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

PROPOSAL TO THE
CENTER FOR MEDICARE AND MEDICAID INNOVATION

STATE DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS

December 7, 2011

DRAFT for PUBLIC COMMENT

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This proposal was prepared with assistance from the University of Massachusetts Medical School, Commonwealth Medicine.

A. Executive Summary

Massachusetts has undertaken a series of strategic initiatives designed to enhance the existing MassHealth program and achieve comprehensive delivery system and payment reform in both MassHealth and the state's broader health care system. This Demonstration is one of those initiatives; it will fully integrate the delivery and financing of Medicare and Medicaid services for full dual eligible adults ages 21-64.[1]

Dual eligible individuals under age 65 have among the most complex care needs of any MassHealth or Medicare members, yet the current delivery system for this population strains, unevenly and inefficiently, to meet those needs. The Demonstration will provide comprehensive services that address enrollees' full range of needs, beyond currently covered standard Medicare and Medicaid benefits. It will ensure that the services are effective by delivering them in a setting of integrated care management and coordination based on a person-centered medical home (PCMH) model. And the Demonstration will employ a payment structure that realigns the conflicting incentives between Medicare and Medicaid.

Under the Demonstration, MassHealth and CMS will use combined Medicaid and Medicare funding to contract with Integrated Care Organizations (ICO), using a blended capitation financial arrangement, to provide integrated, comprehensive care for dual eligible adults under age 65. (See Appendix A for a glossary of terms and acronyms used in this proposal.) The ICOs will be accountable for the delivery and management of all covered medical and long-term services and supports (LTSS) for enrollees. ICOs will employ or contract with providers functioning as PCMHs that will deliver team-based integrated primary and behavioral health care to enrollees, and coordinate their care across providers. The ICOs also will arrange for the availability of care and services by specialists, hospitals, and providers of LTSS and other community supports. Integration will extend to all administrative processes, including outreach and education functions, customer service, and grievances and appeals. Enrollment in the Demonstration will be voluntary and will be supported by clear, useful and accessible information and facilitated by neutral and impartial enrollment brokers. Eligible members will have as wide a choice of ICOs as possible, the opportunity to preserve relationships with current providers and caregivers, and the ability to change plans or opt out of the Demonstration at any time.

MassHealth will continue to gather and incorporate stakeholder feedback and to work collaboratively with state agency and community partners serving dual eligibles during the implementation and operational phases of the Demonstration. MassHealth will monitor member and provider experiences through surveys, focus groups and data analysis, require that contracting ICOs develop meaningful consumer input processes in their ongoing operations, and measure and monitor the quality of service and care.

[1] "Full dual eligible" refers to Medicare beneficiaries who are eligible for full Medicaid benefits. "Partial dual eligibles" receive only Medicare premium and cost sharing assistance from MassHealth through the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individual (QI) programs.

Table A-1 Features of Demonstration proposal

Target Population	Full duals, ages 21-64 upon enrollment
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide (All Ages)	274,000 (CY 2008)
Total Number of Beneficiaries Eligible for Demonstration	109,636 (CY 2008)
Geographic Service Area	Statewide
Summary of Covered Benefits	• Medicaid State Plan • Medicare Parts A, B, D • Behavioral health diversionary services • Additional community support services
Financing Model • Is this proposal using a financial alignment model from the July 8 SMD? • Payment mechanism	 • Yes • Capitation
Summary of Stakeholder Engagement/Input (Provide high level listing of events/dates – Section D asks for more detailed information)	• 10 Stakeholder meetings – March 2010-October 2011 • RFI – March 2011 • 4 member focus groups – June 2011 • 8 State agency and external consumer group outreach sessions with dual eligibles – June-October 2011 • Duals website and email box
Proposed Implementation Date(s)	December 2012

Note: Table A-1 uses data from Calendar Year (CY) 2008, the most current and complete data now available. MassHealth and CMS have recently completed a data use agreement that will soon make CY 2010 Medicare data available to Massachusetts. MassHealth will update these figures with the new data and expects that the target population eligible for the Demonstration will be approximately 115,000 upon implementation.

B. Background

i. Barriers to address

Currently, care for dual eligible adults ages 21-64 lacks coordination between Medicare and Medicaid and among providers, is fragmented and unmanaged at the program level, is not person-centered, and is based on an inefficient fee-for-service (FFS) provider payment system. Further, eligibility and coverage rules vary between the two payers. This Demonstration seeks to eliminate barriers to efficient, high quality care and positive health outcomes for dual eligible adults, by

1) establishing person-centered, coordinated care;
2) increasing access to appropriate and cost-effective services; and
3) integrating various administrative processes for members and providers.

Person-centered, coordinated care

Medicare and Medicaid will spend a projected $3.85 billion in 2011 on health care for dual eligible adults ages 21-64 in Massachusetts.[2] However, most of these members do not receive coordinated care that is person-centered or collaboratively planned by a care team with knowledge about the specific needs of the member or the array of medical, non-medical and behavioral health services available to meet those needs. The lack of financed care management for this population may result in unmet needs, underutilization of community-based services that support long-term recovery, independence and disease management, and the utilization of contraindicated medications and therapies.

Access to the right mix of services

There is a great need for access to diversionary behavioral health services for dual eligible adults, and for integration of behavioral health care with medical care. Two-thirds (69 percent) of dual eligible adults considered for this Demonstration were diagnosed with a behavioral health condition. MassHealth-only members enrolled in managed care have access to a continuum of behavioral health services through the Commonwealth's MassHealth 1115 Demonstration, while most dual eligible adults have access only to the limited range of Medicaid State Plan inpatient and outpatient behavioral health services available through non-managed MassHealth FFS and Medicare. There is little coordination of behavioral health care with other medical and non-medical services.

In addition, while all dual eligible adults can access the community LTSS that are part of the Medicaid State Plan, the Commonwealth has identified that a broader range of LTSS and community support services would be effective for dual eligible adults enabling them to meet their functional needs.

Lack of access to needed services increases the reliance of dual eligible adults on less appropriate and more costly hospital-based care and institutional LTSS. The current misalignment of funding of care for dual eligibles exacerbates this barrier. If MassHealth were to enhance access to these services independently, additional costs would fall to Medicaid, while the savings from reduced acute care would mainly accrue to Medicare, making such care improvements financially unfeasible under current financing arrangements.

Administrative simplification for members and providers

Dual eligible members are often challenged and frustrated by the need to navigate more than one set of prior authorization, grievance and appeals processes for necessary services. Many dual eligible members who participated in focus groups noted difficulties understanding mailings from insurers and expressed dissatisfaction with the ability of customer service to resolve concerns.[3] Medicare and Medicaid offer different yet overlapping benefits, and send separate sets of notices to beneficiaries. Providers are faced with the administrative burden of seeking reimbursement from two different government programs with varying policies and procedures.

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[2] 2011 projection derived from national per capita estimates for dual eligibles from: MedPAC Report to the Congress: Aligning Incentives in Medicare. "Chapter 5: Coordinating the care of dual-eligible beneficiaries." June 2010, page 135.

[3] See Section D.i.a. for a description of these member focus groups.

An additional unintended consequence of multiple payers is the existence of parallel policies and procedures that encourage cost shifting among providers and payers. Under the current system, where care and payments for dual eligibles are not aligned, providers and payers can avoid costs by transferring members and associated costs between services and settings. This shifting can result in increased state and federal spending, further fragmented care not focused on a member's needs, and potentially negative health outcomes.

ii. Description of the population

This proposal focuses exclusively on full dual eligible Massachusetts residents between the ages of 21 and 64 at the time of enrollment in the Demonstration. (MassHealth intends to allow members to stay enrolled in ICOs when they turn 65.) In Calendar Year (CY) 2008, approximately 110,000 MassHealth members were part of this target population (see Table B-1). (Note that Massachusetts and CMS have entered into a Data Use Agreement that will provide more current data. Massachusetts expects the target population to number approximately 115,000 members at the time of implementation.) MassHealth's demographic analysis considered members who in CY 2008 were eligible for full Medicaid benefits under MassHealth Standard or CommonHealth, were enrolled in Medicare Part A and Part B, and did not have any other comprehensive coverage. Individuals enrolled in managed care, including the Program of All-inclusive Care for the Elderly (PACE) and Medicare Advantage, were excluded from the analysis; however, those members will have the option to change their enrollment to the Demonstration. Members of CommonHealth—an expansion program for working and non-working persons with disabilities that is authorized through the MassHealth 1115 Demonstration—are included in the target population because they have full MassHealth benefits that are identical to those provided under the Medicaid State Plan.

The target population used a variety of medical services and LTSS based on their acuity, functional status, waiver enrollment and care setting. Table B-1 (below) shows the diversity of the population according to their care setting and LTSS use. Over two-thirds of this population, 69.3 percent, did not use any institutional or home and community based LTSS. While individuals with serious mental illness (SMI) constitute 34.9 percent of the target population, a disproportionate number, 70.1 percent, of those receiving LTSS in an institutional setting have a diagnosis of SMI. This is in contrast to a more proportionate 36.0 percent of individuals receiving HCB LTSS who have a diagnosis of SMI.

Table B-1 Size of target population for Demonstration, CY 2008

CY 2008	Total	Individuals receiving LTSS in Institutional settings[1]	Individuals receiving LTSS in HCB settings only[2]	Individuals with No LTSS utilization
Target Population:	109,636	14,620	19,072	75,944
(% of Target Population)	(100%)	(13.3%)	(17.4%)	(69.3%)
Individuals under age 65:	109,636	14,620	19,072	75,944
(% of under age 65)	(100%)	(13.3%)	(17.4%)	(69.3%)
Individuals with Serious Mental Illness[3]:	38,247	10,246	6,858	21,143
(% of SMI members)	(100%)	(26.8%)	(17.9%)	(55.3%)
For each LTSS utilization category, percent of individuals with Serious Mental Illness[3]	34.9%	70.1%	36.0%	27.8%

[1] Individuals using Nursing Facilities/Homes, Intermediate Care Facilities, Skilled Nursing Facilities, Chronic Disease Hospitals, Psychiatric Hospitals, or Rehabilitation Hospitals for any length of stay during the year (CY 2008). Includes 5,026 individuals who used both institutional LTSS and HCB LTSS during the year; 3,746 (of the 5,026) had a diagnosis of Serious Mental Illness.

[2] HCBS waiver enrollees, and individuals using Adult Day Health, Adult Foster Care/Group Adult Foster Care, Day Habilitation, Home Health, Personal Care, Private Duty Nursing, or Targeted Case Management at any point during the year (CY 2008). Excludes those that also used Institutional LTSS.

[3] See Appendix A for description of Serious Mental Illness. Only target population individuals are included.

Table B-2 (below) provides CY 2008 distribution and spending data for the full population, and by HCBS waiver enrollment and care setting. The subpopulations in the table are not mutually exclusive. For example, an individual with serious mental illness and a substance use disorder is in the data for both subpopulations. The target population used $2.6B worth of services, with Medicare and Medicaid each paying $1.3B. The average combined spending was approximately $2,200 per member per month; however, there was significant variation around that average.

Highlights of Table B-2 include:

- Non-Waiver individuals residing in the community made up 88.0 percent of the total population and accounted for 74.9 percent of Medicare spending and 32.6 percent of Medicaid spending; about one-third (32,874 out of 96,522) had a serious mental illness diagnosis.
- Individuals that experienced extended episodes in institutional facilities made up 5.3 percent of the total population, yet accounted for over 20 percent of Medicare spending and nearly 30 percent of Medicaid spending; 39.8 percent had a diagnosis of a substance use disorder.

- HCBS Waiver enrollees made up 6.7 percent of the total population, and accounted for 38.8 percent of total Medicaid spending; 79.5 percent had a developmental disability.

Table B-2 Utilization and spending experience of Demonstration target population and subpopulations, by waiver enrollment and care setting, in CY 2008

Population[1]	Measure	Waiver Enrollment and Care Setting[1]			
		Non-Waiver Community	Institutional	HCBS Waiver Enrollees	All
Total Target Population	N (% of total) PMPM • Medicare • Medicaid Spending (% of total) • Medicare • Medicaid	96,522 (88.0%) $934 $403 $988M (74.9%) $426M (32.6%)	5,794 (5.3%) $4,158 $5,752 $269M (20.4%) $372M (28.5%)	7,320 (6.7%) $718 $5,890 $62M (4.7%) $507M (38.8%)	109,636 (100.0%) $1,092 $1,080 $1,319M (100.0%) $1,305M (100.0%)
Developmental Disabilities	N (% of column) PMPM • Medicare • Medicaid	10,315 (10.7%) $1,103 $888	1,829 (31.6%) $3,744 $8,851	5,821 (79.5%) $700 $6,526	17,965 (16.4%) $1,234 $3,557
Serious Mental Illness	N (% of column) PMPM • Medicare • Medicaid	32,874 (34.1%) $1,176 $583	3,561 (61.5%) $4,523 $3,997	1,812 (24.8%) $1,071 $6,038	38,247 (34.9%) $1,484 $1,175
Substance Use Disorders	N (% of column) PMPM • Medicare • Medicaid	28,206 (29.2%) $1,350 $480	2,305 (39.8%) $4,998 $3,330	326 (4.5%) $1,638 $4,880	30,837 (28.1%) $1,631 $745
Chronic Physical Conditions	N (% of column) PMPM • Medicare • Medicaid	39,779 (41.2%) $1,511 $475	3,796 (65.5%) $5,374 $4,403	1,845 (25.2%) $1,587 $5,993	45,420 (41.4%) $1,835 $1,035
3 or more Acute Inpatient Admissions in a calendar year	N (% of column) PMPM • Medicare • Medicaid % of spending (for column) • Medicare • Medicaid	3,916 (4.1%) $5,417 $940 24.3% 9.8%	2,188 (37.8%) $6,782 $4,921 62.5% 32.8%	171 (2.3%) $5,814 $5,961 18.7% 2.3%	6,275 (5.7%) $5,904 $2,467 31.9% 13.5%

[1] See Appendix A for definitions of subpopulations, and waiver enrollment and care setting classifications.

