ADDENDUM to

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid

Proposal to the Center for Medicare and Medicaid Innovation

State Demonstration to Integrate Care for Dual Eligible Individuals
Contract No. HHSM-500-2011-00033C

CMS would like additional information from Massachusetts about how its proposed demonstration would meet the standards and conditions that CMS will require of all states seeking to be considered for participation in the demonstration.

- *Please provide additional information explaining how benefits would appear seamless to beneficiaries and financial accountability would occur under the proposed carve out of HCBS and related State Plan services for 1915(c) waiver enrollees.*

- *Please provide additional information explaining how the proposed HCBS and related State Plan service carve out aligns financial incentives to minimize incentives for cost shifting and maximize incentives for making appropriate cost-effective investments. Please include in your response additional detail about the rationale for this proposed carve out, as well as the amount spent on those services. Please explain how those services would be coordinated with the rest of the enrollee's care. Please describe any monitoring that would occur to detect cost shifting.*

  Response

  Approximately 7,300 of the 115,000 Massachusetts dual eligible members ages 21-64 are enrolled in Home and Community-based Services (HCBS) waivers that are operated by state agencies (the Department of Developmental Services (DDS), the Massachusetts Rehabilitation Commission, and the Executive Office of Elder Affairs) (CY 2008 data). HCBS services are provided on a FFS basis. Medicaid spending on HCBS waiver services and related State Plan services in CY 2009 and number of users in CY 2011 was as follows:

Impact of Carve-out for Waiver Participants	Spending ($M) CY 2009	# of Users CY 2011
HCBS Waivers		
Adult Supports Waiver (DDS)[2]	$0.0	1,120
Community Living Waiver (DDS)	$0.0	993
Adult Residential Waiver (DDS)	$0.0	4,155
Traumatic Brain Injury Waiver	$4.1	64
ABI – No Res. Hab. Waiver[3]	$0.0	17
ABI – Res. Hab. Waiver[3]	$0.0	11
Frail Elder Waiver (EOEA)	$2.2	422
Adult Comprehensive (DDS) – discontinued[4]	$430.7	303
HCBS Subtotal	***$437.6***	**7,085**
Related State Plan Services		
Day Habilitation	$50.9	3,213
Personal Care Attendant	$7.8	425
Adult Foster Care	$6.9	418
Adult Day Health	$3.4	287
Group Adult Foster Care	$0.4	48
State Plan Services Subtotal	***$69.4***	

Total Amount Carved Out:	**$507.0**

Waiver Participants Total Medicare and Medicaid Spending	**$660.0**

[1] The information on number of users for CY 2011 matches information provided by MassHealth to CMS in the document, "Responses to CMS Questions, March 13 2012" sent via email on 3/13/12. Here we have provided spending figures for 2009 because figures from more recent years are less reliable due to claims lag.
[2] Reflects combined spending on the Adult Comprehensive Waiver (DDS), which was discontinued in June 2010 and replaced by the 3 DDS waivers listed here.
[3] The ABI waivers were implemented in May 2010, and transitions began around November 2010. Therefore CY 2009 spending is $0.
[4] Adult Comprehensive DDS waiver ended June 2010. There are 303 people that may still require reassignment in our data systems to one of the 3 current DDS waivers.

After extensive consideration, MassHealth has determined that the most practical course of action is to exclude the population of members enrolled in HCBS waivers from the Demonstration for now. We would like to continue working with CMS to explore the possibilities of including segments of this population in the Demonstration over the course of the Demonstration period.

The advances this Demonstration has been designed to achieve – including person-centered care, integration of primary and behavioral health care, expansion of diversionary services, flexibility in using a non-traditional workforce, innovative models of care made possible by global payments, and focused quality measurement activities across behavioral, primary, acute, chronic care and LTSS – present significant opportunities that we want to make available to as many of our target dual eligible members as possible. However, protecting members enrolled in HCBS waivers from service disruption and confusion about coordination of LTSS that are critical to their day-to-day functioning and safety is paramount. We look forward to continuing discussions with

CMS on how we may be able to achieve these goals and include these members in the Demonstration.

