

Duals Demonstration: Implementation Pathway December 2012

The Duals Demonstration has achieved significant design milestones since the beginning of 2012. MassHealth submitted a final Demonstration design proposal to the Centers for Medicare and Medicaid Services (CMS) in February 2012, following an extensive stakeholder input and public comment process. The proposal outlined key parameters of the Demonstration, including the eligible population, the scope of covered services, the intended model for care delivery, the protections that would be in place for enrollees, and the payment model. In June 2012, MassHealth issued a Request for Responses (RFR) from Integrated Care Organizations (ICOs), which further described requirements for ICOs and expectations for how they would serve enrollees and be accountable to MassHealth and CMS. In August 2012, EOHHS and CMS also signed a Memorandum of Understanding (MOU), signifying CMS's approval of the Demonstration design proposal.

Through the proposal, RFR and MOU processes, which have featured significant stakeholder engagement, many fundamental aspects of the Demonstration have been solidified. However, MassHealth and CMS continue to develop certain Demonstration components. In letters and other communications, stakeholders continue to raise important questions on a variety of topics – from payment rates and quality measures to ensuring an ongoing consumer voice.

As the Demonstration now moves from a design phase toward implementation with selected ICOs, there will be additional opportunities for CMS, MassHealth and stakeholders to work together on addressing and resolving outstanding issues. This document outlines a number of issues that stakeholders have raised in the past several months and provides responses from MassHealth. For each issue and response*, also noted is the mechanism(s) by which MassHealth anticipates addressing the issue; the mechanisms for approaching these issues may change as MassHealth gains more experience with the Demonstration. The mechanisms, and their associated timeframes, are shown in the table below. MassHealth expects that the Implementation Council included in the table will be a critical component of monitoring and ongoing development of the Demonstration. Please see item #54 of this document for a description.

Mechanism	Anticipated Timeframe*
Request for Responses (RFR)	June 2012
Memorandum of Understanding (MOU)	August 2012
Readiness Review	November 2012 – February 2013
Implementation Council	December 2012 – ongoing
Stakeholder Workgroups	December 2012 – ongoing
Three-Way Contract	February 2013
State Regulations	February 2013
Ombudsperson	February 2013 – ongoing
Learning Collaboratives	March 2013 – ongoing
Ongoing Open Stakeholder Meetings	Ongoing
Ongoing Contract Management	February 2013 – ongoing

*Dates are subject to change.

MassHealth remains confident that our experience in building new programs, coupled with the strong engagement we have had and continue to have with stakeholders, will lead to successful implementation of this Demonstration.

* If there is any conflict between the information in this document and the RFR, MOU, or Three-Way Contract, the latter documents shall control.

Issues and Responses

Capacity

1. *ICOs may lack financial resources to build staff and systems, and provide new services.* (Disability Advocates Advancing our Healthcare Rights (DAAHR))

Response: Potential ICOs will be thoroughly evaluated to assess their capacity and readiness to perform as required in the Demonstration before they will be permitted to accept any enrollments, which will include providing evidence of financial viability, adequate financial resources, and reserves, as well as demonstrating network adequacy for all services with signed contracts. This is occurring through a robust, competitive procurement process, and a comprehensive readiness review period that will be jointly conducted by MassHealth and CMS.

Anticipated Mechanism: RFR, MOU, Readiness Review, Ongoing Contract Management

2. *CBOs may lack capacity/infrastructure to carry out roles of IL-LTSS Coordination and ICO training.* (DAAHR)

Response: The IL-LTSS Coordinator is a new role developed for the Demonstration. At the urging of stakeholders, the IL-LTSS Coordinator was established as a role that would be supplied by community-based organizations (CBOs). As this new role is implemented for the first time, CBOs and ICOs will need to work closely together to ensure that IL-LTSS coordination activities are being performed as required and that CBOs and IL-LTSS Coordinators are appropriately supported by the ICO to carry out the role. The phased enrollment process over the first year of the Demonstration will also provide time for CBOs to build additional capacity to provide IL-LTSS Coordinators.

Anticipated Mechanism: RFR, Readiness Review, Implementation Council, Ongoing Contract Management

ICO Competency

3. *ICOs and providers may lack ability to comply with the ADA, integrate the independent living philosophy, integrate LTSS into care plans, understand best practice models for providing care to people with complex needs, provide services in accordance with CLAS standards, and collect data for quality measurement, including on quality of life and patient confidence outcomes.* (DAAHR)

Response: ICOs and providers will need to demonstrate during Readiness Reviews that they have a clear pathway toward meeting key expectations for cultural competence and ADA compliance in the Demonstration. ICOs must develop and implement a work plan for ADA compliance for themselves and their providers. ICOs must engage in training for themselves and their providers on key topics in cultural competence, including the independent living philosophy. With the support of the IL-LTSS Coordinator, Interdisciplinary Care Teams must engage in person-centered planning across medical, behavioral health, and LTSS needs, and develop care plans that include the full range of appropriate services. With regard to data collection, there will be ongoing stakeholder involvement in developing quality of life and satisfaction measures for ICO reporting to ensure sufficient measurement of LTSS through the Demonstration. MassHealth and CMS will monitor ICO progress on all of these areas as the Demonstration is implemented.

Anticipated Mechanism: Readiness Review, Implementation Council, Stakeholder Workgroups, Learning Collaboratives, Three-Way Contract, Ongoing Contract Management

4. *Mandate training of providers by duals to eliminate misconceptions and stigma associated with this population. (DAAHR)*

Response: As described in the RFR, ICOs are required to institute training programs for their staff and providers to ensure cultural competency. In addition, EOHHS will be holding Learning Collaborative training sessions with ICO staff and providers, which will include an opportunity for sessions led by dual eligible individuals and stakeholder organizations. These collaboratives will provide opportunities for ICOs, providers, and dual eligible individuals to interact and exchange perspectives with one another. Per the RFR, each ICO also is required to establish one or more consumer advisory committees that include individuals participating in the Demonstration, and arrange for the participation of consumers with disabilities within the governance structure of the ICO. These committees may play a role in identifying ongoing issues related to the cultural competence of the ICO and its providers and elevating them to the attention of ICO leadership.

Anticipated Mechanism: RFR, Implementation Council, Learning Collaboratives, Three-Way Contract

ADA Compliance

5. *The RFR and MOU require plans and providers to comply with the ADA. The three-way contract should specify how the ICOs will require providers to show commitment and ability to provide physical access and flexible scheduling. (DAAHR)*

Response: Federal law requires ADA compliance. To facilitate compliance with federal law, the three-way contract will specify that ICOs must develop and implement an ADA work plan that includes assessing providers' baseline compliance, establishing plans and timelines for reaching compliance, monitoring providers' progress, and instituting corrective action plans as needed.

Anticipated Mechanism: RFR, MOU Three-Way Contract, Implementation Council, Ongoing Contract Management

Rates that CMS and EOHHS Pay to ICOs

6. *Using Medicaid historical trend rates may not be valid for LTSS since some state plan programs have had rates decreased during recessions. The general payment structure should be "case study" tested with a mix of enrollees to see how the assumptions hold up with present consumers and their services. (The Arc)*

Response: Evaluating historical experience is consistent with standard rate development practices and will be the basis for rate development done by CMS. As ICO rates are re-established each calendar year, MassHealth will work with CMS to create an opportunity within that process to compare ICO rates with trends in FFS. MassHealth will advocate that CMS reflect changes in FFS rate trends as ICO payment rates are re-established. ICOs will be required to show that they have an adequate network of providers for all Demonstration covered services in each county in their service areas. In order to secure such a network, ICOs will have to work with providers to negotiate and establish mutually acceptable rates.

