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National Senior Citizens Law Center

Massachusetts Three-Way Contract
A Summary of Beneficiary Protections

On July 18, 2013 the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) published the three-way contract CMS signed with the Commonwealth of Massachusetts, and the three managed care plans participating in the dual eligible demonstration. The Massachusetts three-way contract is a useful as a starting point for understanding the general structure of the three-way contract and for thinking about how to address consumer protections in future state three-way contracts.

This summary discusses the consumer protections detailed in the contract.[1]

The contract provisions are more specific than those in the Massachusetts Memorandum of Understanding (MOU)[2] that preceded the contract and include numerous elements that advocates will want included in other state contracts. There are, however, several areas where stronger protections or greater clarification of processes would improve future contracts. The contract is available on MMCO's website.[3]

Enrollment (Sec. 2.3, p. 22-26)

Plan reductions: The State expected to contract with six plans to provide care to the 109,000 individuals it anticipated enrolling in the demonstration (known as OneCare). However, this spring, three plans dropped out of the demonstration.[4] The three remaining plans, Commonwealth Care Alliance, Inc., Fallon Community Health Plan, and Network Health, LLC, entered into this three-way contract and will provide care to approximately 90,000 individuals.[5]

1 Many important contract elements, such as marketing, network management and finances, are outside of the scope of this summary.

2 Memorandum of Understanding *available at* www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf.

3 Massachusetts Contract (Contract) *available at* www.cms.gov/Medicare-Medicaid-Coordination/Medicare-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf.

4 Conaboy, Chelsea. "Health plan for disabled adults cut back in Massachusetts." *The Boston Globe*, 29 Jul. 2013. The three plans that dropped out: Blue Cross Blue Shield of Massachusetts, Boston Medical Center Health Net Plan and Neighborhood Health Plan.

5 Patrick Administration Announces New 'One Care' Health Plan to Serve Dual Eligible Individuals in

One result from having fewer plans will mean fewer beneficiaries will be passively enrolled into a plan. The Medicaid statute requires beneficiaries to have a choice of two plans when a state conducts passive enrollment in managed care[6] and MMCO affirmed this requirement in further guidance.[7] If a service region only has one plan, the plan cannot passively enroll beneficiaries in that region. Now, beneficiaries in Hampshire, Hampden, Suffolk and Worcester counties will be eligible for passive enrollment, while beneficiaries in Essex, Franklin, Middlesex, Norfolk, and Plymouth will only enroll voluntarily.[8]

Timing: The contract adheres to the enrollment timeline envisioned by the State in the MOU[9]. The State expects to begin voluntary enrollment no earlier than October 1, 2013, and passive enrollment no sooner than January 1, 2014.[10]

Passive enrollment requirements: The contract provides an extensive explanation of the passive enrollment process from the plan's perspective, but there are several important consumer protections:

1. **Using intelligent assignment, the State Medicaid customer service vendor will passively enroll eligible beneficiaries into one of the three plans.**[11] The only information the contract provides on the intelligent assignment methodology is the state may look at past provider relationship when conducting passive enrollment.[12] The lack of detail leaves the State with extensive flexibility to create an intelligent assignment process.

2. **CMS and the State will monitor enrollment and may stop the process if a plan does not demonstrate compliance with enrollment protections and reporting requirements.** For example, if the plan does not have the capacity to handle the influx of beneficiaries, CMS and the State will make adjustments to the volume or spacing of passive enrollment. A plan may also request a capacity limit.

3. **The plan is required to maintain a mechanism to receive information from CMS and the State about**

Massachusetts, 16 July 2013, *available at* www.mass.gov/eohhs/gov/newsroom/press-releases/eohhs/one-care-health-plan.html.

6 42 CFR 438.52, Choice of MCOs, PIHPS, PAHPS and PCCMS.

7 2014 Capitated Financial Alignment Demonstration Timeline at 5 *available at* www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2013_State_MMP_Annual_Requirements_for_CY_2014.pdf. *See also* Medicare-Medicaid Plan Enrollment and Disenrollment Guidance *available at* www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf.

8 Massachusetts Department of Health and Human Services, Integrating Medicare and Medicaid for Dual Eligibles, *available at* www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/related-information.html.

9 Memorandum of Understanding, *available at* www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf

10 Contract at §2.3A.

11 Contract at §2.3A.

12 Contract at §2.3A.

enrollments in the plan.

