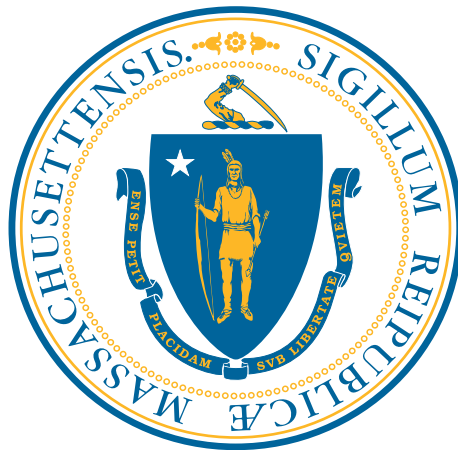


**COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID**

**PROPOSAL TO THE
CENTER FOR MEDICARE AND MEDICAID INNOVATION**

***STATE DEMONSTRATION TO INTEGRATE CARE FOR
DUAL ELIGIBLE INDIVIDUALS***

Contract No. HHSM-500-2011-00033C



February 16, 2012

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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 members' 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 within a primary care centered 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 global 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 their enrollees. ICOs will employ or contract with providers 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 ICOs or opt out of the Demonstration.

The Commonwealth expects to demonstrate that this model of integrated care and financing will improve quality of care and reduce health disparities, improve health and functional outcomes, and reduce costs for enrollees by reducing or avoiding preventable hospital stays and nursing facilities admissions, reducing emergency room utilization, and improving transitions across care settings.

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 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 (Medicaid) through the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individual (QI) programs. Partial dual eligibles are not included in this Demonstration.

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	<ul style="list-style-type: none"> • Medicaid State Plan • Medicare Parts A, B, D • Behavioral health diversionary services • Additional community support services
Financing Model <ul style="list-style-type: none"> • Is this proposal using a financial alignment model from the July 8 SMD? • Payment mechanism 	<ul style="list-style-type: none"> • Yes • Capitation
Summary of Stakeholder Engagement/Input (Provide high level listing of events/dates – Section D asks for more detailed information)	<ul style="list-style-type: none"> • 11 Stakeholder meetings – March 2010-February 2012 • 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 • 30-day public comment period, including two public hearings – December 2011-January 2012
Proposed Implementation Date(s)	January 2013

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 determined that a broader range of LTSS and community support services would be effective for dual eligible adults enabling them to meet their functional needs. Coordination of these services by experienced Independent LTSS Coordinators (LTSS Coordinators) will be critical to ensuring members are connected to the Independent Living supports and LTSS they need.

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.

An additional unintended consequence of multiple payers is the existence of parallel or overlapping 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

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.

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, if they choose.) 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, and were enrolled in Medicare Part A and Part B, without 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 people 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 range of medical services and LTSS that varied based on their acuity, functional status, waiver enrollment and care setting. Table B-1 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 (HCB) 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 Illness³:	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 Illness³	34.9%	70.1%	36.0%	27.8%

¹ Individuals using 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, Independent 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 provides CY 2008 distribution and spending data for the full population, and by Home and Community Based Services (HCBS) waiver enrollment and care setting. The subpopulations in the table are not mutually exclusive. For example, an individual with SMI 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 SMI 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	96,522 (88.0%)	5,794 (5.3%)	7,320 (6.7%)	109,636 (100.0%)
	• Medicare	\$934	\$4,158	\$718	\$1,092
	• Medicaid	\$403	\$5,752	\$5,890	\$1,080
	Spending (% of total)				
	• Medicare	\$988M (74.9%)	\$269M (20.4%)	\$62M (4.7%)	\$1,319M (100.0%)
	• Medicaid	\$426M (32.6%)	\$372M (28.5%)	\$507M (38.8%)	\$1,305M (100.0%)
Developmental Disabilities	N (% of column) PMPM	10,315 (10.7%)	1,829 (31.6%)	5,821 (79.5%)	17,965 (16.4%)
	• Medicare	\$1,103	\$3,744	\$700	\$1,234
	• Medicaid	\$888	\$8,851	\$6,526	\$3,557
Serious Mental Illness	N (% of column) PMPM	32,874 (34.1%)	3,561 (61.5%)	1,812 (24.8%)	38,247 (34.9%)
	• Medicare	\$1,176	\$4,523	\$1,071	\$1,484
	• Medicaid	\$583	\$3,997	\$6,038	\$1,175
Substance Use Disorders	N (% of column) PMPM	28,206 (29.2%)	2,305 (39.8%)	326 (4.5%)	30,837 (28.1%)
	• Medicare	\$1,350	\$4,998	\$1,638	\$1,631
	• Medicaid	\$480	\$3,330	\$4,880	\$745
Chronic Physical Conditions	N (% of column) PMPM	39,779 (41.2%)	3,796 (65.5%)	1,845 (25.2%)	45,420 (41.4%)
	• Medicare	\$1,511	\$5,374	\$1,587	\$1,835
	• Medicaid	\$475	\$4,403	\$5,993	\$1,035
3 or more Acute Inpatient Admissions in a calendar year	N (% of column) PMPM	3,916 (4.1%)	2,188 (37.8%)	171 (2.3%)	6,275 (5.7%)
	• Medicare	\$5,417	\$6,782	\$5,814	\$5,904
	• Medicaid	\$940	\$4,921	\$5,961	\$2,467
	% of spending (for column)				
	• Medicare	24.3%	62.5%	18.7%	31.9%
	• Medicaid	9.8%	32.8%	2.3%	13.5%

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

The data indicate 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 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 SMI 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 SMI 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 SMI

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 person-centered care; coordination of Medicare and Medicaid services and funding to eliminate program conflicts; support for members' needs; more efficient utilization of federal and state resources; and expanded benefit options.

The key delivery mechanism in this Demonstration will be through a fully integrated delivery system with primary care person-centered medical homes as the foundation. For the purposes of this proposal this approach to care is designated as an Integrated Care Organization. The term ICO is used in this Demonstration to mean either an insurance-based or provider-based health organization, notwithstanding any other uses of the term elsewhere. ICOs will operate in service areas throughout the state defined by MassHealth and CMS. The Commonwealth anticipates that both insurance-based and provider based ICOs will respond to solicitations regarding this demonstration.

The ICO will receive a monthly global payment for each enrollee, for which it will provide the full range of services described in Section C.ii (Benefit Design). The ICO will serve as the single accountable entity responsible for the totality of contracted benefits. This model uses global payments to encourage and facilitate care coordination and management, as well as service delivery innovations and flexibility that are not possible through current FFS structures in Medicare or Medicaid. One portion of the global payment rate will come from Medicare and one portion from MassHealth (see Section E.ii.). The ICOs must have internal capacity or make contractual arrangements to ensure availability of all services in an enrollee's care plan – including care managers, specialists, hospitals, and providers of LTSS, home care and other community supports. MassHealth will require ICOs to demonstrate core competencies across disability types, and to contract with community-based organizations that focus on independence for people with disabilities. Further, ICOs will be selected based on existing or developing relationships with organizations knowledgeable about recovery models and integration of behavioral health, and expert in serving homeless persons and other populations with unique needs. Within these requirements, ICOs may have various organizational, contractual and financial arrangements with their networks. It is critical to this Demonstration that the flexibility made possible by the global payment arrangement be effectively used to reform how services are delivered and paid throughout the care system. The payments will reward ICOs that effectively integrate medical, behavioral health, and LTSS best practices in cost-effective innovations that produce quality outcomes for enrollees.

