

OVERVIEW OF THE MASSACHUSETTS ONE CARE INITIATIVE FOR NON-ELDERLY DUAL ELIGIBLES

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OVERVIEW OF ONE CARE: THE MASSACHUSETTS DUAL ELIGIBLE DEMONSTRATION PROJECT

This fact sheet provides a comprehensive description of One Care, Massachusetts' demonstration project for adults with disabilities between the ages of 21 and 64 who are dually eligible for Medicare and Medicaid. Massachusetts is the first state to implement a capitated model and is the furthest along of all states that are implementing projects aimed at improving care for persons dually eligible for Medicare and Medicaid. (See "Federal Initiatives Spur Innovation in Care Delivery to Dually Eligible Americans.") The demonstration launched on October 1, 2013, and is slated to run through December 31, 2016.¹ The Commonwealth of Massachusetts and the Centers for Medicare and Medicaid Services (CMS) have jointly contracted with three health plans to provide all medical, behavioral health, dental, and long-term support services covered by Medicare and Medicaid. One Care plans are paid a prospective monthly capitation rate, with provisions for risk sharing and quality incentives.²

The One Care model of care aims to integrate the full spectrum of services by leveraging an Interdisciplinary Care Team (ICT), which includes the enrollee, a care coordinator or a clinical care manager, and an Independent Living and Long-Term Services and Supports (IL-LTSS) coordinator. This team, working with the enrollee's primary care provider, develops a customized care plan that reflects the enrollee's needs and preferences. The goal is for the model of care to be person-centered, with the enrollee an active participant in developing and implementing the care plan. Depending on the needs of the enrollee, a One Care plan may also provide new ways to get services not available through fee-for-service, such as peer support, home care, wellness support, medical equipment repair, and recovery-based community mental health and substance abuse services.

Six health plans were selected for consideration to participate in the demonstration. Ultimately, three of those plans successfully completed a readiness review process and signed contracts with the Commonwealth and CMS to become One Care plans: Commonwealth Care Alliance, Fallon Total Care, and Network Health.

One Care is available to approximately 93,759 eligible individuals in nine Massachusetts counties, including one county with partial coverage.³ Enrollment is voluntary. In counties with more than one plan available, the Commonwealth will implement an auto-assignment process where persons will be automatically enrolled in a plan but given the opportunity to opt out of the demonstration or to enroll in another plan at any time.

1 The state has requested CMS to incorporate the One Care demonstration into the 1115 waiver, which would then extend the time frame of the demonstration through June 30, 2019.

2 See below for details on the financing and payment model.

3 MassHealth One Care: MassHealth plus Medicare February 2014 Enrollment Report, February 20, 2014. Available at <http://www.mass.gov/eohhs/consumer/insurance/one-care/one-care-enrollment-reports.html>.

FEDERAL INITIATIVES SPUR INNOVATION IN CARE DELIVERY TO DUALY ELIGIBLE AMERICANS

There are approximately 10 million seniors and people with disabilities nationwide enrolled in both Medicare and Medicaid (dual eligibles).^A These individuals are faced with the task of navigating two programs that have different sets of rules and requirements, very often resulting in fragmented and uncoordinated care. Added to this burden, dual eligibles often have poor health status; they make greater use of medical and support services and, too often, are unnecessarily admitted to hospitals or placed in nursing homes. Provisions within the Affordable Care Act (ACA) have created a unique opportunity for improvement in how care is delivered to dually eligible populations.

The Medicare-Medicaid Coordination Office (MMCO), created by the ACA and housed at the Centers for Medicare and Medicaid Services (CMS), is charged with developing innovative care models and demonstrations, to align Medicare and Medicaid in order to more effectively integrate benefits, better coordinate care delivery, improve quality of care, and reduce costs.^B In 2010, the MMCO presented states with a funding opportunity to design a person-centered model of care that will coordinate primary, acute, behavioral health, and long-term supports and services (LTSS) for dually eligible individuals. In 2011, 15 states, including Massachusetts, were each awarded \$1 million planning grants to design such demonstration programs.^C

In 2011, the MMCO introduced the Financial Alignment Initiative, for which all states, including the original design states, were eligible to apply.^D This initiative offers states two financing-mechanism options to test new payment and service delivery models in their demonstrations: capitated and managed fee-for-service. The goal of this initiative is to reduce overall costs under Medicare and Medicaid, while at the same time improving the quality of care delivered. Initially, 37 states submitted a letter of intent^E to pursue one or both of the financing models, including all 15 of the original 2011 grantee states. As of March 2014, only 21 states are planning to pursue a demonstration project.^F States that have withdrawn from the application process have most often cited concerns with the financing details as their top reason for doing so.