Anticipated Mechanism: MOU, Readiness Review, Three-Way Contract, Ongoing Contract Management

7. *Rates are based on expected expense of a population with little LTSS need. For ICOs that enroll a disproportionate share of high-LTSS needs people, the demonstration should use the SCO policy allowing an LTSS assessment prior to enrollment to determine the Medicaid rate in effect on day one. (DAAHR)*

Response: Medicaid rates have been developed based on the expected expense of individuals within each of the rating categories. The C3 (Community High LTSS Need) rating category is based on spending for people with significant LTSS needs, and the F1 (Facility-based care) rating category is based on spending for people in long-term facility settings. ICOs enrolling a disproportionate share of high LTSS need enrollees will be compensated based on the higher rates associated with those rating categories. Because the lowest rating category is the default upon initial enrollment for those in the community, ICOs are strongly incentivized to complete an initial assessment of enrollees as soon as possible in order to receive higher payment rates for enrollees satisfying the criteria of the higher payment rating categories. Comprehensive assessments will inform the development of the Individualized Care Plan (ICP) for all enrollees; MassHealth believes these initial assessments are a critical first step in the establishment of the ICP, and that such incentives are therefore appropriate. Risk adjustment of Medicare rates will occur independent of the Medicaid rating category (see Figure 1).

Anticipated Mechanism: RFR, MOU, Three-Way Contract, Ongoing Contract Management

- 8.** *Care may be compromised because savings targets are unrealistic. There should be no savings expectation in the first year. (DAAHR)*

Response: Anticipated savings percentages are held at a nominal level of 1% for the first seven quarters of the Demonstration. It is important to remember that savings are applied not off of current spending levels; instead, savings are applied against what spending was expected to be if there had not been a Demonstration. The expectation is that any potential cost increases in the early quarters of the first Demonstration Year would be offset in the latter half of the first Demonstration Year when savings due to efficiencies of appropriate, integrated care begin to be realized.

Anticipated Mechanism: MOU, Three-Way Contract, Ongoing Contract Management

- 9.** *Risk corridors will lead to windfall profits for some ICOs and catastrophic losses for others. Create a reinsurance mechanism or C4 and C5 Medicaid rate cells. (DAAHR) Risk corridors are inadequate for persons requiring significant amount of LTSS. (DAAHR, The Arc)*

Response: Risk corridors protect plans from catastrophic losses and limit ICO profits. MassHealth and CMS will pay out or collect from ICOs based on risk corridors in the first, extended waiver year (seven quarters). If they are triggered, ICOs will bear full risk for gains and losses up to 5% and exceeding 10%. MassHealth and CMS will share risk 50/50 with ICOs for profits and losses between 5% and 10%. Further, CMS and MassHealth have a mandatory process, described in the MOU, which is invoked any time that a risk corridor adjustment is implemented, to determine whether permanent changes to the risk adjustment methodology may be needed for setting rates going forward.

Rating categories for Medicaid payments are designed to pay plans higher rates for their enrollees with higher LTSS or behavioral health needs. Further, High Cost Risk Pools (HCRPs) will be established to protect ICOs that enroll a disproportionate share of higher cost enrollees within the rating category compared to other ICOs. The HCRPs will serve as another form of risk adjustment, redistributing Medicaid payments across the ICOs based on their enrollment of high cost individuals. ICOs experiencing LTSS losses due to enrollment of a disproportionate share of higher cost individuals within the C3 or F1 rating categories are expected to consequently receive a disproportionate share of the HCRPs compared to the amount they contribute. Both the risk corridors and the HCRP are intended to provide protection for selection issues and as an additional protection while we define a more sensitive risk adjustment methodology. To the extent

that ICOs disproportionately enroll C3 and F1 individuals with high medical needs traditionally addressed through Medicare services, the CMS-HCC risk adjustment methodology is expected to compensate them appropriately with higher-than-average Medicare payments (see Figure 1). Furthermore, ICOs may pursue their own reinsurance options at their discretion.

Anticipated Mechanism: MOU, Three-Way Contract, Ongoing Contract Management

10. *ICOs profits should be capped at 2% - 3% of their premium surplus; any remainder should be returned to EOHHS to support the ombudsperson and external oversight body. (DAAHR)*

Response: See above response (to #9) with regard to financing arrangements established in the MOU. EOHHS is committed to the ombudsperson, and is seeking appropriate funding for the role. We cannot rely on unknown premium surpluses to support that function.

Anticipated Mechanism: Implementation Council, Demonstration Budget

11. *ICO payment rates should be adjusted to account for costs related to person-centeredness (e.g., reasonable caseloads for providers, coverage of time spent on care coordination and ICT meetings, payment of a living wage to PCAs and peers). (DAAHR)*

Response: Evaluating historical experience is consistent with standard rate development practices. While baseline rates reflect historic costs in a FFS delivery system, better integrated and coordinated care – including better use of community-based services and workforce, resulting in lower spending on high-cost, acute, emergency, and facility care – are expected to produce margins that will be available for increased care coordination activities.

Anticipated Mechanism: MOU, Three-Way Contract, Ongoing Contract Management

12. *Establish strategies for “course corrections,” including options to change risk corridors, establish stop-loss funded reserves, and/or adjust rates as needed. (Providers’ Council)*

Response: The MOU establishes a mechanism for “course correcting” rates. See Appendix 6, Section IX, C.2.b, of the MOU. MassHealth and CMS will be monitoring enrollee experience and access to care in the Demonstration, and those factors will be the most important triggers for potential course corrections. In addition, factors such as shifts in enrollment assumptions, for example, that EOHHS and CMS agree result in a misalignment of payment rates with Demonstration costs may trigger an adjustment to rates. Any payment or recoupment through a risk corridor will also trigger a discussion between EOHHS and CMS about the financial mechanisms in the Demonstration.

ICO rates will be re-established by CMS each calendar year. MassHealth will work with CMS to create an opportunity within that process to compare ICO rates with trends in FFS. MassHealth will advocate that CMS reflect changes in FFS rate trends as ICO payment rates are re-established.

Anticipated Mechanism: MOU, Three-Way Contract, Ongoing Contract Management

13. *There is a lack of comprehensive strategy to ensure financing methodologies are contingent upon population-based quality metrics which adequately factor in community LTSS measures (DAAHR, The Arc). Incentives to providers must be based on measures that include patient confidence, life satisfaction, community involvement, and keeping people in the community. (DAAHR, Mass Home Care)*

Response: The 3-way contract between CMS, EOHHS and each ICO will include provisions for withholding certain percentages of ICO payments to be paid when/if the ICO meets specific quality

withhold measures. Withhold measures expected to be included in the 3-way contract will include indicators reflecting enrollees' assessments of their Quality of Life, access to an IL-LTSS Coordinator, and access to care. MassHealth expects to engage stakeholders in a workgroup in the December/January timeframe to help finalize measures for inclusion in the 3-way contract. While not all quality measures may be tied to payment, they will be used to monitor ICO performance and address performance issues as needed.

MassHealth and CMS will closely monitor encounter data showing utilization of all services for individual enrollees, and will work with ICOs to ensure all contract requirements are implemented to identify and quickly resolve issues. MassHealth is also working with stakeholders to develop an Implementation Council that will review data and enrollee experience to identify and address concerns in concert with MassHealth.

Anticipated Mechanism: MOU, Stakeholder Workgroups, Three-Way Contract, Implementation Council, Ongoing Contract Management

Rates that ICOs Pay to Providers

- 14. Providers are being pressured to sign contracts with ICOs who may be offering provider payments that are less than Medicare or Medicaid FFS rates. Providers are concerned about this. (Association of Developmental Disabilities Providers (ADDP), Massachusetts Hospital Association (MHA), Association for Behavioral Healthcare (ABH))*

Response: While MassHealth and CMS encourage ICOs to be developing their provider networks, ICOs will not be required to produce signed contracts with providers until after the ICOs have an opportunity to analyze the payment rates they will receive from CMS and MassHealth. CMS and the Commonwealth will confirm networks as part of Readiness Reviews. We expect that, based on the methodology being used to set these payment rates, ICOs will be able to offer rates to providers that are not below current Medicare or MassHealth FFS rates. MassHealth expects that providers will come to the table with ICOs, with both parties recognizing that current FFS provider rates are a logical starting point for rate negotiations.

