

**COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

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**One Care, Senior Care Options (SCO) and Duals Demonstration 2.0**

***REQUEST FOR INFORMATION***

**DOCUMENT # FY19EHSCBONECARESCODUALSRFI**

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## **SECTION 1. OVERVIEW**

MassHealth, the Massachusetts Medicaid program, is interested in hearing from current and potential One Care and Senior Care Options (SCO) plans and other interested parties on a range of policy and procurement questions related to One Care, SCO, and the proposed Duals Demonstration 2.0.

## **SECTION 2. BACKGROUND**

### **2.1 One Care**

One Care is an integrated care option for adults with disabilities ages 21-64 at the time of enrollment who are eligible for both MassHealth and Medicare. One Care enrollees can get the full set of services provided by both programs, as well as additional Behavioral Health (BH) diversionary services, dental and vision, and community support services. The goal of One Care is to offer a better, simpler way for people with disabilities to get all the care they need and to be more independent.

As part of its expected procurement for One Care plans anticipated to be in place on January 1, 2020, MassHealth expects to seek One Care plans that will provide coverage in any and all Massachusetts counties with the goal of having statewide coverage available for eligible One Care members. To be a One Care plan, organizations must be selected through the MassHealth procurement process and meet all application and contracting requirements established by CMS to be eligible to participate with Medicare as a Medicare-Medicaid Plan (MMP). The Executive Office of Health and Human Services (EOHHS) and CMS will provide updates about the CMS requirements for 2020 as they become available.

### **2.2 Senior Care Options (SCO)**

SCO is a program of Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) that provide integrated Medicare and Medicaid services to MassHealth Standard eligible members aged 65 and older at all functional levels. The SCO program offers enrollees the full range of MassHealth and Medicare services as well as additional Behavioral Health (BH) diversionary services, dental and vision, and community-based supports. The SCO program requires that each member have an integrated Primary Care Team (PCT), led by a Primary Care Provider (PCP). This team works with each member and their caregivers, if any, using a person-centered approach to develop a comprehensive plan of care for each enrollee and arranges for services by specialists, hospitals, and Long-Term Services and Supports (LTSS) providers.

As part of its expected procurement for SCO plans anticipated to be in place on January 1, 2021, MassHealth expects to seek SCO plans that will provide coverage in any and all Massachusetts counties with the goal of having statewide coverage available for eligible SCO members. To be a SCO plan, organizations must be selected through the MassHealth procurement process and meet all application and contracting requirements established by CMS to be eligible to participate as a Medicare Advantage FIDE SNP plan. The Executive Office of Health and Human Services (EOHHS) and CMS will provide updates about the CMS requirements for 2021 as they become available.

## 2.3 Duals Demonstration 2.0

One Care is currently authorized as a State Demonstration to Integrate Care for Dual Eligible Individuals and a capitated Financial Alignment Demonstration (the “Duals Demonstration”). MassHealth released a Draft Concept Paper on June 13, 2018 for public comment, and submitted a final proposal to CMS on August 22, 2018 for a new Demonstration (“Duals Demonstration 2.0”) that would add to the One Care and SCO programs’ administrative and enrollment flexibilities and financial sustainability. The overall goals of the Duals Demonstration 2.0 proposal are to improve quality of member care and outcomes and to ensure financial sustainability for all entities involved, including MassHealth, CMS, plans and providers.

MassHealth and CMS will be working toward negotiating and codifying the terms of the Duals Demonstration 2.0 with an expected effective date of January 1, 2020. In order to allow time for the structure of the Duals Demonstration 2.0 to be determined, CMS has agreed to extend the current Duals Demonstration authority and One Care plan contracts for one year, through December 31, 2019. The successful negotiation of Duals Demonstration 2.0 would provide MassHealth with the federal flexibilities and permissions necessary to continue One Care beyond 2019.

Beginning in January 2021, MassHealth also expects that the SCO program would have access to the flexibilities available under the Duals Demonstration 2.0. MassHealth expects to procure SCO plans for January 1, 2021 after completion of the current contract term, and those newly selected SCO plans would be part of the Duals Demonstration 2.0. One Care and SCO will remain separate and distinct programs.

In July and August, MassHealth held three open, public listening sessions to discuss topics related to Duals Demonstration 2.0, One Care, and SCO. The topics and questions in this Request for Information (RFI) are based on the topics and questions discussed in those listening sessions. A fourth open, public listening session is planned for Monday September 10<sup>th</sup> in Worcester. Presentation slides and other meeting materials from the first three listening sessions are posted on the Duals Demonstration 2.0 website at: [www.mass.gov/duals-demonstration-20](http://www.mass.gov/duals-demonstration-20) in the “Duals Demonstration Open Meetings” section.

