

The Dual Eligible Population in Massachusetts: COMPARATIVE PROGRAM ASSESSMENT CHART PACK

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BACKGROUND

This comparative assessment is one component of *A Primer on the Dual Eligible Population in Massachusetts*. The primer is comprised of the following components:

- A short issue brief;
- A set of five profiles of dual eligible members;
- This comparative program assessment chart pack; and,
- A data chart pack.

The goal of the comprehensive primer is to help policymakers and other interested stakeholders in Massachusetts better understand the characteristics and needs of the dual eligible population, the programs that currently serve them in Massachusetts, and upcoming reforms to improve care integration and quality for dual eligible MassHealth members.

INTRODUCTION

One Care, the Program of All-Inclusive Care for the Elderly (PACE), and Senior Care Options (SCO) are “integrated care programs” for **dual eligible members** that cover comprehensive Medicare and MassHealth benefits through a single program administered by MassHealth. One Care, PACE, and SCO have a common mission of streamlining and coordinating Medicare and Medicaid coverage and service delivery for dual eligible members, as an alternative to the MassHealth fee-for-service (FFS) program. Yet the programs differ on key programmatic features, including eligibility criteria, enrollment mechanisms, provider networks, care management models, and financing models.

This chart pack seeks to provide a **comparative assessment** of the programs across these programmatic features, highlighting some important implications and key issues related to these features for dual eligible members and providers. Where applicable, contrasts are made between integrated care and FFS program features.

Individuals receiving both Medicare and MassHealth coverage through One Care, PACE, and SCO or MassHealth fee-for-service (FFS) are referred to as “dual eligible” members throughout this chart pack.

OVERVIEW OF MASSACHUSETTS’ INTEGRATED CARE PROGRAMS

PROGRAM DESCRIPTION AND QUALIFYING AGE GROUP	
ONE CARE	One Care provides dual eligible members age 21–64 (at the time of enrollment) with comprehensive Medicare and MassHealth services, as well as additional behavioral health diversionary, dental, vision, and community support services.
SCO	SCO plans offer members age 65 and older comprehensive Medicare and MassHealth services, as well as additional behavioral health diversionary services, dental and vision care, and community-based supports.
PACE	PACE organizations provide or coordinate access to comprehensive medical and support services for people age 55 and older who meet the criteria for receiving a nursing facility level of care in their home or community.

FUTURE REFORMS TO MASSHEALTH INTEGRATED CARE PROGRAMS

As noted in the [issue brief](#), in August 2018, Massachusetts submitted to the Center for Medicare & Medicaid Services (CMS) a Duals Demonstration 2.0 (“Duals Demo 2.0”) Concept Paper, which outlines proposed enhancements to the One Care and SCO programs* under a newly aligned 1115A Demonstration Waiver. This waiver is a mechanism that states can leverage to test innovative payment and service delivery models for dual eligible individuals. Duals Demo 2.0 seeks to build upon the early successes of the state’s integrated care programs for dual eligible members.

Specific Duals Demo 2.0 flexibilities and programmatic requests related to each of the key programmatic features are also included throughout this comparative assessment. A comprehensive table describing the Duals Demo 2.0 requests can be found in the Appendix.

Massachusetts designed the Duals Demo 2.0 around the following vision, goals, and objectives:

VISION	Increase access to integrated care management and improve quality of care for dual eligible individuals in Massachusetts by better aligning the One Care and SCO programs, and grow enrollment by encouraging more dual eligible individuals to enroll in these programs.
GOALS	<ul style="list-style-type: none"> • Maintain critical elements of each program (e.g., aligning Medicare and Medicaid administrative processes and unifying member communications); • Align the two programs by applying SCO’s financing methodology to One Care and applying many of One Care’s administrative, financial, and programmatic features to SCO; and • Align One Care and SCO’s enrollment and quality strategies with each other and with those used in MassHealth’s managed care programs for members who are not dual eligible.
OBJECTIVES	<ul style="list-style-type: none"> • Grow and sustain enrollment in One Care and SCO; • Achieve a more seamless member experience (e.g., program enrollment, maintaining continuity of existing provider relationships, etc.); • Strengthen the fiscal stability of the One Care program for both the state and federal governments; • Use innovative approaches to ensure fiscal accountability and sustainability for the state and federal governments; and • Enter into a shared savings arrangement (determined through a robust evaluation) with CMS in which both the state and federal governments share in savings resulting from Duals Demo 2.0.

Source: Mass.gov, “Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0,” August 20, 2018, available at www.mass.gov/files/documents/2018/08/24/final-concept-paper-duals-demonstration-2.0-08-22-18.pdf.

*Note: PACE was not included in Duals Demo 2.0; therefore, the Duals Demo 2.0 information in this chart pack pertains only to One Care and SCO.

