
Benefits/access	37
Enrollment/disenrollment	25
Customer service	10
Payment/claims	9
Pricing/premium/co-insurance	5
Exceptions/appeals/grievances	3
Marketing	3
Plan administration	3
Contractor performance	2
TOTAL	97

NOTE: This table includes data outside of the time frames generally covered by this report due to limitations in the format in which data were available at the time of the report.

SOURCE: CMS, Complaints Tracking Module, Report covering October 1, 2013–June 30, 2015.

During the first 2 years of implementation, complaints that came to the attention of MassHealth and 1-800-Medicare fell principally in the areas of benefits/access (consistent with the OCO data discussed above) and enrollment/disenrollment. These aggregate data do not show how the types of complaints may have changed over the course of this 2-year period.

Appeals

Beneficiaries have a basic right to appeal decisions made by a One Care plan to deny, limit, terminate, or suspend a service or procedure (known as an "adverse action"). Before taking an adverse action, the plan must provide written notice to the beneficiary about its determination.

A beneficiary can appeal the decision which requires the plan to review and reconsider its initial decision.

CMS and MassHealth developed a coordinated appeals process that is spelled out in the three-way contract. Following a beneficiary's appeal, the One Care plan conducts a first level of review with parties unassociated with the original determination. If the redetermination remains unfavorable to the beneficiary, there are subsequent appeal levels depending on whether the service or procedure in question is covered by Medicare, Medicaid, or both. Subsequent appeals for Medicare A and B services are automatically forwarded by the One Care plan to the Medicare IRE, an independent entity with which Medicare contracts to handle second-level appeals (CMS, April 20, 2012). Subsequent appeals for services covered by MassHealth only (e.g., LTSS) require direct action by the beneficiary to request review by the MassHealth Board of Hearings. Appeals for services for which Medicare and Medicaid overlap (e.g., home health, durable medical equipment, skilled therapies) are automatically forwarded by the One Care plan to the IRE. An enrollee also has the option to separately forward a subsequent appeal that overlaps between Medicare and Medicaid to the MassHealth Board of Hearings. If an appeal is filed with both the IRE and the Board of Hearings, the One Care plan is bound to the outcome most favorable to the enrollee (three-way contract, 2013, p. 108).

The OCO may not represent enrollees who wish to appeal a decision by the plan. If the OCO is contacted by an enrollee seeking assistance with an appeal, the OCO is responsible for referring the enrollee to a legal services provider organization. The OCO does not receive information regarding the number and types of appeals filed directly with the plans; the OCO noted that having access to that information would help fulfill its contractual responsibility of identifying trends and system-related issues.

First-Level Appeals by Outcome and Type

Table 24 shows the number of initial appeals made to One Care plans for six calendar quarters of implementation, starting in January 2014. Of the 342 total appeals received by One Care plans over these six quarters of implementation, 179 (52 percent) had adverse outcomes (i.e., original determination upheld); 151 (44 percent) had fully favorable outcomes to the beneficiary; and 12 (4 percent) had partially favorable outcomes to the beneficiary. This means that at the first level of appeal, One Care plans fully or partially reversed their initial adverse determination upon reconsideration by a neutral party in nearly half (48 percent) of the cases during these six quarters.

Table 24
Number of first-level appeals by outcome across plans, January 1, 2014–June 30, 2015

Calendar quarter	Enrollment	Total fully favorable outcomes	Total partially favorable outcomes	Total adverse outcomes	Total appeals
2014					
Quarter 1	9,696	5	2	16	23
Quarter 2	13,396	18	2	37	57
Quarter 3	17,725	51	1	50	102
Quarter 4	17,917	20	3	26	49
2015					
Quarter 1	17,790	19	0	19	38
Quarter 2	17,715	38	4	31	73
Total	—	151	12	179	342

— data not available.

SOURCE: MMP-reported data for Core Measure 4.2: January 1, 2014, through June 30, 2015.

As with complaints and grievances, One Care plans are required to report the number and type of appeals as part of core reporting measures. These reports identify the number of appeals in six specific areas of interest to CMS: specialty services, LTSS, home and community-based services (HCBS), institutional services, mental health, and substance use disorder. Appeals that do not fall within one of those six areas are grouped under "All Other." Based on data for January 1, 2014 to June 30, 2015, for the select areas of interest, the highest rate of initial appeals with adverse outcomes for all quarters was in the area of denial or limited authorization to specialists followed by mental health and LTSS (data not shown). These denial or limited authorization rates are low, however, ranging from 0 to 3.33 appeals per 1,000 members for specialty services, 0 to 0.69 appeals per 1,000 members for mental health services, and 0 to 0.57 appeals per 1,000 members for LTSS in any given quarter within this time period. Although appeals related to HCBS, institutional, and substance use disorder treatment are also among CMS' areas of special interest, appeals in these categories did not occur in the period between January 1, 2014 and June 30, 2015. Because classification of appeals data is limited to the six select areas of interest, the data do not reflect the top categories of appeal.

Appeals Referred to IRE

As described earlier, initial appeals that result in an adverse outcome related to a Medicare services are automatically referred to the IRE for further review. Data are available from January 1, 2014 through July 31, 2015 on the number of appeals sent to the IRE. During this time period, the IRE received 47 appeals. Of these appeals, the determination made by the One Care Plan was upheld in 34 cases (72 percent); 7 (15 percent) were overturned; and 1 (2 percent) was partially overturned. Appeals relating to practitioner services, ground transportation, durable medical equipment, outpatient mental health, and non-Medicare benefits represented the areas where appeals were overturned in favor of the beneficiary.

Critical Incident and Abuse Reports for Members Receiving LTSS

One Care plans are required to report to MassHealth and NORC on the number of critical incidents and abuse reports. Reporting requirements define "critical incident" as "any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member." Abuse refers to (1) willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish; (2) knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death; (3) rape or sexual assault; (4) corporal punishment or striking of an individual; (5) unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and (6) use of bodily or chemical restraints on an individual which is not in compliance with Federal or State laws and administrative regulations (CMS, November 12, 2014).

Data reported by MMPs related to core reporting measures indicate that the number and rate of critical incidents and abuse reports remained low in calendar Quarters 1 through 6 of the demonstration period. Of the three plans, Fallon had the most reports across all quarters (18) and the highest average rate of reports across all quarters (5.9 reports per 1,000 members).

5.4 Successes

The EIP provided critical beneficiary feedback during implementation. The EIP represented a significant commitment by Massachusetts to gather feedback from beneficiaries on their early perceptions and experiences. The EIP provided actionable information for MassHealth and other stakeholders. For example, MassHealth officials indicated that survey and focus group findings indicating lack of clarity around the role of the LTS coordinator led to the development of additional training and public education.

Findings from the RTI and EIP focus groups and EIP surveys generally indicate that beneficiaries are satisfied with One Care. Many focus group participants and survey respondents reported being pleased with the availability of new or expanded benefits and with the assistance and support provided through care coordination. Very few focus group participants or survey respondents reported that they planned to leave the demonstration.

Many survey respondents and focus group participants expressed satisfaction with their care coordination services. Some focus group participants reported that having a care coordinator helped connect them to new services or resources. Several focus group participants reported that having a contact person to talk to and help resolve problems reduced stress and anxiety.

Survey respondents and focus group participants liked the new and expanded benefits offered under One Care. Participants in the EIP and RTI focus groups discussed that some of the new services, such as dental and expanded transportation services, were important benefits that improved their quality of life. Focus group participants also viewed the elimination of co-pays on medication as an important benefit due to the cost savings.

5.5 Challenges

Some beneficiaries expressed quality concerns with several One Care services. Focus group participants identified quality issues related to some One Care services, including vendors providing transportation, durable medical equipment, and homemaker services. Several focus group participants felt that the plans needed to improve accountability of their vendors because "some of them are just not working out" (RTI focus groups).

There is a lack of clarity in the LTS coordinator role. One of the consistent themes throughout the focus groups and findings from the surveys continues to be the confusion of the LTS coordinator role and access to LTSS. Because LTS coordinators do not have consistent roles and responsibilities, communication to beneficiaries about those roles and responsibilities was prone to misinterpretation. Several RTI focus group participants reported that they did not know who to contact when they had issues with delivery or implementation of LTSS.

Greater awareness of beneficiary protections is needed. Feedback from the RTI and EIP focus group participants suggests that many beneficiaries are not aware of available resources to assist them when they disagree or have issues with the plans. The OCO and other stakeholders reported that it has been challenging to create adequate awareness and recognition of the OCO and its services, and that ongoing work has been needed in this area. For example, several RTI focus group participants reported that they were told over the phone and not in writing that they were unable to get a requested service.

Multiple data sources exist for complaints. It is difficult to generate a single, non-duplicative count of complaints by type at this time, given varying reporting periods for the three principal sources of complaints. It is also unclear whether there is duplication across sources, such as data entered by the OCO into its own reports to the ACL, and into the CTM in cases where the OCO cannot resolve the issue directly.

5.6 Preliminary Findings

One Care was well designed to capture beneficiary experience. Massachusetts solicited information about beneficiary experience using a variety of methods that helped inform implementation of One Care. It also engaged stakeholders from the Implementation Council to inform the work of the EIP.

One Care had a favorable impact on quality of life for enrollees. Accounts provided by beneficiaries participating in the EIP and RTI focus groups illustrate that for some enrollees, the impact of the demonstration on their services and quality of life has been profound. For those individuals, the demonstration has opened up services and opportunities that were not available prior to the demonstration.

Improvements in quality and access are still needed. Some of the One Care benefits that enrollees who participated in the focus groups report as the most important to them are also the areas of greatest complaint for some enrollees. Examples of this are quality issues related to transportation and access issues related to dental services. Some focus group participants reported wanting greater choice of providers under One Care. In addition, focus group participants' feedback suggested that the quality of services provided by vendors is an area for

improvement, particularly vendors contacted by the plans to provide LTSS including transportation, homemaker services, and durable medical equipment.

Additional training and education appears warranted to ensure beneficiary access to complaint and appeal processes. Participants in the RTI focus groups did not always report receiving adequate information or education about the resources available to them when they have a complaint or are notified of a denial of service. The RTI evaluation team heard inconsistent reports about the information that is provided to beneficiaries when a benefit is denied. Some focus group participants reported that they were told of benefit denials over the telephone and not in writing, without being informed of their right to file a complaint or appeal.

6. Stakeholder Engagement

Highlights

- Massachusetts engaged in a robust stakeholder engagement process that was considered unprecedented and that many key informants viewed as a significant success of the demonstration.
- Stakeholder engagement was solicited in a variety of ways, most notably through open meetings hosted by MassHealth and through the work of the Implementation Council established at the start of the demonstration.
- Stakeholder input affected the initial design of the demonstration and made significant contributions to operational aspects of the demonstration.
- Even with some significant disagreements and a certain level of wariness about each other, MassHealth and the Implementation Council have productively collaborated by focusing on their shared commitment to the demonstration's success.

6.1 Overview

Key informants expressed broad agreement that stakeholder engagement has been a critical component of the One Care demonstration from its inception and that the high level of engagement is a notable success of the demonstration. The level of stakeholder involvement is widely perceived as unprecedented and meaningful to the initial demonstration design and operation.

Some of the more significant mechanisms for soliciting public feedback and exchanging information have been the meetings open to the public convened by MassHealth and the establishment of an Implementation Council, described in ***Section 6.2.2***. Significant stakeholder input was also solicited as part of the Early Implementation Project, which gathered feedback on the beneficiary experience with early enrollment and implementation through surveys, focus groups, and other approaches.

This section describes the approach taken by Massachusetts for engaging stakeholders, the mechanisms for soliciting stakeholder feedback; and the impact of those efforts on the demonstration.

6.2 Organization and Support

6.2.1 Commonwealth Role and Approach

Ever since the One Care demonstration's initial inception, Massachusetts has actively engaged a broad representation of stakeholders in the demonstration's planning, development, and implementation phases. The range of stakeholders includes advocacy organizations; medical, behavioral health, and long-term services and supports (LTSS) providers; community-based

organizations; plans; provider professional associations; beneficiaries; other Commonwealth agencies; and governmental offices (State Data Reporting System [SDRS], 4th Quarter).

During the very early planning stages of discussion and design, MassHealth used several mechanisms to gather and incorporate stakeholder feedback, including member focus groups, Commonwealth agency consumer meetings, monthly open stakeholder meetings, and the development of a dedicated demonstration website for consumers, providers, One Care plans, and the general public (Commonwealth Proposal, February 2012, pp. 21–3). The website includes general information on One Care, contact information, frequently asked questions, and summaries of public presentations by MassHealth. In March 2010, MassHealth began to organize formal stakeholder meetings for what would become the One Care demonstration. Input from these meetings informed the demonstration's design, which was outlined in its application to CMS for a design contract. In April 2011, CMS awarded MassHealth a contract to proceed with designing the demonstration. MassHealth also issued a Request for Information in March 2011, which included two public hearings and a process for gathering and responding to public comments on the draft demonstration proposal. Monthly stakeholder meetings continued during the demonstration's design phase. MassHealth documented that stakeholder input led directly to the inclusion of peer supports in the benefit design and the development of specific protections regarding the ability of enrollees to maintain existing provider relationships (Commonwealth Proposal, February 2012, pp. 21–3).

MassHealth has continued to hold open meetings throughout the demonstration's implementation phase. These meetings have provided an opportunity for stakeholders to receive information directly from MassHealth on One Care's implementation and operation and to provide feedback. During the demonstration's early implementation, the open meetings focused on developing member enrollment notices and related materials that beneficiaries could easily understand and effective communication strategies for hard-to-reach populations. These meetings have been held primarily in Boston; materials are posted on the demonstration's website. Accommodations such as Communication Access Realtime Translation (CART) and American Sign Language interpreters are available as requested.

MassHealth also seeks input by attending meetings of the Implementation Council; collaborating with other committees such as the State Mental Health Planning Council (SDRS, 2nd Quarter); and holding quarterly meetings with health care organizations and community agencies to discuss current priorities, policies, and issues as part of its MassHealth Training Forum (MTF). Although the MTF is not exclusive to the One Care demonstration, it has been a venue for discussion of One Care and has offered an opportunity for providers to recommend changes and provide feedback on the demonstration (SDRS, 3rd Quarter).

6.2.2 Implementation Council

Structure and Membership

The Executive Office of Health and Human Services (EOHHS) convened the Implementation Council to operate during the length of the demonstration. It consists of up to 21 appointed members. Based on stakeholder input, EOHHS developed a straw model for the structure, roles, and responsibilities, leaving flexibility for the members of the Implementation Council to develop a work plan based on its identified priorities.

The Implementation Council began meeting in February 2013, before the start of the enrollment process. Individuals or provider representatives interested in becoming Implementation Council members were required to complete a nomination form and provide a letter of reference to EOHHS through a procurement process. A selection committee convened by EOHHS reviewed all applications based on designated criteria and made recommendations to the Assistant Secretary for MassHealth and the Secretary for MassHealth for appointment.

MassHealth established certain requirements for the operation of the Implementation Council, and the Implementation Council established rules of operation in its bylaws and a charter. Meetings must be held at least six times a year, although generally the Council has met more frequently. Because of the intent that the Council be member driven, at least 51 percent of the Council members must be *consumer members*, defined as MassHealth members with disabilities, or family members or guardians of MassHealth members with disabilities. According to the Implementation Council's by-laws, at least one subcommittee chair or co-chair must be a consumer member. MassHealth staff and Implementation Council members indicated that the membership composition generally was considered well balanced and the right size. Membership also included representatives from community-based organizations, providers, trade organization, and unions.

Members of the Implementation Council reported that attracting and retaining consumer participation had been challenging, especially while striving for membership that reflects the diverse needs and interests of the One Care population. To improve participation, the Implementation Council convened special meetings to discuss ways to reduce potential barriers to consumer participation, such as ensuring adequate accommodations. One member speculated that the formal application process for new members might be a deterrent to participation for some consumers, but this member reported that the process was useful in demonstrating the level of commitment needed for serving on the Implementation Council. In summer 2015, EOHHS published a Notice of Opportunity soliciting six new members, with at least four needing to be consumer members, to serve on the Implementation Council through December 2016.

Accommodations for individuals attending the Implementation Council meeting include CART and American Sign Language interpreters. Stipends and travel reimbursements are also provided for MassHealth members with disabilities and family members or guardians of MassHealth members with disabilities who are not paid by a community-based or consumer advocacy organization, provider or trade association, union, or another organization to represent them (One Care Implementation Council Annual Report, 2014, p. 9). The University of Massachusetts Medical School has provided the Council with support staff (One Care Implementation Council Annual Report, 2014, pp. 7–9).

Responsibilities and Operation of the Implementation Council

Responsibilities of the Implementation Council include a broad range of activities, including advising EOHHS; soliciting stakeholder input on One Care; monitoring access to health care and compliance with the Americans with Disabilities Act; tracking quality of services; reviewing issues raised through the grievances and appeals process and ombudsman reports; examining access to services (medical, behavioral health, and LTSS); promoting accountability and transparency; and participating in the development of public education and outreach campaigns. The Implementation Council issues annual reports that summarize its

activities and accomplishments. The reports outline many of the successes and challenges of the work conducted by the Implementation Council over the course of a demonstration year.

Each year, the Implementation Council establishes a work plan to set priorities for the coming year. Its early priorities included access to LTSS, the auto-assignment process, and independent monitoring of the demonstration. Although many of the priorities have not changed in the 2015 work plan, interviews with members of the Implementation Council found a greater urgency and focus on transparency of the data reporting. Generally, the Implementation Council makes its formal requests and recommendations in the form of motions brought forth and voted on by its members.

The Implementation Council developed subcommittees and work groups to address specific issues of broad interest. Demonstration work groups included Early Indicators Project; Behavioral Health Privacy; One Care Quality; Independent Living and Long-Term Services and Supports (LTS) coordinator; and Encounter Data. Composition of the work group membership depended on the issues being addressed. Each of these work groups is discussed below.

Key informants cited as achievements the stakeholder contributions to the Early Indicators Project (EIP) process, described in ***Section 8.4, Overview of Quality Structures and Processes***. Members of the Implementation Council worked with MassHealth and staff from the University of Massachusetts Medical School (UMMS) to provide input on the content of the surveys and identify ways to increase participant response rates. According to a MassHealth staff member:

> *[We got] a lot of very good practical input from some very vocal stakeholders who felt very heard. We heard them, listened to them, and relied [on them]—I personally relied on them a lot in the process of how we did focus groups, develop surveys, what those surveys wanted to capture (interview with MassHealth, June 2015).*

The findings of the EIP are discussed in ***Section 5, Beneficiary Experience***.

Several key informants referred to the work of the Behavioral Health Privacy work group as particularly collaborative and informative to the demonstration. As noted in ***Section 4, Care Coordination***, many reported challenges in reconciling the goal of a fully integrated health care delivery system for medical and behavioral health with the beneficiaries' right to privacy for their health information. Participants of the Behavioral Health Privacy work group included MassHealth, the One Care plans, the Department of Mental Health, the Office of Behavioral Health, and members of the Implementation Council. Meetings have focused on the following:

- refining plans' approaches to protecting an enrollee's right to privacy;
- ensuring clarity in identifying who has access to member information;
- developing provider and member education related to sharing protected information; and

- developing a framework for guiding principles to ensure that members are educated and informed about their rights (SDRS, 4th Quarter).

As a result of these meetings, the work group developed a set of guiding principles that cover the need to decrease stigma, enhance plan policies and procedures around privacy and data sharing, and educate members and providers. The group has begun to develop recommended best practices and a timeline for educating members, providers, and the broader community on issues related to behavioral health privacy.

The One Care Quality Workgroup was formed to promote transparency and accessibility of information and data related to One Care quality measures. The group includes Implementation Council members, MassHealth staff, and staff of the UMMS. The work group's role is to support the MassHealth quality program by offering input and reviewing program output, and identifying ways to increase response rates to surveys and to encourage members to respond to requests for survey participation. The group meets quarterly and provides feedback on quality measurement, quality improvement, and evaluation activities (SDRS, 4th Quarter).

The LTS coordinator work group was formed during early implementation and held several meetings during the first half of 2014 to help clarify the role of the LTS coordinator. With input from the group, MassHealth developed a handout for consumers that explained the LTS coordinator's role and how to access and request such a coordinator. MassHealth also created an online training webinar for providers, plans, and other stakeholders explaining the role and responsibilities of the LTS coordinator. In June 2015, MassHealth indicated that the work group was likely to be reconvening to address ongoing issues.

In summer 2015, a new work group was formed to address issues with encounter data. Although an earlier quality work group had been formed to promote transparency and accessibility of data and information relating to the demonstration's quality measures, this work group was formed in response to the continued concern over the lack of quantitative data. Availability of data has been a major focus for the Implementation Council.

6.3 Successes

Stakeholders have been significantly involved in the demonstration. The Implementation Council includes specific subcommittees as well as work groups. Through this work, stakeholders were able to provide feedback on several aspects of the demonstration, including the enrollment processes, communication strategies, and financing structures. Through the efforts of subcommittees and work groups, MassHealth was able to work with stakeholders and other representatives on several significant projects of shared interest, including the EIP (described in ***Section 8.4, Overview of Quality Structures and Processes***), behavioral health privacy, and the LTS coordinator role.

Stakeholders have contributed significantly to ensuring a beneficiary voice in the demonstration. Massachusetts's stakeholder framework has empowered beneficiaries and advocates to push for changes that were based on beneficiary needs and experiences. Massachusetts involved stakeholders beginning in the initial stages of design. One official from MassHealth observed the following:

> *[I]t's not bureaucrats…who [are] going to say what constitutes an effective delivery system and what services should in fact be delivered and the way in which it will be delivered. It will actually be members consuming those services. That's such a tremendous shift. Literally to have the organization…saying your number one principle in building a new system will in fact be that it will be member-focused, patient focused, that means something now.*

Massachusetts has embedded a formal stakeholder structure into the design of One Care. This framework has allowed the Implementation Council to act as an official body representing the beneficiary voice in One Care. As a result, the Implementation Council has been very effective in engaging a broad array of plan and community stakeholders.

6.4 Challenges

Trust and relationship building takes time and effort, particularly while developing a new initiative. Key informants noted that the population served by One Care had been underserved and left out of previous reform initiatives. One MassHealth official offered the following comments:

> *We had a lot of growing pains to get through. We didn't know each other. We had to really understand what was important to them. They had to get to a place where they were willing to work with us. We did have a good amount of tension at the beginning.*

Attracting and retaining diverse stakeholder participation has been a challenge. Members of the Implementation Council noted that several members had resigned in 2014 and that it was challenging to ensure stakeholders' engagement that reflected the diversity of the One Care population.

The lack of information available regarding service utilization, cost, and related financial data has raised stakeholders' concerns, and, in some cases, suspicions, about transparency. In turn, MassHealth staff reportedly felt constrained by the inability to adequately respond to the call for quantitative data. The lack of service utilization and cost data in the first year made it particularly difficult for stakeholders to accurately assess the performance of the plans and the demonstration's financial sustainability.

6.5 Preliminary Findings

Massachusetts engaged in an unprecedented level of stakeholder involvement as part of the design and implementation of One Care. Members of the Implementation Council described their role in the demonstration as having "more teeth and muscle" than prior Commonwealth efforts. Many key informants believed that this increased level of engagement has been a notable achievement of the demonstration and has set a new standard for public engagement. A MassHealth official offered this example:

> *There are major advocacy groups that exist today that were created because of One Care that literally did not exist before we started working with One Care. They came into being because we were thinking about this, and they established themselves as a major force to be reckoned with. And they're not going anywhere.*

The Implementation Council has added value to the design and implementation of One Care. The Implementation Council has been an effective vehicle for receiving and imparting a consumer voice in the design and operations of One Care. To achieve the level of sophistication seen in the work produced by the Implementation Council, the Massachusetts agency committed significant resources and administrative assistance to support the committee while respecting its autonomy. Members of the Implementation Council noted the quality of support that MassHealth provided to the Council.

MassHealth and stakeholders have stayed focused on their mutual goals and commitment to the demonstration model. Although disagreements have persisted on such issues as the use of passive enrollment and transparency of data, both groups have recognized the need to work together on the broader goal of building a sustainable and integrated service delivery system:

> *An overarching accomplishment of the [Implementation] Council is the relationship established with MassHealth and EOHHS which is built around the shared goal of the success of One Care* (Implementation Council Annual Report, 2014, p. 11).

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7. Financing and Payment

Highlights

- State officials, plans, and stakeholders reported concerns about the adequacy of the Medicare and Medicaid capitation rates, particularly during the start-up phase. Before the demonstration started, several plans that had applied to participate in the demonstration chose not to participate, citing concerns regarding the adequacy of the rates.
- Participating plans reported anticipating losses during the first 18 months of the demonstration. CMS and MassHealth implemented several adjustments to the Medicare and Medicaid rate methodologies during this reporting period, which mitigated but did not eliminate losses. Even with these changes, one Medicare-Medicaid Plan (MMP) announced its withdrawal from One Care in June 2015.
- Plans reported that many factors contributed to financial concerns, including high start-up costs, high levels of unmet needs of new enrollees, difficulties in locating enrollees resulting in longer continuity-of-care periods, assignment of initial rating categories not reflective of the enrollees' true needs, and Part D reimbursement methodology.

7.1 Rate Methodology

All covered Medicare and Medicaid services are paid on a capitated basis. One Care plans receive three monthly capitation payments from CMS and MassHealth. CMS makes a monthly payment reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. MassHealth makes a monthly payment reflecting coverage of Medicaid services. As indicated earlier, two sets of services continued on a fee-for-service (FFS) basis: Targeted Care Management services and rehabilitation option services (three-way contract, 2013, pp. 156–7). This section describes the rate methodology of the demonstration and findings relevant to early implementation.

