kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

April 2012

Massachusetts' Proposed Demonstration to Integrate Care for Dual Eligibles

Executive Summary

Massachusetts was the first state to submit a proposal for an integrated service delivery and payment model for dual eligibles to the Centers for Medicare and Medicaid Services (CMS). This policy brief provides a short background on the current service delivery model, summarizes key aspects of the design proposal, highlights areas in which the proposal was revised in response to stakeholder comments, and raises key questions to consider as the proposal is evaluated by CMS and stakeholders.

Massachusetts proposes delivering Medicare and Medicaid benefits to full benefit duals ages 21 through 64 through Integrated Care Organizations (ICOs) that will establish a network of Patient-Centered Medical Homes (PCMHs) to deliver team-based integrated primary and behavioral health care, coordinate care, and provide clinical care management for duals with complex medical needs. ICOs may use Community Health Workers to assist the PCMH care team. Enrollment in the demonstration will be voluntary, and enrollees may change ICOs or select the fee-for-service (FFS) option at any time. If individuals do not either select an ICO or indicate that they wish to remain in FFS within a prescribed timeframe, they will be assigned to an ICO, from which they may disenroll at any time.

The ICO benefits package will include all Medicare parts A, B and D benefits, all Medicaid state plan benefits, except certain long-terms services and supports, and additional behavioral health diversionary services and community support services. ICOs will receive an actuarially developed, risk-adjusted, global payment from CMS and Massachusetts. ICOs in turn will make enhanced per member per month payments to their PCMHs. Massachusetts proposes risk mitigation strategies and sharing savings with ICOs that meet quality targets. Specific quality metrics are yet to be developed. ICOs must offer "meaningful" consumer input processes, such as governing or advisory boards. The role of an ombudsman is still undefined.

Massachusetts made several key revisions to its proposal based on stakeholder comments. ICOs are now required to provide independent LTSS Coordinators. In addition, certain LTSS for HCBS waiver participants and certain other services for vulnerable populations will be excluded from the ICO benefits package. ICOs must provide self-direction as an option for personal care attendant services. Demonstration enrollees must maintain any state plan community-based LTSS that they receive at the time of enrollment for 90 days, or until the ICO completes an initial assessment of service needs, whichever is longer. Massachusetts also strengthened provisions requiring ICOs and PCMHs to comply with the Americans with Disabilities Act, provided more detail about the proposed unified internal and external grievance and appeals process, and outlined the basic steps for establishing ICO payments.

CMS is presently evaluating Massachusetts' proposal and accepted public comments through March 19, 2012. If approved by CMS, Massachusetts anticipated issuing an RFP for ICOs by April 13, 2012, selecting ICOs by July 30, 2012, and executing ICO contracts by September 30, 2012. Enrollment packages would be distributed in October, 2012, with enrollment effective in January, 2013.

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Introduction

States across the country currently are planning initiatives to test new service delivery and payment models that integrate care for people dually eligible for Medicare and Medicaid. The Centers for Medicare and Medicaid Services (CMS) expects to select state proposals over the next several months, with enrollment effective by January, 2013. As an initial step in this process, CMS awarded design contracts in April, 2011, of up to $1 million each, to 15 states to design integrated models.[1] Subsequently, CMS issued a July, 2011 State Medicaid Director letter inviting any interested state to submit a letter of intent to test CMS's proposed capitated and/or managed fee-for-service financial alignment models for dual eligibles; 38 states, including the 15 that received design contracts, and the District of Columbia responded.[2] In January and March, 2012, CMS issued additional guidance on the state demonstration approval and plan selection process for its proposed capitated financial alignment model.[3]

Massachusetts, one of the 15 states receiving a design contract, was the first state to post its draft proposal, on December 7, 2011, for the required public comment period before submission to CMS,[4] and the first state to submit a proposal to CMS, on February 16, 2012.[5] The public comment period while the proposal is under review at CMS closed on March 19, 2012. Massachusetts also submitted two letters of intent to test CMS's proposed capitated financial alignment model for dual eligibles.[6] One letter describes Massachusetts' intent to test the capitated financial alignment model for dual eligibles ages 21 to 64, as further detailed in Massachusetts' design contract proposal. The other

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[1] For summaries of the 15 states' initial proposals (CA, CO, CT, MA, MI, MN, NC, NY, OK, OR, SC, TN, VT, WA, VI), see Kaiser Commission on Medicaid and the Uninsured, *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS* (Aug. 2011), available at http://www.kff.org/Medicaid/8215.cfm.

[2] For a summary of the two financial alignment models proposed by CMS and the 39 responding states' letters of intent, see Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Models for Dual Eligibles: An Update* (Nov. 2011), available at http://www.kff.org/medicaid/8260.cfm.

[3] See Kaiser Commission on Medicaid and the Uninsured, *An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees* (March, 2012), available at http://www.kff.org/Medicaid/8290.cfm.

[4] 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, Draft for Public Comment* (Dec. 7, 2011), available at www.mass.gov/masshealth/duals. Subsequently, as of mid-April, 2012, seventeen other states (CA, CO, CT, ID, MI, MN, NC, NY, OK, OR, SC, TN, TX, VA, VT, WA, WI) posted proposals for the required state-level public comment period prior to CMS submission, and two other states submitted proposals to CMS after the state-level public comment period (OH, IL). Additional proposals may be released in the coming weeks by other states that submitted letters of intent.

[5] 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* (Feb. 16, 2012), available at http://www.chcs.org/usr_doc/MassachusettsDualsDemonstrationProposal.pdf. Subsequently, as of early April, 2012, Ohio also had submitted its proposal to CMS.

[6] The September 28, 2011 letters of intent are available at www.mass.gov/masshealth/duals.

letter describes Massachusetts' intent to test the capitated financial alignment model for duals ages 65 and older in Massachusetts' integrated Senior Care Options program which presently requires participating companies to be both Medicare Advantage Duals Special Needs Plans and Medicaid managed care organizations.

This policy brief provides a short background on the current service delivery model for dual eligibles ages 21 to 64 in Massachusetts; summarizes key aspects of Massachusetts' design proposal, including the proposed integrated care entity, enrollment, benefits, financing, beneficiary protections, program monitoring and evaluation, stakeholder engagement, and implementation timeframe; highlights areas in which Massachusetts revised its draft proposal in response to stakeholder comments; and raises key questions to consider as the proposal is evaluated by CMS and stakeholders.

Current Service Delivery Model in Massachusetts

The vast majority of dual eligibles in Massachusetts currently do not participate in managed care. In 2009, there were over 233,000 dual eligibles in Massachusetts, 93 percent of whom received Medicare and Medicaid benefits on a fee-for-service (FFS) basis, with 7 percent receiving Medicare benefits through Medicare Advantage Duals Special Needs Plans (SNP) or both Medicare and Medicaid benefits through the Program of All-Inclusive Care for the Elderly (PACE), and less than 1 percent receiving Medicaid benefits through managed care.[7]

Massachusetts's proposed integrated care demonstration focuses on full benefit duals ages 21 to 64, an estimated 115,000 people upon implementation.[8] While this population, unless institutionalized or participating in PACE, currently is enrolled in Massachusetts' § 1115 Medicaid waiver, they are excluded from the managed care features of the waiver and are not eligible for the waiver's additional behavioral health diversionary services. Instead, they receive care on a fee-for-service basis, without funding for care management. Massachusetts estimates that about 7,300 members of the target population also receive expanded Medicaid services through an existing § 1915(c) home and community-based services (HCBS) waiver.