Global payments allow the following types of innovation not supported in the current FFS payment structure:

- The ICO global payment is not volume-based, but instead is expressly for developing integrated systems and provider networks to provide fully integrated care across medical and behavioral health services while ensuring access to appropriate independent living supports and LTSS.
- The ICO may make payments on a per member basis to primary care sites and independent LTSS Coordinators (see Sections C.i.b. and c.) to work with enrollees, families and other key

contacts to do initial and ongoing assessments, develop individualized care plans, assemble and convene care teams, and provide coordination of services and connections to community resources. This approach over time will support the expansion of primary care sites that can function as patient-centered medical homes and health homes that meet the needs of people with disabilities.⁴

- The ICO may pursue models that are more varied and collaborative, including mobile, home-based, or other non-office-based care, as well primary care provided in behavioral health settings.
- The ICO and care team may employ or contract with a non-traditional, non-medical, health professional workforce (“Community Health Workers”) who are duly trained, certified, and supervised. (See Appendix B for a definition of Community Health Workers).
- The ICO has the flexibility to direct resources to innovative approaches that meet the needs of specific high-need, high-cost populations (those affected by homelessness, chronic diseases, dual diagnosis, etc.).
- The ICO has the flexibility to utilize alternate payment methods to incentivize high quality, integrated care throughout its network.

b. Primary Care and the Care Team

When a member enrolls in an ICO, he or she will choose a primary care provider ⁵ from among those contracted with the ICO. With support from the ICOs, primary care providers will integrate primary care and behavioral health services. The primary care providers will ensure routine screening for depression and other behavioral health conditions in enrollees without a behavioral health diagnosis, provide evidence-based treatment and support for enrollees with behavioral health conditions with a goal toward preventing unnecessary hospitalizations, institutional based care and other higher levels of care, and arrange for behavioral health specialists and treatment plans for those with higher levels of need. The integration of primary care and behavioral health services could be 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 ICO will ensure that behavioral health providers, including providers of diversionary services and community-based

⁴ In the Massachusetts Patient-Centered Medical Home Initiative, staff work together to provide care that meets patients' needs and results in the best health outcomes. Care is delivered by a team, with patients as active participants. The care is integrated and coordinated, and uses technology to support clinical practice with care management, patient follow-up and reminders, and ongoing quality improvement and evaluation. The Health Home service delivery model provides access to comprehensive services including medical care, behavioral health care, and LTSS to populations with chronic conditions. Health Homes, as defined in Section 1945(h) of the Social Security Act, include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services; and use of health information technology to link services.

⁵ Primary care incorporates initial and ongoing assessments 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.

resources, participate with the care team in care planning (described below) and provide all medically necessary behavioral health services as well as community-based alternative services that support recovery.

Care Coordination and the Role of the Care Team

ICOs will offer care coordination services to all enrollees, with the ICO making available dedicated staff and other resources when needed to ensure effective care coordination for its enrollees. A Care Coordinator's role will include:

- assuring that referrals to medical/behavioral health specialists result in timely appointments and two-way transmission of useful member information;
- managing and tracking tests, test results, assessments, referrals and outcomes;
- obtaining reliable and timely information about medical/behavioral health services (e.g. emergency, specialty) to assure safe and effective transitions across care settings;
- assisting the enrollee to develop wellness strategies and self-management skills to effectively access and use services; and
- 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.

The Care Coordinator will work with an independent LTSS Coordinator to coordinate community-based LTSS and independent living supports for enrollees (see Section C.i.c).

The primary care provider staff will work in care teams. The care team will use a single medical record to manage communication and information flow regarding an enrollee's clinical referrals, transitions of care, and care delivered outside of the primary care practice. 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 care team will be informed about 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 primary care team also will be accessible to the enrollee, including providing alternatives to face-to-face visits, such as email and telephone contact.

The Care Coordinator will coordinate the enrollee's care team, including convening the appropriate primary care staff. The enrollee will play the central role in choosing care team members, which may also include specialists, peers, family, other informal caregivers, Community Health Workers, advocates, social workers, case managers, and others. The independent LTSS Coordinators work through Independent Living Centers, Recovery Learning Communities, Aging Services Access Points, or other community-based organizations providing substantial support to the enrollee. This role is described further in section c below.

Initial Assessment and Care Plan

The Care Coordinator and LTSS Coordinator will conduct an initial comprehensive assessment of each enrollee's needs, including needs for medical, behavioral health, and ongoing LTSS. Care teams will use a MassHealth-approved assessment tool, and will conduct the assessment in a location that meets the needs of the enrollee, including in his or her home when necessary and feasible.

The assessment tool will encompass multiple domains including social, functional, medical, behavioral, wellness, and prevention, as well as address the enrollee's strengths and goals, need for any specialists and the plan for care management and coordination, etc. Assessment of LTSS will include the enrollee's need for services and supports, the appropriate amount, duration and scope of such services, and, as necessary, an appropriate plan for transition to a different level of service or to alternative services

compared with the enrollee's current service plan. Each element of the assessment will be reflected in the enrollee's plan of care and the ICO will ensure that all relevant aspects of the enrollee's care are addressed in a fully integrated manner on an ongoing basis. MassHealth will work with stakeholders to identify appropriate assessment tools.

The assessment is the starting point for creating an individualized care plan. Care plans typically include a summary of the enrollee's health history (including any current diagnoses and medical or non-medical interventions); a prioritized list of concerns and goals (with the current clinical, educational, and/or social information pertinent to the concern or goal); the plan for addressing that concern or goal; the person(s) responsible for that intervention; and the due date for the intervention. The care team and enrollee will establish and maintain this care plan.

Clinical Care Management

The primary care provider, with support from the ICO, will also provide Clinical Care Management (CCM). Compared with care coordination, CCM constitutes more intensive clinical monitoring and follow-up, and may particularly benefit 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. Specific CCM services will include:

- 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 ICO, primary care provider and care team will be person-centered: built on enrollees' expressed preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity. The ICO will ensure that the primary care provider's staff is culturally competent and trained to work with and address the needs of the diverse population of dual eligible members.

With enrollees at its center, the care team can undertake creative strategies for maintaining wellness, achieving recovery goals and avoiding unnecessary emergencies or facility stays. Respect for the experience of the enrollee will expand the ICOs' and providers' base of knowledge and understanding that lead to informed decisions and cost-effective practices.

c. Independent LTSS Coordinator

Nearly 31 percent of the target population currently uses traditional LTSS; 13.3 percent in an institutional setting, and 17.4 percent in a home and community based setting. Community services are critical supports that enable people to live independently and to remain in their homes and communities. It is essential that the care team has a designated resource with expertise in understanding different kinds of LTSS needs and the resources available in the community to address them. Each care team will have access to an independent, qualified LTSS Coordinator from a community-based organization (CBO) such as an Independent Living Center (ILC), a Recovery Learning Community (RLC), an Aging Services Access Point (ASAP), Deaf and Hard of Hearing Independent Living Services programs, The Arc, or other key organizations expert in working with people with disabilities. ICOs will contract with these CBOs to provide staff specifically trained to serve as independent LTSS Coordinators.

The ICO will be required to maintain contractual agreements with CBOs that have the capacity and expertise to provide LTSS coordinators and to oversee the evaluation, assessment, and plan of care functions to assure that services and supports are delivered to meet the enrollee's needs and achieve intended outcomes. The ICO shall not have a direct or indirect financial ownership interest in an entity which provides an LTSS Coordinator.

The independent LTSS Coordinator is a full member of the care team, serving at the discretion of the enrollee. For enrollees without LTSS needs, the LTSS Coordinator need not continue on the care team; however, the ICO must make an LTSS Coordinator available at any time at the request of the enrollee, and in the event of any contemplated admission to a nursing facility, psychiatric hospital, or other institution.

If after an initial meeting it is clear that the enrollee's needs are specific to an area of expertise that the assigned LTSS Coordinator does not have, the ICO will seek and the original LTSS Coordinator will manage the assignment of a different LTSS Coordinator with the appropriate background and expertise. This change in assignment of LTSS Coordinator will be done in an expeditious manner consistent with timelines the ICO requires to complete the assessment.

Following the initial assessment, the LTSS Coordinator will work with the enrollee to address his or her ongoing independent living and LTSS needs, and to incorporate community based services and other available community resources as appropriate into the enrollee's individualized care plan. The LTSS Coordinator will connect the enrollee to services, drawing on the provider network and other resources of the ICO, as well as on community-based resources, and assisting providers in securing any authorizations or service orders necessary to begin services. In the case of ICO enrollees participating in HCBS waivers (see Section C.ii.d. for more detail), the LTSS Coordinator will support the virtual integration of HCBS waiver services and other LTSS with the medical and behavioral health care delivered through the ICO by including the waiver case manager in care decisions, to the extent desired by the enrollee, and facilitating coordination and sharing between waiver services providers and ICO providers.

