

# Medicare-Medicaid Integration Demonstration for Massachusetts (Duals Demonstration 2.0)

Draft Document for Discussion

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## Introduction

Individuals who qualify for both Medicare and Medicaid, known as “dual eligibles,” have among the most complex care needs of any population served by either Medicaid or Medicare. Members (those individuals enrolled in MassHealth) may be dual eligible either because they have a disability or they are over age 65 and low-income. As a result, many dual eligible members utilize a broad range of health care services, including medical and behavioral health services, as well as long-term services and supports that sustain their ability to live independently in the community or in a nursing facility. MassHealth, Massachusetts’ Medicaid program, currently provides care for approximately 310,000 dual eligible members. Combined Medicare and Medicaid costs of serving dual eligible members in Massachusetts is estimated to exceed \$9 billion, with MassHealth and Medicare each bearing about half of these costs.

Historically, most dual eligible members have received their care on a fee-for-service basis from both Medicare and Medicaid. Without any single health plan or provider having responsibility to coordinate care for members, the fee-for-service system results in fragmented care. Members themselves must take on the task of navigating the health and long term care systems and in order to obtain all the services they need through two different payers. This presents significant challenges, particularly given the complex care needs of the dual eligible population, and it creates the potential for members to not get all of the care they need at the time they need it most.

In order to bring more integrated, coordinated, and person-centered care options to its dual eligible members, MassHealth has worked with its federal partners to develop programs designed to coordinate and integrate Medicare and Medicaid services. For example, Massachusetts was an early adopter of the Program of All-Inclusive Care for the Elderly (PACE) model, which provides site-based integrated care for individuals ages 55 and older who would otherwise be clinically eligible for nursing facility care. Massachusetts maintains its PACE program today, with approximately 4,500 members currently participating.

The focus of this proposal is on two additional integrated care programs offered to dual eligible members in the Commonwealth that are provided through health plans that specialize in serving dual eligible members under age 65 and over age 65, respectively:

- **One Care** is an 1115A Duals Demonstration (both a Financial Alignment Demonstration and a State Demonstration to Integrate Care for Dual Eligible Individuals) for individuals who are ages 21-64 at the time of enrollment and living with disabilities, currently serving about 20,000 members; and
- **Senior Care Options (SCO)** is a program of Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) for individuals ages 65 and older,<sup>1</sup> currently serving over 54,000 members.

Based on its experience serving dual eligibles in both fee-for-service and integrated care programs, the Commonwealth believes that integrated care provides the best support for dual eligibles, promotes the highest quality care, and improves health outcomes in the setting of the member’s choosing (for example, living independently at home). Within this framework, the One Care and SCO programs are high quality vehicles for providing integrated and coordinated care that is uniquely suited to serving the needs of dual eligible members.

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<sup>1</sup> Medicaid-only members in this age group may also participate, with the Commonwealth paying the full cost of their care.

## INTERNAL DRAFT – Policy in Development

One Care and SCO have demonstrated their success through both national comparison data and state-specific evaluations. In their short history since the inception of the One Care program in 2013, One Care plans have outperformed the national Medicare Advantage benchmark and other states' Medicare-Medicaid Plans (MMP) on key patient experience and quality measures.<sup>2</sup> Similarly, the longstanding SCO program, which began in 2004, has delivered improved health outcomes for its members and SCO plans have consistently earned among the highest Medicare Star ratings in the country among Dual Eligible Special Needs Plans (D-SNPs).<sup>3</sup> In addition, members' self-reported experience of care data indicates their satisfaction and positive experiences in One Care and SCO. Given these successes, MassHealth seeks to grow these programs, while ensuring they will continue to be successful and sustainable.

**Figure 1. Total number of dual eligible members as of January 2018 and annualized FY17 Spend<sup>4</sup>**

Plan	Total	Age 65+	Under age 65	Spend	Percent
One Care	19,271	538	18,733	\$273,794,341	6%
SCO	48,684	48,684	0	\$1,090,681,756	23%
PACE	4,243	3,847	396	\$153,739,206	3%
FFS	239,359	108,787	130,572	\$3,134,877,897	67%
<b>Total</b>	<b>311,557</b>	<b>161,856</b>	<b>149,701</b>	<b>\$4,677,299,852</b>	<b>100%</b>

**As Massachusetts seeks to grow its integrated care capacity and expand the participation of dual eligibles in the One Care and SCO programs, we request new state flexibilities to support the programs' long-term financial stability, to enhance integrated person-centered experiences, and to drive improved member outcomes.** We believe these models are cost effective and will help bend the cost curve over time as investments in long term supports and services for members reduce avoidable hospitalizations and other acute medical needs. Our proposal therefore includes an element of shared savings between the Commonwealth and federal government – which will promote sustainability for both the federal government and Commonwealth, while improving quality and member experience.

MassHealth seeks to move One Care and SCO to a new aligned 1115A Demonstration, while maintaining the distinct population focus, service package, eligibility requirements, and competency requirements (including cultural, disability, and elder care competency) of each individual program under the new Demonstration's authority. Under this new, state-specific Demonstration, **“Duals Demonstration 2.0,”** MassHealth proposes to carry over to SCO many features from One Care that serve to align Medicare and Medicaid along administrative, financial, and programmatic lines, while extending much of SCO's financing methodology to One Care. Massachusetts would seek to align further its approaches to enrollment and quality strategy in One Care and SCO, including incorporating elements from MassHealth's managed care programs – such as its new Accountable Care Organizations (ACOs) – for Medicaid-only members under age 65.

Using 1115A demonstration authority for a five-year period, we intend to seek federal flexibility:

1. To **grow and sustain enrollment in One Care and SCO** using common approaches that are also utilized in MassHealth's managed care programs for non-duals (e.g., passive enrollment and fixed enrollment periods);

<sup>1</sup> In One Care, inpatient hospital admissions declined by 7.5% and ED visits declined by 6.4% for members enrolled in Commonwealth Care Alliance (CCA) for one year, and both One Care plans scored better than 90% of Medicare Advantage plans on access to preventative/ambulatory health services. The Tufts One Care plan also connected 68% of enrollees to resources such as fuel assistance, financial assistance, or improved housing (*Information provided by Tufts Health Plan – Network Health, August 24, 2015. – included in October 16, 2015 MH presentation to the Implementation Council*)

<sup>3</sup> In SCO, a study by JEN Associates found that SCO enrollees showed a 12% reduction in nursing facility residency in 12 months, compared to unenrolled Medicaid eligible individuals. Additionally, for plan year 2018, three out of five SCO plans received a Medicare Star rating of at least 4.5 stars.

<sup>4</sup> Excludes about 4375 members who had various special exceptions to enrollment rules as of January 1, 2018.

## ***INTERNAL DRAFT – Policy in Development***

2. **To achieve a more seamless member experience** by aligning Medicare and Medicaid administrative processes and unifying member communications, similar to the approaches used today in One Care;
3. **To strengthen the fiscal stability of the One Care program for both the Commonwealth and federal government** by updating One Care to more closely reflect the financial methodology used in the Medicare Advantage program, and by implementing a modified quality performance rating system specific to under 65, dual eligibles,
4. **To use innovative approaches to ensure fiscal accountability and sustainability for the Commonwealth and federal government** through value-based purchasing, increased transparency and data sharing, and an integrated calculation of the percent of combined Medicare and Medicaid funds that One Care and SCO plans spend on direct care for members (medical loss ratio); and
5. **To enter into a shared savings agreement with CMS**, in which both the Commonwealth and Federal government share in savings resulting from the Duals Demonstration 2.0. Financial savings, value, and quality of care achieved system-wide would be determined **through robust evaluation of both the One Care and SCO programs as part of the Duals Demonstration 2.0.**

These state-driven innovations aim to increase access to integrated care and improve quality for many of our most vulnerable members with disabilities and older adults. At the same time, the proposal ensures a high-value and financially sustainable delivery system that can meet the needs of Massachusetts residents. Our proposal describes a fair and stable pricing structure, which we anticipate will result in financial sustainability for all entities involved, including MassHealth, CMS, participating plans, and providers. Finally, we believe that this Demonstration model will generate value for the health care system overall by improving member outcomes while reducing health care cost growth trends over time for participating members through better coordination of care

MassHealth is committed to robust and ongoing engagement with the stakeholder community during the development and implementation of Duals Demonstration 2.0 through a variety of mechanisms, including public meetings, requests for information, and potential workgroups and community review of health plan proposals.