- *Please provide additional information about the proposal to carve out Targeted Case Management (TCM) and rehabilitation option services. Please include in your response additional detail about the rationale for this proposed carve out, the number of beneficiaries within the target population that receive TCM and rehabilitation option services, as well as the amount spent on those services. Please explain how those services would be coordinated with the rest of the enrollee's care. Please describe any monitoring that would occur to detect cost shifting.*

  Response on Targeted Case Management

  Targeted Case Management (TCM) is a service that assists individuals in gaining access to needed medical, social, educational, and other services, including state agency services. TCM is claimed FFS for individuals residing in the community. In Massachusetts, it is a State Plan service for two populations in the Duals Demonstration target population: people with severe mental disabilities (for whom the Department of Mental Health (DMH) staff serve as the providers of TCM), and people with mental retardation (for whom the Department of Developmental Services (DDS) staff are the providers).[1] The following chart shows utilization and spending for individuals who used TCM in CY 2009 who were not enrolled in HCBS waivers.

CY 2009	
TCM Non-Waiver Utilizers	8,046
TCM Non-Waiver Spending	$24,537,967

  People using TCM used approximately $150 million in other Medicaid services in CY2009. Of those non-waiver members receiving TCM, 48% receive it through DDS and 52% through DMH.

  The scope of activities undertaken in TCM goes significantly beyond the care management and care coordination activities that we contemplate being under an Integrated Care Organization's (ICO's) purview. TCM is focused on assessing a member's need for and providing access to particular state agency services. Targeted Case Managers provide unique and extensive services for state agencies including:

  - Completing a comprehensive assessment of state agency service needs;
  - Developing the Individual Service Plan (ISP), which delineates the state agency services individuals will receive;
  - Monitoring the development of the program-specific treatment plan that is guided by the ISP to ensure that the services in the ISP are provided;
  - Coordinating the individual's access to all of the services that the state agency provides and/or contracts for that are not those services that will be covered by an ICO;

[1] Certain individuals in HCBS waivers use Targeted Case Management; most notably, those in the DDS operated waivers for adults with intellectual disabilities, as TCM is the mechanism for case management in those waivers. However, HCBS waiver participants will now be excluded from the Demonstration, so the financial and utilization information provided about TCM is specific to the Demonstration population as it is now defined, and does not include HCBS waiver participants.

- Serving as the client's advocate to resolve client's issues and concerns regarding care and treatment provided by state agency and contractor staff and programs.

The services under the purview of TCM include services that are provided at 100% state cost that will not be part of the ICO service package, and therefore will continue to be delivered by DMH and DDS as they are now. We would not, for example, expect that ICOs would be involved in helping a member develop and execute a plan for assuring income maintenance, or coordinate members' agency Individual Service Plans (ISP), which are activities in the Massachusetts' State Plan for TCM for the Severely Mentally Disabled. DMH and DDS are unique state agencies designated by state law to provide DMH services to people with Serious Mental Illness and DDS services to people with intellectual disabilities, respectively. The state agency employees of those agencies are best able to assist members to secure these important state-funded and state agency services. We believe the ICOs would be less effective working from outside the state agencies than the state employees are from within.

In addition, TCM qualified providers are described in the State Plan as individuals meeting the qualifications and entrance requirements for certain State positions as described by the Commonwealth's Human Resource Department. These providers are staff at state agencies and their responsibilities are governed by collectively bargained contracts. Therefore, the Commonwealth has made the determination at this point that changing the current delivery model for TCM services is neither feasible within the timeframes required for this Demonstration, nor would it be in the best interest of DMH and DDS clients.

In this Demonstration, TCM services will be coordinated with the rest of the ICO enrollee's care as the Targeted Case Managers will participate in the member's care team and engage in these coordination discussions with the care team. The Targeted Case Managers will play their crucial role, as they do today, in assisting the enrollee to access services provided by the state agency. In addition, the LTSS Coordinator role can facilitate communication between the care team and the Targeted Case Manager whenever necessary. Where Targeted Case Managers are in salaried positions, there is less risk of cost shifting based on unmanaged volume of TCM services.

Metrics about the frequency of communication between the Targeted Case Manager and the rest of the care team, and about the exchange of care coordination information could be used to monitor how this service complements the ICOs' activities. For example, for each ICO member that has a Targeted Case Manager, MassHealth proposes to require the ICO to establish and use written procedures for communicating with the TCM and documenting those communications as follows:

1. During initial 90 days of enrollment, to receive information about the member's current care plan and plan the ICO Initial Assessment;
2. Following the ICO Initial Assessment, to share assessment results and discuss the ICO Care Planning process, including how the TCM may be involved in ICO Care Team Meetings;
3. To participate as appropriate in development of the ICO Care Plan, including signing the Care Plan when it is agreed to by the Team and the member. ICOs would be required to document in Care Team meeting notes and/or the Care Plan itself the TCM's participation and input in decisions about and coordination of the member's care;
4. As appropriate thereafter, including at a minimum:
    a. Before any significant change in the Care Plan is effectuated;

b. After any significant change in the member's health status, emergency, or inpatient admission or discharge;
c. Not fewer than once every 6 months; and
d. Before conducting the member's annual comprehensive reassessment;

5. Maintaining a record of contact information for the member's TCM.

In addition, we propose to establish similar and/or parallel requirements for Targeted Case Managers to establish and use policies for communicating with the ICOs, so as to ensure full commitment to a two-way exchange of information about the member to best care for him or her in a holistic, coordinated way.