7.1.1 Rating Categories and Risk Adjustments

The Medicare Parts A and B component of the rate is risk adjusted based on the risk profile of each enrollee using the existing Medicare Advantage CMS-Hierarchical Condition Categories (HCCs) and CMS-HCC end-stage renal disease risk adjustment methodology. The rates were also adjusted with a coding intensity adjustment factor to reflect the proportion of enrollees who were in Medicare Advantage plans and/or in the demonstration (three-way contract, 2013, p. 163; three-way contract addendum, September 2014, pp. 2–3).

The Medicare Part D component includes the Medicare Part D direct subsidy set at the Part D national average monthly bid amount for the calendar year. The Medicare Part D component is adjusted using the existing Part D prescription drug RxHCC risk score methodology. The prospective payment also includes an amount for the low-income cost-sharing

subsidy and Federal reinsurance (three-way contract, 2013, p. 16). All of these payments are reconciled after the end of each payment year.

The Medicaid component includes six rating categories described in ***Section 3.3.2***, ***Table 6***.

The rates are also adjusted for an estimate of savings. Gains or losses within the risk corridors at year end are shared by the plans, CMS, and MassHealth based on a formula.

Upon initial enrollment into the demonstration, MassHealth uses a proxy methodology based on prior claims experience to assign enrollees to a rating category. Upon enrollment, the One Care plans assess members using the Minimum Data Set-Home Care; based on the information in the assessment, members may be assigned to a new rating category. As discussed in ***Section 4.1.1***, One Care plans discovered that many of the initial rating categories did not reflect the true level of need. In response to these concerns, MassHealth implemented retroactive risk-adjustment payments for the 90-day period before completion of the comprehensive assessment (State Data Reporting System [SDRS], 5th quarter, 2014).

7.1.2 Savings Percentage

In computing the capitation payment rates, aggregate savings percentages are applied to the baseline spending amounts for the Medicare Parts A and B component and the MassHealth component. The original savings percentages were reduced as part of a contract addendum executed in January 2015 (three-way contract addendum, January 2015, p. 2). ***Table 25*** shows the savings percentages for Demonstration Year 1 (October 1, 2013, through December 31, 2014) in the original and amended contract.

Table 25
Savings percentage for Demonstration Year 1

Year	Savings percentage	
	Original contract	Contract addendum
First 6 months of demonstration year	0	0
Remainder of Year 1 through December 31, 2014	1.0%	1.0%

[1] Demonstration Year 1 covers October 1, 2013, through December 31, 2014. Information for DY2 (January 1, 2015, through December 31, 2015) and DY3 (January 1, 2016, through December 31, 2016) is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MassachusettsContract.pdf. This information is outside the period covered by this report. We will report updated data in the second Annual Report.

SOURCE: Three-way contract, 2013; three-way contract addendum, January 2015.

Savings percentages are not applied to the Part D component. CMS monitors Part D costs on an ongoing basis, and material changes may be factored into future year savings percentages (three-way contract, 2013, p. 163).

7.1.3 Performance Incentives

CMS and MassHealth withheld a certain percentage of their respective components of the capitation rates (i.e., to the Medicare Parts A and B and Medicaid components; no withhold was applied to the Part D component). Performance incentive (withhold) measures are identified in ***Appendix D***. The withhold is repaid to the One Care plans subject to each plan's performance with established quality thresholds. The withhold was established at 1 percent in Demonstration Year 1; a determination of whether the plan meets the quality withhold requirements is required to be made public (three-way contract, 2013, p. 168). Additional information on these withholds will be included in subsequent reports.

7.1.4 High-Cost Risk Pools

MassHealth initially established a high-cost risk pool to account for enrollment of high-cost beneficiaries, defined based on spending for select MassHealth long-term services and supports above a defined threshold within MassHealth rating categories across plans. The risk pools were funded by a percentage of the MassHealth capitation. They were designed to redistribute funding between the One Care plans in the event of a disproportionate enrollment of high-cost enrollees. The January 2015 contract addendum eliminated these high-cost risk pools for 2013 and 2014 (Demonstration Year 1). The One Care plans expected this change to be budget neutral and health care reimbursement plan withholdings were refunded to each plan (SDRS, 7th Quarter, 2015).

7.1.5 Risk Corridors

The three-way contract establishes risk-sharing corridors for Demonstration Year 1 (which includes calendar years 2013 and 2014) and sets forth the method for calculating the percentage of the gain or loss that will be shared by the plan, CMS, or MassHealth. The three-way contract was amended in September 2014 and January 2015 to expand and extend the risk corridors for the demonstration. For plans with losses, the extension of the risk corridors reduced their share of losses and increased the proportion that CMS/Massachusetts Executive Office of Health and Human Services (EOHHS) would have to bear.

7.2 Financial Impact

7.2.1 Early Implementation Experience

Even before implementing One Care, State officials, plans, and stakeholders have had ongoing concerns about the adequacy of the Medicare and Medicaid capitation rates, particularly during the start-up phase. MassHealth officials indicated that they designed the One Care demonstration before they fully understood the financial structure that CMS was requiring and the need to base rates on historical FFS expenditures and use. One Care includes the addition of many new or expanded community-based services and significant enhancement of the care coordination/care management functions with additional requirements for assessment and face-to-face visits. MassHealth officials learned during negotiations with CMS that these new costs could not be explicitly built into the Medicaid rates because they were not reflected in either the historical costs or the comparable costs for Medicare-Medicaid beneficiaries not enrolled in the

demonstration. Instead, the plans needed to finance these additional services from savings that they generated under the demonstration.

7.2.2 Rate Methodology Design Implications

Several changes were made to the rate methodologies during the period of this report. The percentage of savings withheld from the capitation rates was reduced in Years 2 and 3, the risk corridors that define the share of gains and losses shared by the plans and CMS/EOHHS were expanded to provide a greater share of losses/gains by CMS/EOHHS, and the method used to code for "intensity adjustments" was revised to reflect the proportion of enrollees with prior Medicare and/or demonstration experience. The high-cost risk pools that were established with the use of a withhold from each plans' rate were eliminated for 2013 and 2014 (three-way contract addendum, September 2014; January 2015). In addition, MassHealth revised the method and timing of assigning members to rating categories to allow for retroactive adjustment of payments when the assigned rate category changed.

7.2.3 Cost Experience

In addition to challenges with the Medicaid rates, the One Care plans report that the Part D capitation payments do not accurately reflect the costs of the One Care population. In the One Care demonstration, the amount the plans were spending on pharmacy payments far exceeded their prior experience with the Senior Care Option (SCO) programs and far exceeded their expectations. In the words of one MMP executive:

> *For example, the drugs the pharmacy spent on the One Care side is astronomical compared to the SCO side. It's about 25 percent of total spending on the One Care side. It's a much lower percentage on SCO, and the types of drugs are so different. The One Care population has about 70 percent with a serious behavioral health condition or at least known diagnosis of a mental health condition. That creates a significant difference in terms of how we can intervene and what types of issues arise in terms of management of the population. So there're really significant differences.*

The cost experience (expenses paid to providers) across the three MMPs in One Care is presented in ***Table 26*** for the first 12 months of the demonstration (October 1, 2013–September 30, 2014). During the June 2015 site visit by the RTI evaluation team, the three plans reported that expenses were higher than anticipated, particularly for pharmacy expenses. Based on preliminary data reported at an Open Meeting by MassHealth in June 2015, approximately 25 percent of the aggregate spending from October 1, 2013 to September 30, 2014 by the One Care plans was on pharmacy (MassHealth, June 8, 2015).

Because of the size of their spending on pharmacy and the lag in payment reconciliation, plans were having to carry large receivable balances (according to one plan, as much as $35 million) while waiting for the year-end payments. The plans reported waiting for final reconciliation results, and presumably payments, up to a year and a half after the end of their fiscal years.

Table 26
Aggregate medical spending, One Care, through September 30, 2014[27]

Service	Spending (in millions)	Percent
Inpatient—acute	$35.05	15%
Inpatient mental health and substance abuse	$12.44	5%
Long-term care facility	$3.84	2%
Outpatient/professional	$53.24	22%
Outpatient—mental health/substance abuse	$8.84	4%
Pharmacy	$61.20	25%
Transportation	$6.90	3%
Community long-term services and supports	$33.66	14%
Incurred but not reported	$2.17	1%
Other	$21.81	9%
Total	$239.16	100%

SOURCE: MassHealth, June 8, 2015.

Another problem with the Part D payment method includes the method for computing the risk score for new Medicare enrollees. Because CMS does not have diagnostic claims-based information at the time of enrollment, new enrollees are assigned a risk score based on age, sex, end-stage renal disease status, and whether they were first eligible for Medicare because of a disability (RTI HCC Evaluation, 2015, p. 17). At year end, their risk score is adjusted using information from their claims experience. The HCC models are also being updated on an ongoing basis, and it is understood that the 2016 model reflects the entry into the market of new high-cost drug therapies for hepatitis C.

Even with changes made to the financial parameters for the demonstration, such as the savings percentages and risk corridor terms, as part of the contract amendments executed in September 2014 and January 2015, the MMPs continued to experience losses during the timeframe of this report. Shortly following Fallon's announcement in June 2015 of its withdrawal from the demonstration, MassHealth presented preliminary data at an Open Meeting indicating plans were reporting potential losses ranging from just under $1 million to $36 million during Demonstration Year 1 (October 1, 2013 through December 31, 2014).[28] Later adjustments to this cost data indicated that plan losses for Demonstration Year 1 ranged from approximately $460,000 to $18.4 million. This data is presented in ***Table 27***.

[27] MassHealth presented this information in June 2015.Updated information and detail regarding cost experiences reported by MMPs will be included as part of the second Annual Report.

[28] The financial report noted that revenue categories did not include payment information for interim or final risk corridors, high-cost risk pool or quality withholds, or certain retroactive rating category adjustments; spending categories included incurred but not reported expenses, which were an estimate of costs that had been incurred for services provided during the reporting period, but that had not yet been billed or adjudicated.

Table 27
One Care plan revenue and spending for DY1

Oct. 1, 2013, to Dec. 31, 2014	Fallon Total Care	CCA	Tufts Health Unify
Total revenue	$97,102,556	$256,946,563	$30,391,126
Total spending	$108,103,203	$291,804,133	$30,853,089
Interim Risk Corridor Payment	TBD	$16,467,408	TBD
Net income	($11,000,647)	($18,390,162)	($461,963)
Net gain/loss	−11.3%	−6.7%	−1.5%

NOTE: This data is based on financial reports submitted to MassHealth by the plans for the period October 2013–December 2014, updated in October 2015.

SOURCE: MassHealth Open Meeting, May 2016.

7.3 Preliminary Findings

As of the end of Demonstration Year 1 (December 31, 2014), MassHealth officials, plans, and stakeholders had ongoing concerns about the adequacy of the Medicare and Medicaid capitation rates. Despite initial adjustments finalized in a contract amendment in January 2015, Fallon subsequently decided to withdraw from the demonstration based on financial considerations. Following the June 2015 notice of Fallon's withdrawal from the demonstration, CMS and MassHealth continued to review all aspects of the rate methodologies including the Medicare rate adjustment methodology.[29]

Many other factors contributed to financial challenges, including high start-up costs, high levels of unmet needs of new enrollees, difficulties in locating enrollees resulting in longer continuity-of-care periods, assignment of initial ratings categories not reflective of the enrollees' true needs, and Part D reimbursement methodology.

Plans reported that initial savings projections for the demonstration were overly optimistic, especially in light of the lead-up time required to fully implement the care model.

[29] More recent information available from the State—but outside the period for this report—shows improvement by the end of 2015. This will be discussed in the second Annual Report.

8. Service Utilization

8.1 Purpose of Service Utilization Analyses

The purpose of the analyses in this section is to understand Medicare service trends over time in the demonstration and comparison groups so that CMS, the State, and stakeholders can understand the beneficiary characteristics of these groups and their utilization patterns before direct group comparisons are made in future reporting that will provide the results of impact analyses. Complete Medicaid data were not available for this report to reliably identify those with any home and community-based services (HCBS) use in the demonstration period, so analyses on individuals eligible for the demonstration and One Care enrollees using any long-term services and supports (LTSS) focus on only the small number of beneficiaries using LTSS nursing facility services. Future Annual Reports will include analyses identifying HCBS users and their Medicare and Medicaid service use.

Highlights

- One Care enrollees were in poorer health than demonstration nonenrollees in Massachusetts, as indicated by higher percentages of beneficiaries with hierarchical condition category (HCC) scores between 1 and less than 2 (33 to 29 percent), a larger percentage of beneficiaries with severe and persistent mental illness (SPMI) (52 to 46 percent), and a larger percentage having disability as their original reason for Medicare entitlement (95 to 89 percent).
- The use of Medicare home health services for those with any use was three to four times higher for enrollees than for nonenrollees, and use of the emergency department (ED) was also higher among enrollees than nonenrollees for those with any use.
- Medicare behavioral health utilization for those enrolled was approximately half that of those not enrolled. Given that the results presented are for Medicare data only, this lower utilization potentially may be due to higher Medicaid utilization for new behavioral health benefits in One Care.
- Results from quantitative analyses on various Medicare services show limited evidence of the demonstration's effect during the first demonstration year, in part because the One Care model needed more time for full implementation at a programmatic and operational level.

8.2 Methods

This section briefly describes the overall evaluation design, the data used, and the populations and measures analyzed.

8.2.1 Evaluation Design

RTI International is using an intent-to-treat (ITT) approach for the quantitative analyses conducted for the evaluation, comparing the eligible population under each State demonstration with a similar population that is not affected by the demonstration (i.e., a comparison group). ITT refers to an evaluation design in which all Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they actively participated in demonstration models. Thus, under the ITT framework, analyses include all beneficiaries eligible for the demonstration, including those who are eligible but are not contacted by the State or participating providers to enroll in the demonstration or care model, those who enroll but do not engage with the care model, and a group of similar eligible individuals in the comparison group.

Results for subpopulations within each of the demonstration and comparison groups are also presented in this section. For example, results are reported for those with any LTSS nursing facility use and those with any mental health diagnoses in prior Medicare claims. In addition, one group for which results are also reported in this section is *not* compared with the comparison group because this group does not exist within the comparison group: Massachusetts demonstration enrollees. Instead, they are compared with nonenrollees in the Commonwealth.

8.2.2 Comparison Group Identification

The comparison group provides an estimate of what would have happened to the demonstration group in the absence of the demonstration. Thus, the comparison group members should be similar to the demonstration group members in terms of their characteristics and health care and LTSS needs, and they should reside in areas that are similar to the demonstration State in terms of the health care system and the area-level socioeconomic environment. For this evaluation, identifying the comparison group members entailed two steps: (1) selecting the geographic area from which the comparison group would be drawn, and (2) identifying the individuals who would be included in the comparison group.

To construct Massachusetts' comparison group, a combination of areas within and outside of the Commonwealth was used. Demonstration and potential comparison areas were compared on a range of measures, including spending per Medicare-Medicaid enrollee by each program, the shares of LTSS delivered in facility-based and community settings, and the extent of Medicare and Medicaid managed care penetration. Using statistical techniques, the individual comparison metropolitan statistical areas (MSAs) were selected that most closely match the values found in the demonstration area on the designated measures. Other factors were considered when selecting comparison States, such as timeliness of Medicaid data submission to CMS. A comparison group was identified from selected MSAs in 10 States (Alabama, Kentucky, Maryland, Massachusetts, Michigan, North Carolina, Pennsylvania, Virginia, West Virginia, and Wisconsin) at least as large as the eligible population in Massachusetts. For details of the comparison group identification strategy, see ***Appendix A***.

8.2.3 Data

Annual Report analyses used data from several sources. First, the Commonwealth provided quarterly finder files that contained information identifying all demonstration-eligible

beneficiaries in the demonstration period. Second, RTI obtained administrative data on beneficiary demographic, enrollment, and Medicare service use characteristics from CMS administrative data systems for both demonstration and comparison group members. Third, these administrative data were merged with Medicare claims data on utilization of Medicare services.

Although plans submitted Medicaid data on use of Medicaid-paid LTSS, behavioral health, and other Medicaid-reimbursed services, complete data were not available for the demonstration period at the time of the analyses and therefore are not included in this report. CMS administrative data identifying eligible beneficiaries who used *any* Medicaid-reimbursed LTSS nursing facility care or *any* Medicare behavioral health services were available, so their Medicare service use could be presented in this report. Future reports will include findings on Medicaid service use once data are available.

8.2.4 Populations and Services Analyzed

Populations Analyzed

Populations analyzed in the report include all demonstration-eligible beneficiaries, as well as the following special populations: demonstration enrollees, those receiving any LTSS nursing facility care, those with any behavioral health service use in the last 2 years for an SPMI, and seven demographic and health condition groups (age, gender, race, any disability, presence of Alzheimer's disease, HCC score category, and whether the beneficiary died).

Addressing Other Medicare Demonstration or Shared Savings Program Enrollment

The populations included in analyses in ***Section 8*** of this report are those beneficiaries who within any analytic year were *not* part of other Medicare shared savings programs. Beneficiaries in each of the populations above were checked for enrollment in other shared savings programs in each analytic year (baseline year 1, baseline year 2, and the demonstration period) using a CMS database. The Pioneer Accountable Care Organization and the Medicare Shared Savings Program were the two programs in which almost all beneficiaries found to be in other shared savings programs were enrolled. Beneficiaries who were enrolled in any non–Financial Alignment Initiative shared savings program in either the demonstration or comparison groups were then removed from analysis *for that year*. If, during a given analytical year (e.g., the demonstration period) but not in another analytic year (e.g., the first baseline year), a beneficiary was enrolled in a shared savings program that was not part of the Financial Alignment Initiative, he or she is included in analyses in all years for which he or she was *not* enrolled in other shared savings programs.

Beneficiaries enrolled in other Medicare shared savings programs were removed from analyses so that when data used in this first Annual Report are used in impact analyses in the Final Report, the effects of One Care will be measured independent of the effects of other shared savings programs. If beneficiaries with enrollment in other shared savings programs were included in impact analyses using the intent-to-treat evaluation design, then estimates of One Care impact in future reports would be confounded with the effects of other shared savings programs. For example, if a One Care beneficiary who had been enrolled at any time in the first demonstration period in another shared savings program was included in impact analyses, CMS

and MassHealth would not know the relative contributions of One Care versus the other shared savings program on outcomes.

Approximately 44 percent of the 110,152 Massachusetts demonstration-eligible beneficiaries in the first demonstration period were in other Medicare shared savings programs, leaving a total of 61,929 eligible (enrolled plus nonenrolled) beneficiaries for analysis. Approximately 37 percent of the 23,872 One Care–enrolled beneficiaries were in other shared savings programs at some point during the first demonstration period, leaving 15,131 beneficiaries for analysis. Given that the Commonwealth passively enrolled beneficiaries in several phases over time throughout most of the first demonstration period, a large proportion of these beneficiaries were in other shared savings programs before enrollment. A slightly larger proportion (46 percent) of the 86,280 nonenrolled beneficiaries in Massachusetts were in other shared savings programs, leaving 46,798 nonenrollees for analysis.

Table 28 identifies selected demographic and health characteristics of the Massachusetts demonstration and comparison group populations by their participation status (e.g., eligible for the demonstration, enrolled in One Care, or whether in the comparison group). Beneficiaries differed little on these characteristics by their participation status. Overall, approximately one-third of beneficiaries were aged 21–44, and the remaining two-thirds were aged 45 or older. Beneficiaries were evenly split by gender. Approximately two-thirds of the groups analyzed were white. Approximately 15 percent of the demonstration group was African American, whereas about one-quarter of the comparison group was. Approximately 12–15 percent of enrollees and nonenrollees in Massachusetts were Hispanic, whereas only about 2 percent of the comparison group was.

Table 28
Descriptive statistics for Massachusetts demonstration eligible, enrolled, and comparison groups

	Demonstration period 10/1/2013–12/31/2014		
Characteristic	**Eligible**	**Enrolled**	**Comparison**
Total beneficiaries	61,929	15,131	149,340
Age			
21 to 44	32.3	35.4	32.7
45 or older	67.7	64.6	67.3
Gender			
Male	50.6	49.8	51.2
Female	49.4	50.2	48.8
Race			
White	66.4	61.6	67.8
African American	14.6	16.8	26.8
Hispanic	11.9	15.3	2.3
Asian/Pacific Islander	2.1	1.7	1.3

(continued)

Table 28 (continued)
Descriptive statistics for Massachusetts demonstration eligible, enrolled, and comparison groups

Characteristic	Demonstration period 10/1/2013–12/31/2014		
	Eligible	Enrolled	Comparison
Hierarchical condition category			
<1	63.8	60.7	66.1
1<2	29.8	32.8	26.4
2<4	5.2	5.2	6.0
4+	1.3	1.2	1.4
Disability as reason for original Medicare eligibility			
No	9.3	4.6	9.0
Yes	90.7	95.4	91.0
Severe and persistent mental illness diagnosis			
No	52.3	47.5	60.2
Yes	47.7	52.5	39.8

SOURCE: RTI Analysis of Medicare Encounters and Claims.

The HCC score is a measure of the predicted relative annual cost of a Medicare beneficiary based on the diagnosis codes present in recent Medicare claims. Beneficiaries with a score of 1 are predicted to have average cost in terms of annual Medicare expenditures. Beneficiaries with HCC scores less than 1 are predicted to have below-average costs, whereas beneficiaries with scores of 2 are predicted to have twice the average annual cost. Approximately 33 percent of One Care enrollees had HCC scores between 1 and less than 2, which was higher than all Massachusetts eligible beneficiaries combined (30 percent) and the comparison group (26 percent), meaning that their annualized costs were predicted to be more than that of the average Medicare beneficiary. In effect, One Care enrollees were predicted to be more expensive that nonenrollees. All groups had relatively similar percentage composition for HCC score categories between 2 and less than 4 (about 5 percent), and 4 or greater (about 1 percent).

In terms of disability status, almost 91 percent of Massachusetts eligible beneficiaries and comparison group beneficiaries were originally eligible for Medicare before age 65 because of their disability status, but about 95 percent of One Care enrollees were originally eligible for Medicare because of disability. The groups differed the most according to SPMI status, with the One Care enrollee group having more SPMI (52 percent) than either the overall Massachusetts demonstration-eligible population (48 percent) or the comparison group (40 percent). Effectively, the One Care enrollee group had a larger proportion of beneficiaries with SPMI than the nonenrolled group.

Services Analyzed

For each group or population and service type analyzed, estimates of three measures are provided: the percentage of demonstration-eligible beneficiaries with any use of a service (an

indicator of access to care), and counts of service use for all eligible beneficiaries and users of the respective service.

The 16 service settings analyzed include institutional (inpatient—including acute, inpatient rehabilitation, and long-term care hospital admissions—inpatient psychiatric, inpatient nonpsychiatric, ED visits not leading to admission, ED psychiatric visits, observation stays, skilled nursing facility, and hospice), and community settings (primary care; behavioral health visits; outpatient and independent physical, speech, and occupational therapy; home health; durable medical equipment; and other hospital outpatient services).

The analyses were conducted for each of the years in the 2-year baseline period (October 1, 2011, to September 30, 2013) and for the first demonstration period (October 1, 2013, to December 31, 2014) for both the demonstration and comparison group in each of the three periods.

8.3 Medicare Utilization for the Eligible Population

8.3.1 Overview of Benefits and Services

Under One Care, eligible beneficiaries enroll in a One Care plan that covers Medicare and Medicaid services, as well as new or expanded services available under the demonstration. Generally, these new services include a set of diversionary behavioral health services that have been available to Medicaid-only beneficiaries enrolled in managed care, but have not otherwise been a covered service for Medicare-Medicaid beneficiaries in Massachusetts; services expanded in amount, duration, or scope over Medicaid State Plan services; and new community-based services. Targeted case management services and rehabilitation option services are not included as part of the integrated One Care benefit, but they continue to be provided as part of the Medicaid fee-for-service (FFS) system. As in Medicare Advantage, Medicare hospice services continue to be provided as part of the Medicare FFS system. Demonstration services are discussed in greater detail in ***Section 1*** of this report; a complete list of services and service definitions is included in ***Appendix E***.

Table 29 presents results on the average percentage of beneficiaries using selected Medicare service types during the months in which they met demonstration eligibility criteria in the baseline and first demonstration periods. In addition, average counts of service use are presented across all such eligible months, and for the subset of these months in which beneficiaries were users of each respective service type. Data are shown for the baseline and demonstration period for Massachusetts-eligible beneficiaries (i.e., the demonstration group) and the comparison group. Subsequent tables in this section examine percentage of use, counts of service use, and payments for selected subgroups. See ***Appendix C*** for a detailed description of populations analyzed and measure definitions. Key findings based on Medicare data for the overall demonstration eligible population are summarized as follows:

- The percentage of the demonstration group with any inpatient admissions declined slightly between the baseline and demonstration periods (3.5 to 2.8 percent), and there was a decline in utilization among those with any inpatient admission (192.2

admissions per 1,000 user months in the first baseline period to 164.2 in the demonstration period). This trend was also observed in the comparison group.

- The percentage of beneficiaries with any inpatient psychiatric admissions remained constant between the baseline and demonstration period for the demonstration group (0.8 to 0.7 percent for each year). However, among those with any inpatient psychiatric admission, admissions declined over the baseline and demonstration periods (163.4 to 144.1 per 1,000 user months), suggesting a decline in the intensity of acute care service for those with any psychiatric admissions. A similar trend was observed in the comparison group.