To allow for a seamless transition of One Care members into the new Demonstration, the Commonwealth appreciates that CMS has partnered with Massachusetts to work to extend the current One Care Demonstration for an additional year - through 2019 - to bridge One Care's authority while the Commonwealth works with CMS to develop the new Demonstration terms. We appreciate CMS's continued attention to the timing of this extension as we move further into negotiations.

Outside of this proposal, MassHealth plans to continue its work to improve the quality and sustainability of our SCO and PACE programs through our ongoing work to migrate these programs to a more financially sustainable platform and to implement Medicaid-specific quality measurement and evaluation. In addition, after Duals Demonstration 2.0 is negotiated and implemented, the Commonwealth would like to explore with CMS and stakeholders future opportunities to potentially extend access to the Demonstration to members enrolled in Home and Community-Based Services Waivers who are not able to access One Care or SCO today.

## Overview of Demonstration Requests

### 1. Flexibility to grow and sustain enrollment in One Care and SCO through passive enrollment and fixed enrollment periods, while expanding both programs state-wide and increasing provider participation

While the Commonwealth believes that One Care and SCO provide superior care for dual eligibles, the majority of dual eligibles in MassHealth are still enrolled in fee-for-service where care is fragmented and services are difficult to navigate. The Commonwealth would like to increase participation in One Care and SCO from members and from the providers who manage and deliver their care today, and to encourage health plans to invest in supporting the health of their members by building relationships with them over time. Scaling the membership in One Care and SCO would maximize efficiency opportunities, enhance plans' ability to invest in innovative services, and better position the plans to attract and effectively engage additional providers in the care models, while contracting with their networks at sustainable rates.

Evidence from the SCO program shows that relatively few members transition out of the SCO program, with only approximately 12% of all SCO members disenrolling from SCO to move to FFS or a PACE program in FY16. This suggests that when members are enrolled into SCO, they are likely to remain in the program year to year, allowing for growth of the SCO population. The high percentage of current One Care members that remained enrolled in One Care following passive enrollment, as well as strong member satisfaction scores as reported during the November 2017 One Care open meeting,<sup>5</sup> also suggests that One Care plans have been effectively meeting members' needs.

**Figure 4. One Care and SCO Retention Rates**  
**Percent of members who remained in the program of all members who remained on MassHealth**

Program (all rating categories)	Remained enrolled (i.e. did not transition to PACE or FFS)
SCO (FY16)	87.89%
One Care (March 2018)	68.6%

**With this in mind, MassHealth requests continued authority for ongoing passive enrollment of dual eligibles into One Care.** We plan to re-procure the One Care plans in order to provide broader geographic coverage and capacity in the program. This would include individuals newly eligible for both Medicare and Medicaid, as has historically been available through the Financial Alignment Demonstration (One Care). As of March 2018, over 60% of One Care's membership was included in passive enrollment, indicating that the passive enrollment has and will likely continue to be an important mechanism to grow participation in the program.

**MassHealth also requests authority to passively enroll dual eligibles** (including those newly eligible for both Medicare and Medicaid) **into SCO on an ongoing basis, as we have done in One Care.** Over the past year, MassHealth has successfully tested passively enrolling non-dual (Medicaid-only) members into SCO with a retention rate in excess of 70%.<sup>6</sup> We would like the authority to expand this effort to dual eligibles as well.

As this would be a new Demonstration, MassHealth seeks the flexibility to consider One Care eligible **members who had previously opted out of passive enrollment under the current**

<sup>5</sup> <https://www.mass.gov/files/documents/2017/12/05/MassHealth%20Presentation%20-%20November%2014%2C%202017.pdf>

<sup>6</sup> <https://www.mass.gov/files/documents/2017/12/05/MassHealth%20Presentation%20-%20November%2014%2C%202017.pdf>

For both One Care and SCO, the retention rates reflect that some individuals included in passive enrollment lose eligibility for MassHealth or for One Care or SCO (such as due to relocation).

**Financial Alignment Demonstration as eligible for passive enrollment into this new Demonstration.** Further, we would propose to treat opt out requests as specific to One Care and SCO, such that a member who had opted out of One Care only could be considered for passive enrollment into SCO as they become age eligible for it. Dual eligibles currently enrolled in Medicare ACOs would not be excluded from passive enrollment into One Care and SCO. MassHealth would expect to use passive enrollment on a regular (quarterly or monthly) and continuing basis throughout the Demonstration, based on the capacity of the Commonwealth, the plans, and the plans’ provider networks, as has been implemented with dual eligibles in One Care and Medicaid-only members into SCO.

**Figure 2. SCO (MassHealth Only) Passive Enrollment Retention Rates**

SCO Enrollment Effective Date	Passive Notices Sent	Passive Members who Enrolled	Percent of Passive Members Enrolled <sup>7</sup>
July 1, 2017	299	209	70%
October 1, 2017	775	566	73%

**Figure 3. Recent One Care Passive Enrollment Retention Rates**

One Care Enrollment Effective Date	Passive Notices Sent	Passive Members who Enrolled	Percent of Passive Members who Enrolled
July 1, 2017	2,001	1,414	71%
October 1, 2017	1,689	1,262	75%
January 1, 2018	999	739	74%
April 1, 2018	1,987	1,475	74%
<b>12-Month Total</b>	<b>6,676</b>	<b>4,890</b>	<b>73%</b>

MassHealth plans to leverage passive enrollment in the new Demonstration 2.0 to grow enrollment gradually and deliberately, minimizing or avoiding care disruptions when possible, and building on the approaches it has developed in concert with stakeholders, including the One Care Implementation Council and SCO Consumer Advisory Committee.

Under the existing process using an “intelligent assignment” approach, members are matched to plans using MassHealth and Medicare crossover claims history and plans’ updated provider network files to make assignments based on members’ existing relationships with primary care providers, behavioral health providers, and/or long-term services and supports (LTSS) providers, when possible (See Appendix IV for passive enrollment assignment methodology). Among new dual eligibles (i.e. those who have either MassHealth or Medicare and are newly gaining eligibility for the other program), most have had a provider match with at least one of their providers, or a previous affiliation with a MassHealth MCO plan (in the new Demonstration, MassHealth would also look to members’ prior MassHealth ACO affiliation, if any). MassHealth has also passively enrolled the small percent of these “new duals” that have not had a prior provider or plan relationship to match from, as these individuals’ provider networks would have been subject to change due to their changing eligibility status. We believe this to be a great advantage to a new dual eligible member as MassHealth’s integrated care programs offer more support through care coordination and continuity of care protections in transitioning to a new network than traditional fee-for-service can provide. MassHealth plans to build operational capacity for more regular passive enrollment of “new duals” into both One Care and SCO and is further planning to update its eligibility determination processes for MassHealth members approaching age 65 to align with

<sup>7</sup> SCO members who were passively enrolled and did not remain in SCO either opted out prior to the effective date or MassHealth cancelled the enrollments due to lost eligibility or undeliverable mail.

## **INTERNAL DRAFT – Policy in Development**

the date of first enrollment into Medicare (i.e. allowing members aging into Medicare eligibility to enroll on the 1<sup>st</sup> of the month in which they will turn 65).