To address any questions regarding the total number of individuals that might be performing a care or case management role for a given member (e.g. Care Coordination, Clinical Care Manager, LTSS Coordinator and Targeted Case Manager), we offer the following clarification. In cases where the ICO Care Team, with the member, determines that the services of a Clinical Care Manager would benefit the member, the Clinical Care Manager would become the point person on the Team for both intensive clinical monitoring *and* care coordination. Therefore, the Care Coordinator role is not additionally required. The Independent LTSS Coordinator and TCM are separate and distinct. These 3 roles are each clearly defined, unique and important:

1. Care Coordinator (or Clinical Care Manager as appropriate): Provides care coordination for medical and behavioral health services, including ensuring appropriate referrals and timely two-way transmission of pertinent member information, and maintaining member's Care Plan. If Clinical Care Manager, additionally monitors the member's complex clinical status and needs, and provides self-management education.
2. Independent LTSS Coordinator: As a contractor to the ICO from a community-based organization, provides expertise to the Care Team to help identify the member's LTSS needs, connect the member to services, and support integration of services provided by the TCM (if needed)
3. Targeted Case Manager: As described above, provides case management services that assist eligible individuals to gain access to needed medical, social, educational, and other services, and particular services provided by the state agency.

It is important to note that not all these roles may be relevant for any individual based on his or her needs. Only approximately 8,050 members out of our target population of 111,000 will have a Targeted Case Manager (CY 2010 data). Ultimately, it will be up to the member to decide who participates in his or her care planning.

Finally, we stress that individuals using TCM services are critical to have in the Demonstration, as they will newly be able to access important integrated diversionary behavioral health benefits that are not available in the FFS system.

<u>Response on Rehab Option</u>

Rehab Option services are provided through DMH contractors to clients of DMH to assist members to relearn and regain skills they may have lost. Individuals may be eligible to receive services from the Department of Mental Health (DMH) if they have a serious and long term mental illness that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious and long term mental illness is a disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to

recognize reality, and that results in an inability to meet the ordinary demands of life. Currently DMH purchases services reimbursable under the State Plan for Rehab Option with other non-Medicaid DMH services in a bundle through the Community Based Flexible Supports (CBFS) program.

CY 2009	Spending ($M) CY 2009	# of Users CY 2009
DMH clients using Rehab Option (without TCM)	$27.8	2,372
DMH clients using Rehab Option and TCM	$37.5	2,565
Total	$65.3	4,937

Individuals who use the Rehab Option service are most important to have in the Demonstration. Like the TCM population above, they will newly be able to access important integrated diversionary behavioral health benefits that are not available in the FFS system, but would bring considerable benefits to this population.

Requirements for communication protocols could be incorporated into the CBFS providers' contracts, and we could monitor for cost-shifting by reviewing utilization and access of Rehab Option services, diversionary behavioral health services, and inpatient psychiatric hospital admissions and stays. As the CBFS program is purchased using a bundled rate, there is no FFS incentive to generate volume for additional reimbursement.

- *Please provide additional information about the rationale for excluding beneficiaries residing in ICF/MRs, and how ICO incentives would promote community alternatives to institutional placement (i.e. if an ICO has responsibility for the beneficiary in the community, but would not if s/he were to move to an ICF/MR).*

  Response

  In Massachusetts, all 6 remaining ICF/MRs are Commonwealth owned and operated. DDS has been making significant strides in transitioning many ICF/MR residents to community placements, and no longer makes new placements in ICF/MR facilities. Four of the 6 facilities are taking steps to close in the next several years. If an individual with ID did require a facility stay, today they would most likely be placed in a nursing facility, but they would not be placed in an ICF/MR. In this case, the ICO has many LTSS, such as Day Habilitation, Personal Care Attendant Services, and Adult Foster Care, at its disposal to support individuals to remain independently living in the community.