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- A. Centers for Medicare and Medicaid Services: Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011 (February 2013). Available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf.
- B. CMS' Medicare Medicaid Coordination Office: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>.
- C. CMS' Medicare Medicaid Coordination Office: State Design Contract Summaries (December 2010). Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDesignContractSummaries.html>.
- D. CMS State Medicaid Directors' Letter: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees (July 2011). Available at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
- E. CMS' Medicare Medicaid Coordination Office: States Submitting Letters of Intent — Financial Alignment Model (February 2012). Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/StatesSubmittingLettersofIntent-FinancialAlignmentModelsUpdate.pdf>.
- F. Kaiser Family Foundation: State Demonstration Proposals to Integrate Care and Align Financing and/or Administration for Dual Eligible Beneficiaries (March 2014). Available at <http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/>.

KEY FEATURES OF THE ONE CARE PROGRAM

POPULATION SERVED

One Care is offered to those individuals with disabilities age 21 to 64 who are enrolled in MassHealth Standard (Medicaid) or CommonHealth (Medicaid for persons with disabilities who are not eligible for Standard); enrolled in Medicare Parts A and B; and eligible for Part D. The population to be served by One Care plans therefore includes individuals with a wide range of disabilities, which could include one or more of the following:⁴

- Physical disabilities
- Intellectual and developmental disabilities
- Serious mental illness
- Substance use disorder
- Multiple chronic illnesses
- Functional or cognitive limitations

In addition, some of these individuals may face other challenges, such as homelessness. Based on 2007 data, 11 percent of the dually eligible population in Massachusetts ages 18-64 are African-American and 7 percent Hispanic.⁵

Non-elderly dual eligibles enrolled in Medicare Advantage plans, Programs of All-Inclusive Care for the Elderly (PACE), employer group plans, or retiree drug subsidy plans cannot participate in One Care unless they meet the One Care eligibility criteria and disenroll from their existing health plan. Those residing in an Intermediate Care Facility for individuals with Mental Retardation (ICF/MR) or enrolled in a home and community based services (HCBS) waiver⁶ are excluded from enrollment in One Care.

ENROLLMENT APPROACH⁷

The One Care demonstration launched on October 1, 2013. Those eligible to participate could choose to enroll in a One Care plan for an effective date as early as October 1. Voluntary enrollment is ongoing and will continue throughout the demonstration. Enrollment changes (including new enrollments, changes from one plan to another, disenrollments, and opt-outs) are effective on the first day of the following month.

⁴ MassHealth: Introduction to One Care Plans Presentation.

Available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/onecare/intro-to-one-care-130523.pdf>.

⁵ CMS' Medicare Medicaid Coordination Office: Medicare-Medicaid Enrollee State Profile Massachusetts.

Available at <http://www.integratedcareresourcecenter.com/PDFs/StateProfileMA.pdf>.

⁶ HCBS waivers offer long-term services and supports to eligible individuals in their own homes or community settings.

The populations served by these waivers are adults with intellectual disabilities or brain injury and frail elders ages 60 to 64.

⁷ In other dual eligible demonstration states, enrollment approaches vary. For example, in California, only Los Angeles County will conduct a three-month voluntary enrollment period; the other counties will use passive enrollment exclusively. In Washington, the state will conduct voluntary enrollment for three months only, followed by three phases of passive enrollment. South Carolina is offering the longest voluntary enrollment period: six months, followed by three phases of passive enrollment, broken down by region.

In addition, in 2014, the Commonwealth is conducting passive enrollment (also called auto-assignment) in three rounds, with coverage effective as of January 1, April 1, and July 1.⁸ Passive enrollment is done through an “intelligent assignment” process, by which the state uses best efforts to match individuals with their primary care or other key providers, based on MassHealth claims history.

In the first round of passive enrollment, only those individuals were auto-assigned who appeared to meet the lowest Medicaid rating category, C1 — Community Other tier, based on historical claims data.⁹ The second round (for an April 1 effective date) includes individuals from a mix of rating categories. The state will continue to consider a variety of factors in determining the composition of the third passive enrollment round, including self-selection enrollment patterns and plan capacity. Passive enrollment can be conducted only in service areas that offer a choice of at least two plans — currently, Hampden, Hampshire, Suffolk, and Worcester counties. The state estimates that 45,000 people live in areas where there can be auto-assignment.

Consumer protections built into One Care ensure that individuals may opt out of the demonstration at any time or chose a different plan on a month-to-month basis. Once opted out of the demonstration, the individual cannot later be passively enrolled back into the program but can voluntarily opt back in.