The data tells us that certain groups of members may particularly benefit from the Demonstration's care integration and enhanced services. Dual eligible individuals will draw on different parts of the integrated service package in order to meet their individual needs. Members with three or more inpatient admissions account for a disproportionate amount of spending: they represented less than 6 percent of the population but accounted for over 30 percent of Medicare spending. Almost 80 percent of those

frequently hospitalized had a diagnosis of serious mental illness or a substance use disorder. Behavioral health conditions affect a substantial portion of the population: over two-thirds of the target group had a diagnosis of behavioral health, including 35 percent that had a diagnosis of serious mental illness and 28 percent a substance use disorder. Compared to spending for the average community non-waiver member, spending for community non-waiver members with a diagnosis of serious mental illness was 26 percent higher for Medicare and 45 percent higher for Medicaid. Similarly, spending for members with substance use disorders was 45 percent higher for Medicare and 19 percent higher for Medicaid.

C. Care Model Overview

i. Proposed delivery system model

a. Integrated Care Organizations (ICO)

The Commonwealth seeks to add significant value to the current experience of dual eligible adults ages 21-64 through this Demonstration. The Demonstration will provide care in a PCMH, coordination of Medicare and Medicaid requirements and funding to eliminate program conflicts, support for members' needs, more efficient utilization of federal and state resources, and expanded benefits.

The key delivery mechanism in this Demonstration will be the ICO. [The term ICO is used in this proposal to mean either an insurance-based or provider-based health organization, notwithstanding any other uses of the term elsewhere.] ICOs will operate in five service areas throughout the state, congruent with the areas defined for MassHealth Managed Care Organizations: Central, Greater Boston, Northern, Southern, and Western. The target population is relatively evenly distributed across the five areas. The Commonwealth is considering how it may adjust geographic requirements in the case of ICO vendors specializing in serving certain subpopulations.

ICOs will be responsible for the delivery and management of all covered services (Medicare, Medicaid and expanded services) for each of its enrollees (see Section C.ii). ICOs will receive a global payment for carrying out this responsibility, with one portion of the rate coming from Medicare and one portion from MassHealth (see Section E.ii). The ICO will, in turn, make an enhanced payment per member (i.e. capitation or other alternative payment) to PCMH practices that will provide care as described in Section C.ii.a. The ICOs must have internal capacity or make contractual arrangements to ensure availability of all services in a member's care plan – including specialists, hospitals, providers of LTSS, home care and other community supports. The Commonwealth will encourage ICOs to explore alternative payment methods for services beyond those provided by the PCMH. ICOs will be required to demonstrate core competencies across disability types, and to maintain relationships with community-based organizations that focus on recovery and independence for people with disabilities, and with organizations expert in serving homeless persons and other populations with unique needs. Within these requirements, ICOs may have various organizational and financial arrangements. (See Appendix B.)

The care of every ICO enrollee will be anchored in a PCMH. PCMHs can be seen as the hub of the integrated care system and will coordinate care for ICO enrollees by providing leadership of care teams

that include providers both within and outside the PCMH's walls. ICOs will be required to contract with practices that operate as PCMHs, providing care and services with the following key features:

- Integrated primary and behavioral health care services
- Multi-disciplinary, team-based approach to care delivery
- Planned care
- Easy and flexible access
- Person-centeredness
- Care Coordination
- Clinical Care Management

PCMHs will be required to achieve National Committee on Quality Assurance (NCQA) PCC-PCMH Recognition at the Level 1 Plus standard or higher within the three-year Demonstration period.[4] Within this period, they must also maintain members' health information with a federally certified electronic health record (EHR) and be able to demonstrate progress toward Meaningful Use.[5]

The ICO's enhanced payments to PCMHs will support the necessary investments those practices will make to operate and deliver care in this manner. To the extent that there may be insufficient capacity of practices in the Commonwealth that are ready to begin operating as PCMHs, enhanced per member reimbursement will support practices to build medical home capabilities during the demonstration.

b. Provider networks

MassHealth will require ICOs to have provider networks with the capacity to provide enrollees, either directly or by subcontracting, the full continuum of current Medicare and Medicaid covered services, as well as the additional services covered under the Demonstration. In providing these services, ICOs and providers participating in the Demonstration must comply with the Americans with Disabilities Act (ADA) and will be required to assure their capacity to deliver services in a manner that accommodates the special needs of their enrollees. MassHealth will require ICOs to outreach to providers who have existing relationships with eligible members and who have demonstrated expertise in serving people with disabilities and complex medical needs. MassHealth will further require ICOs to continually enroll those interested providers that meet network requirements.

Each ICO will be required to include in its network providers with open panels that will accept new patients and that are multi-lingual and culturally relevant for the local community. MassHealth will further require that ICOs meet the standards for provider access in federal Medicaid managed care

[4] Level 1 Plus is the level that must be achieved by practices in the MA PCMHI. This is defined as achieving Level 1 recognition and passing certain NCQA standards with certain scores: Standard 1G The Practice Team – 75%; Standard 3C Care Management – 100%; and Standard 4A Support Self-Care Process – 50%.

[5] Massachusetts is supporting widespread adoption and meaningful use of federally certified electronic health record systems by providers across the Commonwealth through its participation in several Health Information Technology for Economic and Clinical Health (HITECH) Act initiatives and programs. Massachusetts enacted legislation in 2008 that requires providers to be competent in the use of EHRs by 2015.

regulations: that a network provide adequate access to all services covered under the ICO's contract, taking into consideration anticipated enrollment; geographic location; distance, travel time and means of transportation; and physical accessibility for members with disabilities. As part of its implementation planning, MassHealth will build on its experience with its Managed Care Organization (MCO) and Senior Care Options (SCO) programs and will work with stakeholders and CMS to define the specific criteria for "adequate access" to be incorporated into the ICO contracts. The contracts will require ICOs to report regularly on their adherence to the established criteria.

MassHealth will require ICOs to have a clear continuity of care process that allows qualified and willing providers, who already serve eligible members wishing to maintain that relationship, the opportunity to join the ICO's provider network. MassHealth is also considering, under certain defined circumstances, requiring ICOs to offer single-case out-of-network agreements to providers who are currently serving members and are willing to continue serving them at the ICO's in-network payment rate, but who are not willing to accept new patients. The advantage of using out-of-network providers to encourage continuity of care needs to be balanced with the advantages of the enhanced information sharing and coordination of care possible within the contracted provider network. In all cases, whether members continue with current providers or transition to new ones, the ICO will be responsible for ensuring continuity of care. MassHealth is still gathering stakeholder input on this issue.

Each ICO will be responsible for management of its network, including credentialing and re-credentialing providers, establishing and tracking quality improvement goals, and conducting site visits and medical record reviews. The ICO will be responsible for ensuring that a sufficient number of appropriate providers, including community-based LTSS providers, are available to deliver all covered services to the ICO's anticipated enrollees.

c. Enrollment methods

MassHealth proposes a voluntary opt-out enrollment process. This will be the underpinning of MassHealth's efforts to enroll as many eligible members as early as possible in the Demonstration. The Demonstration will require a sufficient volume of enrollees over the Demonstration period to attract enough ICOs to give members choice, and allow evaluators to adequately assess the effectiveness of the innovations. MassHealth recognizes that some dual eligible members with complex care needs may be hesitant to embrace managed care, possibly because of a lack of awareness regarding the availability and benefits of integrated care, fears about losing autonomy and access to their existing group of providers and other caregivers, or for other reasons. MassHealth will continue the work it has started with members, stakeholders and state agency partners to develop mechanisms that will alleviate members' concerns and produce an effective, responsive enrollment process.

MassHealth will develop a transparent enrollment process that respects member preferences and choice, maximizes continuity of care, and provides clear information and comprehensive member protections. Massachusetts will focus on developing clear and accessible information about ICOs to support member enrollment decisions, including whether members' doctors and providers are in the ICO networks and the benefits they can access through an ICO. MassHealth and/or the federal government will contract with neutral and impartial enrollment brokers to help deliver this information

to potential enrollees. The brokers will be oriented toward member interests, not the interests of ICOs or providers. MassHealth expects to use its customer service contractor as an impartial enrollment broker, and is reflecting that expectation in a customer service re-procurement process now underway. Members will be given sufficient time to make an informed choice about enrolling in an ICO. Once members are enrolled, the ICO will take steps to maximize continuity of care as enrollees transition to accessing care through the ICO.

MassHealth intends to conduct outreach and hold information sessions with a broad range of community-based organizations, state agencies and providers with which dual eligible members have existing trusted relationships. MassHealth is particularly interested in partnering with or modeling programs that can supplement impartial enrollment broker resources for members with specific needs around mental health conditions and developmental disabilities. SHINE (Serving the Health Information Needs of Elders) is an example of a program that provides unbiased health insurance information to 60,000 Medicare members per year, including non-elderly people with disabilities. The Commonwealth will partner with community organizations familiar with younger dual eligible adults to replicate this model for members with all disability types.

All dual eligible members will have the opportunity to opt out of the Demonstration. MassHealth will offer sufficient advance notice and information to help members select an ICO in the member's geographic area, or choose to remain in the FFS system, effectively opting out of the Demonstration. If the member does not select an ICO or decline enrollment within a prescribed time frame, MassHealth will assign the member to an ICO. MassHealth will confirm the member's choice of an ICO, or ICO assignment, before coverage begins. The Commonwealth proposes that there be no lock-in period and that members may change ICOs within the Demonstration, or select the FFS option, at any time. When the member expresses a desire to change ICO or to opt out, MassHealth will provide clear, useful and accessible information about those procedures.

MassHealth is committed to preserving members' desired connections to current providers and supports in the Demonstration. When selecting an ICO, members will have information about each ICO's provider networks and whether they include the member's current providers. Because this is a statewide Demonstration, MassHealth is optimistic that most of the providers with whom members have existing relationships will be included in the provider networks of one or more of the ICOs. To make that more likely, MassHealth will undertake an outreach effort to educate providers currently serving the eligible population and will hold ICOs accountable for continuity of care, as described in Section C.i.b.

The details of the enrollment process will be clearly described in the ICO contracts with MassHealth and CMS, in any agreements between MassHealth and CMS, and in state regulations.

Outreach and Marketing

MassHealth intends to promote participation in the Demonstration through extensive and appropriate outreach and marketing activities that highlight the benefits of enrollment while protecting members from deceptive marketing practices and misinformation. To ensure effective communication about the

availability of the Demonstration to people with disabilities, outreach and marketing activities will incorporate appropriate auxiliary aids and services that facilitate effective communication. MassHealth looks forward to working with CMS to develop the marketing protocols for the Demonstration.

MassHealth will partner with ICOs and other vendors, advocates, state agencies, community agencies and other stakeholders to increase awareness of the Demonstration's benefits through a variety of media such as community forums, direct mailings, print and visual media, and advocate and provider forums.

MassHealth will require ICOs to develop a comprehensive marketing plan and submit it to MassHealth and CMS, initially for approval and at least annually thereafter. ICOs' contracts will prohibit them from direct marketing to members and from distributing any marketing material that has not been pre-approved by CMS/MassHealth, or that is inaccurate or false or that misleads, confuses, or defrauds the recipient.

ii. Benefit design

a. Person-centered Medical Home (PCMH)

Each ICO enrollee will choose his or her PCMH. PCMHs will provide integrated primary and behavioral health care services, accomplished through co-location of practices, the placement of a behavioral health clinician in a primary care setting, the placement of a primary care clinician in a behavioral health practice, or an alternative arrangement. The PCMH must provide evidence-based primary care services[6], and, at a minimum: routine screening for depression and other behavioral health conditions in enrollees without a behavioral health diagnosis; and evidence-based treatment and support for enrollees with behavioral health conditions that can be managed without higher levels of care. The ICO will ensure that PCMHs have access to behavioral health providers, including providers of diversionary services, and community-based resources to which enrollees can be referred or with which the PCMH can consult. The PCMH will provide care coordination and management services to support the enrollee across care settings.

PCMHs will provide a multi-disciplinary, team-based approach to care delivery with the enrollee playing the central role in assembling his or her care team. A typical PCMH care team may consist of a lead primary care or behavioral health clinician, and other supporting clinicians, as well as community health workers. This typical team will need to be expanded or adjusted to support a given enrollee's person-centered plan of care. The PCMH must have the infrastructure and systems to support expanded care

[6] Primary care incorporates initial and ongoing assessment to identify a member's conditions and service needs including medical diagnosis and treatment; communication of information about illness prevention; health maintenance; and referral services when necessary. Assessments include physical status and behavioral health screenings; documentation of clinical history, including medications; strengths, preferences or limitations; functional status; activities and instrumental activities of daily living, goals and life planning activities; cultural and linguistic need; existing formal supports; and informal caregiver resources. Based on those assessments, primary care practices offer treatment or other appropriate supports, and assist with referrals for specialty and/or community-based services and coordination across providers and settings.

teams as needed and appropriate for the member. The PCMH will establish a single medical record which will enable the core care team to manage communication and information flow regarding clinical referrals, transitions of care, and care delivered outside of the PCMH (with the member's approval for access outside the PCMH). Each care team member will have a defined role appropriate to his or her licensure and relationship with the enrollee, but collectively the team will share responsibility for delivering care that meets the enrollee's needs. The enrollee may choose to involve other key individuals as important contributors to his or her care, such as peers, family and other informal caregivers, advocates, social workers or case managers.