- The percentage of beneficiaries with an ED visit in the demonstration group declined slightly from the baseline period to the demonstration period (7.8 to 7.3 percent). This decline corresponded with a reduction in the number of ED visits per 1,000 user months (240.1 to 208.7). A similar trend was observed in the comparison group.

- The percentage of beneficiaries with a primary care visit slightly increased between the baseline and demonstration periods for the demonstration (42.2 to 48.1 percent) and comparison groups (43.0 percent to 47.5 percent). In addition, the number of primary care visits increased in the demonstration (803.0 to 956.3 visits per 1,000 eligible months) and comparison groups (833.6 to 937.7 visits per 1,000 eligible months) between the baseline and demonstration periods.

- Among beneficiaries in the demonstration group, the percentage of beneficiaries with Medicare home health use remained relatively stable over the baseline and the demonstration period (1.3 to 1.1 percent). However, among beneficiaries with any home health use, there was an increase of 178.1 per 1,000 user months to 242.6. Home health use in the comparison group declined from the baseline to the demonstration period (165.5 to 142.2 per 1,000 user months), while the percentage with any use remained the same (1.1 percent).

Table 29
Proportion and utilization of institutional and non-institutional services for the Massachusetts demonstration and comparison groups

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Number of beneficiaries	91,633	152,788	70,617	148,912	61,892	147,707
Institutional setting						
Inpatient admissions[1]						
% with use	3.4	3.4	3.2	3.3	2.8	3.0
Utilization per 1,000 user months	192.2	188.2	190.5	185.6	164.2	159.6
Utilization per 1,000 eligible months	40.6	40.1	37.2	38.3	32.4	34.9
Inpatient psychiatric						
% with use	0.8	0.7	0.8	0.7	0.7	0.6
Utilization per 1,000 user months	163.4	167.1	164.8	165.4	144.1	144.0
Utilization per 1,000 eligible months	8.6	7.9	8.3	7.8	7.8	7.1
Inpatient non-psychiatric						
% with use	2.8	2.8	2.5	2.7	2.1	2.5
Utilization per 1,000 user months	179.7	177.0	177.0	174.2	150.5	148.9
Utilization per 1,000 eligible months	32.0	32.2	28.8	30.5	24.6	27.8
Emergency department use (non-admit)						
% with use	7.8	7.2	7.6	7.1	7.3	7.1
Utilization per 1,000 user months	240.1	240.4	236.1	235.5	208.7	214.1
Utilization per 1,000 eligible months	103.7	95.3	99.2	92.5	97.2	93.3
Emergency department use (psychiatric)						
% with use	0.9	0.6	0.9	0.6	0.9	0.5
Utilization per 1,000 user months	182.7	162.0	194.0	160.3	173.6	138.9
Utilization per 1,000 eligible months	11.2	7.2	12.0	7.0	12.8	6.8

(continued)

Table 29 (continued)
Proportion and utilization of institutional and non-institutional services for the Massachusetts demonstration and comparison groups

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Observation stays						
% with use	0.7	0.6	0.7	0.6	0.7	0.7
Utilization per 1,000 user months	119.2	117.0	117.3	117.6	100.3	99.7
Utilization per 1,000 eligible months	7.3	6.3	7.4	6.7	7.4	7.3
Skilled nursing facility						
% with use	0.4	0.4	0.3	0.5	0.3	0.4
Utilization per 1,000 user months	142.1	154.7	146.2	154.6	123.2	130.0
Utilization per 1,000 eligible months	3.8	4.8	3.7	5.2	2.9	4.6
Hospice						
% with use	0.1	0.2	0.1	0.2	0.1	0.2
Utilization per 1,000 user months	399.7	403.6	411.7	417.3	346.2	374.4
Utilization per 1,000 eligible months	1.5	2.0	1.5	2.3	1.0	2.1
Non-institutional setting						
Primary care E&M visits						
% with use	42.2	43.0	46.5	47.0	48.1	47.5
Utilization per 1,000 user months	803.0	833.6	911.8	935.2	956.3	937.7
Utilization per 1,000 eligible months	706.9	724.2	806.0	826.7	867.0	831.4
Behavioral health visits (does not include new behavioral health benefits)						
% with use	21.9	17.7	13.5	11.5	9.8	9.5
Utilization per 1,000 user months	1,010.5	969.8	764.8	759.1	792.1	844.5
Utilization per 1,000 eligible months	437.1	353.6	287.1	247.4	218.5	205.7
Outpatient therapy (PT, OT, ST)						
% with use	2.3	2.5	2.2	2.5	2.0	2.5
Utilization per 1,000 user months	2,123.9	3,065.6	2,071.2	3,151.5	1,856.6	3,320.6
Utilization per 1,000 eligible months	233.2	331.9	216.2	338.3	208.2	404.2

(continued)

Table 29 (continued)
Proportion and utilization of institutional and non-institutional services for the Massachusetts demonstration and comparison groups

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Independent therapy (PT, OT, ST)						
% with use	1.2	1.3	1.1	1.2	1.1	1.3
Utilization per 1,000 user months	2,101.3	2,648.0	2,246.3	2,642.1	2,324.0	2,717.2
Utilization per 1,000 eligible months	116.1	140.3	111.5	136.7	133.3	163.5
Home health episodes						
% with use	1.3	1.1	1.1	1.1	1.1	1.1
Utilization per 1,000 user months	178.1	165.5	171.3	163.9	242.6	142.2
Utilization per 1,000 eligible months	13.0	10.7	11.2	10.8	16.3	10.6
Durable medical equipment						
% with use	12.0	13.0	11.1	12.4	10.3	11.1
Utilization per 1,000 user months	—	—	—	—	—	—
Utilization per 1,000 eligible months	—	—	—	—	—	—
Other hospital outpatient services						
% with use	36.6	21.9	35.4	21.5	34.2	21.6
Utilization per 1,000 user months	—	—	—	—	—	—
Utilization per 1,000 eligible months	—	—	—	—	—	—

— data not available.

E&M = evaluation and management; OT = occupational therapy; PT = physical therapy; ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

NOTE: Utilization for inpatient admissions, inpatient psychiatric admissions, inpatient substance abuse, skilled nursing facility, and hospice are defined as number of admissions during the eligible/user month. Utilization for emergency department (non-admit), emergency department (psychiatric), observation stays, specialist E&M visits, primary care E&M visits, behavioral health visits, home health, and outpatient and independent therapy are defined as the number of visits during the eligible/user month. Durable medical equipment and other outpatient services are defined as having any of those services during the eligible month.

SOURCE: RTI Analysis of Medicare Encounters and Claims.

8.4 Beneficiaries Enrolled versus Not Enrolled during the Demonstration

Highlights

- There were only slight differences in total, psychiatric-, and non-psychiatric-related inpatient admissions between One Care beneficiaries and those eligible beneficiaries who were not enrolled. Total inpatient admissions per 1,000 user months among those enrolled was higher than among those who did not enroll (183.2 vs. 167.8 visits). A similar pattern was observed across the different admission categories.
- Among those who were enrolled in the demonstration, a slightly lower percentage had ED use compared with those who were not enrolled (6.6 to 7.2 percent), but a higher number of visits if any visits per 1,000 eligible months (244.0 vs. 207.5 visits).
- Among those not enrolled in the demonstration, a higher percentage had a primary care evaluation and management (E&M) visit, compared with those who enrolled (49.1 to 41.8 percent). Among those with any use, those who were not enrolled had a higher rate of primary care visits per 1,000 user months, relative to those who enrolled (984.6 vs. 909.6 visits).
- Medicare behavioral health utilization for those enrolled was approximately half that of the nonenrolled. Given that the results presented are for Medicare data only, this lower utilization potentially may be due to higher Medicaid utilization for new behavioral health benefits in One Care, but Medicaid encounter data are not yet ready for analysis to check. The new diversionary behavioral health services are described in ***Table 1*** in ***Section 1.2***.

This subsection of the Annual Report focuses on only the Massachusetts demonstration-eligible population (One Care enrollees vs. nonenrollees). The previous subsection assessed all Massachusetts demonstration-eligible beneficiaries against the comparison group, but because of interest in the enrolled population, this section focuses on comparing enrollees with nonenrollees, who make up 75 percent of all demonstration-eligible beneficiaries, and potentially could become enrollees in the future.

Table 30 identifies selected demographic and health characteristics of the Massachusetts demonstration population by their enrollment status. One Care enrollees, compared with demonstration nonenrollees in Massachusetts, were somewhat younger (35 vs. 31 percent aged 21 to 44); more likely to be African American or Hispanic (32 to 25 percent); and more likely to have higher HCC scores (33 vs. 29 percent having a HCC score between 1 and less than 2), greater percentage with SPMI (52 to 46 percent), and greater percentage with a disability as their original reason for Medicare entitlement (95 to 89 percent). These differences may potentially be associated with beneficiary- and area-level characteristics for which there are no data to make adjustments to make the two groups comparable.

Table 30
Descriptive statistics for Massachusetts demonstration-eligible beneficiaries, by enrollment status

Characteristic	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Total beneficiaries	46,765	15,127
Age (%)		
21 to 44	31.3	35.4
45 and older	68.7	64.6
Gender		
Male	50.9	49.8
Female	49.1	50.2
Race		
White	68.0	61.6
African American	13.9	16.8
Hispanic	10.8	15.3
Asian/Pacific Islander	2.3	1.7
Hierarchical condition category		
<1	64.8	60.7
1<2	28.9	32.8
2<4	5.1	5.2
4+	1.3	1.2
Disability as reason for original Medicare eligibility		
No	10.8	4.6
Yes	89.2	95.4
Severe and persistent mental illness diagnosis		
Yes	53.8	47.5
No	46.2	52.5

SOURCE: RTI Analysis of Medicare Encounters and Claims.

Table 31 presents results on the average percentage of beneficiaries using selected Medicare service types, by enrollment status, during the months in which they met demonstration eligibility criteria during the demonstration period. In addition, average counts of service use are presented across all such eligible-months and for the subset of these months in which beneficiaries were users of each respective service type. Data are shown for those who enrolled in the demonstration, and for those who did not enroll in the demonstration during the demonstration period. Key findings for the demonstration-eligible population by enrollment status are summarized as follows:

- There were only slight differences in total, psychiatric-, and non-psychiatric-related inpatient admissions. Among those enrolled, there was a lower percentage with any inpatient admission, compared with those not enrolled (1.6 vs 3.0 percent). However,

the number of total inpatient admissions per 1,000 user months among those enrolled was greater than among those who did not enroll (183.2 vs. 167.8 visits). A similar pattern was observed across the different admission categories.

- Among those who were enrolled in the demonstration, a slightly lower percentage had ED use compared with those who were not enrolled (6.6 to 7.2 percent), which corresponded with lower rates of use per 1,000 eligible months (87.0 to 94.2 visits).

- Among those not enrolled in the demonstration, there was a higher percentage with a primary care E&M visit, compared with those who enrolled (49.1 to 41.8 percent). Among those with any use, those who were not enrolled had a higher rate of primary care visits per 1,000 user months, relative to those who enrolled (984.6 vs. 909.6 visits).

Table 31
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status

Measures by setting	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Number of beneficiaries	46,765	15,127
Institutional setting		
Inpatient admissions[1]		
% with use	3.0	1.6
Utilization per 1,000 user months	167.8	183.2
Utilization per 1,000 eligible months	34.5	17.8
Inpatient psychiatric		
% with use	0.8	0.3
Utilization per 1,000 user months	147.9	152.6
Utilization per 1,000 eligible months	8.4	3.3
Inpatient non-psychiatric		
% with use	2.3	1.3
Utilization per 1,000 user months	153.2	175.9
Utilization per 1,000 eligible months	26.1	14.5
Emergency department use (non-admit)		
% With use	7.2	6.6
Utilization per 1,000 user months	207.5	244.0
Utilization per 1,000 eligible months	94.2	87.0
Emergency department use (psychiatric)		
% with use	0.9	1.0
Utilization per 1,000 user months	167.9	245.6
Utilization per 1,000 eligible months	11.9	13.6

(continued)

Table 31 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status

Measures by setting	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Observation stays		
% with use	0.7	0.4
Utilization per 1,000 user months	100.9	124.3
Utilization per 1,000 eligible months	7.6	4.5
Skilled nursing facility		
% with use	0.3	0.1
Utilization per 1,000 user months	129.1	132.5
Utilization per 1,000 eligible months	3.3	1.5
Hospice		
% with use	0.1	0.0
Utilization per 1,000 user months	350.9	436.9
Utilization per 1,000 eligible months	1.3	0.4
Non-institutional setting		
Primary care E&M visits		
% with use	49.1	41.8
Utilization per 1,000 user months	984.6	909.6
Utilization per 1,000 eligible months	879.9	782.4
Behavioral health visits (does not include new behavioral health benefits)		
% with use	11.4	3.2
Utilization per 1,000 user months	922.0	291.8
Utilization per 1,000 eligible months	257.4	51.6
Outpatient therapy (PT, OT, ST)		
% with use	2.3	1.2
Utilization per 1,000 user months	2,136.4	1,039.3
Utilization per 1,000 eligible months	249.6	69.1
Independent therapy (PT, OT, ST)		
% with use	1.2	0.7
Utilization per 1,000 user months	2,548.7	2,236.2
Utilization per 1,000 eligible months	144.7	73.5
Home health episodes		
% with use	0.8	2.6
Utilization per 1,000 user months	135.8	935.0
Utilization per 1,000 eligible months	8.3	58.8

(continued)

Table 31 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status

Measures by setting	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Durable medical equipment		
% with use	10.8	7.5
Utilization per 1,000 user months	—	—
Utilization per 1,000 eligible months	—	—
Other hospital outpatient services		
% with use	35.1	25.7
Utilization per 1,000 user months	—	—
Utilization per 1,000 eligible months	—	—

— data not available.

E&M = evaluation and management; OT = occupational therapy; PT = physical therapy; ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

NOTE: Utilization for inpatient admissions, inpatient psychiatric admissions, inpatient substance abuse, skilled nursing facility, and hospice are defined as the number of admissions during the eligible/user month. Utilization for emergency department (non-admit), emergency department (psychiatric), observation stays, specialist E&M visits, primary care E&M visits, behavioral health visits, home health, and outpatient and independent therapy are defined as the number of visits during the eligible/user month. Durable medical equipment and other outpatient services are defined as having any of those services during the eligible month.

8.5 Population with LTSS Needs

Highlights

- LTSS populations are a primary focus of the One Care demonstration. The model of care and service delivery systems as described in this report was specifically designed in part to serve LTSS populations.
- Because of timing of Medicaid data availability, analyses in this section focus only on LTSS nursing facility users (meaning only beneficiaries in nursing facilities as opposed to any other LTSS facility). Results on those with any HCBS use will be presented in the next Annual Report.
- Only 1,131 Massachusetts demonstration-eligible beneficiaries (enrollees and nonenrollees) had any LTSS nursing facility use. Among these beneficiaries, only 56 were One Care enrollees. Therefore, results on One Care enrollees with any LTSS nursing facility use should be viewed with caution because of the small sample size.
- One Care enrollees with any LTSS nursing facility care, compared with the whole group of demonstration-eligible beneficiaries in Massachusetts with any LTSS nursing facility care, have lower HCC scores, a lower percentage with SPMI, and a higher percentage having disability as their original reason for Medicare entitlement.
- Demonstration-eligible beneficiaries with any LTSS nursing facility use in Massachusetts had modestly higher inpatient, ED, primary care, and behavioral health use than those in the comparison group.
- One Care enrollees, as compared with nonenrollees in Massachusetts, had a slightly lower percentage with any inpatient admissions, and fewer admissions, if any. One Care enrollees, as compared with nonenrollees, also had higher ED use and lower primary care use.

Integrating or coordinating care for people with LTSS needs is a major objective of the demonstrations under the Financial Alignment Initiative. This chapter contains information on the Massachusetts LTSS system and the role of Medicare-Medicaid Plans (MMPs) in coordinating care for demonstration enrollees with LTSS. Findings from the evaluation are also reported, including the characteristics of the demonstration-eligible beneficiaries who used any LTSS, the experience of people who used LTSS with care coordination services provided by the demonstration, and the medical and health service utilization for the subset of demonstration-eligible beneficiaries who used any LTSS.

Medicaid data on LTSS users were not available for this report, so RTI identified those with any LTSS use from CMS administrative data derived from monthly State Medicare Modernization Act data submissions that identify Medicaid beneficiaries with any institutional LTSS, any HCBS, and no LTSS use. The Commonwealth excludes HCBS waiver recipients from demonstration eligibility. As a result, the only reliable identifier of LTSS users available to

RTI for purposes of analysis for this report was that of institutional LTSS use. Because of this issue, and because of limited availability of full Medicaid data at the time of this report, the results presented should be viewed in that context. This section focuses on only LTSS nursing facility users.

8.5.1 Background

A substantial portion of the dually eligible population nationally has disabilities, including limitations in the activities of daily living (ADLs), such as eating, bathing, and dressing; instrumental activities of daily living (IADLs), such as meal preparation and money management; or cognitive functioning, such as dementia from Alzheimer's disease. In 2010, 55 percent of dually eligible beneficiaries had limitations in ADLs; one-third had three to six limitations in IADLs, and nearly one-quarter (24 percent) lived in institutions, primarily nursing facilities (Medicare Payment Advisory Commission [MedPAC] & Medicaid and Children's Health Insurance Program Payment and Access Commission [MACPAC], 2015). Nearly one-quarter had Alzheimer's disease or related dementias.

As a result of the high proportion of Medicare-Medicaid beneficiaries with disabilities, these beneficiaries nationally have a very high use of expensive LTSS, such as nursing facilities, personal care services, residential care facilities, and adult day care. In 2010, 21 percent of full-benefit FFS Medicare-Medicaid beneficiaries used institutional services, which accounted for half of Medicaid spending for dually eligible beneficiaries; 13 percent of full-benefit FFS Medicare-Medicaid beneficiaries used Medicaid HCBS waivers, which accounted for 23 percent of Medicaid spending on dually eligible beneficiaries (MedPAC & MACPAC, 2015). Thus, institutional services and Medicaid HCBS waivers accounted for nearly three-quarters of Medicaid spending on Medicare-Medicaid beneficiaries.

Medicare does not cover LTSS, although its benefits include post-acute care services in skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. Medicare-Medicaid beneficiaries have much higher use of Medicare skilled nursing facilities and home health than do non–dually eligible beneficiaries, but use of these services constitute only about 15 percent of Medicare spending for this population. Because users of LTSS are also high users of acute care services, average costs for Medicare-Medicaid beneficiaries who use LTSS are high. In 2010, average Medicare and Medicaid expenditures for Medicare-Medicaid beneficiaries who used any LTSS totaled $60,801, split about 60 percent/40 percent between Medicare and Medicaid (MedPAC & MACPAC, 2015).

Although in the last 2 decades, some States have undertaken demonstrations experimenting with Medicare-Medicaid integrated care, people with disabilities currently receive care in a fragmented and uncoordinated financing and service delivery system, within and between the health and long-term care systems (Wiener, 1996). Financing for acute care is largely the responsibility of Medicare and the Federal government, whereas long-term care is principally the responsibility of Medicaid and State governments. As with the general dually eligible population, the principal problem for older and younger people with disabilities is that no organization has financial responsibility and accountability for both acute care and LTSS; that is, no organization is responsible for managing all aspects of care for a person. Indeed, under the current system, the financial incentives are to shift costs between Medicare and Medicaid,

especially for LTSS users, where Medicaid's financial role is so large and Medicare's financial role is so small (Grabowski, Aschbrenner, Feng, & Mor, 2009).

The fragmented financing and delivery system has negative consequences for Medicare-Medicaid beneficiaries with disabilities. For example, several studies have found that users of LTSS services—such as nursing facility residents and dually eligible beneficiaries receiving services under Medicaid HCBS waivers—have high levels of hospitalization and potentially avoidable hospitalizations (Konetzka, Karon, & Potter, 2012; Polniaszek, Walsh, & Wiener, 2011; Walsh et al., 2012).

Within the LTSS system, Medicaid funding is tilted toward institutional services, although steady progress has been made toward a more balanced delivery system (Eiken et al., 2015). In fiscal year 2013, 40.2 percent of Medicaid LTSS expenditures for older people and younger people with physical disabilities were for HCBS, compared with 34.9 percent in fiscal year 2008. Within this special population, however, much more progress in rebalancing has occurred for younger people with physical disabilities than for older people (Brock et al., 2014). In part, this may be because of difficulties assembling a comprehensive package of services that would allow a beneficiary to remain in the community. Moreover, access is not assured in the current system; in 2014, nationally there were 155,697 older people and younger people with physical disabilities on waiting lists for Medicaid HCBS waivers (Ng et al., 2015).

The capitated model demonstrations under the Financial Alignment Initiative are not the only effort to apply managed care principles to LTSS. States are increasingly turning to capitated Managed Care Organizations (MCOs) to integrate LTSS, sometimes with Medicaid acute care services (Musumeci, 2014). In some of the Financial Alignment Initiative demonstration States, beneficiaries who choose to disenroll from the demonstration must still receive their care through a managed LTSS plan. In addition, enrollment in Medicare Advantage Dual Eligible Special Needs Plans is increasing rapidly and has more than quintupled between 2006 and 2014 (Verdier et al., 2015).

It is hypothesized that serving Medicare-Medicaid beneficiaries with LTSS needs within a capitated environment in which one organization is accountable for both Medicare and Medicaid/acute care and LTSS will have several positive effects on service utilization, expenditures, and quality of care. In these settings, MCOs will be incentivized to serve beneficiaries in a way that produces the lowest total cost for the highest quality care. Thus, health plans will be encouraged to provide services to people receiving LTSS that address their medical as well as social and functional needs, so that inpatient admissions, readmissions, and potentially avoidable admissions will be reduced. If savings occur for acute medical services, MCOs will have the resources to expand services for LTSS. In addition, MCOs are hypothesized to work to reduce nursing facility admissions and serve people in the community, either at home or in residential care facilities (where those settings are covered in the demonstration). Thus, utilization of and expenditures for HCBS should increase and use of nursing facilities should decline where people can be served more cost-effectively and with a higher quality of life in the community. Moreover, people admitted to nursing facilities increasingly should be those with more severe functional and cognitive disabilities whom it would be difficult to serve in the community, and fewer nursing facility residents should have low-care needs. Within HCBS, MCOs should offer a broader range of (lower-cost) services than was permissible under the FFS

system because MCOs are not limited to certain benefits. States in the demonstration that are not using capitation are relying on enhanced coordination to improve outcomes, but without the financial incentives to do so.

8.5.2 Organization and Delivery of LTSS in Massachusetts

Before the One Care demonstration, Medicare-Medicaid beneficiaries younger than age 65 had remained ineligible to enroll in Medicaid managed care. In the absence of One Care, Massachusetts had neither a mechanism to provide comprehensive care coordination and care management services to this population, nor a way to integrate Medicare and Medicaid payments and services. Before the demonstration, most Medicare-Medicaid enrollees received their LTSS services through the existing FFS system under the Medicaid State Plan. This includes a personal care services benefit delivered through a participant-directed delivery model only. Some may have received services in a Program of All-Inclusive Care for the Elderly, which serves people aged 55 or older. Many One Care beneficiaries were also not eligible for existing 1915(c) HCBS waivers; eligibility for One Care also excluded individuals receiving HCBS waivers from enrolling in the demonstration. One Care is the only demonstration under the Financial Alignment Initiative that limits its eligibility to adults younger than age 65 at the time of enrollment.[30]

8.5.3 Demonstration Experience

The goals of One Care are to alleviate fragmentation of care, improve coordination of services, enhance quality of care, and reduce costs. The demonstration's key objectives are to improve the beneficiary experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, and eliminate cost shifting between Medicare and Medicaid (Memorandum of Understanding, 2012, pp. 2–3). According to officials at MassHealth, the demonstration design is based on the premise that improved care coordination; integration of physical, behavioral health, and LTSS; increased consumer engagement in care; and expanded access to enhanced community-based services will improve member experience and result in more cost-effective and efficient delivery of services.

A central feature of the One Care demonstration is the addition of care coordination services for medical, behavioral health, and LTSS. One Care plans are required to offer care coordination to all enrollees through a care coordinator or clinical care manager for medical and behavioral health services employed by or under contract with the One Care plan. LTSS care coordination is provided through an Independent Living and Long-Term Services and Supports (LTS) coordinator under contract with community-based organizations. ***Section 4*** provides detailed information regarding care coordination under One Care, including the roles and responsibilities of care coordinators and LTS coordinators.

As of January 1, 2015, approximately 22 percent of all enrollees (3,867 of 17,867) were in one of the two C3 rating categories for having any activities of daily living needs, and 0.13 percent of beneficiaries (24 of 17, 867 One Care enrollees) were in the F1 rating category for facility-based care (MassHealth Enrollment Report, January 2015).

[30] For Medicare-Medicaid enrollees older than age 65, Senior Care Options is available as a service option.

8.5.4 LTSS Nursing Facility Population Characteristics

Table 32 provides information on demographic characteristics, HCC score, and disability status of beneficiaries with any LTSS nursing facility use. Among LTSS nursing facility users, One Care enrollees were somewhat younger (12.5 to 9.6 percent aged 21 to 44); more likely to be male than female (61 vs. 56 percent), and to be African American (25 to 12 percent); more likely to have lower HCC scores (33 vs. 37 percent having an HCC score greater than 2); and had a lower percentage of beneficiaries with SPMI (25 to 31 percent), and a larger percentage with disability as their original reason for Medicare entitlement (91 to 82 percent).