As is the practice today in One Care and SCO, members would be able to opt out of One Care or SCO at any time prior to the member's passive enrollment effective date, and for a period of time after that date, in order to remain in their current coverage. MassHealth would continue to send two advance notices of the passive enrollment – at 60 days and 30 days prior to the enrollment effective date – and to regularly participate in outreach events and stakeholder engagement to raise awareness of the One Care and SCO programs among stakeholders, members and providers. As in One Care today, members enrolling in One Care or SCO would have a 90-day continuity of care period, through which their prior provider relationships, service authorizations, and their providers' rates of payment would be protected as the member goes through a comprehensive assessment process and develops their person-centered care plan with their One Care or SCO interdisciplinary care team.

Today, dual eligibles statewide are able to enroll in all available integrated care options at any time. While retention rates in One Care and SCO programs are high, MassHealth has observed in both programs a high degree of member movement between plans in those programs (e.g., switching from one SCO plan to another). Without stable membership, plans are somewhat limited in their ability to maximize the potential for improved care coordination and quality over time for their members.

In order to address this challenge, Massachusetts seeks to implement an alternate approach to the new Part D Special Election Period (SEP) policy promulgated in the April 16, 2018 final rule: "Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Program, and the PACE Program." Specifically, Massachusetts seeks authority, with appropriate member protections, to **create fixed enrollment periods for One Care and SCO that are consistent with our other Medicaid managed care products (ACOs and MCOs)**.

These fixed enrollment periods would be implemented in a manner that is consistent with the Medicaid flexibilities and requirements for states described in the 2016 Medicaid Managed Care Rule. Members would be given an annual enrollment period of at least 90 days with the ability to change plans during the year for cause. Prior to the start of the fixed enrollment period, members would be able to change plans or move to the MassHealth Fee-For-Service program and other Medicare coverage, including selecting a Part D plan. In our ACO and MCO fixed enrollment periods, members can choose a new plan every year and are able to request an exemption from fixed enrollment if they meet the reasons set forth in the Medicaid Managed Care rule, such as if the member moves out of the plan's service area, or certain other criteria, such as if the plan has not provided access to providers who meet the member's healthcare needs over time, even after the member's request for assistance (See Appendix III for fixed enrollment exceptions). For the MCO and ACO products, MassHealth has developed exception criteria with stakeholders and would follow a similar process to ensure the exceptions and escalation processes reflect the inclusion of LTSS within One Care and SCO and are appropriate for the specific needs of the One Care and SCO populations. Throughout 2017, only 0.02% of MassHealth MCO enrolled members eligible for fixed enrollment requested an exemption each month.

In operationalizing enrollment in the new Demonstration, including through the passive enrollment and fixed enrollment period authorities requested above, MassHealth would request that SCO obtain and One Care retain the data-sharing flexibilities CMS has made available to Medicare-Medicaid Plans (MMPs) through the Financial Alignment Demonstrations to date, and that may be made available in the future to demonstrations seeking to integrate care for dual eligible members. In addition, as we believe a key to our retention success with Medicaid-only members being passively enrolled into the SCO program was active pre-enrollment outreach allowed under our Medicaid authorities, MassHealth would ask for the flexibility to increase pre-enrollment outreach

## **INTERNAL DRAFT – Policy in Development**

and member data sharing with both One Care and SCO plans to facilitate outreach for members who are likely to be passively enrolled.

With these new requests for authority, **MassHealth is committed to robust member protections and thorough stakeholder engagement**, building on the outreach MassHealth has already begun in the development of this concept paper (see additional stakeholder engagement details later in this paper).

### **Proposed member protections include:**

- Providing clear and transparent member noticing (at 30-days and 60-days) and outreach in advance of enrollment
- Giving members the ability to opt-out any time prior to enrollment
- Giving members the ability to change plans or move to FFS for at least the first 90 days of plan enrollment, and appropriate exceptions to allow members to change plans or move to FFS during the fixed enrollment period for cause
- During this 90-day period, all newly enrolled members would also be entitled to continuity of care protections (e.g., continuing to see their existing providers even if they are not in the plan's network), a requirement that exists in One Care today and would be added as a member protection for all newly enrolled SCO members
- Working with stakeholders to ensure One Care and SCO have robust and appropriate networks to meet the needs of dual eligible individuals
- Providing an independent Ombudsman for One Care, currently operated by a local consumer-run organization, and expanding these services to SCO and PACE
- Providing options counseling through SHINE (Serving the Health Insurance Needs of Everyone - the Commonwealth's SHIP entity) and MassOptions (the state's "No Wrong Door" website and call center for individuals to learn about options for LTSS)
- Continuing formal and informal engagement and feedback opportunities through the One Care Implementation Council, the SCO Consumer Advisory Committee, public-facing email boxes and websites, and other stakeholder outreach and meetings

The Commonwealth has recently re-procured and will soon expand the scope of the One Care Ombudsman (funded for One Care members through a CMS grant) to serve members in all of MassHealth's health plans, including SCO and PACE. Federal financial support through the State Demonstrations to Improve Care for Medicare-Medicaid Members: Support for Demonstration Ombudsman Programs grant for the One Care Ombudsman has been crucial to the success of One Care. Given the importance of this program for Duals Demonstration 2.0, the Commonwealth requests that CMS continue financial support for this program in this new Duals Demonstration 2.0, with a consideration for this Demonstration's expanded program scope and additional eligible and enrolled membership compared to that of One Care alone today.

MassHealth anticipates that the combination of the above requests will create a dynamic allowing for expansion of both One Care and SCO, increasing the number of duals eligible members enrolled in coordinated care plans, while maintaining and improve stability.

## **2. Flexibilities to increase administrative alignment and integration to create a more seamless member experience in each program, building on the approaches used today in One Care**

Dual eligible members in fee-for-service not only have to work with two different payers to receive all of the services they need, but also have two different sets member communications and information regarding their benefits and where to go with questions or for help. These members have separate Medicare and Medicaid membership cards, two different member handbooks, and receive notices from one payer or the other, and sometimes both, when they need important information about their services. One of MassHealth's goals for member experience in both One Care and SCO is for each member's engagement with the plan to feel completely seamless and



## **INTERNAL DRAFT – Policy in Development**

integrated. In order to facilitate member understanding of and access to benefits and services, MassHealth strongly believes that members should receive **unified communications and materials that speak cohesively about the full scope of each program** from the member perspective. This is the case in One Care today, however it is not always the case in SCO. For example, currently the Medicare Advantage Evidence of Coverage template requires the separation of Medicare and Medicaid benefits into different sections, often times requiring a benefit be listed as “non-covered” under the Medicare section but “covered” in the Medicaid section. **Under Duals Demonstration 2.0, MassHealth seeks to ensure that all member-facing materials and communications about One Care (as is in effect today) and SCO are completely integrated.** These materials may include:

- Enrollment and disenrollment notices;
- Provider and pharmacy directories;
- Formularies;
- Annual notice of change;
- Explanation of benefits;
- Evidence of coverage documents;
- Marketing materials; and
- Denial and Appeal notices, etc.

**Similarly, MassHealth requests that appeals and grievances for all Medicare Part A & B and Medicaid services in both One Care and SCO be completely streamlined.** This would improve clarity of the process and simplicity for members, MassHealth and CMS. Today, the appeals and grievances processes are integrated in One Care, but not in SCO, and the processes can be complicated for members to navigate. MassHealth proposes maintaining the first level of appeals within each One Care and SCO plan (as is the case today and required under the 2016 Medicaid Managed Care Rule) but consolidating the second level of appeals (external appeals) through the MassHealth Board of Hearings (the Commonwealth’s Fair Hearings entity). MassHealth is proposing to consolidate the second level appeal process for members providing all members with 120 calendar days from the date of the mailing of the plan’s internal appeal decision to file an appeal with the Board of Hearings. While pending, the member would receive the requested service if the written request for a Board of Hearings appeal was submitted within 10 days of the mailing of the plan’s internal appeal decision. This policy would apply regardless of whether the services is traditionally a Medicare or Medicaid covered service and would replace the existing Medicare auto-appeal process.

