**Slide 1**

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**Duals Demonstration 2.0  
Listening Session #1**

Executive Office of Health & Human Services

MassHealth

One Care and Senior Care Options (SCO)

July 27, 2018

DRAFT – FOR POLICY DEVELOPMENT PURPOSES ONLY

**Slide 2**

*This footnote appears on slides 1-18:*“draft – for policy development purposes only”

**Agenda**

* + Updates
  + Provider Engagement and Networks
  + Service Authorizations
  + Grievances and Appeals
  + Care Management
  + Next Steps

**Slide 3**

**Updates – Status and Timeline**

* Request for Information on High Utilizers - May 25, 2018
* Draft Concept Paper - June 13, 2018
* One Care Implementation Council/MassHealth Duals Demonstration 2.0 Meeting - June 14, 2018
* Listening Session #1 - July 27, 2018 *(Note: this session is highlighted with a red box around it)*
* Listening Session #2 - August 7, 2018:
  + Value based purchasing
  + Risk mitigations
  + Medicare bidding approach
  + Measuring and incenting quality
* Listening Session #3 - August 20, 2018:
  + Continuity of Care
  + Passive Enrollment
  + Enrollment churn
  + Fixed Enrollment/Special Enrollment Periods
  + HCBS Waiver participant access to integrated care in the future
* One Care Plan Procurement Release August 2018 (tentative)

**Slide 4**

**Anticipated Procurement Timeline for One Care Plans**

|  |  |
| --- | --- |
| **August 2018 (tentative)**   * One Care Plan Procurement Release   **September 2018 (tentative)**   * Letters of Intent Requested by MassHealth   **October 2018 (tentative)**   * Bidder Reponses Due   **November 2018**   * Medicare Notice of Intent to Apply (NOIA) Due\*   **January 2019 (tentative)**   * One Care Plan Selection | **February 2019**   * Medicare Applications Due\*   **March 2019**   * Network Submissions Due for Validation\*\*   **February – July, 2019 (tentative)**   * Joint Readiness Reviews\*\*   **June 3, 2019**   * Medicare Bids Due\*   **January 1, 2020**   * First Enrollment Effective Date |
| *\* Milestone is a part of CMS’ annual Medicare application and contracting process*  *\*\* Joint MassHealth and CMS/Medicare process* | |

|  |
| --- |
| MassHealth will post updates about the One Care procurement process:   * On COMMBUYS: [www.commbuys.com](http://www.commbuys.com/) * On the One Care and Duals Demo 2.0 websites: [www.mass.gov/service-details/information-for-organizations-interested-in-serving-as-one-care-plans](http://www.mass.gov/service-details/information-for-organizations-interested-in-serving-as-one-care-plans) |

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**Provider Engagement and Networks – Background**

Network Standards for One Care and SCO:

* Medicare standards have applied for medical services and prescription drugs
* MassHealth sets standards for long-term supports and services and other Medicaid services
* Networks must be sufficient to address the needs of the target populations
  + Time and distance
  + Choice

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**Provider Engagement and Networks – Draft Concept Paper Comments**

* Broad interest in access to One Care and SCO statewide and in ensuring robust provider networks
* Issues to address:
  + Provider participation
  + Access to certain services (e.g. durable medical equipment, transportation)
  + Adjusting network capacity with enrollment growth

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**Provider Engagement and Networks – Discussion Questions**

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

**Slide 8**

**Service Authorizations – Background**

* Plans may require prior authorization (PA) for certain services
* Plans must have utilization management (UM) policies and procedures (for program integrity and equity)
* Service authorization processes must be at least as protective of medical necessity as the combination of Medicare and MassHealth FFS would be
* A member’s assessment, which includes understanding their goals and interests, informs their personal care plan
* Services in a member’s person-centered care plan may be subject to prior authorization or utilization management review

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**Service Authorizations – Draft Concept Paper Comments and Discussion Questions**

**Draft Concept Paper Comments:**

* Service authorization processes should:
  + Be transparent
  + Advance person-centered goals

**Discussion Questions:**

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

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**Grievances – Background and Discussion Questions**

**Background:**

* Timeframes: Respond in 30 days; if expedited, respond within 24 hours
* One Care’s process accepts grievances through several entities, whereas SCO’s process is consolidated at the plan.

