The Commonwealth of Massachusetts
Executive Office of Health and Human Services

Integrating Medicare and Medicaid for Individuals with Dual Eligibility

Summary of RFI Responses

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Duals RFI Responses Summary

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Introduction

The Centers for Medicare and Medicaid Services (CMS) is partnering with the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) Office of Medicaid (MassHealth) to initiate a demonstration program that integrates care and financing for non-elderly adults with disabilities who are eligible for both Medicaid and Medicare ("dual eligibles").

In March 2011, MassHealth issued a Request for Information (RFI) to solicit input from the public about the proposed Duals program. Fifty-five organizations submitted responses to the RFI. Respondents included a wide cross-section of groups, including health plans and managed care organizations (MCO), Senior Care Options (SCO)[1] plans, medical providers including hospitals, community health centers and behavioral health service providers, advocates for consumers and industry groups, and community-based organizations.

The Duals demonstration is predicated on the concept that blending funding streams and coordinating care for dual eligibles will promote higher quality care, better health outcomes, and lower costs in the long run. All respondents who submitted responses to the RFI agreed this is likely to be true. The RFI responses revealed shared principles around person-centered care, improving quality of care and population health, care coordination and management using multi-disciplinary teams, measuring and reporting quality metrics, and many other concepts underpinning the Duals initiative. However, different respondents had different conceptions of what these various terms mean and how the ideas should be implemented in practice.

This summary identifies four major themes that arose from the RFI responses. Within these themes are a number of discrete topics, positions on which ranged from broad agreement to a wide diversity of opinion. The four major themes are:

1) Building a viable program: Person-centered care delivery/decision-making and program enrollment
2) Improving care, improving health: Care coordination and quality measurement
3) Anatomy of an integrated care entity: Aligning Medicaid and Medicare, provider networks, and financial considerations
4) Communication: Technology, outreach, and education

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[1] Through Senior Care Options, MassHealth partners with Medicare to provide a comprehensive package of Medicaid- and Medicare-covered health and social services for over 10,000 low-income elders.

Building a viable program: Person-centered care delivery/decision-making and program enrollment

RFI respondents shared the view that a viable, integrated care program for non-elderly Duals should offer person-centered care and ensure individual decision-making around care needs. They also agreed that integrated care entities would need to maintain adequate finances and sufficient enrollment to achieve the success of care coordination, care integration, and other programmatic innovations.

Many respondents expressed that enrollees in the Duals program should work with care managers and multi-disciplinary teams to craft individualized care plans that patients, their families, and caretakers are involved in directing and implementing. Respondents generally concurred that services should be delivered through culturally and linguistically appropriate means and that education of patients and their families would be essential in supporting them to be active partners in care decisions.

Respondents differed significantly regarding the mechanics of program enrollment and the degree to which sub-populations should receive specialized services.

Summary of implementation challenges respondents identified in this area:

- Create a financially viable program with adequate enrollment while:
    - Sufficiently specializing care for individuals and sub-populations, and
    - Promoting decision-making for patients, their families, and caregivers and care focused on the "whole" person

Specializing care for individuals and sub-populations

Beyond the consensus on the importance of individualized care planning, there were differing opinions about whether MassHealth should allow integrated care entities to focus on one or more specific populations. Most health plans and managed care organizations concurred that integrated care entities should *not* specialize on one or more specific populations. They cited concerns over financial viability and the need to spread risk over a broad population. They suggested that specialization could result in fragmentation of care and duplication of services for some populations, as well as create difficulties with measuring and monitoring quality and performance because integrated care entities could not be compared on an "apples to apples" basis.

Most providers, some advocates, and a couple of SCOs, however, maintained that integrated care entities *should* tailor services to specific populations. Many of these groups named populations with particular health care needs: mental illness, developmental disabilities, physical disabilities, substance abuse and addiction, etc. A few organizations urged MassHealth to allow special treatment of homeless populations. Several groups, including one MCO and a SCO, agreed that specialization was risky but could be beneficial if MassHealth addresses questions of financial viability and enrollment through special risk adjustment, adequate reimbursement for integrated care entities, or a focus on age rather than particular disease or social categories.