ELIGIBILITY CRITERIA

Eligibility criteria refers to a set of financial standards (e.g., income and assets) and nonfinancial conditions (e.g., level of care requirements) that must be met in order for a person to be eligible to enroll in a given integrated care program.

ONE CARE	SCO	PACE
<p>Eligible individuals will:</p> <ul style="list-style-type: none"> • Be age 21–64 at the time of enrollment; • Have Medicare Part A and B; • Have MassHealth Standard or CommonHealth coverage types; and • Not be enrolled in another comprehensive private or public insurance plan (e.g., employer-sponsored insurance). 	<p>Eligible individuals will:</p> <ul style="list-style-type: none"> • Be age 65+; • Have MassHealth Standard coverage type; and • Live at home or in a long-term care facility. <p><i>Note: Most SCO members are dually eligible; however, some are members of MassHealth but not Medicare.</i></p>	<p>Eligible individuals will:</p> <ul style="list-style-type: none"> • Be age 55+ and meet criteria for receiving a nursing facility level of care;* and • Be willing to receive care exclusively through or authorized by a PACE organization. <p><i>Note: Most PACE enrollees are dually eligible; however, some are members of either MassHealth or Medicare. Individuals without either MassHealth or Medicare can also join PACE at their own expense.</i></p>

IMPLICATIONS AND CHALLENGES OF PROGRAM DIFFERENCES

- Program eligibility varies by age. As a result, dual eligible members may have different provider networks, covered benefits, and care experiences based on their age cohort. Additionally, dual eligible individuals between the ages of 21 and 55 have only one integrated care program option (One Care), while those 65+ have the option of enrolling in SCO or (if there is a PACE program in their geographic area) PACE.
- Program eligibility varies by dual-eligibility status. An individual must be dually eligible for Medicare and MassHealth to enroll in One Care. However, an individual does not need to be a dual eligible MassHealth member to receive care through PACE or SCO. Although most PACE and SCO members are dually eligible, others are members of Medicare but not MassHealth (for PACE) or members of MassHealth but not Medicare (for PACE and/or SCO). Additionally, individuals without MassHealth or Medicare can join PACE at their own expense.
- Program eligibility varies by level of care. Enrollment in PACE is limited to dual eligible members whose acute needs deem them eligible for a nursing facility level of care; One Care and SCO do not limit eligibility based on acuity level.

Relevance for MassHealth FFS: Not Applicable.

TERMINOLOGY:

- **Medicare Part A** (Hospital Insurance): Provides coverage for inpatient care in a hospital; skilled nursing facility care; noncustodial nursing home care; hospice care; and home health care.
- **Medicare Part B** (Medical Insurance): Provides coverage for doctor visits, outpatient care, durable medical equipment, and preventive services.
- **MassHealth Standard:** A medical assistance or benefits program administered by the Massachusetts Executive Office of Health and Human Services that provides a full range of medical benefits to individuals who meet MassHealth Standard income or asset limitations, which vary by household size and age.
- **MassHealth CommonHealth:** A MassHealth program available to individuals with disabilities who are not eligible for MassHealth Standard; MassHealth CommonHealth participants must either pay a one-time deductible (or “spend down”), or be working and pay premiums (and in the latter case, would not be subject to income/asset rules).

Duals Demo 2.0—Requested Flexibilities and Program Changes

Duals Demo 2.0 does not request any changes to One Care or SCO eligibility; dual eligible individuals age 21–64 at the time of enrollment will continue to be eligible for One Care, and those ages 65 or older may enroll in SCO.

*A nursing facility level of care is determined based on the state’s assessment of the following four factors: physical functional ability, health issues/medical needs, cognitive impairment, and behavioral problems (American Council on Aging). In Massachusetts, a nursing facility level of care is described in 130 CMR 456.409, and requires an individual to need:

- One skilled service daily; or
- Have a medical or mental condition that requires a combination of at least three services, one of which must be a nursing service. The other services can be additional nursing services or a service that assists the member with activities of daily living.

SOURCES: 1) Mass.gov, “Learn more about eligibility for One Care,” available at <https://www.mass.gov/service-details/eligibility-for-one-care>. 2) Mass.gov, “Senior Care Options (SCO) Overview,” available at <https://www.mass.gov/service-details/senior-care-options-sco-overview>. 3) Mass.gov, “Who is eligible for PACE?,” available at <https://www.mass.gov/service-details/who-is-eligible-for-pace>. 4) CMS and MassHealth, “Massachusetts One Care Demonstration: Three Way Model Contract,” March 2019, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MACContract.pdf>.

ENROLLMENT MECHANISMS

Enrollment is the process by which a dual eligible individual formally applies for and enrolls into an integrated care program whose eligibility criteria they meet. Dual eligible members in Massachusetts have the option to enroll in One Care, PACE, or SCO, although for One Care, MassHealth sometimes uses an automatic enrollment process called “passive enrollment” with the option to opt out of the program.