The Commonwealth requests that the federal government would assume the cost of Medicare services pending appeal, and that CMS continue to pay its proportional share of the cost of these appeal and grievance processes as they are consolidated through the Commonwealth’s operations. Members would be entitled to continuation of Medicare and Medicaid benefits pending any internal and external appeals processes, consistent with current MassHealth regulations and legislation establishing D-SNP permanency. The Commonwealth anticipates that the federal government would assume the cost of Medicare services pending appeal; the Commonwealth would like to explore with CMS ways to operationalize these funding relationships.

Grievances for One Care are today are accepted through to be centrally documented in CMS’s Complaint Tracking Module within in the HPMS system and addressed. MassHealth proposes to align the One Care and SCO grievance processes and to ensure that the Commonwealth has clear and transparent access to all grievances and their resolutions. Changes to the existing grievances and appeals processes are an area that MassHealth plans to particularly focus on in stakeholder discussions to ensure that the Commonwealth is being thoughtful and deliberate in changes to this important set of member protections. The One Care Implementation Council has begun reviewing this area closely, and MassHealth looks forward to incorporating stakeholder recommendations as we update these processes.



**Additionally, MassHealth proposes administering the One Care and SCO programs through a combination of three-way and two-way contracts.** One Care and SCO plans would each have a separate three-way contract between the plan, the Commonwealth, and CMS. One Care and SCO plans would also have a two-way contract with the Commonwealth to achieve additional financial efficiencies in line with MassHealth managed care program administration.

**Figure 5. Summary of Proposed Administrative Alignment and Enrollment Initiatives for One Care and SCO**

Proposal	Current			Duals Demo 2.0		
	One Care	SCO	FFS	One Care	SCO	FFS
Unified communications and materials	✓	☑	✗	✓	✓	✗
Integrated appeals and grievances	✓	✗	✗	✓	✓	✗
Passive Enrollment	✓	☑	✗	✓	✓	✗
90 Day Continuity of Care period	✓	☑	✗	✓	✓	✗
Fixed Enrollment period (with exceptions)	✗	✗	✗	✓	✓	✗

✓ = Integrated    ☑ = Partially Integrated    ✗ = Not Integrated

**3. To align Medicare financing methodologies and ensure fiscal sustainability for the Commonwealth and federal government by updating One Care to more closely reflect the Medicare financial methodology used in DSNPs for Parts A/B and Part D services, and implementing a modified Medicare-Medicaid specific Stars methodology**

MassHealth aims to ensure One Care and SCO are fiscally sustainable models for both the Commonwealth and the federal government and to have appropriate cost protections in place as we seek to grow integrated care for the dual eligible population. While both One Care and SCO have been successful programs, MassHealth believes that both the Commonwealth and CMS can take lessons from historical experience in both One Care and SCO to further improve and stabilize the programs financially. Under Duals Demonstration 2.0, One Care and SCO would continue to include all Medicare Parts A, B, and D services, all MassHealth State plan services, expanded dental and vision benefits, diversionary behavioral health and expanded SUD services, as well as additional community support services, as are available to enrollees today. In addition, SCO would continue to be an optional delivery system for individuals eligible for Massachusetts’ Frail Elder 1915(a/c) Waiver. Members would continue to have no copays in One Care and SCO, and the plans would not be able to charge premiums (MassHealth’s income-based premium schedule for eligibility would continue to apply; however for members receiving care in an institution the Patient Paid Amount would still apply as is the case today). In the new Demonstration, plans would continue to receive capitation payments from MassHealth and Medicare for each enrollee for care management and all covered benefits, including Medicare Parts A, B, and D, MassHealth, and additional services (such as expanded dental and vision benefits, additional community support services, and behavioral health diversionary and substance use disorder treatment services), as is current practice in One Care and SCO. In the new construct, plans that are selected to operate both One Care and SCO products would benefit from the administrative simplifications today available to One Care and One Care and SCO would be aligned with similar financial methodologies.

## **INTERNAL DRAFT – Policy in Development**

### SCO Capitation Rates

Under Duals Demonstration 2.0, MassHealth proposes that the **SCO program’s Medicare financial methodology would remain largely as it is today:**

- SCO plans would continue to bid as Medicare Advantage duals special needs (D-SNP) plans using the established bidding process for Parts A, B, and D
- SCO plans would be eligible for rebates and quality bonuses tied to Medicare Stars ratings
- Medicare would pay the plans’ risk-adjusted capitation rates for Medicare Part A, B, and D
- SCO plans would continue to be eligible for the frailty adjuster if they meet the requirements established by Medicare
- **MassHealth would implement risk-adjusted, experience-based Medicaid capitation rates**, consistent with the 2016 Medicaid Managed Care Rule, including selecting a payment rate from an actuarially sound, experience-based rate range.

However, MassHealth proposes that the Demonstration would include the following changes to SCO financial methodologies to improve further the sustainability for the programs and all parties involved.

- In the D-SNP bidding methodology used today (as described above) MassHealth requests that CMS waive the requirement that the aggregate Medicare Advantage margin for D-SNPs, as a percentage of revenue, be no more than 1 percent higher and no less than 5 percent lower than the aggregate margin for general enrollment plans and I/C SNPs under the same H contract (as outlined in the Instructions for Completing Medicare Advantage Bid Pricing Tools). Currently, this requirement leads to plan losses on the Medicare side which are currently being supplemented with financing received via the Medicaid capitation as plans must bid lower than their actual projected Medicare costs to be compliant. While this may result in a short term increase in plan bids for Medicare capitations, reducing cross subsidization and ties to other MA plans will allow SCOs to improve performance within the Medicare Advantage bidding construct. Removing the complexity associated with cross subsidization will also improve MassHealth and CMS’s ability to evaluate savings from the program.
- **MassHealth proposes developing a quality measure set for Medicaid services**, aligned with the One Care and MassHealth Medicaid ACO measures (where age-appropriate), subject to a withhold for poor performance with the potential to be earned back.
- **MassHealth proposes implementing a two-sided, symmetrical risk corridor structure** similar to the risk corridors that have been used in One Care. As MassHealth expands passive enrollment and migrates to experience based, risk adjusted rates, risk corridors would help protect against instability while the SCO plans onboard new members at a potentially faster pace.
- **MassHealth requests authority to pay full benefit dual eligible (FBDE) members’ Medicare Part B premiums** so that they may participate in SCO or One Care as full dual eligibles. This issue is specific to a small number of individuals eligible for MassHealth through the higher income standard available in the Frail Elder Waiver.
- **MassHealth requests that CMS include a county-level adjustment for bad debt load in the Medicare capitation for SCO plans** beyond the adjustment included in the USPCC (United States per capita cost) for all Medicare enrollees, similar to the bad debt adjuster added to the Medicare A/B capitation in One Care and in certain other states’ Financial Alignment Demonstrations. To operationalize this within the D-SNP bidding process, this adjustment may potentially be implemented as a capitation-add-on after plan bids have been submitted. This add-on would be based on the Medicare Advantage county benchmarks. The methodology for Financial Alignment demonstrations has acknowledged that in some states, including Massachusetts, there is a higher incidence of Medicare bad debt among dual eligible members compared to the Medicare Advantage

## **INTERNAL DRAFT – Policy in Development**

population, Massachusetts anticipates that this is also be the case for SCO enrollees, which justifies a higher adjustment made for bad debt in plan capitation for plans serving only dual eligibles (rather than Medicare members who do not also have MassHealth).