## 2.4 One Care Plan Procurement

The goals and innovative features of One Care include:

- **One Care is designed to actively engage Enrollees in leading or self-directing their care, including through engagement with their care teams and care planning processes.** Integrated care management in One Care is grounded in a person-centered comprehensive assessment of each Enrollee and the Enrollee-directed creation of an Interdisciplinary Care Team and Individualized Care Plan. Individuals with more complex needs will be offered more intensive Clinical Care Management. Long-term Support Coordinators from Community-Based Organizations experienced in working with people with disabilities will participate on the ICTs, at the discretion of the Enrollee, to ensure effective

care coordination across the health and human services delivery system and promote continuity of existing LTSS and behavioral health relationships, including for recovery.

- **Global Capitation Payments to One Care Plans through Medicare and MassHealth provide One Care Plans with the flexibility to develop and advance payment and service delivery innovations.** Consolidating federal and state purchaser payment streams at the plan level gives the One Care Plans necessary flexibility to coordinate and manage care, to invest in high-value, high-quality care, and to provide service flexibility based on the member's care plan that is not possible through current Fee-For-Service structures in Medicare or Medicaid. The first generation of One Care Plans used this flexible resource to invest in additional services, augment and expand behavioral health network capacity, and pilot delegated care management models for certain populations. The second generation of plans will build on this ingenuity and continue experimenting to further improve Enrollees' experiences.
- **Alternative Payment Methodologies (APMs) and Value-Based Payments (VBPs) will be required.** One Care Plans must demonstrate use of APMs and VBPs, including meeting certain thresholds for their provider networks to advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees. MassHealth will give One Care Plans the tools they need to move provider network relationships beyond transactional, and to incent providers to invest in the care and coordination they bring to each member.
- **One Care Plans can bring flexibility to service delivery, incorporating member outcomes and quality of life into the planning and authorization processes.** One Care Plans are required to include certain services within their benefit plans, and they also have the flexibility, with the participation of the Enrollee and ICT, to include as part of the ICP other services as alternatives to or means to avoid high-cost medical services as well as services that best suit the individualized needs and preferences of Enrollees.

Through the One Care procurement, MassHealth plans to require Innovation Plans from respondents, upon which they would be evaluated as part of the procurement process. The Innovation Plans would include each respondent's specific plans, proposals, and commitments that demonstrate their innovative approaches to improving care and outcomes for enrolled individuals, and in particular, their strategies to:

- Engage individuals in driving their care teams;
- Support individuals with disabilities to live independently in the community;
- Prevent, avoid, and delay unnecessary nursing facility admissions;
- Address social determinants of health (SDOH); and
- Develop and implement creative solutions and best practices for the delivery model; including on topics described in **Section 3.A.**

EOHHS may add additional areas to the Innovation Plan requirements in the procurement. The Innovation Plans of selected respondents would be incorporated into their contracts, through which MassHealth will hold them accountable for developing, measuring, and delivering ongoing innovation.

### **SECTION 3. QUESTIONS FOR RESPONSE**

EOHHS requests responses to the following RFI questions. Respondents are invited to respond to *any or all* of the RFI questions; please respond to as many questions as you feel are appropriate. Questions should be answered in order of appearance. Responses, including any attachments thereto, should be clearly labeled with the question number followed by the question text.

All responses must include a completed Respondent Information Cover Sheet (please see **Section 6** below).

Respondents may not withdraw their responses. MassHealth will not return all or part of a response to a respondent. Receipt of RFI responses will not be acknowledged.

***MassHealth invites interested parties to answer any or all of the following questions. For all questions below, please provide examples to support your response.***

#### **A. Innovation**

Under Duals Demonstration 2.0, MassHealth will seek to drive innovation in both One Care and SCO.

1. How could MassHealth further drive One Care and SCO plans to innovate for dual eligibles?
2. What questions should we ask respondents to the One Care and SCO plan procurements to identify plans that will creatively develop, pilot, and implement innovations that:
  - a. Employ best practices in complex care management, practice-based care management, and flexible supports;
  - b. Improve linkages for care teams to effectively communicate and coordinate care at the member's direction;
  - c. Further engage and empower individuals in leading or self-directing their care, including through engagement with their care teams and care planning processes;
  - d. Engage providers through the care model to partner with plans using innovative approaches;
  - e. Design alternative care approaches to reduce and avoid unnecessary acute and hospital-based care;

- f. Design and invest in alternative care approaches that avoid and reduce unnecessary nursing facility care, including returning members from nursing facilities to the community;
- g. Deepen support for individuals with Intellectual or Developmental Disabilities (ID/D) and Autism Spectrum Disorder (ASD) and their families;
- h. Facilitate effective communication access and address accessibility;
- i. Improve member outcomes and quality of life;
- j. Address SDOH; and
- k. Address health disparities and inequities?

### ***B. Provider Engagement and Networks***

In general, for both One Care and SCO, Medicare provider network standards apply to medical services and prescription drugs, while MassHealth sets standards for long-term services and supports and other Medicaid services. Networks must be sufficient to address the needs of the target populations, must meet specific requirements with respect to time and distance standards and give members choices among providers.