A significant portion of the population targeted for Massachusetts' integrated care model has a behavioral health diagnosis. Massachusetts reports that 63% of duals ages 21 to 64 are diagnosed with a behavioral health condition, including 35% with serious mental illness and 28% with a substance use disorder.

The target population also has long-term services and supports (LTSS) needs, and members of the population with mental health diagnoses are disproportionately institutionalized. Massachusetts reports that nearly 31% of duals ages 21 to 64 use LTSS, with 13.3% receiving services in institutions, and

[7] See Table 1 in Kaiser Commission on Medicaid and the Uninsured, *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS* (Aug. 2011), available at http://www.kff.org/Medicaid/8215.cfm.

[8] Massachusetts reports 109,636 full duals ages 21 to 64 statewide who are not enrolled in Medicare Advantage or PACE as of CY 2008. The state recently entered into a data use agreement with CMS that will enable it to obtain CY 2010 Medicare data to update its estimates.

17.4% in the community. In addition, while 35% of duals ages 21 to 64 are diagnosed with a serious mental illness, Massachusetts reports that over 70% of duals ages 21 to 64 who receive LTSS in an institutional setting have a diagnosis of serious mental illness.

Massachusetts reports that, in CY 2008, the average combined Medicare and Medicaid spending for duals ages 21 to 64 was about $2,200 per member per month, with significant variation across the population. For example, Massachusetts found that 5.3% of duals ages 21 to 64 had three or more inpatient admissions, with this population accounting for over 20% of Medicare spending and 30% of Medicaid spending; nearly 80% of this group had a behavioral health diagnosis. Massachusetts also found that spending for duals with serious mental illness living in the community but not receiving waiver services, as compared to spending for the average community-based non-waiver dual, was 26% higher for Medicare and 45% higher for Medicaid. Massachusetts also reports that spending for duals with substance use disorders was 45% higher for Medicare and 19% higher for Medicaid.

Massachusetts is engaged in a Patient Centered Medical Home (PCMH) Initiative and is considering a shift to global payments throughout its health care system. Massachusetts is in the midst of a three year PCMH demonstration that started in April, 2011, and provides technical assistance and enhanced payment from public and private payers to help primary care providers become PCMHs. Massachusetts also is planning a shift from FFS to global payments across the Commonwealth's health care system. Pending state legislation would require public payers to implement alternative methodologies by January, 2014.

Proposed Demonstration Model

Integrated Care Organizations:

Summary*:* Massachusetts proposes delivering Medicare and Medicaid benefits to dual eligibles ages 21 to 64 through Integrated Care Organizations (ICOs), which will be either insurance-based or provider-based health organizations. ICOs must offer care coordination services to all enrollees and make available dedicated staff and other resources when needed to ensure care coordination. ICOs will employ or contract with providers functioning as PCMHs that will deliver team-based integrated primary and behavioral health care to enrollees and coordinate care across all providers within and outside the PCMH. The PCMH will provide a care team that shares responsibility for delivering care that meets the enrollee's needs and in which the enrollee will play a central role. The PCMH, with support from the ICO, will provide clinical care management for duals with complex medical needs. ICOs also may use Community Health Workers to assist the PCMH care team. A key revision to Massachusetts' proposal, based on stakeholder comments, is the requirement for ICOs to provide independent LTSS Coordinators, who must be available any time at the enrollee's request and whenever admission to a nursing facility, psychiatric facility or other institution is contemplated. The LTSS Coordinator will be a full member of the care team, serving at the enrollee's discretion, and will oversee the evaluation, assessment and plan of care to ensure that services are delivered to meet the enrollee's needs. LTSS Coordinators must be independent of ICOs.

Massachusetts proposes delivering Medicare and Medicaid benefits to dual eligibles ages 21 to 64 through Integrated Care Organizations (ICOs), which will be either insurance-based or provider-based health organizations. Massachusetts' demonstration seeks to test CMS's proposed capitated financial alignment model, which involves three-way contracts between CMS, the state, and participating ICOs. ICOs would operate in defined service areas throughout the Commonwealth and be the single entity accountable for the delivery and management of all covered medical, behavioral health, and LTSS for their enrollees. All administrative processes, including outreach and education, customer service, and grievances and appeals, would be integrated in the ICOs. ICOs must maintain relationships with community-based organizations that focus on recovery and behavioral health integration and with organizations expert in serving the homeless and other populations with unique needs. ICOs also will be required to contract with community-based organizations that focus on independence for people with disabilities. Within these requirements, ICOs may have various organizational and financial arrangements.

ICOs must offer care coordination services to all enrollees and make available dedicated staff and other resources when needed to ensure care coordination. The ICO Care Coordinator will ensure that referrals to medical and behavioral health specialists result in timely appointments and two-way transmission of useful member information; manage and track tests, test results, assessments, referrals and outcomes; obtain information about medical and behavioral health services, such as emergency or specialty care, to facilitate transitions across care settings; and assist enrollees with developing wellness strategies and self-management skills to access and use services. Care coordination services will be provided on a temporary, intermittent or ongoing basis depending upon the enrollee's needs and preferences. The Care Coordinator also will work with the independent LTSS Coordinator (described below) to coordinate LTSS and independent living supports for enrollees.

ICOs will employ or contract with providers functioning as PCMHs that will deliver team-based integrated primary and behavioral health care to enrollees and coordinate care across all providers within and outside the PCMH. Primary and behavioral health care will be integrated through the co-location of practices, the placement of a behavioral health clinician in a primary care setting, the placement of a primary care clinician in a behavioral health setting, or an alternative arrangement. The ICO and its PCMHs also will arrange for the availability of care and services by specialists, hospitals, LTSS, and other community services providers. The PCMH will establish a single medical record for communication about referrals, transitions and care delivered outside the PCMH.

The PCMH will provide a care team that shares responsibility for delivering care that meets the enrollee's needs and in which the enrollee will play a central role. A typical team may include a lead primary care or behavioral health clinician, other supporting clinicians, and community health workers, and will be expanded or adjusted to support the enrollee's person-centered care plan. The enrollee will play a central role in choosing care team members, who may include peers, family and other informal caregivers, advocates, social workers, and case managers.

The PCMH, with support from the ICO, will provide clinical care management for duals with complex medical needs, such as those who use many prescription medications, have one or more

chronic conditions,[9] are at high risk of hospital or nursing facility admission, visit the emergency room, or are likely to lose independence. Clinical care management involves more intensive clinical monitoring and follow-up than care coordination. Clinical care management will include the assessment of clinical risks and needs, medication review and reconciliation, medical adjustment by protocol, enhanced self-management training and support, including family member coaching if appropriate, and frequent enrollee contact as appropriate.

ICOs also may use Community Health Workers to assist the PCMH care team. Community Health workers are trained, non-medical public health workers that provide culturally appropriate health education, information and outreach in community-based settings; bridge cultural divides and build capacity among individuals, communities and health and human services; ensure that people access needed services; provide direct services such as informal counseling, social support, care coordination and health screenings; and advocate for individual and community needs. Community Health Workers may be employed directly or by contract with ICOs.

A key revision to Massachusetts' proposal, based on stakeholder comments, is the requirement for ICOs to provide independent LTSS Coordinators, who must be available any time at the enrollee's request and whenever admission to a nursing facility, psychiatric facility or other institution is contemplated. ICOs will contract with community-based organizations, such as independent living centers, recovery learning communities, aging services access points, deaf and hard of hearing independent living services programs, the ARC, or other organizations expert in working with people with disabilities, which will provide staff specifically trained for this role. The ICO will ensure that LTSS Coordinators meet certain qualifications, including training, experience and expertise in working with people with disabilities and seniors in need of LTSS, and a thorough knowledge of the HCBS system.