The ICOs will be responsible for ensuring that LTSS Coordinators meet specific qualifications, including necessary training, experience and expertise in working with people with disabilities and/or elders in need of independent living supports and LTSS, and a thorough knowledge of the home and community-based service system. ICOs will need to verify that CBOs providing LTSS Coordinators are not providers of other services⁶ covered by the Demonstration or, in situations where this cannot be avoided, that CBOs have the necessary firewalls in place to prevent self-interested referrals.

Members who enroll in the Demonstration, either through choosing an ICO or through assignment, will maintain any State Plan community LTSS they are receiving at the time of enrollment for a period of 90 days, or until the ICO completes an initial assessment of service needs, whichever is longer. The enrollee will not experience any reduction to his or her service plan for this period, and the ICO will pay the enrollee's LTSS providers for the same amount, duration and scope of services, and at the same rate such providers were receiving prior to the individual's enrollment in the Demonstration (precluding any significant change in the enrollee's condition or situation that would otherwise warrant additional community or facility-based services, such as a medical crisis, etc.).

⁶ CBOs which provided only referral, training, and assessment services shall not be considered "provider organizations" for the purpose of determining eligibility to provide independent LTSS Coordinator services.

d. Provider networks

MassHealth will require ICOs to have provider networks that can provide enrollees, either directly or by subcontracting, all services available in the Demonstration. In providing these services, ICOs and providers must comply with the Americans with Disabilities Act (ADA) and assure their capacity to deliver services in a manner that accommodates the 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 can adequately address the language and cultural diversity of the local community. ICOs must meet the standards for provider access in federal Medicaid managed care 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 enrollees with disabilities. 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.

Many members have a personal network of doctors, specialists, and other care providers that they carefully assembled over long periods to meet their individual needs and preferences. It is important to the success of this Demonstration that members do not experience gaps or disruptions in services before all of their needs can be assessed and addressed in their new care plan. MassHealth will require ICOs to have a clear continuity of care process that allows qualified and willing providers already serving eligible members wishing to maintain that relationship the opportunity to join the ICO's provider network. As described above (see Section C.i.c.), when members enroll with an ICO they will have access to the same services and providers, at the same levels and rates of payment, that they were accessing in FFS prior to their enrollment for the longer of 90 days or until their initial assessment, any necessary additional assessments, and all noticing for their new care plan are complete.

Beyond this 90-day period, under certain defined circumstances, MassHealth will require 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 or enroll in the ICO network. This should be the exception, not the rule, however. The advantage of using out-of-network providers to encourage continuity of care must 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 will continue to gather 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.

e. Enrollment method

MassHealth proposes a voluntary opt-out enrollment process, with no lock-in period so that members can change ICOs or select the FFS option. 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 will continue to work with members, stakeholders and state agency partners to develop mechanisms to build member understanding about the Demonstration and ICOs, the benefits of enrollment, accessing services, and member rights.

Further collaboration with CMS is necessary to completely account for the implications of ICO enrollment/disenrollment on a dual eligible member's access to Medicare benefits, including Medicare Part D. This information will be critical to ensuring members' access to all covered benefits at all times.

Enrollment in the Demonstration will occur through a transparent process that respects member choice. First, MassHealth will contact members who are eligible for the Demonstration and provide them with clear, accessible information about the Demonstration and the ICOs available to them. Information will include a description of the Demonstration program, the functions of an ICO, availability of ICOs in a member's region, identification of available supports for selecting an ICO, steps in the enrollment procedures, and the right to opt out of the Demonstration. Following this contact, the member will notify MassHealth of his or her selection of an ICO or their preference to opt out. More detailed information about each ICO also will be made available, including whether members' doctors and providers are in the ICO networks. Once members are enrolled, ICOs will take steps to maximize continuity of care as enrollees transition to accessing care through the ICO (see Section C.i.d for more information).

Members will be given sufficient time to make an informed choice about enrolling in an ICO or opting out of the Demonstration. MassHealth will confirm the member's choice of an ICO before coverage begins. Any member who does not communicate his or her choice (to enroll in a given ICO, or to opt out) will be contacted by MassHealth with clear information stating that MassHealth will assign the member to a particular ICO, effective on a specific future date. This communication will again make clear how the member can still choose an ICO, change ICOs, or opt out of the Demonstration at any time.

Although Massachusetts is concerned about the ambitious timeframes, the Commonwealth is working with CMS on CMS's goal of identifying participating ICOs by the time of Medicare Advantage (MA) open enrollment in October 2012, so that Demonstration ICO options are presented to beneficiaries at the same time as the MA options. All ICOs must be prepared to enroll all members who make an ICO choice starting January 2013. MassHealth expects to conduct auto-enrollment roll-out in a deliberate manner for those who do not make a choice or opt out; not all eligible members will be enrolled at the same time. Members enrolled in a Medicare Advantage program will not be auto-enrolled in the Demonstration. The auto-assignment roll-out will help ensure that MassHealth, Medicare, and the ICOs have sufficient capacity to work with members during the transition from FFS, including performing timely initial assessments. 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. The enrollment process also will be the focus of intensive stakeholder discussions, and MassHealth will enlist the help of state agencies, CBOs, families, and other advocates to make information broadly available, to get needed input about communication methods, and to monitor the process once underway.

MassHealth and the federal government will contract with neutral and impartial enrollment brokers representing member interests. 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.

f. Outreach and Marketing

MassHealth intends to promote participation in the Demonstration through 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 will work 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 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 relationships. MassHealth is particularly interested in partnering with or modeling programs that can supplement impartial enrollment broker resources. 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 the affected members and seeks to replicate this model for members with all disability types.

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 and MassHealth, that is inaccurate or false, or that misleads, confuses, or defrauds the recipient.

ii. Benefit design

The Demonstration will include 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, authorized, and coordinated by the care team through the ICO. 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 approved by MassHealth and CMS for determining necessary services. The ICO will 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 currently 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.

a. Joint Medicare and Medicaid 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 described in this section, will be included in the global payment to the ICO. 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. The ICO must use written standards, approved by Medicare and MassHealth, to ensure that entitled benefits from both programs are delivered.

MassHealth proposes that the benefit package include not only 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 certain non-medical transportation. MassHealth's stakeholder discussions and member focus groups identified these as areas where enrollees would see added value in the ICO's benefit package.

MassHealth recognizes the particularly critical role of Personal Care Attendant (PCA) services for members who depend on this service for help with self-care functions and to live independently and participate in their communities. ICOs will be required to provide self-direction as an option for enrollees needing personal care assistance. An enrollee who chooses to self-direct PCA services will be the employer of the PCA and will be responsible for hiring, training, scheduling and firing workers. Personal Care Management (PCM) agencies will provide skills training to enrollees who choose to self-direct their PCA services. MassHealth members currently using the MassHealth PCA program may continue to employ their current PCAs or choose to hire new workers. The ICO will authorize all PCA services, and the LTSS Coordinator will be responsible for facilitating service authorizations with the ICO and connecting enrollees to a PCM and Fiscal Intermediary (FI). The ICO will also make available agency-provided PCA for members preferring that option.

Durable Medical Equipment (DME) is a service that many members have described as problematic in the current FFS system. Medicare limits the scope of service to equipment that is needed for use in the home, and while Medicaid extends this benefit by providing equipment necessary to fulfill a medical purpose, the rules governing the two programs do not result in a cohesive and rational benefit for dual eligible members. Combining the Medicare and Medicaid benefit in this Demonstration, and extending the benefit to include training, repairs, and modifications, will empower the enrollee and the care team to use this resource rationally. For example, an individual who could not get a wheelchair appropriate for his or her weight and had to have frequent repairs under Medicare would be able to work with the care team to access a more appropriate wheelchair. As the ICO will be accountable for all costs, the care team could use DME resources flexibly to make an economically rational, longer term investment that would avoid repetitive repair costs and the cost of loaner equipment during repairs.