1. What would effectively encourage providers to participate in One Care and SCO plan networks? For example, would a provider consider joining a One Care or SCO network if a certain percentage of the provider's clients enrolled with that particular One Care or SCO plan? If so, what percentage?
2. Are there any challenges or barriers that discourage providers from participating in One Care or SCO plan networks? If so, what are they and how do they discourage participation? What mitigations would reduce or address these challenges?
3. What would encourage Medicare ACO providers to participate in One Care or SCO plan networks?
4. Are there any actions or policies you recommend the Commonwealth consider to encourage provider participation in One Care and SCO plan networks?

### ***C. Service Authorizations***

Both One Care and SCO plans may require prior authorization (PA) for certain services. Plans must also have utilization management (UM) policies and procedures (for program integrity and equity). Although a member's care plan is based on his or her assessment, services contained in that care plan may still be subject to prior authorization or utilization management review. Service authorization processes must be at least as protective to the member as the combination of Medicare and MassHealth's medical necessity criteria would be.

1. How could plans better link a member's individualized care plan to the authorization process?

2. What would improve transparency in these processes?
3. What strategies could better balance person-centered processes with system efficiencies necessary to support enrollment at scale?

#### **D. Grievances**

One Care and SCO employ different processes for filing, documenting, and reviewing member grievances.

Today, One Care enrollees may submit grievances through various organizations, including the One Care plans, MassHealth, and Medicare. All grievances are centrally documented and addressed in CMS's HPMS system in the Complaints Tracking Module, where they are reviewed by both MassHealth and CMS.

Today, as is the case for all Medicare Advantage plans including FIDE-SNPs, SCO enrollees may file grievances only with their SCO plans. The SCO plans each report a detailed summary of grievances to EOHHS monthly and are required to provide grievance information to consumers upon request.

In the Concept Paper, MassHealth proposed to align the One Care and SCO grievance processes, to ensure that the Commonwealth and CMS have clear and transparent access to all grievances and their resolutions, and that members would have a clear and responsive process for grievances.

1. What parts of the current processes are working well?
2. What parts of the current processes are most protective to members?
3. Do gaps exist in the current processes and how should MassHealth address them?
  - a. For members;
  - b. For providers;
  - c. For health plans;
  - d. For others involved in the process?
4. To whom should members be able to submit grievances? (Please provide a rationale for your response.)
5. In One Care, all grievances are documented in the Complaints Tracking Module, which is part of the electronic CMS Health Plan Management System (HPMS). States do not currently have access to HPMS for SNP plans (including SCO). While SNP plans have access to HPMS they are not required to track grievances in this system.

- a. Is use of the Complaints Tracking Module in HPMS supporting plans in resolving grievances? If so, how? If not, how could it be improved?
  - b. Should the use of HPMS for this purpose should be extended to SCO?
6. Please provide any additional suggestions to ensure grievance processes are transparent, accessible, and responsive to members.

**E. Appeals**

The first level of appeal for a member in either One Care or SCO is an internal appeal at the plan level (as is required under the 2016 Medicaid Managed Care Rule). One Care and SCO’s second level of appeal processes align in some respects and differ in others. The timeframes for second level appeals are aligned in both programs in accordance with the 2016 Medicaid Managed Care Rule (42 CFR 438.408(f)(2)), and MassHealth proposed in the Concept Paper to continue using those timeframes under Duals Demonstration 2.0. (See **Figure 1.** below.)

**Figure 1, Appeals Timeframes**

<b>Topic</b>	<b>One Care</b>	<b>SCO</b>	<b>Duals Demo 2.0 – For Discussion</b>
<b>Second Level Appeal Timeline</b>	120 days <sup>1</sup> to file, response within 30 days		120 days to file, response within 30 days
<b>Expedited Appeal</b>	Must be requested, response within 72 hours		Must be requested, response within 72 hours

In both One Care and in SCO, the process for the second level of appeal (external appeal) is governed by the type of service being appealed. If a member does not get a favorable result in the first level of an appeal for a service that:

1. Is traditionally covered by Medicare Part A (Institutional) or Part B (Provider), the appeal is automatically forwarded to the Medicare Independent Review Entity (IRE) by the plan;
2. Is traditionally covered only by MassHealth, a member may choose to file an appeal to the MassHealth Board of Hearings (BOH); for appeals filed within 10 days of the plan’s internal decision, the member may request continuing services (aid pending);
3. May be covered by Medicare in some circumstances and MassHealth in others (for example home health or nursing facility care), the appeal is automatically forwarded to the Medicare IRE. Members may also appeal through the MassHealth BOH simultaneously. In the case of two simultaneous appeals through the Medicare and MassHealth appeals processes, the decision most favorable to the member will prevail.