Individual decisions about participation

While most respondents agreed that members should be at the center of care decisions, they differed regarding the mechanics of program enrollment. Most health plans and two SCOs concurred that participants should be directly enrolled in integrated care entities with an opportunity to "opt-out." Generally, health plans acknowledged that patient choice would be a key component of a successful program, yet they expressed concerns that inadequate enrollment would compromise integrated care entities' financial viability and the state's ability to evaluate whether the new program is effective. They contended that an "opt-in" enrollment mechanism could result in program enrollment too low for the program to meet its goals.

Many respondents representing consumers and providers urged MassHealth to allow individuals to opt-out at any time for any reason. A few consumer advocacy groups suggested the Duals program be "opt-in," so individuals would need to choose affirmatively to enroll in the program. Additionally, some organizations recommended that MassHealth give individuals a choice of integrated care entities rather than assigning them automatically based on pre-established criteria. Several groups proposed ways to encourage on-going participation in the Duals program, such as instituting continuous twelve month enrollment irrespective of whether individuals' circumstances change.

Improving care, improving health: Care coordination and quality measurement

There was consensus that key elements of an integrated care system should include coordination of care across settings and quality improvement through adoption of best practices and tracking outcomes and process measures. Respondents broadly agreed that coordination and collaboration of behavioral health and physical health providers would be critical, and that integrated care entities should establish care teams to manage individual cases. Furthermore, organizations recognized that financial and non-financial incentives based around quality metrics would be important tools in moving towards an integrated care system. Differing opinions emerged regarding what quality metrics to use, how to structure care teams, and whether integrated care entities or individual providers should be accountable for care coordination.

Summary of implementation challenges respondents identified in this area:

- Establish quality metrics that are specific enough to be meaningful for the actual populations enrolled in integrated care entities, and broad enough to allow comparisons across entities and other population groups in Massachusetts and beyond.
- Ensure that quality measurement and reporting systems respect patient privacy and do not overly burden providers.
- Craft incentives for integrated care entities to promote successful care integration and management while encouraging financial viability.
- Determine systems of accountability for care coordination that promote patient health and quality improvement while striving to contain costs.

Quality measurement

While all respondents shared the notion that quality measurement and payment incentives based on process and outcomes measures will be important within an integrated care system, there were important differences about which metrics to use. Many respondents representing providers, health plans, and MCOs maintained that quality incentives should be based on nationally recognized quality benchmarks, such as HEDIS. Other respondents, particularly those representing SCOs and ASAPs, urged the state to consider population-specific quality measures developed in conjunction with patients, their families, and other respondents. Some groups noted that it is important to employ agreed-upon metrics and that consensus about specifics has not been reached. These respondents warned that some populations, such as the homeless or those who need long term services and supports, could be disadvantaged by using measures and standards that do not reflect actual local circumstances.

Most respondents agreed that shared savings should be a goal under global payment structures. Many SCOs and providers sought to limit risk sharing, at least initially, because care coordination capacity takes time to develop. Generally, health plans did not seek to limit shared risk. However, two SCOs and two health plans agreed with a provider that limiting risk could promote participation in integrated care entities and global payment systems, especially by smaller providers and those serving sub-populations.