The LTSS Coordinator will be a full member of the care team, serving at the enrollee's discretion, and will oversee the evaluation, assessment and plan of care to ensure that services are delivered to meet the enrollee's needs. If, after an initial meeting, it is clear that the enrollee's needs are specific to an area of expertise that the LTSS Coordinator does not have, the ICO will seek and the original LTSS Coordinator will manage the assignment of a different LTSS Coordinator with appropriate background and expertise in an expeditious manner, consistent with the timelines for completing the initial assessment (described below). After the initial assessment, the LTSS Coordinator will connect the enrollee to services in the ICO network and in the community and assist with securing any authorizations or service orders. For enrollees in HCBS waivers, the LTSS Coordinator will include the HCBS waiver case manager in care decisions to the extent desired by the enrollee and facilitate coordination between waiver service providers and ICO service providers.

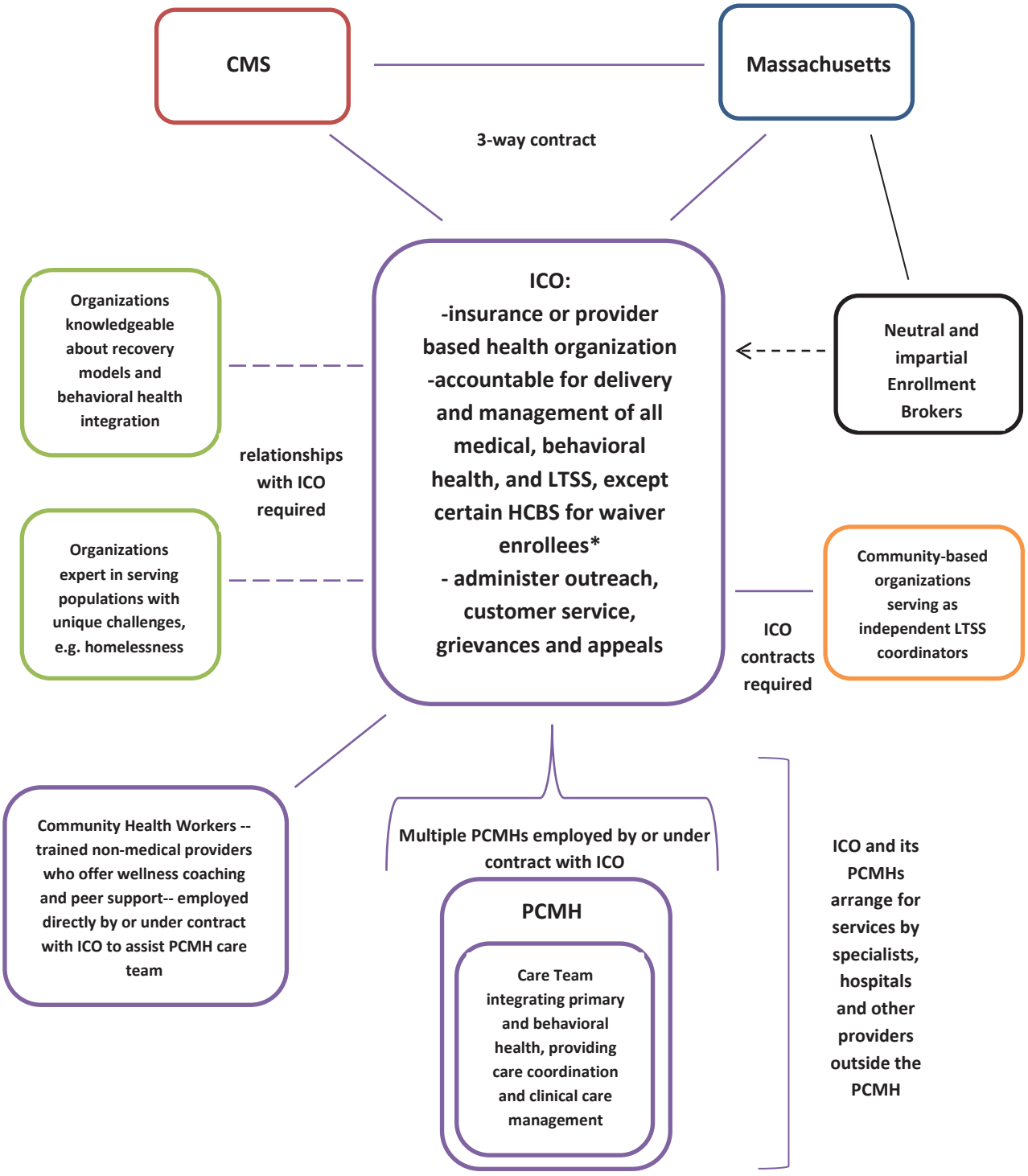
LTSS Coordinators must be independent of ICOs. The ICO shall not have a direct or indirect financial ownership interest in an entity that provides LTSS coordinators. ICOs must verify that community-based organizations providing LTSS coordinators are not providers of other demonstration

[9] Targeted chronic physical conditions include primary diagnoses of asthma, arthritis, congestive heart failure, chronic obstructive pulmonary disease, diabetes, heart disease, and stroke/cardiovascular disease.

services (other than referral, training and assessment), or if unavoidable, that necessary firewalls are in place to prevent self-interested referrals.

Massachusetts' proposed integrated care delivery model is illustrated in Figure 1.

Figure 1:
Massachusetts' Proposed Duals Integration Care Delivery Model



*ICO benefits package excludes HCBS waiver services and state plan LTSS for waiver enrollees (people with developmental disabilities, traumatic brain injuries, and frail elders ages 61 to 64). ICO delivery system also excludes Targeted Case Management provided by state DDS and DMH and Rehabilitation Option services for people with serious and persistent mental health conditions provided by DMH.

Enrollment:

Summary: Enrollment in Massachusetts' demonstration will be voluntary, supported by enrollment brokers under separate contract with the state, and enrollees may change ICOs or select the FFS option at any time. Massachusetts' proposal states that the target population will be given sufficient advance notice to make an informed choice about whether to enroll in an ICO or remain in their existing FFS, Medicare Advantage, or PACE arrangements. If duals in the demonstration's target population do not either select an ICO or indicate that they wish to remain in FFS within a prescribed timeframe, they will be assigned to an ICO, from which they may disenroll at any time. Massachusetts wishes to enroll as many eligible members as early as possible in the demonstration because it maintains that an adequate number of enrollees are needed to attract enough ICOs to provide sufficient member choice and evaluation of the demonstration.

Enrollment in the demonstration will be voluntary, supported by enrollment brokers under separate contract with the state, and enrollees may change ICOs or select the FFS option at any time. Massachusetts recognizes that further collaboration with CMS is necessary to account for the implications of ICO disenrollment on a member's access to Medicare benefits, including subsequent enrollment in a Part D plan. Massachusetts' demonstration will be statewide and include full duals ages 21 to 64 at the time of enrollment. Enrollees could continue in ICOs after turning 65. Massachusetts' proposal states that the enrollment process will be clearly described in the ICOs' contracts, in any agreements between the state and CMS, and in state regulations.

Massachusetts' proposal states that the target population will be given sufficient advance notice to make an informed choice about whether to enroll in an ICO or remain in their existing FFS, Medicare Advantage, or PACE arrangements. To participate in the demonstration, duals must select an ICO and then select a PCMH from the ICO's network. Massachusetts' proposal states that the demonstration will offer as wide a choice of ICOs as possible. Massachusetts' state Medicaid agency will contact duals who qualify for the demonstration to provide information about ICOs, enrollment procedures, and the right to opt out. Duals will then notify the state of their selection of an ICO or their preference to opt out. The state Medicaid agency will confirm the member's ICO selection before coverage begins.