<sup>1</sup> *Timeframe is in use, contracts in process of updating to reflect 120 days*

**Figure 2, Second Level Appeals Process Features**

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

In the Concept Paper, MassHealth proposed maintaining the first level of appeals within each One Care and SCO plan but consolidating the second level of appeals (external appeals), regardless of the type of service, through the MassHealth BOH (the Commonwealth’s Fair Hearings entity). MassHealth also proposed auto-forwarding some, but not all, Medicare service appeals to external review. The member would receive the requested service during the pendency of the appeal if the member submitted his or her written request for a board of hearings appeal and continued services within 10 days of the mailing of the plan’s internal appeal decision. (See above in **Figure 2.**)

1. What are the perceived gaps exist in the current processes and how should MassHealth address them?
  - a. For members;
  - b. For providers;
  - c. For health plans;

- d. For others involved in the process?
2. Are there particular Medicare service appeals that plans should continue to auto-forward to the Medicare IRE? If so, which service appeals, and why?
3. Which Medicare service decisions are most frequently reversed, whether in full or in part, in Medicare's external review process?
4. Are there certain Medicare service categories for which a second level appeal would be more appropriately initiated by a member or provider rather than auto-forwarded? If so, which service categories and why?
5. Please provide any additional strategies, considerations, or approaches MassHealth should consider to ensure external appeals processes are transparent, accessible, and responsive to members.

### ***F. Care Management***

One Care and SCO both include all Medicare Part A (Institutional), Part B (Provider) and Part D (Pharmacy) services and MassHealth State plan services, as well as additional Behavioral Health (BH) diversionary services, dental and vision, and community-based supports. Both programs use a team approach to help members coordinate their medical care, behavioral health services, and long-term services and supports. An assessment informs each member's care plan, which is developed together with their care team.

In One Care, the member is at the center of their Interdisciplinary Care Team, and a Primary Care Provider (PCP) leads the team with a Care Coordinator and/or a Behavioral Health clinician if indicated. In SCO, care is managed by a Primary Care Team led by the member's PCP.

In some cases, plans have delegated care management functions to community-based provider organizations.

1. Do delegated entities provide care management that is as effective as that provided by plans that have not delegated care management functions? Why or why not?
2. Which specific aspects of a delegation arrangement work well?
3. Which specific aspects of a delegation arrangement do not work well?
4. What qualifications or expertise should delegated entities possess to ensure that they effectively provide comprehensive care management?
5. What guardrails should MassHealth consider for these kinds of approaches?

### ***G. Medicare Bidding***

Currently, One Care and SCO plans receive capitated payments from both MassHealth and Medicare for each dual eligible enrollee. One Care and SCO Medicare capitation rates are

experience-based and risk-adjusted. SCO plans participate in the Medicare Advantage bidding process; bidding against a benchmark established by Medicare for each county they cover.

For Duals Demonstration 2.0, MassHealth has proposed combining the Medicare Advantage bidding methodology with experience-based, risk-adjusted Medicaid rates to ensure fiscal sustainability. Plans would receive capitation payments from MassHealth and Medicare for each enrollee as is current practice in One Care and SCO.

For One Care, the Medicare financial methodology would align with that in SCO:

- Plans would participate in the Medicare Advantage bidding process, while maintaining demonstration status
- Plans would have access to the frailty adjuster (if applicable)
- Plans would have continued access to bad debt adjustment currently in place for One Care.

For SCO, the Medicare financial methodology would remain largely the same as today:

- Plans would continue to participate in the Medicare Advantage bidding process
- Plans would bid against the Medicare Advantage benchmark for their capitation
- Plans would continue to have access to frailty adjuster (if applicable)
- Plans would have access to the bad debt adjustment currently available to One Care plans.

In both One Care and SCO, Medicaid rates would be increasingly experience-based, and MassHealth would continue to develop a risk adjustment methodology based on functional status and social determinants.

1. What should MassHealth consider in transitioning from the current One Care Medicare financial methodology to the Medicare Advantage bidding methodology?
2. How would this change impact plans, plan enrollees, network providers, or others?
3. What should MassHealth consider in adding risk adjustment to the Medicaid rate-setting methodology for One Care and SCO?

#### ***H. Risk Sharing***

In One Care, losses and gains exceeding a certain level are shared between the plans, Medicare, and MassHealth. SCO currently has a bidding process, with rebates and quality bonuses and no risk corridors.

For the Duals Demonstration 2.0, MassHealth proposed high-utilization risk corridors that would share losses and gains between the plans, Medicare, and MassHealth for costs associated with the delivery of care to members with extraordinarily high utilization. Other risk mitigation

strategies, such as stop-loss, also could be used to protect against program instability that might occur as a result of the delivery of services to members with extraordinarily high utilization.

MassHealth has also proposed that the two-sided risk corridors in place today in One Care be applicable to both One Care and SCO to protect plans against financial instability.

1. Are there any downsides to including a two-sided risk corridor in SCO? If so, what are they?
2. What other financial methodologies should MassHealth consider to assure the stability of One Care and SCO products until member enrollment reaches a minimum level for sustainability?
3. What other approaches should MassHealth consider so that plans, CMS, MassHealth, and providers share in both risks and potential gains?

### ***I. Provider Payments***

For dual eligibles in Massachusetts who do not participate in One Care and SCO, providers receive MassHealth fee-for-service rates paid by a combination of Medicare as their primary payer and MassHealth which pays the relevant co-payments and deductibles up to the MassHealth rate on behalf of MassHealth members on a secondary basis. Often the amount paid by MassHealth in these circumstances is less than the amount that would be paid if the individual were not MassHealth eligible and were responsible to pay for the Medicare co-payments and deductibles on their own. MassHealth understands that One Care and SCO plans often pay hospitals and physicians at least the amount that would be paid if the individual were not MassHealth eligible and were responsible to pay for the Medicare co-payments and deductibles on their own and in some circumstances, they pay these providers significantly higher amounts. In the Concept Paper, MassHealth proposed limiting the Medicaid portion of provider payments for One Care and SCO. (See **Attachment A** for illustrative examples.)