OUTREACH APPROACH

Initial Public Awareness Campaign

MassHealth launched a campaign¹⁰ in early 2013 to generate public awareness and share general information about the One Care demonstration. The campaign consisted of the following components:

- Qualitative research: gathering stakeholder input, conducting consumer focus groups, and meeting with One Care plans
- Creative development: brand and logo development and testing
- Material development: notices, posters, and information letters
- Statewide outreach: radio public service announcements,¹¹ design of e-communications, Web content updates, and Web-based videos

Outreach to Beneficiaries, One Care Plans, and Providers

In September 2013, MassHealth mailed enrollment guides and self-selection (voluntary enrollment) letters¹² to individuals in the target population. Outreach to potential enrollees also included components of the earlier public awareness campaign, along with promotional presence at One

⁸ One Care Auto-Assignment Plan available at

<http://www.mass.gov/eohhs/consumer/insurance/one-care/automatic-assignment-in-a-one-care-plan.html>.

⁹ C1 is the Medicaid rating category for those dually eligible individuals living in the community who do not fall into the high-needs or the chronic behavioral health needs category. See “Financing and Payment Model” on page 9 of this fact sheet for details.

¹⁰ MORE Advertising Public Awareness Campaign Update presented at Mass Health open meeting, May 17, 2013. Available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/130517-public-awareness-campaign-presentation.ppt>.

¹¹ Public service announcements available at

<http://www.mass.gov/eohhs/consumer/insurance/onecare/one-care-booklet-and-other-materials.htm>.

¹² Letters sent to enrollees available at

<http://www.mass.gov/eohhs/consumer/insurance/onecare/one-care-enrollment-materials.html>.

Care health fairs, community forums, and other events. Passive enrollment notices were, and will continue to be, mailed 60 days and 30 days in advance of each effective-date-of-service milestone (January 1, April 1, and July 1, 2014). Self-selection into a One Care plan can still take place during the passive enrollment periods. Individuals can sign up for coverage by filling out the enrollment decision form mailed to them or by contacting MassHealth customer service. There is no online method for signing up. To make enrollment as accessible as possible to all, the SHINE (Serving the Health Insurance Needs of Everyone) program¹³ is available to assist prospective enrollees through face-to-face, phone, or e-mail counseling.

The state has also planned ongoing outreach to One Care plans and providers¹⁴ by means ranging from provider bulletins to provider and plan-staff trainings.¹⁵

Marketing and Outreach by One Care Plans

Marketing requirements for participating health plans have been established by CMS and the state¹⁶ and set forth in final guidance for 2013¹⁷ and 2014.¹⁸ The three-way contract¹⁹ provides detailed standards that One Care plans must follow in the areas of marketing, outreach, and enrollee communications. For example, One Care plans must:

- Provide materials in alternative formats and other languages, and mail any English-only literature with multi-language inserts that indicate access to free interpreter services
- Receive prior approval on marketing and enrollee communications from CMS and the state
- Provide new enrollees with these materials in a manner and format preferred by the enrollee and in language that is easily understood

One Care plans are prohibited from marketing activities such as:

- Directly enrolling individuals, although they may provide enrollees with factual information about the plan and its benefits package before referring them to the state for the enrollment process
- Conducting educational and marketing/sales events outside their service area, with the exception of direct mail
- Offering financial or other incentives, including private insurance, to enrollees or eligible enrollees or for referring a friend, neighbor, or other person to enroll with the plan

13 SHINE program presentation at One Care open meeting, July 2013. Available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/130729-shine-overview.ppt>.

14 MassHealth Provider Bulletins on One Care available at <http://www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-bulletins/2013-bulletins.html>.

15 MassHealth organizes trainings and webinars for providers and plan staff on topics like ADA compliance and cultural competency. Available at <http://www.mass.gov/masshealth/onecare/learning>.

16 CMS and Medicare Medicaid Coordination Office, Presentation on Medicare-Medicaid Plan (MMP) Marketing Training, April 2013. Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FinalPlanTrainingMMP042213.pdf>.

17 Final CY 2013 Marketing Guidance for Massachusetts Medicare-Medicaid Plans, July 2013. Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FinalCY2013MarketingGuidanceMA.pdf>.

18 Final CY 2014 Marketing Guidance for Massachusetts Medicare-Medicaid Plans, July 2013. Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FinalCY2014MarketingGuidanceMA.pdf>.