Medicare's and MassHealth's home health benefits also have different rules and limitations. For example, Medicare requires its members to be homebound in order to qualify for home health services while people who go out into the community can use the MassHealth benefit. The broader definition of medical necessity used by MassHealth may make home health services more available than they would be under Medicare's narrower definition. The ICO's combined resources would allow the care team to include home health benefits in enrollee care plans whether the enrollee is homebound or can participate more fully in his or her community. This combined benefit should also support better post-acute transitions for enrollees returning to their homes or other community placements.

b. Additional Coordinated Behavioral Health Services

Currently both Medicare and Medicaid State Plan 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. 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 B.)

c. Additional Community Support Services

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 provide a structure that allows the ICO to address this diversity in an appropriate and cost-effective way. With global payments, the ICOs have the opportunity to employ trained non-medical Community Health Workers, either directly or through contract, to support primary care 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; Housing First supports for newly-housed persons who have experienced chronic homelessness⁷; and other interventions that are clinically, functionally and cost effective.

The Commonwealth proposes that ICOs 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; and medication management. 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

⁷ Housing First addresses the housing and community-based services needs of the chronically homeless population. *Home & Healthy for Good* is a Housing First program serving chronically homeless adults by providing housing placement in leased apartments or congregate-based homes while also providing services such as case management, medical, behavioral health and substance abuse services. An Office of Medicaid analysis of the first 96 participants in the program found reductions in Medicaid costs from \$26,124 per person per year before housing to \$8,500 per person per year after housing. The annual savings per person for all Medicaid, shelter and incarceration costs was \$9,610 after accounting for the operating, housing and in-home service costs of the program. [Source: *Home & Healthy For Good* Progress Report, December 2011. <http://www.mhsa.net/matriarch/documents/HHG%20Report%20December%202011%20Final.pdf>]

that ICOs have the flexibility to provide all of these services, and others as identified by the care team, in lieu of high-cost traditional Medicare and Medicaid service options. This flexibility will enable ICOs to better work with enrollees to avoid or transition from acute and long-term care inpatient settings. (See Appendix C, Table C.)

d. Adjusted care model for specific services and populations

Certain beneficiaries in the Demonstration target population receive Targeted Case Management (TCM) services from the Department of Developmental Services (DDS) or the Department of Mental Health (DMH). DMH also provides Rehabilitation option services for certain (but not all) individuals with serious and persistent mental health concerns. Members who receive TCM services have significant needs and rely on the support from these agencies to manage their complex care. Changing the delivery of these fundamental services would present a significant change and could be seriously disruptive to these members who rely on their relationships with their state agency for day-to-day support. The Commonwealth therefore proposes that TCM and DMH-provided Rehabilitation option services remain outside the ICO delivery system and continue to operate as they do today. The global payment for the ICOs will not include TCM and Department of Mental Health (DMH) provided rehabilitation option services. (See Appendix C, Table A.)

Approximately 570 individuals in the target population resided in a state-owned ICF/MR in CY2008, and the number of ICF/MR residents has been declining for several years. For these members, DDS is responsible for the majority of their care, and only a small portion of their spending is for other Medicaid or Medicare services. Given the potential complexity of interfacing with the ICF/MR service structure, Massachusetts proposes that individuals residing ICF/MRs be excluded from the Demonstration. This also means that the ICF/MR service will be excluded from ICO-covered benefits. The Demonstration would become immediately available to these members upon community placement.

Demonstration enrollees who are enrolled in HCBS waivers will continue 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, regardless of level of care need, is neither necessary nor affordable. As this is a new model of care and a significant expansion of managed LTSS for Massachusetts, it will be important to take time to build capacity and a strong infrastructure for the full gamut of intensive waiver services. As with TCM and the Rehabilitation option, population-based state agencies have long-standing relationships with HCBS waiver participants, and have long coordinated those individuals' State Plan and waiver LTSS. For those enrolled in a HCBS waiver, there is concern that, within the three-year period of the Demonstration, ICOs would not be able to replicate the extensive and fundamental LTSS needed by these specific populations, or to add sufficient value by changes to service arrangements for these members. The Commonwealth therefore proposes offering a different benefit "tier," which includes access to medical, behavioral health, and expanded ICO services, except for certain state plan and waiver LTSS, for the approximately 7,300 Demonstration enrollees who are enrolled in HCBS waivers (based on CY2008 data).

Massachusetts proposes that people with intellectual disabilities, brain injury, or other physical disabilities, or frail elders ages 60 to 64, who are enrolled in HCBS waivers that are managed through state agencies (the Department of Developmental Services, the Massachusetts Rehabilitation Commission, the Executive Office of Elder Affairs) continue to access LTSS services through current HCBS waiver arrangements so as not to disrupt essential care. HCBS waiver participants would enroll in an ICO and continue to receive certain LTSS and case management through the operating agency of the HCBS waiver. The ICO's global rate would be adjusted to exclude non-ICO covered LTSS for HCBS waiver participants to ensure there is no duplication of payment between the ICO and the state agencies.

Massachusetts expects that during this three-year Demonstration the integrated care model will build on the existing community-based infrastructure to add capacity, expertise, and provider networks through the ICOs so that, in the future, ICOs might also be able to take increasing responsibility for the complete range of services relied upon by these most vulnerable populations.

For all HCBS waiver participants enrolled in an ICO, the global payment will include all medical and behavioral health services, and certain LTSS also covered by Medicare and Medicaid (Chronic Disease and Rehabilitation Hospital Inpatient, Durable Medical Equipment (DME) and Supplies, Home Health, Hospice, Medically Necessary Non-emergency Transport, Independent Nursing, Skilled Nursing Facility, and Therapy services). For waiver enrollees only, the ICO will not be responsible for providing certain State Plan LTSS that are managed through waiver case managers and that will be excluded from the global payment (Adult Day Health, Adult Foster Care, Day Habilitation, Group Adult Foster Care, and Personal Care), or HCBS waiver services. HCBS waiver participants will be able to access all other services through the ICO.

The Demonstration still holds significant advantages for HCBS waiver populations, including the foundation of care coordination, expanded behavioral health diversionary services, greater flexibility in the provision of services, and ICO-developed innovations around care management. For HCBS waiver enrollees the ICO, through the LTSS Coordinator, will integrate the acute, primary care, and behavioral health aspects of enrollees' care with their HCBS waiver services. The ICO will remain fully responsible for all other aspects of the enrollee's care, and will be required to consider the enrollee's waiver service plan in his or her care plan, and to include the waiver case manager on the care team, to the fullest extent possible and consented to by the enrollee. The LTSS Coordinator's role will be critical as the primary information conduit and integrator between an enrollee's HCBS waiver case manager and the ICO care team. This connection will facilitate communication in particular between physicians and other medical providers on the care team and daily support providers about critical issues such as medication changes, the emergence of acute health issues, and setting changes.

iii. Evidence-based practice

A key element of this model is providing care that is coordinated and evidence-based. This starts with planned key interactions between an enrollee and his or her care team, 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.⁸ In addition, ICOs must ensure that practices employ clinical guidelines-based decision support tools or other mechanisms to guide care. These tools may include electronic medical record-based informational alerts and reminders to follow evidence-based guidelines.

MassHealth will expect ICOs to require 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 will 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.

⁸ 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.

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 and hold providers accountable for the care they deliver. Massachusetts aims to reward quality care, improve health outcomes, and more effectively spend health care dollars.

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 in institutions 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 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.⁹ MFP enrollees also will have access to MFP Demonstration Services, which include Assistive Technology, Transitional Assistance Services, Case Management, and Mobility Training, as needed.

Non-HCBS waiver participants enrolled in the Demonstration also will have access to certain community-based supports (see Appendix C, Table C) 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.

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 members under age 65 who are not in an institution and 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, through a global payment to 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.

⁹ 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.

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 with primary care, 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 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 certain covered services and supports.

PACE was implemented in Massachusetts in 1990 and serves 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 as 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.¹⁰ 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.¹¹ 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 (PCMH), 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

¹⁰ Chapter 58 of the Acts of 2006.

¹¹ Chapter 305 of the Acts of 2008.

entire Massachusetts health care system, using ACOs as the foundation. The Administration filed legislation in 2011 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. 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, 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, multi-payer 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 during the 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, monthly open stakeholder meetings, and a public comment period for the draft Demonstration proposal that included two public hearings. 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 for 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.¹² 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 was consistent and provided critical information on members' understanding of and confusion about Medicare and Medicaid covered services, access to

¹² 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).

