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February 16, 2012

Melanie Bella
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Mail Stop: Room 315-H
Washington, D.C. 20201

Dear Ms. Bella:

It is my great pleasure to submit the enclosed proposal for the Commonwealth of Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals. This proposal is the result of an extensive design process, including rich and robust stakeholder engagement, over the past two years. It reflects MassHealth's commitment to providing the highest quality, integrated, coordinated care, to individuals who are eligible for both MassHealth and Medicare.

This proposal builds on the Commonwealth's strong previous experience with integrated care models for dual eligible individuals, including Senior Care Options and the Program of All-inclusive Care for the Elderly. The proposed benefit package reflects the complex medical, behavioral health, and functional needs of our target population of dual eligibles ages 21-64 by including diversionary behavioral health services and community support services that are not currently covered by either MassHealth or Medicare. In addition, the key delivery mechanism - Integrated Care Organizations supporting a foundation of primary care practices to develop person-centered medical home core competencies – will support integrated primary care and behavioral health, team-based care and care coordination across all providers caring for a member.

We strongly believe that this demonstration will support better health outcomes for our members, improve quality, and reduce costs. Better coordination and management of care will result in improvements in chronic disease management, and better use of community-based support services. Under global payment, ICOs will have the flexibility to use resources in innovative ways that best meet the needs of specific members. No longer will the current lack of integration foster cost-shirting and underinvestment.

Our final demonstration proposal reflects recommendations and concerns voiced through our public comment process, during which time we held two public hearings and received more than 150 written comments from stakeholders. At your request, enclosed is a memo outlining the revisions MassHealth has made to the draft proposal in light of that input. Submission of this proposal is an important step in the partnership between MassHealth and CMS to improve care for dual eligible individuals. We look forward to continuing this important work with you.

Sincerely,

JudyAnn Bigby, MD

Enclosure

To:	**Melanie Bella**
From:	**JudyAnn Bigby, MD**
Date:	**February 16, 2012**
Re:	**Massachusetts' Demonstration to Integrate Care for Dual Eligible Individuals: Changes to the Proposal Based on Feedback from the Public Comment Period**

MassHealth posted a draft Demonstration Proposal to Integrate Care for Dual Eligible Individuals on our website on December 7, 2011 for a public comment period until January 10, 2012. We received roughly 152 written comments from members, and a wide range of providers, health plans, and community-based organizations that serve dual eligible adults ages 21-64. We also held two public hearings at which we received oral testimony from some 80 individuals.

A team of reviewers from MassHealth reviewed and discussed each comment, and revised the Demonstration proposal to address stakeholders' critical concerns and make overall clarifications, adjustments and improvements to the proposal. This memo provides a description of the key clarifications and changes that have been made to the draft Demonstration proposal.

1. Clarify the roles and responsibilities of the ICO as the single accountable entity

The revised proposal clarifies that accountability for access to all covered services lies with the Integrated Care Organization (ICO). In addition, the ICO will have to demonstrate existing or developing relationships with organizations that are knowledgeable about recovery models and behavioral health integration, and are expert in serving populations with unique challenges, such as homelessness. The document emphasizes that the financial incentive to innovate around care delivery and quality outcomes comes from the global payment to the ICO. ICOs will have flexibility to direct resources to innovative approaches that meet the needs of specific high-need, high-cost populations. They will also have flexibility to utilize alternative payment methods to incentivize quality, integrated care throughout their networks.

This clarification also recognizes that primary care providers are in the process of evolving into person-centered medical homes and health homes, and we will expect ICOs to support this evolution. As the single entity for accountability, the ICO is responsible for oversight of care team member qualifications and must provide support to further the expansion of primary care sites that can function as patient-centered medical homes and health homes that meet the needs of people with disabilities.

2. Require that ICOs contract with independent community based organizations for independent living supports and LTSS coordinators

The proposal revision emphasizes that access to LTSS for this population is critical and must be preserved through the ICO. We address comments from stakeholders that the previous draft proposal overly emphasized medical care and the medical delivery system for a target population that has significant functional and other non-clinical needs. The proposal now describes a requirement for ICOs to provide independent Long-term Services and Supports (LTSS) coordinators.

The revised proposal states that the ICO will provide an independent, qualified LTSS Coordinator to each member. ICOs will contract with community-based organizations (CBOs),

such as an Independent Living Centers (ILCs), Recovery Learning Communities (RLCs), Aging Services Access Points (ASAPs), Deaf and Hard of Hearing Independent Living Services programs, the ARC, or other key organizations expert in working with persons with disabilities, to provide staff trained specifically to serve as independent LTSS coordinators. ICOs must have no financial interest in any entity which provides LTSS coordinators.

The LTSS Coordinator will be part of the care team at the enrollee's discretion. The LTSS Coordinator will participate in an initial assessment of the member's functional and medical needs. This process will help identify all LTSS that a member needs to live and function independently in the community and make sure they are addressed in the member's care plan. For individuals enrolled in a Home and Community Based Services (HCBS) waiver, the LTSS Coordinator will connect the member's care team with their waiver case manager and services to ensure integration (see #5 below).