19 Massachusetts Three-Way Contract Signed July 11, 2013. Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf>.

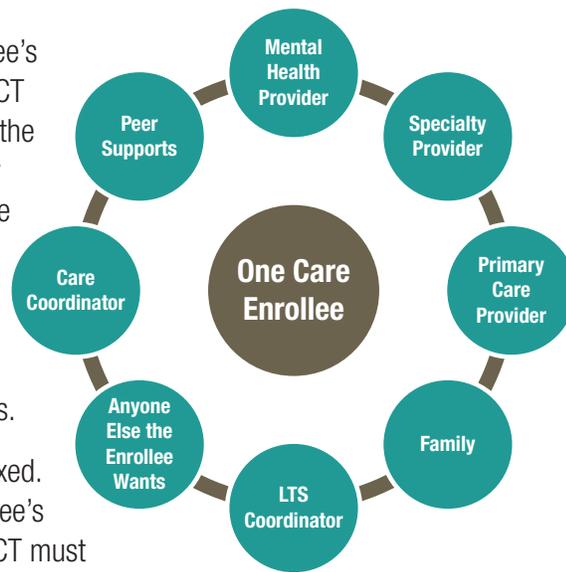
CARE DELIVERY MODEL

The One Care demonstration uses a specially designed care-delivery model in order to ensure enrollees get the full array of integrated services they need. The goal is for the model of care to be person-centered, with the enrollee an active participant in developing and implementing an individualized care plan. Each enrollee is assigned a care coordinator who is the primary contact for the One Care plan and whose job it is to help the enrollee work with the plan to ensure that the enrollee's needs are appropriately addressed. In order to accomplish this, the care coordinator works with the enrollee and an Interdisciplinary Care Team (ICT) to do several things, including setting up and carrying out a personal care plan, making sure the enrollee can get to all appointments, and arranging language interpretation services, as needed.

The Interdisciplinary Care Team

The care coordinator manages all of an enrollee's care needs by coordinating the efforts of the ICT members. The core members of each ICT are the enrollee, the care coordinator, and the primary care provider. The enrollee may choose to have other people on the care team. These may include a mental health provider, an Independent Living Long-Term Services and Supports (IL-LTSS) Coordinator, specialists, family members, and advocates, among others.

The composition of the ICT need not remain fixed. Rather, membership may change as the enrollee's needs change over time. All members of the ICT must participate in training on the person-centered planning processes, cultural competence, accessibility, accommodations, independent living, and recovery and wellness principles.



Adapted from One Care Booklet

Comprehensive Assessment

The first critical step in the care coordination process is conducting a comprehensive assessment of the enrollee's care needs. One Care plans must complete a comprehensive assessment of each new enrollee within 90 days of the effective date of enrollment. This in-person assessment must be conducted in the setting of the enrollee's choosing, which could be his/her home or primary care office. Other people — such as family members, IL-LTSS coordinators, and mental health providers — can take part in the assessment, as agreed to by the enrollee. In addition to administering the Minimum Data Set — Home Care (MDS-HC)²⁰ assessment, the One Care plan must create an assessment tool that covers many critical domains, including:

- Immediate needs and current services in place, including preventive health and preferred providers, as well as identifying what is working well for the enrollee and what can be improved
- Health conditions and current medications

²⁰ Minimum Data Set — Home Care (MDS-HC) assessment form available at <http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/mds-hc-2.pdf>.

- Functional status
- Mental health and substance use
- Accessibility needs
- Transportation access needs
- Housing/home environment
- Informal supports/caregiver supports
- Social supports
- Food security and nutrition

The assessment will help the enrollee and her/his ICT to develop an Individualized Care Plan (ICP), which is meant to help organize the enrollee's physical and mental health care as well as any LTSS. In addition to listing all providers and medications, the ICP will contain the enrollee's health, independent living, and recovery goals, preferences, and concerns. Most important, each ICP will contain an agreed-upon set of steps to address these goals and concerns. The One Care plan must maintain a centralized enrollee record, which documents the ICP.

Continuity of Care

Part of the comprehensive assessment is getting a full understanding of the enrollee's existing services and providers. One Care plans must allow enrollees to continue receiving their current services from their current providers for the first 90 days of their One Care coverage or until a comprehensive assessment is completed. This continuity-of-care period provides an opportunity for providers who have been working with a One Care enrollee but are not already in a One Care plan's network to consider contracting with the plan. One Care plans are not permitted to close their networks, and they are expected to work with enrollees' current providers to establish contracts where feasible and appropriate. If a provider does not join the network and the enrollee does not select a new in-network provider by the end of this transition period, the plan may assist the enrollee in choosing an in-network provider. However, the plan may authorize single-case agreements and make arrangements for an enrollee to see an out-of-network provider on a case-by-case basis.

One Care plans also are required to honor existing prior authorizations for services issued by MassHealth and Medicare until development of the ICP is complete. If a plan proposes modifications to the enrollee's prior authorized services as part of development of the ICP, it must provide the enrollee with written notice. One Care enrollees retain all of their MassHealth and Medicare beneficiary rights and protections, including the right to appeal coverage decisions.²¹

LTSS and IL-LTSS Coordinator

One Care plans must make available to every enrollee an Independent Living and Long-Term Services and Supports Coordinator (IL-LTSS Coordinator), who must be provided by an entity that is independent from the One Care plan. This person's role is to assure that the enrollee receives necessary LTSS and that these services are well-coordinated with the rest of the enrollee's medical and behavioral health services. If the enrollee chooses to have one, the IL-LTSS Coordinator participates in the comprehensive assessment process as a member of the ICT. One Care plans

²¹ Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at pp.53-56.

must contract with multiple community-based organizations to provide IL-LTSS Coordinators, including at least one Independent Living Center, but these may also include Recovery Learning Communities and Aging Services Access Points.