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 the 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 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. 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. 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 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.¹³ 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 draft 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 a thirty-one day period, from December 10, 2011 through January 10, 2012. Massachusetts published a notice in major local newspapers across the state announcing that the Demonstration proposal was posted and inviting public comment, and also circulated the draft Demonstration proposal to all parties on its stakeholder distribution lists. MassHealth accepted oral and written comments through four main sources. MassHealth announced and held two public hearings, one in Worcester on December 16, 2011 and the other in Boston on January 4, 2012. Well over 100 stakeholders attended each meeting. MassHealth also solicited written comments which stakeholders could send directly to MassHealth or submit electronically through its Duals email address (Duals@state.ma.us). MassHealth received over 200 comments from all sources. MassHealth reviewed all comments and has revised and refined the content, ideas and language in the Demonstration proposal to incorporate stakeholder input, as appropriate. MassHealth also held an open stakeholder meeting to discuss changes to the final proposal based on the comments and testimony received.

ii. Beneficiary protections

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

a. Americans with Disabilities Act (ADA)

MassHealth believes that intensifying our focus on ADA compliance is crucial to the success of the ICO model and will support better health outcomes for ICO enrollees. In particular, MassHealth recognizes that successful person-centered care requires physical access to buildings, services and equipment and

¹³ To date, MassHealth has 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, October 11, 2011, and February 6, 2012. Agendas and meeting materials for each of these meetings are posted on the Demonstration web site at: www.mass.gov/masshealth/duals.

flexibility in scheduling and processes. MassHealth will require ICOs to contract with providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their enrollees. MassHealth also recognizes that access includes effective communication. MassHealth will require ICOs and their providers to communicate with their enrollees in a manner that accommodates their individual needs, including providing translators for those who are deaf and hard of hearing and those who do not speak English. Finally, MassHealth recognizes the importance of staff training on accessibility and accommodation, independent living and recovery, and wellness philosophies. MassHealth will continue its work with stakeholders to identify learning opportunities, monitoring mechanisms and quality measures to ensure that ICOs and their providers comply with all requirements of the ADA. Additional successful measures that are employed through this Demonstration to elevate attention to ADA compliance in the provision of health services will pay dividends well beyond the Demonstration in providing a model for all of our programs.

b. Choice of providers

ICOs must offer enrollees provider networks that have sufficient breadth and medical and supportive service expertise to enable access to all covered services. ICOs must also have a continuity of care process that allows enrollees to maintain relationships with their existing provider networks. Section C.i.d describes these and other features of the delivery model that constitute protections related to enrollees' choice of providers.

c. Complaints, Grievances and Appeals Processes

Through contract requirements with ICOs and agreement with CMS, MassHealth will ensure that enrollees have 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 and Medicaid managed care requirements. ICOs will 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 create and maintain records of such activity, using a 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.

Massachusetts proposes that enrollees also have access to a single external appeals process that meets all required Medicare and Medicaid managed care rules and regulations. MassHealth and CMS will develop an integrated and streamlined process that maintains all the rights and protections afforded by both Medicare and Medicaid. 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.

ICOs will provide written notice of any adverse action they take denying, modifying or terminating a requested service, including advance notice of adverse actions related to denying or modifying ICO-approved services or requests for reauthorization of services. Enrollees will have the right to both internal and (if necessary) external appeals from any adverse action, including the ICO's action to deny, modify or terminate the enrollee's plan of care. ICOs will be required to provide written decisions on internal appeals and notice of the enrollee's rights to an external appeal and the process for requesting such an appeal. MassHealth proposes that the MassHealth Board of Hearings hear such external appeals. Aid pending appeal resolution at the Board of Hearings would be provided at the request of the enrollee for any adverse action related to terminating or modifying ICO-approved services or requests for reauthorization of services. Expedited internal and external appeals would be provided if needed.

d. Enrollee Customer Service

All ICOs will 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.

e. 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. The Commonwealth will also continue discussions about including advocates and members in appropriate advisory mechanisms that may be established to track and monitor this Demonstration.

iii. Ongoing stakeholder engagement during the implementation and operation phases

MassHealth will continue to gather and incorporate stakeholder feedback during the implementation and operational phases of the Demonstration. MassHealth 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 hold public stakeholder meetings, as described in Section D.i.d., to share information and feedback about implementation and operation of the Demonstration. All public meetings will continue to offer ASL interpretation and/or Communication Access Realtime Translation (CART). 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 that are easily understood by persons with limited English proficiency, and will 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.

MassHealth will monitor enrollee experiences and satisfaction with the Demonstration through surveys, member focus groups and data analyses. Provider experience and satisfaction also will be collected through surveys, key informant interviews, and data analyses. Masshealth will work with stakeholders to form an advisory group that will monitor the Demonstration throughout implementation and operation phases.

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 patient-centered medical homes, 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 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. A workgroup is currently developing an ACO RFP that will provide non-dual eligible MassHealth members with access to integrated provider-based organizations that promote the delivery and payment system reform goals outlined above.
- **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

The policy goals outlined in other sections of this proposal will drive the payment methodologies. Development of 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. Under the three-way capitated contract, ICOs will receive an actuarially developed, prospective, risk adjusted, blended global rate for the full continuum of benefits they provide to an enrollee. Both Medicare and Medicaid will contribute to the total base global 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.) CMS must approve the final payments to ICOs and all steps in the process of developing the blended global payment. MassHealth has begun collaborating with CMS to determine the approach to building the payment mechanism, but many design aspects are still to be finalized. Based on recent information from CMS regarding its preferred approach

to rate development, MassHealth and CMS may need to negotiate aspects of the proposed MassHealth approach outlined below, and certain aspects of it may change. In addition, the rate development process itself requires the use of linked, validated Medicare and Medicaid data. MassHealth is currently in the process of validating the linked Medicaid and Medicare data. Once the dataset is complete and validated, the rate development process can begin.

The basic steps in establishing ICO payments are:

- Determining rating categories that stratify the population so that higher rates are paid for higher need members;
- Developing the contract year base global rates for each rating category based on historical data;
- Risk adjusting the base global rates for each rating category during the contract year to account for differential risk of enrollees across ICOs;
- Determining additional risk mitigation strategies to address potential underpayments or overpayments to ICOs while the program is in the early stages;
- Determining savings expectations associated with coordinated care and alternative service options and how to reflect those expectations in the global payment; and
- Establishing incentive methodologies in the payment structure tied to defined outcome measures.

Timelines for rate development, risk adjustment, and public information sharing of the data used to inform this process are all dependent on receipt of Medicare data, and validation of the linked Medicare-Medicaid dataset. Once available, the historical Medicaid and Medicare data that will be used to develop the base global rates will also be made publically available in an aggregated manner that assures member privacy. Relevant, de-identified supplemental data used to account for expanded benefits will also be made available.

a. Determining rating categories

MassHealth and its actuaries will construct rating categories that stratify the population based on cost, utilization and some measure or proxy of functional status, into subgroups made up of enrollees with similar risk profiles. Higher base global rates will be paid for rating categories reflecting higher risk populations.

b. Developing the base global rates

MassHealth will use linked Medicare and Medicaid claims data for the most recent experience available (CY 2009 and 2010) to develop the base global rates. Medicare and Medicaid historical payments will be included in the base data. Where data do not exist for this population due to new expanded services, projections will use available comparable data such as behavioral health diversionary services provided to the disabled Medicaid-only population. Expected costs will be trended to the implementation period.

Adjustments to the base data will reflect anticipated savings resulting from improved care management and an integrated care delivery system that includes the expanded service package.

Base global rates for each rating category will be developed for each contract year. The base dataset will be transitioned over time from historical Medicaid and Medicare fee-for-service data to actual ICO experience based on the submitted ICO encounter data.

c. Risk Adjustment across ICOs

The other primary step in aligning enrollee risk and global payments is adjusting risk to account for enrollee risk variation across ICOs. Generally, risk scores are developed for each ICO enrollee at regular intervals during the contract year, and these individual scores are aggregated to develop ICO-specific risk scores for each rating category. ICO risk scores are applied to the base global rates to determine risk-adjusted rates. Within each rating category payments are reallocated across ICOs so that payments are more appropriately matched to enrollee risk; ICOs enrolling individuals with higher risk than average for the rating category are paid higher global rates, while those with lower risk enrollees receive lower rates.