Anticipated Mechanism: Readiness Review, Ongoing Contract Management

- 15. MassHealth should be more specific regarding the standards for rates that ICOs will need to use consistent with Chapter 257 and MassHealth rate setting. Require ICOs, in contract or state regulation, to pay providers no less than Chapter 257 or the Medicare or Medicaid rate for identical services not delivered through an ICO. Financial monitoring and adjustment of rates should occur at least quarterly. (The Arc, ADDP and Providers' Council)*

Response: ICOs will be required to show that they have an adequate network of providers for all Demonstration covered services in each county in their service areas. In order to secure such a network, ICOs will have to work with providers to negotiate and establish mutually acceptable rates. We would expect that providers come to the table with ICOs, both recognizing that current FFS provider rates are the logical starting point. Generally, however, neither CMS nor the state will have a rate-setting role for providers in this managed care framework. (Note that most services impacted by Chapter 257 are purchased by other state agencies and not offered through the Demonstration.)

ICO rates are being developed from base data that reflect historical Medicare and Medicaid provider rates and utilization, with trends that consider changes since the base period. As such, we expect the rates paid to ICOs will support their ability to establish provider rates that are consistent with current and future Medicare and Medicaid FFS levels.

ICO rates will be re-established each calendar year based on prevailing cost trends in FFS..

Ultimately, in this Demonstration, the relationship between the ICO and provider is central to provider payments. The two parties will need to engage in a dialogue that addresses and ensures both the adequacy and appropriateness of the services rendered, and reimbursements received.

Anticipated Mechanism: RFR, MOU, Readiness Review, Three-Way Contract, Ongoing Contract Management

- 16.** *ICOs may seek to reduce payment levels as one way to meet anticipated savings percentages. While this is clearly not the intention of EOHHS or the federal government, we note that it has not been formally expressed in the RFR. (MHA)*

Response: Anticipated savings percentages in the Demonstration are very conservative in the first year of the Demonstration, and are based on better integrated and coordinated care – including better use of community-based services and workforce, resulting in lower spending on high-cost, acute, emergency, and facility care – and not from reductions in provider rates.

Anticipated Mechanism: Readiness Review, Ongoing Contract Management

- 17.** *The RFR stated that ICOs are required to cover and pay for emergency and post-stabilization services regardless of whether the provider that furnishes the services has a contract with the ICO, and further that the ICO is to pay such a provider an amount equal to or less than the MassHealth FFS rates, less any payment for the costs of medical education. This clearly violates assurances from EOHHS that the Demonstration would not attempt to substitute Medicaid reimbursement rates for Medicare rates. (MHA)*

Response: EOHHS issued an amendment to the RFR on July 24 to correct this provision. The amendment replaced the reference to MassHealth FFS rates with “Original Medicare.”

Anticipated Mechanism: RFR, MOU, Three-Way Contract

Quality

- 18.** *Establish “circuit breaker” measures of LTSS use that would trigger state intervention or revocation of contracts if there was measureable reduction in use of LTSS by an ICO’s enrollees. (DAAHR)*

Response: LTSS service authorizations and utilization will be a critical domain for ongoing monitoring in the Demonstration. This is one area that the Implementation Council may identify as a key focus for its work. In the early months of the Demonstration, information on how ICOs are doing in making these services available may come from IL-LTSS Coordinators, LTSS providers, encounter data, grievances and appeals reports, and reports from the ombudsperson. As experience with the Demonstration grows, claims data will also be evaluated to identify trends.

Anticipated Mechanism: Implementation Council, Ongoing Contract Management

- 19.** *The demonstration must support prevention. No ICO should get a contract without demonstrating how it will use the capitated model to develop prevention strategies for enrollees that include DME, peers, and other community-based non-medical interventions. (DAAHR, Mass Home Care)*

Response: MassHealth agrees that prevention and wellness strategies are critical in the Demonstration. In the Readiness Review, ICOs will be required to demonstrate that their policies

and procedures related to service authorizations reflect the use of flexible services – such as peers, Community Health workers, and other non-medical community supports –when they would add value to the enrollee’s care plan. Value is determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the enrollee as well as the role of the service in **preventing** high-cost alternative care. MassHealth expects to include parallel language in ICO contracts. In addition, the use of flexible services especially for prevention is a training topic that could be very appropriate to address in the Learning Collaborative sessions.

Anticipated Mechanism: Implementation Council, Readiness Review, Three-Way Contract, Learning Collaboratives, Ongoing Contract Management

20. Establish quality reporting instruments regarding access to care and ICO/provider progress toward ADA compliance (DAAHR).

Response: Access to Care is included as a withhold measure in the MOU. Measures of access also will be included as ongoing quality measures. In addition, ICOs must identify an individual responsible and accountable for ADA compliance specifically for the Duals Demonstration, and show that they have a work plan for ADA compliance. This will be confirmed during Readiness Review.

Anticipated Mechanism: MOU, Readiness Review, Implementation Council, Stakeholder Workgroups, Three-Way Contract, Ongoing Contract Management

21. Outcome measures that address LTSS must be included (e.g. is LTSS provided adequate to support enrollee’s work objectives?) (DAAHR).

Response: MassHealth agrees that measures should be established that address the effectiveness of LTSS at helping enrollees achieve their goals. These measures must be thoughtfully constructed to ensure that they are actionable for ICOs and outcomes measured are attributable to ICO activities. MassHealth will continue to work with stakeholders to identify potential additional quality measures, including outcome measures that address LTSS in a workgroup prior to finalizing quality measures for inclusion in the three-way contracts.

Anticipated Mechanism: MOU, Implementation Council, Stakeholder Workgroups, Three-Way Contract, Ongoing Contract Management

22. The system being created is reflective of Medicare standards – overlooking vital LTSS standards often associated with Medicaid – that lack associated data collection and quality metrics methodologies. (DAAHR, The Arc)

Response: MassHealth agrees that measures should be established that address LTSS in the Demonstration. As few validated LTSS measures currently exist, the Demonstration will provide an opportunity to develop and test new measures in this area. MassHealth held discussions with stakeholders in a workgroup focused on developing and vetting quality metrics in March 2012, and will continue these workgroup discussions with stakeholders over the next two months to consider additional potential quality measures for the Demonstration.

Anticipated Mechanism: MOU, Implementation Council, Stakeholder Workgroups, Three-Way Contract, Ongoing Contract Management

23. Appropriate population-based data collection and analysis requirements should be included: Outcome measures (Quality of Life) consistent with the goals of long-term services and support in the demonstration’s evaluation of integrated care. Their absence means these

measures, at the core of the integration effort, will not be considered. Some examples of measures that could be added include:

- i. Do case loads of LTSS providers enable providers to give enrollees the level of services set out in Individualized Care Plans (ICP)?*
- ii. Are LTSS adequate to ensure access to community involvement and life goals as desired by the enrollee?*
- iii. Are LTSS adequate to address the life goals and social determinants of health such as a healthy diet (prevent or reduce obesity), exercise, and social involvement?*
- iv. Are behavioral health services optimized to provide community involvement? (DAAHR-The Arc)*

Response: Quality withhold measures are expected to include a set of indicators reflecting enrollees' assessments of their Quality of Life. In addition to the withhold measures, MassHealth will discuss with stakeholders in the Quality workgroup a broad slate of additional quality metrics that will be used to evaluate progress in the Demonstration. MassHealth plans to use member and provider surveys to provide feedback throughout the Demonstration about quality of care and access, and looks forward to discussing potential survey tools and questions with stakeholders.