Provider Networks

One Care plans must ensure adequate access to medical, behavioral health, pharmacy, dental, and community-based services and LTSS providers that are appropriate for, and proficient in, addressing the needs of their enrollees, including physical, communication, and geographical access concerns. This network must be sufficient to provide all enrollees with access to the full range of covered services.

A plan's provider network must be responsive to the linguistic, cultural, and other unique needs of any person of color, individual with disabilities, homeless person, or member of another identified subpopulation served by the plan. Meeting these needs requires the plan to have providers with the capacity to communicate with enrollees who speak languages other than English as well as with those who are deaf, hard of hearing, or blind.

Quality Improvement Program

The One Care demonstration includes a quality improvement program aimed at ensuring that plans provide quality care that enables enrollees to stay healthy, live independently, manage chronic illnesses and/or disabilities, and maintain or improve their quality of life.²² Plans must create the infrastructure necessary to fulfill a broad set of quality improvement activities. These activities include collecting, analyzing, and reporting quality performance data. They also include conducting a variety of member experience surveys. In addition to overseeing their own quality improvement activities, plans must participate in the external evaluation conducted by RTI International (see "Monitoring and Evaluation" on page 11). Plans may also be required to participate in quality improvement work groups led by the state.

Consumer Protections

The One Care demonstration was designed to ensure that enrollees retain their MassHealth and Medicare rights and consumer protections. In particular, plans must use an integrated appeals process that allows enrollees to appeal a plan's decision to deny, terminate, suspend, or reduce services. Initial appeals are filed with the enrollee's health plan.²³ Subsequent appeals for traditional Medicare Part A and B services will be automatically forwarded by the plan to the Medicare Independent Review Entity (IRE), whereas subsequent appeals for services covered by MassHealth only may be appealed to the MassHealth Board of Hearings. For overlapping services, appeals will be forwarded to the IRE and may also be submitted to the Board of Hearings.

While an internal (plan level) appeal is pending, and if requested for appeals submitted to the Board of Hearings, the One Care plan must continue providing services if those services were previously approved.

²² Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at p.116.

²³ Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at p. 108.

FINANCING AND PAYMENT MODEL

CMS and the state each make monthly payments to the One Care plans for their respective portions of the capitated rate.

Medicare Rate Determination

CMS pays One Care plans a monthly capitated rate for Medicare Part A and B services, risk adjusted using the Medicare Advantage risk adjustment model (called the CMS-HCC model²⁴) and the Medicare Advantage model for patients with end-stage renal disease (called the CMS-HCC ESRD model). CMS pays the plans a separate monthly capitated rate for Medicare Part D services, which is also based on a risk adjustment model used with Part D plans (called the Part D RxHCC model).

Medicaid Rate Determination

The Medicaid portion of the capitated rate is determined by assigning each enrollee to a rating category according to the individual enrollee's clinical and demographic status and setting of care as indicated in MassHealth claims data. Medicaid created four rating categories for 2013 and in 2014 began using more refined categories (indicated in italics).²⁵

F1 — Facility-based Care. Individuals identified as residing in a long-term facility for more than 90 days

C3 — Community Tier 3 — High Community Need. Individuals who have either 1) a daily skilled need; 2) two or more Activities of Daily Living (ADL) limitations AND three days per week of a need for skilled nursing; or 3) four or more ADL limitations

C3B: for individuals who meet the above criteria and also have certain diagnoses which lead to costs considerably above the average for current C3 enrollees (e.g., quadriplegia, ALS, Muscular Dystrophy and Respirator dependence)

C3A: for remaining C3 individuals

C2 — Community Tier 2 — Community High Behavioral Health. Individuals who have a chronic and ongoing Behavioral Health diagnosis that indicates a high level of service need

C2B: for individuals with co-occurring diagnoses of substance abuse and serious mental illness

C2A: for remaining C2 individuals

C1 — Community Tier 1 Community Other. Individuals in the community who do not meet F1, C2, or C3 criteria

The development of refinements for 2014 reflects an acknowledgment that a subset of the C3 and C2 enrollees who have certain diagnoses will have greater LTSS needs and therefore that One Care plans serving these individuals will require greater resources to meet those needs.

²⁴ A primer on the CMS-HCC model is contained within *Evaluation of the CMS-HCC Risk Adjustment Model: Final Report* (March 2011) at Section 2. Available at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Evaluation_Risk_Adj_Model_2011.pdf.

²⁵ MassHealth Open Meeting presentation, January 27, 2014. Available at <http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html>.