Table 32
Descriptive statistics for LTSS nursing facility users who are Massachusetts demonstration eligible, enrolled, and in the comparison group

	Demonstration period 10/1/2013–12/31/2014		
Characteristic	**Eligible**	**Enrolled**	**Comparison**
Total beneficiaries	1,133	56	7,949
Age (%)			
21 to 44	9.6	12.5	9.8
45 and older	90.4	87.5	90.2
Gender			
Male	56.0	60.7	58.5
Female	44.0	39.3	41.5
Race			
White	79.8	67.9	76.1
African American	11.5	25.0	22.1
Hispanic	3.7	1.8	0.4
Asian/Pacific Islander	1.1	1.8	0.4
Hierarchical condition category			
<1	21.7	26.8	30.8
1<2	41.6	41.1	37.7
2<4	24.6	21.4	23.2
4+	12.0	10.7	8.3
Disability as reason for original Medicare eligibility			
No	18.4	8.9	14.4
Yes	81.6	91.1	85.6
Severe and persistent mental illness			
No	68.6	75.0	53.4
Yes	31.4	25.0	46.6

SOURCE: RTI Analysis of Medicare Encounters and Claims.

8.5.5 Medicare Health Care Service Use of LTSS Nursing Facility Beneficiaries

Table 33 presents Medicare utilization on those with any LTSS nursing facility use. These results include the proportion of beneficiaries using different Medicare services during the baseline and first demonstration periods. In addition, utilization information is presented for all

demonstration-eligible beneficiaries with any LTSS nursing facility use and for users of these Medicare services. Key findings for the institutional LTSS population are below:

- There was a moderate increase in the percentage of beneficiaries in Massachusetts with any LTSS nursing facility use having any inpatient admissions from the baseline to the demonstration period (8.5 to 9.4 percent). This increase corresponded with a slight increase in use per 1,000 user months among beneficiaries with any inpatient admissions from the baseline to the demonstration period (230.8 to 235.7 visits). The comparison group experienced a decline in inpatient admissions per 1,000 user months from the baseline to the demonstration period (230.1 to 196.9 visits).

- The percentage of institutional LTSS beneficiaries with an ED visit in the demonstration group increased slightly from 6.4 to 7.6 percent from the baseline to the demonstration period. Utilization also increased from 206.5 visits per 1,000 user months, to 246.9 visits. There was not a meaningful trend in utilization among those in the comparison group.

- Among institutional LTSS beneficiaries, in the demonstration and the comparison groups, there was an increase in primary care use, although it was more pronounced in the demonstration group (63.8 to 71.5 percent and 72.0 to 74.5 percent, respectively). Utilization among those with any primary care visits increased from the baseline to the demonstration period, indicating more intensive use of primary care services among the LTSS population in the demonstration group (1,739.1 to 2,232.7 visits per 1,000 user months).

- Behavioral health visits increased for both the demonstration and comparison groups, but the increase was larger for the demonstration group. This potentially may be the result of the One Care demonstration's focus on behavioral health, and MMP information stating that they encountered unexpected unmet need. Still, the diversionary behavioral health services in One Care were likely coded in Medicaid encounter data that are not included in this report.

Table 33
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration and comparison groups, beneficiaries with LTSS nursing facility use

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Number of beneficiaries	2,474	7,305	1,962	7,420	1,131	6,971
Institutional setting						
Inpatient admissions[1]						
% with use	8.5	7.1	7.8	7.1	9.4	6.8
Utilization per 1,000 user months	230.8	230.1	227.7	224.1	235.7	196.9
Utilization per 1,000 eligible months	102.5	83.5	94.0	82.9	114.0	79.5
Inpatient psychiatric						
% with use	0.9	0.6	0.9	0.7	1.4	0.7
Utilization per 1,000 user months	152.8	153.2	154.3	173.6	150.9	153.5
Utilization per 1,000 eligible months	9.5	6.1	9.0	7.2	15.1	7.2
Inpatient non-psychiatric						
% with use	7.8	6.6	7.1	6.5	8.1	6.2
Utilization per 1,000 user months	223.3	223.9	220.0	213.3	225.4	186.2
Utilization per 1,000 eligible months	92.8	77.3	84.8	75.3	98.7	72.2
Emergency department use (non-admit)						
% with use	6.4	5.2	6.0	5.0	7.6	5.4
Utilization per 1,000 user months	206.5	188.3	213.0	194.4	246.9	177.0
Utilization per 1,000 eligible months	82.7	64.4	77.8	64.9	110.3	68.6
Emergency department use (psychiatric)						
% with use	0.7	0.3	0.9	0.4	1.2	0.4
Utilization per 1,000 user months	146.2	142.9	189.5	192.8	207.4	141.3
Utilization per 1,000 eligible months	8.0	4.1	12.3	5.4	18.8	5.1

(continued)

Table 33 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration and comparison groups, beneficiaries with LTSS nursing facility use

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Observation stays						
% with use	1.1	0.6	1.0	0.7	1.5	0.7
Utilization per 1,000 user months	136.2	118.2	120.1	119.4	111.9	99.0
Utilization per 1,000 eligible months	11.7	6.6	11.0	7.3	15.7	7.9
Skilled nursing facility						
% with use	4.7	4.1	4.4	4.2	5.1	4.0
Utilization per 1,000 user months	179.5	184.6	177.2	178.8	169.3	154.6
Utilization per 1,000 eligible months	52.1	45.3	49.0	46.6	58.7	43.8
Hospice						
% with use	1.9	1.6	2.1	1.8	2.2	1.7
Utilization per 1,000 user months	461.2	464.7	458.7	452.5	421.9	402.5
Utilization per 1,000 eligible months	20.2	16.8	21.9	18.0	22.3	17.0
Non-institutional setting						
Primary care E&M visits						
% with use	63.8	72.0	63.6	73.1	71.5	74.5
Utilization per 1,000 user months	1,739.1	1,660.6	1,813.1	1,834.6	2,232.7	1,898.0
Utilization per 1,000 eligible months	1,582.5	1,617.4	1,648.7	1,787.7	2,103.0	1,864.5
Behavioral health visits (does not include new behavioral health benefits)						
% with use	14.0	8.6	17.1	11.5	20.4	12.7
Utilization per 1,000 user months	409.7	399.6	798.8	640.6	915.2	841.8
Utilization per 1,000 eligible months	217.4	130.6	399.7	238.6	497.3	272.7
Outpatient therapy (PT, OT, ST)						
% with use	16.9	13.9	15.7	14.5	20.0	15.8
Utilization per 1,000 user months	7,481.7	6,761.0	6,628.3	7,039.1	7,918.8	8,045.8
Utilization per 1,000 eligible months	3,985.4	3,160.5	3,392.7	3,261.5	5,184.6	4,200.7

(continued)

Table 33 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration and comparison groups, beneficiaries with LTSS nursing facility use

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Independent therapy (PT, OT, ST)						
% with use	0.3	0.8	0.3	0.6	0.3	0.5
Utilization per 1,000 user months	1,981.1	4,231.6	1,047.4	3,197.9	1,871.2	2,586.3
Utilization per 1,000 eligible months	23.2	134.9	17.8	89.5	40.0	72.4
Home health episodes						
% with use	1.8	1.2	1.5	1.5	1.8	1.9
Utilization per 1,000 user months	176.4	152.2	174.3	160.8	164.9	138.0
Utilization per 1,000 eligible months	18.4	12.1	15.7	15.6	19.7	18.9
Durable medical equipment						
% with use	18.5	17.6	17.0	17.1	20.2	17.9
Utilization per 1,000 user months	—	—	—	—	—	—
Utilization per 1,000 eligible months	—	—	—	—	—	—
Other hospital outpatient services						
% with use	33.9	28.3	30.4	27.7	37.8	28.7
Utilization per 1,000 user months	—	—	—	—	—	—
Utilization per 1,000 eligible months	—	—	—	—	—	—

— data not available.

E&M = evaluation and management; OT = occupational therapy; PT = physical therapy; ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

NOTE: Utilization for inpatient admissions, inpatient psychiatric admissions, inpatient substance abuse, skilled nursing facility, and hospice are defined as number of admissions during the eligible/user month. Utilization for emergency department (non-admit), emergency department (psychiatric), observation stays, specialist E&M visits, primary care E&M visits, behavioral health visits, home health, and outpatient and independent therapy are defined as the number of visits during the eligible/user month. Durable medical equipment and other outpatient services are defines as having any of those services during the eligible month.

SOURCE: RTI Analysis of Medicare Encounters and Claims.

Table 34 presents, for the institutional LTSS population by enrollment status, results on the average percentage of beneficiaries using selected Medicare service types during the months in which they met demonstration eligibility criteria during the demonstration periods. In addition, average counts of service use are presented across all such eligible months and for the subset of these months in which beneficiaries were users of each respective service type. Data are shown for those with LTSS nursing facility use who enrolled in the demonstration, and for those who did not enroll in the demonstration during the demonstration period. Key findings for the institutional LTSS population include the following:

- Of enrolled beneficiaries, 8.6 percent had any inpatient admission, compared with 9.2 percent among those who were not enrolled. However, enrollees with any inpatient stays had more frequent hospital admissions during the demonstration year than their nonenrolled counterparts (260.6 visits per 1,000 user months vs. 238.3 visits).

- Of enrolled beneficiaries, 9.1 percent had any ED use, compared with 7.4 percent among the nonenrolled population. The larger percentage of use corresponded with a slightly higher count of utilization per 1,000 eligible months among the enrolled (112.3 to 104.3 visits).

- For those not enrolled in the demonstration, there was a higher percentage of users with a primary care E&M visit, compared with those who enrolled (72.4 to 55.9 percent). Among those with any use, those who were not enrolled had a lower rate of primary care visits per 1,000 user months, relative to those who enrolled (2,234.4 vs. 2,485.1 visits).

Table 34
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status among LTSS nursing facility users

Measures by setting	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Number of beneficiaries	1,083	56
Institutional setting		
Inpatient admissions[1]		
% with use	9.2	8.6
Utilization per 1,000 user months	238.3	260.6
Utilization per 1,000 eligible months	111.6	98.9
Inpatient psychiatric		
% with use	1.3	1.3
Utilization per 1,000 user months	151.4	185.2
Utilization per 1,000 eligible months	14.1	13.4

(continued)

Table 34 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status among LTSS nursing facility users

Measures by setting	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Inpatient non-psychiatric		
% with use	8.0	7.2
Utilization per 1,000 user months	226.7	278.3
Utilization per 1,000 eligible months	97.3	85.6
Emergency department use (non-admit)		
% With use	7.4	9.1
Utilization per 1,000 user months	240.2	276.3
Utilization per 1,000 eligible months	104.3	112.3
Emergency department use (psychiatric)		
% with use	1.2	2.1
Utilization per 1,000 user months	216.6	242.4
Utilization per 1,000 eligible months	18.2	21.4
Observation stays		
% with use	1.4	0.5
Utilization per 1,000 user months	111.2	222.2
Utilization per 1,000 eligible months	15.4	5.3
Skilled nursing facility		
% with use	5.1	6.4
Utilization per 1,000 user months	172.2	247.5
Utilization per 1,000 eligible months	57.9	66.8
Hospice		
% with use	2.3	0.5
Utilization per 1,000 user months	419.3	666.7
Utilization per 1,000 eligible months	23.1	5.3
Non-institutional setting		
Primary care E&M visits		
% with use	72.4	55.9
Utilization per 1,000 user months	2,234.4	2,485.1
Utilization per 1,000 eligible months	2,098.2	2,232.6
Behavioral health visits (does not include new behavioral health benefits)		
% with use	21.0	8.6
Utilization per 1,000 user months	951.3	354.6
Utilization per 1,000 eligible months	514.3	133.7

(continued)

Table 34 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status among LTSS nursing facility users

Measures by setting	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Outpatient therapy (PT, OT, ST)		
% with use	20.7	5.1
Utilization per 1,000 user months	8,060.0	4,000.0
Utilization per 1,000 eligible months	5,362.7	941.2
Independent therapy (PT, OT, ST)		
% with use	0.3	0.8
Utilization per 1,000 user months	1,753.3	4,700.0
Utilization per 1,000 eligible months	34.3	251.3
Home health episodes		
% with use	1.6	4.0
Utilization per 1,000 user months	150.8	555.6
Utilization per 1,000 eligible months	16.2	80.2
Durable medical equipment		
% with use	20.8	9.9
Utilization per 1,000 user months	—	—
Utilization per 1,000 eligible months	—	—
Other hospital outpatient services		
% with use	37.4	34.2
Utilization per 1,000 user months	—	—
Utilization per 1,000 eligible months	—	—

— Durable medical equipment and other outpatient services are defined as having any of those services during the eligible month.

E&M = evaluation and management; OT = occupational therapy; PT = physical therapy; ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long term care hospital admissions.

[2] Results for the enrolled population should be viewed with caution given the sample size is greater than 30 but less than 60.

NOTE: Utilization for inpatient admissions, inpatient psychiatric admissions, inpatient substance abuse, skilled nursing facility, and hospice are defined as number of admissions during the eligible/user month. Utilization for emergency department (non-admit), emergency department (psychiatric), observation stays, specialist E&M visits, primary care E&M visits, behavioral health visits, home health, and outpatient and independent therapy are defined as the number of visits during the eligible/user month. Durable medical equipment and other outpatient services are defines as having any of those services during the eligible month.

8.5.6 Measures on the Long-Stay Nursing Facility Population from Analysis of the Minimum Data Set Data

Although the previous table of results was derived from Medicare claims and encounter data, the results presented in this subsection on LTSS use are derived from the CMS Minimum

Data Set 3.0 containing information on only the nursing facility population. These analyses provide information on the annual nursing facility utilization of demonstration-eligible beneficiaries, including the rate of new long-stay nursing facility admissions, and the percentage of demonstration-eligible beneficiaries who are long-stay users. RTI defines long-stay users as those who have stayed in a nursing facility for at least 101 days. Because of the eligibility criteria for the Massachusetts demonstration, which excludes beneficiaries older than age 65 at the time of enrollment, a very small percentage of One Care long-term nursing facility users are enrolled in the demonstration (<30). Thus, no results are shown by enrollment status.

The admission rate defines the population of *new* long-stay nursing facility residents at admission, for whom health characteristics are presented in ***Table 35***. Then the overall population of *all* (new and existing) long-stay nursing facility users is examined, along with their health characteristics and certain quality measures related to nursing facility services in ***Table 36***.

The analyses of annual nursing facility utilization and characteristics of newly admitted—and separately, new and existing—long-stay residents are indirect measures of access to care in the community based on two hypotheses. First, fewer people will need nursing facility care if they are receiving adequate medical care and HCBS. Thus, the admission rate for newly admitted long-stay residents and the percentage of all long-stay users in the demonstration population are generally expected to eventually decrease. Second, those who do require care should have higher levels of impairment and care needs if access to medical care and HCBS are adequate, because those with lower impairment and care needs are more likely to have those needs met through HCBS. Therefore, health characteristics of newly admitted long-stay residents, and separately, all long-stay residents, would be expected to worsen over time. We are also evaluating selected measures of nursing facility quality to identify whether there are any changes in nursing facility quality as a result of the demonstration.

Table 35 presents results on the admission rate and characteristics of new long-stay residents at admission. Successful rebalancing is expected to eventually shift utilization more toward HCBS, reducing new nursing facility admissions, and increasing the level of impairment and care need for these admissions.

- There was not a consistent pattern in the long-stay nursing facility admission rate in the Massachusetts demonstration group, which ranged from 3.3 to 2.6 admissions per 1,000 eligible beneficiaries during the baseline period to 2.9 admissions during the demonstration period. The comparison group remained constant (3.5 to 3.7 admissions per 1,000 eligible beneficiaries).

- In the demonstration group, the percentage of admitted beneficiaries with a low level of care need increased slightly from 2.7 percent during the baseline period to 3.1 percent during the demonstration period. There was also an increase in the comparison group, from 1.9 to 3.3 percent.

- There was not a consistent pattern over time in other characteristics of new long-stay residents at admission in the demonstration group. In the comparison group, there was a decrease in the percentage of admitted beneficiaries with severe cognitive impairment (25.8 to 19.8 percent), but no other changes.

Table 35
Annual nursing facility utilization and characteristics at admission, Massachusetts demonstration and comparison groups

Measures of long-stay residents at admission	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 1 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Annual nursing facility utilization						
Weighted number of beneficiaries	73,478	95,336	56,205	91,941	50,209	88,310
New long-stay nursing facility admissions per 1,000 eligibles[1]	3.3	3.6	2.6	3.5	2.9	3.7
Characteristics of new long-stay nursing facility residents at admission						
Weighted number of admitted beneficiaries	243	343	148	323	143	331
Functional status (RUG-IV ADL scale)[2]	6.4	8.1	7.3	7.5	6.9	7.6
Percent with severe cognitive impairment[3]	15.9	25.8	14.8	27.5	15.7	19.8
Percent with SPMI[4]	36.6	32.6	26.0	32.9	31.1	29.3
Percent with low level of care need[5]	2.7	1.9	3.0	2.2	3.1	3.3

ADL = activity of daily living; RUG = Resource Utilization Group; SPMI = severe and persistent mental illness.

[1] Eligibles refers to beneficiaries who were demonstration eligible for the corresponding time period. The denominator for the admission rate measure also excludes those who were already residing in a nursing facility at the start of the time period.

[2] Lower numbers indicate higher functional status.

[3] Severe cognitive impairment was defined by a low score on the Brief Interview for Mental Status, poor short-term memory, or severely impaired decision-making skills.

[4] SPMI was defined as having an active diagnosis of schizophrenia or bipolar disorder, determined by the Minimum Data Set 3.0.

[5] Low level of care need was defined as users in the reduced physical function RUG who required no assistance with late-loss ADLs (bed mobility, transfer, toilet use, eating).

Table 36 presents results on long-stay nursing facility users, their characteristics, and several measures usually considered as reflecting quality of care. Although the prior table was based on new long-stay residents at admission, the following table is based on both new and existing long-stay residents. Although the annual nursing facility utilization measures draw from a similar sample of demonstration-eligible residents, the characteristics and quality measures refer to only those residents who were either newly admitted or part of the overall long-stay population for a given time period. Thus, the weighted number of long-stay beneficiaries/eligible beneficiaries is much larger than the weighted number of admitted beneficiaries/eligible beneficiaries.

- The percentage of long-stay users in the Massachusetts demonstration group decreased from 2.2 percent during the baseline period to 1.3 percent during the demonstration period. The comparison group declined more modestly, from 5.0 to 4.5 percent.

- There was a slight decrease in the percentage of long-stay residents with low level of care need in the demonstration group, from 10.9 to 9.0 percent. There was a similar drop in the comparison group. Other characteristics of long-stay residents remained stable.

- The percentage of long-stay residents in the demonstration group who received an antipsychotic medication decreased from 39.9 percent during the baseline period to 28.8 percent during the demonstration period, with a similar drop in the comparison group. There were no other notable changes in the quality measures.

Table 36
Annual utilization, characteristics, and quality measures of long-stay nursing facility residents, demonstration and comparison groups

Measures of long-stay residents	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 1 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Annual nursing facility utilization						
Weighted number of beneficiaries	74,849	100,007	57,295	96,342	50,744	92,205
Long-stay nursing facility users as % of eligibles[1]	2.2	5.0	2.2	4.9	1.3	4.5
Characteristics of long-stay nursing facility residents						
Weighted number of long-stay beneficiaries	1,623	5,000	1,250	4,717	667	4,191
Functional status (RUG-IV ADL scale)	7.0	8.5	7.1	8.5	7.2	8.6
Percent with severe cognitive impairment[2]	29.8	32.0	30.9	32.2	28.1	31.3
Percent with SPMI[3]	35.8	23.9	37.4	24.5	37.3	23.1
Percent with low level of care need[4]	10.9	7.7	10.3	7.6	9.0	7.0
Quality measures for long-stay nursing facility residents						
Weighted quality measure denominator	1,623	5,000	1,250	4,717	666	4,190
Percent of long-stay residents who were physically restrained	3.0	3.0	2.8	2.2	2.7	2.2
Weighted quality measure denominator	1,211	4,182	898	3,946	491	3,575
Percent of long-stay residents who received an antipsychotic medication	39.8	35.3	37.0	31.0	28.8	31.2
Weighted quality measure denominator	990	3,726	801	3,558	437	3,232
Percent of long-stay high-risk residents with pressure ulcers	15.5	15.4	14.4	14.2	15.6	15.2
Percent of long-stay residents who self-report moderate to severe pain	—	—	—	—	—	—
Percent of long-stay residents experiencing one or more falls with major injury	—	—	—	—	—	—

— Not included in this year's annual report, but planned for future analyses.

ADL = activity of daily living; RUG = Resource Utilization Group; SPMI = severe and persistent mental illness.

[1] Eligibles refers to beneficiaries who were demonstration-eligible for the corresponding time period.

[2] Severe cognitive impairment was defined by a low score on the Brief Interview for Mental Status, poor short-term memory, or severely impaired decision-making skills.

[3] SPMI was defined as having an active diagnosis of schizophrenia or bipolar disorder, determined by the Minimum Data Set 3.0.

[4] Low level of care need was defined as users in the reduced physical function RUG who required no assistance with late-loss ADLs (bed mobility, transfer, toilet use, eating).

8.6 Population with Behavioral Health Care Needs

Highlights

- About 52 percent of all One Care enrollees had an SPMI (7,938 of 15,131).
- The demonstration group experienced a slight increase in ED psychiatric visits.
- Both the demonstration and comparison groups had increases in primary care visits.
- Although the percentage of those in the demonstration group with use of any Medicare home health care services was similar to the comparison group, Medicare home health visits for those in the demonstration group increased by about 50 percent between the baseline and demonstration periods, and they had more than double the number of Medicare home health visits as the comparison group in the demonstration period. This finding may be due to One Care demonstration care coordination activities identifying unmet need for Medicare home health services.
- One Care enrollees had slightly lower inpatient use, lower ED use, and much higher Medicare home health service use when compared with Massachusetts demonstration-eligible beneficiaries. Again, this latter finding may be because MMPs were contracting directly with Medicare home health agencies to perform assessments and care management activities.
- The demonstration and comparison groups experienced slight declines in acute, psychiatric, and non-psychiatric inpatient admissions, as well as in ED use that did not lead to inpatient admissions.
- Given that the analyses on the population with SPMI use only Medicare data, they do not provide information on any of the new One Care behavioral health service benefits, which were likely contained in Medicaid encounter data that will be included in future reports. Medicare behavioral health use was somewhat lower in the demonstration group during the first demonstration period, perhaps because any new diversionary benefit use is contained in Medicaid encounters.

Integrating or coordinating care for people with behavioral health disorders is a major objective of the demonstrations under the Financial Alignment Initiative. This chapter includes information about the prevalence of behavioral health disorders among Medicare-Medicaid beneficiaries nationwide and in Massachusetts. Findings from the evaluation are also reported, including information about demonstration activities to coordinate care across the medical and behavioral health systems, the characteristics of the demonstration eligible population with SPMI, the experience of people with SPMI with care coordination services provided by the demonstration, and the medical and behavioral health service utilization and quality for the subset of demonstration eligibles with SPMI in Massachusetts. In the quantitative analyses reported in tables below, the subpopulation with SPMI are those with any behavioral health service use for an SPMI as identified in Medicare claims data in the last 2 years.

8.6.1 Background

Behavioral health disorders (e.g., serious mental illnesses and/or substance use disorders) are highly prevalent among Medicare-Medicaid enrollees. An estimated 9 million of these beneficiaries live in the United States today, a group composed of low-income seniors and under-65 adults with disabilities, many of whom have complex physical and mental health disorders (Congressional Budget Office, 2013). It has been widely documented that Medicare-Medicaid enrollees generate greater health care costs than those with Medicare only, and research has documented that Medicare-Medicaid enrollees with behavioral health disorders have greater health care expenditures than Medicare-Medicaid enrollees without such disorders (Kasper et al., 2010; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Despite the obvious need to provide behavioral health care to Medicare-Medicaid enrollees, the demand for these services remains unmet in various parts of the country, especially in States with large portions of populations in rural areas (SAMHSA, 2012).

In 2014, behavioral health treatment expenditures totaled $220 billion. In terms of all national health care spending, mental health treatment expenditures accounted for 6.4 percent and substance use disorder treatment expenditures accounted for 1.2 percent. From 2009–2014, nationwide spending growth for mental health (5.1 percent) and substance use disorder treatment (6.2 percent) outpaced all health spending growth (4.3 percent) (Mark et al., 2015).

Medicare-Medicaid enrollees often have co-occurring physical and behavioral health illnesses, and their needs are often greater than Medicare-Medicaid enrollees with only physical conditions. In 2003, almost 40 percent of Medicare-Medicaid enrollees had both a physical and mental illness, compared to only 17 percent of all other Medicare beneficiaries (Kasper et al, 2010). Of these beneficiaries, Medicare-Medicaid enrollees with co-occurring conditions were found to utilize a greater amount of inpatient hospital, nursing facility, and community-based long term care services than those with only a physical condition (Kasper et al., 2010). A greater prevalence of co-occurring physical and behavioral conditions has also been documented in older Medicare-Medicaid enrollees (aged 65 and older) than those aged 18–64 (Congressional Budget Office, 2013; Kasper et al., 2010). Given their greater use of services, Medicare-Medicaid enrollees with co-occurring conditions have been found to generate greater health care costs than Medicare-Medicaid enrollees without co-occurring conditions (Congressional Budget Office, 2013; Kasper et al., 2010; SAMHSA, 2014).