### One Care Capitation Rates

In parallel with the above requests, MassHealth proposes the following changes to better align the Medicare financial methodology of One Care with that of SCO:

- **MassHealth requests that One Care be moved to the Medicare Advantage bidding process applicable to D-SNP plans for Parts A, B, and D.**
- As with SCO, Medicare would pay the plans risk-adjusted capitation rates for Medicare Part A, B, and D
- **One Care plans would be eligible for the frailty adjuster** if they meet the requirements SCO plans and other FIDE-SNPs are subject to today.
- As with the request related to the D-SNP bidding methodology in SCO, **MassHealth requests that CMS waive the requirement that the aggregate MA margin for D-SNPs, as a percentage of revenue, be no more than 1 percent higher and no less than 5 percent lower than the aggregate margin for general enrollment plans and I/C SNPs under the same H contract** (as outlined in the Instructions for Completing Medicare Advantage Bid Pricing Tools).
- MassHealth requests that One Care plans be **eligible for rebates and quality bonuses tied to a demo-specific quality rating methodology appropriate for the under 65 duals population** (“One Care Stars”) in a manner consistent with the application of the Medicare Stars methodology (as the number of One Care enrollees who are aging in place – remaining enrolled after they turn 65 – increases over time, MassHealth would evaluate and update quality metrics used in this approach). MassHealth would like to explore a phase-in approach for the first two years of Duals Demonstration 2.0 to mitigate an immediate drop in the Medicare A/B capitation rates based on the new plan 3.5 stars assumption used in Medicare Advantage plans to measure their performance in accordance with the quality approach under the new Demonstration.
- As is proposed for SCO, **MassHealth would like to further refine the slate of quality measures for Medicaid services** to align with Medicaid ACO measures, subject to a withhold for poor performance with the potential to be earned back.
- **MassHealth would continue to develop and implement risk-adjusted, experience-based Medicaid capitation rates**, consistent with the Medicaid Managed Care Rule, including selecting a payment rate from an actuarially sound, experience-based rate range. MassHealth would begin incorporating encounter experience into the Medicaid rate-setting over time. As One Care encounters enter the historical mix for rate development, MassHealth requests the ability to develop appropriate mitigations with CMS in the event using encounters would lead to significant cost-shifting between payers due to the plans successfully shifting utilization from more acute settings and services to Medicaid funded long term services and supports.
- Additionally, MassHealth proposes **retaining the two-sided risk corridor structure that is currently used in One Care**, given the high level of cost volatility in the under 65 duals population, and as a critical protection for new or expanding plans selected during One Care re-procurement.
- In addition to the current two-sided risk corridor, **MassHealth requests the creation of “high-utilizer” stop loss in order to assure stability in the One Care program.** Currently, the One Care program is at risk of fiscal instability, largely due to the relatively small size of the program. As of January 2018, the total One Care program had about 19,000 total members split between two plans (for relative comparison, this total enrollment is fewer members than the average number of members enrolled per ACO in the MassHealth ACO program). Actuarially, when a program or plan has small membership numbers, such as those in One Care, it is unlikely that there is a normal

## **INTERNAL DRAFT – Policy in Development**

distribution of members, both in terms of acuity and cost. This means that for the specific population enrolled in One Care, individuals at the extreme ends of the distribution can significantly swing both utilization and spending trends for a plan, even after risk adjustment. Consistent with this, historical trends show that much of plan spend and plan losses in One Care can be attributed to a relatively small number of individuals who use a disproportionately large share of services as compared to their peer members.

Implementing an additional actuarially sound, cost neutral stop-loss around these “high utilizers” would allow for increased plan stability by protecting plans against cost volatility driven by a subset of the One Care population. MassHealth believes that this stability will not only attract plans to participate in a One Care procurement, but will ensure that the One Care program and participating plans are able to provide appropriate and high quality care to its members. MassHealth would work with CMS to implement such a stop loss in a thoughtful and fair manner.

- **MassHealth also requests that CMS continue to include a county-level adjustment for bad debt load in the Medicare capitation for One Care plans** beyond the adjustment included in the USPCC for all Medicare enrollees. This adjustment is included today in One Care and in certain other states’ Financial Alignment Demonstrations. MassHealth believes that the need for this adjustment will remain under Duals Demonstration 2.0 as Massachusetts continues to expect a higher incidence of Medicare bad debt among dual eligible beneficiaries versus the total Medicare population. This effect justifies a higher adjustment made for bad debt in plan capitation for plans serving only dual eligibles (rather than Medicare members who do not also have MassHealth).

The financial methodologies outlined above work to ensure that both One Care and SCO operate in a financial construct that is sustainable for MassHealth, CMS, and plans in the long term. As MassHealth continues to grow and improve its integrated care programs, such sustainability and cost protections (e.g. risk corridors and bad debt adjustments) will be increasingly important. Similarly, aligning and improving Medicaid and Demonstration specific quality measures will encourage these two programs to develop in a way that is beneficial to members and payers alike.

#### **4. To ensure fiscal accountability for the Commonwealth and CMS through value-based purchasing, increased transparency and data sharing, blended MLR reconciliation, and shared savings evaluations of Dual Eligibles in Massachusetts**

##### *Value-Based Purchasing*

Currently, MassHealth promotes the use of value based purchasing in its MCO and ACO programs through a variety of mechanisms, including contractual requirements for plans to have a certain percentage of provider arrangements that are considered value-based agreements. This is not the case in One Care and SCO today, resulting in misalignment between MassHealth’s managed care programs and potential missed opportunities for innovative care models. MassHealth believes that increasing value-based purchasing arrangements is beneficial for members, plans, CMS, and the Commonwealth.

Thus, MassHealth is seeking authority to create significant opportunities to **align the value-based purchasing initiatives in One Care and SCO with those used in MassHealth’s MCOs and ACOs, as well as Medicare ACOs**. MassHealth proposes to work with CMS to develop policies in One Care and SCO that, over time, align programmatically with the MCO and ACO programs, creating significant administrative efficiencies for MassHealth and CMS. As a preliminary step towards increased value-based purchasing in the integrated care plans, MassHealth has encouraged the SCO plans to implement value-based purchasing; the January 1, 2018 SCO contract amendment also requires plans to notify MassHealth of any such arrangements. MassHealth may also set **targets for value-based purchasing as a percentage of the plans’ provider network**, including encouraging contracting with Medicare or MassHealth ACOs, and/or

## ***INTERNAL DRAFT – Policy in Development***

alignment with existing ACO payment methodologies and organizations, through its two-way contract. In particular, MassHealth would like to encourage plans to explore risk-sharing agreements with MassHealth ACOs, and bundled payments for Home Health and Skilled Nursing Facilities, as well as strategies similar to those in the Money Follows the Person (MFP) program to identify and support members who wish to live in the community by transitioning from a facility to community setting. This would allow us to continue our longstanding community first care strategy and improve member experience of care. MassHealth would also consider financial incentives and/or quality measurement for plans that effectively use rebalancing strategies to reduce or delay the use of long-term care facilities for individuals that would prefer to reside in a home or community-based setting.

### *Transparency and data-sharing*

Currently, MassHealth has limited data-sharing abilities with CMS that also differ between One Care and SCO. To increase data available to both the federal government and the Commonwealth for One Care and SCO, **MassHealth requests increased transparency of Medicare-specific data**, including but not limited to: current year Medicare Advantage bid amounts and supplemental benefits, beneficiary level Medicare risk scores for dual eligibles in Massachusetts that MassHealth serves either directly through FFS or through one of its integrated programs, and beneficiary-level plan payment data. Additionally, while MassHealth currently has access to HPMS for joint administration of One Care, the Commonwealth **requests expanded access to HPMS for joint administration of One Care, SCO, and PACE** to support parallel integration and administrative alignment efforts in each program. For example, in One Care today, MassHealth accesses information in HPMS to review plan-marketing materials, monitor and enter items into the complaints tracking module; CMS also shares submissions of plan benefit packages, including pharmacy benefits. MassHealth would like to continue this important partnership for One Care and further the ability to share in a similar partnership for its SCO and PACE programs. Further, we propose **that MassHealth have the ability to interface with CMS IT systems, as may be necessary to accomplish the administrative alignment and data sharing** needed to support the implementation, enrollment, and ongoing operation of the programs.