Anticipated Mechanism: MOU, Readiness Review, Implementation Council, Stakeholder Workgroups, Three-Way Contract, Ongoing Contract Management

ICO Provider Networks

24. We are particularly concerned about the definition of adequacy for behavioral health providers as two within a 30-minute or 15-mile radius. Given this definition of network adequacy and where personal relationship with the provider is so important, the need for single-case, out-of-network agreements should be obvious and guaranteed to enrollees. (DAAHR)

Response: The RFR states that an ICO must provide each enrollee with a choice of at least two outpatient Behavioral Health providers within the time and distance standards noted above. This reflects the current MassHealth managed care access standards. ICOs are also expected to conduct 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 also require ICOs to have a process that allows qualified and willing providers already serving eligible members and wishing to maintain that relationship the opportunity to join the ICO provider network. ICOs must continually enroll those interested providers that meet network requirements, and networks may not be closed at any point to new providers.

The continuity of care process must also include giving enrollees 90-day 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 until their initial assessment by the ICO is completed and a new care plan developed. Requiring that current services and providers be maintained until the enrollee's ICO care plan is in place will provide additional time for the ICO to conduct outreach to enrollees' current providers, and for any transitions to new providers that may be necessary.

Beyond this initial period, ICOs must 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 join the ICO network. MassHealth requires these agreements if the provider network does not include an otherwise qualified provider, or if a transition would cause the enrollee harm or require a substantial change in treatment (see RFR Section 4.8. E). In the Readiness Review, ICOs must provide their policies

and procedures for single-case agreements. MassHealth expects that single-case agreements should be the exception, however, not a routine practice. One of the core features of care in the ICO is that it will be coordinated, with different providers, types of care (medical, behavioral health and functional), and the enrollee's goals represented in a care team and a unified, integrated care plan. The advantage of using out-of-network providers must be balanced with the advantages of the enhanced information sharing and care coordination that are expected across the ICO's contracted provider network.

Anticipated Mechanism: RFR, MOU, Three-Way Contract, Ongoing Contract Management

25. *The RFR indicated that an ICO provider of emergency services would be required to obtain for the enrollee an Emergency Services Program (ESP) service prior to obtaining inpatient or outpatient services. This is of significant concern, as it could force delays in appropriate care. (MHA)*

Response: MassHealth is conducting a review of the ESP and the role of ESP providers in serving MassHealth members. ESPs provide vitally important services for linking enrollees with community-based behavioral health services that are important in diverting from inpatient hospitalization, and shortening length of stay in inpatient facilities and post-stabilization care. We look forward to identifying any ways to strengthen and improve their role within the care delivery system.

Anticipated Mechanism: Three-Way Contract, Ongoing Contract Management

Enrollment

26. *Enrollment must be voluntary. (DAAHR)*

Response: MassHealth and CMS's MOU established that the Demonstration will be conducted through a voluntary, opt-out process. Individuals may choose whether to participate in the Demonstration and may choose a different ICO or opt out at any time. Changes in enrollment will always become effective on the first day of the following month.

Anticipated Mechanism: RFR, MOU

27. *The passive enrollment process is being driven by a rush to get to scale rather than adequate attention to competency and capacity. (DAAHR, The Arc)*

Response: Potential ICOs will be thoroughly evaluated to assess their capacity and readiness to perform as required in the Demonstration before they will be permitted to accept any enrollments. This is occurring through a robust, competitive procurement process, and a comprehensive readiness review period that will be jointly conducted by MassHealth and CMS. MassHealth and CMS are in the process of establishing monitoring systems to track ICO performance, and will closely watch early indicators in the initial months of the Demonstration.

Enrollment into the Demonstration will occur in phases. The first enrollments, which will be effective April 1, 2013, will be for those who make an active selection to enroll in an ICO. Following that date, there will be at least two phases of an auto-assignment process, with effective dates of July 1, 2013, and October 1, 2013. MassHealth may change those dates based on Demonstration experience, including voluntary enrollments, ICOs' performance on conducting comprehensive assessments, and any other early indicators over the first 90 days of the Demonstration. MassHealth continues to develop the auto-assignment process and expects to have significant additional discussions with stakeholders about it as implementation proceeds.

Anticipated Mechanism: RFR, MOU, Implementation Council, Stakeholder Workgroups, Ombudsperson, Ongoing Contract Management

28. *If passive enrollment is done, it should be phased. For July 1, 2013, only those with low LTSS needs should be passively enrolled. (DAAHR)*

Response: Auto-assignment will occur in phases. The current target for the first effective date for auto-assignment is July 1, 2013. The date may change based on Demonstration experience, including self-selected enrollment, ICOs' performance on conducting comprehensive assessments, and any other early indicators over the first 90 days of the Demonstration. MassHealth continues to develop the auto-assignment process and expects to continue discussing it with stakeholders.

Anticipated Mechanism: RFR, MOU, Implementation Council, Stakeholder Workgroups, Ombudsperson, Ongoing Contract Management

29. *Reliance on SHINE /ADRCs will be insufficient; more in-depth discussion on enrollment counseling must begin soon. (DAAHR)*

Response: The CMS options counseling opportunity through ADRCs/SHINE will be only one component of a broad-based outreach and education campaign. MassHealth will engage stakeholders in conversation to help formulate additional aspects of the campaign that are under development.

Anticipated Mechanism: Implementation Council, Stakeholder Workgroups, Ombudsperson

30. *When the assessment and care plan are completed and changes made to an enrollee's care plan, will the option to opt out of the demonstration be reiterated?*

Response: An enrollee has the opportunity to opt out of the Demonstration at any time. Enrollees will receive information on how to opt out at many points in the Demonstration. The expectation is that the enrollee is the center of the care planning process, and that the care plan is developed in light of his or her needs and preferences. If the ICO, the enrollee's care team, and the enrollee are unable to reach consensus on a care plan, the ICO and the care team should continue working with the enrollee and try to find solutions that are acceptable to all. If resolution is not achieved, the enrollee may file an appeal on any element of the care plan to which he or she objects.

Anticipated Mechanism: RFR, MOU, Implementation Council, Stakeholder Workgroups, Ombudsperson Ongoing Contract Management

Continuity of Care

31. *Does the care plan need to be in place before the continuity of care period ends (90 days or longer), or is it just that the assessment needs to have been conducted? (Various stakeholders) Clarify that the ICP must be in place prior to modification of existing services and that the enrollee must be given notice and appeal rights prior to any proposed modification. (DAAHR, Mass Home Care) The 90-day continuity of care period should be expanded to 6 months. (DAAHR)*

Response: The 90-day continuity of care period balances the crucially important need to ensure that enrollees' access to critical services is not disrupted with the need for ICOs to integrate an enrollee into its health plan. Enrollees with unmet needs may benefit right away from services that they cannot access in Fee for Service, but that will be available through the ICO.

The initial and comprehensive assessments must be completed within the 90-day continuity of care period. The assessment process culminates in establishing the care plan, which should also be completed within the 90-day period. In the event that 90 days does not prove to be a sufficient period of time for an ICO to complete a comprehensive, in-person assessment with an enrollee, the ICO must continue to allow enrollees to access his or her current services and providers until the requirements of the assessment process are met and the enrollee's care plan is created.

Per the RFR, in the event that the care planning process results in a change being made to the enrollee's current course of treatment, the ICO must provide written notice of those changes – and an opportunity to appeal the proposed modifications – no fewer than 10 days prior to implementation of the new care plan. This requirement will also be reflected in three-way contracts.

ICOs must give enrollees a meaningful opportunity to participate in their care planning. The enrollee is the center of the care planning process, and each ICP must reflect the enrollee's preferences and needs.