4. **If a beneficiary is enrolled in a plan, and decides to enroll in another demonstration plan, the current plan must transfer all assessment information to the new plan.**[13]

Enrollment notices: The contract also includes some language access and notification requirements. For example, the plan is required to inform beneficiaries that translations of information are available in prevalent languages[14] and the plan must ensure that all orientation materials are provided in a manner and format that can be easily understood, including providing written materials in prevalent languages and oral interpretation services when requested. [15]

Issues to consider:

- The State's flexibility to design an intelligent assignment algorithm.
- The contract requires translation of enrollment documents by plans into prevalent languages, but does not specifically identify the documents that must be translated.
- The contract does not identify what enrollment documents created by the state must be translated.

13 Contract at §2.3B.

14 The contract defines prevalent languages as English, Spanish and any languages spoken by 5% of more of enrollees in the service area. Service area is plan specific and is defined as the area where the plan will provide services to beneficiaries who enroll in the plan, whether through voluntary enrollment or passive enrollment. Because this information is plan specific, it was not included in the published contract.

15 Contract at §2.3C.

Care Team and Care Coordinator (Sec. 2.5, p. 28-45)

Interdisciplinary Care Team: One distinguishing feature of care in the demonstration versus fee-for-service is the availability of an Interdisciplinary Care Team (ICT) to coordinate care.[16] It is led by the beneficiary's Primary Care Provider (PCP), and members of the team include the care coordinator, IL-LTSS coordinator, other professional disciplines, family members, caregivers and advocates.[17] The contract details the team's many responsibilities, including: developing an integrated care plan (ICP), promoting independent functioning, and communicating with the beneficiary about medical, social and psychological needs.[18]

Care coordinator: Two distinct entities provide coordination services: the care coordinator and the Independent Living-Long-Term Services and Supports (IL-LTSS) Coordinator. The care coordinator serves a medical role. The care coordinator may be a clinician, and is responsible for participating in the comprehensive assessment, monitoring services and making referrals.[19] The contract allows the plan to develop its own written qualifications for the care coordinator.[20] If the plan or a provider identifies the beneficiary as an "enrollee with

16 Contract at §2.4.

17 Contract at §2.5.

18 Contract at §2.3C.

19 Contract at §2.5.

20 Contract at §2.5.

complex care needs,"[21] then a clinical care manager will serve as the care coordinator.[22] The clinical care manager must be a licensed registered nurse.

The IL-LTSS coordinator is an advocate and educator. To date, Massachusetts is the only state to require plans to provide a beneficiary with such a coordinator as part of the care team. The IL-LTSS coordinator's responsibilities include educating the beneficiary and his care team about LTSS and coordinating and authorizing community LTSS resources.[23] The contract details the minimum qualifications for an IL-LTSS coordinator. For example, the IL-LTSS coordinator must have knowledge of the HCBS system, complete a person-centered planning and person-centered direction training, be culturally competent, be able to provide informed advocacy, and have experience conducting LTSS needs assessments.[24]

The plan must contract with local community-based organizations (CBOs) for the IL-LTSS coordinator, however, the plan cannot have a financial interest in the CBO contracted for IL-LTSS.[25] Specifically, if the CBO provides facility or community-based LTSS, and is compensated by the plan, the CBO cannot function as an IL-LTSS coordinator. If, however, the CBO is compensated by the plan to only provide evaluation, assessment, coordination, skill training, peer supports, and fiscal intermediary services, then the CBO is not considered an LTSS provider, and the plan may contract with the CBO. The plan is also required to contract with multiple CBOs for the IL-LTSS coordinator role, including at least one Independent Living Center (ILC), if that is geographically feasible in the plan service area. Beneficiaries must have a choice of at least two IL-LTSS coordinators.

Behavioral Health: Integrating behavioral health with acute and LTSS care is a critical component of the Massachusetts model. The contract provides extensive detail on how the plan must incorporate behavioral health into the care plan.[26] All of the ICT behavioral health providers will participate in the development and implementation of a care plan. The contract details specific behavioral health protections the plan must provide the beneficiary, including: 1) ensuring that all referrals for specialty behavioral health services are made promptly, and with the beneficiary's consent, 2) ensuring that beneficiaries with a serious and persistent mental illness have access to care and services; 3) offering a continuum of behavioral health care; and 4) maintaining a structured process for identifying and addressing complex behavioral health needs at all levels of care and in all residential settings.[27]

Issues to consider:

21 The contract definition of complex care need: Enrollees who are determined to have significant health care needs and require intensive care coordination services/activities geared towards addressing their physical, behavioral health and/or social care needs. These Enrollees typically have comorbidities and psychosocial needs that if not addressed can significantly diminish their quality of life as well as their ability to adhere to treatment plans.