### *Medical Loss Ratio Requirements*

Currently, a plan's Medical Loss Ratio (MLR) is based on Medicaid-only costs and capitation. As One Care and SCO programs are jointly funded by Medicaid and Medicare with services provided in a coordinated manner, MassHealth believes that an MLR construct that blends Medicaid and Medicare financial information will be a more accurate representation of a plan's performance and will reflect a more integrated approach to plan financing.

MassHealth seeks **authority to implement a plan-specific post-risk corridor Medicare-Medicaid blended Medical Loss Ratio (MLR)**, starting at a minimum of 85%. Remittances would be paid back to Medicare and Medicaid proportional to the amount of capitation paid to plans. In addition, MassHealth proposes a **post-risk corridor MLR reconciliation arrangement**, structured as follows to ensure fair share financing of the One Care and SCO programs:

- Each year, the separate Medicaid and Medicare medical loss ratios of each One Care/SCO plan would be calculated, in accordance with 42 CFR 438.8;
- If a plan's Medicaid MLR is more than 4 percentage points lower than the Medicare MLR, a reconciliation would occur;
- Reconciliation would require payments from the plan and/or Medicare to MassHealth equal to the amount required to bring the Medicare and Medicaid MLRs to within a 4 percentage point difference;
- If the plan's blended MLR is less than the blended floor set by MassHealth and CMS, the reconciliation payment would first be a payment from the plan to MassHealth if the Medicaid MLR is below the blended MLR floor, and from the plan to CMS if the Medicare MLR is below the blended MLR floor; and

**INTERNAL DRAFT – Policy in Development**

- If the plan’s blended MLR is above the blended floor set by MassHealth and CMS and/or is insufficient to bring the Medicare MLR within a 4 percentage point difference with the Medicaid MLR, the remaining reconciliation payment would be a payment from CMS to MassHealth.

**Figure 7. Historical Context and MLR Samples Scenarios**

**Historic Medical Loss Ratios from Integrated Duals programs**

	Medical Loss Ratio - CY 16		
	Medicaid	Medicare	Total
Senior Care Options	77%	103%	87%
One Care	57%	102%	81%

**Notes:**

- Based on supplemental financial statement prepared by each plan through September 29, 2017.
- Based on CY2016 reporting period.

**Post Risk Corridor MLR Reconciliation Sample Scenarios**

Blended MLR	Medicare-only MLR	Medicaid-only MLR	Reconciliation Payment
85%	85%	85%	None
85%	90%	80%	CMS to MH
90%	95%	85%	CMS to MH
80%	85%	75%	Plan to MH & CMS to MH
80%	80%	80%	Plan to MH & Plan to CMS

Note: Illustrative example. Assumes spending is evenly split across Medicare and Medicaid

Limitations on Medicaid Crossover Payments in One Care and SCO

For dual eligibles in FFS, Medicare first reimburses providers of health care services at 80% of the Medicare fee schedule. The provider can then submit the claim to MassHealth to recoup a portion of the coinsurance for which MassHealth would otherwise be financially liable for a non-dual

## **INTERNAL DRAFT – Policy in Development**

member. MassHealth pays crossover claims (in the form of a Medicaid wrap payment) up to its fee schedule, but for most services for which Medicare is the primary payer MassHealth's fee schedule is below Medicare's. (This is why Massachusetts expects that bad debt is always higher for its dual eligible population than for Medicare beneficiaries without MassHealth.) Certain providers eligible for bad debt reimbursement may claim the difference between the Medicare fee schedule and the Medicare FFS plus the MassHealth FFS payments as bad debt; this is currently reimbursed by Medicare at 65% of eligible bad debt. (Note that this does not account for any payment reductions due to Medicare sequestration.) The Medicare Advantage/D-SNP capitation rates are built up using the 80% of Medicare FFS fee schedule, with an adjustment in the USPPC for FFS bad debt claims. MassHealth's capitation rates for One Care and SCO have historically been based on its FFS payment experience and rates. This means that capitated rates for the One Care and SCO plans are built using the rate pricing from FFS but are typically priced to reimburse at less than 100% of Medicare's fee schedule for Medicare covered services.

Based upon data reported by our One Care and SCO plans, MassHealth believes that in some circumstances One Care and SCO plans are paying providers in excess of 100% of the Medicare fee schedule today. This means that as a condition of joining plan networks providers may be able to negotiate for far higher rates than they would be paid for seeing the same dual eligible member in FFS. This dynamic is causing instability and financial strain on the programs today. Addressing this dynamic and building appropriate incentives to make participating in the One Care and SCO plan networks attractive to providers is another key pillar to the Demonstration's success.

**To address this issue, MassHealth plans to use existing authority under Medicaid to put in place limits on the Medicaid crossover portion of provider payments for both One Care and SCO.** The purpose of these limits is to ensure fiscal sustainability for the Commonwealth and the federal government. The fee schedule would put maximums on permissible amounts for the Medicaid crossover portion of payments from plans to certain classes of providers to limit excess spending on network above and beyond what is funded within capitation rates. While One Care and SCO plans do not structure payments in contracts with providers as a Medicare allowable amount plus a Medicaid crossover payment, MassHealth will implement limitations in this way so that any limitations put in place would *not* have an impact on the Medicare portion of provider payments (in other words, providers will always receive the full amount of the Medicare payment from One Care and SCO, as is the case in dual eligible in FFS). Similar limitations are already in place in our ACO and MCO programs, and these limitations would not affect provider payments for dual eligibles in FFS.

Under this construct, for services where the Medicare FFS rate is greater than the Medicaid FFS rate, the Medicaid crossover payment limitations will be set so that total provider payments are no greater than what a provider would receive in FFS for a dual eligible (e.g. Medicare FFS at 80% of Medicare rate + MassHealth FFS crossover payments + a member's MassHealth allowed copay) but less than or equal to the Medicare FFS rate for a non-dual. For services where the Medicaid FFS rate is greater than the Medicare FFS rate, the limitation would be set so that the full provider payment is equal to the Medicaid FFS rate. Value-based payment arrangements may have a wider range, a higher price cap ceiling, or more flexibility than FFS payments from plans to providers.