If duals in the demonstration's target population do not either select an ICO or indicate that they wish to remain in FFS within a prescribed timeframe, they will be assigned to an ICO, from which they may disenroll at any time. Medicare Advantage members will not be auto-enrolled in ICOs. Not all eligible duals will be auto-enrolled in ICOs at the same time to allow for time for initial assessments during the transition to ICOs.

Massachusetts wishes to enroll as many eligible members as early as possible in the demonstration because it maintains that an adequate number of enrollees are needed to attract enough ICOs to provide sufficient member choice and evaluation of the demonstration. Massachusetts will work with CMS to develop marketing protocols to promote participation in the demonstration. Outreach and marketing will incorporate appropriate auxiliary aids and services to

ensure effective communication with people with disabilities. Massachusetts plans to conduct outreach through a variety of media, such as community forums, direct mailings, print and visual media, and advocate and provider forums, and notes that beneficiaries must be protected from deceptive practices and misinformation. Massachusetts will require ICOs to develop a comprehensive marketing plan that is submitted to the Commonwealth and CMS for initial approval and at least annually thereafter. ICO contracts will prohibit direct marketing and distributing material that is not preapproved by CMS and the state or that is inaccurate, false, misleading, confusing or fraudulent.

Proposed Integrated Benefits Package:

Summary: The demonstration will replace the distinction between Medicare and Medicaid with a single expanded benefits package. Based on enrollee assessments, PCMHs will offer primary care and behavioral health treatment or other supports and assist with referrals for specialty and/or community-based services and coordination across providers and settings. ICOs will be required to include certain services in their benefit plans and will have flexibility to use a range of other services to substitute for or avoid high cost traditional services. In response to stakeholder feedback, certain LTSS for HCBS waiver participants and certain other services for vulnerable populations will be excluded from the ICO benefits package. Also in response to stakeholder feedback, ICOs must provide self-direction as an option for personal care attendant (PCA) services, so that an enrollee can employ her personal care attendant and be responsible for hiring, training, scheduling and firing workers. The ICO Care Coordinator and independent LTSS Coordinator will conduct an initial assessment of each enrollee's needs for medical, behavioral health, and ongoing LTSS, which will be the starting point for creating an individualized care plan. After the initial assessment, the PCMH care team, including the enrollee, Care Coordinator, and LTSS Coordinator, will establish an individualized care plan. ICOs must have internal capacity or contracts to ensure the availability of all services in the member's care plan, including specialists, hospitals, LTSS, home care and other community supports, and must include community-based long-term care service providers in their networks. ICOs will determine utilization management tools, including any prior authorization requirements, for all services provided by its network and procedures for determining medical necessity according to a plan approved by the Commonwealth and CMS.

The demonstration will replace the distinction between Medicare and Medicaid with a single expanded benefits package. Covered benefits will include all Medicare parts A, B, and D benefits and all current Medicaid state plan benefits, except certain LTSS for waiver participants described below, as well as additional behavioral health diversionary services and additional community support services not currently available through Medicare and Medicaid. The expanded ICO benefits package will offer additional services identified by stakeholders, including preventative, restorative and emergency oral health care; personal care assistance including cueing and monitoring; durable medical equipment included training in equipment usage, repairs, and modifications; environmental aids and assistive/adaptive technology; vision services, including examination, treatment and glasses (through ICO-contracted providers); and non-medical transportation. Additional behavioral health diversionary services to be offered include community crisis stabilization, community based acute treatment services for substance use disorders, community support services, partial hospitalization, structured outpatient addiction programs, community based psychiatric treatment, and intensive outpatient programs.

Based on enrollee assessments, PCMHs will offer primary care and behavioral health treatment or other supports and assist with referrals for specialty and/or community-based services and coordination across providers and settings. The PCMH must provide primary care services and at minimum, routine screening for depression and other behavioral health conditions for enrollees without a behavioral health diagnosis; provide evidence-based treatment and support for enrollees with behavioral health conditions that can be managed without a higher level of care, with the goal of preventing unnecessary hospitalizations and institutionalization; and arrange for behavioral health specialists and treatment plans for people who need higher levels of care. Primary care services include initial and ongoing assessments to identify the member's conditions and service needs including medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services when necessary. Assessments includes physical status and behavioral health screenings, documentation of clinical history including medication, strengths, preferences or limitations, functional status, ADLs and IADLs, goals and life planning activities, cultural and linguistic need, existing formal supports, and informal caregiver resources.

ICOs will be required to include certain services in their benefit plans and will have flexibility to use a range of other services to substitute for or avoid high cost traditional services. For example, Massachusetts proposes that ICOs provide certain community support services in addition to those already covered under the Medicaid state plan as alternatives to costly acute and institutional long-term care services, some of which may be provided by non-clinical community health workers. Expanded community support services include day services, home care services, respite care, peer support, transitional assistance across care settings, home modifications, health coaching, and medication management. Community Health Workers, at ICO option, will support PCMHs and the implementation of care plans by providing wellness coaching for smoking cessation, exercise, diet, screening, and prevention activities; evidence-based practices and techniques for chronic disease self-management; peer support for mental health and substance use disorder recovery activities and other disabling conditions; housing supports for newly housed persons who have experienced chronic homelessness; and other clinically, functionally and cost effective interventions.

In response to stakeholder feedback, certain LTSS for HCBS waiver participants will be excluded from the ICO benefits package. Massachusetts will adjust the ICO capitation rate and offer a different benefit tier so that HCBS waiver participants with developmental disabilities, traumatic brain injuries, and frail elders ages 61 to 64 can access PCMHs and all other ICO services except the LTSS that are currently managed by HCBS waiver case managers. The excluded services are adult day health, adult foster care, day habilitation, group adult foster care, personal care, and HCBS waiver services. In the future, ICOs may take increased responsibility for these services. Other LTSS (chronic disease and rehabilitation inpatient hospital, durable medical equipment and supplies, home health, hospice, medically necessary non-emergent transportation, independent nursing, skilled nursing facility, and therapy services) will be included in the ICO global payment and benefits package.

Certain other services for vulnerable populations also will be excluded from the ICO benefits package, in response to stakeholder feedback. Targeted Case Management services from the Department of Developmental Disabilities or Department of Mental Health and rehabilitation option

services from the Department of Mental Health will not be part of the ICO benefits package and will continue to be provided by the responsible state agencies. In addition, ICF/MR services and their institutional residents will not be part of the demonstration.

In response to stakeholder feedback, ICOs must provide self-direction as an option for personal care attendant (PCA) services, so that an enrollee can employ her personal care attendant and be responsible for hiring, training, scheduling and firing workers. The ICO will authorize all PCA services, and the LTSS Coordinator will facilitate service authorizations and connect enrollees to a personal care management agency and fiscal intermediary. ICOs also will make agency-provided PCA services available for members who do not wish to self-direct their care.

The ICO Care Coordinator and independent LTSS Coordinator will conduct an initial assessment of each enrollee's needs for medical, behavioral health, and ongoing LTSS, which will be the starting point for creating an individualized care plan. The assessment will use a state agency approved tool, and Massachusetts will work with stakeholders to identify appropriate tools. The assessment will be performed in a location that meets the enrollee's needs, including in her home when necessary and feasible. The assessment will encompass social, functional, medical, behavioral, wellness and prevention, the enrollee's strengths and goals, the need for specialists, and the plan for care management and coordination. The LTSS assessment will include the enrollee's need for LTSS, the appropriate amount, duration and scope of services, and as necessary, an appropriate plan for transition to a different level of service or to alternative services.