These planned refinements were the result of successful negotiations among the Commonwealth, CMS, and health plans, as well as input from stakeholders and the disability community.

Rating categories will be assigned based on the plan’s submission of information from the Minimum Data Set — Home Care assessment (MDS-HC),²⁶ which must be completed in person within 90 days of enrollment by a registered nurse. Until the MDS-HC is submitted, however, the state may make temporary rating category assignments using other available data sources, such as claims data. On a monthly basis, each enrollee’s rating category will be determined on the basis of the most recent MDS-HC information as of the first of the month. An enrollee’s MDS-HC information must be updated at least annually for individuals in C2 and C3 rating categories, and also whenever there is a substantial change in the enrollee’s health status. For individuals in C1, the MDS-HC must be completed to change the rating category.

As with Medicare, the Commonwealth will establish a baseline estimate of what it would have spent in each demonstration county had the demonstration not existed. This estimate will be based on historical Medicaid spending.

Risk Sharing

In order to mitigate the financial risk One Care plans take on as they begin to provide integrated services to the Medicare-Medicaid population, the state and CMS created a risk-sharing mechanism that applies to Medicaid and Medicare A/B costs.²⁷ The following risk corridors will be in place for the first demonstration year only.

Plan gains/losses 0% - 1%	No risk sharing; One Care plan bears all the risk/reward
Plan gains/losses 1.1% - 3%	CMS and MassHealth share 90%; plan 10%
Plan gains/losses 3.1% - 20%	50%-50% sharing between CMS/MassHealth and the plan
Plan gains/losses >20%	No risk sharing; One Care plan bears all the risk/reward

High-Cost Risk Pools

To further mitigate the risk that One Care plans will assume, the state created two high-cost risk pools (HCRPs) to account for the enrollment of high-cost members in two rating categories: Facility-Based Care (F1) and Community Tier 3 — High Community Need (C3).²⁸ Each HCRP is created by withholding a portion of the base Medicaid rate for F1 and C3 enrollees from all One Care plans and placing this funding into a risk pool. Payment out of the risk pool will be divided across plans based on their percentage of the total costs above a defined per-enrollee threshold amount associated with the enrollees in these rating categories. These HCRPs will be used until a more refined long-term-care risk adjustment methodology is in place.

²⁶ Minimum Data Set — Home Care (MDS-HC) assessment form available at <http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/mds-hc-2.pdf>.

²⁷ Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at p. 180.

²⁸ Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at p. 164.

Quality Withhold

To provide an incentive for quality improvement, CMS and the Commonwealth will withhold a portion of the capitation payments — 1 percent in demonstration year one, 2 percent in year two, and 3 percent in year three — which One Care plans can earn back if they meet certain quality thresholds.²⁹ These measures are a combination of certain core quality measures — which apply to all state demonstrations and are a subset of a larger set of national quality measures — and state-specific performance measures designed for the target population of the One Care demonstration. The quality withhold applies to the Medicaid and Medicare A/B components of the rate but not to the Part D component.

Aggregate Savings Percentages

Under the agreement between the Commonwealth and CMS, the demonstration is expected to achieve savings resulting from reductions in hospital readmissions, emergency room utilization, and unnecessary nursing home admissions.³⁰

The aggregate savings percentages for the One Care demonstration are as follows:

Demonstration year one (October 1, 2013 – December 31, 2014)	0% (October 1, 2013 – March 31, 2014) 1% (April 1, 2014 – December 31, 2014)
Demonstration year two (January 1, 2015 – December 31, 2015)	1.5%
Demonstration year three (January 1, 2016 – December 31, 2016)	> 4%

The savings percentages will be applied to the baseline spending amounts for the Medicare Parts A and B component and for the MassHealth component of the capitated rates.³¹

MONITORING AND EVALUATION

CMS and the state established several mechanisms to monitor and evaluate the One Care demonstration.

Contract Management Team

The One Care demonstration will be monitored regularly by a team of CMS and state representatives responsible for overseeing all aspects of the contracts with health plans.³² This Contract Management Team (CMT) will monitor plan compliance with the terms set forth in the three-way

²⁹ Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at pp. 167-176.

³⁰ Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at p. 162.

³¹ Joint Rate-Setting Process for the Capitated Financial Alignment Model, available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf>.

³² Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at pp. 153-155.

contract and has the authority to issue joint notices of noncompliance/enforcement. For instance, the CMT may require a noncompliant plan to develop and submit a corrective action plan that is designed to correct identified deficiencies. Or it could impose sanctions ranging from financial penalties to suspension of enrollment to termination from the demonstration. The CMT also is responsible for coordinating periodic audits and surveys of the plans, as well as fielding requests for assistance from the plans and assigning staff with appropriate expertise to provide technical assistance. Among the CMT's other oversight duties are coordinating the review of plan marketing materials and procedures, collecting grievance and appeals data, and reviewing appeals procedures.