Anticipated Mechanism: RFR, MOU, Three-Way Contract, Ombudsperson, Ongoing Contract Management

Assessment

32. *MDS-HC is insufficient to separate high intensities of need in behavioral and functional domains. It should not be used for rating category determination. It will lead to problems in Rating Categories C3 and C2. (Providers' Council). Require in contract or state regulation the adoption of a mutually agreed upon evaluation and assessment tool that will have the sensitivity needed to separate intense needs and to develop a rate setting system which will allocate resources appropriate to serve the highest need individuals. (ADDP).*

Response: MassHealth recognizes there are limitations to the current MDS-HC with respect to this population. Accordingly, a modified version of the MDS-HC will be used to make rating category determinations. The tool will be augmented with information about behavioral health diagnoses and ADL/IADLs in a way that will allow assignment to the High LTSS and High BH Needs rating categories.

The MDS-HC tool is being used for the purpose of establishing the appropriate rating categories for the Medicaid portion of the ICO rate only. The Medicare rates paid to ICOs will be risk adjusted based on acute care needs using the CMS-HCC methodology (see Figure 1). This will allow adjustment for skewed selection to any given ICO of higher- or lower-than-average cost enrollees.

With regard to using the MDS-HC, MassHealth has invested resources into upgrading the platform so that it collects and automates rating category data to ensure more standardization and reduces the possibility of category assignment errors. MassHealth is also creating special instructions for ICOs on using the MDS-HC. These instructions are designed to ensure that ICOs collect the data needed for appropriate rating category determination for this target population. This includes the appropriate behavioral health diagnosis information and information on ADL/IADLs in sufficient detail.

ICO rates are being developed from base data that reflect historical Medicare and Medicaid provider rates and utilization, with trends that consider changes since the base period. Higher rates will be paid for rating categories designed to support enrollees with higher Behavioral Health

or LTSS needs. High Cost Risk Pools will be in place for the C3 and F1 rating categories, and MassHealth will pay out or collect from ICOs based on risk corridors in the first, extended waiver year (seven quarters). Further, CMS and MassHealth have a mandatory process, described in the MOU, which is invoked any time that a risk corridor adjustment is implemented, to determine permanent changes to the risk determination methodology that may be needed for setting rates going forward.

Anticipated Mechanism: RFR, MOU, Readiness Review, Three-Way Contract, Ongoing Contract Management

33. *The MDS-HC is inadequate in assessing behavioral and functional challenges of younger people with disabilities. (DAAHR, The Arc) The MDS-HC is not an appropriate assessment tool for the target population. (The Arc) The MDS-HC is inadequate and should be augmented with use of the DREEM model or others that capture medical and quality of life goals. ICOs should be encouraged to use innovative tools and the demo should be used to determine which tools are best in supporting person-centered care. (DAAHR)*

Response: For care planning purposes, all ICOs will be required to supplement the MDS-HC with a broader, more comprehensive assessment tool. As part of the RFR submission process, prospective ICOs were required to submit their draft comprehensive assessment tool. MassHealth will work with the ICOs to standardize their tools, especially to ensure that they address areas needed to ensure appropriate, person-centered care planning for people with all types of disabilities, including intellectual and/or development disability, behavioral health concerns, and LTSS needs. MassHealth will work with DDS, DMH and stakeholders to develop the right elements for these tools. This will include particular focus on subpopulations such as:

- Adults with physical disabilities;
- Adults with Developmental or Intellectual Disabilities;
- Adults with Serious Mental Illness;
- Adults with substance use disorders;
- Adults with disabilities who have multiple chronic illnesses or functional or cognitive limitations; and
- Adults with disabilities who are homeless.

A key part of the Readiness Review period will be to ensure ICOs can complete and send MDS-HCs per the MassHealth instructions, and that the comprehensive assessment tool contains all the necessary additional questions to support appropriate care planning for all enrollees.

Anticipated Mechanism: RFR, Readiness Review, Implementation Council, Stakeholder Workgroups, Three-Way Contract, Ongoing Contract Management

34. *What is the timeframe for conducting the ongoing assessments that will be conducted using a tool proposed by the ICO? Will the first such assessment be conducted before the continuity of care period ends?*

Response: The first comprehensive assessment must occur within the initial 90-day period. An ICO and enrollee may choose to conduct the comprehensive assessment at the same time as they complete the initial MDS-HC assessment, or separately from it. Ongoing assessments must occur at least annually, or whenever an enrollee experiences a major change in his or her health status.

Anticipated Mechanism: RFR, Three-Way Contract, Ongoing Contract Management

35. Who employs the RN that conducts the initial assessment? Will/can caregivers be involved in the initial assessment? EOHHS must require that the initial assessment be done by both an RN and IL-LTSS Coordinator, in the primary residence of the member. (DAAHR)

Response: The ICO is the organization that is accountable for performing the initial assessment. The nurse who conducts this assessment will be employed or contracted by the ICO. The initial assessment will be conducted using the modified MDS-HC tool, which must be completed by a registered nurse. Because the IL-LTSS Coordinator role is new, enrollees are not expected to come to the ICO already having an IL-LTSS Coordinator. An ICO may need to engage in an initial assessment in order to understand the LTSS needs of the enrollee and connect him or her with an appropriate IL-LTSS Coordinator. However, an IL-LTSS Coordinator must be involved in the comprehensive assessment and forming the care plan for enrollees wanting, needing, or receiving LTSS completed. Caregivers can be included in the initial assessment at the discretion of the enrollee. If there is a legal guardian, that individual must be involved in the assessment.

Per the terms of the RFR, the initial and comprehensive assessments must be completed in person, and must be done in a location that meets the enrollee's needs and preferences. Some enrollees may prefer the assessment be done in their home, while others may prefer a different location.

Anticipated Mechanism: RFR, MOU, Three-Way Contract, Ombudsperson, Ongoing Contract Management

Care Planning and Care Team

36. There must be a mechanism for the enrollee to sign off on his or her Individualized Care Plan. (DAAHR)

Response: An enrollee can indicate approval of – or dissatisfaction with - his or her care plan at any point in the care planning process in which the enrollee will be engaged with the ICO and his/her care team members. In addition, the ICO may institute a formal process for the enrollee sign or otherwise indicate approval of their care plan. The most important goal for each ICO and care team is to engage the enrollee in a meaningful care planning process, not just to secure the enrollee's signature or sign-off.

Anticipated Mechanism: RFR, Three-Way Contract, Implementation Council, Ongoing Contract Management

37. An enrollee should have control over who participates in his or her care team and who can see his or her records, especially psychiatric records. (DAAHR)

Response: As described in the RFR, the Interdisciplinary Care Team (ICT) will consist of the enrollee's selected primary care provider, a Care Coordinator/Clinical Care Manager, an IL-LTSS Coordinator, and a behavioral health clinician if appropriate. At the discretion and choice of the enrollee, the ICT also may include other individuals, including specialists, peers, family members, caregivers, and advocates. The MOU states that CMS and the Commonwealth shall require all ICOs to meet legal requirements to ensure privacy and security of Enrollee health records. MassHealth understands that confidentiality of records, and particularly of psychiatric records, is a sensitive issue and will explore the specifics of this issue further with the selected ICOs and stakeholders.

Anticipated Mechanism: RFR, MOU, Three-Way Contract, Ombudsperson, Ongoing Contract Management

38. *Care Coordinators/Clinical Care Managers should be responsible for communicating the enrollee's needs to his or her providers, and finding out how the providers will meet those needs. (DAAHR)*

Response: The care plan should capture the enrollee's needs, including any accessibility modifications. Care Coordinators and Clinical Care Managers will be responsible for communicating those needs to an enrollee's providers.

Anticipated Mechanism: RFR, Three-Way Contract, Ombudsperson, Ongoing Contract Management

Authorization of LTSS and Other Services

39. *ICOs should be required to authorize LTSS consistent with the ICP and sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose (The Arc); ICOs should be required to adhere to current industry hours and duration of service standards for access and authorization for LTSS services. (ADDP)*

Response: Per the terms of the MassHealth RFR, ICOs must, at a minimum, provide LTSS consistent with MassHealth FFS authorization criteria (see RFR Section 4.9.E). The ICO has the discretion to authorize LTSS and flexible community-based services more broadly in terms of criteria, amount, duration, and scope, if the ICO determines that such authorization would provide sufficient value to the enrollee's care. This will allow ICOs to offer services of duration or units that would not be available under FFS regulations, but expressly does not allow ICOs to authorize at levels below those required by Medicare or MassHealth FFS regulations. Ultimately, while flexibility is enhanced, entitlement to benefits has not changed due to the Demonstration. Medicare and Medicaid rules still serve as the baseline for entitlement to services.