ONE CARE	SCO	PACE
<ul style="list-style-type: none"> • No fixed enrollment. Eligible individuals can enroll and disenroll at any time. • Enrollment in One Care can be self-selected or “passive.” • One Care members who are passively enrolled in the program receive two notices before coverage becomes effective, giving them the choice of accepting the auto-assignment into a One Care plan (discussed in the Provider Network section), selecting a different One Care plan, or opting out of the program. 	<ul style="list-style-type: none"> • Fixed enrollment via “Special Enrollment Periods” (as currently required by CMS). • Enrollment in SCO is self-selected. Eligible individuals must opt in and select a SCO plan available in their geographic service area to serve as their managed care plan. 	<ul style="list-style-type: none"> • No fixed enrollment. • Enrollment in PACE is self-selected. Individuals must meet eligibility requirements, select PACE coverage, and complete a PACE application form.

TERMINOLOGY:

- **Fixed Enrollment:** An enrollment approach where a plan allows individuals to enroll only within a specific time period (e.g., individuals may only enroll in a MassHealth plan during an annual 90-day plan selection period). Individuals are precluded from changing plans within the period of time between annual plan selection periods unless they meet specified exception criteria (e.g., moved out of a plan’s service area).
- **Passive Enrollment:** An enrollment method through which an individual who meets a coverage program’s eligibility criteria is automatically enrolled by the state. Individuals do not need to take any action to enroll into a program. After they are enrolled, they receive notice of their passive enrollment and have the option to opt out of coverage.
- **Self-Selected Enrollment:** An enrollment method by which individuals are not automatically or passively enrolled in a coverage program by the state. They must proactively choose to enroll in one by submitting a formal application and selecting a specific plan.

IMPLICATIONS AND CHALLENGES OF PROGRAM DIFFERENCES

- The absence of fixed enrollment periods in One Care and PACE ensures that dual eligible members can transition into and out of these plans at any time, for any reason. Nonetheless, fixed enrollment periods could promote continuity of care for dual eligible members and enrollment, administrative, and financial stability for plans.
- While ensuring full freedom of choice and minimizing confusion for members, limiting enrollment pathways for SCO and PACE to only self-selected enrollment may be causing lower enrollment rates. Dual eligible individuals may not be aware of these coverage options, and/or may not want to pursue submitting a formal application to enroll.
- Passive enrollment, which is not used in SCO or PACE, is a feature within One Care that can help educate dual eligible members about the One Care coverage option and ease the administrative tasks associated with formal enrollment. However, passive enrollment sometimes results in confusion among members who may not be aware they were enrolled in a plan. CMS allowed states, including Massachusetts, to implement passive enrollment in programs designed through the FAI* in an effort to promote enrollment in integrated care programs.

Relevance for MassHealth FFS: With the exception of members who are passively enrolled in One Care and then opt out, MassHealth FFS is the default program option for dual eligible members. As a result, the majority of dual eligible members (~75%) remain in the MassHealth FFS program without access to comprehensive care coordination or care management. However, dual eligible members enrolled in MassHealth FFS can transition into One Care or PACE at any time (assuming they meet the eligibility criteria) because these programs do not impose a fixed enrollment period.

Duals Demo 2.0—Requested Flexibilities and Program Changes

In an effort to grow enrollment in One Care and SCO and promote care integration for dual eligible members, **the state has made a request to extend to the SCO program the passive enrollment currently in place for One Care**. Dual eligible individuals could opt out of coverage from One Care or SCO if they were passively enrolled, but under the proposed Duals Demo 2.0:

- Individuals who previously opted out of One Care under the current demonstration would be eligible for passive enrollment in One Care (or SCO if now eligible); and
- Opt-out requests for One Care and SCO would be treated separately. Individuals who previously opted out of One Care but became newly eligible for SCO based on age could be passively enrolled in SCO.

*FAI is the Centers for Medicare & Medicaid Services’ Financial Alignment Initiative (FAI), which authorized states to procure private health plans that align Medicare and Medicaid coverage and financing.

SOURCES: 1) Mass.gov, Automatic Assignment in a One Care Plan,” available at <https://www.mass.gov/service-details/automatic-assignment-in-a-one-care-plan>. 2) Mass.gov, “Enrolling and Receiving Care Under Senior Care Options(SCO),” available at <https://www.mass.gov/service-details/enrolling-and-receiving-care-under-senior-care-options-sco>. 3) Centers for Medicare and Medicaid Services, “Programs of All-Inclusive Care for the Elderly (PACE): Chapter 4-Enrollment and Disenrollment,” available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c04.pdf>.