Ombudsman Program

Following a competitive procurement process, the state selected the nonprofit Disability Policy Consortium (DPC) to serve as the One Care Ombudsman. DPC is subcontracting with two other nonprofit organizations, Health Care for All and Consumer Quality Initiatives, to support the Ombudsman program. The primary roles of the Ombudsman are to answer questions about One Care and to help enrollees resolve issues or conflicts.³³ Ombudsman services are available to enrollees by phone, e-mail, or face-to-face assistance. Through its work with individual enrollees, the program will identify systemwide concerns and problems to discuss with the state and One Care health plans in order to improve existing services. The Ombudsman office began providing services on March 3, 2014.

Consumer Engagement in One Care Plans

One Care health plans must set up a consumer advisory board or include consumers on the plan's governance board. Establishing a consumer advisory board is a CMS- and state-defined quality withhold measure for year one of the demonstration only. To meet this requirement, each plan must hold a board meeting that includes consumers within 90 days of the first effective enrollment date for the demonstration. On an ongoing basis, each plan must hold a quarterly board meeting that includes consumers.³⁴ The plan must submit meeting minutes to demonstrate compliance with these requirements.

Implementation Council

A key component of the monitoring and oversight of the One Care demonstration lies in the Implementation Council, a working committee established by the Commonwealth to monitor access to health care and compliance with the Americans with Disabilities Act (ADA), by tracking quality of services, providing support and input to the state, and promoting accountability and transparency.³⁵ There are 21 members of the Council, selected by a nomination process. At least half of all members are required to be MassHealth members with disabilities or family members or guardians of MassHealth members with disabilities. Membership also includes advocates and peers from organizations such as community-based groups, consumer advocacy organizations, service providers, trade organizations, and unions.

³³ One Care Ombudsman Update presented at the December 2013 MassHealth open meeting. Available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/131205-one-care-ombudsman.pptx>.

³⁴ Three-Way Contract: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf> at p. 170.

³⁵ <http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/implementation-council.html>.

The Implementation Council meets monthly. It is co-chaired by consumers, who develop agendas, facilitate the meetings, and ensure completion of work plan deliverables and an annual report of the Council's activities, which is required to be submitted to the Commonwealth's Medicaid Director and the Secretary of the Executive Office of Health and Human Services (EOHHS). EOHHS, through the University of Massachusetts Medical School (UMMS), supports the Council by handling all meeting planning, accommodations, and logistics; producing meeting materials; and supporting the consumer chairpersons, as requested. EOHHS staff members attend all meetings to exchange information with the Implementation Council. The meetings are open to the public.

Early Indicators Project

The Commonwealth is analyzing early quantitative and qualitative indicator data to assess the perceptions and experiences of enrollees (both self-selected and auto-assigned) in One Care, as well as those who have chosen to opt out. An Early Indicators Project (EIP)³⁶ work group was formed in October 2013 to spearhead this effort. The work group includes four representatives from the Implementation Council, three MassHealth staff members, and two UMMS staff members.

The EIP will allow the Commonwealth to consider any programmatic adjustments based on early feedback and significant data trends, and make course corrections as needed. This is a separate project from the program evaluation and quality reporting measures requirement. The EIP will draw data from:

- Indicator data reported by One Care plans, MassHealth customer service, the One Care Ombudsman, and SHINE
- Focus groups of One Care eligible members
- Surveys of One Care enrollees

The results will be made public through monthly reports, which are available on the One Care website. The EIP work group also plans to develop a dashboard of infographics based on the available data and analysis of trends on a quarterly basis, starting in April 2014.

Reporting Guidelines for One Care Plans

The CMS has set national guidance related to reporting requirements for Medicare-Medicaid Plans (MMP) for the capitated financial alignment model.³⁷ The guidance provides technical specifications for the data that must be reported by MMPs. CMS and the Commonwealth can consider MMP performance on the quality measures as a requirement for ongoing enrollment. If MMPs fail to meet any single measure or set of measures, CMS and the Commonwealth can stop enrollment altogether. The reporting guidelines also link certain measures to quality withhold

³⁶ Early Indicators Project Update provided at December 2013 MassHealth Open Meeting. Available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/131205-presentation.pptx>.