Anticipated Mechanism: RFR, Readiness Review, Three-Way Contract, Ombudsperson, Ongoing Contract Management

40. *The staff who know the enrollee best should have the authority to make decisions and immediately authorize care. Service authorizations must be individualized, not rule-based; consistency of individual authorizations can be tracked and monitored after the fact. (DAAHR)*

Response: ICOs will have their own authorization processes, but each must respect the individualized nature of the care plan.

Anticipated Mechanism: RFR, Readiness Review, Three-Way Contract, Ombudsperson, Ongoing Contract Management

41. *We are concerned about diversion of dollars from LTSS to medical services contracts, including hospitals. (DAAHR, The Arc)*

Response: The MassHealth RFR requires that ICOs at a minimum provide LTSS consistent with MassHealth FFS authorization criteria (see RFR Section 4.9.E). The ICO has the discretion to authorize LTSS and flexible community-based services more broadly in terms of criteria, amount, duration, and scope, if the ICO determines that such authorization would provide sufficient value to the enrollee's care. This will allow ICOs to offer services of duration or units that would not be available under FFS regulations, but expressly does not allow ICOs to authorize at levels below those required by Medicare or MassHealth FFS regulations.

ICOs will need to invest financial resources in the appropriate provision of LTSS to be successful under this Demonstration. MassHealth expects that Individualized Care Plans will consider

preventive services and LTSS when appropriate for an individual, and that provision of these services may prevent or divert from acute episodes of care as well as extended facility stays.

ICOs will also be required to show that they have an adequate network of providers for all Demonstration covered services in each county in their service areas. In order to secure such a network, ICOs will have to work with providers to negotiate and establish mutually acceptable rates. MassHealth expects that providers will come to the table with ICOs, with both parties recognizing that current FFS provider rates are a logical starting point for rate negotiations.

Finally, MassHealth recognizes that LTSS service authorizations and utilization will be a critical domain for ongoing monitoring in the Demonstration. This is one area that the Implementation Council may identify as a key focus for its work. In the early months of the Demonstration, information on how ICOs are doing in making these services available may come from IL-LTSS Coordinators, LTSS service providers, grievances and appeals reports, and reports from the ombudsperson. As experience with the Demonstration grows, claims data will also be evaluated to identify trends.

Anticipated Mechanism: RFR, Readiness Review, Implementation Council, Three-Way Contract, Ombudsperson, Ongoing Contract Management

42. *MassHealth should provide guidelines to CBOs to help protect access and authorization levels of service for LTSS. (Providers' Council)*

Response: Per the terms of the MassHealth RFR, ICOs must, at a minimum, provide LTSS consistent with MassHealth FFS authorization criteria (see RFR Section 4.9.E). An IL-LTSS Coordinator, contracted from a CBO, will serve on each enrollee's ICT as needed, and provide input into service authorizations and other care planning decisions. IL-LTSS Coordinators will need to be qualified, including having education and experience in person-centered planning, needs assessments for LTSS, and the home and community-based service system. IL-LTSS Coordinators will need to work with enrollees and others on the ICT to incorporate appropriate levels of LTSS into the care plan.

Anticipated Mechanism: RFR, Readiness Review, Three-Way Contract, Ongoing Contract Management

43. *The scope, duration and intensity of LTSS should be tied to some standards. Rates should be established that can be applied regardless of ICO for long term supports and services. In other words, sub-capitation rates for LTSS providers should be adequate for consumers' LTSS. This is important given that most ICOs will have limited experience in managing LTSS. Standards should include:*

- a. Protection of baseline spending on LTSS measured at the aggregate level;*
- b. Demonstration of increased spending on LTSS at the aggregate level in balance with reduced costs associated with medical services, i.e., hospitalizations and emergency room visits;*
- c. Protections against reductions in spending on LTSS at the individual level for those with both high medical and LTSS needs. (DAAHR, The Arc)*

Response: Per the terms of the MassHealth RFR, ICOs must, at a minimum, provide LTSS consistent with MassHealth FFS authorization criteria (see RFR Section 4.9.E). Please see the response to question 42 above.

An IL-LTSS Coordinator, contracted from a CBO, will serve on each enrollee's ICT as needed, and provide input into service authorizations and other care planning decisions. IL-LTSS

Coordinators will need to work with enrollees and others on the ICT to incorporate appropriate levels of LTSS services into the care plan.

MassHealth and CMS will be collecting encounter data from all ICOs and will monitor trends in ICO spending and service authorizations.

Anticipated Mechanism: RFR, Readiness Review, Three-Way Contract, Ombudsperson, Ongoing Contract Management

44. What will be the access/network adequacy requirements for supplemental services, if they are not “medical” and covered by medical necessity? Will the standards include ability of the service to enable the enrollee to stay in the community, or will they be time/distance as with Medicaid services?

Response: ICOs have flexibility and discretion to authorize LTSS and flexible community-based services using criteria that are broader than medical necessity if the ICO determines that such authorization would provide sufficient value to the enrollee’s care. Value is determined in light of the full range of services included in the ICP, considering how the services contribute to outcomes, including the health and independent living of the enrollee, as well as the cost-effectiveness of the services.

Anticipated Mechanism: RFR, Readiness Review, Three-Way Contract, Ombudsperson, Ongoing Contract Management

45. We are concerned about the loss of consumer and family control of Long-Term Services and Supports (LTSS). (DAAHR, The Arc)

Response: Under the Demonstration, each enrollee will be at the center of his or her care planning process, working with an Interdisciplinary Care Team (ICT) to develop a care plan that meets his or her needs. The ICT will consist of the enrollee’s selected primary care provider, a Care Coordinator, and an IL-LTSS Coordinator. At the discretion and choice of the enrollee, the ICT also may include other individuals, including family members, peers, or advocates, and specialists or other caregivers.

The IL-LTSS Coordinator, contracted from a community-based organization (CBO), will serve on each enrollee’s ICT as needed, and provide input into service authorizations and other care planning decisions. IL-LTSS Coordinators will need to meet certain qualifications, including having education and experience in person-centered planning, needs assessments for LTSS services, and the home and community-based service system. They will work with enrollees and others on the ICT to incorporate appropriate levels of LTSS into a person-centered, Individualized Care Plan (ICP). The ICO will have the discretion to authorize LTSS and flexible community-based services to meet the needs identified in each enrollee’s ICP.

For Personal Care Attendant (PCA) services, it is important to note that consumers will continue to be able to self-direct PCA under the Demonstration if they so choose. ICOs are required to offer enrollees the option of self-directing their PCA services.

Anticipated Mechanism: RFR, Readiness Review, Implementation Council, Three-Way Contract, Ombudsperson, Ongoing Contract Management

Medical Necessity Definition

46. The definition of medical necessity must be broadened and relate more to a person’s functioning in the community and social determinants of health (The Arc); The definition of

medical necessity must be more expansive to fit with concepts of person-centered care and services (DAAHR). Olmstead protection: safeguard community living by adding to the definition of medical necessity; giving focus on a person's functioning in the community and addressing social determinants of health. We recommend one clause from a definition used in Michigan to be merged into the present definition cited by MassHealth: Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his/her goals of community inclusion and participation, independence, recovery, or productivity. (DAAHR, The Arc)

Response: Please see response to #44.