8.6.2 Demonstration Design Intended to Improve Care for People with Behavioral Health Needs

One Care is the only demonstration under the Financial Alignment Initiative that limits its eligibility to younger adults under the age of 65. Before the One Care demonstration, Medicare-Medicaid beneficiaries under age 65 had remained ineligible to enroll in Medicaid managed care. This group of beneficiaries included those with the most complex conditions, highest costs, and the greatest need for care coordination and care management. This group encompassed a high proportion of people with behavioral health needs who did not have access to the diversionary behavioral health services available to the MassHealth-only members with similar needs. The model of care and service delivery system of the One Care demonstration has been designed with this population in mind and has an emphasis on integrating services within the medical, behavioral health, long term service and supports system. This model has been more

fully described other sections of this report, including ***Section 1*** (Overview), but in particular, One Care includes new benefits for diversionary behavioral health services that generally were not available to the One Care population.

8.6.3 Demonstration Experience

As of January 1, 2015, approximately 29 percent (5,111 of 17,867) of all One Care enrollees were in one of the two C2 risk rating categories for having high behavioral health care needs (MassHealth Enrollment Report, January 2015).

8.6.4 SPMI Population Characteristics

Table 37 provides information on demographic characteristics, HCC score, and disability status of beneficiaries with an SPMI diagnosis. Among those with SPMI, One Care enrollees, compared to the larger Massachusetts eligible group, were younger (39 vs. 36 percent were ages 21 to 44), and were less frequently white (64 to 70 percent), compared with 74 percent of the comparison group. Otherwise, the groups were not much different on other characteristics. About 74 percent of the comparison group were white. Remarkably though, about 52 percent of all One Care enrollees had an SPMI (7,938 of 15,131).

Table 37
Descriptive statistics for Massachusetts demonstration eligible, enrolled, and the comparison groups, diagnosed with SPMI

	Demonstration period 10/1/2013–12/31/2014		
Characteristic	**Eligible**	**Enrolled**	**Comparison**
Total beneficiaries	29,561	7,938	59,467
Age			
21 to 44	36.2	39.1	34.2
45 and older	63.8	60.9	65.8
Gender			
Male	47.7	47.5	49.5
Female	52.3	52.5	50.5
Race			
White	69.9	64.4	74.2
African American	12.9	15.4	21.5
Hispanic	11.3	14.2	2.2
Asian/PI	1.5	1.4	0.8
Hierarchical condition category			
<1	54.6	53.2	54.8
1<2	36.6	38.7	34.4
2<4	7.0	6.6	8.7
4+	1.8	1.6	2.1
Disability as reason for original Medicare eligibility			
No	5.1	3.2	5.1
Yes	94.9	96.8	94.9

SOURCE: RTI Analysis of Medicare Encounters and Claims.

8.6.5 Health Care Utilization of SPMI Beneficiaries

Table 38 presents results on those diagnosed with an SPMI during the baseline and demonstration periods. This data includes the proportion of beneficiaries using different Medicare services during the baseline and first demonstration periods. In addition, utilization information is presented overall and for users of the services. Results are shown for both Massachusetts (baseline and demonstration period) and for the comparison group (baseline and demonstration period). Key findings from the SPMI demonstration eligible population are summarized below:

- There was small decline in the proportion of beneficiaries with an inpatient admission in the demonstration group from the baseline to the demonstration period (4.9 to 4.0 percent). This decline corresponded with a decline in utilization per 1,000 eligible months (59.3 to 47.3 admissions). A decline in proportion and utilization was seen for both psychiatric and non-psychiatric admissions. A similar pattern was seen in the comparison group.

- There were slight declines in the proportion of beneficiaries with an ED visit for both the demonstration and comparison groups over the baseline and the demonstration period (10.1 to 9.4 percent, and 9.5 to 9.3 percent, respectively). This decline corresponded with a decline in use from 278.3 visits per 1,000 user months to 242.5 visits. A similar decline was observed in the comparison group. There was, however, no noticeable trend in psychiatric related visits.

- In both Massachusetts and the comparison group, there was a sharp uptick in the proportion of beneficiaries with primary care visits (45.2 to 57 percent, and 47.2 to 58.3 percent, respectively). Primary care visits per 1,000 eligible months also increased from the baseline to the demonstration period (791.5 to 1,081 visits). This increase in utilization was also seen in the comparison group.

- The proportion of beneficiaries with any home health use remained stable from the baseline to the demonstration period. However, there was a sharp increase in home health visits for the demonstration group using home health services during the demonstration periods (176.4 to 301.7 per 1,000 user months). In contrast, the comparison group experienced a decline in use for any users of the home health services (176.4 to 134.9 visits).

Table 38
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration and comparison groups, beneficiaries with SPMI

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Number of beneficiaries	42,259	57,164	31,823	55,312	29,545	53,616
Institutional setting						
Inpatient admissions[1]						
% with use	4.9	5.0	4.6	4.9	4.0	4.5
Utilization per 1,000 user months	206.8	203.1	202.8	200.5	176.5	171.7
Utilization per 1,000 eligible months	59.3	59.3	54.8	57.5	47.3	52.2
Inpatient psychiatric						
% with use	1.6	1.7	1.6	1.7	1.4	1.5
Utilization per 1,000 user months	163.6	167.4	165.0	165.7	144.4	144.3
Utilization per 1,000 eligible months	17.9	18.5	17.5	18.5	15.4	16.8
Inpatient non-psychiatric						
% with use	3.5	3.5	3.2	3.4	2.8	3.1
Utilization per 1,000 user months	190.2	185.9	184.0	183.1	158.4	154.8
Utilization per 1,000 eligible months	41.4	40.7	37.2	39.0	32.0	35.5
Emergency department use (non-admit)						
% with use	10.1	9.5	9.9	9.3	9.4	9.3
Utilization per 1,000 user months	278.3	283.7	270.9	275.1	242.5	250.3
Utilization per 1,000 eligible months	141.0	134.3	135.3	129.9	130.8	129.7
Emergency department use (psychiatric)						
% with use	1.6	1.2	1.7	1.2	1.7	1.1
Utilization per 1,000 user months	190.1	170.9	200.4	170.2	180.9	148.7
Utilization per 1,000 eligible months	20.7	15.0	22.5	14.9	22.9	14.3

(continued)

Table 38 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration and comparison groups, beneficiaries with SPMI

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Observation stays						
% with use	0.9	0.8	0.9	0.8	0.9	0.9
Utilization per 1,000 user months	125.6	122.0	122.0	120.7	103.0	102.2
Utilization per 1,000 eligible months	9.9	8.6	10.0	9.0	9.4	9.6
Skilled nursing facility						
% with use	0.5	0.7	0.5	0.7	0.4	0.7
Utilization per 1,000 user months	145.6	158.5	150.9	157.9	126.1	133.7
Utilization per 1,000 eligible months	5.4	7.2	5.3	8.1	3.9	7.3
Hospice						
% with use	0.2	0.2	0.1	0.2	0.1	0.2
Utilization per 1,000 user months	410.0	379.5	403.0	409.6	330.0	331.6
Utilization per 1,000 eligible months	1.7	2.0	1.5	2.4	0.9	2.1
Non-institutional setting						
Primary care E&M visits						
% with use	45.2	47.2	55.4	56.3	57.0	58.3
Utilization per 1,000 user months	875.8	930.6	1,074.7	1,118.8	1,128.3	1,151.7
Utilization per 1,000 eligible months	791.5	836.9	1,017.7	1,059.2	1,081.0	1,095.8
Behavioral health visits (does not include new behavioral health benefits)						
% with use	38.6	35.9	24.0	23.7	16.8	19.6
Utilization per 1,000 user months	1,046.6	1,036.1	773.3	797.8	805.5	880.5
Utilization per 1,000 eligible months	777.4	733.4	511.7	514.9	375.4	426.8

(continued)

Table 38 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration and comparison groups, beneficiaries with SPMI

Measures by setting	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Outpatient therapy (PT, OT, ST)						
% with use	2.8	3.0	2.6	3.0	2.2	3.1
Utilization per 1,000 user months	2,415.9	3,478.5	2,285.7	3,586.2	1,964.1	3,780.4
Utilization per 1,000 eligible months	308.8	442.1	281.0	454.7	244.3	561.5
Independent therapy (PT, OT, ST)						
% with use	1.3	1.4	1.2	1.3	1.2	1.4
Utilization per 1,000 user months	2,018.6	2,553.5	2,141.9	2,632.2	2,180.5	2,657.0
Utilization per 1,000 eligible months	121.7	152.5	115.9	150.8	136.5	184.2
Home health episodes						
% with use	1.4	1.1	1.3	1.1	1.4	1.1
Utilization per 1,000 user months	176.4	153.6	176.5	155.4	301.7	134.9
Utilization per 1,000 eligible months	14.6	10.9	12.9	11.2	23.2	11.4
Durable medical equipment						
% with use	11.5	12.8	10.8	12.2	9.9	11.2
Utilization per 1,000 user months	—	—	—	—	—	—
Utilization per 1,000 eligible months	—	—	—	—	—	—
Other hospital outpatient services						
% with use	42.0	25.6	40.9	25.1	38.3	25.3
Utilization per 1,000 user months	—	—	—	—	—	—
Utilization per 1,000 eligible months	—	—	—	—	—	—

— data not available.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

NOTE: Utilization for inpatient admissions, inpatient psychiatric admissions, inpatient substance abuse, skilled nursing facility, and hospice are defined as number of admissions during the eligible/user month. Utilization for emergency department (non-admit), emergency department (psychiatric), observation stays, specialist E&M visits, primary care E&M visits, behavioral health visits, home health, and outpatient and independent therapy are defined as the number of visits during the eligible/user month. Durable medical equipment and other outpatient services are defines as having any of those services during the eligible month.

SOURCE: RTI Analysis of Medicare Encounters and Claims.

Table 39 presents results on the average percentage of beneficiaries using selected Medicare services among those with SPMI by enrollment status. In addition, average counts of service use are presented across all eligible-months and for the subset of these months in which beneficiaries were users of each respective service type. Key findings for those with SPMI by enrollment status include the following:

- Of enrolled beneficiaries, 2.2 percent had any inpatient admission, compared to 4.3 percent of those who were nonenrolled. Those who enrolled and had any inpatient stay had more frequent hospital admissions during the demonstration year than their nonenrolled counterparts (197.2 visits per 1,000 user months vs. 180.3 visits).

- The percentage of enrolled beneficiaries with any ED use was similar to those who were nonenrolled. However, those who were enrolled and had any ED use had more frequent visits per 1,000 user months, relative to the nonenrolled (285.6 to 238.5 visits).

- For those not enrolled in the demonstration, there was a higher percentage of users with a primary care E&M visit, compared to those who enrolled (59.0 to 47.8 percent). Among those with any use, those who were not enrolled had a higher rate of primary care visits per 1,000 user months, relative to those who enrolled (1,169.9 vs. 1,024.2 visits).

Table 39
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status among those with SPMI

	Demonstration period 10/1/2013–12/31/2014	
Measures by setting	**Nonenrolled**	**Enrolled**
Number of beneficiaries	21,671	7,935
Institutional setting		
Inpatient admissions[1]		
% with use	4.3	2.2
Utilization per 1,000 user months	180.3	197.2
Utilization per 1,000 eligible months	50.8	25.6
Inpatient psychiatric		
% with use	1.6	0.6
Utilization per 1,000 user months	148.2	152.6
Utilization per 1,000 eligible months	17.0	6.3
Inpatient non-psychiatric		
% with use	2.9	1.7
Utilization per 1,000 user months	160.5	189.9
Utilization per 1,000 eligible months	33.8	19.3

(continued)

Table 39 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status among those with SPMI

Measures by setting	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Emergency department use (non-admit)		
% With use	9.2	8.4
Utilization per 1,000 user months	238.5	285.6
Utilization per 1,000 eligible months	126.9	118.1
Emergency department use (psychiatric)		
% with use	1.6	1.7
Utilization per 1,000 user months	173.6	256.0
Utilization per 1,000 eligible months	21.5	24.0
Observation stays		
% with use	0.9	0.5
Utilization per 1,000 user months	102.5	131.8
Utilization per 1,000 eligible months	9.7	5.8
Skilled nursing facility		
% with use	0.4	0.2
Utilization per 1,000 user months	133.8	135.3
Utilization per 1,000 eligible months	4.6	1.9
Hospice		
% with use	0.1	0.0
Utilization per 1,000 user months	332.4	354.8
Utilization per 1,000 eligible months	1.1	0.3
Non-institutional setting		
Primary care E&M visits		
% with use	59.0	47.8
Utilization per 1,000 user months	1,169.9	1,024.2
Utilization per 1,000 eligible months	1,114.0	929.5
Behavioral health visits		
% with use	19.7	5.3
Utilization per 1,000 user months	935.1	301.2
Utilization per 1,000 eligible months	448.5	85.9
Outpatient therapy (PT, OT, ST)		
% with use	2.5	1.4
Utilization per 1,000 user months	2,305.0	1,014.1
Utilization per 1,000 eligible months	301.7	72.5

(continued)

Table 39 (continued)
Proportion and utilization for institutional and non-institutional services for the Massachusetts demonstration group, by enrollment status among those with SPMI

Measures by setting	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
Independent therapy (PT, OT, ST)		
% with use	1.2	0.8
Utilization per 1,000 user months	2,404.7	2,184.5
Utilization per 1,000 eligible months	147.8	85.1
Home health episodes		
% with use	0.8	4.2
Utilization per 1,000 user months	131.7	1,102.5
Utilization per 1,000 eligible months	8.4	97.7
Durable medical equipment		
% with use	10.4	7.6
Utilization per 1,000 user months	—	—
Utilization per 1,000 eligible months	—	—
Other hospital outpatient services		
% with use	39.7	27.8
Utilization per 1,000 user months	—	—
Utilization per 1,000 eligible months	—	—

— Durable medical equipment and other outpatient services are defined as having any of those services during the eligible month.

E&M = evaluation and management; OT = occupational therapy; PT = physical therapy; ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

NOTE: Utilization for inpatient admissions, inpatient psychiatric admissions, inpatient substance abuse, skilled nursing facility, and hospice are defined as number of admissions during the eligible/user month. Utilization for emergency department (non-admit), emergency department (psychiatric), observation stays, specialist E&M visits, primary care E&M visits, behavioral health visits, home health, and outpatient and independent therapy are defined as the number of visits during the eligible/user month. Durable medical equipment and other outpatient services are defines as having any of those services during the eligible month.

8.7 Utilization for Selected Demographic and Health Conditions Groups

This section presents results on Medicare service utilization from subgroup analyses on age, gender, race, disability, Alzheimer's and other dementias, HCC score, and death. ***Tables A.1-1*** to ***A.1-7*** in ***Appendix 1*** provide the detailed results from which this narrative text was derived on the utilization and percentage of beneficiaries using various inpatient and outpatient services for each of these subgroups in both Massachusetts and the comparison group over the baseline and demonstration periods. These subgroups are analyzed in each State demonstration, and the significance of these analyses may vary depending on the State and demonstration design. Within each subgroup analyzed in this section, the text reflects potential differences identified. Text was not provided if no differences were observed for a particular service type.

8.7.1 Age Groups

Although the demonstration is limited to enrolling those between 21 and 64 years of age, age has been categorized as 21 to 44, and 45 and older, because a beneficiary can potentially be older than 64 if they were 64 at any point during the baseline period. Key findings for the demonstration eligible population by age categories are summarized below.

- The percentage of those in the demonstration group who were 45 years and older who had an inpatient admission declined from the baseline to the demonstration period (3.6 to 2.7 percent). A similar decline was observed among those between the ages 21 and 44, and among those in both age categories in the comparison group.

- In both the demonstration and the comparison group, those who were between 21 and 44 years old had slightly higher rates of psychiatric related inpatient admissions. For example, in the demonstration period, among those with any psychiatric inpatient stays, those ages 21 to 44 years old had 152.8 visits per 1,000 user months, whereas those 45 years and older had 136.2 visits. A similar trend was observed in the comparison population.

- Among those eligible in Massachusetts, between the ages 21 and 44, ED visits were consistently greater than those 45 years and older over the baseline and demonstration periods (i.e., 8.7 to 6.7 percent in the demonstration period). A similar trend was observed in the comparison group. Utilization among those between the ages 21 and 44 who had any ED visit declined from the baseline to the demonstration period (266.7 to 231.6 visits per 1,000 user months). This trend was observed in the comparison group.

- The percentage of demonstration eligible beneficiaries with a primary care visit increased in both age categories across the baseline and the demonstration periods (33.3 to 41.5 percent among those between the ages 21 and 44, and 46.6 to 51.4 percent among those 45 years and older). Utilization among those with any use also increased from the baseline to the demonstration period. For example, among ages 21 to 44, visits per 1,000 user months increased from 641.4 to 833.6 from the baseline to the demonstration period.

8.7.2 Gender

- Among males in the demonstration group, the percent having an inpatient admission declined slightly from 3.5 to 2.9 percent from the baseline to the demonstration period. A similar decline was observed among females. Males consistently had a higher rate of use than their female counterparts. The difference in the rate per 1,000 user months expanded from 21.4 to 26.4 visits from the baseline to the demonstration period. In the comparison group, while women generally had a higher percent of use relative to their male counterparts, males had higher utilization among those with any use (165.7 visits per 1,000 user months vs. 153.8 visits among women during the demonstration period).

- A similar trend was observed for psychiatric-related inpatient admissions. For example, while the rate of use among males with any psychiatric-related admission declined from 167.4 visits per 1,000 user months to 148.4 visits, men consistently had a higher rate of use than their women counterparts. This trend was observed in the comparison group as well.

- The percentage of women in Massachusetts with an ED visit was 1 to 1.2 percentage points higher than their male counterparts across the baseline and demonstration years. Despite a higher percentage of use, males who had any ED visit had a similar rate of use, and by the demonstration period had a higher rate (215.6 visits per 1,000 user months vs. 202.3). A similar pattern was observed in the comparison group, suggesting that males in both Massachusetts and the comparison group have more intensive ED use than their female counterparts.

- Across the baseline and demonstration periods, the percentage of women in the demonstration group with a primary care visit was approximately 10 percentage points higher than their male counterparts. For both women and men, visits per 1,000 eligible months increased during that time. For example, among men the rate increased from 611.2 to 754.9 visits, and 801.9 to 982.0 visits among women. This trend was observed in the comparison group.

8.7.3 Race

"Race" was categorized as White, African American, Hispanic, and Asian/Pacific Islander.

- The percentage of beneficiaries in the demonstration group with an inpatient admission declined for all racial groups from the baseline to the demonstration period. However, African American beneficiaries maintained a slightly higher rate of admissions relative to Whites, Hispanics, and Asians during the baseline and demonstration period. During the demonstration period, for example, African Americans had 36.2 visits per 1,000 eligible months, Whites had 34.9, Hispanics 20.0, and Asians 16.7 visits. The same general trend was observed in the comparison group.

- A similar trend in utilization was observed for ED use: the percentage of beneficiaries in the demonstration group with an ED visit declined by at least 0.3 percentages points from the baseline to the demonstration period. African Americans had higher rates of utilization of the baseline to the demonstration period, relative to other racial groups. For example, during the demonstration period, African Americans had 108.5 visits per 1,000 eligible months, Whites had 96.8, Hispanics 99.0, and Asians 38.5 visits. The same general trend was observed in the comparison group.

- The percentage of demonstration group beneficiaries with a primary care visit increased from the baseline to the demonstration period for all racial groups. However, the increase was greatest for those who were White (43.1 to 50.2 percent) and Asian (36.0 to 44.2 percent). White beneficiaries who had any primary care visit

consistently had a higher rate of use per 1,000 user months (1,011.9 to 848.2 visits for Whites and other racial groups, respectively, during the demonstration period).

- The percentage of demonstration group beneficiaries with any outpatient therapy was higher among Whites compared to other racial groups over the baseline and the demonstration period (2.5 to 2.2 percent, compared to the next highest 2.0 to 2.2 percent among African Americans). The higher percentage of use among Whites corresponded with more intensive utilization of services for those with any outpatient therapy; Whites had 7 to 20 percent more visits per 1,000 user months, relative to the next highest user in the baseline and the demonstration periods. There was not a notable or similar trend in the comparison group.

8.7.4 Disability Status

Beneficiaries were defined as having a disability if it was indicated as the original reason for entitlement to Medicare benefits.

- Among those in the demonstration group, there was small decline in the percentage of beneficiaries with a disability who had any inpatient stay from the baseline to the demonstration period (3.4 to 2.7 percent). This decline corresponding with close to a 25 percent relative decline in utilization per 1,000 eligible months. A similar trend was observed in the comparison group.

- There was a similar decline in the percentage of demonstration group beneficiaries with an ED visit from the baseline to the demonstration period (8.2 to 7.5 percent). This amounted to a 14 percent relative decline in utilization for those with any ED visit. This trend was observed in the comparison group.

- Among those in the demonstration group, there was an increase in the percent of beneficiaries with any primary care visits from the baseline to the demonstration period (41.1 to 48.0 percent). Among those with any primary care use, utilization also increased over the baseline and demonstration period (784.2 to 952.8 visits per 1,000 user months). A similar increase in primary care utilization was seen in the comparison group.

8.7.5 Alzheimer's and Other Dementias Diagnosis

Alzheimer's and other dementias were defined using diagnosis codes from inpatient and outpatient claims data.

- There was no obvious trend in inpatient admissions over the baseline and demonstration periods. However, the percentage of those with Alzheimer's who had an inpatient use was consistently 1.6 to 1.9 percentage points higher than those with other dementias over the baseline and demonstration periods. Despite no overall change in the percentage with inpatient admissions, those with Alzheimer's had declining rates of any inpatient admissions per 1,000 user months (215.5 to 192.4 visits). There was not an apparent trend in the comparison group.

- There was a small increase in the percent of beneficiaries with an ED visit among those with Alzheimer's in the demonstration group (7.8 to 8.3 percent from the baseline to the demonstration period). Despite an increase in the percent of users, there was a decline in utilization among those with any ED use from the baseline period 2 to the demonstration period (240.7 to 228.0 visits per 1,000 user month). This decline perhaps indicates less intensity of ED use among those in the demonstration with Alzheimer's, despite more beneficiaries utilizing the ED.

8.7.6 Hierarchical Condition Category

Beneficiaries were categorized into four groups: those with HCC scores less than 1, 1 < 2, 2 < 4, and 4 or greater.

- The percentage of demonstration group beneficiaries with an HCC score of 4 or higher with an inpatient admission declined from the baseline to the demonstration period (20.3 to 13.6 percent). As expected, utilization among those with any inpatient stay was greater among those with an HCC score of 4 or more, compared to those with a lower score, in each baseline and demonstration period. A similar trend was observed for the comparison group.

- In the demonstration group, psychiatric-related inpatient stays were greater for those with HCC scores between 2 and 4, compared to those with a score of 4 or more across the baseline and the demonstration periods (174.6 to 170.5 visits per 1,000 user months in the demonstration period). This trend was not observed in the comparison group, where those with HCC scores from 2 to 4 had a similar percentage of use in the demonstration period (1.1 percent).

- There was not a notable trend in ED use from the baseline to the demonstration period; however, as expected, the number of visits among those with HCC scores 4 or more was at least 42 visits per 1,000 user months greater than those in other HCC categories, across the baseline and the demonstration period. In the comparison group, there was small decline in the percent of beneficiaries with an ED visit among those in the highest HCC category.

- In the demonstration group, the percentage of beneficiaries with a primary care visit declined among those with HCC scores 4 or more, from the baseline to the demonstration period (71.3 to 67.8 percent). A similar decline was not observed in the comparison group. As expected, those with higher HCC scores had a greater rate of primary care use across the baseline and the demonstration periods, compared to those with lower HCC scores. For example, the demonstration period, those with HCC scores of 4 or more had 1,719.3 visits per 1,000 eligible months, HCC scores between 2 and 4 had 1,442.0 visits, those with HCC scores between 1 and 2 had 1,059.0 visits, and those with HCC scores less than 1 had 696.0 visits.

8.7.7 Death

Those who died were categorized as having died during the year of observation.

- Among beneficiaries who died in the demonstration group, the percentage who had any inpatient admission dropped from 21.0 to 16.8 percent from the baseline to the demonstration period. This decline corresponded with a decline in utilization for those with any admissions (374.3 to 333.9 visits). A similar trend was observed in the comparison group.

- Among beneficiaries who died in the demonstration group, the percentage who had any ED visits remained stable from the baseline to the demonstration period (13.3 to 13.4 percent). There was no pattern of changes in utilization per 1,000 user months. There was no meaningful trend in the comparison group.

- The percentage of beneficiaries with hospice use declined from 8.9 to 6.9 percent among those who died while in the demonstration group. Utilization declined among those with any hospice admissions in the demonstration group (351.0 to 327.4 visits per 1,000 user months). This decline indicates that by the demonstration period, an individual was in hospice for shorter periods. The decrease in the percentage of people with any hospice use in the demonstration group is likely due to the higher presence of beneficiaries in the baseline period with any HCBS use, who were more likely to die than those in the demonstration group in the demonstration period.

8.8 Minimum Data Set Results by Gender, Race, Age, and Rural Status

The following section provides descriptive statistics on nursing facility use stratified by gender, race, age group, and rural status. Subgroup definitions are consistent with those used for the Medicare service utilization results. To address small sample size, cells with fewer than 30 weighted subjects are not presented. Measures with fewer than two special populations of sufficient sample size are also excluded. ***Tables A.2-1*** to ***A.2-4*** in ***Appendix 2*** provide the associated detailed results.

8.8.1 By Age

The age groups were characterized as those aged 21–44 and those aged 45 and older (largely 45–64).