22 Contract at §2.5.

23 Contract at §2.6.

24 Contract at §2.6.

25 Contract at §2.6.

26 Contract at §2.5E.

27 Contract at §2.5E(3).

- What are the qualifications for the care coordinator?
- How are the roles and responsibilities for members of the care team distinct?
- For future states without an IL-LTSS coordinator, who is the advocate? Who is the educator?

Comprehensive and MDS-HC Assessment (Sec. 2.6, pg. 46-56)

During the care continuity period, the plan will complete a comprehensive assessment that the care team uses to create the care plan.[28] The plan creates the assessment tool. The contract details the 20 domains the plan must include in the assessment tool, including social domains, such as employment status, transportation access, food security and nutrition, and personal goals.[29] The tool will also capture information regarding the beneficiary's understanding of services, desire to self-manage his or her care, and understanding of enrollee rights.[30] Based on the comprehensive assessment, the ICT creates the Individualized Care Plan (ICP). The ICP specifies how the medical and social service providers will integrate and coordinate services and care.[31]

In addition to the comprehensive assessment for care, the plan must evaluate each beneficiary's health and service use through an MDS-HC assessment.[32] The MDS-HC is used to determine the rating categories the plan will use for the capitated payment. The MDS-HC must be completed by a registered nurse in this timeframe:

- Within 90 days of enrollment, and then annually, for a high community-need (C3) rating category;
- Within six months of enrollment, and then annually, for a behavioral health (C2) rating category;
- Whenever a community other (C1) individual needs to change rating categories.[33]

Issues to consider:

- Will there be any oversight from CMS and the State on the assessment tool?

Authorization for Long-Term Services and Supports, Expanded Services, and Supplemental Community-Based Services (Sec. 2.6, p. 51-59 and Appendix B)

Together, the comprehensive assessment

28 Contract at §2.6A.

29 Contract at §2.6A.

30 Contract at §2.6A.

31 Contract at §2.6C.

32 MDS-HC is the federally-mandated Minimum Data Set for Home Care, a clinical screening system using proprietary tools developed by inter-RAI Corporation, which assesses the key domains of function, health, and service use. Contract at §1.

33 Contract at §4.2. F1: Enrollees are classified as F1 if they have been identified by the State as having a stay exceeding 90 days in a skilled nursing facility or nursing facility or chronic hospital, rehabilitation hospital, or a psychiatric hospital. C3 individuals who have a daily skilled need, a skilled need, four or more ADL impairments requiring supervision; four or more ADL impairments and moderately to severely impaired cognitive decision making skills; or 4 or more ADL impairments and one or more behavioral health diagnoses. C2 individuals do not meet F1 or C3 criteria, and their most recent MDS-HC assessment indicates one or more behavioral health diagnoses. C1, or Community Other, individuals do not meet F1, C2 or C3.

and the ICP dictate the services, including long-term services and supports the plan is required to provide to the beneficiary. Both the care coordinator and the IL-LTSS coordinator are critical in determining services, as receipt of these services is determined by the assessment and the ICP.[34]

The plan is required to provide expanded Personal Care Attendant (PCA) and expanded Durable Medical Equipment (DME) services as well as a specified list of new supplemental community-based services. These services are detailed in Appendix B to the contract. The new community-based services covered by the plan include: day services, home care services, respite care, peer support, care transitions assistance, home modification, community health workers, medication management and non-medical transportation.[35] However, the beneficiary's assessment and ICP will determine whether or not the beneficiary is authorized to receive these services.

The plan must create authorization criteria for the expanded PCA and DME services and for the supplemental community-based services.[36] The plan can determine the amount, direction and scope of the service for the beneficiary, if the plan determines the authorization would provide sufficient value to the beneficiary's care.[37] A letter from the MMCO to advocates clarifies that beneficiaries may appeal denial of expanded and supplemental benefits in the same manner as any Medicare or Medicaid benefit.[38]

In addition to the required expanded and supplemental services, plans have the discretion to cover other community-based services, also basing authorization on value to the beneficiary's care. These benefits are flexible benefits, and are included in the beneficiary's care plan, and provided as appropriate for each beneficiary.[39]

Issues to consider:

- In future states that do not include the expanded and supplemental services in the benefit package, will beneficiaries retain appeals rights to additional flexible benefits?