The risk score must be sensitive enough to identify the highest cost, highest need enrollees. 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, including those with disabilities. Medicare uses the related CMS-HCC model to risk adjust Medicare Advantage payments. Both of these systems are based on diagnoses and may not be sufficient to account for risk differential in the Demonstration target population.

MassHealth proposes to establish a continuous quality improvement approach to enhance the precision of the risk adjustment methodology during the Demonstration period and beyond. For this target population in particular, the methodology should be tailored to appropriately account for behavioral health, LTSS, and community support service needs. MassHealth believes functional status should be included in the risk score development, but this requires more complete data than are currently available. As functional status data become available, MassHealth and CMS should consider how best to incorporate this information into the risk adjustment methodology. MassHealth is exploring risk adjustment strategies that will better align risk and payment prior to the availability of the necessary, complete data. 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

Until complete data on actual program experience are available and a more robust risk adjustment methodology is in place, supplemental risk mitigation strategies are needed to avoid unintended incentives and consequences. 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. 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 enrollees. MassHealth therefore proposes to use risk mitigation strategies for the new program. The strategies include risk corridors (MassHealth and Medicare would share some defined level of profits or losses within the ICOs, protecting against both underpayment and overpayment to ICOs), and stop loss (a premium based mechanism by which the amount any one enrollee can cost an ICO is capped at a certain level, limiting loss for an ICO). While risk corridors have implications for projecting precise spending levels, they could be tiered and/or designed to diminish over the three year period as actual program data become available and the program stabilizes.

e. Apportioning the ICO payments 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 the historical proportional Medicare payment (based on the CY2009 and 2010 data) and reasonable administrative costs to support the program be applied to the blended global payment rate for each rating category.

f. 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 proposes 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 global 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 ensure 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

Massachusetts will test several hypotheses with this Demonstration. The Commonwealth expects that this Demonstration will show that integrated care improves quality by: reducing over-utilization of high-cost hospital and long-term institutional care and under-utilization of outpatient and community-based services and supports; improving chronic disease management; reducing health disparities; improving patient satisfaction; increasing the use of evidence-based practices; and improving provider ADA accessibility. Second, this Demonstration is expected to improve outcomes, through gains in health status and functional status and by lessening or altogether diverting long term care facility stays. Third, the Demonstration is expected to reduce costs compared to the historical FFS experience for this population. MassHealth also will compare costs for the target population enrolled in the Demonstration to costs for dual eligible individuals ages 65 and over and for MassHealth-only members ages 21-64 with disabilities, who are served in MassHealth's managed medical and behavioral health delivery system.

MassHealth expects that this model will improve coordination among providers, will reduce preventable and avoidable hospitalizations, and will reduce the incidence of "never" events. Finally, Massachusetts will review the impact of health information technology (HIT) and electronic medical record (EMR) adoption on the speed of intervention with enrollees, whether severity of acute conditions can be mitigated, and whether administrative costs can be reduced after initial investments.

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

MassHealth, in consultation with CMS, will use a comprehensive stakeholder process to develop a sound quality and cost measurement and management strategy for the Demonstration. This process will include the development and incorporation of quality measures specific to the use of community LTSS to address members' functional capabilities and limitations and their related outcomes. 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 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 RFR and prospective ICO responses, and then incorporated into the contracts between MassHealth, CMS and each ICO.

MassHealth proposes to explore with CMS the use of incentive payments to ICOs based on meeting or exceeding quality targets, and would:

1. develop, with consultation from stakeholders, an approach to link quality measurement and outcomes to payments to the ICO;
2. develop short and long term performance monitoring strategies; and
3. engage in long term Demonstration evaluation (with the CMS-contracted national evaluator) to discern the value of the Demonstration.

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. The table in Appendix F 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.**

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, input from trusted providers, and needed community based LTSS.
- 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, community support services and network development. The effects are an underinvestment in these important cost-effective services, missed savings potential and missed opportunities to better coordinate care and improve health outcomes for members.

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, gain better access to coordinated behavioral health services, and remain in community settings longer. This Demonstration's target population does not currently have access to either a provider-based or health plan integrated care option. Better coordination and management of care will result in improvements in chronic disease management, and better use of community-based services and LTSS. Care coordination will support enrollees through transitions across care settings to ensure more highly desired, as well as more cost effective options post-discharge. For example, well-coordinated transition support will provide timely management with discharge planners when an enrollee leaves an acute facility, allowing the enrollee, when appropriate, to return home instead of being admitted to a nursing facility. These care coordination improvements will lead to expected savings in the short term associated with reductions in acute care admissions, readmissions, length of stay in psychiatric facilities and ER use.

The Medicare data, which are expected to be fully available in February 2012 with the provision of Part D data, 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 analyzed 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 MassHealth-only members with disabilities with access to these services, and data from Medicaid managed behavioral health programs in other states. This actuarial analysis supports the prospects for

the proposed model, with expanded benefits and program investment in the earlier years, to produce both short term and longer term savings for Medicare and MassHealth.

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 agencies¹⁴ and through DDS, EOEA, and

¹⁴The 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).

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.

ii. Need for waivers

Appendix D summarizes Massachusetts' current and proposed 1915(c) waiver authority for the services certain Demonstration enrollees may access through their participation in HCBS waivers. MassHealth will work with CMS to identify additional waivers or other federal authority that would be needed for certain services and for other operational and financial aspects of the Demonstration. Minimally, MassHealth anticipates needing a federal waiver of Medicaid comparability rules, and to receive expenditure authority for services currently provided under the MassHealth 1115 Demonstration and other expanded benefits not included in the State Plan.

iii. Plans to expand to other populations

While Massachusetts is targeting dual eligible members ages 21- 64 in this Demonstration, 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 care, 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. Over 90,000 individuals use many of the same services as dual eligible members in this age group, and many of them 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. Demonstration enrollees turning 65 will be offered the choice of remaining in the Demonstration, selecting a PACE or SCO plan, or returning to FFS.

iv. Overall implementation strategy and anticipated timeline

Massachusetts anticipates 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. 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

MassHealth will seek partnership and administrative resources from CMS to support the build-out of new infrastructure, IT, staff, and member and provider outreach necessary to implement the Demonstration. MassHealth will collect and/or provide data to CMS to inform program management, rate development and Demonstration evaluation, as specified in standard terms and conditions and other contractual documents to be executed between MassHealth and CMS.

Providers that contract 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 opportunities, 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, managing 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 MassHealth to administer the Medicaid program. Nevertheless, changes to state statute might be required depending on the specifics of the Demonstration. For example, MassHealth is exploring statutory authority that may be necessary or appropriate in order to authorize provider based entities to participate in this Demonstration as ICOs. With regard to regulatory changes, at a minimum MassHealth managed care member eligibility and managed care provider regulations will need to be amended to address the new Demonstration.

MassHealth also is exploring including this Demonstration in the context of the broader legislative approach to health reform implementation in the state. MassHealth will collaborate with stakeholders and legislators on legislation that supports the Demonstration to ensure forward progress on our shared goals.