**Discussion Questions:**

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

**Slide 11**

**Appeals – Background**

|  |  |  |  |
| --- | --- | --- | --- |
| **Second  Level Appeals** | **One Care** | **SCO** | **Duals Demo 2.0 – For Discussion** |
| **Standard** | 120 days1 to file Response within 30 days | | 120 days to file; Response within 30 days |
| **Expedited** | Must be requested,  Response within 72 hours | | Must be requested,  Response within 72 hours |

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**Appeals – Background Cont.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Topic** | **One Care** | **SCO** | **Duals Demo 2.0 – For Discussion** |
| **Second Level Appeals** | Medicare services – Medicare Independent Review Entity (IRE)  MassHealth services – MassHealth Board of Hearings  For Medicare/Medicaid services - May pursue both appeal routes at the same time | Medicare services – Medicare IRE  MassHealth services – MassHealth Board of Hearings  For Medicare/Medicaid services - May pursue both appeal routes at the same time | All appeals – MassHealth Board of Hearings |
| **Auto-Forward** | Medicare services – Yes to IRE MassHealth services – No | | For discussion |
| **Aid-Pending** | 1st Level Appeals - all prior approved non-Part D benefits must continue  2nd Level Appeals to MassHealth Board of Hearings (BOH) –continuing services must be requested within 10 days of the plan’s internal appeal decision  2nd Level Appeals to Medicare IRE – no continued services provided | 1st Level Appeals – all prior approved non-Part D benefits will continue if the member appeals within 10 days  2nd Level Appeals to BOH - continuing services must be requested within 10 days of the plan’s internal appeal decision  Medicare appeals – no continued services provided | During the second level appeal process – all services\* will continue if the member requests a BOH appeal within 10 days of the plan’s internal appeal decision  *\*assumes Medicare funding for Medicare services* |

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**Appeals – Draft Concept Paper Comments**

* Some interest in consolidating/aligning the appeals process
* Suggestions:
  + All appeals at Board of Hearings (BOH) only
    - Ensure sufficient staffing, timeliness, Medicare-knowledge on BOH team
    - In-person BOH review process
  + Medicare reviews Medicare covered services (i.e. no BOH review)
  + Create on-line option for requesting appeal and seeing status of appeal

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**Appeals – Discussion Questions**

* What gaps exist in the current processes and how should MassHealth address them? (e.g. for members, providers, health plans, and others involved in the process)
* For which Medicare services is auto-forwarding most important, and why?
* Which Medicare services are most frequently (fully or partially) reversed in Medicare’s external review process?
* Which Medicare services are more appropriate for a member or provider initiated second level external appeal?
* Please provide any additional strategies, considerations, or approaches MassHealth should consider to ensure external appeals processes are transparent, accessible, and responsive to members.

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**Care Management – Background**

* One Care and SCO both include:
  + All Medicare Part A, B, and D services and MassHealth State plan services
  + Additional Behavioral Health (BH) diversionary services, dental and vision, and community-based supports
* Team approach to help member coordinate their medical care, behavioral health services, and long-term services and supports
* Assessment informs member’s care plan, developed together with their care team; in One Care, member is center of care team
  + One Care: Member is at center of their Interdisciplinary Care Team; Primary Care Provider (PCP) leads team with Care Coordinator, and with BH clinician if indicated
  + SCO: Care managed by a Primary Care Team lead by the PCP

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**Care Management – Draft Concept Paper Comments**

* Overwhelming support for coordinated, integrated care for dual eligible beneficiaries
* Consider:
  + Allowing/encouraging plans to contract with non-medical entities to provide care coordination
  + Using Substance Use Disorder (SUD) and behavioral health providers for care coordination

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**Care Management – Discussion Questions**

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

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**Next Steps**

**Listening Session #2**

**Date:** August 7, 2018 **Time:** 2:00pm – 4:00pm

**Location:** 1 Ashburton Place, 21st Floor, Boston, MA

Expected Topics for Discussion

* + - Value-based purchasing
    - Risk mitigations
    - Medicare bidding approach
    - Measuring and incenting quality

**Listening Session #3**

**Date:** August 20, 2018 **Time:** 2:00pm – 4:00pm

**Location:** 1 Ashburton Place, 21st Floor, Boston, MA

Expected Topics for Discussion

* + - Continuity of Care
    - Passive enrollment
    - Enrollment churn
    - Fixed Enrollment / Special Enrollment Periods
    - HCBS Waiver access to integrated care in the future

**Slide 19**

**One Care logo which includes this text:
One Care
MassHealth+Medicare
Bringing your care togetherSCO logo which includes this text:
Senior Care Options**

**VISIT US ONLINE** [**www.mass.gov/duals-demonstration-20**](http://www.mass.gov/one-care)

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