- The admission rate of beneficiaries aged 45 and older was much higher than the admission rate for those aged 21–44. In the demonstration group during the demonstration period, there were 0.5 admissions per 1,000 eligibles among those aged 21–44, and 4.0 admissions for those aged 45 or older. A similar trend was found for the percentage of long-stay users, which also declined from the baseline to demonstration periods, dropping from 0.6 to 0.3 percent among those aged 21–44, and 3.0 to 1.8 percent among those 45 and older. Similar patterns by age, but not time, were exhibited in the comparison group.

- Across all time periods and groups, functional status among long-stay nursing facility residents was slightly worse (higher) in those aged 21–44 than those aged 45 and older. In the Massachusetts demonstration group, the percent with low level of care need decreased slightly from 10.8 during baseline to 9.6 during the demonstration period in the 45 and older group, but dropped markedly in the 21–44 age group, from 12.2 to 2.3. In the comparison group, those aged 45 and older had a consistently higher low level of care relative to those aged 21–44 (approximately 7 to 8 percent vs. 4 to 5 percent).

- Beyond the measures reported above, there were no consistent patterns by age group for quality measures.

8.8.2 By Gender

- While there was no consistent pattern in the admission rate per 1,000 eligibles among males in the Massachusetts demonstration group, which ranged from 3.8 to 2.7 admissions during the baseline and demonstration periods, the admission rate among women decreased from 2.8 to 2.3 admissions. There was no consistent pattern among either males or females in the comparison group, but as in the demonstration group, males had a consistently higher admission rate.

- In the demonstration group, women had worse functional status then men for all time periods. There were no other consistent patterns by gender for the other characteristics at admission for either the demonstration or comparison group.

- The percentage of long-stay users declined from the baseline period to the demonstration period among both men and women in the Massachusetts demonstration group, with men having a consistently higher percentage of long-stay users (from 2.5 to 1.4 percent) than women (from 1.8 to 1.2 percent). A similar trend was found in the comparison group.

- Among both men and women in the demonstration group, the percent with low level of care need decreased from the baseline period to the demonstration period. Men had a higher relative rate of low level of care need, declining from 11.6 to 9.9 percent, while women declined from 10.0 to 7.9 percent. Functional status was also consistently worse for women than men. There was a similar pattern in the comparison group.

- In both the demonstration and comparison groups, men generally had a higher percentage of high-risk residents with pressure ulcers (range of approximately 16 to 18 percent in men vs. 12 to 14 percent in women; both 16 percent in Massachusetts during the demonstration period.)

8.8.3 By Race

Race was categorized as White, African American, Hispanic, and Asian/Pacific Islander. For annual nursing facility utilization measures (admission rate and percentage of long-stay

users), results are presented for all races. For the characteristics and quality measures of long-stay residents, measures of Hispanic and Asian residents are not presented because of their small sample size.

- In the demonstration group, for all time periods, White and African American beneficiaries had a higher admission rate (range of 2.6 to 4.1 admissions per 1,000 eligibles) than Hispanic and Asian beneficiaries (range of 0.0 to 3.5 admissions). This pattern was generally found, but not as consistently, in the comparison group.

- The percentage of long stay users dropped from the baseline to demonstration period for all races in Massachusetts, with a higher relative percent in the White and African American groups (from 2.5 to 1.6 percent and 1.9 to 1.1 percent, respectively) than the Hispanic and Asian groups (from 0.5 to 0.4 percent and 1.6 to 0.6 percent, respectively.

- The percentage of beneficiaries with SPMI was higher among White beneficiaries than African American beneficiaries in the demonstration group, although there was no change over time (range of approximately 37 to 40 percent among White beneficiaries, and 30 to 34 percent among African American beneficiaries). This pattern was also found in the comparison group.

- The percentage of residents who were physically restrained was higher among White beneficiaries than African American beneficiaries in the demonstration group for all time periods (range of 2.8 to 3.0 percent for White beneficiaries, and 0.7 to 1.7 percent for African American beneficiaries). The percent of long-stay residents with antipsychotic use dropped from the baseline to demonstration period, with White beneficiaries also having a slightly higher relative rate (decline from 40.3 to 30.3 percent) than African American beneficiaries (from 39.0 to 22.0 percent). A similar trend was found in the comparison group.

9. Quality of Care

Highlights

- A robust set of core and State-specific measures developed by MassHealth and CMS are the foundation for assessing the quality of services under One Care.
- MassHealth facilitated a strong working relationship with and among the One Care plans to identify barriers to quality and share best practices to improve performance.
- One Care focused on structural measures during the first year of implementation to ensure that the demonstration was operating as intended. Attention will shift in future years to clinical process and outcome measures to improve the quality of beneficiary health and outcomes.
- Early indicators show successes and challenges in managing One Care members' care.
- Although the measure for all eligible individuals for 30-day follow-up after hospitalization for mental illness calculated from Medicare claims showed little change over time, enrollees had much lower follow-up than nonenrollees. This measure is defined as follow-up with an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. The enrollee population potentially had poorer health and/or the One Care demonstration had difficulty managing care for enrollees. Conversely, enrollee needs were potentially met with some of the new behavioral health benefits that would not have been captured in this measure.
- Because Massachusetts enrolled beneficiaries incrementally over time and because Medicare-Medicaid Plans (MMPs) had difficulty identifying and then finding beneficiaries in the community, the One Care demonstration likely did not make substantial progress on care management until near the end of the first demonstration period. These findings are not surprising for a new demonstration. More time is needed for the demonstration to mature.

9.1 Quality Measures

The One Care demonstration requires that One Care plans report standardized quality measures. These measures include the following:

- A set of core measures specific to all capitated Financial Alignment Initiative demonstrations that address domains of access, assessment, care coordination, enrollee protection, organization structure and staffing, performance and quality improvement, provider network, and systems and service utilization (CMS, October 21, 2014).

- A set of state-specific measures that were selected by One Care staff in consultation with CMS. According to One Care officials, the measures selected focused primarily

on long term care services and supports and care coordination (CMS, November 12, 2014).

The demonstration also utilizes quality measures required of Medicare Advantage plans, including applicable measures from the Part C and Part D Reporting Requirements such as appeals and grievances, pharmacy access, payment structures, and medication therapy management.

One Care plans are required to submit three additional measure sets as part of the Medicare Advantage requirement:

- A modified version of Medicare's Consumer Assessment of Healthcare Providers and Systems survey that included 10 supplemental questions proposed by the RTI Evaluation Team to capture beneficiary experience specific to integration, behavioral health and long-term services and supports (LTSS)

- Selected Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures, a standard measurement set used extensively by managed care plans and required of all Medicare Advantage plans

- Selected Health Outcomes Survey measures based on a recurring survey of a random sample of Medicare beneficiaries to assess physical and mental health outcomes (three-way contract, 2013)

Appendix D includes a list of core and state-specific measures. Data related to these measures are reported in relevant sections of this report.

In addition, the RTI Aggregate Evaluation Plan identified a set of quality measures that will be calculated by the RTI Team using encounter and fee for service data. Many of these measures are part of the HEDIS measurement set and are largely clinical in nature (e.g., preventive screens, follow-up care) or related to service use (e.g., avoidable hospitalizations, emergency department use) (Walsh et.al., 2013, pp. 77–85).

According to established intervals set forth in the three-way contract, One Care plans submit measures to a variety of sources depending on the type of measure. One Care staff emphasized their reliance on the data from the core and state-specific measures to assess early trouble spots in implementation, such as completion of assessments within 90 days of enrollment and referral to an Independent Living and Long-Term Services and Supports (LTS) coordinator. To provide more detailed information on measures pertaining to assessments and referrals to LTS coordinators, One Care staff worked with plans and CMS to develop a LTS and Assessment tracking tool (State Data Reporting System [SDRS], 4th and 5th Quarters). With these data, One Care staff were able to determine that the refusal rate for referral to a LTS coordinator was higher than expected. Based on this finding, combined with information obtained from beneficiary focus groups (see ***Section 5, Beneficiary Experience***), One Care staff worked with plans to ensure their understanding of the LTS coordinator's role and also developed educational materials for use by beneficiaries (SDRS, 5th Quarter).

During site visit interviews, all plans spoke of the hefty administrative burden associated with providing data on this large number of measures, some of which were seen as redundant or requiring slightly different formats or time periods. To these plans, time spent on reporting took valuable resources away from focusing on program development. "There's a tremendous amount of reporting… just the build-out of all those reports has been a Herculean effort."

While acknowledging the usefulness of measures in monitoring quality, a One Care plan reported the challenge of collecting some measures and the effort it takes to modify processes when measures change.

> *Some things are not easy to report. We have a centralized enrollee record, not a claims system, so we have measures based off of text fields. It's really, really hard. We definitely struggled a lot with that. We have [centralized electronic records] and they're built more as a practice tool than [to] tell me how many members in June had an assessment.*

The Contract Management Team (CMT) shares results of core and State-specific measures during its biweekly meetings with the plans as a way of reviewing progress and identifying improvement opportunities. Best practice sessions may be developed in areas where the three plans share similar weaknesses or, in the case of a plan-specific issue, the CMT works with the plan to identify improvement strategies (SDRS, 4th Quarter). Additional information on best practice sessions appears in **S*ection 9.2.1, State and CMS Quality Management Structures and Activities***.

Commonwealth officials noted that they are hampered by the lack of established benchmarks for most of the measures, especially those related to care coordination, LTSS, and plans of care. Lacking established benchmarks, officials reported improvement over time or comparison to the demonstration average as their principal means of assessing performance. As of September, 2015, all core and state-specific measures were reported, with the following exceptions:

- Core 2.3: Members with an annual re-assessment. Reporting of this measure becomes effective on October 29, 2015 (CMS, October 29, 2014).

- MA 4.3: Tobacco Use: Screening and Cessation. This measure requires a 2-year look-back period (CMS, November 12, 2014).

Three quality measures were identified by the Commonwealth and CMS as "quality withhold measures" for Year 1 of the demonstration: (1) members with an assessment completed within 90 days of enrollment; (2) the establishment of a Consumer Advisory Board by One Care plans; and (3) a complete Centralized Enrollee Record (CER) (CMS, October 27, 2014). Performance on these measures are used to determine whether a plan receives none, some, or all of the withheld payment.

9.2 Quality Management Structures and Activities

MassHealth has extensive experience with managed care and the quality management systems necessary to oversee contract compliance and program performance. Implementation of One Care, however, has required both an expanded set of measures to define how quality will be assessed under an integrated Medicare and Medicaid plan, and the establishment of an oversight system, in collaboration with CMS. This section examines the components of the One Care quality management system, including its interface with CMS, One Care plans, and other independent entities, and describes how well the quality management system is working from various perspectives.

9.2.1 State and CMS Quality Management Structures and Activities

The One Care quality management system is a joint effort between MassHealth and CMS. For the system to be effective, it also must interface with the systems of One Care plans for assessing and improving the quality of beneficiary care.

Staff of MassHealth's Providers and Plans unit are responsible for the day-to-day monitoring of all MassHealth managed care programs, including the One Care demonstration. Each One Care plan is assigned a contract manager from the MassHealth team. In addition, MassHealth staff with expertise in the areas of behavioral health and LTSS are available to advise One Care contract managers when needed. Although the framework for quality management is similar across programs, Commonwealth officials reported several key distinctions under One Care. First, One Care has a three-way contract in which CMS is a partner. Contract standards were the result of a negotiated process in which Medicaid and Medicare requirements were aligned to eliminate redundancy and inconsistency while ensuring that the core requirements of each program were addressed. The end product is a joint set of standards for which MassHealth and CMS are both stewards. Similarly, the selection of quality measures, as described above, was a joint process between MassHealth and CMS (interviews with MassHealth staff, 2014).

As discussed in ***Section 2***, the CMT also plays an important role in managing quality. Standard agenda items for these meetings included reviews of data on core and State-specific reporting measures on plan performance against quality measures, complaints and status of appeals, quality improvement projects, and follow up on any outstanding issues (interview with MassHealth officials, 2015).

Also at the Commonwealth level, MassHealth established an Early Indicators Project (EIP) with a core group of Implementation Council members, One Care staff, and the University of Massachusetts Medical School (UMMS) to assure that data were available to measure performance during the early months of implementation. Members of the Implementation Council and One Care staff reported that the EIP was an essential mechanism for determining how well the program was working from the beneficiary's perspective (interviews with MassHealth officials, and Implementation Council representatives, 2014). Data for the EIP were collected from four beneficiary focus groups, two beneficiary surveys, and monthly enrollment reports (MassHealth, Monthly Enrollment Reports, 2014). Findings of focus groups and surveys are discussed in ***Section 5, Beneficiary Experience***. In November 2014, the Implementation

Council established a Quality Committee to serve as a quarterly forum to discuss and provide feedback on quality measurement, quality improvement, and Commonwealth-led evaluation activities. Similar to the EIP, the Committee consists of Implementation Council members, One Care staff, and UMMS staff (EIP Work Group, October 17, 2014).

Early in 2015, the Quality Committee began convening best practice sessions focused on data collection issues and low-performing areas related to the core and State-specific reporting requirements. The February 2015 session focused on two topics: completion of assessments within 90 days and access to LTS coordinators. Sessions are a chance for the three One Care plans and members of the Contract Management Team to strategize together on approaches for improving performance. A second session focused on emergency use among members with behavioral health diagnoses (SDRS, 6th and 7th Quarters). Without exception, plans spoke of the collaborative atmosphere in these sessions, the available expertise, and their value in raising awareness on improving care of these populations (interviews with One Care plans, 2015).

One Care staff conduct quarterly on-site visits with the plans to dig deeper into areas that are working well or areas where improvement is needed. In July 2015, MassHealth began conducting biannual on-site clinical reviews of each plan's CER to determine if mandatory fields were appropriately completed and if the care plan supports the clinical and LTSS needs as documented in the beneficiary's assessment (SDRS, 4th Quarter). In addition, the protocol used for these reviews examines the CER for evidence that initial contact was made with a member within 30 days of enrollment, a comprehensive assessment was completed within 90 days, care coordination was offered, integration and coordination of services occurred, an LTS coordinator was offered, and health promotion and wellness activities were offered (communication with MassHealth official, September 24, 2015). One Care staff take a collaborative approach to these reviews, recognizing that there is a learning curve among plans to fully satisfy the intent of this contractual requirement (interview with MassHealth official, 2015).

9.2.2 One Care Plan Quality Management Structure and Activities

One Care plans must have "a well-defined quality improvement (QI) organizational and program structure that supports the application of the principles of continuous quality improvement to all aspects of the Contractor's service delivery system" (three-way contract, p. 117). The three-way contract lays out the components of such a QI program, including staff qualified in QI across the spectrum of populations and services; adherence to consensus-based clinical guidelines; use of standardized measurement sets and the information systems necessary to report them; processes for the systematic identification of quality issues; and implementation of quality improvement projects (QIPs) (three-way contract, 2013). With the exception of broadening requirements related to the collection of standardized measures, these requirements closely parallel those required of all Medicare Advantage plans and were not viewed by plan staff as onerous.

Plans are required to conduct at least two QIPs per year. During Demonstration Year 1, One Care plans selected from two chronic care areas defined by One Care: cardiovascular disease or diabetes. A second QIP, required by Medicare, was selected from one of the following topics: emergency department use among enrollees and the impact of LTSS on such use, use of Independent Living-LTSS coordinators by enrollees, or access issues experienced by enrollees.

Before initiation, plans submitted their QIP concepts and methods to CMS and MassHealth for approval (CMS, November 3, 2014).

The establishment of a Consumer Advisory Board is a core requirement of One Care plans. Several plans reported that these boards help ground them in the real lives of their beneficiaries and the significance of the care model to beneficiaries' daily lives. One plan noted that it was through the Advisory Board that administration finally understood the value of the care coordinator to the member, oftentimes far more so than their relationship with a provider. "We were missing the relationship piece, that value. That [came] directly from the member advisory board" (interviews with One Care plan, 2015).

9.2.3 Independent Quality Management Structures and Activities

In March 2014, the One Care Ombudsman (OCO) program was established as a result of a competitive procurement process by the Massachusetts Executive Office of Health and Human Services with funding from CMS. The OCO is an independent entity operating in partnership with other disability and health care advocacy organizations: initially, the Disabilities Policy Consortium, Health Care for All, and Consumer Quality Initiatives.[31] The OCO has three major functions:

- Individual advocacy by assisting enrollees, their families, and caregivers with information and resources about One Care; helping to identify, explore, and resolve complaints; and directing individuals to legal resources for resolving grievances and appeals when appropriate.

- Systemic monitoring by reporting on trends and serving as an "early warning system" on issues that may require program or policy resolution.

- Overall program support by effectively communicating about the resources available through the ombudsman program, documenting findings in reports, and proposing policy and program recommendations (MassHealth, June 27, 2013).

Under Medicaid regulations (42 CFR Part 438, Subpart E), State Medicaid agencies must contract with an External Quality Review (EQR) organization on an annual basis to provide an independent assessment of their managed care plan performance. Massachusetts contracted with APS Healthcare to conduct the three mandatory EQR functions: assessment of compliance with contract requirements; validation of performance measures submitted by plans; and validation of performance improvement projects (PIPs) (CMS, Mandatory EQR-Related Activity Protocols, n.d.). After assessing plan compliance with Federal and Commonwealth contract requirements, Commonwealth officials suspended the EQR contract for the remainder of the year to reduce redundancy with CMS efforts. Specifically, validation of core measures 2.1 and 2.2 was being conducted by Health Services Advisory Group, a CMS vendor; and one of the two PIPs was under review by Medicare. The second PIP was at early baseline stage and review was premature (SDRS, 7th Quarter).

[31] Consumer Quality Initiatives ceased operations as of June 30, 2015.

As discussed earlier in this section, plans are required to have a consumer advisory board. To show compliance with this requirement, plans must report for each meeting: the date of each meeting; the full names of those invited with indication of who are actual beneficiaries or caregivers; full names of those in attendance in person or remotely, with indication of who are actual beneficiaries or caregivers; and minutes.

9.3 Results for Selected Quality Measures

This subsection provides results on two groups of quality measures analyzed by RTI for this report.

First, selected HEDIS measures for calendar year 2014 are reported for each of the three One Care plans. These measures are as follows:

- Blood pressure control (the percentage of members 21–65 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year)

- Antidepressant medication management (the percentage of members 21 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment)

- Comprehensive diabetes care (the percentage of members 18–65 years of age with diabetes (type 1 and type 2) who had each of the following in the measurement year: hemoglobin A1c (HbA1c) testing, HbA1c poor control (>9.0 percent), HbA1c control (<8.0 percent), eye exam (retinal) performed, medical attention for nephropathy, blood pressure control (<140/90 mm/Hg)

- Annual monitoring for patients on persistent medications (the percentage of members 21 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year)

- Initiation and engagement of alcohol and other drug dependence treatment (the percentage of adolescent and adult members with a new episode of alcohol or other drug dependence who received initiation of, and separately, engagement in alcohol and other drug treatment in the measurement year)

- Adult access to preventive/ambulatory health services (the percentage of members 21 years and older who had an ambulatory or preventive care visit in the measurement year)

Second, RTI International developed the following six quality measures for the evaluation: 30-day all-cause risk-standardized readmission rate; preventable emergency department visits per 1,000 demonstration eligible months; rate of 30-day follow up after hospitalization for mental illness; an overall composite measure for ambulatory care sensitive

condition admissions per 1,000 eligible months; a chronic condition composite measure for ambulatory care sensitive condition admissions per 1,000 eligible months; and screening for clinical depression per 1,000 eligible months. These measures are reported for four different populations of interest: demonstration eligible beneficiaries (including *both* enrollees and nonenrollees without respect to enrollment status), enrollees versus nonenrollees, demonstration eligible beneficiaries with any LTSS use, and demonstration eligible beneficiaries with severe and persistent mental illness (SPMI) diagnoses.

9.3.1 HEDIS Quality Measures Reported for One Care Plans

Fifteen selected Medicare HEDIS measures for MMP enrollees are reported in ***Table 40***. Results across MMPs vary, and there was not a consistent trend across measures for one MMP versus other MMPs. The only measure for which we had access to any type of benchmark was the last measure in the table (Adults' Access to Preventive/Ambulatory Health Services), for which the national Medicaid plan 90th percentile value was 89 percent. This benchmark has limited value for comparison given it applies to Medicaid-only plans. Still, all three MMPs, with values above 89 percent, were in the top 10 percent of service provision on this measure compared to national Medicaid-only plan performance. Other benchmark measures were not available to RTI at the time of this report.

Table 40
Selected HEDIS measures for One Care plans

Measure	CCA (percent)	Fallon (percent)	Tufts (percent)
Blood pressure control[1]	54.7	64.0	63.4
Antidepressant medication management			
Effective acute phase treatment[2]	65.0	88.6	NA
Effective continuation phase treatment[3]	53.7	82.9	NA
Comprehensive diabetes care			
Received Hemoglobin A1c (HbA1c) testing	95.9	92.6	91.9
Poor control of HbA1c level (>9.0%) (higher is worse)	55.2	40.2	31.6
Good control of HbA1c level (<8.0%)	35.8	51.6	56.6
Received eye exam (retinal)	66.9	58.7	72.8
Received medical attention for nephropathy	92.5	88.3	93.4
Blood pressure control (<140/90 mm/Hg)	66.7	62.8	75.0
Annual monitoring for patients on persistent medications			
Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	89.6	90.1	82.3
Annual monitoring for members on diuretics	90.9	88.9	81.7
Total rate of members on persistent medications receiving annual monitoring	89.9	89.4	81.8

(continued)

Table 40 (continued)
Selected HEDIS measures for One Care plans

Measure	CCA (percent)	Fallon (percent)	Tufts (percent)
Initiation and engagement of alcohol and other drug (AOD) dependence treatment			
Initiation of AOD treatment[4]	43.8	44.0	32.8
Engagement of AOD treatment[5]	7.1	11.8	9.4
Adults' access to preventive/ambulatory health services	96.9	92.8	96.4

[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm/Hg for members aged 18–59 years, diagnosis of diabetes and <140/90 mm/Hg for members aged 60–85, and no diagnosis of diabetes and <150/90 mm/Hg for members aged 60–85.

[2] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

[3] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

[4] Represents the percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

[5] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

NOTE: Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf.

SOURCE: RTI analysis of 2014 HEDIS measures.

9.3.2 RTI Quality and Care Coordination Measures

The quality measures presented in this section of the Annual Report are the evaluation's key measures, which were identified and calculated by RTI, in contrast to the core and State-specific reporting requirements for the demonstration, which were identified by CMS and MassHealth and reported by the plans. Qualitatively, they differ from those presented in the previous subsections in that these measures include all demonstration eligibles—both One Care enrollees and nonenrollees. Doing so effectively minimizes any potential selection bias from unobserved characteristics on which enrollees and nonenrollees may differ. Additionally, these measures are calculated using the evaluation's comparison group for Massachusetts, providing an opportunity to compare Massachusetts demonstration eligibles with a statistically comparable group of beneficiaries (excluding those beneficiaries with enrollment in other shared savings programs). All measures are calculated using Medicare data—complete Medicaid data were available for this report.

Six tables appear in this subsection:

- All demonstration eligibles
- All demonstration group demonstration period eligibles stratified by enrollment status

- All demonstration eligibles with any LTSS nursing facility use
- All demonstration group demonstration period eligibles with any LTSS stratified by enrollment status
- All demonstration eligibles with SPMI
- All demonstration group demonstration period eligibles with SPMI stratified by enrollment status

RTI Quality Measures for All Demonstration Eligibles, and then Stratified by Enrollment Status

Table 41 displays values for the RTI quality of care and care coordination measures across the baseline and demonstration periods. Similar to the service utilization measure results presented in ***Section 8***, the demonstration had likely not yet sufficiently engaged enough beneficiaries by December 2014 to have had a major effect on quality of care, so any trends that appear were likely associated with other factors.

- There was a significant increase in the 30-day all-cause risk-standardized readmission rate among beneficiaries in the demonstration group, from baseline period 1 to period 2 (20.2 to 36.8 percent). There was a large decline in the rate from baseline period 2 to the demonstration period (36.8 to 19.3 percent). The comparison group experienced a sharp increase from the baseline to the demonstration period (18.3 to 32.8 percent).
- Beneficiaries in the demonstration group experienced a small decline in the number of preventable ED visits per 1,000 eligible months from the baseline to the demonstration period (146.9 to 134.2 visits). The rate of preventable ED visits in the comparison group was relatively unchanged over that period.
- In the demonstration and comparison group, there was a slight decline in the rate of overall ambulatory care sensitive conditions hospital admissions per 1,000 eligible months from the baseline to the demonstration period (10.9 to 9.5 visits and 11.8 to 10.0 visits for the demonstration and comparison groups, respectively).

Table 41
Quality of care and care coordination outcomes for Massachusetts demonstration and comparison groups

Quality and care coordination measures	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
30-day all-cause risk-standardized readmission rate	20.2	18.3	36.8	34.6	19.3	32.8
Preventable ER visits per 1,000 eligible months	146.9	135.7	137.4	132.8	134.2	134.4
Rate of 30-day follow up after hospitalization for mental illness	57.3	49.5	57.3	48.9	55.6	48.2
Ambulatory care sensitive condition admissions per 1,000 eligible months—overall composite (AHRQ PQI # 90)	10.9	11.8	9.4	11.4	9.5	10.0
Ambulatory care sensitive condition admissions per 1,000 eligible months—chronic composite (AHRQ PQI # 92)	6.4	6.9	5.7	6.5	6.9	6.0
Screening for clinical depression per 1,000 eligible months	0.0	0.1	0.6	0.3	1.8	1.3

NOTE: The adjusted probability for the 30-day all-cause risk-standardized readmission rate was calculated on the whole population and was not confined to those in this sample after applying the MDM exclusion.

SOURCE: RTI Analysis of Medicare Claims.