- *Please clarify the intent and scope of the Commonwealth's proposal to provide housing support services. What services would be included?*

  Response

  The Housing First model is an approach that our managed behavioral health contractor pursued and helped to develop for chronically homeless individuals for whom state data indicates have exceptionally high acute spending. By leveraging housing supports in a permanent environment, we believe that costs for this group could be substantially decreased. Models using the Housing

First philosophy first get the member into stabilized housing, and then focus on addressing the issues that led to homelessness (substance abuse, mental illness, etc.). The Housing First model has been found to be highly cost-effective (initially saving $9,610 per person per year), as they have more success in addressing a person's medical and health needs once they are in a safe and stable home environment. Health care and supports can become more regular and replace emergency room care. This is an example of a strategic partnership that an ICO could leverage when it is cost-effective, but the model would not be an entitlement under the ICOs' contract.

If members obtain permanent housing, they are more likely to follow established clinical practices for their chronic behavioral health and medical conditions and reduce the use of emergency rooms and unnecessary hospitalizations. The activities of locating, obtaining, and subsidizing housing would not be paid for from the ICO's capitation payment. The ICO would only provide the connection and the treatment and supportive services necessary to address the underlying issues that led to the individual being homeless. The ICO, through member care plans, will support the specific needs of chronically homeless individuals by stabilizing them with regard to their behavioral health and chronic disease needs, and their needs for intense community support.

- *Please provide additional detail explaining the rationale for not providing certain supplemental services (described in proposal Table C of Appendix C) to demonstration enrollees who are also enrolled in HCBS waivers.*

  Response

  Four of the services in this category – Day Services, Home Care Services, Respite Care Services, and Home Modifications – are available in many of Massachusetts' Home and Community Based Services (HCBS) Waivers. Massachusetts has decided to exclude HCBS waiver participants from participation in the demonstration, at least initially. The ICOs will use their global payments to provide these services as indicated in member care plans to all participating demonstration populations.

- *CMS understands that Massachusetts plans to submit legislation that describes the proposed duals demonstration and its relationship with CMS. Please provide additional information on whether there is any foreseeable risk that the Commonwealth legislation will not be passed. Please describe the expected impact of this legislation on the ability of the proposed demonstration to move forward (e.g. can the demonstration proceed if the legislation is not passed?). Does the Commonwealth expect to need any regulatory changes? If so, what is the anticipated timeframe of those changes?*

  Response

  Legislation establishing the Duals Demonstration and giving EOHHS authority to certify non-DOI plans and their solvency to CMS was passed by both houses and signed by the Governor in June 2012.

Massachusetts has begun work to draft regulations for the Duals Demonstration. Regulatory changes can be completed and implemented within 6 months, and often in less time.

- *Please provide an update on the expenditure authority that the Massachusetts proposal anticipated would be needed for the demonstration.*

  Response

  Massachusetts and CMS have determined that expenditure authority is not needed, as the Memorandum of Understanding and three-way contracts will provide the authority to require ICOs to provide the proposed set of benefits. And CMS has determined that, as structured through the MOU, no additional expenditure authority is needed for these services.

- *Please provide written confirmation that the Commonwealth will provide to CMS any required beneficiary-level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models.*

  Response

  Yes, the Commonwealth will provide to CMS any required beneficiary-level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models. Since the time of the proposal submission, Massachusetts now has access to linked Medicare and Medicaid data through CY 2010.

- *Please provide written confirmation that the Commonwealth will provide to CMS a description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.).*

  Response

  Yes, the Commonwealth will provide to CMS a description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.).

- *Please provide written confirmation that the Commonwealth will provide to CMS data on State supplemental payments to providers (e.g., DSH, UPL) during the three year period.*

  Response

  Yes, the Commonwealth will provide to CMS data on State supplemental payments to providers (e.g., DSH, UPL) during the three year period.

- *Please confirm that the Commonwealth will provide/has provided appropriate tribal consultation.*

  Response

  Yes, tribal consultation calls conducted over the last year on April 27, 2011, July 27, 2011, October 25, 2011, January 19, 2012, and April 27, 2012. Each included status updates on the Duals project, and shared the web address for the Duals project (www.mass.gov/masshealth/duals), which included postings for all public meetings and information related to the project, including the Draft Proposal for Public Comment and Final Demonstration Proposals. In accordance with our State Plan, follow-up emails were sent after each consultation call to document the discussion from the call. The Commonwealth will continue to provide tribal consultation as described in our State Plan, and has added all tribal contacts to our Duals stakeholder distribution lists.