The enrollee, the care team, and the Care Coordinator (described below) will work together to establish a care plan for the enrollee. Individualized care plans typically include a summary of the person's health history including any current diagnoses and interventions (both medical and non-medical); a prioritized list of main concerns and goals with the current clinical, educational, and/or social information pertinent to the concern or goal; the current plan for addressing that concern or goal; the person(s) responsible for that intervention; and the due date for the intervention.

The care plan will include regularly scheduled appointments with the care team, ensuring planned encounters rather than episodic, reactive care. The care team will be informed and ready to address the enrollee's needs holistically whenever he or she makes contact, and will follow up with enrollees after encounters, as necessary. The enrollee will have easy and flexible access to the care team, including alternatives to face-to-face visits, such as email and telephone.

Most importantly, care in the PCMH will be person-centered, meaning that it is built on enrollees' expressed preferences and needs, and is delivered with transparency, individualization, recognition, respect, linguistic and cultural competence, and dignity. PCMHs must have an ongoing focus on the enrollee, working with them to define their care goals and direct their care, and regularly soliciting their feedback on the practices' execution of that vision. Enrollees will have an active role in their own care, supported by the care team. The care team is responsible for educating enrollees about the PCMH concept and the enrollees' role, responsibilities and rights within it, using culturally relevant and understandable materials. Enrollee education also includes health literacy to improve enrollee-provider communication and information on primary preventive care and self-management of chronic illness. The PCMH will ensure that its workforce is culturally competent and has training to work with and address the needs of the diverse population of dual eligible members.

Care Coordination and Clinical Care Management

PCMHs will support enrollees who need or have complicated services and supports arrangements, or who have complex needs that influence their health and well-being. They will offer two types of care coordination and management:

- Care Coordination to ensure effective linkages and coordination between the PCMH and other providers and services that may be needed and accessed by the enrollee; and
- Clinical Care Management for those with complex medical needs, such as several chronic conditions.

Care Coordination

Care coordination is central to the delivery system improvements that are a major part of the enhanced value of this Demonstration relative to the FFS system. PCMHs will devote specific resources to ensuring effective linkages and coordination across the spectrum of care delivered to a given enrollee.

PCMHs will provide a Care Coordinator to serve on the enrollee's care team. The Care Coordinator and enrollee will work together to determine the enrollee's needs and medical and non-medical care options. The Care Coordinator will help the enrollee access services and will facilitate bringing together the care team, including providers outside of the PCMH, to develop a person-centered care plan. The Care Coordinator will seek the enrollee's direction in bringing together the appropriate members of the care team.

The Care Coordinator will work with the enrollee and the care team to develop and maintain the enrollee's care plan, coordinate activities and critical information sharing among members of the care team, and perform other activities, including:

- assuring that referrals made by the PCMH result in timely appointments and timely two-way transmission of useful member information, and that such referrals address enrollee and PCMH concerns without duplication or provision of inappropriate services;
- managing and tracking tests, test results, assessments, referrals and outcomes;
- obtaining reliable and timely information about external services not initiated by the PCMH, such as emergency, enrollee-initiated, or other provider-initiated care in order to provide and receive patient information, and to assure safe and effective transitions across care settings;
- providing linkages to covered community-based services as necessary;
- identifying available community resources other than covered services, and communication to/education of enrollees about such resources;
- assisting the enrollee to develop wellness strategies, and self-management skills to effectively access and use services;
- providing all of these services to the enrollee on a temporary, intermittent, or ongoing basis, depending on the nature of the enrollee's needs and preferences.

Clinical Care Management

In addition to care coordination, PCMHs will provide clinical care management services to enrollees for whom intensive clinical monitoring and follow-up may be beneficial. Enrollees with many prescription medications or one or more chronic health conditions, or those who are assessed to be at high risk of hospital or nursing facility admission, emergency department use, or loss of independence will be likely candidates for these services. The goals of clinical care management are to:

- improve enrollees' functional health status;
- ensure high quality, evidence-based and efficient medical care;
- enhance coordination across specialties and settings;
- eliminate duplication of services;
- reduce avoidable medical complications and hospitalizations; and

- avoid complications due to drug interactions.

Clinical care management includes:

- assessment of the clinical risks and needs of each enrollee;
- medication review and reconciliation;
- medication adjustment by protocol;
- enhanced self-management training and support for complex clinical conditions, including coaching to family members if appropriate; and
- frequent enrollee contact as appropriate.

The Clinical Care Manager will be on the enrollee's care team, and will work closely with all the other medical and non-medical staff on the team to ensure that the enrollee's complex clinical care is part of his or her overall care plan.

b. Covered Services

The Demonstration will include all services to which dual eligible members are entitled through both Medicare and the Medicaid State Plan. The robust package of covered services will be fully managed, coordinated and authorized through the ICO and its PCMHs. Locating care decisions at the point of the PCMH care team ensures that services are directed toward the unique needs of the ICO enrollee. The ICO will determine the utilization management tools, including any prior approval requirements, for all services provided by the ICO and its provider network, and will have procedures for determining what is a medically necessary service, according to a plan approved by MassHealth and CMS. The ICO will be required to have written and accessible internal policies with regard to grievances and appeals of denials, terminations, reductions or suspensions of covered services. Those internal processes will be subject to further appeal through mechanisms developed by MassHealth and Medicare to ensure protection of all enrollee rights to entitled services.

The Demonstration's benefits are structured to bring added value to the services available to dual eligible members. The Demonstration will replace the distinction between Medicare and Medicaid services with a single robust benefit package that integrates currently covered Medicare and Medicaid services with additional behavioral health diversionary and community support services. ICOs will be required to include certain services within their benefit plans and will have the flexibility to use a range of other services as substitutions for or means to avoid high-cost traditional services.

Medicare and Medicaid State Plan Services

All Medicare-covered Part A (inpatient, hospice, home health care), Part B (outpatient), and Part D (pharmacy) services, and all Medicaid State Plan services will be included in the capitated payment to the ICO. (See Appendix C, Table A.) The ICO will manage and fully integrate the combined inpatient, outpatient, and pharmacy services covered by Medicare and MassHealth in a seamless manner, eliminating administrative burden and delays for both enrollees and providers in arranging for and accessing care. Standards used by the ICO must be written and approved by Medicare and MassHealth to ensure that entitled benefits from both programs are delivered.

Modifications to Existing Services

MassHealth proposes that the ICO's benefit package bring with it not only those State Plan services as they are currently covered, but also expansions of certain State Plan services. These include: preventive, restorative, and emergency oral health (dental) benefits; personal care assistance that includes cueing and monitoring (including access to MassHealth's fiscal intermediary contracts to support self-direction for enrollees who wish to access personal care services in that manner); a durable medical equipment benefit that includes training in equipment usage, equipment repairs, modifications, and environmental aids and assistive/adaptive technology; vision services which would allow the ICO to contract with vision care providers of its choosing for examination, treatment and eyeglasses; and non-medical transportation. MassHealth's stakeholder discussions and member focus groups identified these as areas where enrollees would see real added value in the ICO's benefit package. (See Appendix C, Table B.)

Additional Coordinated Behavioral Health Diversionary Services

Currently both Medicare and Medicaid State Plan covered behavioral health services rely heavily on acute psychiatric hospitalization, limited outpatient treatment, and pharmacy. The Commonwealth's experience is that offering coordinated behavioral health diversionary services for members with serious mental health and substance use disorders is critical to improving quality of care and redirecting care from expensive, ineffective patterns. Further, it is also important to ensure 24/7 staff availability to authorize certain behavioral health services. MassHealth has the opportunity through the ICOs to integrate medical care with non-medical, recovery-based interventions, using peers and non-medical staff to support enrollees in connecting with community-based resources that will help stabilize them and advance their life objectives as well as provide real alternatives to hospitalization, emergency room dependency and cyclical crises.

Sixty-nine percent of the eligible population received a diagnosis related to behavioral health in CY 2008. The Commonwealth seeks to offer diversionary behavioral health services and recovery-focused community-based mental health and substance use services to dual eligible members through the ICO. Diversionary services include: community crisis stabilization; community-based acute treatment services for substance use disorders; community support services; partial hospitalization; structured outpatient addition programs; Programs of Assertive Community Treatment (PACT) for community-based psychiatric treatment; and intensive outpatient programs. (See Appendix C, Table C.)

Additional Community Support Services and Community Health Workers

Dual eligible members ages 21-64 are a diverse group of individuals: culturally, linguistically, ethnically, and with regard to primary disabling conditions and the constellation of chronic illnesses and secondary medical and non-medical concerns. The Demonstration will address this diversity in an appropriate and cost-effective way. ICOs must employ trained non-medical community health workers, either directly or through contract, to support PCMH practices to implement care plans with regard to: wellness coaching to engage the enrollee in prevention activities (smoking cessation, exercise, diet, screenings, etc); evidence-based practices and techniques for chronic disease self-management; peer support for mental health and substance use disorder recovery activities and for other disabling conditions as appropriate.

The Commonwealth proposes that the ICO provide certain community support services in addition to those covered under the State Plan, as alternatives to costly acute and long-term institutional services. These expanded community support services include: day services; home care services; respite care; peer support; transitional assistance across care settings; home modifications; health coaching; and medication management. Some of these community-based services may be provided by non-clinical peers and community health workers. The ICO will be required to include community-based service providers in their networks to ensure the effective use of LTSS that advance the independence of enrollees, redirect care away from long-term institutional settings, and help maintain enrollees' tenure in the community. The Commonwealth proposes that ICOs have the flexibility to provide all of these services, and others as identified by the care team, as substitution services for high-cost traditional Medicare and Medicaid service options. Massachusetts believes that this flexibility will enable ICOs to better work with members to avoid or transition from acute and long-term care inpatient settings. (See Appendix C, Table D.)

iii. Evidence-based practice

A key element of the PCMH model is providing care that is organized and evidence-based. This starts with ensuring that interactions between an enrollee and his or her care team are planned, so that the care team can best meet the enrollee's needs and has adequate time during visits to give care that evidence suggests is most effective.[7] In addition, PCMHs will be accountable to the ICOs to employ clinical guidelines-based decision support tools or other mechanisms that guide evidence-based care. These tools may include electronic medical record-based informational alerts and reminders to follow evidence-based guidelines.

MassHealth will expect PCMHs to apply well-established national, and Massachusetts-specific, evidence-based clinical practice guidelines relevant to populations with chronic conditions, such as guidelines relating to the detection and ongoing management of diabetes, depression, chronic obstructive pulmonary disease (COPD) and asthma. However, rigorous evidence is not available to inform all health decision making, and enrollees with complex needs may require flexibility in treatment approaches. In developing person-centered care plans, evidence-based practice will be appropriately balanced by an approach to care that takes account of enrollees' needs.

iv. Context of other Medicaid initiatives and health care reform

This Demonstration is a key component of a series of strategic initiatives designed to enhance the existing MassHealth program and achieve comprehensive delivery system and payment reform in both MassHealth and the state's broader health care system. Through these initiatives, Massachusetts seeks to ensure access to appropriate services, integrate comprehensive services at the person level, improve care coordination, and create payment systems that provide proper incentives, encourage flexible, responsive care as well as hold providers accountable for the care they deliver. Massachusetts aims to reward quality care, improve health outcomes, and more effectively spend health care dollars.

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[7] Safety Net Medical Home Initiative. Austin B, Wagner E. Organized, Evidence-Based Care Implementation Guide: Planning Care for Individual Patients and Whole Populations. 1st ed. Burton T, ed. Seattle, WA: The MacColl Institute for Healthcare Innovation at the Group Health Research Institute and Qualis Health, March, 2011.

a. Current Medicaid waivers and/or state plan services available to this population

Dual eligible members ages 21-64 are eligible for all Massachusetts Medicaid State Plan services. This population, with the exception of dual eligibles who are institutionalized or participating in PACE, is also enrolled in the Commonwealth's 1115 MassHealth Demonstration. Through the 1115 Demonstration, MassHealth provides streamlined eligibility; managed primary, acute, and behavioral health care (excluding dual eligible adults); and subsidies for low income individuals up to 300% FPL to purchase insurance through an exchange. Approximately 7,300 members of this population are also eligible for an expanded package of HCBS waiver services and supports through their enrollment in one of the state's existing HCBS waivers for adults with developmental disabilities or brain injury, or for frail elders ages 60 and older. Others may be eligible for these services through one of the two HCBS waivers that are planned as part of Massachusetts' Money Follows the Person (MFP) demonstration.[8] MFP enrollees also will have access to MFP Demonstration Services, which include Assistive Technology, Transitional Assistance Services, Case Management, and Mobility Training, as needed.

Under the Demonstration, enrollees will continue to access all Medicaid State Plan services to the extent they are medically necessary and desired, either solely or in combination with Medicare-covered primary care, acute and post-acute services. They also will have access to certain community-based supports currently covered only through the HCBS waivers and, for the first time, behavioral health diversionary services designed to keep individuals out of more costly emergency departments and inpatient treatment facilities and help them better function in the community. Currently, only MassHealth members under age 65 who are not living in a facility and who do not have third party coverage (including Medicare) can access behavioral health diversionary services through the 1115 Demonstration's managed care products. Dual eligible adults are thus precluded from accessing these services.

Demonstration enrollees who are enrolled in one of the existing HCBS waivers will continue to be enrolled in those waivers, as not all of the services covered under those programs will be covered through this Demonstration. Offering the full range of HCBS waiver services for all Demonstration enrollees is neither necessary nor affordable. For those enrolled in a HCBS waiver, though, it is possible that, within the three-year period of the Demonstration, ICOs may not be able to replicate the extensive and fundamental LTSS needed by these specific populations, or to add sufficient value for these members. The Commonwealth therefore seeks consultation with CMS on the feasibility and desirability of offering a different benefit "tier," which includes access to a PCMH and all other ICO services, except LTSS, for those Demonstration enrollees who are enrolled in HCBS waivers.

