Duals Consumer Meeting – September 27, 2011

Facilitator and presenter, Robin Callahan, Deputy Medicaid Director for Policy and Programs

Welcome and Introduction/Update on Proposal submission

- MassHealth held two "open" meetings in June and August 2011, but this is a consumer-focused meeting, designed to focus on the needs and concerns of dually eligible *members*.

- MassHealth will soon be submitting a proposal to the Centers for Medicare & Medicaid Services (CMS) and the goal is to have stakeholders understand the proposal *before* its submitted.

- This is a critical milestone for this program and sharing the content of the proposal to CMS is the main agenda item for the day.

- Original plan was to submit by October 31, 2011 but that may be delayed to allow adequate time after the 30-day public comment period to review and address those public comments.

Questions/Discussion

Proposal to CMS and cost savings:

- Is the original model that Massachusetts proposed, where the state receives the Medicare funding, no longer being considered?
  - **MassHealth Response**: Massachusetts will use the 3-way model described in the July 8, 2011 CMS State Medicaid Director's letter. The Commonwealth's goals were to achieve simplicity for providers and members, accountability, and joint streams of effort. The Feds are supporting these goals and the 3-way contract will meet these needs.
- Are the cost savings still coming from the Medicare services?
  - **MassHealth Response**: The 3-way model allows the state to blend rates to achieve savings. New investments will lead to decreased costs in acute care which is typically paid by Medicare. And the blending will lead to savings. This conceptually looks the same as the original proposal but the primary difference is that the entity will receive two checks, not one.
- Upon completion of the proposal, will there be projects with certain providers or will that happen after the agreement is made with CMS?
  - **MassHealth Response**: Medicare and MassHealth will issue a joint procurement. This will not happen unless the proposal is accepted.
- When will we hear back from CMS regarding implementing the program?
  - **CMS response**: A time period has not been identified. States have 18 months from last April to submit proposals. Massachusetts' early submission may speed up this time frame but processes have not been developed on the CMS side yet.
- When will the draft proposal be available for review?

    - **MassHealth response**: The draft proposal will be posted to Comm-Pass in the next few weeks. Email notifications will be sent out when it is posted.
- Since this is a three-year demo, is there a concern about how administration changes could affect the program. Are there thoughts about legislative approaches to ensuring continuity of the program?
    - **MassHealth Response**: Massachusetts will be committed to a three-year demonstration per the terms of agreement with CMS. There hasn't been thinking to date about the need for legislative action. There will be a presentation to the legislature about the demonstration in two weeks.
- Will the extra services be in the plan first, or added in once there are savings?
    - **MassHealth Response**: They'll be there from the beginning of the program.
    - Audience comment: It is important to do this right and not to work in fear. We should do this with knowledge and understanding about the complexity of the population and how to do this.
- How has MassHealth thought about the evaluation? What is the experimental design?
    - **CMS response**: CMS will contract with an external contractor that will select comparison groups, possibly within different states. The state will also do an evaluation.

<u>Enrollment/Continuity of care</u>

- Will someone on the integrated care team be conflict-free and not an ICE provider, like in the Senior Care Options (SCO) model?
    - **MassHealth Response**: The team should reflect the predominant needs of the member. If the member wants/needs someone to join the team, that should happen.
    - Audience comment: Also supportive of the SCO model. The option to have a conflict-free team member should be mandated as many mainstream medical providers do not know the community options that are available.
    - **MassHealth Response**: Someone on the team must have this knowledge.
- How quickly will this be implemented across the population and is there a phase-in strategy?
    - **MassHealth Response**: Massachusetts will identify a cohort and get that cohort enrolled as quickly as possible; the implementation will be statewide.
- Members should have the ability to change plans. Will the plans be geographically proximate or will the member be able to go where they want to go?
    - **MassHealth Response**: There will be geographic service areas, likely consistent with the MCO plans. There will be some assignment for geographic accessibility. Entities must have sufficient networks. The state is still open to the ICE serving some regions as a local network. When this is the case, it will be important to make assurances that the network is sufficient.
- Some providers will not want to be in networks but will want to continue serving enrollees. Will that be allowed?
    - **MassHealth response**: The networks will not be limited. Single use agreements will be available for members utilizing providers that are not within the network. This should be an allowance.
- How will medical transportation be purchased?