1. How should MassHealth balance the need for broader provider networks with the need for greater provider accountability and responsibility (i.e., deeper engagement with care teams)?
2. What other mechanisms to encourage sustainable plan-provider network contracting should MassHealth consider?
3. How should creating choices in networks be balanced with contracting efficiently, particularly if few providers are geographically available?

### ***J. Value Based Payment***

MassHealth encourages Value-Based Payments (VBP) in both One Care and SCO. MassHealth Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs) operating in the Commonwealth's Payment and Care Delivery Innovation (PCDI) program have established thresholds for VBP as a percent of total business. The Duals

Demonstration 2.0 proposed aligning Value-Based Payment strategies across all MassHealth integrated care programs (ACO, MCO, One Care, and SCO).

1. Should MassHealth add incentives for VBP? If so, which? How would additional incentives for VBP impact provider networks, both from the plan and provider perspective?
2. Are plans and providers interested in VBP methodologies that include shared risk? Why or why not?
3. Which (if any) existing Medicare and Medicaid VBP models should be considered to improve One Care and SCO performance?
4. What other strategies should we consider to better engage Medicare ACOs in plan networks?

### ***K. Measuring and Incenting Quality***

The Duals Demonstration 2.0 proposed creating a MassHealth quality slate specific to dual eligible populations (e.g., under age 65 with disabilities, and age 65 and older). This would include creating a One Care specific quality measurement program administered like the Medicare Advantage Stars quality program, to be phased in over time and limited to a targeted set of measurable metrics uniquely relevant to dual eligible under the age of 65. Both One Care and SCO Plans would have the opportunity to gain back a quality withhold for high quality scores.

1. What should MassHealth consider in developing One Care Stars (e.g., quality withhold, slate of quality measures tailored to population) for the population under age 65 with disabilities?
2. How could MassHealth further align One Care and SCO quality measurement with the approaches and measures used in MassHealth ACOs, and incentivize improved quality across the MassHealth portfolio of products?

### ***L. Passive Enrollment***

Enrollment in both One Care and SCO is voluntary. Passive enrollment is used to add predictability for plan enrollment volume; planned enrollment increases may also create incentives for providers to join plan networks. Enrollment is monthly (changes are effective the first day of the next month). Members can opt out from passive enrollment at any time – if members opt out of passive enrollment into One Care they will not be passively enrolled during the current Demonstration. MassHealth makes plan assignments based on the member's provider relationships, starting with their PCP.

MassHealth sends 60-day and 30-day notices to members being passively enrolled. Plans may outreach to passively enrolled individuals before the enrollment effective date:

- One Care plans are required to send welcome packets 30 days before enrollment, and may engage members in comprehensive assessments 20 days before enrollment;
- SCO plans or their contractors were able to outreach for orientation and assessment 60 days before enrollment.
  1. How can MassHealth encourage collaboration between providers and plans to better leverage passive enrollment for different populations (i.e. all or some of a provider's eligible members)?
  2. What strategies would improve the passive enrollment process in One Care and SCO?
    - a. For Members;
    - b. For Plans;
    - c. For Providers?
  3. How should MassHealth consider prioritizing relationships between PCPs and other medical specialists, behavioral health, or LTSS providers when making plan assignments?
  4. At what point should plans be able to outreach to members in the passive enrollment process? (Possible range: 20 - 60 days prior to enrollment)

### ***M. Continuity of Care***

#### *Policy*

Members who enroll in a One Care or SCO plan have a Continuity of Care period until their care plan is complete. Continuity of Care protects enrollees' provider relationships, services, and prior authorizations during their assessment and care planning processes.

- One Care assessments are required within 90 days of enrollment; Continuity of Care continues until their care plan is complete;
- SCO assessments are required within 30 days of enrollment. When members are passively enrolled in SCO, like in PCDI and One Care, continuity of care continues for 90 days

Continuity of Care allows for transition planning and for plans to connect new enrollees with network providers, if needed.

#### *Data Sharing*

In One Care, MassHealth also shares claims history with plans for new enrollees. In addition, One Care plans may access current Medicare claims data directly from CMS for new enrollees.

1. What additional strategies should MassHealth consider to make entering One Care and SCO easier for members?
2. What strategies should One Care and SCO plans consider using to improve onboarding for new enrollees?
3. What strategies should Plans employ to more effectively outreach to providers and build their networks?
4. What additional tools or strategies should MassHealth consider to support plans to operationalize continuity of care and care transitions?
5. Should the data sharing capabilities today in place for One Care plans be extended to SCO plans?