Specifically, Massachusetts proposes to examine a model in which persons with intellectual disabilities or brain injury, or frail elders ages 60 to 64, who use HCBS waiver LTSS that are managed by state

[8] As part of its Money Follows the Person demonstration, MassHealth plans to implement two new 1915(c) waivers in July 2012 that will include the behavioral health diversionary services.

agencies, could continue to access those services through current arrangements so as not to disrupt essential care. With this option, HCBS waiver participants would enroll in the ICO and continue to receive LTSS and case management through the operating agency of the HCBS waiver. The ICO's capitation rate would be adjusted to exclude these designated services. The ICO would remain fully responsible for all other aspects of the enrollee's care, and would be required to consider the enrollee's state agency waiver service plan in his or her care plan, and to include the waiver case manager on the care team, if that is agreeable to the parties.

b. Existing managed long-term care programs

Massachusetts operates two managed long-term care programs, SCO and PACE, which are described in Section C.iv.d.

c. Existing specialty behavioral health plans

Through its 1115 Demonstration authority, MassHealth operates a specialty behavioral health plan for non-institutionalized enrollees under age 65 without third party coverage in its Primary Care Clinician (PCC) plan. Through this managed care program, PCC plan members—including many adults with disabilities— receive all of their behavioral health services, including community-based diversionary behavioral health services, on a capitated basis through a single behavioral health contractor. The 1115 Demonstration also requires MassHealth's contracted Managed Care Organizations (MCO) to provide a full range of behavioral services, including diversionary services, through their provider networks.

A major added value of this Demonstration will be that ICO enrollees will be able to access the broad array of behavioral health diversionary services that are currently offered only to non-dual eligible members through those other programs. MassHealth will require that ICOs ensure access to behavioral health services through integration in the PCMH, active care coordination and linkages to appropriate behavioral health service providers. These services will be included in the ICO's capitated payment. Integration of behavioral health and medical care for the 69 percent of MassHealth dual eligible adults who have a diagnosis of mental illness or substance use disorder will support more effective care and avoidance of inpatient psychiatric or other expensive treatment.

d. Integrated programs via Medicare Advantage Special Needs Plans or PACE programs

The Demonstration builds on Massachusetts' experience with its SCO and PACE programs, two existing capitated integrated care programs primarily for older dual eligible members. Because the Demonstration is tailored to the needs of non-elderly dual eligible members, key features differ, including the care coordination model, care team composition and covered services and supports.

PACE was implemented in Massachusetts in 1990 and serves non-institutionalized individuals ages 55 and over; Massachusetts currently has six PACE programs. Because of the age overlap between PACE and the Demonstration, some individuals ages 55-64 may be eligible for both programs. SCO was implemented in 2004 and currently enrolls over 18,000 low-income elders ages 65 and older. Like PACE, SCO is a comprehensive, integrated and coordinated managed care plan that includes all services

covered by Medicare and MassHealth. Massachusetts' four SCOs operate concurrently as Medicare Advantage duals special needs plans (D-SNPs) and Medicaid Managed Care plans.

e. Other payment/delivery efforts underway in the state

The Demonstration is a fundamental component of a Patrick-Murray Administration strategy to transform the Commonwealth's health care system. In 2006, Massachusetts enacted Phase I of health care reform in the state.[9] The state's health care reform law expanded access to insurance coverage to over 98 percent of the population through public coverage expansions and insurance market reforms, and set the stage for Phase II of health care reform with the creation of the Health Care Quality and Cost Council (HCQCC).

Phase II of health care reform in Massachusetts focuses on innovative delivery system and payment reforms designed to improve quality of care, expand access to care coordination and enhance accountability, and to stem rising health care costs.[10] In October 2009, the HCQCC released *The Roadmap to Cost Containment*, which envisions a redesigned health care delivery system with the appropriate structure, incentives, and regulatory tools to promote these needed changes. The Roadmap outlines a system where patients have access to safe, high-quality, and effective patient-centered care that is affordable and equitable.

Other key initiatives that are aligned with the Demonstration to achieve this transformation include the Patient-centered Medical Home Initiative (PCMHI), the development of accountable care organizations (ACOs), the implementation of the Money Follows the Person (MFP) rebalancing demonstration, bundled payment pilots in MassHealth, and exploration of the health homes Medicaid State Plan option. Most of these reform initiatives are supported by opportunities in the Patient Protection and Affordable Care Act (ACA). The Patrick-Murray Administration is promoting a shift from FFS to global payments across the entire Massachusetts health care system, using ACOs as the foundation. The Administration filed legislation earlier this year to put the Commonwealth on that path. The structure of this Demonstration, with ICOs compensated by a global payment and accountable for an enrollee's overall health and care, are an important component of this approach.

The MFP demonstration will lay a foundation to expand access to LTSS and to build expertise around transitioning people with disabilities or functional limitations from facility settings to less restrictive community based settings. ICOs will provide a new delivery system option for MFP participants to transition to community based settings. All entities that bid to provide integrated care under the Demonstration must be built on a foundation of primary care practices that adopt Massachusetts' PCMHI model. The Commonwealth seeks to engage a broad range of prospective bidders to be ICOs, including those that may serve a particular enrollee population, reflecting both the history of successful managed care and the aspirations for new models of service delivery and payment reform. In addition,

[9] Chapter 58 of the Acts of 2006.

[10] Chapter 305 of the Acts of 2008.

the Commonwealth is also working with CMS through its MassHealth 1115 Demonstration to create a model that uses incentive payments to transform safety net hospitals and their networks into integrated delivery systems that improve care, improve population health, and reduce spending.

The elements of this Demonstration proposal are consistent with approaches in CMS initiatives or demonstrations, such as health homes, Medicare ACOs, multipayer advanced primary care practice demonstrations, and demonstrations to reduce preventable hospitalizations among nursing home residents.

D. Stakeholder Engagement and Beneficiary Protections

i. Engagement of stakeholders in design phase

Massachusetts has actively engaged a broad representation of internal and external stakeholders in the planning and development phases of its integrated care model for dual eligible individuals ages 21-64. Massachusetts has used several key activities to gather and incorporate stakeholder feedback on the design of the model, including member focus groups, state agency consumer meetings, a Request for Information (RFI) and analysis of the responses, the development of a "Duals" web site and email box, ongoing open stakeholder meetings, and a public comment period for the Demonstration proposal. The Commonwealth will ensure that stakeholder input continues to inform the design, implementation and operation of the Demonstration, and that ICOs develop and incorporate meaningful consumer input processes into their ongoing operations. (See Section D.iii.)

a. MassHealth Member Input during the Design Phase

Massachusetts obtained critical feedback on member care experiences and the opportunities and concerns around an integrated care model from four "cross-disability" focus groups and several "disability-specific" state agency consumer meetings. MassHealth conducted the four focus groups with a total of 40 dual eligible members, selected randomly from the MassHealth caseload. The focus groups were conducted in June 2011 in areas that varied in geographic location, population density and primary language.[11] Massachusetts also conducted a series of state agency and external consumer group outreach sessions with dual eligible members with specific disabilities (e.g., mental health disabilities, development disabilities, and physical disabilities) from June through October 2011. The substantive feedback MassHealth obtained through these activities echoed one another and provided critical information on members' understanding of and confusion about Medicare and Medicaid covered services, access to and receipt of services, unmet need, care coordination and care management, care team composition, administrative complexities and the benefits of an integrated model from members' perspectives. A summary of the member focus group results was presented at our July 21, 2011 stakeholder meeting, and is posted on the Demonstration's web site at www.mass.gov/masshealth/duals. This feedback was essential to shaping the design of Massachusetts' model and Demonstration proposal. For example, members expressed frustration that mailings and

[11] MassHealth held the four focus groups as follows: on June 2 in Boston, June 9 in Greenfield (rural site), June 16 in Fall River, and June 23 in Lawrence (Spanish-speaking).

other official information was confusing, too long and often duplicative. Based on this feedback, MassHealth plans to place particular emphasis on working with stakeholders to improve its communication with members. In response to widespread concerns about limited access to dental services, MassHealth plans to expand those services as part of this Demonstration.

b. Broad Stakeholder Input during the Design Phase

Massachusetts also solicited broad stakeholder input on the design of the Demonstration through a Request for Information (RFI) issued in March 2011. The state received 55 responses to roughly 45 questions, which were analyzed and synthesized into a summary document. Both the RFI and the summary of responses are posted on the Demonstration's web site (www.mass.gov/masshealth/duals). The RFI was organized into questions for all interested parties and questions for potential ICOs. This enabled the Commonwealth to obtain comprehensive input on diverse topics, including:

- Features that would make the integrated care model attractive to and encourage member enrollment;
- Specific services that would be critical to addressing the needs of enrollees;
- Key quality metrics;
- Necessary linkages among participating ICOs, community-based organizations and state agencies;
- Opportunities for Medicare-Medicaid alignment;
- Provider capacity and network management issues;
- Optimal financing structures and risk sharing arrangements;
- Eligibility and enrollment policies; and
- Data reporting and data exchange requirements.

c. "Duals" Web Site and Email Box

Massachusetts created a web site dedicated to its integrated care initiative on which are posted all stakeholder meeting announcements and agendas, prior meeting presentations, materials and summary notes, the RFI Summary Analysis and other related information (www.mass.gov/masshealth/duals). The web site and all written meeting materials direct all interested parties to a dedicated email address (Duals@state.ma.us) if they have any questions, comments or concerns about the Demonstration. The email box is monitored daily and all emails are reviewed and directed to an appropriate member of the MassHealth staff.

d. Ongoing Stakeholder Meetings

Massachusetts has been considering the development of an integrated delivery system and payment model for non-elderly dual eligible members for several years, based on the experiences of SCO. Internal and external stakeholders, including state agencies serving these MassHealth members, consumers, family members and caregivers, consumer advocates and providers, have been involved in these discussions.

Massachusetts formalized its stakeholder meetings around the development of an integrated care model for non-elderly dual eligible members when it began convening regular Duals Consumer

Advocates Meetings starting in March of 2010. This group was instrumental in providing input into Massachusetts' successful application for a design contract for a State Demonstration to Integrate Care for Dual Eligibles, which CMS awarded to the state in April 2011. The group includes state agencies representing dual eligible members ages 21-64, including the Department of Mental Health, Department of Developmental Services, Massachusetts Rehabilitation Commission, Massachusetts Commission for the Deaf and Hard of Hearing and Massachusetts Commission for the Blind, as well as consumers, consumer advocacy groups, community-based organizations and provider associations. In the spring of 2011, MassHealth expanded the scope of this meeting to include providers, health plans, Medicaid managed care organizations, CMS representatives, and all other interested parties. These groups met at least monthly throughout the design phase and engaged in a collaborative process to design the Demonstration, including its benefit design, care delivery and care management structures, quality metrics, network management, and administrative and operational features.[12] These groups will continue to meet regularly throughout the design *and* implementation phases. Stakeholder input led directly to MassHealth's inclusion of peer supports in the benefit design and to the development of strong protections regarding enrollees' ability to continue existing provider relationships.

e. Public Comment

MassHealth has complied with all CMS requirements around inviting public comment on the Demonstration proposal. Massachusetts' proposal was posted on the state's public procurement/public record web site (Comm-PASS) and on the Demonstration's web site at www.mass.gov/masshealth/duals for thirty days. Massachusetts published a notice in major local newspapers across the state announcing that the Demonstration proposal was posted and inviting public comment. MassHealth also circulated the Demonstration proposal draft to all parties on its stakeholder distribution lists. MassHealth has reviewed all comments and incorporated them, as appropriate, into the Demonstration proposal.

ii. Beneficiary protections

Through agreement with CMS and contract provisions with ICOs, MassHealth will ensure that strong beneficiary protections are in place to ensure enrollee health and safety and access to high quality health and supportive services. These protections will include requirements around choice of providers, access to robust and user friendly internal and external grievance and appeals processes, and accessible and supportive enrollee customer service assistance. These protections are in addition to the beneficiary protections around the enrollment process described in Section C.i.c.

a. Choice of providers

MassHealth will require ICOs to ensure enrollee choice of primary care provider and access to a broad array of specialists, including behavioral health providers, who have experience in serving populations with diverse disabilities. ICO provider networks must have sufficient breadth and medical and supportive service provider expertise to enable enrollee access to all covered services. ICOs will be required to

[12] MassHealth held stakeholder meetings on March 1, 2010, June 30, 2010, September 20, 2010, February 28, 2011, May 5, 2011, June 28, 2011, July 21, 2011, August 31, 2011, September 27, 2011 and October 11, 2011. Agendas and meeting materials for each of these meetings are posted on the Demonstration web site at: www.mass.gov/masshealth/duals.

enroll providers with whom an enrollee wishes to continue a relationship and who are able and willing to meet network requirements and accept network rates. If a provider does not wish to enroll in the network and accept new patients, MassHealth is exploring the extent to which single-case out-of-network agreements may be required, under specified circumstances in order to ensure continuity of care. ICOs must demonstrate the capacity to provide, directly or through sub-contracts, the full continuum of Medicare and Medicaid covered benefits, as well as any supplemental benefits.

b. Complaints, Grievances and Appeals Processes

Through contract requirements with ICOs and agreement with CMS, MassHealth will ensure that enrollees have full access to robust unified internal and external complaints, grievances and appeals processes.

MassHealth and CMS together will develop a unified set of requirements for ICOs' internal complaints, grievances and appeals processes that incorporate all relevant Medicare Advantage and Medicaid managed care requirements. ICOs will be required to maintain written policies and procedures for the receipt and timely resolution of complaints and appeals. All internal processes are subject to CMS's and MassHealth's review and prior approval. As part of this process, ICOs will be required to create and maintain records of such activity, using the health management and information system as required by MassHealth to document:

1. the type and nature of each complaint, grievance, internal appeal, and external appeal; and
2. how the contractor responded to and resolved each complaint, grievance, or appeal.