After the initial assessment, the PCMH care team, including the enrollee, Care Coordinator, and LTSS Coordinator, will establish an individualized care plan. The care plan typically will include a summary of health history, including any current diagnoses and interventions, both medical and non-medical; a prioritized list of main concerns and goals with current pertinent clinical, educational or social information; the current plan for addressing the goals and concerns; the person responsible for the intervention; and the due date. The care plan will include regularly scheduled appointments with the care team to ensure planned encounters rather than reactive episodic care.

ICOs must have internal capacity or contracts to ensure the availability of all services in the member's care plan, including specialists, hospitals, LTSS, home care and other community supports, and must include community-based long-term care service providers in their networks. ICOs must ensure access to behavioral health providers including diversionary services and community-based resources to which enrollees can be referred or with whom PCMHs can consult; these providers must participate in the care team.

ICOs will determine utilization management tools, including any prior authorization requirements, for all services provided by its network and procedures for determining medical necessity according to a plan approved by the Commonwealth and CMS. The standards used by the ICO must be written and approved by CMS and the Commonwealth to ensure that the Medicare and Medicaid benefits to which enrollees are entitled are delivered. Care decisions will be made by the PCMH care team. PCMHs must apply well-established national and state-specific evidence-based clinical

practice guidelines relevant to populations with chronic conditions (to be determined), while recognizing that enrollees with complex needs may require flexibility in treatment approaches. ICOs must have written, accessible internal policies regarding grievances and appeals of denials, termination, reductions or suspensions of covered services.

Financing:

Summary: ICOs would receive an actuarially developed, risk-adjusted, global payment with one portion of the rate coming from Medicare and one from the Commonwealth for all covered Medicare, Medicaid and expanded services. After receiving the global payment, ICOs in turn will make enhanced per member payments, through capitated or alternative methods, to their network PCMHs. In response to stakeholder feedback, Massachusetts outlined the basic steps in establishing ICO payments, beginning with establishing rating categories. Second, base global rates for each rating category would be developed, based on historical Medicare and Medicaid data, for each contract year. Next, the base global rates for each rating category would be risk adjusted to account for the differential risk of enrollees across ICOs. Fourth, additional risk mitigation strategies to address potential underpayments or overpayments to ICOs while the program is in early stages would be determined. Fifth, savings expectations associated with coordinated care and alternative service options would be determined, along with how to reflect anticipated savings in global payments. Finally, incentive methodologies tied to defined outcome measures would be established.

ICOs would receive an actuarially developed, risk-adjusted, global payment with one portion of the rate coming from Medicare and one from the Commonwealth for all covered Medicare, Medicaid and expanded services. Both Medicare and Medicaid will contribute to the total base capitation rate, but the contributions will not be directly aligned with payment for particular services – that is, Medicare will not pay solely for Medicare services, and Medicaid will not pay solely for Medicaid services. Massachusetts plans to use the capitated financial alignment model outlined in CMS's July 8, 2011 State Medicaid Director Letter in which the Commonwealth and CMS will use combined Medicaid and Medicare funds to provide a blended capitated payment to ICOs, and share in savings, as compared to the lower of the expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area.[10] However, certain aspects of Massachusetts' proposal deviate from the capitated financial alignment model guidance issued by CMS: Massachusetts states that it will seek "significant flexibility" to achieve administrative integration, clear accountability and shared financial contributions to the prospective blended global payments.

After receiving the global payment, ICOs in turn will make enhanced per member payments, through capitated or alternative methods, to their network PCMHs. The enhanced payments will support the investments that practices need to operate as PCMHs. Massachusetts will encourage ICOs to explore alternative payment methods for services beyond those provided by the PCMHs, such as

[10] Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees (July 8, 2011), available at http://www.cms.gov/smdr/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

hospitals, specialists, and LTSS and community supports providers, and is interested in ICO bidder proposals that describe innovative value-based purchasing strategies.

In response to stakeholder feedback, Massachusetts outlined the basic steps in establishing ICO payments, beginning with establishing rating categories. First, the demonstration population would be stratified into subgroups based on cost, utilization and some measure or proxy of functional status, so that higher rates are paid for higher need members.

Second, base global rates for each rating category would be developed, based on historical Medicare and Medicaid data, for each contract year. Massachusetts proposes that base capitation rates be developed through linked Medicare and Medicaid claims data for CY 2009 and 2010, with the historical Medicare payment and "reasonable" administrative costs applied to the blended payment rate as the starting point for each rate category. Rate setting data for the expanded services will come from Medicaid claims, behavioral health diversionary service use by the non-dual Medicaid population in the targeted age group, and review of certain LTSS and community support services in HCBS waivers. Over time, the base global rates would be based on ICO encounter data.

Next, the base global rates for each rating category would be risk adjusted to account for the differential risk of enrollees across ICOs. Risk adjustment scores should account for behavioral health, LTSS, and community support service needs and functional status as those data become available. Massachusetts and CMS will jointly select the software and methodology and seek substantive input on the risk adjustment methodology.

Fourth, additional risk mitigation strategies to address potential underpayments or overpayments to ICOs while the program is in early stages would be determined. These include risk corridors in which Massachusetts and CMS would share some defined level of profits or losses with the ICOs, and stop loss, a premium based mechanism in which the amount any one enrollee can cost an ICO is capped at a certain level. Risk corridors could be tiered or designed to diminish over the three year demonstration.

