**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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**Slide 5**

**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

**Slide 6**

**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

**Slide 7**

**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

**Slide 9**

**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?

**Slide 10**

**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 fileResponse 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 |

**Slide 12**

**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 HearingsFor Medicare/Medicaid services - May pursue both appeal routes at the same time | Medicare services – Medicare IREMassHealth services – MassHealth Board of HearingsFor Medicare/Medicaid services - May pursue both appeal routes at the same time | All appeals – MassHealth Board of Hearings |
| **Auto-Forward** | Medicare services – Yes to IREMassHealth services – No | For discussion |
| **Aid-Pending** | 1st Level Appeals - all prior approved non-Part D benefits must continue2nd Level Appeals to MassHealth Board of Hearings (BOH) –continuing services must be requested within 10 days of the plan’s internal appeal decision2nd 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 days2nd Level Appeals to BOH - continuing services must be requested within 10 days of the plan’s internal appeal decisionMedicare 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* |

**Slide 13**

**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

**Slide 14**

**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.

**Slide 15**

**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

**Slide 16**

**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

**Slide 17**

**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?

**Slide 18**

**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**

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

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