#### ***N. Special Election Periods (SEPs)/Fixed Enrollment Periods***

##### *Special Election Periods*

SCO and One Care currently provide all of a member's Medicare benefits. In traditional Medicare, these benefits are offered through 3 parts of Medicare: Part A (Institutional), Part B (Provider) and Part D (Pharmacy). All dual eligible MassHealth members who do not elect SCO, PACE, One Care, or a Medicare Advantage Part D plan either choose or are assigned to a Part D plan.

Historically, Medicare has allowed dual eligible members to change their Medicare and Part D plans in any month of the year. For 2019, Medicare has made changes that will apply nationally to limit when dual eligible members can change plans that cover Medicare Part D (pharmacy) benefits to specific Special Election Periods (SEPs). This policy change applies to:

- Part D plans (Part D);
- Medicare Advantage and Part D (MAPD) Plans, including D-SNPs (Parts A, B, and D);
  - Note that SCO plans are FIDE-SNPs (these cover parts A, B, and D and Medicaid); FIDE-SNPs and D-SNPs are subsets of MAPD plans; and
- Medicare-Medicaid Plans (Parts A, B, and D and Medicaid);
  - Note that One Care plans are MMPs. CMS is waiving these new SEP limitations for One Care in 2019, to allow members to enroll in or disenroll from One Care on a monthly basis.

Based on enrollment as of April 2018, approximately 86% of Massachusetts dual eligibles under age 65 and approximately 97% of dual eligibles age 65 or older are receiving their Medicare benefits through plans where that will be impacted by this change. Members enrolled in One Care are among the 14% of members under age 65 who would not be impacted as CMS has granted a waiver to One Care for 2019. (No similar waiver option is available for SCO).

Further, to implement the federal Comprehensive Addiction and Recovery Act (CARA), Medicare will also identify certain individuals who are potentially at risk/at risk for misuse/abuse of a frequently abused drug. CMS will apply extra limits to when these individuals may change plans covering their Part D benefits. CARA provisions supersede the One Care waiver of the new SEP rules; One Care eligible members and enrollees identified for extra limits via CARA will be subject to those limits beginning in 2019.

With the exception of individuals subject to CARA provisions, most other members getting their Part D benefits from these types of plans would have a SEP they could use to change plans for their Part D benefits at certain times:

- Once each calendar quarter during the first three quarters of the year:
  - January to March
  - April to June
  - July to September
  - No changes October to December (Medicare Annual Election Period)
- Additional exceptions would be available to members who:
  - Have a change in their dual eligible or Low-Income Subsidy (LIS) status
  - Are assigned to a plan by CMS or their state
  - Move out of their current service area
  - Are getting care in a nursing home or hospital
  - Want to enroll in or disenroll from PACE
- States that have received a waiver from CMS through their Financial Alignment Demonstration (e.g. One Care) may allow members not impacted by the CARA provisions to continue to enroll/disenroll from Medicare-Medicaid Plans once a month, maintaining the current One Care policy.

### Fixed Enrollment Periods

Through the Duals Demonstration 2.0, MassHealth proposed an alternative approach. MassHealth would instead adopt fixed enrollment periods in One Care and SCO that align with the approach used in MassHealth's Accountable Care Organization (ACO) and Managed Care Organization (MCO) programs. In the ACO/MCO programs, members have an annual 90-day Plan Selection Period to choose or switch a health plan for any reason. The Plan Selection Period is followed by a Fixed Enrollment Period, during which enrollees stay enrolled in their health plan unless they meet certain exceptions, such as: moving out of a plan service area, poor quality care, lack of access to services or to providers experienced in dealing with their health care needs, or a plan is not meeting language, communication or other accessibility

preferences/needs of the members. (A full list of Fixed Enrollment Period exceptions is available at [www.mass.gov/service-details/fixed-enrollment-period](http://www.mass.gov/service-details/fixed-enrollment-period). Additional information is also available in MassHealth’s regulations at 130 CMR 508.000).

1. In addition to the current exceptions for ACOs and MCOs, should MassHealth consider additional exceptions for One Care and SCO enrollees? If so, what additional exceptions?
2. What other factors should MassHealth consider in applying or updating the current ACO/MCO program Fixed Enrollment Period approach for One Care and SCO under the Duals Demonstration 2.0?

### **O. Enrollment Churn**

Some One Care and SCO enrollees experience short-term changes in their eligibility, but regain their eligible status within a short period of time (e.g., often 0-3 months). Monthly enrollments for One Care and SCO allow plans to work with enrollees to address eligibility gaps before enrollment ends. MassHealth also shares upcoming enrollee redetermination dates with plans weekly so that the plans may outreach to members who may need assistance in completing the redetermination process. However, when eligibility is not resolved within the same month, members may be disenrolled from their plan; sometimes also from MassHealth (i.e., involuntary disenrollment).