Care teams

Every respondent named care coordination and management by specialized care teams as a crucial element of an integrated care system. Respondents held that each dually eligible patient should have a dedicated team of physicians, nurses, and other non-clinical professionals—care managers, social workers, peer specialists, personal care attendants (PCAs) interpreters, etc.—focused on care planning and implementation of services. Several respondents said that Community Health Workers—particularly those that come from the same communities as their patients—could play an important role in communicating with patients, bridging socio-cultural differences, and coordinating non-clinical services. Many wrote that integrated care entities should follow the Medical Home model where multi-disciplinary care teams focus on primary care and prevention. Many respondents said that patients should be at the center of their care teams and completely involved in decision-making about their own care. Many maintained that individuals or their surrogates should help to determine the composition of their own specialized teams. There was consensus that care teams should thoroughly assess patients' health history, current care needs, and prognosis, as well as update these assessments regularly to tailor services to evolving conditions and care needs. Respondents suggested that there be multiple means of identifying patients with behavioral health needs and that care teams should include behavioral health expertise as well as clinicians focused on physical care needs, especially where these issues co-exist with physical health conditions.

Despite the broad agreement about care team responsibilities, respondents differed on who should manage the care team. A few respondents held that a clinical leader, particularly the patient's primary care physician or nurse practitioner, should oversee all clinical issues and manage the care team. Several respondents wrote that care teams could be managed by a non-clinical professional who would interface closely with the dual eligible member and serve as a coordinator, health coach, and advocate.

Some reasoned that individuals with behavioral health needs should have a care manager or team focused primarily on this issue.

Care coordination and transitions

Differing opinions emerged about what parties should be accountable for ensuring care coordination and management, as well as how to achieve seamless care transitions. A few respondents expressed differing opinions about where care coordination services should reside, either within provider infrastructure or within a managed care entity. Many respondents – a cross section of health plans, provider groups, and advocates – suggested that care coordination be at the treatment level, with a behavioral health setting as the primary care site or health home for participants who are already linked to the behavioral health system. Several respondents noted that while a number of state agencies may have case managers working with the member, the integrated care entity should take the lead in coordinating all of a member's services. A different organization suggested that MassHealth should guide decisions about final decision-making authority when several case managers are involved with a patient's care.

Virtually all respondents named care teams and care management as critical to facilitating safe, effective, and seamless transitions between settings. While many respondents agreed that integrated care entities should adopt a formal care transitions program, several advocated for a specific model. Several organizations wrote that these entities could connect with local community-based organizations to assist with care transitions, while others identified an important role for MassHealth in educating individuals, providers, and setting minimum standards. Respondents listed many other actions integrated care entities could take to facilitate transitions, ranging from early discharge planning to aiding patients with transportation to appointments. Additionally, some respondents representing health plans and medical providers focused on means to improve communication between primary care physicians and behavioral health providers, as well as ways to seamlessly transfer members between inpatient and community settings.

Anatomy of an integrated care entity: Aligning Medicaid and Medicare, provider networks, and financial considerations

As mentioned above, respondents share a general vision of what integrated care entities should do: coordinate and manage care, measure quality and outcomes, integrate care across various providers (both medical and non-medical), promote individualized service delivery by teams of care professionals, and ensure patients or their surrogates have a voice in key decisions and planning. Respondents also agreed these entities should offer enhanced services compared to Medicaid or Medicare fee-for-service plans. However, respondents held differing opinions on many issues underpinning program design, particularly about what kind of organizations should become integrated care entities, how to align Medicaid and Medicare benefits and practices, and the extent of requirements around provider networks and financial qualifications.

Summary of implementation challenges respondents identified in this area:

- Define what it means to be an integrated care entity and delineate their responsibilities and requirements—including provider networks and financial qualifications—given different ideas among important stakeholders and potential bidders.
- Align coverage and practices under Medicaid and Medicare to protect consumers, improve health, integrate disparate administrative systems, and ensure adequate payment for providers.
- Create a system where community-based organizations and local providers maintain their key role while more effectively integrating care across multiple providers and specialties.

What kind of organization could become an integrated care entity?