Care Coordination

47. A single point of contact for each enrollee must be defined – a nurse practitioner, IL-LTSS Coordinator, BH professional, or some other ICT member that the enrollee identifies as being his or her contact person of choice. (DAAHR)

Response: Enrollees and care teams should have flexibility to determine a system of communication that works for them. This could include having a centralized, single point of contact through which an enrollee could access the team as needed; in other cases, the enrollee may contact different individuals in the ICT directly based upon his or her needs.

Anticipated Mechanism: RFR, Readiness Review, Three-Way Contract, Ongoing Contract Management

IL-LTSS Coordinator

48. Can an ICO contract for IL-LTSS Coordination and LTSS service provision from the same organization to serve a specific member? Is a waiver required if the ICO wants to contract for IL-LTSS Coordinator and LTSS services from ILCs, RLCs, ASAPs or other community based organizations if the organization providing the LTSS Coordination and LTSS Services is the same for a specific member? (Multiple sources). Developmental Disability Organizations should be eligible for selection as CBOs, providing LTSS coordination, identical to the pending decision to allow Independent Living Centers to function in the same manner. (ADDP)

Response: In the interest of ensuring independence and avoiding conflicts of interest, the ICO RFR stated that, "Providers of facility- or community-based LTSS on a compensated basis by the ICO may not function as IL-LTSS Coordinators, except if the ICO obtains a waiver of this requirement from EOHHS." The RFR also stated: "For purposes of this provision, an organization compensated by the ICO to provide only evaluation, assessment, coordination, skills training, peer supports and Fiscal Intermediary (FI) services is not considered a provider of LTSS." (See RFR Section 4.6.D.1). Such language also has been codified in statute regarding the Demonstration.

If an ICO wishes to contract with the same organization to provide IL-LTSS Coordination as well as direct services, the ICO must obtain a waiver from EOHHS. The purpose of this requirement is to ensure that appropriate steps are taken to prevent IL-LTSS Coordinators from steering members toward their own organizations for services.

Examples:

- An ICO signs a contract with a provider of Adult Day Health (ADH). The ADH provider expresses an interest in also contracting with the same ICO to provide IL-LTSS

Coordinators. A waiver would be required. That is, the ICO would have to apply for a waiver in order to contract with the ADH provider for both ADH and IL-LTSS Coordinators.

- An Independent Living Center (ILC) is contracted by an ICO to provide Personal Care Management (PCM) services. The ILC then seeks to contract with the ICO to provide IL-LTSS Coordinators. A waiver would not be required because the ILC is not the direct provider of Personal Care Attendant (PCA) services; the PCA hired by the member or family is the direct service provider.

The ICO RFR stated that ICOs must contract with multiple community-based organizations (CBOs) for IL-LTSS Coordination, and that enrollees must be offered a choice of at least two IL-LTSS Coordinators. This can include Developmental Disability Organizations and other disability-specific organizations that are qualified and meet all the requirements to contract for this role.
Anticipated Mechanism: RFR, Readiness Review, Three-Way Contract, Ongoing Contract Management

Grievances & Appeals

- 49. We want to be sure that if a physician states that an appeal needs to be expedited, that the ICO will do so without question as is now the rule in MassHealth, in the SCO, and in Medicare (130 CMR 508.010). (DAAHR)*

Response: MassHealth will be clarifying via regulation that if a provider requests an expedited appeal the ICO must resolve the internal appeal on an expedited basis.

Anticipated Mechanism: Three-Way Contract, State Regulation, Ombudsperson, Ongoing Contract Management

- 50. It should be clearly stated that an enrollee who disagrees with the ICO decision whether to continue services that were authorized prior to enrollment in the ICO may continue receiving these services pending appeal to the same extent as if the ICO had made the original authorization. (DAAHR)*

Response: An enrollee will continue to receive previously authorized covered services until the conclusion of the ICO's internal appeals process. This includes appeals related to changes in services that the enrollee was receiving prior to enrolling in the ICO. Enrollees that pursue further appeal to the MassHealth Board of Hearings may request aid pending the BOH decision.

Anticipated Mechanism: MOU, RFR, Three-Way Contract, Ombudsperson, Ongoing Contract Management

- 51. In terms of Part D appeals and hospital discharge appeals, the Demonstration should take care not to restrict the existing rights of people on Medicare. Further clarification is needed to assure this. (DAAHR)*

Response: The Demonstration will not restrict the existing rights of people on Medicare related to Part D appeals and hospital discharge appeals. This will be clearly stated in the three-way contracts.

Anticipated Mechanism: MOU, Three-Way Contract, Ongoing Contract Management

- 52. Per the RFR, enrollees are provided with a standard 30 days appeal as well as a 72-hour review for medically time-sensitive treatment. MHA is very concerned that the 72-hour review*

period is greater than what is required by state patient protection law, which provides a 48-hour time period (Chapter 176O as well as 105 CMR 128.309). (MHA)

Response: MassHealth appreciates MHA's interest in maximizing appeals protections for ICO enrollees. The statute cited (Chapter 176O) does impose a 48-hour expedited appeals timeframe; however we note that, under Chapter 118E, Section 9F(c), Chapter 176O is not applicable to the Duals Demonstration. The 72-hour time period given in the RFR for expedited appeals is consistent with current requirements in the SCO program.

Anticipated Mechanism: RFR, MOU, Three-Way Contract, State Regulation, Ongoing Contract Management

Ombudsperson

53. EOHHS should put in place a strong, external ombuds-entity that is available before, simultaneously with, and after a formal appeal. (DAAHR, Mass Home Care)

Response: MassHealth is committed to working with stakeholders to design and implement an Ombudsperson that will be available to an enrollee for assistance with an array of issues in the Demonstration, including any appeals at any stage.

Anticipated Mechanism: Implementation Council, Stakeholder Workgroups

Consumer Voice

54. Establish an external oversight entity with significant consumer and advocate participation. (DAAHR)

Response: MassHealth is working with stakeholders to design and establish an Implementation Council. We will work with stakeholders to develop key aspects of the Council, including membership, scope of responsibilities, and operations. The Council's roles and responsibilities would include providing input into the readiness process, examining ICO quality, reviewing issues raised through the grievances and appeals process and ombudsperson reports, examining access to services (medical, behavioral health, and LTSS), and participating in the development of public education and outreach campaigns. Membership on the Council is expected to be majority consumer, and include representation of the key Demonstration target populations; other members may include family members/guardians, advocates and peers from community-based organizations, providers, provider/trade associations, and unions.

Anticipated Mechanism: Implementation Council, Open Stakeholder Meeting (November 2, 2012)

55. Include duals in the development and implementation of ICO readiness reviews. (DAAHR)

Response: MassHealth expects to continue engaging with stakeholders in all aspects of the Demonstration. CMS and MassHealth created a Readiness Review tool customized for the Massachusetts Demonstration. The Readiness Review tool has been posted on the Duals website (www.mass.gov/masshealth/duals). Stakeholder questions and discussions were helpful in developing the tool, and many of these suggestions are reflected in it. During the joint Readiness Review conducted by CMS and MassHealth, selected ICOs will be required to submit documentation as part of desk reviews, and participate in site visits. MassHealth expects to consult with the Implementation Council throughout implementation of the Demonstration, including the Readiness Review process.

Anticipated Mechanism: Implementation Council, Ongoing Open Stakeholder Meetings

56. Protection of consumer control of services:

- a. *Establishment of an independent consumer-run oversight entity to monitor and advance the Demonstration in coordination with all stakeholder groups. ICOs should be required to fund the independent entity. (DAAHR-The Arc)*

Response: MassHealth will work with stakeholders to design and establish an Implementation Council. This was a primary area of discussion at the November 2, 2012 stakeholder meeting. Ongoing dialogue is helping flesh out key aspects of this organization, including membership, scope of responsibilities, and operations.