To help address this complex issue, CMS allows Medicare-Medicaid Plans (MMPs) to offer a grace period for members who experience a change in their Medicaid status that is expected to be short-term. (See “Medicare-Medicaid Plan Enrollment and Disenrollment Guidance” as Revised 8/2/2018; Section 40.2.3.2. “Optional Period of Deemed Continued Eligibility Due to Loss of Medicaid Eligibility,” p. 62-63.<sup>2</sup>)

For example, MMPs in Michigan allow these members to remain enrolled for up to 3 months while short-term Medicaid eligibility lapses are resolved:

- During the grace period, MMPs continue to provide all services to impacted members
- MMPs assume the financial responsibility for Medicaid services
- In some cases, the state may reimburse the MMP for periods of restored retroactive eligibility

To date, no One Care plans have requested to use this approach.

1. What strategies should MassHealth consider to support One Care and SCO plans to address individual eligibility gaps quickly (i.e. within the same month)?

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<sup>2</sup> [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPEnrollmentGuidanceManual\\_CY2019\\_08022018.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPEnrollmentGuidanceManual_CY2019_08022018.pdf)

2. What strategies should plans use to reduce eligibility-related enrollment churn?
3. What operational or other barriers prevent plans from seeking authority for grace periods?
4. Should MassHealth require plans to offer a grace period? Under what conditions?

***P. Home and Community-Based Services (HCBS) Waiver Participant Access to Integrated Care***

Currently, individuals may not simultaneously enroll in One Care and participate in any of the 9 1915(c) Home and Community-Based Services (HCBS) Waivers offered by MassHealth and its EOHHS sister agencies to eligible adult populations even if the individual is eligible for both programs. Individuals eligible for both One Care and a HCBS Waiver must choose which program to participate in.

By comparison, the SCO program includes services available through the Frail Elder Waiver (FEW). Members who are at least 65 years old and at a nursing facility level of care can choose to get their MassHealth and FEW services either through a SCO plan or through MassHealth FFS.

The intersection of these programs is a policy area MassHealth may consider in the future together with all relevant stakeholders. While MassHealth does not propose seeking changes to this policy for the beginning of the Duals Demonstration 2.0 MassHealth is seeking stakeholder input to inform EOHHS's thinking on this issue.

1. What issues should EOHHS consider when thinking about integrating HCBS waiver services within One Care?
2. Should MassHealth consider prioritizing certain HCBS Waiver populations in providing access to or integration with One Care? For example:
  - a. Waivers with services MassHealth buys directly
  - b. Waivers targeted to individuals needing residential or other 24/7 supports
3. What purchasing, licensing, quality oversight, operational, or other issues should MassHealth and State Agency partners address and resolve before considering creating new enrollment options for HCBS Waiver participants?
4. In addition to FEW services, should services available to other HCBS Waiver populations be available to those populations through SCO, so that other waiver participants who are at least 65 have the opportunity to participate in SCO?

***Q. Other***

1. Are there any other comments on this subject not specifically addressed by the questions above that you wish to make?

## SECTION 4. RFI SUBMISSION INSTRUCTIONS

EOHHS requests that RFI responses be submitted to EOHHS by **SEPTEMBER 24, 2018 by 10:00 a.m.** Eastern Time.

**Interested Parties are invited to respond to any or all of the above questions; please respond to as many as you feel are appropriate.** Responses should be limited to **20 pages** in length. Parties interested in responding to this RFI should prepare a typewritten response that includes a completed Respondent Information Cover Sheet (see **Section 6**) that states the respondent's name, title, organization, telephone number, e-mail address, and URL address.

EOHHS prefers to receive electronic submissions via email but will also accept typewritten hard copy responses. Any hard copy responses should be double-sided, single-spaced pages in **Times New Roman 12 point font**. Hard copies must include **one original and three copies** of the response.

Responses should be submitted as follows:

- By email (preferred) to Melissa Morrison at: [Melissa.Morrison@state.ma.us](mailto:Melissa.Morrison@state.ma.us)
- In writing to: Melissa Morrison, Procurement Coordinator  
Executive Office of Health and Human Services  
One Ashburton Place, 11<sup>th</sup> Floor  
Boston, MA 02108

## SECTION 5. ADDITIONAL INFORMATION

### 5.1. Electronic Distribution

This RFI has been distributed electronically via COMMBUYS, the only official procurement record system for the Commonwealth of Massachusetts' Executive Departments. COMMBUYS is an electronic mechanism used for advertising and distributing the Commonwealth's procurements and related files. No individual may alter (manually or electronically) the RFI or its components except those portions intended to collect the respondent's response. Interested parties may access COMMBUYS at the following address: <http://www.commbuys.com>. Questions specific to COMMBUYS should be made to the COMMBUYS Help Desk at [commbuys@mass.gov](mailto:commbuys@mass.gov) or call during normal business hours (8am - 5pm ET Monday - Friday) at 1-888-627-8283 or 617-720-3197.

### 5.2. RFI Amendments

Interested parties are solely responsible for checking COMMBUYS for any addenda or modifications that are subsequently made to this RFI. The Commonwealth and its subdivisions accept no liability and will provide no accommodation to interested parties who fail to check for amended RFIs.

