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July 11, 2011

Donald Berwick, M.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-5507-NC, P.O. Box 8013
Baltimore, MD 21244-8013

Re: Responses to Request for Information issued by the Centers for Medicare & Medicaid Services ("CMS") in connection with the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office") of Section 2602 of the Affordable Care Act.

Dear Dr. Berwick:

The Commonwealth of Massachusetts ("the Commonwealth") is pleased to offer comments on the Request for Information on Opportunities for Alignment Under Medicaid and Medicare issued on May 16, 2011. The Commonwealth strongly supports the creation of the Medicare-Medicaid Coordination Office and its goal to more effectively integrate Medicare and Medicaid benefits and improve the coordination between the Federal and State governments for dual eligible beneficiaries.

The Commonwealth has a long history of working with CMS to integrate Medicare and Medicaid for dual eligible individuals. Partnering with CMS, the Commonwealth implemented the Program for All-inclusive Care for the Elderly (PACE) program in 1990 for dual eligibles age 55 and older, and the Senior Care Options (SCO) Program in 2004 for dual eligibles age 65 and older. Both programs have shown increased member satisfaction, positive steps toward improving health outcomes, and improved and more efficiently provided health care services. Over the past two years, the Commonwealth has focused its attention on integrating care for younger dual eligible individuals ages 21-64. CMS has tremendous opportunities to partner with States to improve access, quality, and the cost of care for people who depend on these two programs, and we very much look forward to a productive relationship with the Medicare-Medicaid Coordination Office to help address these issues. The Commonwealth has identified broad areas of challenges and resulting opportunities in aligning Medicare and Medicaid programs, as listed in the section below.

How Misalignments between Medicare and Medicaid Impact Access to High-Quality care

The current system lacks sufficient care coordination for the comprehensive care this population needs, which inhibits access to critical services and encourages cost-shifting between providers and payers. All of these factors adversely impact this population's quality of care and health outcomes, and contribute to increased Medicaid and Medicare spending. As this group uses a wide array of services, the lack of care management may increase the incidence of duplicative services, contraindicated therapies and drugs, and inefficiencies in care.

Challenges for providers

In the current fee-for-service (FFS) system, particularly when multiple payers are involved, providers face challenges communicating and collaborating with one another about a person's care. Providers may not be aware of the different types and sources of care provided or available to the dual eligible individuals they serve. Further, neither the Medicare nor Medicaid programs can alone afford to invest in the full range of services and comprehensive care coordination necessary to meet the needs of dual eligible individuals. Even with such an investment, potential savings may accrue to the other program in the absence of a shared savings mechanism. Many FFS providers lack the information systems, reimbursement incentives, and financial or staff resources necessary to coordinate the comprehensive care needs of dual eligible individuals and to help ensure these individuals receive the highest quality, most cost effective services in the right settings. Further, providers have the administrative burden of billing and navigating different sets of policies, procedures and reimbursement rules for two different government programs as they attempt to provide comprehensive care. CMS should consider how to provide resources or allow flexibility within current resources to support comprehensive care management or coordination. Providing states and providers the flexibility to share savings with Medicare would be a critically important tool to encourage and support this investment.

Challenges for beneficiaries

Dual eligible individuals with complex care needs interact frequently with various parts of the health care system and many simultaneously use acute care services, Medicaid or state-funded LTSS, behavioral health services, prescription drugs, and other supports. In a FFS system, many of these individuals, who already struggle with the daily challenges of their conditions or disabilities, must arrange their own care. This may entail communicating with multiple providers, coordinating numerous doctor appointments and arranging for transportation needs. These activities may be even more difficult and complex for individuals with cognitive impairments. CMS should allow coordinated and simplified literature explaining how both programs work together for dual eligible individuals and what care is available for beneficiaries to access. CMS should collaborate with states to respond to questions dual eligible individuals have about their combined coverage.

Inadequate access to coordinated behavioral health services

A subgroup of particular concern is individuals with behavioral health needs. In the Commonwealth, for example, these beneficiaries represent a substantial portion of dual eligible adults ages 21-64, and face particular challenges with accessing appropriate care. The integration of behavioral health and medical care is an important challenge in any health care system, but it is especially problematic for dual eligible individuals who need to navigate across different payers. In 2008, 64% of MassHealth's dual eligible adults age 21-64 experienced chronic mental illness and/or substance abuse. Behavioral health services provided by Medicare and FFS Medicaid are generally limited to only acute inpatient psychiatric care, acute substance abuse services, psychiatric day treatment, and traditional behavioral health ambulatory care. Medicare and Medicaid's FFS systems also lack the infrastructure to coordinate behavioral health care services for dual eligible beneficiaries.