Enrollees also will have access to a single external appeals process that meets all required Medicare Advantage and Medicaid managed care rules and regulations. MassHealth and CMS will develop an integrated and streamlined process ensuring that all the rights and protections afforded by both Medicare and Medicaid are maintained. This will necessitate a comprehensive review and comparison of the requirements for each program noting similarities and differences, and identifying how to address issues such as:

- timing and notification (to enrollees, providers, authorized appeal representatives, MassHealth and external appeal entities);
- criteria for type of appeal (expedited or standard);
- levels of appeal (internal and external);
- external appeal entities;
- continuing services and reimbursement; and
- authorized appeal representatives.

c. Enrollee Customer Service

All ICOs will be required to operate enrollee customer service departments to assist enrollees, enrollees' family members and/or guardians, and other interested parties in learning about and obtaining services from their ICO. Enrollee customer service departments will be required to:

- Operate a toll-free enrollee services telephone line a minimum of nine hours per day during normal business hours, Monday through Friday;
- Make oral interpretation services available free-of-charge to enrollees in all non-English languages spoken by enrollees, including American Sign Language (ASL);
- Maintain the availability of services, such as TTY services or comparable services for the deaf and hard of hearing;
- Make written materials available in alternative formats, as needed to assure effective communication for the blind and vision impaired;
- Provide assistance to enrollees with cognitive impairments, for example written materials in simple, clear language and individualized guidance from customer service representatives to ensure materials are understood;
- Provide reasonable accommodations needed to assure effective communication and provide enrollees with a means to identify their disability to the ICO;
- Maintain employment standards and requirements (e.g. education, training, and experience) for enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives;
- Ensure that customer service department representatives shall, upon request, make available to enrollees and potential enrollees information concerning the following:
    - The identity, locations, qualifications, and availability of providers;
    - Enrollees rights and responsibilities;
    - The procedures available to an enrollee and provider(s) to challenge or appeal the failure of the contractor to provide a covered service and to appeal any adverse actions (denials);
    - How to access oral interpretation services and written materials in prevalent languages and alternative formats;
    - Information on all ICO covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and
    - The procedures for an enrollee to change plans or to opt out of the Demonstration.

d. Other protections

MassHealth will implement other beneficiary protections that ensure privacy of records, access to culturally and linguistically appropriate care, and care that includes caregivers, guardians and other enrollee representatives. The Commonwealth recognizes the importance of enrollees having accessible avenues of support and assistance — external to the ICO, Medicaid and Medicare — to help enrollees resolve concerns about treatment, access to services and navigation of formal grievance and appeals processes. This ombudsman-type role must be performed by an entity that does not stand to benefit from an increase or decrease in service utilization, and that can support enrollees to ensure that they are receiving appropriate levels of care. The Commonwealth will continue discussions with stakeholders and CMS to determine how this function can best be provided.

iii. Ongoing stakeholder input

MassHealth will continue to gather and incorporate stakeholder feedback during the implementation and operational phases of the Demonstration through several mechanisms. MassHealth will continue to hold public stakeholder meetings, as described in Section D.i.d., throughout the Demonstration. MassHealth also will maintain its dedicated web site (www.mass.gov/masshealth/duals) and email box throughout the Demonstration so enrollees, their representatives and other members of the public can regularly receive and provide information about the Demonstration.

MassHealth will continue to provide ASL interpretation and/or Communication Access Realtime Translation (CART) at all public meetings regarding the Demonstration. Information that MassHealth posts online about the Demonstration will be available in alternative formats. In addition, MassHealth will focus on developing member notices and related materials about the Demonstration which are sent directly to enrollees and/or their representatives to make sure they may be easily understood by persons with limited English proficiency. MassHealth will also translate materials into prevalent languages as determined by the Commonwealth. All notices will include a language card depicting languages in the communities served. The cards will indicate that the enclosed materials are important and should be translated immediately, and provides information on how the enrollee may obtain help with getting the materials translated.

Once the Demonstration is implemented, MassHealth will monitor enrollee experiences and satisfaction through surveys, member focus groups and data analyses. Provider experience and satisfaction also will be collected through surveys, key informant interviews, and data analyses.

Finally, MassHealth will require in its contract provisions that ICOs develop meaningful consumer input processes in their ongoing operations, including but not limited to governing or advisory boards that include sufficient numbers of enrollees and representatives.

E. Financing and Payment

i. State-level payment reforms

MassHealth's overall payment reform goals are to:

1. Create payment models that hold providers accountable for the care they deliver, reward quality of care and improved health outcomes, link payment incentives with quality metrics, and reduce health care spending;
2. Support a delivery system that is built on the foundation of PCMHs, integrates and coordinates comprehensive services, and incorporates robust quality measurement;
3. Encourage a move to global payments to entities responsible for effectively delivering and coordinating all the health care services an enrollee needs.

MassHealth is pursuing these goals through this Demonstration and through several other key efforts:

- **Legislative reforms.** The Patrick-Murray Administration's health reform bill, introduced in February 2011, seeks to reduce costs while ensuring quality health care by giving the providers and payers incentives and freedom to innovate. The bill encourages movement away from current FFS payment structures and directs public payers to implement alternative payment methodologies by January 2014. The bill also promotes the development of more integrated models of care delivery based upon a strong foundation of primary care, provided in PCMHs and fully integrated with behavioral health.
- **Creation of accountable care organizations.** Massachusetts issued a Request for Information (RFI) to solicit information from interested parties regarding the initiative by state payers to use ACOs throughout the Commonwealth to increase the coordination and delivery of integrated health care services.
- **Development of patient-centered medical homes.** Through the multi-payer Patient-Centered Medical Home Initiative (PCMHI), Massachusetts is supporting the transformation of primary care practices into PCMHs by providing a rich curriculum of technical assistance and additional payments from participating payers. The PCMHI demonstration will last 3 years (April 2011 through March 2014) and provide the foundation for the transformation of primary care delivery into the future.
- **Bundled payments.** Massachusetts is implementing a demonstration to test a bundled payment methodology for the care of pediatric asthma.

In keeping with overall payment reform goals and strategies, the Commonwealth intends to use the capitated three-way contract model, outlined by CMS in the July 8, 2011 State Medicaid Directors letter, as the mechanism to implement integrated care for dual eligible members ages 21-64. Massachusetts sees administrative integration, clear accountability, and shared financial contributions to prospective blended global payments as innovations critical to the success of this Demonstration, and will be seeking significant flexibility to achieve these alignment features.

ii. Payments to ICOs

Under the three-way capitated contract, ICOs will receive an actuarially developed, risk adjusted, blended capitation rate for the full continuum of benefits they provide to an enrollee. Both Medicare and Medicaid will contribute to the total base capitation rate for the range of covered services, but these contributions will not be directly aligned with payment for particular services. (Medicare will not pay solely for Medicare services and Medicaid will not pay solely for Medicaid services.) MassHealth has begun collaborating with CMS to determine the approach to building the payment mechanism; many design aspects are still to be finalized. The policy goals and key principles outlined in other sections of this proposal will drive the payment methodologies. Developing the global payment approach will be an iterative, data-driven process influenced by program design decisions such as the covered benefit package and enrollment policies.

a. Developing the base capitation rates

MassHealth will use linked Medicare and Medicaid claims data for the most recent experience available (CY 2009 and 2010) to develop the base capitation rates. Medicare historical payments for acute care services will be included in the base data. Data for the expanded services package will come from

Medicaid claims and encounters for use of behavioral health diversionary services by the Medicaid-only population in the targeted age group, and from review of certain LTSS and community support services in the HCBS waivers.

b. Apportioning the base capitation rates to Medicare and Medicaid

A fundamental goal of integrating Medicare and Medicaid financing is to address the current funding misalignment. While expanding essential behavioral health and community-based services to this target population is expected to reduce acute care spending and improve outcomes, such a beneficial expansion is unfeasible in the current financing framework. The costs of that expansion would currently fall to Medicaid and the savings would accrue to Medicare. In the proposed integrated funding model, Medicare funds would be shifted away from acute care services to a new, optimal service mix and to support the infrastructure necessary to administer and monitor the new integrated program.

MassHealth has begun discussions with CMS to develop a mutually agreeable payment methodology that accounts for all covered services and assumes reasonable savings over the course of the Demonstration. As a starting point, MassHealth proposes that for each rating category the historical Medicare payment and reasonable administrative costs to support the program be applied to the blended global payment rate.

c. Risk Adjustment across ICOs

The two primary steps in aligning enrollee risk and global payments are the development of rating categories for the base capitation rates and the use of a supplemental risk adjustment methodology to account for variation across ICOs. It will be very important to determine how to appropriately account for behavioral health, LTSS, and community support service needs in the rating category and/or risk adjustment methodology. In addition, to the extent that functional status data are, or become, available, MassHealth and CMS need to consider how best to incorporate this information.

Rating categories will reflect the expected cost and utilization differences among subgroups made up of enrollees with similar risk profiles, with higher base capitation rates paid for higher risk populations. MassHealth also proposes the use of a risk adjustment methodology to account for the different risk of the enrolled populations across ICOs. MassHealth and CMS will collaboratively choose the software and methodology to use for the risk score development; MassHealth currently uses Verisk DxCG software to risk-adjust prospective capitation payments to managed care organizations for Medicaid-only members under age 65. Risk adjustment must be sensitive enough to appropriately account for costs for the highest cost, highest need enrollees. MassHealth and CMS must share access to technical expertise and broadly solicit substantive input from knowledgeable parties in this important area.

d. Supplemental Risk Mitigation Strategies

Even with stratification into rating categories, a robust actuarial rate development process and risk adjustment across ICOs, it will be difficult to predict risk selection for this new program, which may be particularly pronounced for smaller or specialized ICOs. There is a need to prevent program instability and to more fully account for the cost variations across subpopulations that could lead to significant underpayments or overpayments. This is to be expected in a new, voluntary program with new ICOs

serving new members. MassHealth is interested in exploring with CMS the use of risk corridors during the Demonstration period to assure that there is protection against underpayment or overpayment to ICOs. Stop loss and reinsurance arrangements should also be considered, but these approaches alone may not be sufficient. While risk corridors have implications for projecting precise savings levels, they could be capped and/or designed to diminish over the three year period as actual program data become available and the stability of the program is continuously evaluated.

e. Incentives for Quality and Savings

MassHealth proposes the extensive use of quality metrics as part of the ongoing monitoring of the Demonstration, for both short term results and longer term evaluation. ICOs will be required to meet clear, achievable quality thresholds in delivering high quality services to enrollees in a way that enhances care coordination and improves health outcomes.

In addition to quality metrics for program monitoring, as described in Section F.i and F.ii., MassHealth would like to explore with CMS the use of incentive payments based on meeting or exceeding quality targets for care integration improvements. MassHealth proposes that a meaningful amount of these payments be established either as a withhold amount from the base capitation rate or as a performance incentive payment. MassHealth will be interested in bidder proposals that describe innovative value-based purchasing strategies internal to the ICO, such as episode-based payments, bundled payments, and shared savings.

As ICOs assume increased risk for care delivery and the risk corridors are phased out, they should share in the savings attributable to this Demonstration. Any shared savings must be firmly linked with clear quality metrics to insure that the savings are the result of care improvements, not limits to enrollee access. MassHealth and CMS must consider all program goals in collaborating on this aspect of payment methodology.

F. Expected Outcomes

i. Key metrics related to the Demonstration's quality and cost outcomes

Massachusetts has extensive experience identifying, collecting, monitoring and analyzing data related to quality and costs outcomes in its existing programs, and for ongoing program improvement purposes. Various offices in MassHealth, supported by the MassHealth Quality Office, establish and monitor metrics in these key areas for MassHealth's PCC plan, MCO program, SCO and PACE programs, and HCBS waiver programs. Examples of existing metrics include HEDIS and CAHPS.

MassHealth will build on this experience and infrastructure to develop a sound quality and cost measurement and management strategy for the Demonstration. This performance management strategy will hold ICOs accountable for providing high quality and cost effective care, provide rapid, formative feedback to program administrators and track both short-term and long-term quality and cost outcomes. It will lay the foundation for metrics used for the statewide transformation to ACO-based

care, of which this Demonstration is an essential component. These data will be used for continuous quality improvement and for state and federal Demonstration evaluations.

MassHealth is developing a set of quality and cost measures based on a review of both state and national quality frameworks relevant to this population and direct input from members and stakeholders. Requirements for these expected outcomes will be addressed in MassHealth's forthcoming request for proposals and prospective ICO responses, and then incorporated into the contracts between MassHealth, CMS and each ICO.