PROVIDER NETWORK

The provider network refers to the array of providers of medical, behavioral health, long-term services and supports (LTSS), and social services that a plan participating in an integrated care program makes available to its members. Prior to enrolling in an integrated care plan, dual eligible members often have long-standing relationships with teams of providers who are keenly aware of the individual's unique needs and are responsible for managing their complex issues. Maintaining access to these established providers is a critical goal for dual eligible members enrolled in integrated care programs.

ONE CARE	SCO	PACE
<ul style="list-style-type: none"> Members have a continuity of care period, during which their prior provider relationships, service authorizations, and FFS providers' payment rates are protected. On enrollment, a member goes through a comprehensive assessment process and develops a person-centered care plan with their One Care interdisciplinary care team (described in detail in the Care Management section). The continuity of care period concludes when the member's care plan is complete and agreed to by the member, generally within 90 days.* Passively enrolled One Care members are "intelligently assigned" to a One Care plan based on their existing provider relationships. Members who enroll through self-selection choose their own plan. One Care plans must offer single-case out-of-network agreements to providers who are 1) unwilling to enroll in the plan's provider network; 2) currently serving enrollees; and 3) willing to continue serving enrollees at the plan's in-network rate under special circumstances. Members may access out-of-network providers for emergency conditions and urgent care. In addition, if the One Care plan is unable to provide necessary medical services in the plan's provider network, the plan must cover these services out of network, for as long as the plan is unable to provide them. 	<ul style="list-style-type: none"> Continuity of care period only for passively enrolled members (MassHealth has passively enrolled Medicaid-only members into SCO in the past). Members select their own SCO plan available in their geographic service area. SCO plans must maintain a sufficient network that provides all members with access to the full range of covered services, including behavioral health and other specialty services. Members may access out-of-network providers for emergency conditions and urgent care. 	<ul style="list-style-type: none"> No continuity of care period. Members select their own PACE program available in their geographic service area. After doing so, they have access to providers who are employed directly by or contract with their PACE organization. Members may access out-of-network providers for urgent care and care provided after an emergency medical condition has been stabilized.

TERMINOLOGY:

- Continuity of Care Period:** The period of time immediately following enrollment in a plan during which a member may continue to maintain access to providers outside the plan's usual provider network. After the continuity of care period, members would need to seek care from providers within the plan's provider network.
- Intelligent Assignment:** A process by which an integrated care program matches a member to a specific plan for the purposes of passive enrollment based on the member's existing relationships with primary care, behavioral health providers, and/or LTSS providers, in order to maintain the member's existing provider relationships when possible.

IMPLICATIONS AND CHALLENGES OF PROGRAM DIFFERENCES

- Relative to SCO and PACE, the One Care program has instituted measures such as a 90-day continuity period and intelligent assignment, to help ensure a smooth transition of benefits between an old and a new plan with different provider networks, and to protect critical relationships that dual eligible members have developed with established providers. All three programs allow members to seek urgent and other emergency care with out-of-network providers when necessary.
- Dual eligible members who transition into SCO and PACE may experience service disruptions if their established providers are not covered under their new plan's provider network.

Relevance for MassHealth FFS: MassHealth FFS members have access to any provider in the MassHealth-contracted primary care and specialty provider network. MassHealth FFS does not have continuity of care, intelligent assignment, or other provider network mechanisms in place.

Duals Demo 2.0—Requested Flexibilities and Program Changes

The state recognizes the importance of maintaining dual eligible members' relationships with established providers during the coverage transition period.

To that end, **Duals Demo 2.0 proposed maintaining the existing 90-day continuity of care period in One Care and requested new authority to do the same for SCO.**

*In addition to maintaining new enrollees' access to their established providers during the first 90 days of enrollment, One Care plans are also encouraged to contact any out-of-network providers who have established relationships with new enrollees within their first 90 days of membership to provide them with information about becoming credentialed in-network providers.

SOURCES: 1) Mass.gov, "Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0," August 20, 2018, available at <https://www.mass.gov/files/documents/2018/08/24/final-concept-paper-duals-demonstration-2.0-08-22-18.pdf>. 2) United States Department of Health and Human Services Centers for Medicare and Medicaid Services, The Commonwealth of Massachusetts, Commonwealth Care Alliance, and Tufts Health Public Plans, "Massachusetts Contract for One Care Plans," April 1, 2019, <https://www.mass.gov/doc/massachusetts-contract-for-one-care-plans-april-1-2019/download>. 3) MassHealth, "Senior Care Options Model Contract 2015," available at <https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/Senior%20Care%20Options%20Model%20Contract%202015.doc>. 4) Centers for Medicare & Medicaid Services, "Programs of All-Inclusive Care for the Elderly (PACE) Manual," available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019036>.