Respondents expressed significantly different visions of what kind of organizations should be able to become an integrated care entity. Many health plans and managed care organizations said they would bid to become integrated care entities. However, a couple of organizations expressed concern that MassHealth would embed the new Duals program within HMOs or MCOs rather than with providers. Many providers also will seek to become integrated care entities. At least one hospital system said that it already considered itself an integrated care entity. Other providers said they wanted to specialize with a specific sub-population, or said they would sub-contract with an entity to provide specialized services. Many advocates and SCOs wanted current SCOs to become integrated care entities. Some even urged MassHealth to formulate them as “SCO-like” organizations.

Aligning Medicaid and Medicare

Although respondents agreed in principle that it is important to align Medicare and Medicaid coverage and practices, differences emerged about how MassHealth should do so regarding coverage, provider payments, billing and accounting, and various administrative issues. Respondents tended to focus on the issues that most concerned the constituencies they represented. Providers raised concerns that reducing payments from current Medicare rates would harm their ability to deliver care. Advocates maintained the new Duals program should provide the broadest range of services possible under both programs. All types of respondents urged MassHealth to align processes for member enrollment and changes in status, as well as data reporting, collection, and monitoring, yet no common strategies emerged about how to do so. Similarly, respondents mentioned a wide array of services that would need to be aligned under Medicaid and Medicare, but there was only limited overlap in those mentioned by different respondents (areas of agreement included preventive care, prescription drugs, behavioral health and care management). Two advocacy groups urged caution about including long term services and supports in the benefits package because of the complicated interaction of Medicare and Medicaid payments. Some providers and health plans noted concerns with billing and accounting under a merged Medicaid and Medicare system but, again, no consensus emerged about which direction to take or even which elements to target.

Provider networks

Most respondents acknowledged that integrated care entities would need to offer a comprehensive—yet still limited—network of providers. Virtually all respondents agreed that greater accessibility of medical care and other services such as behavioral health would help to improve care and contain costs by averting preventable ED visits and inpatient admissions. Several respondents wrote that providers could extend clinic hours, open more access points, or adopt open scheduling to allow for more urgent care appointments. Nearly all agreed that availability of support at all hours of day and night, either through a telephone hotline or other means, would help to divert care from ERs and resolve problems before they require hospitalization.

There was consensus that integrated care entities should partner with community-based organizations to assist with care transitions, reach potential participants, and provide key services. As mentioned above, several groups suggested that community-based organizations would need funding to support their engagement with integrated care entities. One respondent noted these entities would duplicate efforts if they tried to offer too many “in-house” services, such as long-term services and supports, rather than relying on local partners who are already doing this work. Many groups maintained that flexibility of services and provider networks would be necessary to optimize care for patients, particularly by continuing therapeutic relationships with physicians. Two consumer advocacy groups wrote that integrated care entities should be obligated to bring in all providers that an individual needs, including those that are out-of-network. Several respondents said that providers participating on a care team and providers connecting with community-based organizations to provide services should establish contractual relationships. Other groups suggested that integrated care entities should be able to engage with local providers without formal contracts and even include them in care team meetings.

Financial considerations

Although some respondents wrote about risk adjustment and reserve requirements, most did not weigh in extensively on these or other financial issues.

A few respondents discussed capital and reserve requirements. One behavioral health provider said the state should ensure integrated care entities have adequate capital and reserves. Two SCOs urged MassHealth to allow letters of credit or subordinated debt to satisfy reserve requirements, which would align rules for integrated care entities and SCOs and could possibly promote diversity by allowing smaller entities to meet financial obligations.

Most respondents concurred that global payments to integrated care entities would need to be risk-adjusted to account for cost difference among sub-populations and specific high-cost individuals, but there was not universal agreement on this point. Several respondents noted clinical and social factors that would require risk adjustment, such as LTSS, hemophilia, homelessness, and mental illness. One health plan suggested spreading risk equitably across all membership.