Care Continuity (Sec. 2.5, p. 53-56)

The plan has the authority to develop a care continuity policy, within the parameters established in the contract. The care continuity period is 90 days, or until the plan completes the assessment, whichever is longer.[40] Completion of the assessment means that the assessment has been developed and reviewed by the beneficiary. The policy must ensure that during the care continuity period: 1) the beneficiary does not experience any gaps in ongoing services, 2) the beneficiary is able to maintain current

34 Contract at §2.6.

35 Appendix B, Exhibit 4.

36 Contract at §2.9H.

37 Contract at §2.9H. Sufficient value is determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the beneficiary in the least restrictive setting and with reduced reliance on emergency department use, acute inpatient care and institutional long-term care.

38 MMCO Letter, August 9, 2013, *available at* www. dualsdemoadvocacy.org/wp-content/uploads/2013/08/MMCO-response-to-advocate-letter.pdf.

39 Letter.

40 Contract at §2.6D.

providers at Medicare or Medicaid fee-for-service rates, and 3) the plan honors prior authorizations issued by Medicaid and Medicare until the ICP is complete.[41]

The plan is also required to contract with all current state transportation brokers for medically necessary non-emergency transportation.[42]

The beneficiary has a right to appeal violations of care continuity protections in several instances. First, if the plan modifies the beneficiary's prior authorized services, as a result of an assessment or ICP, the plan must provide the beneficiary with notice of the modification and the opportunity to appeal. Also, if the beneficiary is receiving a service that the plan will not cover after the care continuity period ends, the beneficiary is entitled to all appeal rights. In both situations, the beneficiary may receive aid paid pending.[43]

Issues to consider:

- The contract protects access to prior "authorized" services, but is silent about services that have been scheduled, e.g., surgery, but had not required authorization.
- The contract does not address continuity rights if a prior authorization period expires.

Appeals (Sec. 2.12, 108-115)

The appeals system detailed in the contract is consistent with the MOU, with an important clarification regarding the Independent Review Entity (IRE). The beneficiary must file the initial appeal with the plan. If the appeal is for Medicare services, the plan will forward subsequent appeals to the Medicare IRE.[44] If the appeal is for Medicaid services, after the initial appeal, the beneficiary or may appeal to the Board of Hearings (BOH).[45]

For Medicare and Medicaid overlap services (such as home health and DME), the plan will auto-forward subsequent appeals to the IRE, and the beneficiary can also file a request a hearing with the BOH. The contract clarifies an outstanding question in the MOU regarding what happens if the IRE and the BOH both make a determination. In this situation, any decision in favor of the beneficiary binds the plan, and the plan will be required to pay for the service or item closest to the relief the beneficiary requested.[46]

For external appeals, the contract clarifies that the CMS IRE will apply both the Medicare and Medicaid definition for medically necessary services when adjudicating the beneficiary's appeal for Medicare and supplemental services. The IRE must decide the appeal based on whichever definition or combination of definitions provides a more favorable decision for the beneficiary.[47]

The beneficiary may also file an appeal to the BOH after the internal plan-level appeal for Medicaid services. If both the IRE and the BOH make a decision, the plan is held to the

41 Contract at §2.6D.

42 Contract at §2.3C.

43 Contract at §2.4

44 Contract at §2.12A(4)(d).

45 Contract at §2.12A(4)(d).

46 Contract at 2.12A(4)(d).

47 Contract at §2.12C(1)(b).

decision in favor of the beneficiary.[48]

In a step toward an integrated appeals process, the plan will develop a single, integrated notice to inform the beneficiary of all applicable demonstration, Medicare and Medicaid appeal rights. CMS and the State will approve the notice, and the contract details the format and accessibility requirements the plan must adhere to in developing the notice.[49]

Issues to consider:

- Will the IRE be prepared to apply the Medicaid standard in demonstrations for other states?

Quality (Sec. 4.3D, p. 169-176)

The MOU envisioned an evaluation process where the state and CMS would evaluate the plan based on a set of quality measures. This contract does not include the measures and seems to defer decisions on quality to a later time. The only detail on quality is the quality measures the State and CMS will use to determine the quality withhold.

The contract maintains the high level explanation of the interaction between the quality withholds and risk adjustment included in the MOU. The contract defers the specific information on the withhold to future technical guidance.[50]

The contract does explain the metrics the plan will use for the different quality measures. For example, one of the quality measures for the plan quality withhold is the "Quality of Life Measure." As explained in the contract, the plan will use the Young and Bullock Mental Health Recovery Measure for determining quality of life.[51]

The contract states that whether a plan meets the quality withhold requirements in a given year will be made public.