Lack of integration fosters cost-shifting and underinvestment

Medicare and Medicaid coverage rules create unintended incentives for cost-shifting among providers and between payers. With two parallel but unaligned systems of care, providers and payers can avoid costs by transferring beneficiaries from one service or setting to another that is the responsibility of a different provider or payer. This practice unnecessarily increases state and federal spending, may not be in the best interest of the beneficiary, and could adversely affect the beneficiary's health. Medicaid programs could, in the existing framework, pursue bringing diversionary behavioral health and LTSS into the service mix for dual eligible individuals that could substantially impact acute care spending and health outcomes. However, there is no current mechanism by which resulting acute care savings accrued by the Medicare program can be redirected to the Medicaid program to help finance the increased non-acute spending, making this unaffordable for states. The net effect is an underinvestment in appropriate, cost-effective care for dual eligible adults. CMS can ease this with

shared savings opportunities between Medicare and state Medicaid programs. Clear, straight lines of accountability and resources to provide care focused on the whole person rather than discreet services would mitigate cost-shifting. Strategies that emphasize person-centered care and that focus on the complete needs of the individual will be more successful than those that focus on treating distinct diseases or conditions.

Comments on the Request for Information *List of Alignment Opportunities*

We applaud the Medicare-Medicaid Coordination Office efforts to compile the **List of Alignment Opportunities** by gathering input from numerous and diverse stakeholders. The Medicare-Medicaid Coordination Office's **List of Alignment Opportunities** is comprehensive, informative and useful for future policy development regarding the areas in which the Medicare and Medicaid programs have conflicting requirements. These conflicting requirements prevent dual eligible individuals from receiving seamless, high quality care, and prevent providers and payers from effectively designing systems of integrated care.

The Commonwealth would like to suggest one additional "Topic" area: home and community based services delivered through 1915(c) waivers (HCBS). Many dual eligibles benefit from Medicaid HCBS by receiving supportive services and case management in the community rather than in institutions. Improving the coordination between Medicare and Medicaid with regard to HCBS provides the opportunity to improve beneficiary outcomes, improve quality of life and allow beneficiaries to live longer in their own home. Better aligning HCBS between Medicare and Medicaid also has the potential for both programs to reduce costs that are associated with episodic acute care and extended long-term care in facilities.

Improved alignment of Medicare and Medicaid HCBS would also support the Medicare-Medicaid Coordination Office's goals of: more effectively integrating Medicare and Medicaid benefits, improving coordination to eliminate cost-shifting between Medicare, Medicaid and among related health care providers, addressing issues related to quality of care and beneficiary satisfaction; and promoting access to Medicare and Medicaid services that promote more seamless benefits and transitions.

Comments on Request for Information, *Section IV. Questions*

In response to the questions CMS posed in Section IV of the Request for Information, the Commonwealth is providing the following information. In the creation of our responses we found common themes underlying most of the answers that would improve the alignment between Medicare and Medicaid. The themes include elements such as: an accountable entity for all care, one central point to access all care, multi-disciplinary care teams, individualized care plans developed through a person-centered process, the importance of care coordination across all settings and during transitions, the importance of access to and coordination of behavioral health services, the critical role of long-term support services in the community, the establishment of appropriate quality metrics, appropriate financial incentives and the need to successfully engage providers and stakeholders in all aspects of integrated care model elements.

1. How can the Medicare and Medicaid programs better ensure dual eligible individuals are provided full access to the program benefits?