ADDENDUM to

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid

Proposal to the Center for Medicare and Medicaid Innovation

State Demonstration to Integrate Care for Dual Eligible Individuals
Contract No. HHSM-500-2011-00033C

CMS would like additional information from Massachusetts about how its proposed demonstration would meet the standards and conditions that CMS will require of all states seeking to be considered for participation in the demonstration.

- *Please provide additional information explaining how benefits would appear seamless to beneficiaries and financial accountability would occur under the proposed carve out of HCBS and related State Plan services for 1915(c) waiver enrollees.*

- *Please provide additional information explaining how the proposed HCBS and related State Plan service carve out aligns financial incentives to minimize incentives for cost shifting and maximize incentives for making appropriate cost-effective investments. Please include in your response additional detail about the rationale for this proposed carve out, as well as the amount spent on those services. Please explain how those services would be coordinated with the rest of the enrollee's care. Please describe any monitoring that would occur to detect cost shifting.*

  Response

  Approximately 7,300 of the 115,000 Massachusetts dual eligible members ages 21-64 are enrolled in Home and Community-based Services (HCBS) waivers that are operated by state agencies (the Department of Developmental Services (DDS), the Massachusetts Rehabilitation Commission, and the Executive Office of Elder Affairs) (CY 2008 data). HCBS services are provided on a FFS basis. Medicaid spending on HCBS waiver services and related State Plan services in CY 2009 and number of users in CY 2011 was as follows:

Impact of Carve-out for Waiver Participants	Spending ($M) CY 2009	# of Users CY 2011
HCBS Waivers		
Adult Supports Waiver (DDS)[2]	$0.0	1,120
Community Living Waiver (DDS)	$0.0	993
Adult Residential Waiver (DDS)	$0.0	4,155
Traumatic Brain Injury Waiver	$4.1	64
ABI – No Res. Hab. Waiver[3]	$0.0	17
ABI – Res. Hab. Waiver[3]	$0.0	11
Frail Elder Waiver (EOEA)	$2.2	422
Adult Comprehensive (DDS) – discontinued[4]	$430.7	303
HCBS Subtotal	***$437.6***	**7,085**
Related State Plan Services		
Day Habilitation	$50.9	3,213
Personal Care Attendant	$7.8	425
Adult Foster Care	$6.9	418
Adult Day Health	$3.4	287
Group Adult Foster Care	$0.4	48
State Plan Services Subtotal	***$69.4***	

Total Amount Carved Out:	**$507.0**

Waiver Participants Total Medicare and Medicaid Spending	**$660.0**

[1] The information on number of users for CY 2011 matches information provided by MassHealth to CMS in the document, "Responses to CMS Questions, March 13 2012" sent via email on 3/13/12. Here we have provided spending figures for 2009 because figures from more recent years are less reliable due to claims lag.
[2] Reflects combined spending on the Adult Comprehensive Waiver (DDS), which was discontinued in June 2010 and replaced by the 3 DDS waivers listed here.
[3] The ABI waivers were implemented in May 2010, and transitions began around November 2010. Therefore CY 2009 spending is $0.
[4] Adult Comprehensive DDS waiver ended June 2010. There are 303 people that may still require reassignment in our data systems to one of the 3 current DDS waivers.

After extensive consideration, MassHealth has determined that the most practical course of action is to exclude the population of members enrolled in HCBS waivers from the Demonstration for now. We would like to continue working with CMS to explore the possibilities of including segments of this population in the Demonstration over the course of the Demonstration period.

The advances this Demonstration has been designed to achieve – including person-centered care, integration of primary and behavioral health care, expansion of diversionary services, flexibility in using a non-traditional workforce, innovative models of care made possible by global payments, and focused quality measurement activities across behavioral, primary, acute, chronic care and LTSS – present significant opportunities that we want to make available to as many of our target dual eligible members as possible. However, protecting members enrolled in HCBS waivers from service disruption and confusion about coordination of LTSS that are critical to their day-to-day functioning and safety is paramount. We look forward to continuing discussions with

CMS on how we may be able to achieve these goals and include these members in the Demonstration.