Issues to consider:

- Will the promised future technical guidance be made public?
- Will details of plan performance be made public or only the fact that a plan did or did not meet quality withhold requirements?
- Are the measures included in the quality withhold adequate for measuring beneficiary experience?

Coordination of Customer Service Information (Sec. 2.6, p. 56-58, Sec. 2.10, p. 103-106)

The contract also includes requirements for plan coordination of enrollee information. The plan is required to maintain a Centralized Enrollee Record (CER), or a single, centralized, comprehensive record that documents the beneficiary's medical, prescription, functional and social status.[52] The plan must implement the CER systems, update them in a timely manner and make them available and accessible to health and LTSS providers.[53]

In addition, the contract explains in extensive detail the requirements for the "Enrollee

48 Contract at §2.12C(3).

49 Contract at §2.12A(12).

50 Contract at §4.3D.

51 Contract at §4.3E.

52 Contract at §2.6(F).

53 Contract at §2.6(F).

Service Representatives" (ESRs). The contract details the training, background, and response times required for ESRs.[54] For example, the ESRs must be knowledgeable about Medicaid, Medicare and the terms of the contract, and must be available to the beneficiary to provide assistance with resolving beneficiary complaints.[55]

Issues to consider:

- What is the relationship between the ESR in the plan and the demonstration ombudsman?

Enrollee Rights (Appendix C)

The plan is required to ensure beneficiaries receive and understand the Enrollee Rights detailed in Appendix C. The provider manual must include the enrollee rights,[56] and the manual must explain that beneficiaries are allowed to exercise these rights without having their treatment effected.[57] Beneficiaries will have access to the enrollee rights through the member handbook.[58] The provider manual includes the steps the plan may take to address beneficiary grievances against providers who violate enrollee rights.

The rights are protections provided by the MOU and federal Medicare managed care regulations.[59] The inclusion of a list of enrollee rights is consistent with the recent CMS guidance requiring MLTSS states to include this protection.[60] The list of rights is extensive and includes the right to be treated with dignity, to access to an adequate network of providers, to have a voice in the governance and operation of the integrated system, to covered services detailed in the contract, to involve caregivers in treatment discussions and decisions, and to receive advance notice of a transfer to another treatment setting.[61]

Issues to consider:

- How is the enrollee informed of the grievance process if a provider or if the plan violates the rights detailed in this Appendix C?

CMS, State and Plan Coordination (Sec. 2.5H, p. 41-43, Sec. 3.1)

Beyond the care coordination promised in the demonstration, another major element of the initiative is better coordination among state agencies, CMS and the plans. The contract requires plans to implement a system to coordinate with federal, state and community agencies.[62] In addition, the plans are required to designate a liaison to work with the State Medicaid staff.[63]

Section 3 sets out extensive detail on CMS

54 Contract at §2.10.

55 Contract at §2.10.

56 Contract at 2.8A(4)(a).

57 Contract at 2.8A(4)(a).

58 Contract at 2.14(D).

59 Contract at Appendix C. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. §438.100, 42 C.F.R. §422 Subpart C, and the state Memorandum of Understanding (MOU).

60 CMS MLTSS Guidance at 4, *available at* www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.

61 Contract at Appendix C.

62 Contract at §2.5H.

63 Contract at §2.5H.

and State responsibilities. As explained in the MOU, the State and CMS will create a Contract Management Team. The team is responsible for monitoring contract compliance, and resolving issues with the plans. In addition, CMS and the

state will review, approve and monitor contracts and materials, and maintain systems to provide enrollment, disenrollment, and rating-category determination information.[64]

Conclusion

This summary provides an overview of the major consumer protections in the Massachusetts three-way contract. Consumer representatives should become familiar with the contract to better advocate for consumers and clients when the demonstration goes live. MMCO's publication of this contract is an important step in transparency. With access to this contract, consumer representatives can better understand the rights and responsibilities detailed in the contract.

However, the contract also demonstrates the extensive decisions the plan, CMS and State made about consumer care. While review of the contract after the fact is helpful, understanding the development of the contract and providing consumer feedback during the drafting process would help ensure the consumer perspective is a part of the final demonstration agreement.

For more information on dual eligible demonstration projects, visit NSCLC's dual demonstration website, www.dualsdemoadvocacy.org. The site contains information and tools to help state and national advocates be more effective in representing consumers through the planning and implementation of the demonstrations.

64 Contract at §3.1.

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