3. Strengthen member protections

ADA Compliance

MassHealth strengthened its language about expectations around ICO and provider compliance with the ADA, confirming that ADA compliance will be critical to the Demonstration's success. In particular, MassHealth recognizes that successful person-centered care requires physical access to buildings, services and equipment, and flexibility in scheduling and processes. MassHealth will require ICOs to contract with providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their enrollees, and communicate with their enrollees in a manner that accommodates their individual needs, including providing translators for those who are deaf and hard of hearing and those who do not speak English. MassHealth will continue its work with stakeholders, including an advisory committee, to identify learning opportunities, monitoring mechanisms and quality measures to ensure that ICOs and their providers comply with all requirements of the ADA.

Enrollment Process

The Demonstration proposal clarifies in several areas that communications to members about the Demonstration will be clear, specific, accurate, and easily understandable. Communications to potential members will highlight the benefits of enrollment in an ICO, the ICOs available to them, how members would access services and the member's rights and responsibilities through the enrollment process. MassHealth will confirm a member's choice of an ICO (or a member's choice to opt-out of the Demonstration), and provide clear information about how MassHealth will assign a member who does not make a choice to a particular ICO, all before coverage begins. This communication will again make clear that the member can still choose an ICO, change ICOs, or opt-out of the Demonstration at any time, and what the processes are for doing so.

A clarified feature of the Demonstration is that MassHealth expects to roll out enrollment so that not all eligible individuals will be enrolled at the same time. This will help ensure that MassHealth, Medicare, and the ICOs have sufficient capacity to work with members during their transition from FFS.

Continuity of Care

Members, their families, and advocates expressed a concern during the public comment period about continuity of care for members during and after the transition from FFS to an ICO. To mitigate some of these concerns, MassHealth revised the proposal to require ICOs to perform an initial comprehensive assessment of the member's strengths and needs within 90 days of the coverage effective date. Until that assessment and appropriate noticing of any changes to the

care plan are performed, the ICO must ensure access to a member's services and providers, at the same amount, type, and rate of payment that they were accessing in FFS. This includes allowing enrollees to access current providers, even if they are not in the ICO network. This will help ensure that members do not experience gaps or disruptions in their services before all of their needs can be assessed and addressed in their new care plan and the enrollee has the opportunity to contest any changes with which the enrollee disagrees

This change helps address a key concern of advocate groups that members would suddenly lose access to critical services and care providers upon enrolling in an ICO without warning or recourse.

Grievances and Appeals

MassHealth revised the proposal to clarify the ICOs' responsibilities around written and advance notification of adverse actions and other aspects of their internal appeals processes, including written decisions on internal appeals and information about the member's rights to external appeals. Additionally, MassHealth proposes that external appeals be heard by the MassHealth Board of Hearings. Aid pending appeal resolution at the Board of Hearings would be provided at the request of the member for any adverse action related to terminating or modifying ICO approved services or requests for reauthorization of services. Expedited internal and external appeals would be provided if requested. Further, MassHealth will work with stakeholders on the formation of an advisory group that includes members, family caregivers, advocates, state agency staff and others, which will monitor the Demonstration and review issues of care plan development, service authorization, access and appeals.

4. Recognize PCA, DME and Home Health as critical services

Recognizing the critical nature of Personal Care Attendant (PCA) services for many people in the target population, the revised draft clarifies the requirement of ICOs to provide self-direction as a choice for enrollees who need PCA services. The revised proposal describes the roles of the ICO, LTSS Coordinator, Personal Care Management (PCM) agencies, and Fiscal Intermediaries (FIs) in facilitating access to self-directed PCA services.

The revised proposal also notes the additional value that the Demonstration can bring to the delivery of needed Durable Medical Equipment (DME) and Home Health services. In FFS, these services are subject to different coverage rules and limitations by MassHealth and Medicare. Under the global payment, ICOs will be able to use resources flexibly to best meet the member's needs.

5. Propose certain services remain outside demonstration for HCBS waiver populations

The revised proposal acknowledges the significant challenges faced by the approximately 7,300 dual eligible members who are enrolled in Home and Community-based Services (HCBS) waivers that are operated by state agencies (the Department of Developmental Services (DDS), the Massachusetts Rehabilitation Commission, the Executive Office of Elder Affairs). Protecting this population from service disruption and confusion about coordination of LTSS that are critical to day-to-day functioning and safety is paramount. Therefore, the revised document proposes that:

- For individuals in HCBS waivers only, all waiver services and State Plan LTSS services managed by waiver case managers[1] will not be provided by the ICO.

- For those who are not in a HCBS waiver, the ICO will be responsible to provide all LTSS, coordinated by the independent LTSS coordinator, as those services will be part of the fully-integrated care model we are advancing.