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

State appropriations will need to be sufficient to support the Demonstration. Appropriations are currently in place for Medicaid services currently being provided to Duals-eligibles. 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 because 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 H 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:

- **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 Coordinators - to work with assigned ICOs to ensure compliance with contract requirements
- Quality Manager – to oversee and manage reporting on quality management with individual ICOs, and across the program
- Hearing Officer – to add capacity at the Board of Hearings for processing appeals for dual eligibles related to the Demonstration
- **IT system changes:** Support member enrollments, encounter data collection and analysis, develop customized cubes and queries, federal reporting, financial analysis, new assignment plans, modifications to the capitation payment system, and transferring eligibility and enrollment data between systems, including sharing information with ICOs and CMS
- **Procurement costs:** Resources for consultant support in developing the procurement, developing a data book, 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 state evaluation activities, development and deployment of survey tools, costs of accessing, transferring, and analyzing ICO data and other quality data, and report infrastructure development
- **Actuarial analysis and rate setting:** Actuarial support for rate development and analysis, analytical support during procurement, and development or purchase of risk adjustment tools
- **Marketing and outreach:** Production and mailing of marketing and program information materials, including communications about enrollment, resources to conduct targeted and broad outreach/marketing for members and providers, and regular stakeholder meetings (bi-monthly during implementation)
- **Customer Service:** Support for members during enrollment processes, including enrollment process customer communications capacity, hands-on assistance to members evaluating their enrollment choices, informational materials to members and those assisting with decision support, and coordination with Medicare enrollment processes
- **Staff Travel and Mileage:** Resources for out-of-state travel for key project staff, such as to technical assistance meetings or to meet with CMS, and for mileage reimbursements for staff travel to meetings around the state.
- **Monitoring and Oversight:** Resources for monitoring and oversight of the ICO, including participation by stakeholders and enrollees

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 care team (see section C.i.b). 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 Appendix F.

Massachusetts had five groups selected to become **Pioneer ACOs**. This model is intended to allow groups already experienced in coordinating care for patients across care settings to move rapidly from a shared savings payment model to a population-based payment model, consistent with the Medicare Shared Savings Program. The Pioneer model will use a shared savings payment policy initially, then shift to a population-based payment model for organizations that have reached a specified savings threshold. This initiative is designed to align provider incentives, which will improve quality and health outcomes for patients across the ACO and achieve cost savings for Medicare, employers, and patients.¹⁵

¹⁵ Center for Medicare and Medicaid Innovation, "Pioneer ACO Model." <http://innovations.cms.gov/initiatives/aco/pioneer/>. Accessed February 9, 2012.

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”

Institution: A Skilled Nursing Facility, Intermediate Care Facility, chronic or rehabilitation hospital, or psychiatric hospital.

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

Independent Living and 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 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. Community Health Workers

The Massachusetts Department of Public Health (DPH) defines Community Health Workers (CHWs) as public health workers who apply their unique understanding of the experience, language, and/or culture of the populations they serve in order to carry out one or more of the following roles:

- Providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses, and community centers;
- Bridging/culturally mediating between individuals, communities, and health and human services, including actively building individual and community capacity;
- Assuring that people access the services they need;
- Providing direct services, such as informal counseling, social support, care coordination, and health screenings; and
- Advocating for individual and community needs.

CHWs are distinguished from other health professionals because they:

- Are hired primarily for their understanding of the populations and communities they serve;
- Conduct outreach a significant portion of the time in one or more of the categories above;
- Have experience providing services in community settings.

“Community Health Worker” is an umbrella term for a number of job titles that perform one or more of the functions listed in the DPH definition. In its 2005 report, *Community Health Workers: Essential to Improving Health in Massachusetts*, DPH reported some 50 job titles in current use that fit the department’s CHW job description. Examples include:

- Outreach Worker
- Street Outreach Worker
- Outreach Educator
- Health Educator
- Community Health Educator
- Patient Navigator
- Enrollment Worker
- Health Advocate
- Family Advocate
- Peer Advocate
- Peer Leader
- Promotor(a)
- Promotor(a) de Salud
- Family Support Worker

Source: Massachusetts Department of Public Health Community Health Worker Advisory Council, “Community Health Workers in Massachusetts: Improving Health Care and Public Health.” December, 2009 (<http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf>)

Appendix C. Covered Services

Table A. MassHealth State Plan Benefits to be Provided by the ICO

Benefits	ICO Enrollees Not in HCBS Waivers	ICO Enrollees Participating in HCBS Waivers
Inpatient Hospital	X	X
Adult Day Health ¹	X	
Adult Foster Care ¹	X	
Ambulance (emergency)	X	X
Audiologist Services	X	X
Behavioral Health Services (mental health and substance abuse)	X	X
Chiropractic Care	X	X
Chronic Disease and Rehabilitation Hospital Inpatient	X	X
Community Health Center (includes FQHC and RHC services)	X	X
Day Habilitation ¹	X	
Dental Services	X	X
Durable Medical Equipment and Supplies	X	X
Family Planning	X	X
Group Adult Foster Care ¹	X	
Hearing Aids	X	X
Home Health	X	X
Hospice	X	X
Laboratory/X-ray/Imaging	X	X
Medically Necessary Non-emergency Transport	X	X
Nurse Midwife Services	X	X
Nurse Practitioner Services	X	X
Orthotic Services	X	X
Outpatient Hospital	X	X
Outpatient Surgery	X	X
Oxygen and Respiratory Therapy Equipment	X	X

Personal Care ¹	X	
Pharmacy	X	X
Physician	X	X
Podiatry	X	X
Independent Nursing	X	X
Prosthetics	X	X
Rehabilitation ²	X ²	X ²
Renal Dialysis Services	X	X
Skilled Nursing Facility	X	X
Speech and Hearing Services	X	X
Targeted Case Management ³		
Therapy: Physical, Occupational, and Speech/Language	X	X
Vision Care	X	X

¹ Benefits not provided by the ICO are provided to enrollees through MassHealth's FFS system, and coordinated through the HCBS waiver operating agency.

² Rehabilitation option services purchased by DMH are excluded from the Demonstration benefit package to be managed by ICOs.

³ Targeted Case Management provided by designated State Agencies is excluded from the Demonstration benefit package to be managed by ICOs, but will continue to be provided by the State Agencies on a FFS basis.

Table B. Diversionary Behavioral Health Services to be Provided by the ICO

Diversionary Behavioral Health Service	Setting	Definition of Service	Current State Plan	Current 1115	ICO Enrollees Not in HCBS Waivers	ICO Enrollees Participating in HCBS Waivers
Community Crisis Stabilization	24-hour facility	Services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.		X	X	X
Community Support Program (CSP)	Non-24-hour facility	An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.		X	X	X
Partial Hospitalization**	Non-24-hour facility	An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.		X	X	X

Acute Treatment Services for Substance Abuse	24-hour facility	24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.		X	X	X
Clinical Support Services for Substance Abuse	24-hour facility	24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.		X	X	X

Psychiatric Day Treatment*	Non-24-hour facility	Services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.	X		X	X
Intensive Outpatient Program	Non-24-hour facility	A clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.		X	X	X
Structured Outpatient Addiction Program	Non-24-hour facility	Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.		X	X	X

Program of Assertive Community Treatment	Non-24-hour facility	A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.		X	X	X
Emergency Services Program	Non-24-hour facility	Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.	X		X	X

Table C. Additional Community Support Services to be Provided by the ICO

New Benefits
Day Services*
Home Care Services*
Respite Care*
Peer Support/Counseling/Navigation
Transitional Assistance (across settings)
Home Modifications*
Community Health Workers
Medication Management

*** For HBCS waiver enrollees, the service is provided through the waiver, not the ICO**

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) ¹⁶	MFP Community Living Waiver (NEW) ¹⁷
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						

¹⁶ Proposed Waiver, not yet in operation.