### **5.3 Use of RFI Information**

EOHHS reserves the right to accept or reject, in part or in full, any information contained in or submitted in response to this RFI. The RFI is not binding on EOHHS and shall not obligate EOHHS to issue a procurement that incorporates any RFI provisions or responses. Responding to this RFI is entirely voluntary, will in no way affect EOHHS' consideration of any proposal submitted in response to any subsequent procurement, and will not serve as an advantage or disadvantage to the respondent in the course of any procurement that may be issued. Responses to this RFI become the property of the Commonwealth of Massachusetts and are public records under the Massachusetts Freedom of Information Law, M.G.L. c. 66, § 10 and c. 4, § 7, cl. 26, regarding public access to such documents. However, information provided to EOHHS in response to this RFI and identified by the respondent as trade secrets or commercial or financial information shall be kept confidential and shall be exempt from disclosure as a public record (see M.G.L. c. 4, § 7, cl. 26). This exemption may not apply to information submitted in response to any subsequent procurement.

### **SECTION 6: RESPONDENT INFORMATION COVER SHEET**

*[Starts on the following page.]*

**COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN  
SERVICES**

**REQUEST FOR INFORMATION**

Related to

**One Care, Senior Care Options (SCO) and Duals Demonstration 2.0**

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**Respondent Information Cover Sheet**

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**Include the following information for the individual who should be contacted for purposes of discussing any aspect of the Respondent's completed Response Form:**

**First Name:** [     ]                      **Last Name:** [     ]

**Title:** [     ] **Organization or Interest:** [     ]

**Respondent Principal Address:**

[     ]

[     ]

**City:** [     ] **State:** [   ] **Zip:** [     ]

**Telephone:** (    )   -       **E-mail:** [     ]

**URL:** [     ]

- **I am responding to this RFI on behalf of the Organization listed above:**   **Yes:**            **No:**
- **The information in this response is my own individual opinion:**           **Yes:**            **No:**

**Responses to RFI Questions:** Please provide the question number first [e.g., Question A.1 or Question L.3], followed by your response.

## Attachment A. Implementation of Limitations on Medicaid Crossover Payments

PRELIMINARY – FOR DISCUSSION

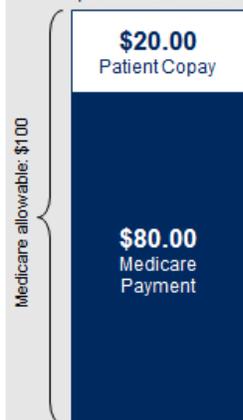
### Illustrative example of potential limits on Medicaid wrap payments in One Care and SCO: Hospitals

ILLUSTRATIVE EXAMPLE

Dual Member (Medicare + Medicaid) Provider Payments

Non-Dual (Medicare Only) Provider Payments

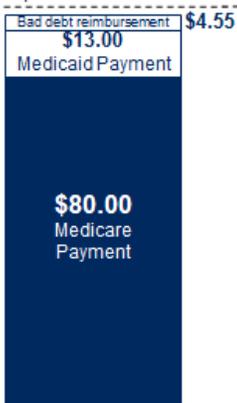
\$100.00 total



Medicare only (non-duals)

In FFS, providers receive less than the total Medicare payment allowable, as Medicaid wrap is less than the traditional patient co-pay

\$97.55 total



Dual in FFS

One Care and SCO plans have historically paid providers the full Medicare allowable amount (more in some cases)

≥ \$100.00 total



Dual in One Care/SCO

Limits on the Medicaid wrap portion of provider payments in One Care and SCO could reduce the amount One Care and SCO plans pay providers; providers would still receive more on average for a Dual in integrated managed care products than in FFS

More than \$97.55, but less than \$100.00  
Payment from One Care / SCO plan with provider pricing benchmark

Demo 2.0: Dual in One Care/SCO

Example Medicaid Wrap Limit in One Care/SCO: 97.5-100% of Medicare allowable

PRELIMINARY – FOR DISCUSSION

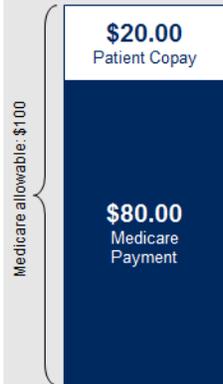
### Illustrative example of potential limits on Medicaid wrap payments in One Care and SCO: Professional Services

ILLUSTRATIVE EXAMPLE

Dual Member (Medicare + Medicaid) Provider Payments

Non-Dual (Medicare Only) Provider Payments

\$100.00 total



Medicare only (non-duals)

In FFS, providers receive less than the total Medicare payment allowable, as Medicaid wrap is less than the traditional patient co-pay

\$88.00 total



Dual in FFS

One Care and SCO plans have historically paid providers the full Medicare allowable amount (more in some cases)

≥ \$100.00 total



Dual in One Care/SCO

Limits on the Medicaid wrap portion of provider payments in One Care and SCO could reduce the amount One Care and SCO plans pay providers; providers would still receive more on average for a Dual in integrated managed care products than in FFS

More than \$88.00, but less than \$100.00  
Payment from One Care / SCO plan with provider pricing benchmark

Demo 2.0: Dual in One Care/SCO

Example Medicaid Wrap Limit in One Care/SCO: 88-100% of Medicare allowable