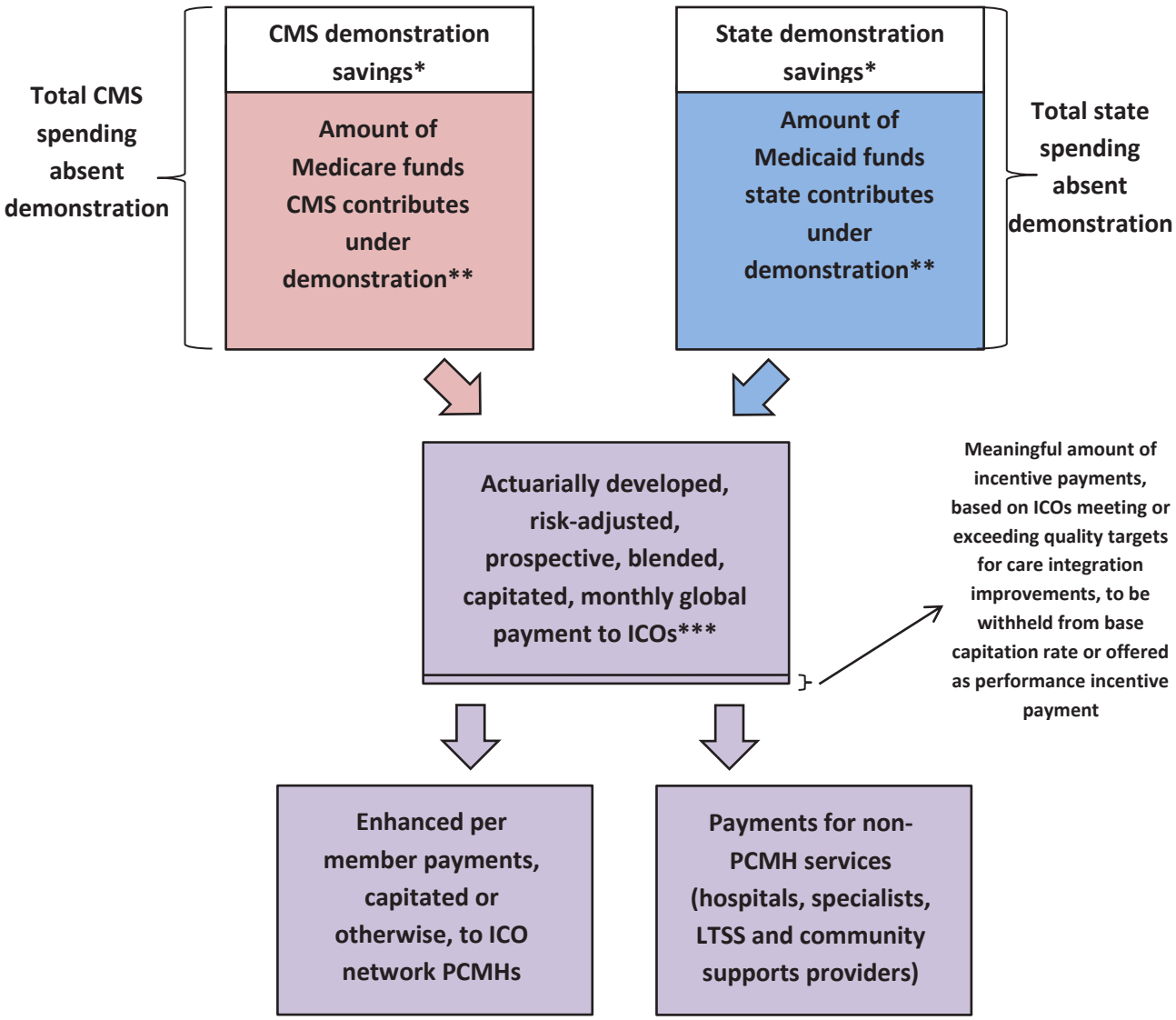
Fifth, savings expectations associated with coordinated care and alternative service options would be determined, along with how to reflect anticipated savings in global payments. Massachusetts expects the demonstration to yield short term savings due to reduced acute care admissions, readmissions, emergency room use, and pharmacy services and anticipates that the inclusion of behavioral health diversionary services will offset inpatient behavioral health services. Savings are expected to grow over time as ICOs influence utilization patterns by helping enrollees to stay well, manage chronic conditions, gain better access to coordinated behavioral health services and remain in the community settings longer.

Finally, incentive methodologies tied to defined outcome measures would be established. Massachusetts proposes that ICOs should share in the demonstration savings as they assume increased risk for care delivery and risk corridors are phased out. Shared savings would be linked to clear quality metrics to insure that savings result from care improvements and not from limits on enrollee access to services. Massachusetts proposes that a "meaningful" amount of these payments either be withheld

from the base capitation rate or offered as a performance incentive payment, which would be based on ICOs meeting or exceeding quality targets for care integration improvements.

The proposed financing arrangements for Massachusetts' demonstration are illustrated in Figure 2.

Figure 2:
Massachusetts' Proposed Financing Arrangements for Duals Integration Demonstration



*Proportions depicting demonstration savings are not to scale. It is unclear whether CMS's savings will include only the Medicare program or also the federal portion of Medicaid spending.

** CMS and Massachusetts' contributions to the ICO base capitation rate will not be directly aligned with payment for particular services – Medicare will not pay solely for Medicare services, and Medicaid will not pay solely for Medicaid services. CMS and state to share savings, as compared to lower of expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area.

***Financing methodology would include rating categories for base capitation rates and also use supplemental risk adjustment methodology to account for variation across ICOs to account for highest cost, highest need enrollees. Massachusetts also will explore with CMS the use of risk corridors and stop loss provisions to protect ICOs from under or overpayments due to cost variations among subpopulations. Risk corridors could be capped or diminish over the 3 year demonstration. ICOs would share in demonstration savings as they assume increased risk for care delivery.

Beneficiary Protections:

Summary: ICOs must have provider networks that can deliver, either directly or through subcontracts, all covered services, including community-based LTSS, to their anticipated enrollees. Massachusetts will work with CMS and stakeholders to define specific criteria for determining adequate provider access, which will be incorporated into ICO contracts. ICOs must have a clear continuity of care process that allows qualified and willing providers who already serve eligible members wishing to maintain that relationship to join the ICO provider network. Massachusetts also is considering requiring ICOs in certain circumstances to offer single case out-of-network arrangements to providers who currently serve members and are willing to do so at the ICO network payment rate but who are not willing to accept new patients. In response to stakeholder feedback, Massachusetts revised its proposal to provide that enrollees in the demonstration will maintain any Medicaid state plan community-based LTSS that they receive at the time of enrollment for 90 days, or until the ICO completes an initial assessment of service needs, whichever is longer; strengthened provisions requiring ICOs and their providers to comply with the Americans with Disabilities Act (ADA) and assure capacity to deliver services in a manner that accommodates enrollees' special needs, including physical access to buildings, services and equipment and flexibility in scheduling and processes; and provided additional detail about its proposed unified internal and external complaints, grievance and appeals process, which will be set out in its contracts with ICOs and agreement with CMS. ICOs must provide an internal appeals process. Enrollees also will have access to a single external appeals process, which Massachusetts proposes to be administered by the MassHealth Board of Hearings. The role of an ombudsman is still undefined in Massachusetts' proposal.

Provider Network Adequacy: **ICOs must have provider networks that can deliver, either directly or through subcontracts, all covered services, including community-based LTSS, to their anticipated enrollees.** ICO networks must include providers that will accept new patients and that can adequately address the language and cultural diversity of the local community. ICOs must ensure that enrollees have a choice of primary care providers and access to a broad array of specialists including behavioral health, with experience serving a population with diverse disabilities. PCMHs must ensure that their workforce is culturally competent and has training to work with and address the needs of a diverse population. Enrollees must be able to access the PCMH care team through face to face visits and alternatives such as email and phone.

Massachusetts will work with CMS and stakeholders to define specific criteria for determining adequate provider access, which will be incorporated into ICO contracts. ICOs must meet the federal Medicaid managed care provider access standards, which require adequate access to all ICO covered services, taking into consideration anticipated enrollment, geographic location, distance, travel time, and means of transportation, and physical accessibility. ICOs will regularly report on their adherence to the criteria. ICOs will be responsible for credentialing providers, establishing and tracking quality improvement goals, and conducting site visits and medical record reviews.

Continuity of Care: **ICOs must have a clear continuity of care process that allows qualified and willing providers who already serve eligible members wishing to maintain that relationship to join the**

ICO provider network. ICOs will be required to reach out to providers who have existing relationships with eligible members and who have demonstrated expertise in serving people with disabilities and complex medical needs and must continually enroll interested providers that meet network requirements.

Massachusetts also is considering under certain circumstances requiring ICOs to offer single case out-of-network arrangements to providers who currently serve members and are willing to do so at the ICO network payment rate but who are not willing to accept new patients. Massachusetts wishes to balance continuity of care with the enhanced care coordination and information sharing available within the ICO provider network.

In response to stakeholder feedback, Massachusetts revised its proposal to provide that enrollees in the demonstration will maintain any Medicaid state plan community-based LTSS that they receive at the time of enrollment for 90 days, or until the ICO completes an initial assessment of service needs, whichever is longer. There will be no service plan reductions during this period, and the ICO will pay the enrollee's LTSS providers for the same amount, duration and scope of services and at the same rate they received prior to the demonstration, precluding any significant change in the enrollee's condition or situation that would warrant additional community or facility based services such as a medical crisis.