CARE MANAGEMENT MODEL

Care management is a broad set of person-centered, coordinated activities that support an individual's health, welfare, and daily living goals and that help ensure access to necessary services. Care management is typically provided by a primary care provider or health plan staff member, working with the individual. Effective care management is the cornerstone of integrated care programs for dual eligible members. Care management services are vital to understanding and meeting the complex care needs of the dual eligible population, and may include completing a comprehensive assessment of an individual's health, functional, and social support needs, goals, and preferences; developing person-centered care plans; ongoing monitoring and coordinating provider visits and transportation; connecting patients to social and community supports; facilitating dialogues across interdisciplinary care team members; and managing medication.

ONE CARE	SCO	PACE
<ul style="list-style-type: none"> • Initial assessment required within 90 days of enrollment. Ongoing assessments required at least annually. • Members assigned to an interdisciplinary care team (ICT) led by the member's PCP in coordination with a One Care plan care coordinator, and behavioral health clinician if indicated. The coordinator is the member's single point of contact at the One Care plan and is responsible for working with the member and the ICT to develop the member's individualized care plan, ensure the member can attend appointments, and arrange for any other services (e.g., social supports, language interpretation) needed. • Members are offered a Long-term Supports (LTS) Coordinator. 	<ul style="list-style-type: none"> • Initial assessment required within 30 days of enrollment. Ongoing assessments conducted at least every 6 months. • Members assigned to an integrated primary care team led by the primary care provider the member selected upon enrolling in SCO. • Members are assigned a Geriatric Support Services Coordinator. 	<ul style="list-style-type: none"> • Initial assessment required "promptly following enrollment." Ongoing assessments conducted once every 6 months or more often if a member's condition dictates. • Members are assigned to an interdisciplinary care team that must include at least 11 members who are employed or contracted by the PACE organization.* • No LTS or Geriatric Support Services Coordinator.

TERMINOLOGY:

- **Initial Assessment:** A critical enrollment step, where a plan or coverage organization (such as a PACE organization) conducts a detailed assessment to gain an understanding of the new member's complex clinical, functional and social support needs, goals, and preferences. Details gathered during the assessment are typically used to inform the development a member's person-centered care plan and organize the member's interdisciplinary care team / integrated primary care team.
- **Interdisciplinary Care Team (One Care and PACE) / Integrated Primary Care Team (SCO):** A team of individuals that are responsible for developing a member's care plan and coordinating their care, teams meet regularly to ensure the medical, behavioral, and social needs of members are met. These teams are typically composed of a combination of care coordinators, primary care providers, nurses, specialists, peer support/counselors, among others that members may choose to include (e.g., a personal representative or family member), and led by one individual from the team.
- **LTS Coordinator (One Care)/Geriatric Support Services Coordinator (SCO):** An individual who is responsible for ensuring that a member receives necessary LTSS or geriatric support services that are well-coordinated with the individual's medical and behavioral health services.

IMPLICATIONS AND CHALLENGES OF PROGRAM DIFFERENCES

- Initial assessments and interdisciplinary/integrated primary care teams are two critical and impactful services offered by One Care, SCO, and PACE. Without these features, the plans would be ill equipped to understand and coordinate the complex medical, behavioral, LTSS, and social service needs of dual eligible members.
- One Care and SCO plans are unique in that they offer dual eligible members the support of a specialized LTS or Geriatric Support Services Coordinator, respectively, who can help members understand their LTSS needs, connect them with community services and resources, and assist in developing their personal care plans. PACE enrollees are not assigned a personal LTSS or geriatrics support services coordinator but likely receive similar care coordination support from members of their interdisciplinary care team and staff through their PACE organization.

Relevance for MassHealth FFS: Dual eligible members receiving care through MassHealth FFS generally do not receive any of the care management activities afforded to those enrolled in One Care, PACE, and SCO. The lack of access to care management services for MassHealth FFS dual eligible members may contribute to inefficient service utilization and suboptimal outcomes experienced by members because they are left to assess, navigate, and coordinate their medical, behavioral, LTSS, and social service needs independently.

Duals Demo 2.0—Requested Flexibilities and Program Changes

Duals Demo 2.0 does not request major changes to the One Care or SCO care management models or processes.

Current care management supports and services provided by One Care and SCO are relatively aligned, and the state has not requested enhancements to current protocols.

*Note: PACE interdisciplinary teams must include a primary care physician, registered nurse, Master's level social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietitian, PACE center manager, home care coordinator, personal care attendant or their representative, and driver or his or her representative.