Medicare and Medicaid programs can better ensure dual eligible individuals are provided full access to the program benefits by creating integrated delivery systems that provide:

- **Person-Centered Care:** Places the dual eligible individual and, at the individual's discretion, family members and other informal caregivers, client advocates and peers, at the center of the care team to ensure person-centered planning and promote self-direction
- **Comprehensive Care Coordination:** Maintains a close relationship between the beneficiary, primary care practitioners, care coordinators, and all other providers of services; relies on a team-based approach to care delivery; performs comprehensive care assessments, care planning, self-management coaching; has a regular process for monitoring and updating care

plans; provides particular focus on improving transitions between care settings; and, addresses intensive care management needs of populations with specific challenges (e.g., homelessness, complex medical conditions, behavioral health issues, substance use disorders)

- **Accountability for Delivery of Covered Services:** Identifies one entity as accountable for the delivery and management of all covered health and support services for each individual
- **Improved Health Information Technology:** Uses mechanisms (such as electronic medical records) to collect, store, integrate, analyze and report data in a timely manner, including the measurement of person-level outcomes and identification of high utilizing members for increased attention; and to support comprehensive care coordination across providers and settings of care
- **Quality Management:** Measures health outcomes, adheres to evidence-based best practices and promotes continual quality improvements;
- **Administrative Simplicity:** Unifies policies, procedures, payments and administrative processes
- **Financial Integration:** Uses an alternative payment methodology; a single global Medicare/Medicaid payment with incentives for quality outcomes, efficient health care delivery and effective care coordination; and employs mechanisms to ensure appropriate risk adjustments for the population and risk and savings arrangements
- **Mechanisms to Reduce Health Disparities:** Increases access to care, provides care and develops care teams with awareness of the cultural perspectives and languages of beneficiaries, and is accountable for quality metrics aimed at reducing incidences of health disparities.

2. What steps can CMS take to simplify the processes for dual eligible individuals to access the items and services guaranteed under the Medicare and Medicaid programs?

CMS can simplify the processes for dual eligible individuals to access Medicare and Medicaid benefits by supporting integrated care models that combine Medicare and Medicaid funding and contract with entities to integrate comprehensive care at the person level to provide both MassHealth and Medicare services. These integrated care models should be responsible to deliver care with a person-centered approach that ensures that all health needs of individuals are met and coordinated across the health care and long term support delivery system. These programs should be evaluated based on a comprehensive set of quality metrics that are developed to assess their performance and health outcomes. These integrated models of care should be administered at the state level for optimal care coordination and full integration of all state sponsored and affiliated long-term care support services.

3. Are there additional opportunities for CMS to eliminate regulatory conflicts between the rules under the Medicare and Medicaid programs?

A major area of opportunity to eliminate regulatory conflicts between the Medicare and Medicaid programs is contracting flexibility; specifically, allowing 3-way contracts between CMS, States, and integrated care entities.

For example, the Commonwealth's SCO program started out promoting full integration between Medicare and Medicaid with 3-way contracts between CMS, MassHealth and SCO health plans. In 2003, the Medicare Modernization Act authorized a new managed care model for Medicare beneficiaries with "special" needs. Special Needs Plans (SNPs) were defined as Medicare Advantage plans which would provide targeted care to Medicare beneficiaries who were dual eligible or institutional residents in need of services for a chronic illness. In January 2006, the three SCOs in the Commonwealth were among the first plans to be approved as SNPs for dual-eligibles with Medicare Part D pharmacy coverage included. The Center for Beneficiary Choices at CMS determined that it did not wish to continue the SCO demonstration and its 3-way contracting approach between CMS, MassHealth and the SCOs. CMS ended the 3-way contracts with MassHealth and the SCOs on December 31, 2008.

From that point forward, SCO plans have had to maintain Medicare Advantage contracts with CMS, and separate Medicaid contracts with MassHealth. Unfortunately, two separate contracts with MassHealth and CMS have, in effect, eroded the administrative simplicity SCO enjoyed under the 3-

way contract. Although separate contracts makes meaningful Medicare-Medicaid integration difficult across acute and long-term care settings, the current SCOs had the opportunity to develop integrated systems under the 3 way contract initially, and have continued to function much as they did under the 3-way contract. New integrated care programs would not have such strong incentives for full coordination and full alignment if required to have separate contracts with Medicare and with Medicaid.

4. How can CMS best work to improve care continuity and ensure safe and effective care transitions for dual eligible beneficiaries?

