Welcome and Introduction/Update

Robin Callahan, Deputy Medicaid Director and **Greg Wilmot**, Senior Advisor for Strategic Planning from Massachusetts's Executive Office of Health and Human Services facilitated the meeting.

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- Would some of the entities focus on specific populations, such as populations in need of mental health care or long-term services and supports?
    - **MassHealth response:** The entity must serve the integrated, whole care needs of the member. How they meet these needs will vary based on contractual relationships. Each entity is completely responsible for the full set of service options.
- Slide 10 references flexibility and "in lieu of" services. Is this only a suggested list? Can the entity support whatever is needed to meet the member's needs as determined through a person-centered planning process?
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<u>The managing entity or integrated care organization (no specific name decided on yet):</u>

- There is a fear that the entity will profit from the service plan if a conflict-free broker is not required. Patient-Centered Medical Home (PCMH) is a good model. The entity should contract with community-based providers and not build new services "in house."

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- May the ICO provide additional services?
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- How would enhanced services work within a patient-centered care model?
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<u>Clinical care team/community health workers</u>:

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that all professionals will meet the individual's needs and know about all other care the person is receiving?

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<u>Opt-out option/enrollment</u>

- Why is there a voluntary opt-out for Duals, but a voluntary opt-in for the Senior Care Options (SCO) program?
  - **MassHealth response:** This program is being developed during a different time. We need to put together a demonstration for a population that currently has very limited access to any integrated model and that will have significant scale and impact within the three years allotted by CMS. Programs for All-inclusive Care for the Elderly (PACE) and SCO do not have the impact and quick scale that CMS is looking for within this proposal. We need to have stability of enrollment guaranteed for the entities so that they can offer robust services to the members. We need to design a program that will win the approval of CMS.
- Do you have an estimate of the numbers of enrollees with an opt-in and with opt-out?
  - **MassHealth Response:** We're not able to evaluate who would select this option or whether they would tend to be high-cost or low-cost. The primary attractions for this program are the extra benefits – care

coordination and long-term supports and services. This program has the makings of a superior offering.

- Can we assume that in areas where there isn't a choice of ICOs, there will be no auto enrollment of members?
    - **MassHealth response:** Yes
- The default should be fee-for-service (FFS). If the product is good, members will opt for that product. Members value their relationship with current providers. Currently, SCO relationships with community mental health providers are inadequate.
- Opt-out looks like cherry-picking. If the member appears to be more difficult, the ICO would move them back to FFS.
    - **MassHealth response:** If there are other measures to mitigate this, additional input is appreciated.
- I fully support having no lock-in period, but it can be problematic if someone has complex needs and wants to switch plans but doesn't have a transition plan in place.
    - **MassHealth response:** We'd expect that providers *would* need to create a transition plan for that individual.
- Can members opt-out without ever having been enrolled in one of these plans?
    - **MassHealth response:** Yes, they can opt-out before auto assignment occurs.
- Will there be a penalty for opting out if too many people decide to do so?
    - **MassHealth response:** No, there will be a lot of concern from CMS and MassHealth but no member issues.
- When can a member's plan be changed?
    - **MassHealth response:** There is no lock-in period, so the member can change any time. Opting out will not have a penalty; it just means going back to what the current default is: fee-for-service. We will actively seek further input on communications and the production of understandable materials and customer service support.
    - The proposed demo will not change what's currently offered under fee-for-service. If you like what you've got now, you can keep it, but we believe that for many people, like those with behavioral health issues, the current system is insufficient. We will try to explain to members why this will be a better model of care due to the significant added value.
- I'm concerned about a geographic emphasis, rather than a skill or competency-based emphasis in the roll out. How can we be more creative?
    - **MassHealth Response:** The enrollment will probably need to be phased in. Future meetings can better define the roll-out process. There will be plenty of time for feedback during implementation after submitting the proposal to CMS and negotiating terms and conditions.
- Can this be explained more in the next presentation?

- **MassHealth response:** Yes, there will be a 30- day public comment period on the proposal to CMS. There will be negotiations between the state and CMS. CMS must decide what they are willing to pay for and if it is financially sustainable.

Consumer comments:

- There needs to be a change to MassHealth notices. No one can understand them because they are far too complex and confusing.
  - **MassHealth response:** Agreed
- Make sure to make this consumer-friendly; all these acronyms are confusing.
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Geography:

- If a person living in Western Mass doesn't have transportation access and available providers within the region, will transportation be provided to Boston if needed?
  - **MassHealth response:** That is an open question. The hope is that multiple networks and providers will be available to all. However, some regions will be more difficult and this is a challenge.
- It is difficult to align the focus on certain populations with a breakdown by geographic areas. What happens to those in Western MA that cannot access these specialty plans?
  - **MassHealth response:** We will need to look at this more. The approach is to identify regions like the MCO regions but if there are special opportunities, they could be made available in a different way.

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- Regarding reducing acute expenditures, could we use the under-65 PCC population as a comparison group?
  - **MassHealth response:** We're looking at that data. However, we don't currently have a model that looks like this proposal and integrates LTSS. However, there still is a lot to gain from that data set.
- Have you considered including the Department of Housing and Urban Development (HUD) in the proposal? HUD and CMS have been working together already federally.
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- Please talk further about risk adjustment.
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