SOURCES: 1) Mass.gov, "Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0," August 20, 2018, available at <https://www.mass.gov/files/documents/2018/08/24/final-concept-paper-duals-demonstration-2.0-08-22-18.pdf>. 2) MassHealth, "Senior Care Options Model Contract 2015," available at <https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/Senior%20Care%20Options%20Model%20Contract%202015.doc>. 3) Mass.gov, "Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0," August 20, 2018, available at <https://www.mass.gov/files/documents/2018/08/24/final-concept-paper-duals-demonstration-2.0-08-22-18.pdf>. 4) Centers for Medicare and Medicaid Services, "Programs of All-Inclusive Care for the Elderly (PACE) Manual," available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IO-Items/IO-Items/CMS019036>.

FINANCING MODEL

Financing models are the ways in which Medicare and MassHealth develop their rates of payment to integrated care plans and how plans allocate these funds for services provided to members. Financing models within integrated care programs that serve dual eligible members are particularly complicated, as they seek to combine Medicare and Medicaid dollars in a way that is equitable for both payers, appropriate to meet dual eligible members' needs, and sufficient to encourage plans to participate in the program and assume risk for this high-cost population.

ONE CARE	SCO	PACE
<ul style="list-style-type: none"> Financed based on capitated monthly Medicare and Medicaid payments. The Medicare rate is risk-adjusted, but the MassHealth rate is not. No frailty adjuster applied. Two-sided risk corridors, which mitigate risk assumed by One Care plans caring for high-cost members. Subject to 85% minimum medical loss ratio, based on Medicaid-only costs and capitation rates. 	<ul style="list-style-type: none"> Financed based on capitated monthly Medicare and Medicaid payments. The Medicare rate is risk-adjusted, and a portion of the SCO's MassHealth rate is risk-adjusted. Individual SCO plans may apply for the frailty adjuster, but their case mix must meet a certain clinical threshold for them to be eligible for it. Two-sided risk corridors were implemented for 2020 and 2021 due to COVID-19. Subject to 85% minimum medical loss ratio, based on Medicaid-only costs and capitation rates. 	<ul style="list-style-type: none"> Financed based on capitated monthly Medicare and Medicaid payments. The Medicare rate is risk-adjusted, but the MassHealth rate is not. Frailty adjuster rate applied to PACE organizations' Medicare risk-adjustment rate. No two-sided risk corridors. Not subject to medical loss ratio.

TERMINOLOGY:

- Capitated Payments:** Fixed prospective monthly payments the state makes to a health plan to cover the cost of care for each member. Unlike in an FFS system, in which the state reimburses providers directly for each service they provide to the member, capitated payments remain the same regardless of how much health care a member uses that month. Capitated payments are often "risk-adjusted," or calculated to reflect the risk (i.e., health status or acuity) of the plan's specific membership.
- Frailty Adjuster:** A special rate that is sometimes applied to a plan's Medicare risk-adjustment rate to reflect the higher expenditures associated with caring for individuals with complex health needs. It is intended to help those plans cover the higher cost of caring for those members.
- Medical Loss Ratio (MLR):** Measures the proportion of collected health insurance premiums that plans use to pay for members' medical expenses, as opposed to administrative expenses. The Affordable Care Act required insurers across the country to meet specific MLR standards. For example, large group plans are required to maintain an MLR of 85%, meaning that for every dollar in premiums collected, they must spend 85 cents on medical expenses.
- Risk Adjustment:** A way of calculating a plan's capitation rates to reflect the risk (i.e., the health status or acuity) of its members. Under risk-adjusted capitated payments, a health plan will receive a higher payment for members who are very sick or have greater health care needs and a lower payment for members who are generally healthy.
- Two-Sided Risk Corridors:** A provision of the Affordable Care Act that limits losses and gains incurred by plans beyond an allowable range. Under this system, if a plan's capitation payments were much higher than the plan's actual expenses for their members' care, the plan would pay back some of their capitation payments to the state. Similarly, if a plan paid its providers far more for the health care of their members than they received in capitated payments, the plan would receive additional payments to offset some of its losses.

IMPLICATIONS AND CHALLENGES OF PROGRAM DIFFERENCES

- All three integrated care programs have the same baseline Medicare reimbursement mechanism: Plans rely on risk-adjusted capitated monthly payments from Medicare Parts A/B and Medicare Part D (prescription drug coverage) to cover the cost of caring for their dual eligible members. By directing more money to plans that cover riskier members, risk-adjusted payment rates enable states to more accurately account for the costs of providing care to high-need populations; incentivize plans to participate in managed care programs; and promote long-term sustainability of these care delivery models for dual eligible members.
 - MassHealth reimbursement mechanisms are not uniform across programs. A portion of SCO MassHealth capitation rates are risk-adjusted; however, remaining SCO, PACE, and One Care MassHealth rates are not risk-adjusted.
- SCO and PACE are different from One Care in that their Medicare risk-adjusted rate includes a frailty adjuster, intended to take into account that they care for a predominantly elderly population. The frailty adjuster leads to higher capitated payments for plans with members who require complex and high-cost care.
- The two-sided risk corridors applied to One Care and SCO plans provide vital protection against potential financial losses based on plans' ability to deliver care within the capitated payments.
- PACE organizations do not have risk corridors. Therefore, they are more exposed to potential financial risks as a result of caring for high-cost members. PACE could strengthen its fiscal sustainability by adopting risk corridors.
- Unlike One Care and SCO, PACE organizations are not subject to a medical loss ratio. Therefore, they have more discretion as to how they allocate and spend their capitated funds.