- *Please provide additional information about the proposal to carve out Targeted Case Management (TCM) and rehabilitation option services. Please include in your response additional detail about the rationale for this proposed carve out, the number of beneficiaries within the target population that receive TCM and rehabilitation option services, as well as the amount spent on those services. Please explain how those services would be coordinated with the rest of the enrollee's care. Please describe any monitoring that would occur to detect cost shifting.*

  Response on Targeted Case Management

  Targeted Case Management (TCM) is a service that assists individuals in gaining access to needed medical, social, educational, and other services, including state agency services. TCM is claimed FFS for individuals residing in the community. In Massachusetts, it is a State Plan service for two populations in the Duals Demonstration target population: people with severe mental disabilities (for whom the Department of Mental Health (DMH) staff serve as the providers of TCM), and people with mental retardation (for whom the Department of Developmental Services (DDS) staff are the providers).[1] The following chart shows utilization and spending for individuals who used TCM in CY 2009 who were not enrolled in HCBS waivers.

CY 2009	
TCM Non-Waiver Utilizers	8,046
TCM Non-Waiver Spending	$24,537,967

  People using TCM used approximately $150 million in other Medicaid services in CY2009. Of those non-waiver members receiving TCM, 48% receive it through DDS and 52% through DMH.

  The scope of activities undertaken in TCM goes significantly beyond the care management and care coordination activities that we contemplate being under an Integrated Care Organization's (ICO's) purview. TCM is focused on assessing a member's need for and providing access to particular state agency services. Targeted Case Managers provide unique and extensive services for state agencies including:

  - Completing a comprehensive assessment of state agency service needs;
  - Developing the Individual Service Plan (ISP), which delineates the state agency services individuals will receive;
  - Monitoring the development of the program-specific treatment plan that is guided by the ISP to ensure that the services in the ISP are provided;
  - Coordinating the individual's access to all of the services that the state agency provides and/or contracts for that are not those services that will be covered by an ICO;

[1] Certain individuals in HCBS waivers use Targeted Case Management; most notably, those in the DDS operated waivers for adults with intellectual disabilities, as TCM is the mechanism for case management in those waivers. However, HCBS waiver participants will now be excluded from the Demonstration, so the financial and utilization information provided about TCM is specific to the Demonstration population as it is now defined, and does not include HCBS waiver participants.

- Serving as the client's advocate to resolve client's issues and concerns regarding care and treatment provided by state agency and contractor staff and programs.

The services under the purview of TCM include services that are provided at 100% state cost that will not be part of the ICO service package, and therefore will continue to be delivered by DMH and DDS as they are now. We would not, for example, expect that ICOs would be involved in helping a member develop and execute a plan for assuring income maintenance, or coordinate members' agency Individual Service Plans (ISP), which are activities in the Massachusetts' State Plan for TCM for the Severely Mentally Disabled. DMH and DDS are unique state agencies designated by state law to provide DMH services to people with Serious Mental Illness and DDS services to people with intellectual disabilities, respectively. The state agency employees of those agencies are best able to assist members to secure these important state-funded and state agency services. We believe the ICOs would be less effective working from outside the state agencies than the state employees are from within.

In addition, TCM qualified providers are described in the State Plan as individuals meeting the qualifications and entrance requirements for certain State positions as described by the Commonwealth's Human Resource Department. These providers are staff at state agencies and their responsibilities are governed by collectively bargained contracts. Therefore, the Commonwealth has made the determination at this point that changing the current delivery model for TCM services is neither feasible within the timeframes required for this Demonstration, nor would it be in the best interest of DMH and DDS clients.

In this Demonstration, TCM services will be coordinated with the rest of the ICO enrollee's care as the Targeted Case Managers will participate in the member's care team and engage in these coordination discussions with the care team. The Targeted Case Managers will play their crucial role, as they do today, in assisting the enrollee to access services provided by the state agency. In addition, the LTSS Coordinator role can facilitate communication between the care team and the Targeted Case Manager whenever necessary. Where Targeted Case Managers are in salaried positions, there is less risk of cost shifting based on unmanaged volume of TCM services.

Metrics about the frequency of communication between the Targeted Case Manager and the rest of the care team, and about the exchange of care coordination information could be used to monitor how this service complements the ICOs' activities. For example, for each ICO member that has a Targeted Case Manager, MassHealth proposes to require the ICO to establish and use written procedures for communicating with the TCM and documenting those communications as follows:

1. During initial 90 days of enrollment, to receive information about the member's current care plan and plan the ICO Initial Assessment;
2. Following the ICO Initial Assessment, to share assessment results and discuss the ICO Care Planning process, including how the TCM may be involved in ICO Care Team Meetings;
3. To participate as appropriate in development of the ICO Care Plan, including signing the Care Plan when it is agreed to by the Team and the member. ICOs would be required to document in Care Team meeting notes and/or the Care Plan itself the TCM's participation and input in decisions about and coordination of the member's care;
4. As appropriate thereafter, including at a minimum:
    a. Before any significant change in the Care Plan is effectuated;

b. After any significant change in the member's health status, emergency, or inpatient admission or discharge;
c. Not fewer than once every 6 months; and
d. Before conducting the member's annual comprehensive reassessment;

5. Maintaining a record of contact information for the member's TCM.

In addition, we propose to establish similar and/or parallel requirements for Targeted Case Managers to establish and use policies for communicating with the ICOs, so as to ensure full commitment to a two-way exchange of information about the member to best care for him or her in a holistic, coordinated way.