Table 42 displays values for the RTI quality of care and care coordination measures for all eligible beneficiaries in the demonstration period, comparing *enrollees* in the Massachusetts demonstration with *nonenrollees*. Key findings are provided below:

- Beneficiaries who were enrolled in the demonstration had fewer preventable ED visits per 1,000 eligible months than those who did not enroll (116.1 to 130.2 visits, respectively).
- Beneficiaries who were enrolled in the demonstration had a lower rate of post-discharge follow-up care for hospitalization for mental illness (42.6 to 57.8 percent) through services identified as Medicare services.
- The count of overall and chronic related ambulatory care sensitive condition (ACSC) hospital admissions were similar between those enrolled and the nonenrolled.
- Screening for clinical depression was slightly lower for enrollees than for nonenrollees.

Table 42
Quality of care and care coordination outcomes for Massachusetts demonstration-eligible beneficiaries, by enrollment status

Quality and care coordination measures	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
30-day all-cause risk-standardized readmission rate (%)	—	—
Preventable ER visits per 1,000 eligible months	130.2	116.1
Rate of 30-day follow up after hospitalization for mental illness (%)	57.8	42.6
Ambulatory care sensitive condition admissions per 1,000 eligible months—overall composite (AHRQ PQI # 90)	9.7	6.2
Ambulatory care sensitive condition admissions per 1,000 eligible months—chronic composite (AHRQ PQI # 92)	6.8	4.6
Screening for clinical depression per 1,000 eligible months	2.3	0.3

— This measure will be filled in the next version of this report pending further data analysis.

SOURCE: RTI Analysis of Medicare Claims.

RTI Quality Measures for all Demonstration Eligibles with any LTSS, and then Stratified by Enrollment Status

Whereas the previous subsection focused on the eligible population at large, this subsection focuses on demonstration eligible beneficiaries with any LTSS nursing facility use. ***Table 43*** displays values for Quality of Care and Care Coordination measures for eligible beneficiaries with LTSS nursing facility use in the Massachusetts demonstration and comparison groups, across the baseline and demonstration periods. Key findings are as follows:

- The count of preventable ED use per 1,000 eligible months increased from 88.7 to 110.4 visits in the demonstration group, as well as in the comparison group (69.9 to 77.1 visits).

- The demonstration group experienced a sharp increase in the rate of follow-up within 30-days of a mental health related hospitalization (33.4 to 49.4 percent). A similar trend was observed for the comparison group.

- There was an additional increase in the count of ACSC admissions per 1,000 eligible months for the demonstration group over the baseline and the demonstration period (32.6 to 43.8 visits and 13.9 to 30.8 visits for the overall and chronic composites, respectively). This trend perhaps suggests ongoing challenges for care coordination in the outpatient setting.

Table 43
Quality of care and care coordination outcomes for Massachusetts demonstration and comparison groups, among LTSS users

Quality and care coordination measures	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
30-day all-cause risk-standardized readmission rate (%)	—	—	—	—	—	—
Preventable ER visits per 1,000 eligible months	88.7	69.9	72.1	66.4	110.4	77.1
Rate of 30-day follow up after hospitalization for mental illness (%)	33.4	24.4	45.3	35.0	49.4	42.3
Ambulatory care sensitive condition admissions per 1,000 eligible months—overall composite (AHRQ PQI # 90)	32.6	27.0	31.5	24.4	43.8	23.1
Ambulatory care sensitive condition admissions per 1,000 eligible months—chronic composite (AHRQ PQI # 92)	13.9	12.6	15.2	12.3	30.8	11.5
Screening for clinical depression per 1,000 eligible months	0.0	0.1	0.1	0.6	0.4	2.9

— This measure will be filled in the next version of this report pending further data analysis.

SOURCE: RTI Analysis of Medicare Claims.

Table 44 displays values for Quality of Care and Care Coordination measures for all eligible beneficiaries with LTSS nursing facility use in the demonstration period, comparing *enrollees* with any LTSS use vs. *nonenrollees* with any LTSS nursing facility use. These results focus on nursing facility users as opposed to home and community-based services (HCBS) users because of lack of complete Medicaid data. HCBS users were a key subpopulation of focus for One Care program design. Key findings are provided below:

- The count of preventable ED visits per 1,000 eligible months was slightly higher for enrollees with any LTSS vs. nonenrollees with any LTSS (100.4 vs. 105.3) visits.
- The rate of 30-day follow-up after hospitalization for mental illness was higher for enrollees with any LTSS vs. nonenrollees with any LTSS (80.0 vs 43.7 percent).
- Both of the ACSC admission count measures were somewhat higher for enrollees with any LTSS vs. nonenrollees with any LTSS. Depression screening was much lower for enrollees with any LTSS vs. nonenrollees with any LTSS (0 vs 0.4 screenings per 1,000 eligible months).

Table 44
Quality of care and care coordination outcomes for Massachusetts demonstration-eligible beneficiaries, by enrollment status among those using LTSS

Quality and care coordination measures	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
30-day all-cause risk-standardized readmission rate (%)	—	—
Preventable ER visits per 1,000 eligible months	100.4	105.3
Rate of 30-day follow up after hospitalization for mental illness (%)	43.7	80.0
Ambulatory care sensitive condition admissions per 1,000 eligible months—overall composite (AHRQ PQI # 90)	42.7	56.5
Ambulatory care sensitive condition admissions per 1,000 eligible months—chronic composite (AHRQ PQI # 92)	29.7	48.4
Screening for clinical depression per 1,000 eligible months	0.4	0.0

— This measure will be filled in the next version of this report pending further data analysis.

NOTE: The results in this table should be interpreted with caution because of sample size greater than 30 but less than 60 in the enrolled group.

SOURCE: RTI Analysis of Medicare Claims.

9.3.3.3 RTI Quality Measures for all Demonstration Eligibles with SPMI, and then Stratified by Enrollment Status

Whereas the previous subsection focused on the eligible population with any LTSS, this subsection focuses on demonstration eligible beneficiaries with SPMI. ***Table 45*** displays values for Quality of Care and Care Coordination measures for all eligible beneficiaries in the Massachusetts demonstration and comparison groups with SPMI, across the baseline and demonstration periods. Key findings are as follows:

- In both the demonstration and the comparison group there was a slight decline in the number of preventable ED visits per 1,000 eligible months from the baseline to the demonstration period (190.7 to 170.6 visits in the comparison group, and 184.0 to 178.9 visits in the demonstration group).

- There was no meaningful trend in overall or chronic ACSC hospital admissions for the demonstration group from the baseline to the demonstration period. However the comparison group experienced a slight decline in counts of overall and chronic ACSC hospital admissions per 1,000 eligible months from the baseline to the demonstration period (14.4 to 11.9 visits, and 8.2 to 6.9 visits, for overall and chronic related admissions, respectively).

Table 45
Quality of care and care coordination outcomes for Massachusetts demonstration and comparison groups, among those with SPMI diagnosis

Quality and care coordination measures	Baseline period 1 10/1/2011–9/30/2012		Baseline period 2 10/1/2012–9/30/2013		Demonstration period 10/1/2013–12/31/2014	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
30-day all-cause risk-standardized readmission rate (%)	—	—	—	—	—	—
Preventable ER visits per 1,000 eligible months	190.7	184.0	177.4	177.9	170.6	178.9
Rate of 30-day follow up after hospitalization for mental illness (%)	57.3	49.5	57.3	48.9	55.8	48.2
Ambulatory care sensitive condition admissions per 1,000 eligible months—overall composite (AHRQ PQI # 90)	13.1	14.4	11.3	13.8	12.1	11.9
Ambulatory care sensitive condition admissions per 1,000 eligible months—chronic composite (AHRQ PQI # 92)	7.5	8.2	6.6	7.9	8.7	6.9
Screening for clinical depression per 1,000 eligible months	0.0	0.1	0.8	0.5	2.7	2.0

— This measure will be filled in the next version of this report pending further data analysis.

SOURCE: RTI Analysis of Medicare Claims.

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Table 46 displays values for Quality of Care and Care Coordination measures for all eligible beneficiaries with SPMI in the demonstration period, comparing *enrollees* with SPMI versus *nonenrollees* with SPMI. Key findings are provided below:

- There were slightly fewer preventable ED visits per 1,000 eligible months for enrollees with SPMI vs. nonenrollees with SPMI (149.3 vs. 165.9) visits.
- The rate of 30-day follow-up after hospitalization for mental illness was much lower for enrollees with SPMI vs. nonenrollees with SPMI (42.6 vs 57.8 percent).
- Enrollees with SPMI had slightly fewer ACSC admissions per 1,000 eligible months for both the overall and chronic composites compared to those nonenrollees with SPMI (7.9 vs. 12.3 admissions and 5.9 and 8.6 admissions for the overall and chronic composites, respectively).
- Depression screening was lower for enrollees with SPMI vs. nonenrollees with SPMI (0.6 vs 3.4 screenings per 1,000 eligible months).

Table 46
Quality of care and care coordination outcomes for Massachusetts demonstration and comparison groups, by enrollment status among those with SPMI

Quality and care coordination measures	Demonstration period 10/1/2013–12/31/2014	
	Nonenrolled	Enrolled
30 day all-cause risk-standardized readmission rate (%)	—	—
Preventable ER visits per 1,000 eligible months	165.9	149.3
Rate of 30-day follow up after hospitalization for mental illness (%)	58.0	42.6
Ambulatory care sensitive condition admissions per 1,000 eligible months—overall composite (AHRQ PQI # 90)	12.3	7.9
Ambulatory care sensitive condition admissions per 1,000 eligible months—chronic composite (AHRQ PQI # 92)	8.6	5.9
Screening for clinical depression per 1,000 eligible months	3.4	0.6

— This measure will be filled in the next version of this report pending further data analysis.

SOURCE: RTI Analysis of Medicare Claims.

9.4 Successes

MassHealth has successfully leveraged its experience in quality management of Medicaid managed care to the One Care demonstration. MassHealth team members' expertise in quality measurement, contract management, on-site plan reviews, and improvement initiatives allowed them to focus on new aspects of the demonstration, including Medicare rules and regulations; joint contract oversight; systems interfaces with CMS, especially those related to enrollment; and the integration of physical and behavioral health services for the under 65 population for whom managed care was a new option.

The One Care Implementation Council had the forethought to put into place an Early Implementation Project (EIP) that could provide near real-time feedback on the demonstration during a time when it was too soon to obtain quantitative measurement on performance. Findings from focus group and surveys collected through the EIP were seen as absolutely critical to identifying changes needed to enhance marketing materials, the passive enrollment process, and referral to LTS coordinators.

The One Care Ombudsman program became operational in March 2014; established as an independent organization, it supports external oversight of One Care quality issues, including monitoring and reporting of beneficiary experience and identification of trends and overall system issues.

9.5 Challenges

One Care plans repeatedly indicated that the extensive reporting requirements on quality measures were a major challenge and, for some plans, redundant. Many of the measures require data from the enrollee record for their calculation resulting in a time-consuming manual collection process and/or the re-design of systems to allow for auto abstraction. Changes to data requirements on measures relating to the assessment process, care plan, and referral to LTS coordinators were seen as particularly problematic.

9.6 Preliminary Findings

During the first demonstration year, MassHealth and One Care officials placed emphasis on the development of quality management systems. Going forward, One Care plans will need to shift their focus to the outcomes and adjusting the care model to improve performance.

One Care has put into place a multi-faceted quality management process that uses multiple methods and payers to assess program performance. There is a collaborative process for identifying issues and working together to find solutions while maintaining accountability for action.

The University of Massachusetts Medical School (UMMS) has provided substantial expertise and has added to the credibility to One Care's quality management system. UMMS' collection of focus group and survey data, as well as UMMS staff members' clinical contributions to best practice sessions and management of the external quality review contract, gave credibility to quality management and improvement efforts. As a result, UMMS helped facilitate a unique partnership and collaboration that everyone recognized as essential to building a robust quality program.

10. Conclusions

10.1 Success, Challenges, and Lessons Learned

Overall, State officials and stakeholders indicated strong support for One Care and its integrated approach to service delivery for the population of Medicare-Medicaid beneficiaries it serves. Before the One Care demonstration, Medicare-Medicaid beneficiaries younger than age 65 were ineligible to enroll in Medicaid managed care. For many enrollees, One Care provided access to care coordination services for the first time, as well as access to new and expanded benefits. A central feature of the One Care demonstration is the use of medical care coordinators and, as appropriate, community-based Independent Living and Long-Term Services and Supports (LTS) coordinators to assess the enrollee's needs and facilitate access to and coordination of services within the medical, behavioral health, and long-term services and supports (LTSS) systems.

Using the LTS coordinator was considered to be a key component of the One Care demonstration, and MassHealth, the plans, and stakeholders widely supported it. Although challenging to implement, the LTS coordinator role was seen as particularly important to introducing independent living skills and recovery model services to One Care enrollees. The lack of clearly defined roles and responsibilities led to inconsistencies and confusion in implementing the position across plans and community-based organizations. This led to MassHealth working with stakeholders during the first demonstration year to clarify the roles and responsibilities of the LTS coordinator, although some issues continued.

As described in ***Section 3***, enrollment in the demonstration has been low, with about 18 percent of eligible Medicare-Medicaid beneficiaries enrolled in One Care as of July 1, 2015. During the early implementation and enrollment phases, MassHealth staff devoted considerable resources to align the Commonwealth's MassHealth eligibility system with the enrollment systems of CMS and its contractors. During the first demonstration year, some of these issues were resolved or manual systems were designed to assist with processing enrollments. From the perspective of MassHealth officials, passive enrollment was a necessary and important component of the demonstration and provided the vehicle for bringing the model to scale and achieving the greatest impact on the most people.

Especially important to beneficiaries have been enhanced benefits, such as care coordination, LTSS, and dental services, not all of which were available to all enrollees before the demonstration. However, several of those who participated in the focus groups conducted by the RTI evaluation team reported quality issues related to some of the services they received, including but not limited to transportation services. Beneficiaries, and stakeholders and plans, believe One Care has made a difference in their quality of life and provided access to previously unavailable services. Beneficiaries provided several examples of this during the focus groups. One Care has facilitated innovations not otherwise possible under the previous health care delivery system. For example, as an alternative to institutional care, one plan developed new community-based programs to support enrollees with behavioral health needs. Overall, findings from the Consumer Assessment of Healthcare Providers and Systems survey reflected enrollees' satisfaction with One Care services and their health plans.

Implementation of One Care has been challenging. It has required a substantial commitment of time and resources on the part of Commonwealth staff, and all parties experienced a learning curve, which was particularly significant in Massachusetts because One Care is the first capitated model demonstration under the Financial Alignment Initiative. However, some of these challenges were mitigated by an unprecedented level of collaboration throughout the demonstration, as reported by MassHealth, CMS, plans, and other stakeholders. The Contract Management Team, in particular, was viewed as a valuable and effective mechanism for raising and resolving issues affecting the demonstration's operation.

10.2 Preliminary Findings

The purpose of the quantitative analyses was to understand the characteristics of the Massachusetts demonstration group and, separately, the comparison group for the evaluation conducted by the RTI evaluation team. Quantitative results were presented for each group for each of the two baseline years, and for the 15-month demonstration period, in order to understand the service use patterns of these two groups before they are directly compared in future analyses. This report also provided results for important subpopulations of interest, including demonstration enrollees, those with any LTSS nursing facility use, and those with severe and persistent mental illness (SPMI). These analyses focused on the time trend within each group, and the demonstration was slow to begin; therefore, differences over time were generally not large.

One Care enrollees were in poorer health than demonstration nonenrollees in Massachusetts, partly because a larger percentage of enrollees had SPMI and had disability as their original reason for Medicare entitlement. Generally, enrollees were anticipated to cost more than nonenrollees, given their higher hierarchical condition category scores.

Some Medicare service use was higher for enrollees than nonenrollees, potentially because of unmet health care needs before demonstration enrollment. For example, Medicare home health service use was three to four times higher for enrollees than for nonenrollees, and emergency department (ED) use was also higher among enrollees than nonenrollees for those with any use. Prior research has shown that Medicare-Medicaid enrollees tend to have poorer access to care, and thus may be underserved.

Few One Care enrollees (56) and few eligible beneficiaries who were not enrolled in One Care (1,131) used LTSS nursing facilities. Among these, One Care enrollees, compared with nonenrollees, had a slightly lower percentage with any inpatient admissions, and fewer admissions, if any. Similarly, One Care enrollees with nursing facility utilization, compared with nonenrollees, also had higher ED use and lower primary care use. Enrollees in nursing facilities may have been somewhat more likely to have disability as the reason for original Medicare eligibility, but they were generally in somewhat better health than nonenrollees. Medicare behavioral health utilization for enrollees was approximately half that of nonenrollees. Given that the results presented are for Medicare data only, this lower utilization potentially may be due to higher Medicaid utilization for new behavioral health benefits in One Care.

Overall, results from quantitative analyses on various Medicare services show limited evidence of the demonstration's effect during the first demonstration year, in part because the

One Care model needed more time for full implementation at a programmatic and operational level. Similar to the Medicare service utilization measure results, the demonstration had likely not yet sufficiently engaged enough beneficiaries by December 2014 to have had a major effect on quality of care, so any quality trends that appear were likely associated with other factors. Compared with nonenrollees, beneficiaries who were enrolled in the demonstration had a lower 30-day all-cause risk-adjusted readmission rate and fewer preventable ED visits.

10.3 Next Steps

The RTI evaluation team will continue to collect information on a quarterly basis from Massachusetts officials through the online State Data Reporting System, covering enrollment statistics and updates on key aspects of implementation. The RTI evaluation team will continue conducting quarterly calls with the One Care State staff and will request the results of any evaluation activities conducted by the State or other entities, such as results from the CAHPS and State-specific demonstration measures the State is required to report to CMS. During the demonstration, additional site visits and focus groups will take place.

As noted previously, Massachusetts and CMS have effectuated an extension to continue the demonstration through December 31, 2018, which will provide further opportunities to evaluate the demonstration's performance. The second Annual Report on One Care will include information about the Commonwealth's decision to extend the duration of the demonstration. In addition, the next report will include qualitative information on the status of the demonstration and descriptive analyses of quality and utilization measures for those eligible for the demonstration and for an out-of-State comparison group. The quantitative analyses will cover the period from January 2015 through December 2015. Qualitative information will include findings through June 30, 2016.

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Appendix A:
Identification of the Massachusetts Comparison Group

The Massachusetts demonstration area consists of three large urban Metropolitan Statistical Areas (MSAs) (Boston-Cambridge-Newton; Worcester; and Springfield) plus one Rest-of-State area containing rural areas. The comparison area is composed of 24 MSAs from 10 States (116 counties). The comparison areas also include three other areas in Massachusetts. All comparison MSAs are listed in ***Table A-1***.

Table A-1
Metropolitan Statistical Areas for the Massachusetts comparison group, by State

Alabama MSAs	**Maryland MSAs**	**Pennsylvania MSAs**
Birmingham-Hoover	Baltimore-Columbia-Towson	Allentown-Bethlehem-Easton
Daphne-Fairhope-Foley	Washington-Arlington- Alexandria	Philadelphia-Camden-Wilmington
Gadsden	**Massachusetts MSAs**	**Virginia MSA**
Huntsville	Barnstable Town	Winchester
Tuscaloosa	Pittsfield	**West Virginia MSAs**
Kentucky MSAs	Providence-Warwick	Charleston
Lexington-Fayette	**Mississippi MSA**	Huntington-Ashland
Louisville/Jefferson County	Jackson	Morgantown
	North Carolina MSA	Parkersburg-Vienna
	Asheville	Wheeling
		Rest of State
		Wisconsin MSA
		Milwaukee-Waukesha-West Allis

The Massachusetts demonstration was restricted to dually eligible beneficiaries under the age of 65 years and who met other all other demonstration eligibility criteria. Beneficiaries in the demonstration group during the demonstration period were identified from quarterly finder files submitted by the Commonwealth. Beneficiaries qualified for the demonstration group if they participated for at least one month during the demonstration period. During the two baseline periods, all beneficiaries meeting the age restriction, other eligibility requirements, and MSA residency requirements were selected for the demonstration and comparison groups, as were beneficiaries in the demonstration period comparison group.

Table A-2 below shows the distribution of beneficiaries by comparison State in the first baseline year. Pennsylvania contributed the largest share of comparison beneficiaries. State shares were very similar in the other two time periods. Since at least three States were included and no State contributed more than half of the total comparison beneficiaries, it was not necessary to do any sampling to reduce the influence of a single State. The total number of comparison beneficiaries was comparatively stable throughout the three time periods (155,430 in baseline year 1, 151,633 in baseline year 2, and 151,289 in the first demonstration period.

Table A-2
Distribution of comparison group beneficiaries for the Massachusetts demonstration, first baseline year, by comparison State

Comparison State	Percent of comparison beneficiaries
Pennsylvania	28.5
Maryland	19.3
West Virginia	13.3
Massachusetts	11.2
Wisconsin	9.0
Alabama	8.4
Kentucky	7.2
Mississippi	2.9
North Carolina	0.1
Virginia	0.1
Total percent	100
Total beneficiaries	149,340

RTI's methodology uses propensity scores to examine initial differences between the demonstration and comparison groups and then to weight the data to improve the match between them. The comparability of the two groups is examined with respect to both individual beneficiary characteristics as well as the overall distributions of propensity scores. A propensity score (PS) is the predicted probability that a beneficiary is a member of the demonstration group conditional on a set of observed variables. ***Table A-3*** displays the means of beneficiary and area-level characteristics used in the propensity model after applying the PS weights to balance the distribution of the demonstration and comparison group members' characteristics. The distributions of the demonstration and comparison groups on these characteristics are similar after weighting. The PS weights were used in all Annual Report analyses.

Table A-3
Massachusetts dual eligible beneficiary covariate means by group before and after weighting by propensity score, demonstration period 1: 10/1/2013–12/31/2014

Demonstration period 1	Demonstration group	Unweighted comparison group	PS-weighted comparison group
Characteristic	**Mean**	**Mean**	**Mean**
Age	49.413	48.712	49.265
Died	0.017	0.027	0.017
Female	0.495	0.518	0.488
White	0.663	0.594	0.678
Disability as reason for original Medicare eligibility	0.910	0.891	0.910
ESRD	0.013	0.033	0.013
Share mos. elig. during period	0.821	0.767	0.823
HCC score	1.024	1.063	1.018
MSA	0.983	0.909	0.983
% of pop. Living in married household	63.311	62.821	64.898
% of Households w/ member >= 60	33.400	35.328	33.532
% of Households w/ member < 18	32.367	31.522	32.606
% of nonelderly w/ college education	29.969	23.539	31.491
% of nonelderly w/self-care limitation	2.058	2.681	1.986
% of nonelderly unemployed	11.006	11.857	10.624
Distance to nearest hospital	4.004	5.695	4.114
Distance to nearest nursing facility	2.516	3.932	2.590

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Appendix B:
Additional Methodological Details

Minimum Data Set 3.0 Analysis Methods

Estimates of nursing facility outcomes are presented for the demonstration and comparison groups. Estimates were developed for these two groups for each of the 2 years preceding demonstration implementation, referred to as baseline periods 1 and 2 (12 months each), and demonstration period 1 (18 months). RTI matched data on the two groups with the Nursing Home Minimum Data Set Version 3.0 (MDS 3.0). The MDS 3.0 includes assessment data from all Medicare- and Medicaid-certified nursing facilities for every resident (regardless of individual payment sources) upon admission and at least quarterly thereafter. We first constructed a population of beneficiaries who were demonstration-eligible for each corresponding time period, split into demonstration and comparison groups. These groups were used to calculate the annual nursing facility utilization measures, which include new long-stay nursing facility admissions per 1,000 eligibles, and the percentage of all long-stay nursing facility users as a percentage of demonstration eligibles. The numerators of these annual nursing facility utilization measures became the admissions and long-stay samples for their respective analyses. For the admissions sample, characteristics of new long-stay nursing facility residents at admission are reported. For the long-stay resident sample, user characteristics and measures of quality for all long-stay nursing facility residents are reported. Detailed specifications for each measure are described in ***Appendix C***.

In addition to the propensity score weights that are applied to all results to adjust the composition of comparison group eligibles to that of Massachusetts eligibles, the nursing facility measures also incorporate an eligibility fraction weight. This accounts for the fraction of months during a given time period a beneficiary was demonstration-eligible. Because the MDS results are presented on a per-person basis, the weights account for partial eligibility over a given period.

Several data nuances could have influenced the count of nursing facility residents. The weighted number of beneficiaries after matching to MDS data were calculated; this produced the weighted number of beneficiaries that served as the population of eligibles for the denominator for the two measures of annual nursing facility utilization. For the new admission and all long-stay resident groups, a beneficiary was often simply not matched to an MDS record indicating they had been admitted or were long-stay. In addition, for the long-stay nursing facility admission rate, beneficiaries who were already long-stay were excluded. A reduction in the number of weighted beneficiaries could also be due to not having been eligible for the entire period.

The MDS descriptive statistics provide an understanding of the time trend of the health care experience of the Massachusetts demonstration group, and separately, its comparison group. Because no multivariate analyses were conducted to control for differences between these two groups over time, these estimates should not be used to draw inferences or conclusions about any differences between the two groups. Multivariate results that control or adjust for any differences will be reported after additional years of demonstration period data are available.

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Appendix C:
Detailed Measure Definitions

Population, Special Population, and Utilization Measure Definitions

Population Definitions

Demonstration eligible beneficiaries. Beneficiaries are identified in a given month if they were a Medicare-Medicaid enrollee and met any other specific demonstration eligibility criteria. Beneficiaries in the demonstration period are identified from quarterly State finder files, whereas beneficiaries in the 2-year baseline period preceding the demonstration implementation date are identified by applying the eligibility criteria in each separate baseline quarter.