Relevance for MassHealth FFS: Transitioning a higher percentage of Massachusetts' dual eligible population from MassHealth FFS into capitated, integrated care programs may help reduce inefficient service delivery and the financial risk the state currently assumes in caring for dual eligible members. This is because capitated payment methodologies are designed to address concerns about overutilization of services in FFS delivery systems. Since they are paid in advance and on a per person basis, capitated payments incentivize plans to authorize and providers to deliver only appropriate and high-quality medically necessary services. In contrast, the state assumes the financial risk for caring for the majority of dual eligible members who are enrolled in MassHealth FFS without some of the financial protections and risk adjustments afforded to the integrated care plans.

Duals Demo 2.0—Requested Flexibilities and Program Changes

The state has requested changes to the financing models for One Care and SCO, in order to ensure the fiscal sustainability and accountability of each program. Most notably, the state has asked to **better align One Care's financial methodologies with SCO's by making capitation rate methodology changes to both programs**. To achieve alignment, the state would, for example, apply a frailty adjuster to One Care as it does for SCO, allowing individual One Care plans to apply for the frailty adjustment if they meet certain requirements.

Other fiscal sustainability and accountability measures have been proposed, including enhancements to transparency and data-sharing efforts, implementation of value-based payment arrangements, and participation in shared savings arrangements.

SOURCES: 1) BCBS MA Foundation/Massachusetts Medicaid Policy Institute, "Overview of the Massachusetts One Care Initiative for Non-Elderly Dual Eligibles," November 2014, available at <https://www.bluecrossmafoundation.org/publication/updated-massachusetts-one-care-initiative-non-elderly-dual-eligibles>. 2) Mass.gov, "Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0," August 20, 2018, available at <https://www.mass.gov/files/documents/2018/08/24/final-concept-paper-duals-demonstration-2.0-08-22-18.pdf>. 3) Health Management Associates, "Value Assessment of the Senior Care Options (SCO) Program," July 21, 2015, available at https://www.mahp.com/wp-content/uploads/2017/04/SCO-White-Paper-HMA-2015_07_20-Final.pdf. 4) Mass.gov, "Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0," August 20, 2018, available at <https://www.mass.gov/files/documents/2018/08/24/final-concept-paper-duals-demonstration-2.0-08-22-18.pdf>. 5) National PACE Association, "Understanding PACE," 2016, available at https://www.npaonline.org/sites/default/files/Profile%20of%20PACE_December%202016.pdf. 6) Centers for Medicare and Medicaid Services, "Programs of All-Inclusive Care for the Elderly (PACE) Manual," available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019036>. 7) 42 CFR § 460.186 - PACE premiums, October 1, 2007, available at <https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec460-186/context>. 8) Federal Register, "Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs," May 23, 2013, available at <https://www.federalregister.gov/documents/2013/05/23/2013-12156/medicare-program-medical-loss-ratio-requirements-for-the-medicare-advantage-and-the-medicare>. 9) CMS, "The Center for Consumer Information and Insurance Oversight: Medical Loss Ratio," available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio>.