To address any questions regarding the total number of individuals that might be performing a care or case management role for a given member (e.g. Care Coordination, Clinical Care Manager, LTSS Coordinator and Targeted Case Manager), we offer the following clarification. In cases where the ICO Care Team, with the member, determines that the services of a Clinical Care Manager would benefit the member, the Clinical Care Manager would become the point person on the Team for both intensive clinical monitoring *and* care coordination. Therefore, the Care Coordinator role is not additionally required. The Independent LTSS Coordinator and TCM are separate and distinct. These 3 roles are each clearly defined, unique and important:

1. Care Coordinator (or Clinical Care Manager as appropriate): Provides care coordination for medical and behavioral health services, including ensuring appropriate referrals and timely two-way transmission of pertinent member information, and maintaining member's Care Plan. If Clinical Care Manager, additionally monitors the member's complex clinical status and needs, and provides self-management education.
2. Independent LTSS Coordinator: As a contractor to the ICO from a community-based organization, provides expertise to the Care Team to help identify the member's LTSS needs, connect the member to services, and support integration of services provided by the TCM (if needed)
3. Targeted Case Manager: As described above, provides case management services that assist eligible individuals to gain access to needed medical, social, educational, and other services, and particular services provided by the state agency.

It is important to note that not all these roles may be relevant for any individual based on his or her needs. Only approximately 8,050 members out of our target population of 111,000 will have a Targeted Case Manager (CY 2010 data). Ultimately, it will be up to the member to decide who participates in his or her care planning.

Finally, we stress that individuals using TCM services are critical to have in the Demonstration, as they will newly be able to access important integrated diversionary behavioral health benefits that are not available in the FFS system.

<u>Response on Rehab Option</u>

Rehab Option services are provided through DMH contractors to clients of DMH to assist members to relearn and regain skills they may have lost. Individuals may be eligible to receive services from the Department of Mental Health (DMH) if they have a serious and long term mental illness that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious and long term mental illness is a disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to

recognize reality, and that results in an inability to meet the ordinary demands of life. Currently DMH purchases services reimbursable under the State Plan for Rehab Option with other non-Medicaid DMH services in a bundle through the Community Based Flexible Supports (CBFS) program.

CY 2009	Spending ($M) CY 2009	# of Users CY 2009
DMH clients using Rehab Option (without TCM)	$27.8	2,372
DMH clients using Rehab Option and TCM	$37.5	2,565
Total	$65.3	4,937

Individuals who use the Rehab Option service are most important to have in the Demonstration. Like the TCM population above, they will newly be able to access important integrated diversionary behavioral health benefits that are not available in the FFS system, but would bring considerable benefits to this population.

Requirements for communication protocols could be incorporated into the CBFS providers' contracts, and we could monitor for cost-shifting by reviewing utilization and access of Rehab Option services, diversionary behavioral health services, and inpatient psychiatric hospital admissions and stays. As the CBFS program is purchased using a bundled rate, there is no FFS incentive to generate volume for additional reimbursement.

- *Please provide additional information about the rationale for excluding beneficiaries residing in ICF/MRs, and how ICO incentives would promote community alternatives to institutional placement (i.e. if an ICO has responsibility for the beneficiary in the community, but would not if s/he were to move to an ICF/MR).*

  Response

  In Massachusetts, all 6 remaining ICF/MRs are Commonwealth owned and operated. DDS has been making significant strides in transitioning many ICF/MR residents to community placements, and no longer makes new placements in ICF/MR facilities. Four of the 6 facilities are taking steps to close in the next several years. If an individual with ID did require a facility stay, today they would most likely be placed in a nursing facility, but they would not be placed in an ICF/MR. In this case, the ICO has many LTSS, such as Day Habilitation, Personal Care Attendant Services, and Adult Foster Care, at its disposal to support individuals to remain independently living in the community.