CMS can work to improve care continuity and ensure safe and effective care transitions for dual eligible beneficiaries by working with states to develop integrated care programs that:

- Place the dual eligible individual and, at the individual's discretion, family members and other informal caregivers, client advocates and peers, at the center of the care team to ensure person-centered planning
- Provide comprehensive care coordination that maintains a close relationship between the beneficiary, primary care practitioners, care coordinators, and all other providers of services
- Rely on a team-based approach to care delivery
- Perform comprehensive care assessments, care planning, self-management coaching;
- Have a regular process for monitoring and updating care plans
- Provide particular focus on improving transitions between care settings
- Address intensive care management needs of populations with specific challenges (e.g., homelessness, complex medical conditions, substance use disorder).

To ensure safe and effective transition the integrated care programs must be accountable for the delivery and management of all covered health and support services for each individual. To do so, these programs should have mechanisms in place to collect, store, integrate, analyze and report data in a timely manner regarding transitions, have performance and quality metrics that measure transition activities and health outcomes, adhere to evidence-based best practices, and promote optimal and continual quality improvements. Minimum elements in transition programs should include:

- Multi-disciplinary care teams;
- Patient –centered medical home models of care;
- Connections with local community-based organizations to assist with care transitions
- Minimum standards for infrastructure and staffing to achieve seamless transitions, educating about operationalizing effective care transitions and discharge planning protocols (as early as possible to create seamless care transitions)
- Performance measurement for accountability before, during, and after transitional care
- Medical practice protocols for care transitions
- Use of technology to improve communication (e.g. electronic health records)
- Alignment of financial incentives to promote collaboration and comprehensive care coordination

5. How can CMS work to eliminate cost-shifting between the Medicare and Medicaid programs? How about between related health care providers?

CMS can help eliminate cost shifting between the Medicare and Medicaid programs by allowing states increased flexibility to combine funding streams. Allowing integrated care entities to maintain a single, 3 way contract between Medicare, Medicaid, and the entities, or delegating operational responsibilities and funding to state Medicaid agencies would clarify accountability for care and health outcomes for dual eligible individuals, as well as create incentives to use flexible resources efficiently.

Other avenues to eliminate cost shifting include looking at opportunities for providing global Medicare and Medicaid payments. These global payments should reflect a full set of covered services, need to be adjusted to ensure the overall payment is sufficient given the risks and health needs of the population, and ensure appropriate risk and shared savings arrangements are established. The global

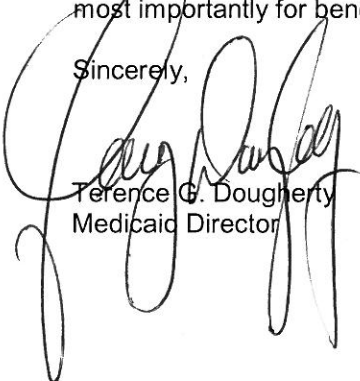
payment planning will need to include: the identification of the services to be covered, development of risk adjustment methods, creation of appropriate rating categories, shared savings arrangements, and quality metrics that appropriately reward the integrated care programs for high-quality performance and improved health outcomes.

Global Medicare and Medicaid payments have the opportunity to reverse the existing fragmentation care that many dual eligible individuals experience in their care today. Reimbursing for services and procedures inhibits providers from caring for the whole person. A financial structure that rewards an integrated and comprehensive approach to care will support better health outcomes and higher quality care. Ineffective payment incentives, absence of comprehensive care coordination, insufficient care options, conflicting rules and practices in parallel silo systems, and lack of full accountability for a person's care and quality of life all contribute to Medicare and Medicaid programs spending significantly more on their dual eligible populations than on their non-dual eligible beneficiaries. CMS should collaborate with states and providers to adopt a global payment that:

- Replaces financial incentives for discrete services with incentives for holistic, person-centered care
- Incentivizes and allows flexibility for the individual and care providers to develop and engage in care together
- Creates a single clear path of accountability for outcomes, individuals' satisfaction, and optimal use of resources
- Protects individuals' rights consistent with both Medicare and Medicaid principles
- Creates opportunities for shared risk and mechanisms to share savings that can be invested in additional supports and services that will improve the beneficiaries' outcomes and experiences

By combining Medicare and Medicaid funds, creating global payments with appropriate incentives and using joint concepts of sole accountability and complete service integration for a seamless member experience, CMS can achieve better results for Medicare, Medicaid, providers, and most importantly for beneficiaries.

Sincerely,



Terence G. Dougherty
Medicaid Director