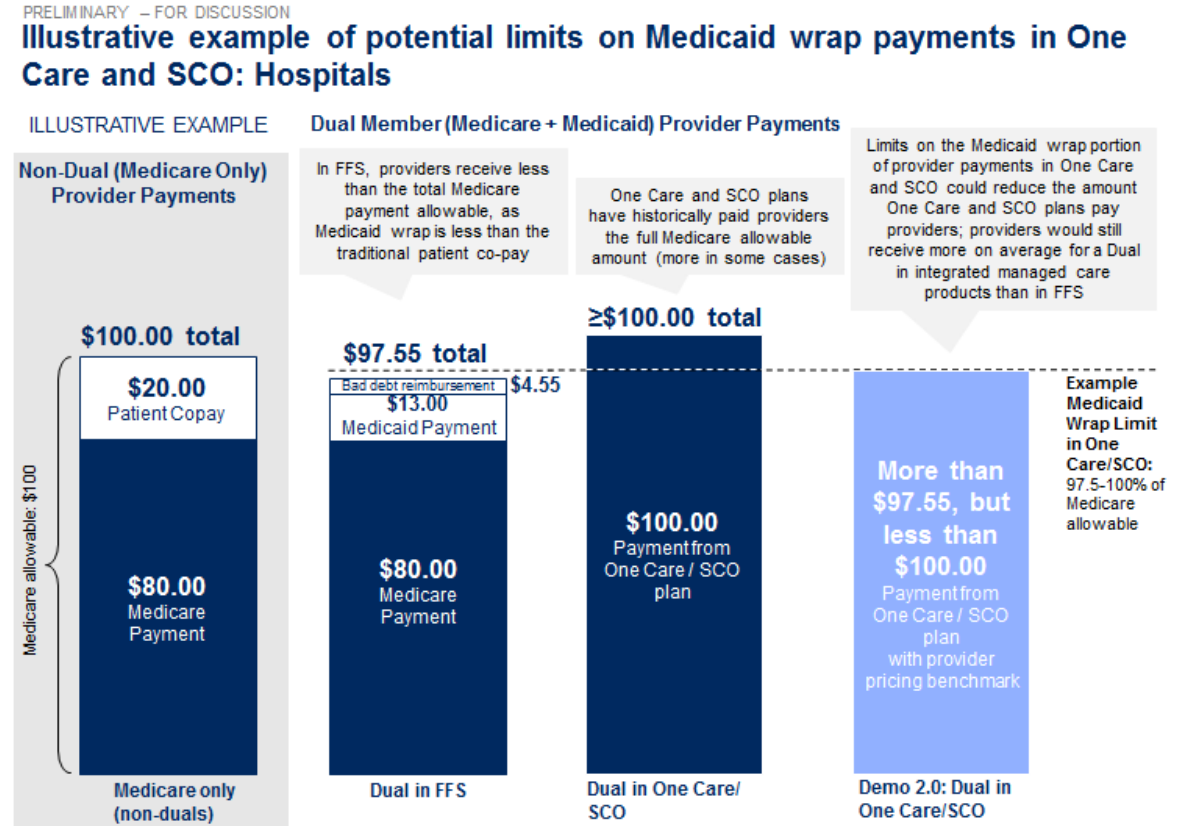
MassHealth believes that reasonable limitations on Medicaid crossover payments in One Care and SCO are critical to ensuring cost effectiveness for both Medicare and Medicaid across integrated Duals products and preventing plans from increasing provider rates to meet minimum medical loss ratio requirements. MassHealth also plans to ensure that these limitations are set in conjunction with new enrollment strategies (i.e. passive and fixed enrollment as described above) as we believe that the resulting increased enrollment in these program will ensure plan and provider sustainability.

By building enrollment in One Care and SCO over Fee-for-Service (FFS), and by setting Medicaid cross over payment parameters for targeted services in One Care and SCO that are better than



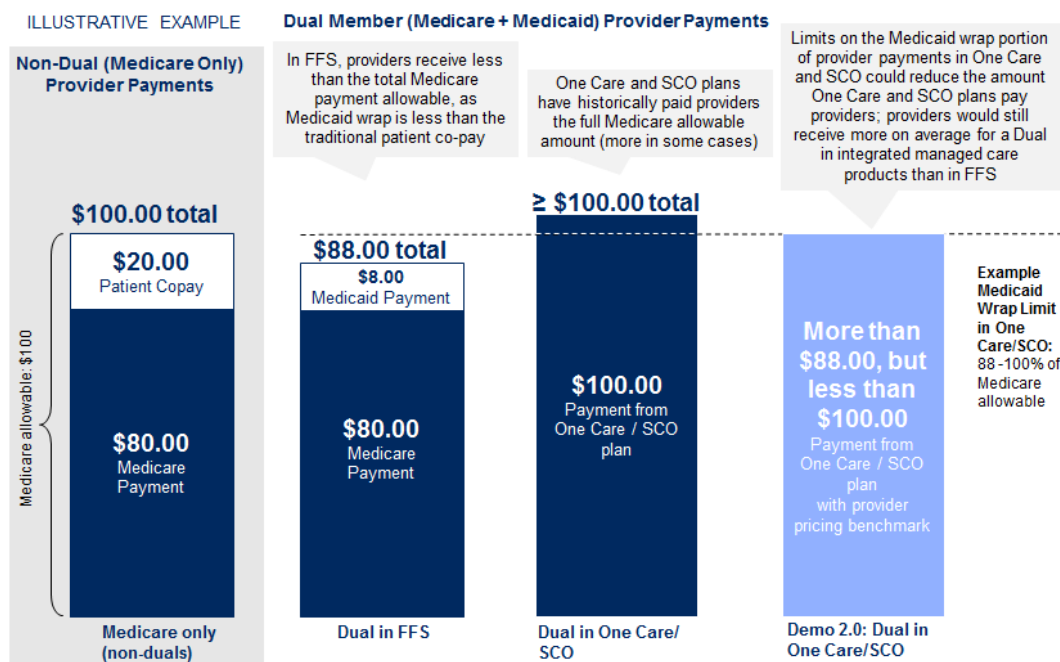
those providers would have been paid for serving the same members in Original Medicare with MassHealth paying crossovers at the MassHealth fee schedule, the Commonwealth believes it can make participating in One Care and SCO financially favorable for providers compared to FFS. As of January 2017 in Massachusetts, only 2.2% of dual eligibles under age 65 were participating in Medicare Advantage plans with MassHealth FFS wrap, and 84.2% were in Original (FFS) Medicare with MassHealth FFS. Among dual eligibles age 65 and older, only 6.5% were in a Medicare Advantage plan with MassHealth FFS wrap, and 60.5% were in FFS Medicare and MassHealth. Even with limited Medicaid crossover payments from One Care and SCO, many providers could realize opportunities by contracting with these plans as enrollment shifts from FFS to the plans. Providers may also find efficiencies from participating in One Care and SCO, where payer authorizations and bill paying would be consolidated with a single payer, rather than following both of the separate Medicare and MassHealth processes for a single patient visit. The plans will also have flexibility and incentives to work with providers to create and adopt innovative payment arrangements and value-based purchasing strategies.

**Figure 8. Implementation of Limitations on Medicaid Crossover Payments**



PRELIMINARY – FOR DISCUSSION

### Illustrative example of potential limits on Medicaid wrap payments in One Care and SCO: Professional Services



- To enter into a shared savings agreement with CMS**, in which both the Commonwealth and Federal government share in savings resulting from the Duals Demonstration 2.0. Financial savings, value, and quality of care achieved system-wide would be determined through **robust evaluation of both One Care and SCO programs as part of the Duals Demonstration 2.0**. Both One Care and SCO programs, especially as enhanced by the above requests, are designed to provide improved care coordination and integration, which is intended to improve beneficiary outcomes and slow cost growth or reduce overall costs over time. Investments in care coordination, increased care management, and community-based services such as behavioral health and long-term services and supports (funded by MassHealth) are expected to slow cost growth or bring down acute, post-acute and medical costs (funded by Medicare), while improving the quality of care and outcomes One Care and SCO beneficiaries experience. Given the nature of the investments made by MassHealth leading to reductions in medical costs funded by Medicare, the Commonwealth proposes **incorporating a shared savings adjustment into our mutual financing of One Care and SCO**. The intent of this shared savings adjustment is to alleviate fragmentation and improve coordination of services for Medicare-Medicaid enrollees by providing further incentive to increase care coordination and investment in cost-saving services (such as those listed above). MassHealth envisions a Demonstration, similar to the shared savings approach CMS has used previously in the Managed Fee-For-Service Financial Alignment Demonstrations (for example, in Washington state), under which MassHealth is accountable for improving the coordination and quality of care for dual eligibles through integrated managed care plans. In return, MassHealth would be eligible to receive a retrospective performance payment based on its performance on quality and savings to both MassHealth and Medicare.

**MassHealth proposes that the shared savings adjustment payments would be retrospective and contingent on performance and achieving overall Federal savings.** This shared savings arrangement would be triggered by Federal savings over a certain percentage (to be defined by MassHealth and CMS) to ensure materiality of savings. When triggered, shared savings would go back to the first dollar. Federal savings would be determined based on independent evaluation (described below) and comparison with a matched group of Medicare-Medicaid enrollees. This

## **INTERNAL DRAFT – Policy in Development**

comparison group would be used to determine the amount of savings achieved by the Demonstration that would not have been expected in absence of the Demonstration. Any savings achieved by the Demonstration (as determined by the comparison with a matched group) will be shared by CMS with MassHealth.

