Review of plan presentations since September 2021 and IC member feedback

April 12, 2022 Implementation Council Meeting

Timeline of Plan Presentations

- **September 2021**: The IC, in collaboration with plans and MassHealth, started conversation on how plans can best share data on authorizations, modifications and denials for PCA hours, acupuncture, and DME.
- **October 2021**: Plans shared data on Personal Care Attendant (PCA) authorizations for PCA hours.
- **November 2021**: Plans shared claims data for acupuncture.

  Plans also pulled data on claims for DME but decided in conversation with the IC that it was not the best way to show DME usage.
- **February 2022**: Plans shared information on the full UM process including the definition of medically necessary, the determination of need process, and the role of the care team in the UM process.
- **March 2022**: Plans shared data on DME approvals, denials and modifications based on the authorization letters sent to members. Plans also shared draft authorization letters.

April IC Meeting Discussion

Agenda: Discussion on what we have learned so far about plan Utilization Management systems, data collection, and authorizations for DME

- Network adequacy and the impact on DME
- Impact of Vendor on DME Authorizations
- Discussion Questions for Plans, IC members, and MassHealth
- Next Steps
- Remaining Questions

DME Discussion Points

Network Adequacy / Impact on DME

- One Care members report that plans used to be more flexible in providing access to needed single use DME in the past.
- One Care members report not being able to get single use DME through One Care vendors, despite online availability on websites such as Amazon.

  - How do plans ensure access to single use DME when contracting with limited vendor networks?
  - How do plans track:
    - utilization of single use DME
    - decreases in use of DME supplies
  - How do plans address gaps in access to single use DME?
  - How do plans communicate to plan members gaps in access to single use DME?
  - Are plans able to provide members information about the vendor's current capacity to provide the services approved by the plan?
  - How many members have requested reimbursement for single use DME? How many are denied reimbursement? What percentage of requests are denied?
  - How many appeals / grievances regarding single use DME are filed?

Network Adequacy / Vendor Role in DME

- One Care members express confusion about
  - approvals/denials for DME that is not available in network.
  - the authorization process for services when the service is not available within the plan network.
- One Care members report shrinking vendor network capacity
  - How do plans ensure network adequacy prior to authorizing services? How do plans ensure vendors can provide services before authorizing them?
  - How do plans track disparities between services authorized and services provided?
  - How is this data used to address unmet member needs?

IC Round Robin

In this Round Robin we want to provide IC Members the opportunity to discuss the plan presentations on Service Authorizations that started in September and cover the following topics:

- Utilization Management process
- Personal Care Attendant (PCA) hour approvals / denials / modifications
- Acupuncture approvals / denials / modifications
- DME approvals / denials / modifications
- Letters reporting service authorization approvals / denials / modifications
- Data transparency in formats accessible to One Care Members

Do you have any questions about the plan presentations or these topics more generally?

Other Questions Arising from Plan Presentations since September

These are lessons learned from the DME presentations, however, they apply to all services.

- It is not clear if plans are always providing members the “most generous” benefit available to them.
- Data for One Care services is not collected in the same way across the plans and is not regularly made available to the public.
- The relationship between the utilization management (UM) team, the care team, the care coordinator and the approval of services remains confusing.
- It is not clear how plans:
  - Apply independent living philosophy to care plan creation and UM decisions.
  - Utilize One Care authorization flexibility in UM decision-making?
  - Factor in total cost of care per person per year in making authorization decisions for persons with complex, high-cost needs?

Round Robin Priorities

- Understanding the role of the care coordinator is, what they are responsible for, and include this in the contract. Understand the minimum expected ratio of care coordinators per member, by rating category.
- Data that is meaningful to people.
- Letters that have meaningful information.
- Utilization management procedures that are understandable to members (for appeals).
- Understand what plans are doing to support the empowerment of members.
- Ensuring that plans are following the independent living model not the medical model.
- MassHealth, what is feasible?
- Plans, what are your barriers?

Appendix

Background Information

IC Round Robin / Action Steps

- What actions steps would council members like to see MassHealth and the plans take in response to the plan presentations over the last 6 months?

  Here are some things to consider:
  - Who is ensuring people have a point person for communication about the utilization management process from start to finish for getting services authorized?
  - Can plans provide a cover letter written at the fourth grade reading level, notifying the member of the outcome of their authorization request and provide next steps that the member can take if the service request was modified or denied? This cover letter should include:
    - the name and contact information of the specific person who will assist the member in the authorization process
    - clear information on what was approved, what was modified, and what was denied
  - Data on trends reported at level that is appropriate for IC members to understand. Including:
    - appeals that are overturned in favor of the member
    - approvals, modifications and denials by specific category
    - percentage of approvals, modifications and denials

- Any other action steps you would like to see?

Plan Data Presentations - Background

The IC, working in collaboration with MassHealth and Plans in September, developed outlines for plan information data sharing on the following topics:

- Personal Care Attendant (PCA) - authorizations for PCA hours
- Massage Therapy - authorizations
- DME - new purchase requests and repairs requests for:

  Power Beds, Power Wheelchairs, Electric Lifts, Ceiling Lifts, Other DME
- Acupuncture - requests
- Nonmedical Transportation – authorizations

For each of these services, the IC asked plans to explain their utilization management process, define approvals, modifications, and denials for each presentation, break up data by One Care Rating Category, and to show data over time (for years 2018 – 2022).

Proposed Authorization, Denial and Modification language for member letters

Reason	Approved	Reason	Approved with modification	Denied
Met authorization requirements for most generous payer (identify payer e.g.) Medicare or MassHealth		Did not meet Medicare and MassHealth medical necessity requirements		
Necessary to meet care plan goals		Not necessary to meet care plan goals		
Eligible for flexibilities in medical necessity guidelines within One Care model)		Not eligible for flexibilities in medical necessity guidelines within One Care model)		
Administrative Requirements Met		Administrative Requirements Not Met		