Anticipated Mechanism: Implementation Council, Stakeholder Workgroups

- b. *Protection of peer-run and community-based organizations providing LTSS, including Independent Living Centers, Recovery Learning Communities and chapters of The Arc. Contractual relationships should provide incentives and preferential options for such entities in order to ensure consumer self-direction and cultural competence, which is critical to the population-approach of the Demonstration. (DAAHR, The Arc)*

Response: The RFR made it clear that ICOs are required to contract with community-based LTSS providers for covered services, and the three-way contract will protect current provider relationships through continuity of care requirements. MassHealth has provided information about current LTSS providers serving the target population to ICOs to assist them in their provider contracting work. The RFR also encouraged ICO respondents to consider alternative payment mechanisms, including for their contracts with LTSS providers.

ICOs are separately required to contract with CBOs for the Independent Living and Long Term Services and Supports (IL-LTSS) Coordinator role. IL-LTSS Coordinators will be a key mechanism for ensuring that ICO enrollees' care plans include appropriate access to community-based, culturally competent services. Individual CBOs will need to determine whether to contract with each ICO for either services or for provision of IL-LTSS Coordinators to avoid conflict of interest.

Anticipated Mechanism: RFR, Readiness Review, Implementation Council, Three-Way Contract, Ongoing Contract Management

Ongoing Monitoring

- 57. Provide in contract or state regulation the assurance of effective monitoring and reporting procedures, including publicly available forums conducted quarterly providing an opportunity for as-needed course corrections. (ADDP)**

Response: We will establish a Duals Demonstration Implementation Council that will meet publicly. We expect the duties of the Council will include reviewing key performance indicators for the Demonstration, including: enrollments, disenrollments, and ICO switches; service utilization; and quality outcomes including satisfaction, functional, behavioral, and medical domains of health and well-being. The specifics of the Council are being developed in concert with stakeholders. MassHealth has had a robust stakeholder process throughout the Demonstration design phase, and will continue holding regular open meetings through the implementation phase and the Demonstration period.

Anticipated Mechanism: MOU, Three-way Contract, Implementation Council, Stakeholder Workgroups, Ongoing Contract Management, Ongoing Open Stakeholder Meetings

58. Monitoring and reporting on enrollment, disenrollment, plan changes, access to services, payment amounts, costs/savings, and service utilization, and on measures of care coordination, satisfaction, and outcomes, should be done in publicly available forums bimonthly or quarterly. (Providers' Council)

Response: Please see the response above. MassHealth will continue to work with stakeholders to determine what information is necessary to ensure transparency and effective monitoring, and how it should be shared.

Anticipated Mechanism: MOU, . Three-Way Contract, Implementation Council, Stakeholder Workgroups, Ongoing Contract Management

Eligibility/Expansions

59. Individuals in institutions should be included in the Demonstration. (The Arc)

Response: Individuals residing in facility settings are, generally, included in the Demonstration. The exception to this policy is that individuals residing in Intermediate Care Facilities (ICF/MRs) are not included in the eligible population. In Massachusetts, all 5 remaining ICF/MRs are Commonwealth owned and operated. 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. The Department of Developmental Services has made significant strides in transitioning many ICF/MR residents to community placements, and no longer makes new placements in ICF/MR facilities. Three of the five facilities are taking steps to close in the next several years (and a sixth closed in August 2012). The Demonstration would become immediately available to these members upon community placement.

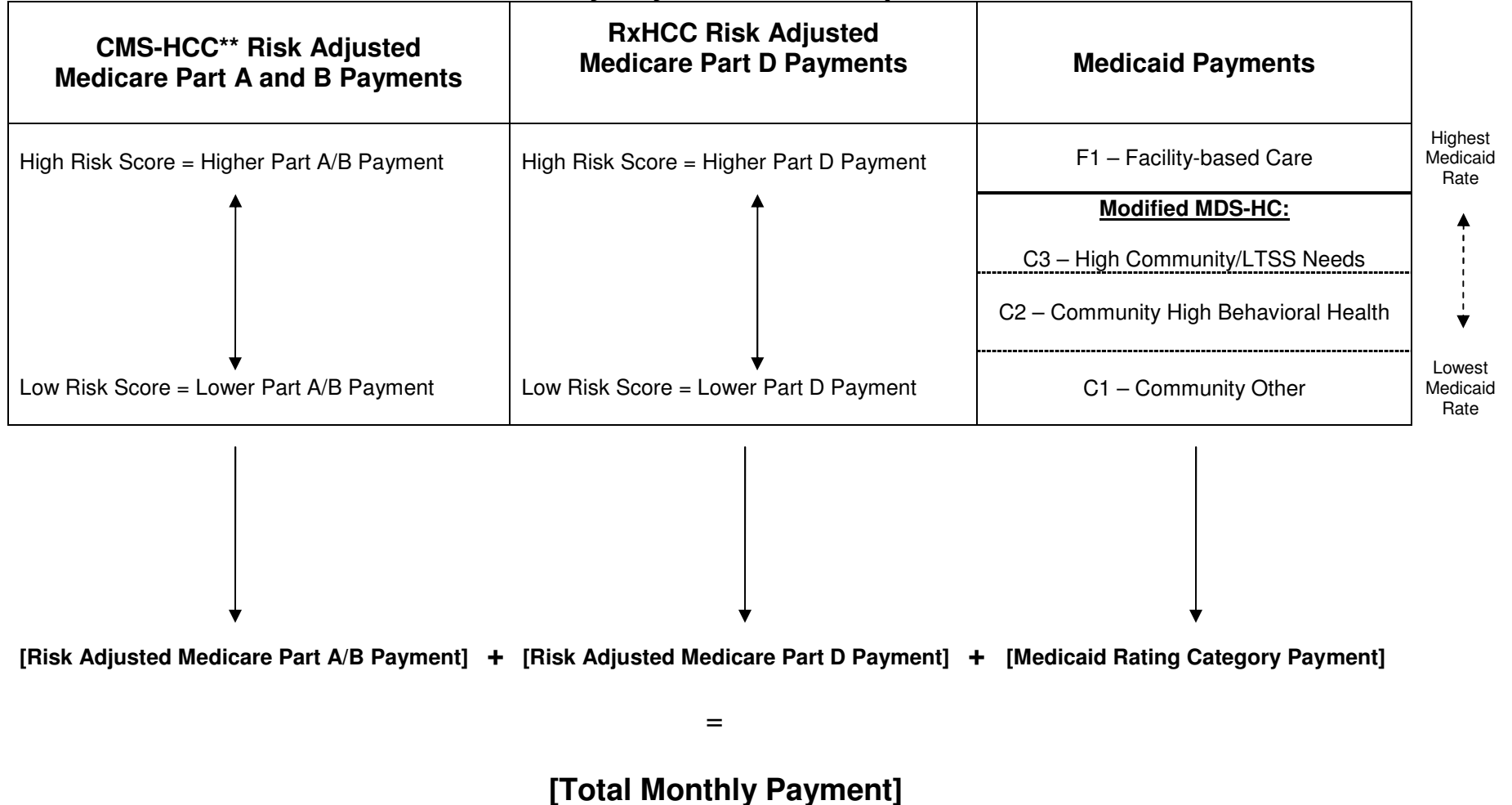
Anticipated Mechanism: RFR, MOU

60. Request a 5-year commitment to preserve the HCB Waiver services carve-out. (ADDP)

Response: EOHHS and CMS have both committed to working with stakeholders and state agencies to determine how and when to extend the benefits of participating in the Demonstration to HCBS Waiver participants who wish to enroll during the Demonstration period.

Anticipated Mechanism: RFR, MOU, Ongoing Open Stakeholder Meetings

Figure 1
Monthly Payments to ICOs per Enrollee



Possible Scenarios:

- ICOs can receive **high** Medicare A/B and/or Medicare D payments for C1 enrollees
- ICOs can receive **low** Medicare A/B and/or Medicare D payments for F1 enrollees
- Higher payments in total may be received for C1 or C2 enrollee than C3 enrollee

** Diagnosis and demographic risk adjustment of county rates based on acute care needs