    - **MassHealth response**: Medical transportation will be included. There are no plans for wraps or carve-out services.
- Can enrollees also be HCBS waiver enrollees?
    - **MassHealth response**: This is possible. About 6,000 of the 110,000 dual adults are also waiver enrollees. MassHealth will have something more definitive to say about how this will work next week.
- Why would the waiver population be different?
    - **MassHealth response**: This program is not the same as a 1915c waiver. Many waiver services are not within this service package. A full waiver package would not be affordable. This is an alternative way of delivering Medicare and Medicaid services.
- Our concerns have been well-addressed, but how can we get to a point of having a voluntary opt-in?
    - **MassHealth response**: Opt-in is not going to get us to the scale we need in three years to have an impact on spending and the confidence of CMS and the networks. SCO usage is empirical evidence to that point. It's a great model, but does not have the impact we need to see. The state is willing to do what it takes to make the opt-out work.
- Please explain what is meant by "scale."
    - **MassHealth Response**: CMS is looking to invest in proposals that have enough scale to make an impression on the service delivery system. They need to be able to measure the impact on quality and cost. CMS said that SCO has a great reputation nationwide and members like it; it is a good program and we consider it a model. But the enrollment in SCO is small and it's difficult to assess the effect on spending for that population. CMS needs a plan that will engage the members of the cohort quickly so they can measure impact.
- This program is a product that consumers reasonably should and will want, and it's politically problematic to tell people what plan they need to be in. They should have the chance to choose it, to decide they want it. Mass Home Care supports opt-in.
    - **MassHealth response**: But even with the SCOs, a great program that people like a lot, enrollment is not nearly as high as it needs to be. Our current fee-for-service system will result in gradual cuts over time due to budget issues. The default needs to be a service delivery system that provides better results.
    - **MassHealth Response on SHINE**: Would like to use a similar approach to SHINE. We will have people knowledgeable about the program and options in the community. Information will be provided to providers and patients to ensure they are both aware of the advantages. An early ramp-up will improve the auto-enrollment process and early information will provide more time for enrollees to make a choice.

Delivery of care

- I would be excited to get a letter about a program that provides the option to choose from two networks that both have experience in complex care delivery. There are concerns that people with complex needs like those with behavioral health issues and physical disabilities will not have access to adequate providers with these competencies. Where will these options come from?

    - **MassHealth response**: Need to focus on making the current service system better.
- Would MassHealth consider using community-based organizations as the neutral broker?
    - **MassHealth response**: A customer service staff will be available. We don't know to what extent the community-based organizations are going to want to contract with the ICEs to provide services. This may be possible if there is no financial interest.
    - Audience comment: Program called SHINE (Serving the Health Information Needs of Elders) is a good model. They are well trained and have no vested interest.
- It is important to also discuss cultural competency.
    - **MassHealth response**: One of the things that this model does is tells perspective plans, if you're going to be a player, you have to help in the development of a workforce, including developing a workforce of physicians and other professionals who will serve this population well. That's the way they're going to be successful.
- There is concern about the adequacy of the networks. There is insufficient cultural competency education. Providers need more education. In the current system, many adults with ID/DD continue using pediatricians into adulthood because of a lack of culturally competent providers.
    - **MassHealth response**: Providers must support the development of the workforce. There will be an incentive created for plans to develop the workforce to serve disability populations. There will also be contract expectations.
- Is there any discussion about changing medical necessity requirements for this demonstration? Is MassHealth no longer considering adding in non-traditional services such as the ability to purchase an air conditioner to prevent acute episodes?
    - **MassHealth response**: The entities will not use the current prior authorization process and will provide services within a global budget. Within a fiscal range, the care team will manage the services and be expected to provide community services. Offering non-traditional services has not been an issue for SCOs. Everyone should look at this model and if the language is not adequate, language should be suggested.
- A lot of publicity will be needed. When the Medicare Part D roll out happened, there was a lot of publicity but still a ton of people were unaware of the change and that it affected their benefits. It is important to make sure enrollees with current PAs get what they need.
    - **MassHealth response**: An option would be to build into the requirements for the integrated care entity an obligation to accept current MassHealth prior authorizations during a certain transition period. Should continue to think about ways to do this.
- How many plans are you expecting to enter the bidding process?
    - **MassHealth response**: The current task is to create a program with clear specifications regarding what MassHealth is buying. Would like as many providers as possible to engage in the RFP process.
- What is the role of MassHealth and CMS in choosing a benefit package versus allowing providers to select "tools" from a "toolkit." Is further debate on the benefit needed now or will providers be able to manage the package?
    - **MassHealth response**: The capitated services have been decided. There will be "in lieu of" services what will also be a part of the "toolkit." This conversation should continue at the next meeting. Plans should be person-specific and non-traditional services should be used effectively.
- How will the entity need to "employ" community-based organizations?

  - **MassHealth response**: The entities will need to have relationships in the community that support their panel of members. It may be that many of the members have recovery issues and connections must be made with recovery-focused community organizations.
- Do providers need to be a recognized vendor to be considered in the RFP process?
  - **MassHealth response**: Not aware of this requirement. Will do further research into this question and will provide an answer.

Please continue to share your ongoing questions and comments by emailing Duals@state.ma.us.

The next meeting will be on October 11, 2011 at the Transportation Building, Rooms 2-3, in Boston, from 10:00 am – 12:00 noon.