Accessibility, Disability Accommodations, and Enrollee Communications: **In response to stakeholder feedback, Massachusetts strengthened provisions requiring ICOs and their providers to comply with the Americans with Disabilities Act (ADA) and assure capacity to deliver services in a manner that accommodates enrollees' special needs, including physical access to buildings, services and equipment and flexibility in scheduling and processes.** ICOs and their providers must communicate with enrollees in a manner that accommodates individual needs, including providing interpreters for people who are deaf and hard of hearing and people who do not speak English. ICOs must operate an enrollee customer service department with a toll-free number at least nine hours during the business day Monday to Friday, provide free oral interpretation services in all non-English languages spoken by enrollees including ASL, maintain TTY or comparable services, provide alternative format written materials, assist enrollees with cognitive impairments, provide reasonable accommodations to ensure effective communication, and use employment standards and defined performance objectives in these areas. ICOs must ensure that their employees upon request make available to enrollees and potential enrollees the identity, location, qualifications, and availability of providers and information about enrollee rights and responsibilities, appeal procedures, how to access interpretation and alternative written formats, all ICO covered services and other available state agency services either directly or through referral or authorization, and procedures for changing ICOs or opting out of the demonstration. Massachusetts also will implement beneficiary protections to ensure privacy of records.

Grievances and Appeals: **In response to stakeholder feedback, Massachusetts provided additional detail about its proposed unified internal and external complaints, grievance and appeals process, which will be set out in its contracts with ICOs and agreement with CMS.** Massachusetts and

CMS will develop a single set of requirements for ICO internal complaints, grievances and appeals that incorporate "all relevant" Medicare Advantage and Medicaid managed care requirements. ICOs must have written accessible internal policies regarding grievances and appeals of denials, terminations, reductions or suspensions of covered services and must maintain written policies and procedures for the receipt, type and nature, and timely resolution of complaints and appeals. All internal ICO processes are subject to CMS and Commonwealth review and prior approval.

ICOs must provide an internal appeals process. This includes written notice of any adverse action they take denying, modifying or terminating a requested service, including advance notice of adverse actions related to denying or modifying ICO-approved services or requests for reauthorizations of services. ICOs also must provide written decisions on internal appeals and notice of the enrollee's right to an external appeal.

Enrollees also will have access to a single external appeals process, which Massachusetts proposes to be administered by the MassHealth Board of Hearings. Continued benefits pending appeal resolution at the Board of Hearings would be provided at the enrollee's request for any adverse action related to terminating or modifying ICO-approved services or requests for reauthorization of services. Expedited internal and external appeals would be provided if needed. Massachusetts' budget request for the demonstration includes a hearing officer to add capacity at the Board of Hearings for processing appeals related to the demonstration.

The role of an ombudsman is still undefined in Massachusetts' proposal. Massachusetts will continue discussions with stakeholders and CMS about how to best provide an ombudsman that does not stand to benefit from changes in service utilization to support enrollees and ensure they are receiving the appropriate level of care and resolve enrollee concerns about treatment, service access and navigation of grievances and appeals.

Demonstration Monitoring and Evaluation:

Summary: Massachusetts will monitor member and provider experiences in the demonstration through surveys, member focus groups, interviews, and claims and encounter data analysis, with measures taken at baseline and various times after implementation, some rapid cycle and some over the longer term. ICOs will be required to meet "clear achievable" quality thresholds to deliver high quality services that enhance care coordination and improve health outcomes.

Massachusetts will monitor member and provider experiences in the demonstration through surveys, member focus groups, interviews, and claims and encounter data analysis, with measures taken at baseline and various times after implementation, some rapid cycle and some over the longer term. Massachusetts expects to test the following hypotheses with its demonstration:

1. Integrated care improves quality by reducing over-utilization of high-cost hospital and long-term institutional care and under-utilization of outpatient and community-based services and supports; improving chronic disease management; reducing health disparities;

improving patient satisfaction; increasing use of evidence-based practices; and improving provider accessibility for people with disabilities.

2. Integrated care improves outcomes through gains in health status and functional status and lessening or diverting long-term care facility stays.

3. Integrated care reduces costs compared to historical FFS spending for the demonstration population. Costs also will be compared to those for duals 65 and over and for Medicaid only members ages 21 to 64 with disabilities in MassHealth managed care.

ICOs will be required to meet "clear achievable" quality thresholds to deliver high quality services that enhance care coordination and improve health outcomes. Requirements for expected outcomes will be addressed in the RFP and incorporated into ICO contracts. Massachusetts proposes to assess ICOs in at least eight domains, to be further defined by key concepts and specific metrics for each domain. The eight domains are access, person-centered care, health and safety, comprehensive care coordination, integration of services, administrative simplicity, cost savings, and enrollee outcomes. The final selection of specific quality and cost measures will be based on a review of national and state frameworks relevant to the target population and informed by the stakeholder process; the measures included in the draft proposal are only illustrative. The process will include the development and incorporation of quality measures specific to use of community-based LTSS to address functional capabilities and limitations and related outcomes. In addition, PCMHs must achieve NCQA PCC-PCMH recognition at the Level 1 Plus standard or higher within the 3 year demonstration.

Stakeholder Engagement:

Summary: Massachusetts will continue to hold public stakeholder meetings to share information about the implementation and operation of the demonstration, and its budget request for the demonstration envisions bi-monthly stakeholder meetings during implementation. ICO contracts will require "meaningful" consumer input processes in ongoing operations, including but not limited to governing or advisory boards that include "sufficient" numbers of enrollees and representatives.

Massachusetts will continue to hold public stakeholder meetings to share information about the implementation and operation of the demonstration, and its budget request for the demonstration envisions bi-monthly stakeholder meetings during implementation. Eleven stakeholder meetings were held between March, 2010 and February, 2012. Massachusetts issued a Request for Information in March, 2011. Four member focus groups were held in June, 2011. Eight state agency and external consumer group outreach sessions were held from June to October, 2011. Massachusetts maintains a website, www.mass.gov/masshealth/duals, and dedicated email box for the demonstration. Prior to submission to CMS, Massachusetts' proposal was posted for the required 30 day public comment period. Text Box 1 summarizes key revisions to Massachusetts' proposal in response to stakeholder feedback prior to submission of the proposal to CMS.

Text Box 1:
Key Revisions to Massachusetts' Proposal Based on Stakeholder Feedback

- ICOs must provide independent LTSS Coordinators.
- Certain LTSS for HCBS waiver participants and certain other services for vulnerable populations are excluded from the ICO benefits package.
- ICOs must provide self-direction as an option for personal care attendant services.
- Demonstration enrollees must maintain any state plan community-based LTSS that they receive at the time of enrollment for 90 days, or until the ICO completes an initial assessment of service needs, whichever is longer.
- Provisions requiring ICOs and PCMHs to comply with the Americans with Disabilities Act are strengthened.
- Additional detail about the proposed unified internal and external grievance and appeals process provided.
- Basic steps in establishing ICO payments outlined.

ICO contracts will require "meaningful" consumer input processes in ongoing operations, including but not limited to governing or advisory boards that include "sufficient" numbers of enrollees and representatives. PCMH care teams will "regularly" solicit enrollee feedback. Massachusetts will work with stakeholders to form an advisory group to monitor the demonstration implementation and operation.