Communication: Technology, outreach, and marketing

Respondents agreed that patients or their surrogates would need a strong voice in care decisions and planning and that care teams, particularly the care manager, would facilitate collaboration between patients and providers, as well as amongst providers. Respondents also concurred that communication would be essential for educating patients and providers about the new integrated care system for duals and for delivering feedback about the program from these parties to MassHealth.

Summary of implementation challenges respondents identified in this area:

- Integrate use of Electronic Health Records (EHRs) and other valuable technologies into program design while assisting providers and patients to understand, adopt, and benefit from these innovations.
- Design an outreach, marketing, and education plan that reaches both dually eligible patients and their providers in multiple ways.
- Establish rules and systems to promote communication and collaboration between providers, members of care teams, and patients.

Technology systems

Respondents identified four types of technologies to improve communication among providers, engage patients, and facilitate care transitions: 1) inter-operable electronic health records systems, 2) HIPAA-compliant web-based communication platforms that are accessible to both patients and providers, 3) data warehouses to assist with sharing consumer information, analyzing claims and enrollment data, and providing access to utilization and cost information, and 4) "smart technologies" to reach patients and engage them in care planning and delivery.

Virtually all respondents agreed that an inter-operable electronic health records system would be very important to successfully integrating care. Many respondents also cited the other technologies as means to facilitate patient tracking, team communication and collaboration, monitoring trends across patients, and quality improvement. A significant number of respondents urged caution about requiring adoption of health information technologies, and specifically EHRs, because of implementation costs; citing that while most major health plans and hospitals already have functioning high-tech systems, instituting new technologies and training staff to use them can be prohibitively expensive and time-intensive for smaller providers. Furthermore, to effectively integrate care across different providers, including community-based organizations, technology platforms and information portals must be compatible and inter-operable. A few respondents noted they have internal technology systems that are most likely incompatible with the systems employed by possible partner organizations. Several groups suggested that financing from the state may be necessary to help with technology implementation for integrated care entities and their local partners. Many respondents urged implementation of "smart technologies" to connect with patients, such as text messages about upcoming appointments or web-based portals to access health records. The comments indicated that successful implementation of these innovations would require training and education for many patients, their families, and caregivers, which could be costly and impractical for some members who would have difficulty accessing the services due to physical, developmental, or other limitations.

Marketing and outreach

Respondents shared a belief that member education and targeted incentives would be necessary to ensure adequate enrollment and participation in the integrated care program for non-elderly duals. They suggested an array of outreach and marketing approaches, including one-on-one contact, group meetings, direct-mail correspondence, written materials posted on the internet, and educational forums. Nearly all groups posited that MassHealth and other state agencies would need to play a key role in informing individuals, providers, advocates, and others about this new initiative. Respondents urged the state to partner with community-based organizations and advocacy groups to reach their clients and members. Some advocates suggested providing funding to these groups, similar to the outreach and enrollment grants under Chapter 58, the Massachusetts health care reform law. Many respondents agreed that MassHealth should continue to engage with respondents while developing and implementing the Duals program because these groups would help to draw participants. Several respondents—particularly those representing providers—argued that medical providers would be important advocates to encourage participation in this program. Nearly all respondents agreed that integrated care entities should be able to market their services directly to potential enrollees.

There was consensus that offering more comprehensive benefits and better integrated and coordinated care would attract members. Some groups noted that financial incentives, such as eliminating co-pays for some services or offering small gift cards or food vouchers, could attract members. Several respondents suggested that financial and non-financial incentives may also be needed to attract providers to participate in integrated networks.

Respondents urged integrated care entities, providers, and the state to consider literacy levels and to develop culturally and linguistically appropriate materials for members. Some groups noted that many potential members and their families may have low literacy, so materials should be easy to understand and available in a variety of formats. Many emphasized that materials should be offered in multiple languages and address issues in a culturally appropriate manner. Several wrote that cultural competency should extend beyond ethnicity and language to religious or spiritual background, lesbian, gay bisexual, and transgender (LGBT) populations, non-traditional families, and others.