August 31, 2011 Duals Stakeholder Summary Meeting Notes

From the Leadership

Comments from Dr. Julian Harris, Massachusetts Medicaid Director

Dr. Harris conveyed how both Governor Deval Patrick and Secretary of Health and Human Services Dr. JudyAnn Bigby have made this project of providing a more integrated and robust system for dual eligible individuals a priority, in partnership with the full range of stakeholders. He said that the successes of the SCO and PACE programs, as models for other parts of the country, also provide lessons learned. He noted we are learning from people who live with a range of physical and cognitive disabilities who struggle with behavioral health issues and substance abuse challenges. The boldness of this project, Dr. Harris said, is similar to the bold initiatives Massachusetts has taken on in the past decade, with successes that have been demonstrated to the nation, which will continue as long as there are partnerships with stakeholders.

Comments from Melanie Bella, Director, Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid (CMS)

This newly formed office has three priorities:

1. *Program alignment*: working to fix issue areas where Medicare and Medicaid do not work well together such as enrollment, eligibility, appeals and grievances;
2. *Data and analytics*: for CMS to have its own data/statistical grounding, building a stronger analytic approach and ensuring states have access to data;
3. *Models and demonstrations*: partnering with the Medicare and Medicaid Innovation Center to test new models. Massachusetts is one of 15 states chosen for funding. One of the models in the CMS State Medicaid Director's letter, the 3-way contract, was developed based on features of the Medi-Medi demonstration within the Senior Care Options program (SCO). CMS will require a transparent process with consumer protections and meaningful stakeholder involvement.

Comments/discussion with stakeholders

CMS Financial Models

- Two payment streams are manageable if they can be deposited into a blended account and there is only a single set of reporting requirements.
- The 3-way contract relieves some concerns of Medicare dollars flowing through the state and potentially decreasing Medicare payments.
- A single source global payment could positively affect culture change by moving the focus away from administration and towards healing and health.
- A one payer financing stream could move incentives away from shifting members to services with higher reimbursement.

- A request was made to describe an entity in a 3-way model vs. a 2-way model. **MassHealth responded**: The 3-way model has three parties: the integrated care entity, MassHealth and CMS. It is preferable that only one set of processes is used, i.e., grievances, appeals, quality measures, etc.

Benefit Design

- Will consumers be engaged in the procurement process? **MassHealth responded:** We have a model for a consumer panel that we have used in the behavioral health reprocurement that we can consider here.
- Residential habilitation should be offered as an alternative to nursing facility care. **MassHealth responded** that the program is about designing a service delivery model that will be an alternative to FFS. It's a delivery *system* change, not a service expansion. The benefit package cannot include all waiver services due to the cost. Nothing is "off the table" at this point but residential-habilitation is very expensive and is unlikely due to the cost.
- Emergency psychiatric services were described as a successful program that has a full clinical team including certified peer specialists but certified peer specialists are not a covered service in MA even though this service is available in 22 other states. **MassHealth clarified that** the service is covered in other states in *FFS models*. This service will be addressed through this program as part of the scope of the new model's services under non-traditional services. No state plan amendment is necessary to achieve this.
- Medicaid-only populations should have access to the program as they are likely a clinically similar population.
- PCA services are part of MassHealth's state plan and people who choose the new model will have access to PCA, and perhaps more broadly (such as to include cueing and monitoring).
- ICEs will not need to utilize the current FFS prior authorization process for services.
- Consumer choice is vital.
- Benefit package should be considered a floor; flexible model allows for additional services to be added as part of the care planning process. Other services should not be a carve-out.
- Benefits should have two tiers to allow for an intensive team-based approach for members with high need. **MassHealth response:** A broad range of benefits will be available to cover people with varying needs. Stratifications will ensure adequate tiered payments are in place.
- Establish Care Planning Teams.
- Community organizations should have active involvement in the development of care plans
- Joint care planning should occur with the current care management network.
- LTSS should be the centerpiece of the ICE.
- Community-based organizations need funding to prepare for the program.

- Organizations must be culturally competent and held to a standard.
- Must have a mechanism to ensure providers uphold ADA and serve consumers in an accessible manner.
- Must consider inequities in access and outcomes for people with disabilities and ethnic minority populations.
- Nursing facility services are included in the benefit package because they are in the state plan and because including them gives a financial incentive to the contracted plans to use more flexible and less costly community-based supports; it holds the plans at risk for using nursing facility services.

Financing

- Although there will not be carve-outs, there are still concerns that if an entity contracts with another provider, there could be incentives not to provide certain services for a profit-making entity. These should be tracked.
- Risk adjustment should consider social circumstances, not just medical diagnosis.
- Actuaries may not have expertise on special populations. **MassHealth response:** Currently reviewing data to identify populations with unique spend patterns. Monitoring will be needed to ensure ICEs can serve all populations.
- Where will funding for non-traditional providers come from if payments to hospitals and other services do not change? **MassHealth response:** The ICE will have a "toolbox" of services to fund appropriate care. Emergency and hospital use should decrease, making funding available for non-traditional services and providers.
- Multiple attendees stated the program should be voluntary opt-in. It was noted that an alternative passive opt-out approach would result in non-compliant members.
- The early Senior Care Options program was operated under a 3-way contract – this had shared risk sharing which helped with some of the uncertainty of establishing risk categories for the 65+ population. It would be a shame to only make this program available to dual eligibles when so many people who look very similar are only enrolled in Medicaid.