**MassHealth proposes using a similar method to the Medicare Shared Savings evaluation approach used in Washington State.** However, given that One Care and SCO are distinct programs serving distinct populations based on age, MassHealth proposes two “eligible populations” (i.e. eligible for One Care and eligible for SCO) and, thus two separate evaluations per the intent-to-treat design.

MassHealth also proposes an additional intent-to-treat approach that includes both eligible populations above including all One Care and SCO dual eligibles (i.e. all dual eligibles under or over age 65), whose results also display results of enrolled versus non-enrolled. Evidence that significant per-member, per-month savings were accomplished among enrolled members, but not among non-enrolled members, would trigger an adjustment in the standard intent-to-treat savings methodology (subject to further discussion with CMS). **Using these evaluations, the experience of all One Care and SCO dual eligibles in the Commonwealth will be compared with a matched group comprised of other statistically similar populations in other Metropolitan Statistical Areas (MSAs).**

## **Public Process for Proposed Duals Demonstration 2.0**

The Commonwealth has actively engaged a broad representation of internal and external stakeholders in the initial planning of this proposal. From March through May, 2018, MassHealth held in-person meetings and shared draft concept materials with plans, providers, and advocates to describe our Duals Demonstration 2.0 concept and to seek and incorporate stakeholders’ feedback which has been incorporated into this concept paper.

We were pleased with the high level of engagement with the proposed Demonstration and appreciate the thoughtful input and feedback provided by stakeholders to date. In response, we have adjusted certain aspects of this proposal and have sought to clarify our intent with respect to others, as described below.

Certain stakeholders from the nursing facility industry expressed concerns about passive enrollment including individuals residing in nursing facilities. MassHealth has committed to working with the plans, providers, and other stakeholders to implement and refine passive enrollment in a way that provides continuity protections for members and considers their critical provider relationships. MassHealth has not used its passive enrollment authority to target members residing in long-term care facilities into One Care, and does not intend to do so at this time. However, MassHealth seeks to retain passive enrollment authority for One Care, and expand it to SCO, in order to promote choice among future One Care and SCO members who wish to live in the community. Prior to any changes in current practice in passive enrollment for individuals in long-term care facilities, MassHealth would engage the member, advocate and provider communities in robust discussions around appropriate member protections, changes to the assignment algorithm, notices, etc. Additionally, MassHealth intends to explore ways to improve prompt payment policies for One Care and SCO members residing in a long term care facility to ensure that as the One Care and SCO populations increase, long term care facilities will receive prompt payment for these members.

Some stakeholders from the hospital community expressed concerns about applying pricing limitations to certain provider groups. Through feedback from these conversations, MassHealth updated this proposal to reflect more accurately the role of bad debt payments for eligible providers and moderated the proposed limitations on Medicaid crossover payments. MassHealth has also clarified how provider pricing limitations will be set so that the payments cannot be less than the Medicare portion of payments made for dual eligible in FFS. Some providers also expressed concern about losing access

## ***INTERNAL DRAFT – Policy in Development***

to dual eligible beneficiary attribution to Medicare ACO models. In response, MassHealth has clarified that plans and providers would have flexibility to replicate these financial methodologies and would be encouraged to enter into a range of value-based purchasing arrangements. MassHealth looks forward to continuing to work with these and other providers to understand how to best engage Medicare providers in One Care and SCO networks and care models.

Some stakeholders from the Home Health community expressed concern about being paid by One Care and SCO plans today at Medicaid rates during the initial period of Home Health service provision in cases where traditional Medicare would pay a higher, bundled rate. MassHealth would like to address these concerns through exploration of increased value-based purchasing, including potential for bundled payments to Home Health providers.

Further, we heard concerns raised by representatives of our MassHealth member advocacy community regarding the design and implementation of fixed enrollment periods, integrated appeals and grievances, and quality measures. We have committed to working with stakeholders to develop appropriate exceptions and member protections as we develop implementation rules for fixed enrollment periods, integrated appeals and grievances, and quality measures, including using quality and other data to improve continually One Care and SCO under the Demonstration.

## **Next Steps**

MassHealth has actively engaged with a broad representation of internal and external stakeholders in the initial planning of this proposal. Going forward, Massachusetts plans to expand these efforts leveraging several key activities to continue to gather and incorporate stakeholder feedback on the design of Duals Demonstration 2.0, including through the One Care Implementation Council, the SCO Advisory Board, Tribal consultation, sister state agency consultation, meetings with provider organizations, advocates, and members, and open public meetings. The Commonwealth will ensure that stakeholder input continues to inform the design, implementation, and operation of Duals Demonstration 2.0.

## Appendix

### I. Fixed Enrollment Period Exceptions for Duals Demonstration 2.0 Requests

Massachusetts is seeking authority in Duals Demonstration 2.0, with appropriate member protections, to create fixed enrollment periods for One Care and SCO that are consistent with our other Medicaid managed care products (ACOs and MCOs).

In our ACO and MCO fixed enrollment periods, members can choose a new plan every year and are able to request an exemption from fixed enrollment if they meet the reasons set forth in the Medicaid Managed Care rule, such as if the member moves out of the plan's service area, or certain other criteria, as listed below. MassHealth developed exception criteria for the ACO and MCO programs with stakeholders and would follow a similar process to ensure the exceptions and escalation processes reflect the inclusion of LTSS within One Care and SCO and are appropriate for the specific needs of the One Care and SCO populations. Throughout 2017, only 0.02% of MassHealth MCO enrolled members eligible for fixed enrollment requested an exemption each month.

#### ACO and MCO Fixed Enrollment Exceptions:

- You move out of your health plan's service area.
- You need related services to be performed at the same time, and those related services are not all available within your health plan's network, and your primary care provider or another provider determines that receiving those related services separately would be an unnecessary risk to you.
- Your health plan is not meeting your needs for other reasons including but not limited to poor quality of care, lack of access to covered services or lack of access to providers experienced in dealing with your health-care needs.
- Your health plan no longer serves your geographic area. MassHealth will let you know if this happens.
- Your health plan has not provided access to health care providers that meet your health care needs over time, even after you've asked for help.
- MassHealth has information that you are homeless, and your health plan does not have providers who can meet your specific geographic needs.
- Your health plan is not meeting your language, communication, or other accessibility needs or preferences.
- Your key network providers, including primary care physicians, specialists, or behavioral health providers, have left your health plan's network.
- Your health plan, because of moral or religious objections, does not cover a service you seek.
- Your health plan has substantially violated a material provision of its contract with MassHealth.
- MassHealth sanctions your health plan by allowing members to dis-enroll from the health plan. MassHealth will let you know if this happens.

## **II. Passive Enrollment Assignment Methodology**

One Care and SCO use an “intelligent assignment” approach to passively enroll members into both programs. Members are matched to plans using MassHealth and Medicare crossover claims history and plans’ updated provider network files to make assignments based on members’ existing relationships with primary care providers, behavioral health providers, and/or long-term services and supports (LTSS) providers, when possible.

One Care:

- MassHealth selects members with existing provider relationships with the One Care plan into which they are being enrolled
- For C1 members, preferred matches are those who have a relationship with a primary care provider who is also in the One Care plan into which they are being enrolled
- For C2 and C3 members, preferred members will be those who have a primary care match (similar to C1s) AND who also have three or more visits to a behavioral health or LTSS provider in the One Care plan

SCO:

- Level 1 match: Adult Foster Care providers
- Level 2 match: Behavioral health providers and physicians with the most frequent claims;
- Level 3 match: LTSS providers
- Level 4 match: All other providers