- *Please clarify the intent and scope of the Commonwealth's proposal to provide housing support services. What services would be included?*

  Response

  The Housing First model is an approach that our managed behavioral health contractor pursued and helped to develop for chronically homeless individuals for whom state data indicates have exceptionally high acute spending. By leveraging housing supports in a permanent environment, we believe that costs for this group could be substantially decreased. Models using the Housing

First philosophy first get the member into stabilized housing, and then focus on addressing the issues that led to homelessness (substance abuse, mental illness, etc.). The Housing First model has been found to be highly cost-effective (initially saving $9,610 per person per year), as they have more success in addressing a person's medical and health needs once they are in a safe and stable home environment. Health care and supports can become more regular and replace emergency room care. This is an example of a strategic partnership that an ICO could leverage when it is cost-effective, but the model would not be an entitlement under the ICOs' contract.

If members obtain permanent housing, they are more likely to follow established clinical practices for their chronic behavioral health and medical conditions and reduce the use of emergency rooms and unnecessary hospitalizations. The activities of locating, obtaining, and subsidizing housing would not be paid for from the ICO's capitation payment. The ICO would only provide the connection and the treatment and supportive services necessary to address the underlying issues that led to the individual being homeless. The ICO, through member care plans, will support the specific needs of chronically homeless individuals by stabilizing them with regard to their behavioral health and chronic disease needs, and their needs for intense community support.

- *Please provide additional detail explaining the rationale for not providing certain supplemental services (described in proposal Table C of Appendix C) to demonstration enrollees who are also enrolled in HCBS waivers.*

  Response

  Four of the services in this category – Day Services, Home Care Services, Respite Care Services, and Home Modifications – are available in many of Massachusetts' Home and Community Based Services (HCBS) Waivers. Massachusetts has decided to exclude HCBS waiver participants from participation in the demonstration, at least initially. The ICOs will use their global payments to provide these services as indicated in member care plans to all participating demonstration populations.

- *CMS understands that Massachusetts plans to submit legislation that describes the proposed duals demonstration and its relationship with CMS. Please provide additional information on whether there is any foreseeable risk that the Commonwealth legislation will not be passed. Please describe the expected impact of this legislation on the ability of the proposed demonstration to move forward (e.g. can the demonstration proceed if the legislation is not passed?). Does the Commonwealth expect to need any regulatory changes? If so, what is the anticipated timeframe of those changes?*

  Response

  Legislation establishing the Duals Demonstration and giving EOHHS authority to certify non-DOI plans and their solvency to CMS was passed by both houses and signed by the Governor in June 2012.

Massachusetts has begun work to draft regulations for the Duals Demonstration. Regulatory changes can be completed and implemented within 6 months, and often in less time.

- *Please provide an update on the expenditure authority that the Massachusetts proposal anticipated would be needed for the demonstration.*

  Response

  Massachusetts and CMS have determined that expenditure authority is not needed, as the Memorandum of Understanding and three-way contracts will provide the authority to require ICOs to provide the proposed set of benefits. And CMS has determined that, as structured through the MOU, no additional expenditure authority is needed for these services.

- *Please provide written confirmation that the Commonwealth will provide to CMS any required beneficiary-level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models.*

  Response

  Yes, the Commonwealth will provide to CMS any required beneficiary-level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models. Since the time of the proposal submission, Massachusetts now has access to linked Medicare and Medicaid data through CY 2010.

- *Please provide written confirmation that the Commonwealth will provide to CMS a description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.).*

  Response

  Yes, the Commonwealth will provide to CMS a description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.).

- *Please provide written confirmation that the Commonwealth will provide to CMS data on State supplemental payments to providers (e.g., DSH, UPL) during the three year period.*

  Response

  Yes, the Commonwealth will provide to CMS data on State supplemental payments to providers (e.g., DSH, UPL) during the three year period.

- *Please confirm that the Commonwealth will provide/has provided appropriate tribal consultation.*

  Response

  Yes, tribal consultation calls conducted over the last year on April 27, 2011, July 27, 2011, October 25, 2011, January 19, 2012, and April 27, 2012. Each included status updates on the Duals project, and shared the web address for the Duals project (www.mass.gov/masshealth/duals), which included postings for all public meetings and information related to the project, including the Draft Proposal for Public Comment and Final Demonstration Proposals. In accordance with our State Plan, follow-up emails were sent after each consultation call to document the discussion from the call. The Commonwealth will continue to provide tribal consultation as described in our State Plan, and has added all tribal contacts to our Duals stakeholder distribution lists.