¹⁷ 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) ¹⁶	MFP Community Living Waiver (NEW) ¹⁷
Supplement									
Day Services	X	X	X	X ¹⁸	X	X	X	X	X
Family Training	X	X	X ¹⁹					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					
Independent Living Supports									X
Individual Goods and Services	X	X							
Individual Support and Community Habilitation			X		X		X	X	X

¹⁸ Supportive Day Program for Frail Elder Waiver

¹⁹ 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) ¹⁶	MFP Community Living Waiver (NEW) ¹⁷
Individualized Day Supports	X	X	X						
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) ¹⁶	MFP Community Living Waiver (NEW) ¹⁷
Specialized Medical Equipment	X	X		X ²⁰	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 Services²¹	X	X		X	X	X	X		
Vehicle Modification	X			X					X

²⁰ This service in Frail Elder Waiver is Home Based Wandering Response System

²¹ 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
December 2011-February 2012	Submit proposal to CMS <ul style="list-style-type: none"> • Stakeholder engagement/discussions • Draft proposal • Public comment period • Final revisions/submission 	Deputy Medicaid Director for Policy and Programs
February 2012-April 2012	Negotiations/MOU with CMS <ul style="list-style-type: none"> • Identify Waivers needed • Draft MOU/contract terms • Finalize MOU with CMS 	MassHealth Deputy Director, Director of Planning and Development, Director of Member Policy, MassHealth Legal, CMS
March 2012-Sept 2012	ICO procurement and selection <ul style="list-style-type: none"> • Draft and release procurement (4/13/12) • Bidder responses due • CMS network adequacy determination (mid-July) • Select ICOs (7/30/12) • Execute contracts (9/20/12) • Bidder readiness (Late July – Sept) 	MassHealth procurement team, CMS, ICOs, MassHealth Legal
February 2012-July 2012	Actuarial analysis and rate setting <ul style="list-style-type: none"> • State receives 2009 and 2010 Medicare 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
April 2012-Sept 2012	Develop quality metrics and outcomes management targets <ul style="list-style-type: none"> • Expand initial quality metrics list • Develop measures for each quality metric • Develop expected outcomes • Develop targets 	MassHealth, UMMS
March 2012- Sept 2012	IT/Systems adaptations <ul style="list-style-type: none"> • MMIS changes for enrollments • Add ICOs to MMIS • Develop new assignment plans in MMIS • Modify capitation payment system in MMIS • Develop communication with ICOs/CMS on member enrollments • Develop encounter data specs and reports • DW to accept encounter data • Develop new analytic views/reports • DW to accept new ICOs/reflect global payments 	MMIS, DW Leads, MassHealth CIO, Federal Reporting team, Director of Federal Finance

Timeframe	Key Activities/Milestones	Responsible Parties
	<ul style="list-style-type: none"> • Update federal reporting specs 	
July 2012-Jan 2013	Member outreach/marketing and enrollment support <ul style="list-style-type: none"> • Develop outreach/marketing materials • Update CST contract to support ICO enrollments • Contract for member decision support • Mail out enrollment packages • Members return enrollment packages • Member enrollment begins 	MassHealth Operations, Customer Service Team, ICOs, Members
January 2013-April 2013	Contract monitoring and compliance <ul style="list-style-type: none"> • 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
March 2012-July 2012	Legislation and budget alignment <ul style="list-style-type: none"> • Develop budget projections for SFY13 (7/2012 – 6/2013) • Draft legislative language • Draft budget realignment • Include budget/language in legislative vehicle 	MassHealth CFO, MassHealth Legal
June 2012-October 2012	Regulations <ul style="list-style-type: none"> • Identify new regulations needed • Identify revisions to existing regulations needed • Draft regulations • Public comment period • Promulgate regulations 	MassHealth Legal, MassHealth Policy unit
July 2012	Hire program staff <ul style="list-style-type: none"> • 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

Appendix F. Examples of 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, behavioral health and LTSS) ADA compliance Accessible equipment / examination rooms Accessible communication Geographic access Organizational access	<ul style="list-style-type: none"> • # 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 LTSS options explained/included Self-management support and choice Culturally sensitive service delivery (practices and communications)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • % 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	<ul style="list-style-type: none"> • 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
Integration of Services	Comprehensive services and supports Primary care, behavioral health, medical specialty care, and LTSS integration	<ul style="list-style-type: none"> • 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 • Enrollee usually contacts <u>personal doctor</u> 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	<ul style="list-style-type: none"> • Simplified process for provider reimbursement • Timeliness of provider claims submission • # of provider claims appealed

Domain	Key Concepts	Illustrative Measures (for illustration only; actual measures will be selected via a multi-stakeholder process)
Cost savings	Service utilization management Minimizing duplication of services Delivering care in most appropriate setting Promoting administrative efficiencies	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

Appendix G. Budget Request

Budget Area	FTE	Annual Base Salary	Indirect/ Payroll Tax	Implementation Cost	Annualized Cost	Implementation Months	Annual Ongoing Months	Implementation Phase	Ongoing Annual Cost	Request for 1st Demonstration Term
Program Staff										
Direct Hire Staff Positions										
ICO Program Manager	1	\$100,000	38.20%	\$138,200	\$138,200	9	12	\$103,650	\$138,200	\$518,250
Data Analysts	2	\$65,000	38.20%	\$89,830	\$89,830	9	12	\$134,745	\$179,660	\$673,725
Program Coordinators	2	\$60,000	38.20%	\$82,920	\$82,920	9	12	\$124,380	\$165,840	\$621,900
Contract Coordinators	2	\$60,000	38.20%	\$82,920	\$82,920	9	12	\$124,380	\$165,840	\$621,900
Quality Manager	1	\$80,000	38.20%	\$110,560	\$110,560	9	12	\$82,920	\$110,560	\$414,600
Hearing Officer	1	\$65,000	38.20%	\$89,830	\$89,830	3	12	\$22,458	\$89,830	\$291,948
Contracted Staff Positions										
Analytic Lead*	1	\$170,000	4.90%	\$178,330	\$178,330	3	12	\$44,582	\$178,330	\$579,572
IT System Changes										
Developer/Programmer - Data Warehouse, MMIS	3	\$180,000	4.90%	\$188,820	\$188,820	18		\$849,690	\$0	\$849,690
Procurement Costs										
Consulting				\$150,000		12		\$150,000	\$0	\$150,000
Data Book				\$40,000		12		\$40,000	\$0	\$40,000
Bidders Conferences				\$20,000		12		\$20,000	\$0	\$20,000
Quality Measurement and Evaluation										
Surveys					\$300,000		12	\$0	\$300,000	\$900,000
Data Access					\$140,000		12	\$0	\$140,000	\$420,000
Reporting Infrastructure					\$20,000		12	\$0	\$20,000	\$60,000
Actuarial Support										
ICO Rate Setting				\$500,000	\$350,000	12	12	\$500,000	\$350,000	\$1,550,000
Procurement support				\$150,000		12	12	\$150,000	\$0	\$150,000
Risk adjustment				\$100,000	\$100,000	12	12	\$100,000	\$100,000	\$400,000
Marketing and Outreach										
Outreach and enrollment materials creation and distribution				\$200,000	\$200,000	12	12	\$200,000	\$200,000	\$800,000
Ongoing stakeholder engagement				\$60,000	\$40,000	12	12	\$60,000	\$40,000	\$180,000
Customer Service										
Enrollment materials - creation and distribution				\$200,000		12		\$200,000	\$0	\$200,000
Ongoing enrollment support					\$200,000		12	\$0	\$200,000	\$600,000
Staff Travel and Mileage										
Conference/Out of State				\$7,200	\$600	12	12	\$7,200	\$600	\$9,000
Mileage Reimbursements				\$450	\$450		12	\$0	\$450	\$1,350
Monitoring and Oversight										
Monitoring/Oversight of ICO					\$100,000		12	\$0	\$100,000	\$300,000
Total Request								\$2,914,005	\$2,479,310	\$10,351,935

Appendix H. Letters of Support

**Commonwealth of Massachusetts Proposal to CMS: *State Demonstration to
Integrate Care for Dual Eligible Individuals***

APPENDIX H: LETTERS OF SUPPORT

Index

Governor Deval Patrick

Association for Behavioral Healthcare
Association of Developmental Disabilities Providers
Boston Center for Independent Living
Boston Health Care for the Homeless Program
Boston Public Health Commission
Cape Organization for Rights of the Disabled
Center for Living and Working
Consumer Quality Initiatives, Inc.
Dennis Heaphy, Member
Department of Developmental Services
Department of Mental Health
Department of Public Health
Disability Law Center
Executive Office of Elder Affairs
Greater Boston Legal Services
Independence Associates, Inc.
Mass Home Care
Massachusetts Commission for the Blind
Massachusetts Commission for the Deaf and Hard of Hearing
Massachusetts Developmental Disabilities Council
Massachusetts Housing and Shelter Alliance
Massachusetts League of Community Health Centers
Massachusetts Rehabilitation Commission
MetroWest Center for Independent Living
Multi-cultural Independent Living Center of Boston
National Alliance on Mental Illness
Northeast Independent Living Program
Partners HealthCare
Providers' Council
SEIU 509
SEIU 1199
Stavros
The Arc of Massachusetts
The Transformation Center