MassHealth proposes to assess the performance of ICOs in at least eight domains, which are further defined by key concepts. Specific metrics to measure process and outcomes will flow from the key concepts in each domain. Table F-1 shows the eight domains with their key concepts and *illustrative* measures. **The final selection of quality and cost measures will be made through a multi-stakeholder process.**

Table F-1: Quality and Cost Performance Measurement

Domain	Key Concepts	Illustrative Measures (for illustration only; actual measures will be selected via a multi-stakeholder process)
Access	Improved access to care (particularly new services and supports) ADA compliance Accessible equipment / examination rooms Accessible communication Geographic access Organizational access	• # and type of services received • # of behavioral health diversionary services provided • # of preventative health care services received • # of enrollees receiving dental services (or community supports or LTSS) • Demonstrated effective communication to people with disabilities
Person-Centered Care	Enrollee experience and satisfaction Family / caregiver involvement in decision-making and care planning to extent enrollee desires Enrollee treated with respect and dignity Self-management support and choice Culturally sensitive service delivery (practices and communications)	• Enrollee speaks with personal doctor (includes concepts of respect, shared decision-making, spending enough time) • Enrollee receives culturally and linguistically appropriate services • Care plan development is directed by enrollee and Care plans based reflect enrollee preferences
Health and Safety	Effectiveness Safe medical care delivery Wellness promotion/chronic disease self management Quality of life	• % of enrollees screened for depression annually • % of enrollees screened to identify impairments in physical and cognitive functioning annually • Care team reviews and reconciles medications with enrollees/families after care transitions • % of enrollees receiving medical assistance with smoking and tobacco use cessation
Comprehensive Care Coordination	"Right care, right time, right place" Needs assessment and goal setting Care planning and management Care delivered in least restrictive setting Seamless transitions in care Linkages to community resources	• Care team and enrollee develop written, holistic care plan within 30 days of enrollment • # of care plans developed • Care team sees or communicates with enrollee within 72 hours of discharge to a new setting • # of follow-up contacts by care team • Proportion of enrollees that have a potentially avoidable complication during year • # and type of transitions in care

Domain	Key Concepts	Illustrative Measures (for illustration only; actual measures will be selected via a multi-stakeholder process)
Integration of Services	Comprehensive services and supports Patient-centered medical home Behavioral health / medical care integration Primary care / specialty care integration	• Changes in patterns of care (facility-based care to community-based care, where appropriate) • Reduced preventable and acute hospital admissions, readmissions and emergency departments visits • Reduced pharmacy utilization • Enrollee usually contacts personal doctor if check-up is needed, if s/he is sick or hurt, or if s/he wants advice about a health problem • Enrollee receives follow-up after hospitalization for mental illness
Administrative Simplicity	Provider experience and satisfaction Interoperability and health information exchange Ease of referral and authorization processes Effective / user friendly complaints, grievance and appeals processes	• Simplified process for provider reimbursement • Timeliness of provider claims submission • # of provider claims appealed
Cost savings	Service utilization management Minimizing duplication of services Delivering care in most appropriate setting Promoting administrative efficiencies	• Spending per member and per month to identify enrollees who may need additional care planning • Rates of avoidable admissions and readmissions to hospitals, ERs and nursing facilities • Utilization of providers/facilities who consistently exceed state benchmarks for quality of care and length of stay • ICO spending and revenue
Enrollee Outcomes	Enrollee's functional status and health outcomes	• Pain and fatigue scores for persons with mobility impairments (CAPHS PWMI survey) • Hospitalization rates for care coordination-sensitive conditions (e.g. bowel impaction, UTI, pressure ulcers) • % of enrollees with hypertension whose BP was adequately controlled (<140/90) • OASIS tool (for enrollee functional status) • SF-36; SF-12

MassHealth will measure ICO performance in these areas using qualitative and quantitative data collection methods, including enrollee and provider surveys, member focus groups, key informant interviews and claims and encounter data analysis. Measures will be taken at baseline and at various times after implementation of the Demonstration (e.g., every 6 months or every 12 months) depending on the nature of the expected outcome.

ii. Potential improvement targets

MassHealth will finalize the performance measures it will use to monitor quality and cost in the Demonstration only after significant input from multiple stakeholders. Therefore, MassHealth has not yet developed the potential improvement targets for the key metrics. The process for developing improvement targets includes: (1) conducting baseline measurement, or where data exist, reviewing data trends; (2) identifying measure-specific interventions to improve performance as well as feasible levels of improvement based on both the data and stakeholder input; and (3) monitoring intervention

impact. Some interventions may be doable in a rapid-cycle improvement environment; other interventions may require a longer ramp up and implementation.

Some *potential* improvement targets include:

- Access / Access to behavioral health services: % decrease in preventable and avoidable hospitalizations due to behavioral health conditions.
- Access / ADA compliance: % of enrollees over baseline receiving communication materials in alternative formats, where appropriate.
- Person-Centered Care / Enrollee experience and satisfaction: % of enrollees over baseline completing a formal satisfaction survey tool during the measurement period, and % of enrollees reporting satisfaction.
- Person-Centered Care / Care planning: % of enrollees who have up-to-date strengths-based individualized care plans which incorporate enrollee and family preferences as well as input from trusted providers.
- Comprehensive Care Coordination / Seamless transitions in care: % of enrollees over baseline transitioning from a hospital or other facility-based setting who have telephonic or in-person follow-up with their care team within two days of discharge during the measurement period.

iii. Expected impact on Medicare and Medicaid costs

The current lack of integration fosters cost-shifting and underinvestment. 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, and community support services. 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.

Better coordination and management of care will result in expected savings in the short term associated with reductions in acute care admissions, readmissions, ER use and pharmacy expenditures. The inclusion of behavioral health diversionary services will further offset the cost of inpatient psychiatric and substance use services.

The real potential of this Demonstration to affect enrollees and Medicare and Medicaid as payers will be felt over several years. Savings should grow over time as ICOs influence utilization patterns by helping enrollees stay well, manage chronic conditions, and gain better access to coordinated behavioral health services, and remain in community settings longer.

Massachusetts' Data Use Agreement with CMS was approved on August 26, 2011. The Medicare data, which is expected by mid-November, will be essential to the detailed actuarial analysis necessary to

estimate potential Demonstration savings. In the meantime, MassHealth and its actuaries have refined the preliminary analysis of key subgroups of the target population, and confirmed that the initial savings estimates of 1.5 to 2 percent within the term of the Demonstration appear to be obtainable. There will be a need for program investment in the earlier years. Further, MassHealth has analyzed behavioral health services to assess the potential impact of adding behavioral health diversionary services to the Demonstration benefit package. The analysis compared historical FFS utilization and cost data for the target population to benchmarks for comparable populations, including Medicaid-only members with disabilities with access to these services, and data from Medicaid managed behavioral health programs in other states. Actuarial analysis supports the prospects for this model with expanded benefits to produce both short term and longer term savings, offsetting the cost of providing the additional behavioral health diversionary services.

G. Infrastructure and Implementation

i. State infrastructure/capacity to implement and manage the Demonstration

The Massachusetts Executive Office of Health and Human Services (EOHHS), under the leadership of Secretary JudyAnn Bigby, MD, is the single state agency for the Medicaid program. Secretary Bigby directly oversees the multiple human services agencies and offices that will be involved with implementing and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across EOHHS as described below.

Massachusetts' Medicaid Director, Julian Harris, MD, reports directly to Secretary Bigby and will oversee the Demonstration through his Deputy Medicaid Director for Policy and Programs, who will report directly to Dr. Harris on all aspects of the Demonstration. MassHealth recently restructured its organization to consolidate oversight and management of key units under the Deputy Medicaid Director in order to fully support integration goals, and to align policy development with program implementation. This team will oversee the ICOs, with dedicated program management staff taking on daily management responsibilities. Anticipated dedicated staff will include:

- ICO program manager – to oversee daily program operation
- Data analysts – to aggregate, analyze, and report on encounter data, quality data, financial data for quality control and other purposes
- Program coordinators – to work to resolve program and enrollee issues
- Contract managers – to work with ICOs to ensure compliance and program success
- Medicare-Medicaid federal financial analyst – to oversee unique Demonstration-related federal financial reporting requirements

MassHealth will manage many functions associated with the Demonstration through existing infrastructure, such as:

- Contracted Customer Service –handles enrollments and information distribution for MassHealth's MCO and PCC plans, and will include these functions for the ICOs
- Integrated Care Contracting unit – handles routine contracting and procurements for managed care plans, and will be responsible for these activities for the ICOs
- Information Technology – enrolls members, makes global payments, collects and manages encounter data. An Information Systems team manages federal reporting activities, including MA-21 for enrollment and eligibility, MMIS for capitation payments, and Data Warehouse for encounter data collection, analysis and federal reporting production
- MassHealth Finance – manages all financial, budgetary, accounting, federal reporting, rate setting, and program integrity functions for the MassHealth program

MassHealth has developed the Demonstration with input and participation from many key state agency partners, through a workgroup of representatives from key agencies[13] and through DDS, EOEA, and DMH involvement in the Demonstration's Steering Committee. These groups will convene regularly throughout implementation. Additionally, MassHealth's new organizational structure has a unit specifically dedicated to Cross-Agency Integrated Care Coordination; as this unit is developed, it will provide a natural opportunity for partnering state agencies to provide input on evolving policy and implementation issues.

The following formal linkages will be the foundation for strategic direction, information exchange and support throughout the Demonstration planning and implementation phases:

- The EOHHS Secretary convenes a monthly Leadership meeting that includes the heads of every EOHHS agency
- Interagency Duals Steering Committee
- Medical Care Advisory Committee (MCAC)
- Medical Director meetings (MCOs, SCOs, PACE)
- The Medicaid Director convenes bi-weekly MassHealth Leadership Team meetings where MassHealth development projects are discussed
- Ongoing Duals Stakeholders meetings, which include open meetings for all interested parties, consumer-focused meetings, and State Agency Partners meetings
- Monthly MassHealth Advocates meetings
- Quarterly Massachusetts Health Care Training Forums

Certain MassHealth contracts will include resources and responsibilities related to the ICO program – these include actuarial support, management and hosting of a linked MassHealth and Medicare database, and analytic capacity for Demonstration monitoring activities.

[13]The Department of Developmental Services (DDS), the Massachusetts Rehabilitation Commission (MRC), the Massachusetts Commission for the Blind (MCB), the Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), the Department of Public Health (DPH), the Executive Office of Elder Affairs (EOEA) and the Department of Mental Health (DMH).

ii. Need for waivers

Appendix D summarizes Massachusetts' current and proposed 1915(c) waiver authority for the services it will make available under the Demonstration. MassHealth will work with CMS to identify additional waivers that would be needed for certain services and for other operational and financial aspects of the Demonstration.

iii. Plans to expand to other populations

While Massachusetts is targeting dual eligible members ages 21- 64 in its current Duals initiative, there is a clear expectation that the program designed as part of this initiative will be used to provide invaluable information about how to enhance the options available to dual eligible members of all ages and to MassHealth members regardless of their Medicare eligibility. The Commonwealth is initially focusing on dual eligible members ages 21-64 since these members currently do not have any integrated care option (except for PACE, for people age 55 and above).

a. Medicaid-only members with disabilities

MassHealth currently has mandatory managed care enrollment into either the PCC plan or the MCOs for most of its Medicaid-only members with disabilities under age 65. Medicaid MCOs now cover acute, primary care, and behavioral health services, with a FFS wrap for State Plan LTSS. The Medicaid-only population with disabilities is in many ways a "pre-Duals" population. This population of over 90,000 individuals uses many of the same services as dual eligible members in this age group, and many of these individuals have the same or similar complex and chronic conditions as their dually eligible counterparts, and would realize many of the same benefits of participating in more fully integrated care. MassHealth will evaluate the Demonstration's implementation progress and results, and plans to move decisively over time to make the ICO care delivery model available to Medicaid-only members, including the full range of acute and primary care, behavioral health diversionary services, LTSS, and community support services.

b. Elders

MassHealth members age 65 and over have access to SCO in regions where SCOs are available. The Commonwealth expects the distinction between SCO and the new Demonstration to diminish over time, especially since Demonstration enrollees will be allowed (but not required) to remain in the Demonstration as they turn 65. The Commonwealth will engage in discussions with the SCOs and their stakeholder communities about transitioning their plans from a SNP/Medicaid Managed Care Entity model to the capitated three-way contract mechanism to improve administrative integration and financing structures. Massachusetts would build on the strong relationships and LTSS networks that the SCOs have developed and use MassHealth's existing and new infrastructure to improve outreach, marketing, and quality management support. Massachusetts is not pursuing a change to the current SCO enrollment process, but would bring to elders many of the Demonstration's enhancements (broad information sharing, marketing by MassHealth, decision support, network transparency) as further enticements to enroll in a SCO. MassHealth also would like to move to statewide coverage for the SCO program, and would use the three-way contract mechanism to create more favorable conditions for bidders in the Western part of the state.

iv. Overall implementation strategy and anticipated timeline

Massachusetts is anticipating an intensive implementation process across most MassHealth business areas. An implementation team led by senior staff reporting to the Deputy Medicaid Director for Policy and Programs, and coordinated by the MassHealth Leadership Team and the inter-agency Duals Steering Committee will provide strategic direction for:

- ICO procurement and selection
- Rate setting and actuarial analysis
- Quality and outcomes management targets
- IT readiness
- Member enrollment support
- Contract monitoring and compliance
- Legislative budget alignment
- Regulations

After MassHealth submits this Demonstration proposal to CMS, MassHealth will shift its focus to begin drafting the procurement for ICOs. MassHealth anticipates releasing the ICO procurement in the Spring of 2012 and selecting ICOs by mid- 2012. Selected ICOs would have four months for contract readiness activities, and enrollment packages would begin to go out to the target population in October 2012. Enrollment would begin in January 2013. Stakeholders have requested a phased roll-out period for enrollment effective dates so that MassHealth can address any process issues that arise in the early phases. MassHealth likely would begin enrollments in the Greater Boston region first, then phase in enrollment across all five regions. See Appendix E for MassHealth's proposed workplan and timeline.