ICO payments will be adjusted to exclude non-ICO covered LTSS for HCBS waiver participants to ensure there is no duplication of payment between the ICO and the state agencies. The independent LTSS Coordinator will play a key role in linking the member's waiver-based case management with the rest of the ICO-based care team.

Massachusetts expects that during this three-year Demonstration ICOs will build capacity, expertise, and provider networks such that, in the future, they might also be able to take increasing responsibility for the complete range of services relied upon by these most vulnerable populations.

6. Preserve access to critical services provided by state agencies

Some members of the target population have daily and intensive interactions with state agencies to help manage their complex care and ensure access to critical services. Stakeholders expressed significant concerns about changes in the delivery of these services and disruptions in care for these members. Therefore, MassHealth revised the proposal to exclude from the ICO delivery system and global payment certain fundamental services: Targeted Case Management (TCM) provided by DDS and the Department of Mental Health (DMH), and Rehabilitation Option services for certain members with serious and persistent mental health conditions provided by DMH. These services will remain outside the ICO delivery system, but members receiving these services will be enrolled in ICOs and receive other Medicaid and Medicare benefits. The independent LTSS Coordinator will play a key role in linking member's TCM and Rehabilitation Option services with the rest of the ICO-based care team.

Also, MassHealth will exclude from the Demonstration roughly 570 members (based on CY2008 data) of the target population residing in state-owned Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) who receive most of their care through DDS and for whom the Demonstration would not add significant value.

7. Provide more detail on development of the global payments to ICOs

Several stakeholders commented on the lack of specific information around the rate development process, how CMS and MassHealth will pay ICOs, and how ICOs will pay their network providers. While many of these are dependent on access to additional Medicare data, and will be based on forthcoming negotiations with CMS and ICOs, this information will be critical for ICOs to establish provider networks and stimulate innovation around care delivery, care management, and integration of services in a manner that produces quality outcomes for members.

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[1] These services are: HCBS wavier services, Adult Day Health, Adult Foster Care, Day Habilitation, Group Adult Foster Care, and Personal Care.

To address some of the stakeholder questions or concerns, MassHealth revised the proposal to outline the specific steps it will follow to develop the global payments, including more detail on the establishment and purpose of rating categories, a risk adjustment process that will incorporate member's functional status, and various risk mitigation strategies. The revised proposal establishes the ultimate goal that payments will align as best as possible with patient risk around functional status, utilization and cost. The revisions also clarify that savings adjustments built into the base data will not assume any provider unit cost reductions; that ICOs will have the flexibility to use alternative payment methods with network providers to incentive integration and improved quality; and that MassHealth, working with stakeholders, will enhance the precision of the payment development process over time.

8. Describe how integrated care will achieve savings

The revised proposal clarifies the features of the Demonstration that we expect will lead to cost-savings for Medicare and Medicaid. Having ICOs accountable for the overall care and care management of enrollees will promote more rational use of services than volume-driven payments in the current FFS system. Currently, the lack of alignment between Medicare and MassHealth coverage rules creates incentives for providers to shift costs by transferring patients from one service or setting to another. In addition to not serving members in the best way possible, this shifting increases both state and federal spending over time. In the current system, MassHealth is not able to share in the acute care savings that would result from investment in expanded behavioral health care, LTSS, community support services and network development. The effects are an underinvestment in these important cost-effective services, missed savings potential and missed opportunities to better coordinate care and improve health outcomes for members.

Specifically, the addition of care coordination and aligned financial incentives are expected to produce cost savings. Care coordination and integrated care management will support investments in preventive health care, and incentive investments to address issues before they escalate and require costlier interventions. The addition of diversionary behavioral health services will divert from more expensive acute and inpatients settings for behavioral health needs. Care coordination will support enrollees through transitions across care settings to ensure more highly desired, as well as more cost effective, options post-discharge. For example, well-coordinated transition support will provide timely management with discharge planners when an enrollee leaves an acute facility, allowing the enrollee, when appropriate, to return home with appropriate supports instead of being admitted to a more expensive nursing facility. These care coordination improvements will produce savings by reducing acute care admissions, readmissions, length of stay in psychiatric facilities and ER use.

9. ICO Service Areas

The final proposal states that ICOs will operate in service areas throughout the state as defined by MassHealth and CMS. MassHealth's draft proposal had indicated that ICOs would operate in five services areas throughout the state, congruent with the areas defined for the MassHealth managed care organizations (MCOs). Some commenters noted differences between Medicare service areas and MassHealth's MCO regions. This broader language will allow MassHealth flexibility in negotiating final terms of the demonstration with CMS. It remains MassHealth's goal to achieve statewide access to the duals demonstration.

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The attached Demonstration proposal reflects a balance of concerns and suggestions raised by a diverse group of stakeholders and others who submitted public comments. We are eager to advance this important initiative to the next stage, and look forward to continued engagement with stakeholders, and a collaborative partnership with CMS as we implement this innovative Demonstration.