APPENDIX: DUALS DEMO 2.0—DETAILED LIST OF REQUESTED FLEXIBILITIES AND PROGRAM CHANGES

DUALS DEMO 2.0 REQUESTS	KEY FLEXIBILITIES AND PROGRAM CHANGES
<p>Flexibility to grow and sustain enrollment in One Care and SCO through passive enrollment and fixed enrollment periods, while expanding both programs statewide and increasing provider participation</p>	<ul style="list-style-type: none"> • Passive Enrollment: Maintain authority to passively enroll dual eligible individuals in One Care, and request new authority to do the same for SCO. • Opting Out and Transition Into Coverage: Continue opt-out practices for One Care and SCO, but ensure that: <ul style="list-style-type: none"> – Individuals who previously opted out of One Care under the current demonstration are eligible for passive enrollment under the new demonstration. – Treat opt-out requests for One Care and SCO separately; individuals who previously opted out of One Care but become newly eligible for SCO based on age can be passively enrolled in SCO. • Continuity of Care: <ul style="list-style-type: none"> – Maintain 90-day continuity of care period for One Care, and plan to do the same for SCO. – Continue advance notice and other outreach activities prior to coverage effective date. • Fixed Enrollment: Implement fixed enrollment periods for One Care and SCO that align with other MassHealth managed care products (ACOs and MCOs). • Member Retention Strategies: <ul style="list-style-type: none"> – Make data-sharing and other administrative, enrollment, and marketing flexibilities (e.g., member data-sharing, pre-enrollment plan outreach) available to One Care plans through the Financial Alignment Initiative available to SCO. – Continue federal financial support for My Ombudsman.* – Ensure robust and appropriate One Care and SCO networks to meet the needs of individuals who are dual eligible. – Offer options counseling through SHINE (a program that offers unbiased health insurance counseling and assistance to Massachusetts residents with Medicare, their caregivers, and those approaching Medicare eligibility) and Mass Options. – Maintain formal and informal engagement and feedback opportunities.
<p>Flexibilities to increase administrative alignment and integration to create a more seamless member experience in each program, building upon the approaches used today in One Care</p>	<ul style="list-style-type: none"> • Communications and Appeals: Extend the following current One Care practices to the SCO program. <ul style="list-style-type: none"> – Distribute unified and comprehensive communications and member materials that provide consistent information on the scope of both the Medicaid and the Medicare program. – Integrate appeals and grievances for all Medicare Parts A and B and Medicaid services. • Contracting: Administer One Care and SCO through a combination of three-way and two-way contracts to achieve financial efficiencies in line with MassHealth managed care programs. Three-way contracts will prevail among the One Care or SCO plans, the state, and CMS; and two-way contracts will do so between the plans and the state. <ul style="list-style-type: none"> – <i>Note:</i> Two-way contracts between plans and the state, which CMS is not party to, allow the state to be more transparent about pricing (relative to plans administered by CMS), thus enabling greater financial efficiencies.

*The Federal Financial Alignment Initiative that established One Care also funded the *One Care Ombudsman*, an independent advocate that helps address member concerns and ensures access to all program benefits. The State recently re-procured and expanded the scope of *One Care Ombudsman* to serve members of all MassHealth plans and renamed it *MyOmbudsman*.

DUALS DEMO 2.0 REQUESTS	KEY FLEXIBILITIES AND PROGRAM CHANGES
<p>To align Medicare financing methodologies and ensure fiscal sustainability for the Commonwealth and the federal government by updating One Care to more closely reflect the Medicare financial methodology used in D-SNPs for Parts A/B and Part D services, and implementing a modified Medicare-Medicaid specific Stars methodology*</p>	<ul style="list-style-type: none"> • Payment Approach: Continue current payment approaches and methodologies under both One Care and SCO plans but extend the low-income cost-sharing subsidy that is currently offered in One Care plans to SCO. • Capitation Rates: Better align One Care’s financial methodologies with SCO’s. Notable changes include: <ul style="list-style-type: none"> – <i>Changes to One Care</i>: Apply frailty adjuster and transition One Care to the Medicare Advantage bidding process applicable to Dual Eligible Special Needs Plans (D-SNP plans) for Medicare Parts A/B and Part D.
<p>To ensure fiscal accountability for the Commonwealth and CMS through value-based purchasing, increased transparency and data sharing, blended Medical Loss Ratio reconciliation, and shared savings evaluations of integrated care programs for dual eligible members</p>	<ul style="list-style-type: none"> • Value-Based Purchasing (VBP): Develop VBP initiatives in One Care and SCO that align with MassHealth’s MCOs and ACOs and Medicare ACOs. Establish VBP targets as a percentage of a plan’s provider networks. • Transparency and Data Sharing: <ul style="list-style-type: none"> – Increase transparency of Medicare-specific data and expand access to the Health Plan Management System (HPMS) to enable joint administration of One Care, PACE, and SCO. MassHealth is currently able to access HPMS information for One Care and would like to expand this access for SCO and PACE. – Achieve capacity to interface with CMS IT systems in order to achieve administrative alignment and data sharing across programs. • Other Fiscal Accountability Measures: <ul style="list-style-type: none"> – Implement a plan-specific, post-risk corridor, blended Medicare-Medicaid medical loss ratio, starting at a minimum of 85%. – Place limits on crossover payments (i.e., in cases where One Care or SCO plans pay providers in excess of 100% of the Medicare fee schedule).
<p>To enter into a shared savings agreement with CMS, in which the Commonwealth and federal government share in savings resulting from the Duals Demonstration 2.0</p>	<ul style="list-style-type: none"> • Shared Savings Arrangement: <ul style="list-style-type: none"> – Implement retrospective shared savings adjustment payments based on performance and the achievement of overall federal savings in both One Care and SCO. – Develop an evaluation approach and conduct evaluations to compare experiences of One Care and SCO members with the experiences of a statistically similar group.

*Note: The Stars methodology refers to a quality rating system CMS uses to measure the experiences Medicare beneficiaries have with their health plan and health care system.