Implementation Timeframe: **If approved by CMS, Massachusetts anticipates issuing an RFP for ICOs by April 13, 2012, selecting ICOs by July 30, 2012, and executing ICO contracts by September 30, 2012.** ICOs would have four months for contract readiness activities. Enrollment packages would begin to be distributed to the target population in October, 2012, with enrollment effective in January, 2013. The program would be phased in and eventually be statewide. Massachusetts proposes using § 1915(c) waiver authority to provide services under the demonstration and will work with CMS to identify additional waivers needed for particular services as well as for the operational and financial aspects of the demonstration. Massachusetts expects that the demonstration, while focused on duals ages 21 to 64, will yield information applicable to older duals and other Medicaid beneficiaries and expects over time to make the ICO demonstration model available to Medicaid-only beneficiaries with disabilities under age 65. Figure 3 illustrates key dates in the implementation timeframe if CMS approves Massachusetts' proposal, and Figure 4 illustrates the main decision points for duals affected by the demonstration.

Figure 3:
Proposed Timeline if CMS Approves Massachusetts Proposal

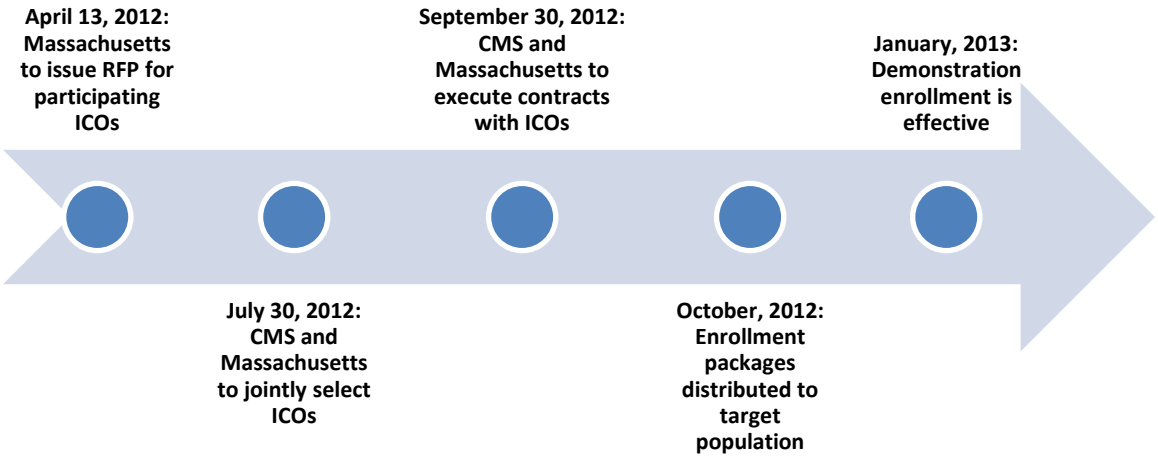
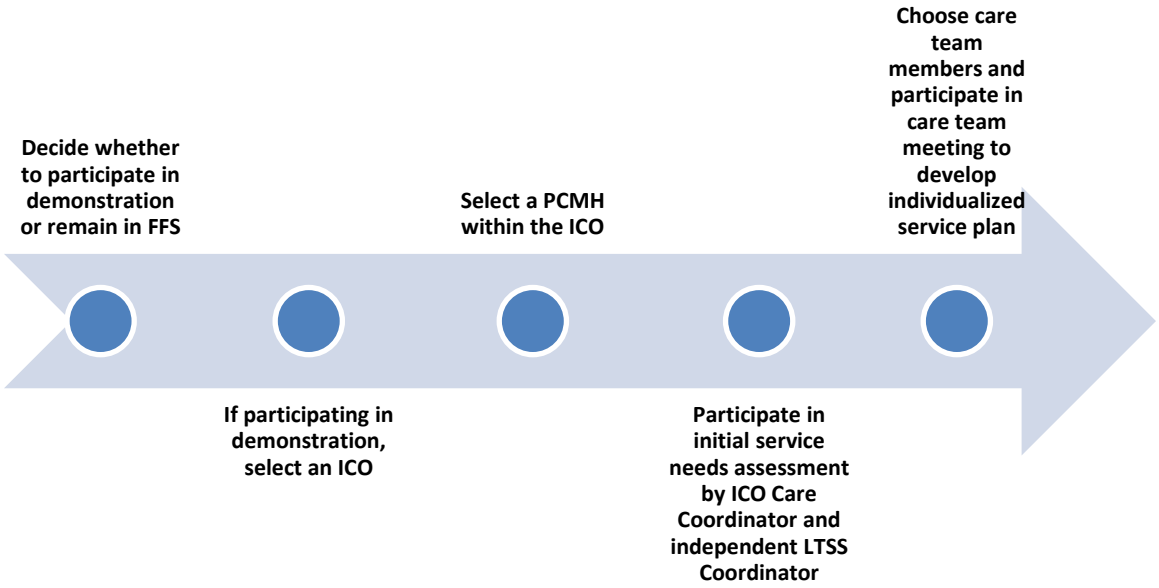


Figure 4:
Key Decision Points for Duals Affected by Massachusetts' Proposal



Looking Ahead

CMS is presently evaluating whether Massachusetts' proposal meets its standards and conditions and will move forward into the implementation phase. As part of that review, CMS accepted public comments on Massachusetts' proposal through March 19, 2012.

A number of key questions arise from Massachusetts' proposal, including:

ICO Formation and Contracting Process: What are the various organizational and financial arrangements that ICOs will use within the general parameters of the demonstration? To what extent will the specific standards that ICOs must meet to participate in the demonstration vary from existing Medicare Advantage and Medicaid managed care requirements?

Enrollment: How will the enrollment and disenrollment processes function? How much time will beneficiaries have to make initial enrollment decisions? How will beneficiaries be adequately informed about the demonstration so as to avoid being auto-enrolled in an ICO not of their choice? How will the demonstration be phased-in to avoid disruptions in care?

Benefits: Will the demonstration result in increased HCBS access? How will the expanded benefits package offered by ICOs affect quality and cost? What standard will be used by ICOs to determine medical necessity? How will care decisions be made by the PCMH care team? How will enrollees obtain information about all available care options? How will enrollees appeal care team decisions with which they disagree? How will the role of the independent LTSS Coordinator and community health workers affect the demonstration?

Financing: Will Massachusetts be permitted to deviate from the parameters of the capitated financial alignment model as proposed by CMS? How will the Medicare and Medicaid portions of the blended capitated rate be calculated and risk-adjusted for variations across the population? How will Medicare and Medicaid payments be adjusted annually? What amount of savings will be realized by the demonstration over the short and long term, where will the savings come from, and how will the savings be shared among CMS, Massachusetts, ICOs, and providers?

Beneficiary Protections: Will demonstration enrollees be able to maintain continuity of care with current providers? Will enrollees have access to an adequate provider network to meet their complex needs? What standards will be used to measure adequate access? How will the internal and external appeals processes be administered and monitored? Will there be an independent ombudsman to resolve enrollee concerns? How will stakeholders continue to be engaged throughout the design and implementation process?

Quality Evaluation and Oversight: What specific quality thresholds and outcomes must ICOs meet? How will ICOs be held accountable? How will the demonstration be evaluated and by whom?

Since Massachusetts issued its proposal, many of the other 14 states that received design contracts, as well as some additional states that submitted letters of intent to test CMS's proposed financial alignment models, also issued their proposed plans to integrate care for dual eligibles, and

more are expected. The questions above and others will remain relevant as members of the public, stakeholders, and CMS evaluate the states' proposals, and CMS determines which proposals will be implemented.

This policy brief was prepared by MaryBeth Musumeci of the
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