Additional special populations were identified for the analyses as follows:

- *Enrollee.* A beneficiary was defined as being enrolled in the demonstration if they were enrolled in One Care in any month during the demonstration period.
- *Age*. Age was defined as a categorical variable where beneficiaries were identified as *21 to 44*, and *45 years and older* during the observation year (e.g., baseline period 1, baseline period 2, and demonstration period).
- *Gender*. Gender was defined as binary variable where beneficiaries were either *male* or *female*.
- *Race*. Race was defined as a categorical variable where beneficiaries were categorized as *White*, *African American*, *Hispanic*, or *Asian*.
- *Hierarchical condition categories (HCC)*. HCC score was defined as a categorical variable where the beneficiary was identified as having a score *less than one*, *between one and two*, *between two and four*, or *four and greater*.
- *Died*. A beneficiary was categorized as having died if there was a date of death during the observation year.
- *Disability*. Disability was defined as a dichotomous indicator using the Original Reason for Entitlement Code (OREC) from the State Medicaid enrollment files. The beneficiaries with this status during the observation year have OREC = 1.
- *Long-term care services and supports (LTSS)*. A beneficiary was defined as using LTSS if there was any use of institutional or home and community based services during the observation year.
- *Severe and persistent mental illness (SPMI).* A beneficiary was defined as having a SPMI if there were any inpatient or outpatient mental health visits for schizophrenia or bipolar disorders during the observation year.
- *Alzheimer's disease and other dementias*. A beneficiary was defined as having Alzheimer's disease or other dementias if there were at least two inpatient or outpatient diagnosis during the observation year.

Utilization Measure Definitions

For any health care service type, the methodology for estimating average monthly utilization and the percentage of users during the year takes into account differences in the number of eligibility months across beneficiaries. Because full-benefit dual eligibility status for the demonstration can vary by month over time for any individual, the methodology used determines dual eligibility status for the demonstration for each person on a monthly basis during a baseline or demonstration period. That is, an individual is capable of meeting the demonstration's eligibility criteria for 1, 2, 3, or up to 12 months during the observation year. The methodology adds the total months of full-benefit dual eligibility for the demonstration across the population of interest and uses it in the denominator in the measures in ***Section 1.3***, creating average monthly utilization information for each service type. The methodology effectively produces average monthly use statistics for each year that account for variation in the number of dually eligible individuals in each month of the observation year.

The utilization measures below were calculated as the aggregate sum of the unit of measurement (counts, etc.) divided by the aggregated number of eligible member months [and user months] within each group (g) where group is defined as (1) Massachusetts Base Year 1, (2) Comparison Base Year 1, (3) Massachusetts Base Year 2, (4) Comparison Base Year 2, (5) Massachusetts Demonstration Period, and (6) Comparison Demonstration Period.

The average number of services was calculated per 1,000 eligible months and per 1,000 user months by beneficiary group (g). *User month* was defined as an eligible month where the number of units of utilization used [for a given service] was greater than zero. Each observation is weighted using yearly propensity weights. The average yearly utilization outcomes are measured as:

$$Y_g = \frac{\Sigma_{ig} Z_{ig}}{\left(\frac{1}{1{,}000}\right) * \Sigma_{ig} n_{ig}}$$

Where

Y_g = average count of the number services used [for a given service] per eligible or user month within group g.
Z_{ig} = the total units of utilization [for a given service] for individual i in group g.
n_{ig} = the total number of eligible/user months for individual i in group g.

The denominator above is scaled by $\frac{1}{1{,}000}$ such that the result is interpreted in terms of average monthly utilization per 1,000 eligibles. This presentation is preferable, compared with per eligible, because some of the services are used less frequently and would result in small estimates.

The average percentage of users [of a given service] per eligible month during the baseline or demonstration year is measured as follows:

$$U = \frac{\Sigma_{ig} X_{ig}}{\Sigma_{ig} n_{ig}} \text{ x } 100$$

Where

U_{ig} = average percentage of users [for a particular service] in a given month among beneficiaries in group g.
X_{ig} = the total number of eligible months of service use for an individual i in group g.
n_{ig} = the total number of eligible or user months for an individual i in group g.

Quality of Care and Care Coordination Measures

Similar to the utilization measures, the quality of care and care coordination measures were calculated as the aggregated sum of the numerator divided by the aggregated sum of the denominator for each respective outcome within each beneficiary group.

Average 30-day all-cause risk standardized readmission was calculated as follows:

$$30 - Risk\ Standardized\ Readmission\ = \frac{\left(\frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}} X\ C\right)}{Prob_g}$$

Where

C = the national average of 30-day readmission rate, .238.
X_{ig} = the total number of readmissions for individual i in group g.
n_{ig} = the total number of hospital admissions for individual i in group g.
$Prob_g$ = the annual average adjusted probability of readmission for individuals in group g. The average adjusted probability equals:

Average Adjusted Probability of Readmission by Demonstration Group

Demonstration Group		Average Adjusted Probability of Readmission
Baseline Period 1		
	Massachusetts	0.231713283
	Comparison	0.220171257
Baseline Period 2		
	Massachusetts	0.231703099
	Comparison	0.220802089
Demonstration Period		
	Massachusetts	0.220549052
	Comparison	0.21633023

Average 30-day follow-up in a physician or outpatient setting after hospitalization for mental illness was calculated as follows:

$$MHFU = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

MHFU = the average rate of 30-day follow up care after hospitalization for a mental illness for individuals *in* group *g*.
X_{ig} = the total number of discharges from a hospital stay for mental health that had a follow-up for mental health within 30 days of discharge for individual *i* in group *g*.
n_{ig} = the total number of discharges from a hospital stay for mental health for individual *i* in group *g*.

Average Ambulatory Care Sensitive Condition (ACSC) admissions per 1,000 eligibles, overall and chronic composite (Agency for Healthcare Research and Quality [AHRQ] Prevention Quality Indicator [PQI] #90 and PQI #92) was calculated as follows:

$$ACSC_{ig} = \frac{\Sigma_{ig} x_{ig}}{\left(\frac{1}{1000}\right) * \Sigma_{ig} \mathrm{n}_{ig}}$$

Where

$ACSC_{ig}$ = the average number of ACSC admissions per 1,000 eligible months for overall/chronic composites for individuals in group *g*.
X_{ig} = the total number of discharges that meet the criteria for AHRQ PQI #90 [or PQI #92] for individual *i* in group *g*.
n_{ig} = the total number of eligible months for individual *i* in group *g*.

Preventable emergency room (ER) visits per 1,000 eligible month was calculated as follows:

$$ER_{ig} = \frac{\Sigma_{ig} x_{ig}}{\left(\frac{1}{1000}\right) * \Sigma_{ig} \mathrm{n}_{ig}}$$

Where

ER_{ig} = the average number of preventable ER visits per 1,000 eligible months for individuals in group *g*.
X_{ig} = the total number ER visits that are considered preventable based in the diagnosis for individual *i* in group *g*.
n_{ig} = the total number of eligible months for individual *i* in group *g*.

Average number of beneficiaries who received a pneumococcal vaccination during the observation year was calculated as follows:

$$PN_{ig} = \frac{\Sigma_{ig} x_{ig}}{\left(\frac{1}{1000}\right) * \Sigma_{ig} \mathrm{n}_{ig}}$$

Where

PN_{ig} = the average number of pneumococcal vaccinations per 1,000 eligible months among individuals in group g.
X_{ig} = the total number eligible beneficiaries age 65+ who ever received a pneumococcal vaccination in group g.
n_{ig} = the total number of eligible months among beneficiaries 65 years and older in group g.

Average number of beneficiaries per 1,000 eligible months who received depression screening during the observation year was calculated as follows:

$$D_g = \frac{\Sigma_{ig} x_{ig}}{\left(\frac{1}{1000}\right) * \Sigma_{ig} \mathrm{n}_{ig}}$$

Where

D_g = the average number of beneficiaries per 1,000 eligible months who received depression screening in group g.
X_{ig} = the total number eligible beneficiaries age 65+ who ever received depression screening in group g.
n_{ig} = the total number of eligible months among beneficiaries in group g.

Average rate of beneficiaries per positive depression screening who received a follow-up plan during the observation year was calculated as follows:

$$PD_g = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

PD_g = the average number of beneficiaries per positive depression screening who received a follow-up plan among beneficiaries in group g.
X_{ig} = the total number beneficiaries who received a positive depression screen and a follow up plan in group g.
n_{ig} = the total number of beneficiaries who received a positive depression screen in group g.

Average number of beneficiaries per 1,000 eligible months, aged 65 and older, who received a fall screening assessment during the observation year was calculated as follows:

$$F_g = \frac{\Sigma_{ig} x_{ig}}{\left(\frac{1}{1000}\right) * \Sigma_{ig} \mathrm{n}_{ig}}$$

Where

F_g = the average number of beneficiaries per 1,000 eligible months who received a fall screening assessment among beneficiaries in group g.
X_{ig} = the total number eligible beneficiaries age 65+ who received a fall screening assessment among individuals in group g.
n_{ig} = the total number of eligible months among beneficiaries aged 65 and older in group g.

Average rate of beneficiaries in each year who were age 65 and older and had a history of foals within the preceding 12 months, and had a plan of care for falls within the preceding 12 months.

$$PF_g = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

PF_g = the average rate of care plans after falls among beneficiaries in group g.
X_{ig} = the total number beneficiaries, aged 65 and older, and had a history of falls within the preceding 12 months and a care plan in group g.
n_{ig} = the total number of beneficiaries who were 65 and older and had a history of falls with the preceding 12 months in group g.

Minimum Data Set 3.0 Analysis Measure Definitions

RTI produces Minimum Data Set (MDS 3.0)-based outcome measures for LTSS on both a quarterly and annual basis. Two quarterly measures track the impact of the demonstration on nursing facility utilization patterns: (1) new long-stay nursing facility admissions per 1,000 eligibles, and (2) long-stay nursing facility users as a percentage of the eligible population. The annualized version of these measures are presented in this Annual Report.

The rate of new long-stay nursing facility admissions is calculated as the number of nursing facility admissions for whom there is no record of nursing facility use in the 100 days prior to the current admission and who subsequently stay in the nursing facility for 101 days or more. Individuals are included in this measure only if their nursing facility admission occurred after their first month of demonstration eligibility.

The percentage of long-stay nursing facility users is calculated as the number of individuals who have stayed in a nursing facility for 101 days or more, who were long-stay after the first month of demonstration eligibility.

RTI also analyzes characteristics of new long-stay nursing facility residents at admission to monitor nursing facility case mix and acuity levels, as well as these same characteristics for the overall long-stay nursing facility population, from the most recently available quarter of data during the demonstration. Quality measures of nursing facility care for the long-stay users are also included.

Resident characteristics include functional status determined by Resource Utilization Groups Version IV (RUG-IV), activities of daily living (ADL) score, level of care need, severe cognitive impairment, and SPMI.

RTI uses the RUG-IV classification system to measure both resident ADL score and level of care need. RUG-IV is used for Medicare reimbursement of skilled nursing facility care and consists of 66 groups based on the resident's ADL score and the amount of care time a nursing resident receives (Mor et al., 2007; Walsh, Greene, & Kaganova, 2006). ADL score is based on level of dependence in the four late-loss ADLs (i.e., bed mobility, transferring, using the toilet, and eating) and is used as a summary measure of long-term care need (Walsh, Greene, & Kaganova, 2006).

Previous studies on LTSS rebalancing have focused on residents with low levels of care need who are the best candidates for transitioning from institutional care to home and community-based services (HCBS). A 2007 study by Mor et al. found that residents with low care needs make up about 12 percent of the long-stay nursing facility resident population (2007). Based on definitions of low care need used by previous studies, RTI defines residents with low care needs as those who did not require physical assistance in any of the four late-loss ADLs and who were in the three lowest RUG-IV categories (i.e., behavior symptoms and cognitive performance, reduced physical function, and clinically complex) (Ikegami, Morris, and Fries, 1997; Irvin et al., 2013; Mor et al., 2007; Ross, Simon, Irvin, & Miller, 2012).

In addition to functional status and level of care need, RTI is also measuring the percentage of individuals with severe cognitive impairment and serious mental illness (SMI). Individuals with SMI are at increased risk of being placed in a nursing facility and may be unable to transition from nursing facilities to community care, hindered by a lack of safe and affordable residential options and community supports (Aschbrenner, Cai, Grabowski, Bartels, & Mor, 2011). Consistent with other studies, RTI limits its definition of SMI to schizophrenia and bipolar disorder, as these conditions are considered to be the most disabling and most frequently associated with serious mental illness and institutionalization (Fullerton, McGuire, Feng, Mor, & Grabowski, 2009; Grabowski, Aschbrenner, Feng, & Mor, 2009). RTI measures cognitive impairment using the Brief Interview for Mental Status, or poor short-term memory or severely impaired decision-making skills.

RTI also produces several annual quality measures to indicate the initiative's impact on quality of care that eligible individuals receive in nursing facilities. Most measures are for long-stay residents (those in facilities for 101 days or more and thus receiving LTSS) who experienced an adverse outcome for at least one quarter during the corresponding time period. These include percentage of residents who were physically restrained, percentage of residents who received an antipsychotic medication without appropriate clinical indications, and percentage of high-risk residents with pressure ulcers (Stages II–IV). We also plan to include the percentage of residents who experienced one or more falls with major injury and the percentage of residents who self-report moderate to severe pain. These measures were selected based on CMS and RTI's review of each measures' mean score and variation. They are also aligned with other CMS and partners' initiatives including Nursing Home 5-Star Rating System, Advancing Excellence and Value-Based Purchasing Demonstration.

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Appendix D:
Quality Measures: Core, Massachusetts-Specific, and Quality Withhold

Table D-1
Quality measures: Core, Massachusetts-specific, and quality withhold

No.	Measure	Core	MA–specific	Quality withhold	
				CY13 [1]	CY14
	Access				
1.1	Claims (excluding pharmacy) denied during the first 90 days of enrollment with MMP (removed 10/29/2015)	x			
1.2	Pharmacy point of sale claims denied during the first 2 weeks of passive enrollment*	x			
	Assessment				
2.1	Members with assessment completed within 90 days of enrollment*	x		x	x
2.2	Members with an assessment completed	x			
2.3	Members with an annual reassessment (added 10/29/2015)				
	Care coordination				
3.1	Members discharged from inpatient facility to home or any other site for whom a transition record was transmitted within 24 hours of discharge to family and PCP or other health professional.	x			
MA1.1	Members with care plans within 90 days of assessment		x		
MA1.2	Members with documented discussion of care goals		x		x
MA1.3	Members with LTSS needs who have an LTS coordinator		x		x
	Enrollee protection				
4.1	Part D appeals [removed 10/29/2014]	x			
4.2	Grievances and appeals (by category)	x			
MA2.1	Number of critical incident and abuse reports for members receiving LTSS		x		
	Organization structure and staffing				
5.1	Care coordinator to member ratio	x			x
5.2	Annual staffing worksheets (suspended for 2015)	x			
5.3	Establishment of Consumer Advisory Board	x		x	x
MA3.1	Care coordination training for supporting self-direction		x		

(continued)

Table D-1 (continued)
Quality measures: Core, Massachusetts-specific, and quality withhold

No.	Measure	Core	MA–specific	Quality withhold	
				CY13 [1]	CY14
	Performance and quality improvement				
6.1	Screening for clinical depression and follow-up plan	x			
MA4.1	Mental Health Recovery Measure (based on survey administered by state)		x		
MA4.2	Screening and brief counseling for unhealthy alcohol use		x		
MA4.3	Tobacco use: screening and cessation		x		
MA4.4	Medication reconciliation post-discharge		x		
MA4.5	Care for adults (for those members meeting inclusion criteria: at least one medication review; present of medication list in record; one functional status assessment; at least one pain screening or pain management plan)		x		
	Provider network				
	Guidance to be forthcoming	x			
	Systems				
8.1	LTSS clean claims paid within 30, 60 and 90 days	x			
MA5,1	ICO centralized medical record (including: ethnicity; language; homelessness; disability type)			x	x
	Utilization				
9.1	Emergency room behavioral health service use	x			
9.2	Nursing facility diversion	x			
MA6.1	Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate		x		
MA6.2	Congestive heart failure (CHF) admission rate		x		
CW4	Encounter data				x

[1] CY13 includes 3 months from the start of implementation October 1, 2013 thru December 31, 2013.

SOURCES: CMS, October 29, 2014; CMS, November 10, 2014; CMS, October 27, 2014.

Appendix E:
New and Expanded Services

New Diversionary Behavioral Health Services[32]

- **Community crisis stabilization** – services provided as an alternative to hospitalizations, including short-term psychiatric treatment in structured, community-based therapeutic environments.

- **Acute treatment services (ATS) for substance abuse disorders** – 24-hour, 7-day-a-week medically monitored addiction treatment services that provide evaluation and withdrawal management.

- **Clinical support services for substance use disorders** – 24-hour treatment services, which can be used independently or after ATS services, including education and counseling, outreach to families, and aftercare planning related to recovery.

- **Community support program** – outreach and support services delivered by community-based mobile, multidisciplinary teams of professionals and paraprofessionals to individuals with a history of psychiatric or substance abuse.

- **Partial hospitalization** – an alternative to inpatient mental health services, including short-term day mental health programming available 7 days a week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and daily psychiatric management.

- **Structured outpatient addiction program** – clinically intensive, structured day and/or evening substance abuse use disorders.

- **Intensive outpatient program** – a clinically intensive service designed to improve functional status, provide stabilization in the community, and divert an inpatient admission.

- **Program of Assertive Community Treatment** – a multi-disciplinary team approach to providing acute, active, and community-based psychiatric treatment; assertive outreach, rehabilitation, and support.

[32] Diversionary behavioral health services under One Care also include Psychiatric Day Treatment and Emergency Services Programs (24-hour crisis treatment services), which were previously available under the MassHealth fee-for-service system.

Services Expanded in Amount, Duration, or Scope over Medicaid State Plan Services

- **Durable medical equipment (DME)** – Environmental aids and assistive/adaptive technology.
- **DME** – Training in usage, repairs, and modifications.
- **Personal Assistance Services (PAS)** – cueing and monitoring with activities of daily living and instrumental activities of daily living.[33]
- **Dental** – Preventive, restorative, and emergency oral health benefits including dentures, crowns, periodontic services (root canals), and endodontic services (gum treatment); One Care Brochure; and Dental Services through One Care (April 2014).[34]

New Community-Based Services

- **Day services** – on-site structured activities that often include assistance to learn activities of daily living and functional skills, language and communication training; and interpersonal and socialization skills.
- **Home care services** – including general household tasks such as meal preparation, housekeeping, laundry; personal support and assistance with bathing, dressing, and other activities of daily living. This can include hands-on assistance, cueing, or supervision; skills training related personal finance, shopping, use of community resources, and other skills to live in the community.
- **Respite care** – services for an enrollee to support a caregiver and/or to relieve an informal caregiver from daily stresses and demands of caregiving.
- **Peer support/counseling/navigation** – Training, instruction, and mentoring to individuals about self-advocacy, participant direction, civic participation, leadership, benefits, and participation in the community.
- **Care transition assistance** – services that facilitate safe and coordinated transitions across settings.

[33] Prior to the demonstration cueing and monitoring of activities of daily living and instrumental activities of daily living were not covered as a benefit.

[34] A State Plan Amendment to broaden fee-for-service (FFS) adult dental benefits went into effect on September 15, 2014. This did not change the One Care dental benefit which was already broader than the FFS dental benefit and continues to be so. It did translate into an increase in the MassHealth portion of the One Care capitation rate, since rates are based on FFS spending (State Data Reporting System, 2nd Quarter). Under MassHealth FFS, dental benefits include fillings, oral surgery, extractions, routine cleanings, exams, x-rays, and emergency services. Each One Care plan may have different coverage rules or limits on dental services such as prior authorizations or limits on the number of visits.

- **Home modifications** – physical adaptations to an enrollee's residence that ensure health, welfare, and safety or enable enrollee to function with greater independence. This includes modifications such as ramps, grab-bars, widening of bathroom facilities, and other installations to accommodate medical equipment and supplies.

- **Community health worker**s – people who provide culturally appropriate health education, information, and outreach; information counseling, support, and care coordination; and who advocate for individual and community needs.

- **Medication management** – services to support enrollees capable of self-administration of prescription and over-the-counter medications.

- **Non-medical transportation** – services within the community to enable the enrollee to access community services, activities, and resources to foster independence and support integration and full participation in the community.

- **Personal Assistance Services through an agency** – personal assistance services for enrollees who choose not to self-direct services or who are not able to find a surrogate. The One Care plans must provide the enrollee with the choice of at least two PAS agency providers (three-way contract, p. 84).[35]

[35] Before the demonstration, personal assistance services were only available under the Medicaid State Plan to those who chose to self-direct services or who had a surrogate to assist with self-direction.

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Appendix F:
Summary of Predemonstration and Demonstration Design Features for Medicare and Medicaid Beneficiaries and Massachusetts

Table F-1
Demonstration design features

Key features	Predemonstration	Demonstration
Summary of covered benefits		
Medicare	Medicare Parts A, B, and D	Medicare Parts A, B, and D.
Medicaid	Medicaid State Plan	Medicaid State Plan services, as well as new diversionary behavioral health and community support services, and expanded State Plan services (e.g., dental, DME services). Exclusions are listed below.
Payment method (capitated/FFS)		
Medicare	Mostly FFS; very small percentage in Medicare Advantage plans, or PACE	Capitated. Medicare hospice services remain FFS (as in Medicare Advantage).
Medicaid (capitated or FFS)		
Primary/medical	FFS	Capitated
Behavioral health	FFS	Capitated. Service exclusions: Targeted Care Management (TCM) for beneficiaries with severe and persistent mental illness (SPMI) or intellectual disabilities and Rehabilitation Option services for beneficiaries with SPMI are not included in the capitation rate under the demonstration. The Commonwealth continues to provide these services on an FFS basis.
LTSS	FFS	Capitated. Individuals enrolled in 1915(c) HCBS waivers and individuals residing in ICF/IIDs are not eligible to enroll in the demonstration.
Other (specify)		
Diversionary behavioral health services, including community crisis stabilizations, community support program, and partial hospitalization	Not available to the eligible population; some services available via HCBS waivers or Medicaid managed care plans	Capitated

(continued)

Table F-1 (continued)
Demonstration design features

Key features	Predemonstration	Demonstration
Expanded services, including preventive, restorative, and emergency oral health benefits; personal care assistance that may be hands on or cueing and supervision); and certain DME (e.g., environmental aids, training in use, repairs, cueing and monitoring)	Not available	Capitated
New Community Support Services (day services, home care services, respite, peer support, care transition assistance, home modifications, community health workers, medication management, nonmedical transportation)	Not available to the eligible population; some services available via HCBS waivers or Medicaid managed care plans	Capitated
Care coordination/care management		
Care coordination for medical, behavioral health, or LTSS and by whom	Medical homes provided some care coordination for medical and behavioral services.	One Care plans offer care coordination through a care coordinator or clinical care manager for medical and behavioral health services and through an LTS coordinator, contracted with a community-based organization, for LTSS.
Care coordination/care management for HCBS waivers and by whom	Care management of LTSS via HCBS waivers operated by Department of Developmental Services (DDS), the Massachusetts Rehabilitation Commission, and the Executive Office of Elder Affairs	People enrolled in HCBS waivers are not eligible for the demonstration.
Targeted Care Management	Provided to certain individuals served by DDS and DMH.	No change; TCM is not included in the capitation rate under the demonstration. The Commonwealth continues to provide this service on an FFS basis. People receiving TCM are eligible to participate in the demonstration.
Rehabilitation Option services	Provided through DMH contractors to clients of DMH.	No change; Rehabilitation Option services are not included in the capitation rate under the demonstration. The Commonwealth continues to provide on an FFS basis. People receiving Rehabilitation Option services are eligible to participate in the demonstration.

(continued)

Table F-1 (continued)
Demonstration design features

Key features	Predemonstration	Demonstration
Clinical, integrated, or intensive care management	None	Primary care provider, with One Care plan support, provides clinical care management for individuals with complex care needs.
Enrollment/assignment		
Opt-in enrollment method	N/A	Beneficiaries are offered a choice of any One Care plan operating in their county of residence or to remain in MassHealth and Medicare FFS (or join Medicare Advantage or another program, if applicable).
Passive enrollment method	N/A	Passive enrollment applies to those beneficiaries who live in a county with at least two plans. Those who do not select a One Care plan and who do not opt out may be passively enrolled in the demonstration and can change One Care plans or disenroll from the demonstration on a monthly basis.
Implementation		
Geographic area	N/A	Nine counties: Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth (partial), Suffolk, Worcester.
Phase-in plan	N/A	The first enrollment period was opt-in only. Beneficiaries were offered the opportunity to select a One Care plan or indicate that they would like to opt out of the demonstration. First enrollments took effect on October 1, 2013. There have been four waves of passive enrollment through Demonstration Year 1: those waves were effective January 1, 2014; April 1, 2014; July 1, 2014; and November 1, 2014.
Implementation date	N/A	October 1, 2013

DME = durable medical equipment; DMH = Department of Mental Health; FFS = fee for service; HCBS = home and community-based services; ICF/IID = intermediate care facilities for individuals with intellectual disabilities; LTS coordinator = Independent Living and Long-Term Services and Supports coordinator; LTSS = long-term services and supports; N/A = not applicable; PACE = Program of All-Inclusive Care for the Elderly.

SOURCE: MOU, 2012.