H. Feasibility and Sustainability

i. Potential barriers, challenges and future State actions that could affect implementation

a. Administrative resources

MassHealth will seek partnership and support from CMS to fund the build-out of new infrastructure, IT, staff, and member and provider outreach necessary to implement the Demonstration.

b. Aligning potential legislative activity with demonstration goals

It is possible that legislation may be enacted that would affect aspects of the Demonstration. MassHealth will collaborate with stakeholders and legislators to address any concerns, and to ensure forward progress on our mutual goals.

c. Attracting bidders to be ICOs in all regions

MassHealth expects that its extensive stakeholder engagement through the development stage will engender substantial interest among health organizations that might bid to become ICOs. MassHealth

also will adopt clear and transparent enrollment processes to convey assurances of sufficient ICO enrollee volume to entities that may consider bidding.

d. Aligning provider capacity and competencies with member population

Providers who participate with an ICO will be required to demonstrate a level of capacity and cultural competence to serve the dual eligible members who are the focus of this initiative. MassHealth expects that it will be in the interest of the both the enrollees and the ICOs to support improvement in these areas beyond the baseline capabilities and knowledge of the ICOs and their providers. To that end, MassHealth proposes to support shared learning through methods such as a learning collaborative model that will address topics such as the recovery model of care; how to make best use of community resources to support people with disabilities, behavioral health concerns, and complex needs; addressing racial and ethnic disparities; and providing equal access to care in accordance with the Americans with Disabilities Act (ADA).

ii. State statutory and/or regulatory changes needed to move forward with implementation

Massachusetts General Laws grant broad authority for the Medicaid agency to enter into contracts for the provision of Medicaid services, providing (at MGL 118e Section 12) that "the division may enter into any types of contracts with providers of medical services as the division deems necessary to carry out the provisions of this chapter, including, but not limited to, selective contracts, volume purchase contracts, preferred provider contracts, and managed care contracts." Nevertheless, changes to state statute might be required depending on the specifics of the Demonstration. With regard to regulatory changes, MassHealth managed care member eligibility and managed care provider regulations will need to be amended to address the new Demonstration.

iii. State funding commitments or contracting processes necessary before full implementation

State appropriations will need to be sufficient to support the Demonstration. Massachusetts will need to procure ICOs in accordance with state and federal procurement laws.

iv. Scalability of the proposed model and its replicability in other settings or states

The concepts of streamlined administrative integration, ICO accountability to the state, and complete service integration for a seamless member experience are easily replicable in other states interested in using contracted care arrangements to integrate comprehensive care packages for their dual eligible members in partnership with the federal government. The model also provides significant flexibility for states to build in new payment reform concepts and opportunities introduced in the Affordable Care Act. Particularly as it is built on the capitated three-way contract framework, this model could be replicated in other states and modified as needed to address local issues.

v. Letters of Support

Please see Appendix F for letters of support for this Demonstration.

I. CMS Implementation Support – Budget Request

Massachusetts' budget request for this Demonstration is detailed in Appendix G. Major funding areas include:

- **IT system changes:** Support member enrollments, encounter data collection and analysis, federal reporting, financial analysis, and quality and evaluation data analysis
- **Program staff:** dedicated staff to manage the ICO program, including
    - ICO program manager – to oversee daily program operation
    - Analytic lead and data analysts – to aggregate, analyze, and report on encounter data, quality data, financial data for quality control and other purposes
    - Program coordinators – to work to resolve program and member issues
    - Contract managers - to work with assigned ICOs to ensure compliance with contract requirements
- **Procurement costs:** Resources to develop and publicize the procurement, including conducting bidders' conferences and providing public notice of the procurement
- **Quality Measurement and Evaluation:** Resources to conduct and analyze short-cycle and longer-cycle quality measurement and evaluation activities
- **Actuarial analysis and rate setting:** Actuarial support for rate development and analysis
- **Marketing and outreach:** Resources and staff time to prepare marketing activities and to conduct targeted and broad outreach to members and providers, including conducting regular stakeholder meetings
- **Customer Service**: Support for members during enrollment processes, including enrollment process customer communications capacity, hands-on assistance to members evaluating their enrollment choices, and informational materials to members and those assisting with decision support

J. Additional Documentation (as applicable)

MassHealth will provide additional documentation at CMS's request.

K. Interaction with Other HHS/CMS Initiatives

One of the two major goals of the **Partnership for Patients** is to reduce hospital readmissions by 20 percent by 2013, primarily by improving care transitions. In 2008, approximately 20,000 members in the target population had one or more acute hospitalizations, and 3,800 experienced a readmission within 30 days of discharge. The Demonstration seeks to improve this rate by addressing many of the elements of safe, effective, and efficient care transitions identified by the Partnerships for Patients. Under this Demonstration, all enrollees will develop person-centered care plans to ensure services are responsive to their needs and social situation and will be managed by a care team that coordinates care among

providers in all settings. The care team will provide a service coordination and linkage role to ensure standardized, accurate and timely information exchange among providers. Health care-related travel and durable medical equipment, noted by Partnership for Patients as key elements to improving care transitions, will be available services through this Demonstration and access will be ensured by the care team. Because the ICO will be responsible for all service authorizations for their enrollees, the Demonstration should improve authorization and delivery times.

The Demonstration will build upon the strategies and activities in the HHS **Action Plan to Reduce Racial and Ethnic Health Disparities** (Action Plan). Several key strategies within the Action Plan are also essential components of this Demonstration, including increasing access to care coordination, increasing the ability to identify and address racial and ethnic disparities through data collection, and ensuring access to information for people with limited English proficiency. Strategy I.B of the Action Plan seeks to reduce disparities in access to primary care services and care coordination. Through the Demonstration, ICO enrollees will have access to a primary care provider and a PCMH (see section C.ii.a.). Through the Demonstration's enhanced benefit package, enrollees will have access to culturally competent and appropriate care including community health workers and peer supports. ICOs will be required to provide notices and materials in prevalent languages, alternative formats and language card inserts depicting languages used in the community. Customer service oral interpretation services also will be available. ICOs will be required to report data on health and quality of care measures that include demographic information on race and ethnicity.

The goal of the **Million Hearts Campaign** is to prevent one million heart attacks and strokes in the United States over the next five years through a variety of activities. In 2008, 6,400 dual eligible members in Massachusetts had a history of stroke or CVD, 4,800 members had congestive heart failure and about 15,500 members had heart disease. The Demonstration seeks to reduce the prevalence of these conditions by including wellness programs and chronic disease management in the service mix, monitoring progress through quality measurement, and offering opportunities to share evidence-based practices with providers through a learning collaborative model. As part of the care planning process, the enrollee and care team may elect to engage community health workers, peers with familiarity with substance use disorders, and wellness coaches to enable enrollees to improve cardiovascular health. Specific quality measures related to cardiovascular health will be collected from each ICO to monitor continuous quality improvement. Examples of these measures are in Table F-1.

Appendices

Appendix A. Glossary of Terms and Acronyms as Used in this Proposal

1115 MassHealth Demonstration Waiver- A waiver authorized pursuant to Section 1115 of the Social Security Act that permits the Secretary of Health and Human Services to exempt a state's Medicaid program from compliance with certain Title XIX requirements and for the purpose of conducting a demonstration that promotes the objectives of Medicaid. Massachusetts operates certain portions of the MassHealth program under Section 1115 demonstration authority.

1915(c) Waivers or Home and Community-Based Services Waivers (HCBS waivers) – A waiver authorized pursuant to Section 1915(c) of the Social Security Act that permits the Secretary of Health and Human Services to exempt a state's Medicaid program from compliance with certain Title XIX requirements so that it can provide home and community based long-term care services to specified populations who would otherwise require institutional services reimbursable by Medicaid. Using this waiver authority states can provide home and community based services not usually covered under Medicaid. Massachusetts operates multiple HCBS waiver programs.

[+]Acute Inpatient Admission – Admission to an acute care hospital.

Behavioral Health (BH) – Mental health and substance use.

Behavioral Health Diversionary Services – Community-based mental health and substance use disorder services that provide clinically appropriate alternatives to inpatient services or support individuals returning to the community following an inpatient stay or provide intensive support to maintain functioning in the community.

Case Management – Activities that assist individuals in gaining access to needed Medicaid and HCBS waiver services, as well as social, educational, and other services, regardless of the funding source for the services to which access is gained.

[+]Chronic Physical Condition – A primary diagnosis[*] of Asthma, Arthritis, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (OPD), Diabetes, Heart Disease, or Stroke/Cardiovascular Disease (CVD).

CMS – Centers for Medicare & Medicaid Services

Community Support Services - Services that promote disease management, wellness, and independent living, and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

Covered Services –The set of services to be offered by the Integrated Care Organizations and paid for with a Global Payment.

[+]Developmental Disabilities – A primary diagnosis[*] of Intellectual Disability or Down Syndrome.

Enrollee – A member enrolled in an ICO.

Executive Office of Health and Human Services (EOHHS) - The single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the

Social Security Act, the § 1115 Medicaid Research and Demonstration Waiver and other applicable laws and waivers.

Fee-For-Service (FFS) - A method of paying an established fee for a unit of health care service.

Global Payment – Consolidated payment to entities or providers for all or most of the care that their patients may require over a certain period, such as a month or year.

Home and Community Based Services (HCBS) Waiver – See "1915(c) Waivers"

Institutionalized: Describes a member who received services at a Nursing Home, Skilled Nursing Facility, Intermediate Care Facility, chronic or rehabilitation hospital, or psychiatric hospital for an extended period of time.

Integrated Care Organization (ICO) – An insurance-based or provider-based health organization contracted to and accountable for providing integrated care to enrollees.

Long Term Services and Supports (LTSS) – A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Massachusetts Patient-Centered Medical Home Initiative (PCMHI): A 3-year, multi-payer demonstration that began in April 2011 with 46 primary care practices selected through a competitive procurement by MassHealth. The practices are receiving a package of technical assistance to help them transform into patient-centered medical homes (see http://www.mass.gov/Eeohhs2/docs/eohhs/healthcare_reform/med_home_framework.pdf for more information). Some practices are receiving enhanced payment from participating public and private payers to support their transformation.

MassHealth – The medical assistance and benefit programs administered by the Executive Office of Health and Human Services pursuant to the Title XIX of the Social Security Act (42 U.S.C. 1396), M.G.L.c. 118E, and other applicable laws and regulations (Medicaid).

MassHealth CommonHealth – A MassHealth coverage type as specified at 130 CMR 505.004 that offers health benefits to certain disabled children under age 19, and certain working and non-working disabled adults between the ages of 19 and 64.

MassHealth Standard – A MassHealth coverage type as specified at 130 CMR 505.002 that offers a full range of health benefits to certain eligible Members, including families, children under age 18, pregnant women, disabled individuals under 65, and elders.

Medicaid - The program of medical assistance benefits under Title XIX of the Social Security Act (also see "MassHealth").

Medicare- Title XVIII of the Social Security Act, the federal health insurance program for people age 65 and older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD)

(permanent kidney failure requiring dialysis or a kidney transplant). Medicare Part A provides coverage of inpatient hospital services and services of other institutional Providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides coverage for most pharmaceuticals.

Member –A person enrolled in MassHealth or Medicare.

Program of All-Inclusive Care for the Elderly (PACE) – A comprehensive service delivery and financing model that integrates medical and LTSS under dual capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the skilled-nursing-facility level of care criteria and reside in a PACE service area.

[+]Serious Mental illness – A primary diagnosis[*] of Schizophrenia/Other Psychoses, Bipolar Disorders, and/or Major Depression**.**

Service Area – the specific geographical area of Massachusetts for which an ICO agrees to provide Covered Services to all enrollees who select the ICO.

[+]Substance Use Disorder – A primary diagnosis[*] of Substance Use.

[+]Waiver Enrollment and Care Setting – For Table B-2, MassHealth members in the target population were classified into one (and only one) of three distinct groups.

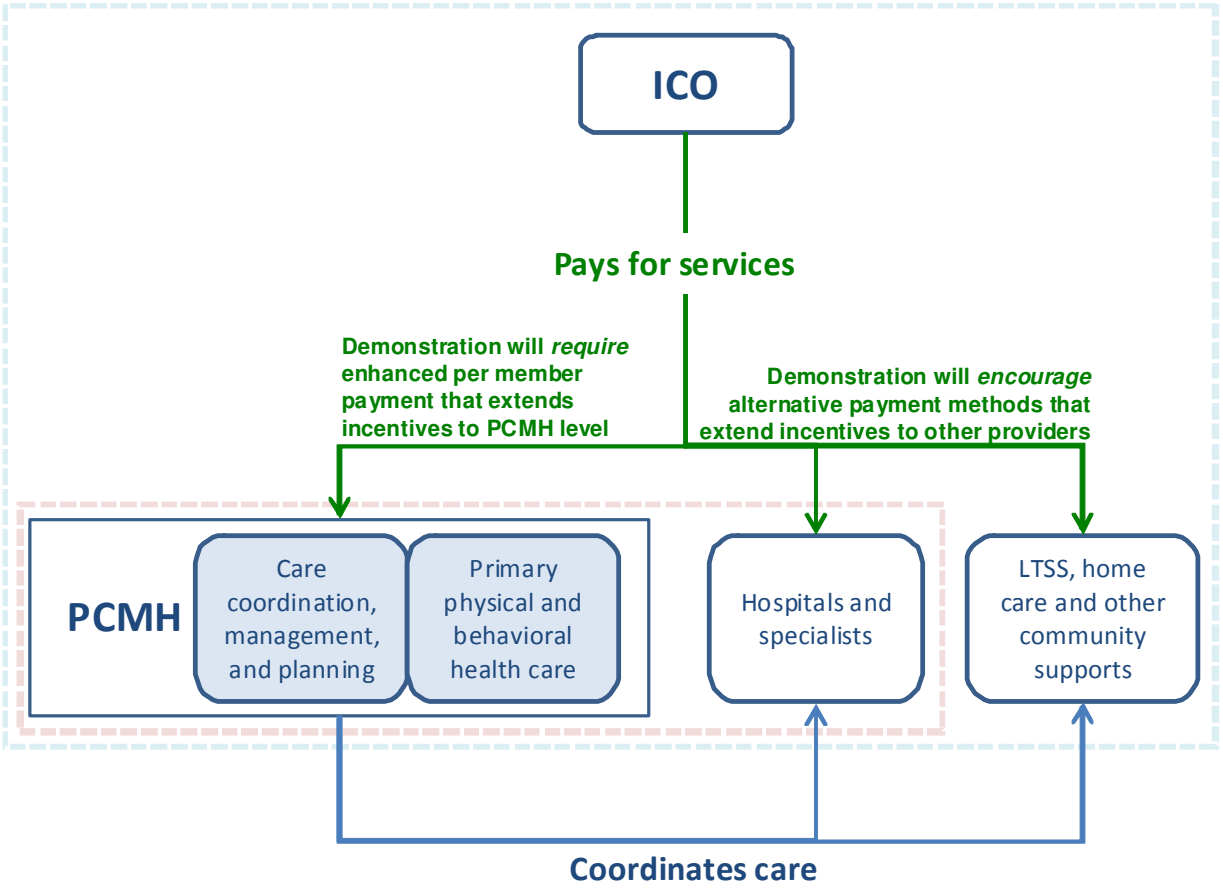
> **[+]Non-Waiver Community –** Members who were not enrolled in a HCBS waiver during Calendar Year 2008, and who did not have an extended stay in a facility (see definition of "Institutional" following)
>
> **[+]Institutional –** Members who had extended episodes of care during Calendar Year 2008 in or across facilities. Facilities include Nursing Facilities/Homes, Intermediate Care Facilities, Skilled Nursing Facilities, Chronic Disease Hospitals, Psychiatric Hospitals, or Rehabilitation Hospitals. Episodes of care are determined using an algorithm developed by JEN Associates that examines a 5 month window around facility utilization to distinguish between stays involving at least 3 of the 5 months examined and those stays that are temporary in nature. This group includes almost 200 members who were also enrolled in a HCBS waiver at some point during the year, either prior to or after their extended facility stay.
>
> **[+]HCBS Waiver –** Members who were enrolled in a HCBS waiver at some point during Calendar Year 2008, and who did not have an extended facility stay. There were approximately 200 HCBS waiver enrollees excluded from this group because they also had an extended facility stay, either prior to or after their HCBS waiver enrollment; they were classified as **Institutional**.