³⁷ Medicare Medicaid Coordination Office: Final Medicare Medicaid Capitated Financial Alignment Model Reporting Requirements, November 2013. Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014CoreReportingRequirements.pdf>.

measures that MMPs will be required to meet. In addition to these national measures, One Care plans must adhere to Massachusetts-specific reporting requirements established by CMS.³⁸

Evaluation

CMS has hired RTI International to conduct an evaluation of the dual eligibles demonstrations including the One Care program.³⁹ The goals of this evaluation are to:

- Provide rapid-cycle evaluation of **demonstration implementation** by conducting interviews and site visits and examining data entered by states into a state data reporting system on a quarterly basis
- Evaluate the impact of the demonstration on the **beneficiary experience** by conducting focus groups and stakeholder interviews and analyzing survey results and utilization/encounter data to understand trends related to grievances and appeals, enrollment/disenrollment, access to care, quality, and outcomes
- Evaluate the demonstration's impact on **quality, utilization, access to care, and cost** for the eligible population and for subpopulations (e.g., people with mental illness and/or substance use disorders and LTSS recipients).⁴⁰ This will be done through:
 - analyzing information from the Minimum Data Set⁴¹ to monitor trends in facility admissions
 - examining reports the state must provide on the quality measures listed in the Memorandum of Understanding
 - analyzing Medicare and Medicaid claims and encounter data from the One Care plans

RTI will use a comparison group methodology to evaluate the impact of the demonstration.

RTI will be producing several reports of its One Care evaluation. These will include evaluation plans, six-month implementation reports, quarterly reports intended to monitor trends (e.g., enrollment, disenrollment, and selected measures of quality, utilization, and costs), and annual reports. At the conclusion of the demonstration, RTI will produce a final report aimed at providing an analysis of the overall impact of the One Care demonstration on quality, utilization, and costs. The annual reports and the final report will be made available to the public.

Other Research Projects

In addition to the CMS/RTI evaluation, two additional research projects are studying the impact of the One Care initiative:

- The Patient-Centered Outcomes Research Institute (PCORI) has awarded a three-year grant to Lisa Iezzoni, M.D., of the Massachusetts General Hospital to test a consumer-driven interven-

38 Medicare Medicaid Coordination Office: Final Medicare Medicaid Capitated Financial Alignment Model Reporting Requirements: Massachusetts Specific Reporting Requirements, November 2013. Available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014ReportingAppendixMA.pdf>.

39 Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Massachusetts Evaluation Design Plan, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MassEvalPlan.pdf>.

40 Presentation by Edith Walsh, RTI International, available at <http://www.nashpconference.org/wp-content/uploads/2013/presentations/e.walsh.19.duals.pdf>. Accessed December 15, 2013.

41 The Minimum Data Set is a clinical screening system mandated by federal law for use in nursing facilities that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 3.0 for nursing facility residents.

tion whereby persons with significant physical disabilities or serious and persistent mental illness will continually assess and provide real-time feedback on their care to their clinicians.⁴² The project will include administration of a new patient survey designed for this project (Persons with Disabilities Quality Survey, or PDQ-S) as well as the creation of a process for real-time, continuous feedback of quality information from One Care patients (Persons with Disabilities Quality Monitoring Intervention, or PDQ-MI). The PDQ-S survey will be designed starting with specifying a quality framework for persons with disabilities and then identifying key quality metrics, drawing from 12 focus groups of English- and Spanish-speaking persons with physical or mental health disabilities. These focus groups will be organized by the Consumer Quality Initiative, an advocacy group for persons with mental illness. The one-year PDQ-MI will involve intensive consumer education, a website, and other outreach to solicit reports about care quality. PDQ-MI will be run through the Disability Policy Consortium, a statewide disability civil rights advocacy group. The project will judge success by a PDQ-S survey after PDQ-MI is finished and by interviews with One Care clinicians, managers, and leaders and with Medicare and MassHealth officials. Three individuals with disabilities will co-lead this three-year project.

- Colleen Barry of the Johns Hopkins Bloomberg School of Public Health, Haiden Huskamp of Harvard Medical School, and Alisa Busch of McLean Hospital and Harvard Medical School are conducting a Kaiser Family Foundation study on the early implementation experience of the Massachusetts One Care program. Researchers are conducting interviews with key personnel from state agencies, health plans, consumer advocacy groups, provider groups, and others who have been involved in a variety of aspects of the One Care demonstration. The final product of the study will be a policy brief to be released in late fall 2014 describing early insights from the Massachusetts program. The Kaiser Family Foundation is conducting parallel studies in a handful of other Financial Alignment Demonstration states.

⁴² Available at <http://pfaawards.pcori.org/node/20/datavizwiz/detail/1424>.

CONCLUSION

As CMS and other states move to design and implement programs that aim to improve coordination of care for persons dually eligible for Medicare and Medicaid, the experience of Massachusetts' One Care initiative will provide important insights. In particular, the focus of One Care on integrating care and financing for dually eligible people with disabilities age 21 to 64 will provide novel experience, since most prior initiatives in other states have focused on senior populations. The One Care early indicators monitoring will be critical to inform any needed course corrections, if issues are identified. And the longer-term evaluation and research projects will help inform our understanding of the impact of the initiative on consumers, providers, and participating health plans, as well as on the state and federal governments.

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