* Diagnosis groups and specific codes used in groupings are from the Agency for Health Research and Quality (AHRQ), a federal agency that conducts the Medical Expenditure Panel Survey (MEPS). For

example, MEPS defines a series of ICD-9 diagnosis codes as Bipolar Disorder; these code groupings were used in this proposal to designate that a member had a primary diagnosis of this condition.

[+]Refers to definitions used for purposes of data reporting.

Appendix B. Example of ICO Organizational and Financial Arrangement



Colored dashed rectangles represent possible alternative configurations for how an ICO may be structured and function. In any configuration, the entity serving as the ICO and receiving capitated payments from MassHealth and CMS, will either internally provide, or pay through contracts, for all covered services.

Appendix C. Covered Services

Table A. MassHealth Direct Coverage Benefits

Benefits	Standard	CommonHealth	ICO
EPSDT	X	X	X
Inpatient Acute Hospital	X	X	X
Adult Day Health	X	X	X
Adult Foster Care/Group Adult Foster Care	X	X	X
Ambulance (emergency)	X	X	X
Audiologist Services	X	X	X
Chiropractic Care	X	X	X
Chronic Disease and Rehabilitation Hospital Inpatient	X	X	X
Community Health Center	X	X	X
Day Habilitation	X	X	X
Dental Services	X	X	X
Durable Medical Equipment and Supplies	X	X	X
Family Planning	X	X	X
Hearing Aids	X	X	X
Home Health	X	X	X
Hospice	X	X	X
Laboratory/X-ray/ Imaging	X	X	X
Medically Necessary Non-emergency Transport	X	X	X
Nurse Midwife Services	X	X	X
Nurse Practitioner Services	X	X	X
Orthotic Services	X	X	X
Outpatient Hospital	X	X	X
Outpatient Surgery	X	X	X
Oxygen and Respiratory Therapy Equipment	X	X	X
Personal Care	X	X	X
Pharmacy	X	X	X
Physician	X	X	X
Podiatry	X	X	X

Benefits	Standard	CommonHealth	ICO
Private Duty Nursing	X	X	X
Prosthetics	X	X	X
Rehabilitation	X	X	X
Renal Dialysis Services	X	X	X
Skilled Nursing Facility	X	X	X
Speech and Hearing Services	X	X	X
Targeted Case Management	X	X	X
Therapy: Physical, Occupational, and Speech/ Language	X	X	X
Vision Care	X	X	X

Table B. Expanded Services Proposed for the ICO, Notwithstanding State Plan Limitations

Expanded Benefits	ICO
Preventive, Restorative, and Emergency Oral Health (Dental) Benefits	X
Personal Care Assistance (including cueing and monitoring)	X
Durable Medical Equipment (training in usage, repairs, modifications)	X
Environmental Aids and Assistive/Adaptive Technology	X
Vision Services (ICO contracted providers)	X
Non-Medical Transportation	X

Table C. Behavioral Health Services Offered to Adults in MassHealth

Benefits	State Plan	1115	ICO
A. Inpatient Services			
Inpatient Mental Health Services	X		X
Inpatient Substance Use Disorder Services (Level IV)		X	X
Observation/Holding Beds		X	X
Administratively Necessary Day (AND) Services		X	X
B. Diversionary Services			
Community Crisis Stabilization		X	X
Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7)	X		X
Clinical Support Services for Substance Use Disorders (Level III.5)	X		X

Benefits	State Plan	1115	ICO
Community Support Program (CSP)		X	X
Partial Hospitalization (PHP)		X	X
Psychiatric Day Treatment	X		X
Structured Outpatient Addiction Program (SOAP)		X	X
Program of Assertive Community Treatment (PACT)		X	X
Intensive Outpatient Program (IOP)	*	X	X
C. Outpatient Services			
Family Consultation	X		X
Case Consultation	X		X
Diagnostic Evaluation	X		X
Dialectical Behavioral Therapy		X	X
Psychiatric Consultation on an Inpatient Medical Unit		X	X
Medication Visit	X		X
Medication Administration		X	X
Couples/Family Treatment	X		X
Group Treatment	X		X
Individual Treatment	X		X
Inpatient/Outpatient Bridge Visit		X	X
Acupuncture Treatment	X		X
Opioid Replacement Therapy	X		X
Ambulatory Detoxification (Level II.d)		X	X
Psychological Testing	X		X
D. Emergency Services Program (ESP)			
ESP Encounter	X		X
E. Other Behavioral Health Services			
Electro-Convulsive Therapy (ECT)		X	X
Specialing		X	X

**IOP is available through State Plan for pregnant women with Substance Use Disorder*

Table D. Additional Community Support Services Proposed for the ICO

New Benefits	ICO
Day Services	X
Home Care Services	X
Respite Care	X
Peer Support/Counseling/Navigation	X
Transitional Assistance (across settings)	X
Home Modifications	X
Health Coaching	X
Medication Management	X

Appendix D. Home and Community Based Waiver Services

	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Adult Supports Waiver (DDS)	Frail Elder Waiver (EOEA)	Traumatic Brain Injury Waiver (MRC)	ABI –RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)[14]	MFP Community Living Waiver (NEW)[15]
Adult Companion	**X**			**X**	**X**		**X**		**X**
Agency Personal Care				**X**	**X**		**X**		**X**
Assisted Living Services								**X**	
Behavioral Health Diversionary Services								**X**	**X**
Behavioral Supports and Consultation	**X**	**X**							
Chore Service	**X**			**X**	**X**		**X**		**X**
Community Based Substance Abuse Treatment					**X**	**X**	**X**	**X**	**X**
Day Habilitation	**X**	**X**	**X**						

[14] Proposed Waiver, not yet in operation.

[15] Proposed Waiver, not yet in operation.

	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Adult Supports Waiver (DDS)	Frail Elder Waiver (EOEA)	Traumatic Brain Injury Waiver (MRC)	ABI –RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)[14]	MFP Community Living Waiver (NEW)[15]
Supplement									
Day Services	**X**	**X**	**X**	**X**[16]	**X**	**X**	**X**	**X**	**X**
Family Training	**X**	**X**	**X**[17]					**X**	**X**
Grocery Shopping and Home Delivery				**X**					
Home / Environmental Accessibility Modifications	**X**	**X**		**X**	**X**		**X**	**X**	**X**
Home Health Aide				**X**					**X**
Homemaker	**X**			**X**	**X**		**X**		**X**
Home-Delivered Meals				**X**					
Individual Goods and Services	**X**	**X**							
Individual Support and Community Habilitation			**X**		**X**		**X**	**X**	**X**
Individualized Day Supports	**X**	**X**	**X**						

[16] Supportive Day Program for Frail Elder Waiver

[17] Service titled Family Support Navigation

	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Adult Supports Waiver (DDS)	Frail Elder Waiver (EOEA)	Traumatic Brain Injury Waiver (MRC)	ABI –RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)[14]	MFP Community Living Waiver (NEW)[15]
Individualized Home Supports	**X**								
Laundry				**X**					
Live-in Caregiver	**X**								
Non-Medical Transportation	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Occupational Therapy	**X**	**X**			**X**	**X**	**X**	**X**	**X**
Peer Counseling/Peer Support	**X**	**X**						**X**	**X**
Physical Therapy	**X**	**X**			**X**	**X**	**X**	**X**	**X**
Prevocational Services								**X**	**X**
Residential Habilitation		**X**			**X**	**X**		**X**	
Respite	**X**	**X**	**X**	**X**	**X**		**X**		**X**
Self-Directed 24 Hour Supports		**X**							
Shared Home Supports									**X**
Shared Living								**X**	
Skilled Nursing				**X**				**X**	**X**

	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Adult Supports Waiver (DDS)	Frail Elder Waiver (EOEA)	Traumatic Brain Injury Waiver (MRC)	ABI –RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)[14]	MFP Community Living Waiver (NEW)[15]
Specialized Medical Equipment	**X**	**X**		**X**[18]	**X**	**X**	**X**	**X**	**X**
Speech Therapy	**X**	**X**			**X**	**X**	**X**	**X**	**X**
Stabilization	**X**	**X**							
Supported Employment	**X**	**X**	**X**		**X**	**X**	**X**	**X**	**X**
Supportive Home Care Aide				**X**					**X**
Transitional Assistance Services[19]	**X**	**X**		**X**	**X**	**X**	**X**		
Vehicle Modification	**X**			**X**					**X**

[18] This service in Frail Elder Waiver is Home Based Wandering Response System

[19] Transitional Assistance Services may include such components as: Non-recurring set-up expenses (security deposits, essential furnishings, pest eradication, etc.), environmental adaptations, adaptive equipment, assistive technology; pre-discharge assessment by an RN and OT (related to home navigation, medication self-management, chronic disease self-management, need for Care Transition Counseling), peer support and companion services, activities to assess need, arrange for and procure needed resources (individual support, transportation), service animals, Family support/training, Community re-integration, 24 hour services, (i.e. personal care services and/or peer/companion support for a specified post-transition period), Housing locator/roommate matching, telehealth monitoring or reminders, substance abuse treatment, cognitive adaptive training

Appendix E. Workplan and Timeline

Timeframe	Key Activities/Milestones	Responsible Parties
	Submit proposal to CMS • Stakeholder engagement/discussions • Draft proposal • Public comment period • Final revisions/submission	Deputy Medicaid Director for Policy and Programs
	Negotiations/MOU with CMS • Identify Waivers needed • Draft MOU/contract terms • Finalize MOU with CMS	MassHealth Deputy Director, Director of Planning and Development, Director of Member Policy, CMS
	ICO procurement and selection • Draft and release procurement • Bidder responses due • Select ICOs • Execute contracts • Bidder readiness	MassHealth procurement team, CMS, ICOs, MassHealth Legal Unit
	Actuarial analysis and rate setting • State receives 2009 and 2010Medicare data • Actuarial analysis • Develop rating categories/risk adjustment methodology • Propose risk corridors/shared savings • Negotiate prospective payments with CMS • Set rates	MassHealth Director of Planning and Development, Actuary, CMS
	Develop quality metrics and outcomes management targets • Expand initial quality metrics list • Develop measures for each quality metric • Develop expected outcomes • Develop targets	MassHealth, UMMS
	IT/Systems adaptations • Update MA-21 enrollment logic • Add ICOs to MMIS • Develop encounter data specs • DW to accept encounter data • DW to accept new ICOs/reflect global payments • Update federal reporting specs • Develop new analytic views/reports	MA-21, MMIS, DW Leads, MassHealth CIO, Federal Reporting team, Director of Federal Finance
	Member outreach/marketing and enrollment support • Develop outreach/marketing materials • Update CST contract to support ICO enrollments • Contract for member decision support • Mail out enrollment packages • Members return enrollment packages	MassHealth Operations, Customer Service Team, ICOs, Members

Timeframe	Key Activities/Milestones	Responsible Parties
	• Member enrollment begins first region • Member initial enrollment complete last region	
	Contract monitoring and compliance • Develop regular ICO reporting requirements • Collect initial ICO data • First contract monitoring meeting with ICOs	MassHealth Director of Integrated Care Delivery, Providers and Plans unit, Director of Integrated Care Contracting, ICO Program Manager
	Legislative budget alignment • Develop budget projections for FY13 (7/12 – 6/13) • Draft legislative budget language • Include budget/language in Governor's budget (H.1) • Include budget/language in subsequent legislative releases (HWM, House Amendments, SWM, Senate Amendments) • Include budget/language in FY13 budget (General Appropriations Act)	MassHealth CFO, Legal unit
	Regulations • Identify new regulations needed • Identify revisions to existing regulations needed • Draft regulations • Public comment period • Promulgate regulations	MassHealth Legal unit, MassHealth Policy unit
	Hire program staff • Develop job descriptions • Post openings • Interview and select candidates • Complete HR hiring process • New staff begin	MassHealth Director of Integrated Care Delivery, Providers and Plans Unit, HR unit

Appendix F. Letters of Support

Appendix G. Budget Request